MARYLAND HEALTH CARE COMMISSION

Certificate of Need Application
Seasons Residential Treatment Program, LLC
Prince George's County

TABLE OF CONTENTS

LIST OF EXHIBITS

LIST OF CHARTS AND TABLES

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

OTHER THAN HOSPITAL AND COMPREHENSIVE/ EXTENDED CARE SERVICES APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1a. Seasons Residential Treatment Program, LLC
Legal Name of Project Applicant
(i.e., Licensee or Proposed Licensee)

b. 1101 30th Street, NW, 4th Floor
Street

c. Washington, DC 20007
City Zip County

d. 202 295-1280
Telephone No.

e. Tyeaesis Johnson, CEO
Name of Owner/Chief Executive

2.a. N/A
Legal Name of Project Co-Applicant
(ie. if more than one applicant)

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

e. _____
Name of Owner/Chief Executive

3.a. Seasons Residential Treatment Program
Name Of Facility

b. Allentown Road (Tax Parcel Number 09-23334)
Street (Project Site)

c. Fort Washington, MD 20744-0000
Street (Project Site)

4. Strategic Behavioral Health
Name of Owner (if different than applicant)

5.a. N/A
Representative of
Co-Applicant

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

6. Person(s) to whom questions regarding this application should be directed: (Attach sheets if additional persons are to be contacted)

a.	Tyeaesis Johnson, CEO Name and Title	a. _____ Name and Title
b.	1101 30th Street, NW, 4th Floor Street	b. _____ Street
c.	Washington, DC, 20007 City Zip County	c. _____ City Zip County
d.	202 295-1280 Telephone No.	d. _____ Telephone No.
e.	202 452-8555 Fax No.	e. _____ Fax No.

7. Brief Project Description (for identification only; see also item #14):
This section has been revised and is consistent with response in Completeness Letter

Seasons Residential Treatment Program, LLC, is a (proposed) 72-bed **Residential Treatment Center (RTC)** and will meet all regulatory and licensure standards required by the State of Maryland and the Department of Health and Mental Hygiene (DHMH) to deliver intensive inpatient psychiatric services to male and female youth between the ages of 13 and 21 years old.

If approved by the state-licensing agency, the program will seek immediate federal certification from the Center for Medicare and Medicaid (CMS) to operate as a **Psychiatric Residential Treatment Facility (PRTF).** The project is designed to deliver a rigorous clinical program and allow admission for more challenging behaviors and mental health presentation in accordance with federal **PRTF** standards, from the first day of operation.

The adolescents and young adults we plan to serve will generally require treatment for more severe and chronic behavior disorders, emotional challenges and trauma-related mental illness. The youth in our care will likely have a history of: fire setting/arson, assaultive and aggressive behaviors, substance abuse, emotional disturbance and will likely present with dual diagnoses as defined by the DSM-IV.

The youth we plan to serve will benefit from a more rigorous clinical program, are among the toughest to place in traditional residential programs and have a high rate of recidivism. Seasons Residential is designed to treat the most refractory residents with a history of multiple "out of home" placements. Our model delivers clinically sound, culturally competent, evidenced-based treatments and multi-disciplinary assessments designed to meet the immediate and long-term needs of our residents.

The program is divided in to a continuum of care that includes two (2) treatment tracks: an assessment unit and a residential program. The diagnostic and assessment inpatient unit is

designed to work closely with youth, referral agencies, and parents to help make informed decisions about next level of care placement. The average length of stay for this unit is approximately ***30 days.*** The average length of stay for the residential program is ***6 months.*** Both programs will be staffed with a multi-disciplinary team to include: staff psychiatrist, pediatrician, therapists, social workers and a behavioral support team. .

An integral part of successful reintegration for youth who meet this level of care includes active participation in an education program. Our youth will likely have significant gaps in their academic record and come to us with individualized education plans (IEP's) and special education needs. Our academic program will include day and residential students and will meet all the requirements outlined by the State of Maryland Department of Education for a *Type 1, Special Education School.*

We will employ experienced special and general education teachers, interactive technology and creative learning tools to overcome issues of credit recovery, remedial needs and grade-level placement. Seasons Residential Treatment Program will also provide vocational, career technical, life skills and independent living programming for residents 18-21 and youth who have earned their high school or general education diploma (GED).

As part of our commitment to excellence, we will continue our partnership with the University of North Carolina-Wilmington to track and report youth progress in the local program three (3) years post-discharge and will eventually seek partnerships with the University of Maryland to determine how to best synthesize the information we collect for state agency use. These data will be made available to all stakeholders, including federal and state agencies, parents and community based providers.

We plan to build a 55,000 square foot building on the 16.01-acre site located on Allentown Road in Fort Washington, Maryland and Prince George's County (identified by Tax Parcel Number: 09-23334). The site is currently void of any building structure and the topography is on excellent condition for intended use. The new construction will adhere to all local and state licensing and occupancy standards and meets all local zoning requirements for the intended use. The program will maximize the latest technology and best practices in all therapeutic, residential and academic areas of the new building.

The new construction will also meet the physical plant standards necessary to certify as a Psychiatric Residential Treatment Facility. The nature and intensity of services for a PRTF are outlined later in this application and are defined in **43 C.F.R. 483.352.**

Seasons Residential Treatment Program is a Maryland corporation in good standing, as of the date of this filing, and was organized in 2012.

8. Legal Structure of Licensee (check one from each column):

a.	b.	c.
Governmental __	Sole Proprietorship __	To be Formed __
Proprietary __	Partnership __	Existing __
Nonprofit __	**Corporation X**	
	Subchapter "S" __	

9. Project Services (check below, if applicable):

Service	Included in Project
ICF-MR	
ICF-C/D	
Home Health Agency	
Residential Treatment Center	
Ambulatory Surgery	
Other (Specify) Certified **PRTF***	YES

*The proposed program will be licensed as a Residential Treatment Center (RTC), however, we are petitioning the Commission to differentiate the program and Need standard based on the *level and intensity* of services we wish to provide. The program is designed to support an intensive service model and will seek post-license certification for a Psychiatric Residential Treatment Facility (PRTF), as outlined in **42 C.F.R. 483.352** and described in greater detail in this application.

10. Current Capacity and Proposed Changes:

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	___/___		
ICF-C/D	Beds	___/___		
Residential Treatment	Beds	___/___		
Ambulatory Surgery	Operating Rooms			
	Procedure Rooms			
Home Health Agency	Counties	___/___		
Hospice Program	Counties	___/___		
Other (Specify) **PRTF**	Beds			72
TOTAL				72

11. Project Location and Site Control:
This section has been revised and is consistent with response in Completeness Letter

A. Site Size 16.01 acres

B. Have all necessary State and Local land use approvals, including zoning, for the project as proposed been obtained? YES ___NO _X_ (If NO, describe below the current status and timetable for receiving necessary approvals.)**
See Attached: **Exhibit 1.**

**Site is currently zoned RA, which allows for our intended use. Estimated date to obtain all necessary State and Local land use approvals is 9/6/2016 is based on the following timetable:

- Site will require a water and sewer category change we plan to submit for water and sewer category change on 8/1/15 and approval date of 11/30/15.
- Site will require subdivision approval once water and sewer category change has occurred. Estimated subdivision process start date is 12/1/15 and subdivision approval date of 140 days after submission.
- Final resolution and approval of subdivision process is 21 days after approval
- Appeal process for any interested party: 30 days after final resolution and approval
- Recording of plat: 90 days after appeal process period has expired

C. Site Control:

(1) Title held by: Roman Catholic Archdiocese of Washington, D.C.
See Exhibit 2

(2) Options to purchase held by: Seasons Residential Treatment Program, LLC

(i) Expiration Date of Option: 13 months after date agreement was executed: 5/17/16.

(ii) Is Option Renewable? ___Y___ If yes, Please explain:
A: Agreement is written in such a way buyer can extend due diligence/ feasibility period for as long as needed to obtain Certificate of Need and agency state approvals.

(iii) Cost of Option:
A: Buyer has agreed to pay the ongoing property tax and maintenance of the parcel. Property tax and maintenance to be paid out of escrow funded by buyer and shall not exceed $7,000 per year.

(3) Land Lease held by: N/A

(i) Expiration Date of Lease _____

(ii) Is Lease Renewable _____ If yes, please explain

_____

_____

(iii) Cost of Lease _____

(4) Option to lease held by: N/A

(i) Expiration date of Option _____

(ii) Is Option Renewable?_____ If yes, please explain

_____

_____

(iii) Cost of Option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained: _____NA_____

_____

(INSTRUCTION: IN COMPLETING ITEMS 12, 13 & 14, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

12. Project Implementation Target Dates (for construction or renovation projects):
    A. Obligation of Capital Expenditure **zero (0)** months from approval date.
    B. Beginning Construction **eighteen (18)** months from capital obligation.
    C. Pre-Licensure/First Use **thirty (30)** months from capital obligation.
    D. Full Utilization **thirty (30)** months from first use.

13. Project Implementation Target Dates (for projects not involving construction or renovations): **N/A**

    A. Obligation of Capital Expenditure _____ months from approval date.
    B. Pre-Licensure/First Use _____ months from capital obligation.
    C. Full Utilization _____ months from first use.

14. Project Implementation Target Dates (for projects not involving capital expenditures): **N/A**

    A. Obligation of Capital Expenditure _____ months from approval date.
    B. Pre-Licensure/First Use _____ months from capital obligation.
    C. Full Utilization _____ months from first use.

15. Project Description:
    Provide a summary description of the project's construction and renovation plan and all medical services to be establish, expanded, or otherwise affected if the project receives approval. Please attach this description as a separate sheet or section to your application. **(Page 12-16)**

Project Description
This section has been revised and is consistent with response in Completeness Letter

Seasons Residential Treatment Program is a (proposed) 72-bed residential program designed to support the intensive psychiatric and behavioral health needs of male and female clients between the ages of 13 and 21. Programmatically, we separate youth as follows: ages 13 to 17 years; 18 to 21 years/young adults and youth assigned to the assessment unit (less than 30 days).

Our program model and philosophy of care is built around a safe, secure and healthy environment committed to successful family and community reintegration. Residents will receive medical evaluations, treatment and coordinated care based on their specific needs under the direct supervision of a dedicated child and adolescent psychiatrist. We will deliver care and accept admissions from local and national referral partners 24 hours per day, 365 days per year.

The youth in our program will come to us from Maryland (and around the country) with significant emotional and behavioral challenges, diagnosed mental illness, likely substance abuse and a pattern of academic truancy. The youth we plan to treat include those with a history of arson/fire setting, emotional disturbance, aggressive and assaultive behavior and meet more than one clinical diagnosis for mental illness.

Our youth will be among the toughest to place in traditional residential programs, have a high rate of recidivism in RTC settings, meet the requirements for PRTF level of care and most likely failed in multiple community-based programs. Our goal is to return these youth to their family and community with the appropriate, sustainable tools to cope and manage their illness.

Under the direction and supervision of our licensed and board-certified psychiatrists, the multi-disciplinary team will employ a holistic, evidenced-based, trauma-informed, approach to care. Our staff will draw on the most recent and relevant culturally competent, theoretical and applied treatment modalities and "best-practice" safety measures to support youth presenting with all forms of trauma, aggressive behaviors and co-morbid substance abuse.

Seasons Residential Treatment is designed for short-term, intensive placement, with a proposed average length of stay in our residential program of approximately (six) 6 months. Our assessment unit plans to partner with youth, parents, community partners and referral sources to make next level of care recommendations within 30 days of admission to the assessment unit.

Our experienced team will serve a broad range of needs and will be adept at adjusting individual treatment plans and tweaking therapeutic resources to address local and national issues of trauma related to gang violence, gender identity and sex and human trafficking. The goal is to provide flexible, appropriate programming and interventions based on the specific needs of each resident.

We plan to provide intensive post-discharge support by leveraging community resources, requiring intensive family therapy and coordinating stakeholder involvement during placement. As part of our effort to continually improve our program and delivery of care, we will also retain

the services of an independent research partner to collect and synthesize data from program participants for three (3) years post discharge. The post-discharge data will be posted on our company website and available to all stakeholders.

The proposed site for Seasons Residential Treatment Program is located on a 16.01 acre site on Allentown Road (Parcel Number 09-23334) in Fort Washington, Maryland and Prince George's County. The building and site plan are designed to maximize peer interaction, provide secure programming and facilitate community and family reintegration.

The physical plant will meet all federal, state and local regulatory requirements for PRTF level of care (highest standard outside of acute inpatient hospital). Seasons Residential Treatment Program will meet PRTF standards mandated by the Center for Medicare and Medicaid Services (CMS) on the first day the program is licensed and operational. As part of the requirements for PRTF certification, the program is required to have separate resident seclusion rooms. The attached **project drawings** includes space allocation for seclusion rooms as outlined in **C.F.R 482, subpart G**, *Conditions of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities.*

The intensity of our clinical care and delivery of services will also meet all federal regulations and PRTF standards, (definition: *42 C.F.R. 483.352).* Our residents and program model will meet the federal standards set in *42 C.F.R Part 441, Subpart D - Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Residential Facilities or Programs.* However, because the State of Maryland does not issue a *license* to operate as a PRTF, we will apply to the Maryland Department of Health and Mental Hygiene to operate the 72-bed facility under the RTC licensing requirements **(Exhibit 3)**.

The proposed project includes a separate diagnostic and assessment unit and dedicated residential programming for youth between the ages of 13 and 17 and young adults between the age of 18 and 21. Externally, our strategic partnerships with community-based providers will support effective reintegration efforts and seamless discharge planning by working on campus as part of our treatment team. At every level of care, we will collaborate with youth, family and placing agency, to support decisions in three key areas: academic, therapeutic and social.

Physical Plant Specifications

The facility will be a one-story, 52,263 SF facility serving adolescents for long-term psychiatric treatment. The structure is type VA construction with the following occupancies: Institutional (I-2) at patient units, Assembly (A-2) at the Dining Room, Assembly (A-3) at the Gym, Education (E) at the classrooms, and Business (B) at the administrative, assessment and outpatient suites.

The building structure consists of spread footings (unless the soil report dictates otherwise), concrete slab-on-grade, load-bearing steel studs, and pitched wood roof trusses. The exterior walls are clad in two colors of brick, the roof is asphalt shingles, and the glazing is frosted in patient areas to protect patient privacy. On-site parking is provided per local zoning guidelines. A covered ambulatory entrance is also included in the site plan.

Each resident room is double-occupancy and is served by an adjacent bathroom with shower, toilet and lavatory. The adult unit (for 18-21 y.o.) is a coed 16-bed unit. The unit is separate from the 13-17 year old youth and includes a living room, group room, doctor's office, seclusion room with dedicated toilet room and a centralized nurses' station.

The short-term assessment unit is a coed unit with two separate wings able to accommodate 10 male and female residents on each wing. The unit will have assigned clinical, direct care and administrative staff with specific training required to meet the reporting requirements for this population.

The additional 36 residential beds are separated into two units designed to accommodate18 male and female youth between the ages of 13 and 17. Each unit houses a dayroom and group room. Two units share one (1) nurses' station, medication room, and seclusion room with dedicated toilet room. The nurses' station is located so the nursing staff has direct line of site for both units.

There are two large classrooms close to the gymnasium and outdoor recreational area. The plan also has provides for several smaller classrooms throughout the building. Each classroom will be equipped with the latest technology, software and hardware to maximize teaching and foster learning. We will support youth referred to our program with significant gaps in their academic record and students who come to us with individual education plans and/or special education needs.

Our academic program will meet all the requirements outlined by the State of Maryland Department of Education for a *Type 1, Special Education School.* The proposed building design will allow us to serve the needs of **Level V non-public and Level VI** students on our campus in full compliance of **COMAR 13A.05.01** and **COMAR 13A.09.09** and **COMAR 13A.09.10.**

There is also a full-service commercial grade kitchen and adjacent dining room in the program plans. The dining room can be easily divided based on operational needs. The gymnasium will be equipped with sports equipment to support recreational therapy, youth sports and Department of Education required curriculum.

Each unit is self-contained and designed to be separate and secure from the rest of the units. The assessment suite includes rooms dedicated to resident assessment, financial counseling agency collaboration and private family visitation and therapy rooms. The adult unit also has extra classroom space for specialized programming (i.e. credit recovery). The day school suite houses classrooms, group rooms, and an administrative office. The administrative suite includes staff offices and a large conference area.

All fixtures, hardware and finishes have been selected to support our commitment to resident safety and an environment that closely mimics a warm and non-clinical environment. Great care is placed in the selection of plumbing fixtures, door hardware, shower curtain hangers, and community and bedroom furniture. All windows are protected with polycarbonate; corridor and resident room walls are protected below the chair rail with FRP panels.

The topography is clear of any significant issues and the construction team has successfully completed a test fit of the building for the site and required parking. The 16.01 acre site is undeveloped land on Allentown Road in Fort Washington located in Prince Georges County. The site is zoned R-A: Residential – Agricultural and will not require a re-zone for our intended use.

As indicated in the site plan and project drawings, **(Exhibit 4),** the facility will be located on the west side of the site with frontage and access along Allentown Road. The portion of the site that will be developed is currently cleared and the remainder of the site is wooded. A Phase 1 Environmental Study of the site will be completed during the site due diligence process and prior to construction. To our knowledge no hazardous substances are, will be, or have ever been stored, treated, disposed of or incorporated into, on, or around the property.

As outlined in "Chart 1. Project Construction Characteristics," site preparation costs will include the following: placement of storm drains, rough grading, preparation to extend and expand current (on-site) sewer and water lines and paving to include labor and materials (concrete and asphalt.)

Please see the attached drawings in **Exhibit 4**. The overall floor plan shows each patient unit labeled as well as the perimeter lineal feet (2,493). The overall floor plan is a 1/32 scale and all the rest are 1/16

The proposed site plan/building design will meet local and state building requirements and regulations set forth by the State of Maryland in **COMAR 10.24.07G** and Health-General Article, **§19-308, Annotated Code of Maryland,10.07.04.08 (**Physical Plant) with specific consideration of the following:

- .08D: Bathrooms
- .11: Food Services
- .15: Accommodations

The proposed physical plant renovation also considers the PRTF certification requirements outlined in *42 C.F.R. 483.352,* specifically, the construction team included consideration of the following:

- Seclusion room to be monitored 24 hours per day and 7 days per week by a member of our clinical team and used only when a clinician agrees to its use after all efforts to deescalate have failed;
- Office space for clinical therapists on every residential unit;
- Dedicated office/medication administration space
- Dedicated station for nursing staff with line of site to units;
- 24 hours per day/ 7 days per week nursing coverage;
- Locked office(s) for on-site medical records/storage room

Total Budget:
The proposed construction budget is $12,366,000 (Twelve Million Three Hundred Sixty Six Thousand Dollars) and includes construction costs, site preparation, offsite costs, signs and landscaping.

16. Project Drawings: **(Exhibit 4)**
Projects involving renovations or new construction should include architectural schematic drawings or plans outlining the current facility (if applicable), the new facility (if applicable) and the proposed new configuration for inpatient facilities. These drawings should include:

1) the number and location of nursing stations,
2) approximate room sizes,
3) number of beds to a room,
4) number and location of bath rooms,
5) any proposed space for future expansion, and
6) the "footprint" and location of the facility on the proposed or existing site.

*The building square footage supports space allocation requirements outlined in **COMAR 10.07.04.08** (physical plant) for both (proposed) current and future usage.

For free-standing (including office-based) ambulatory surgical facilities, these drawings should include: **N/A**

1) dimensions of major architectural features and equipment of all operating rooms and procedure rooms, existing and proposed,
2) clear demarcation of restricted sterile corridor,
3) any proposed space for future expansion, and
4) the "footprint" and location of the facility on the proposed or existing site.

17. Features of Project Construction:

A. Please Complete **"CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS"** describing the applicable characteristics of the project, if the project involves new construction. **Section Revised and is consistent with response in Completeness Letter**

CHART 1. Project Construction Characteristics and Costs			
Base Building Characteristics	**Complete if Applicable**		
	New Construction	Renovation	Cost
	Y	N	
Class of Construction			
Class A	Type 3A and 5A		10,000,000
Class B			
Class C			

Class D			
Type of Construction/Renovation			
Low			
Average			
Good			
Excellent	Excellent		
Number of Stories	1		
Total Square Footage			
Basement	N/A		
First Floor	Approximately 52,263		
Second Floor	N/A		
Third Floor	N/A		
Fourth Floor	N/A		
Perimeter in Linear Feet			
Basement	N/A		
First Floor	2493		
Second Floor	N/A		
Third Floor	N/A		
Fourth Floor	N/A		
Wall Height (Floor to Eaves)			
Basement	N/A		
First Floor	10' main building and 28'Gymnasium		
Second Floor	N/A		
Third Floor	N/A		
Fourth Floor	N/A		
Elevator	N/A		
Sprinklers (Wet or Dry system)	Wet		
Type of HVAC System	Split System		
Type of Exterior Walls	Main Building: Metal Stud Construction with Brick Veneer. Gymnasium:		

	Concrete Masonry Unit		
Site Preparation Costs			
Normal Site Preparation*			
Demolition			
Storm Draining			$250,000
Rough Grading			$923,000
Hillside Foundation			-0-
Terracing			-0-
Pilings			-0-
On-Site Sewer and Water			$403,000
Paving- Asphalt and Concrete			$450,000
Site Preparation Costs Total			**$2,026,000**
Offsite Costs			
Roads			-0-
Utilities			$35,000
Jurisdictional Hook-up Fees			$150,000
Offsite Costs Total			**$185,000**
Signs			**$5,000**
Landscaping			**$150,000**
Total (Construction, Site Preparation, Offsite Costs, Signs, Landscaping			**$12,366,000**

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

B. Explain any plans for bed expansion subsequent to approval, which are incorporated in the project's construction plan. N/A

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.
This section has been revised and updated from original submission.

Utilities:

The proposed site has all utilities *available* for the proposed project, however, water and sewer will need to be expanded and category change submitted for intended use. We plan to submit for water and sewer category change on 8/1/15 with an approval date of 11/30/15 based on county regulations. Please see the detail for each utility below:

Sewer
The sanitary sewer drawing (Washington Suburban Commission Drawing 212-SE 3-S) for the area indicates an existing 6" sewer line in Allentown Road that crosses approximately 60% of the frontage of the property on Allentown Road that ends with sewer manhole 114-N. The sewer line for the new facility could be run from the building and tied into manhole 114-N.

Water
The water drawing (Washington Suburban Commission Drawing 212-SE-3-W) for the area indicates an existing 16" water line in Allentown Road and a fire hydrant along the frontage of the property. The service for the new facility could require tapping the existing 16" water line and extending it onto the site for tie-in with the new facility.

Electric
There is electrical service in the vicinity that would be extended onto the property with PEPCO setting a new transformer that would feed the new facility.

Gas
Per discussion with Washington Gas they advise there is an existing gas line that runs down Allentown Road. The gas company would need to tap the line and bring the service to the facility and set the meter to serve the facility.

Telephone
Verizon Business/Commercial Plan

PART II - PROJECT BUDGET

INSTRUCTION: All estimates for 1.a.-d., 2.a.-j., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs:

a.	New Construction	$ -0 -
(1)	Building	10,000,000
(2)	Fixed Equipment (not included in construction)	- 0 -
(3)	Land Purchase	475,000
(4)	Site Preparation	2,366,000
(5)	Architect/Engineering Fees Architect ($200,000) Civil Engineer ($60,000) Landscape Design ($5,000)	265,000
(6)	Permits, (Building, Utilities, Etc)	87,000
SUBTOTAL		**$ 13,193,000**
b.	Renovations	
(1)	Building	$ -0-
(2)	Fixed Equipment (not included in construction)	-0-
(3)	Architect/Engineering Fees	-0-
(4)	Permits, (Building, Utilities, Etc.)	- 0 -
SUBTOTAL		**$ - 0 -**
c.	Other Capital Costs	
(1)	Major Movable Equipment Kitchen ($105,000) Security/CCTV ($330,000)	435,000
(2)	Minor Movable Equipment Furniture ($300,000) Computers ($80,000)	380,000
(3)	Contingencies 5% of subtotal from Section A	659,650
(4)	Other (Specify)	-0-
TOTAL CURRENT CAPITAL COSTS (a - c)		**$ 14,667,650**
d.	Non Current Capital Cost	
(1)	Interest (Gross) Based on 4.6% interest rate over a 12 month construction period	$ 300,000
(2)	Inflation (state all assumptions, Including time period and rate)	$ - 0 -

	TOTAL PROPOSED CAPITAL COSTS (a - d)		$ **14,967,650**
2.	Financing Cost and Other Cash Requirements:		
	a.	Loan Placement Fees	$ - 0 -
	b.	Bond Discount	- 0 -
	c.	Legal Fees (CON Related)	4,000
	d.	Legal Fees (Other)	50,000
	e.	Printing	3,000
	f.	Consultant Fees	- 0 -
		CON Application Assistance	- 0 -
		Other (Specify)	- 0 -
	g.	Liquidation of Existing Debt	- 0 -
	h.	Debt Service Reserve Fund	- 0 -
	i.	Principal Amortization Reserve Fund	- 0 -
	j.	Other (Specify) Land due diligence, W&S approvals Subdivision appraisals	50,000
	TOTAL (a - j)		$ **107,000**
3.	Working Capital Startup Costs		$ 1,143,662
	TOTAL USES OF FUNDS (1 - 3)		$ **16,218,312**
B.	**Sources of Funds for Project:**		
1.	Cash Assumes 60% cash and 40% financing		$ 9,730,987
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net		- 0 -
3.	Gifts, bequests		- 0 -
4.	Interest income (gross)		- 0 -
5.	Authorized Bonds		- 0 -
6.	Mortgage Assumes 60% cash and 40% financing		6,487,325
7.	Working capital loans		- 0 -
8.	Grants or Appropriation		
	(a) Federal		- 0 -
	(b) State		- 0 -
	(c) Local		- 0 -
9.	Other (Specify)		- 0 -
TOTAL SOURCES OF FUNDS (1-9)			$ **16,218,312**

Lease Costs:

a. Land	$_____	x _____	= $_____
b. Building	$_____	x _____	= $_____
c. Major Movable Equipment	$_____	x _____	= $_____
d. Minor Movable Equipment	$_____	x _____	= $_____
e. Other (Specify)	$_____	x _____	= $_____

PART III - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3): (INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G(3) Each criterion is listed below.)

COMAR Standard 10.24.01.07G(3)(a) The State Health Plan.
List each standard from the applicable chapter of the State Health Plan and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application. **(Copies of the State Health Plan are available from the Commission. Contact the Staff of the Commission to determine which standards are applicable to the Project being proposed.)**

State Health Plan Chapter for Psychiatric Services: *Interim Residential Treatment Center Capacity* at COMAR 10.24.07G

COMAR Standard 10.24.07G(1)(a-c): Core Principles
***Please note we were advised during the pre-application submission process to disregard the requirements outlined in COMAR Standard 10.24.07 G(1)(a)-(c) and COMAR Standard 10.24.07 G(2)(a)-(e). The Need standard is to be measured against the Core Principles outlined in COMAR Standard 10.24.07 G(1)(a)-(c).*

COMAR Standard 10.24.07G(3)(a): Need
Standard is to be measured against the Core Principles outlined in COMAR Standard 10.24.07 G(1)(a)-(c) as directed during pre application meeting with CON Committee.
This section has been revised to reflect answers to Completeness Letter

Seasons Residential Treatment Program is petitioning the Maryland Health Care Commission for permission to serve youth between the ages of 13 and 21 in need of intensive, comprehensive psychiatric residential treatment within an effective system of care. Our program will meet the needs of youth presenting with severe emotional disturbances and aggressive behaviors who require medical monitoring in either our short-term diagnostic and assessment unit, or residential program.

The youth we hope to serve will present with severe emotional disturbances and documented mental illness and require a safe, secure, non-punitive, therapeutic environment. These youth meet a level of inpatient service intensity that currently requires placement agencies to look outside of the State of Maryland for residential placement because they are tough to treat. These youth tend to be court involved, likely will have "failed" in lower levels of care with an average of 17 years old. Seasons Residential Treatment Program plans to admit, treat and support youth identified in **COMAR 10.24.07G(4)a.**

If approved, we will support youth through a continuum of care that includes: crisis stabilization, evidence-based clinical services, individual academic and vocational programming, family therapy and outreach, community-based care, prevention services and access to transitional housing for our young adult residents. We will use a third party research institution to collect, aggregate and synthesize post discharge data and will publish the outcomes data in an annual report available to our stakeholders on our website. Our parent company is currently partnering with the University

of North Carolina at Wilmington to conduct post-discharge interviews **(see Exhibit 5).**

While we have established the program as a primary resource for Maryland referral sources, we also propose to support youth referred from regional and national social service and juvenile justice agencies, parents and guardians. We will work closely to support all youth meeting admissions standards able to benefit from an array of best practice treatments and intensive, integrative services matching the level of care identified by federal PRTF standards.

In summary, Seasons Residential Treatment Program proposes to fill an unmet need for inpatient mental health beds in a residential treatment facility by:

- Establishing an integrative system of care designed to collaborate, communicate and cooperate with stakeholders to return youth back to family and community;
- Treating "tough to treat," highly aggressive and assaultive who may also present with severe emotional disturbance and are dually diagnosed;
- Delivering short-term, intensive, round-the-clock, services based on national standards of excellence;
- Implementing a treatment philosophy based upon evidence-based practices, research, and supported by outcomes data and quality assurance reporting;
- Identifying and leveraging community and stakeholder assets early in the admissions process;
- Supporting family-focused care and comprehensive discharge planning for better community reintegration;
- Offering a comprehensive model of multi-model treatment interventions designed to meet the needs of the youth and family;

Size of the Market

Unlike hospitals, Residential Treatment Centers and Psychiatric Residential Treatment Facilities appeal to referral sources from around the country and in some cases, international sources. According to information from the American Academy of Child and Adolescent Psychiatry, national trends indicate the number of youth placed in residential programs around the country has decreased in the past 10 years as the shift towards more community-based programming and services increases. However, there is still a need for residential treatment programs able to provide intensive out of home help for youth with serious emotional and behavioral problems.

As local jurisdictions are being held more accountable for lengths of stays, clinical outcomes and recidivism rates for RTC/PRTF placed youth, the decision to fund and place youth in RTC and PRTF level care remains significant. Very often, a more national approach to program selection and location is required when the needs of the youth are very specific (young adults, medically fragile, sex-offender, gender dysphoria) or challenging (aggressive, assaultive). The admission should be driven by the specific needs of the child and family with every consideration given to proximity of program to the youth's natural resources. If Seasons Residential Treatment is issued a license to operate as a RTC and certified as a PRTF, we expect the intensity of our clinical program, short-term focused care and willingness to serve tough behaviors, will likely attract admissions from around the region and the country.

Our "target area" is a 150-mile radius of our program. We plan to provide significant opportunities for family therapy, agency visits and access to local vocational, independent living and social outlets for our older residents. We plan to grow our program very slowly with a primary focus on serving the youth and families within the State of Maryland with secondary markets to include the District of Columbia, Virginia and West Virginia.

We estimate the census mix to be as follows for Year(s) 1-3:

- **45%%** Maryland youth
- 30% District of Columbia placed youth
- 5% Virginia placed youth
- 10% West Virginia placed youth
- 10% other states out side the mid-Atlantic region

Location of Current Maryland Programs

Need for PRTF level program in Southern Maryland

Although a disproportionate number of youth are from the City of Baltimore, Prince George's County ranks high among RTC/PRTF placements. None of the current RTC's are located in the area of the state we propose. According to DJS data, "the Southern region has the fewest residential programs overall."

There are only three (3) programs in the State that serve tough to treat **male and female youth** over the age of 18 (see below) and also meet the rigorous certification standards for a Psychiatric Residential Treatment Facility (PRTF) designation.

Excerpted from **page 75 of** *FY2014 State of Maryland Out-of-Home Placement and Family Preservation Resource Plan:* "There are 10 RTCs located in five jurisdictions...youth from jurisdictions other than these five will necessarily be placed outside his/her jurisdiction. The in-State RTCs are located in Baltimore County (4), Baltimore City (2), Montgomery County (2), Dorchester County (1), and Frederick County (1). Finally, each RTC determines which youth will be admitted, considering programming and vacancy constraints upon admissions."

See chart below for a list of the current programs, certification status, gender and age(s) served:

Program Name	Beds/Youth Served	Certified PRTF	City, State, Zip, County, Web Site
Adventist Behavioral Health: 2 programs (Rockville, MD & Cambridge, MD)	**83 beds:** Rockville **59 Beds:** Cambridge Adolescents, 12-18 years, Co-Ed	Not certified PRTF, admit only to age 18	1) Rockville, MD 20880, Montgomery County 2) Cambridge, MD 21613, Dorchester County website: www.adventisthealthcare.com
Woodbourne Center	**48 beds;** Adolescent Boys, 12-18 years	Not certified as PRTF; male only	Baltimore, MD 21239 www.nexustreatment.org
Berkeley & Eleanor Mann Residential Treatment Center (Sheppard Pratt Health System)	**68 Beds (some restricted);** Adolescents, 12-21 years, Co-Ed	Certified as PRTF; admit to age 21; **website states, average length of stay is 11 months.**	Baltimore, MD 21204, Baltimore county, www.shepardpratt.org
Jefferson RTC (Sheppard Pratt Health System)	**50 Beds** Adolescents, 12-21 years, Co-Ed	Certified as PRTF; admit to age 21, average length of stay, (according to website) is 11 months. **Website states, average length of stay is 11 months.**	Jefferson, MD, 21755 and Frederick County. Website: www.sheppardpratt.org
Good Shepherd Services	**105 Beds;** Adolescents, 13-21 years (Co-Ed)	Certified as PRTF; admit to age 21; located in Baltimore County	Baltimore, MD 21227, Baltimore County. www.gssmaryland.org
Chesapeake Treatment Center*	**29 Beds;** Males 13-21 years;	Unsure of PRTF certification. Restricted to programming for sex offenders.	*This comes up in MD directory as same as Adventist Behavioral program in Cambridge...not the same program. Program did not give information due to the sensitive nature of the program. It is housed at the Hickey School in Baltimore. Zip 21212
St. Vincent's Villa	**95 Beds;** Adolescents, 5-14 years (Co-Ed)	RTC; only to age 14 years old	Timonium, MD 21093, Baltimore County. http://www.catholiccharities-md.org/st-vincents-villa/residential-treatment-center.html

State of Maryland Referral Agencies

MD Mental Hygiene Administration (MHA)

The nomenclature for Residential Treatment Center(s) and Psychiatric Residential Treatment Facilities (PRTF's) are used interchangeably. MHA only funds RTC/PRTF placements through funds distributed by the Maryland Medicaid Assistance fund. This agency currently has the highest number of youth in residential placement according to the most recent one-day snapshot data (see below).

Maryland Department of Juvenile Services (DJS)

In recent years, DJS has focused on reducing the time youth who have been committed by the Juvenile court to out-of-home placement must stay in detention centers prior to placement. The agency is committed ensuring youth are ultimately placed into programs meeting both security and treatment needs, to confirm a successful placement that does not result in removal back to detention. The agency contracts with providers from around the country to support youth in their care and has the second highest number of youth in residential placement

Department of Human Resources

Less than 1% of children in DHR OOH care are placed in the State's most restrictive placements (hospitalizations), while an average of 4% are in non-community-based placements (Residential Treatment Centers, Correctional Institutions, or Secure Detention). Placements of children/youth in these settings are driven by severe mental health and medical needs, and/or the juvenile/adult criminal justice system, although past abuse and trauma may contribute to individual children's mental health issues and/or criminal acting-out behaviors.

Maryland State Department of Education

MSDE will fund youth who meet the level of care for a residential educational facility. These decisions are made at the local school system level in partnership with the parent and special education team. Less than .005% of the total population with disabilities will be placed in residential programs, according to the Governor's report.

In order to more closely explore the need for this level of programming by agency, we reviewed data from **FY2014 Out-of-Home Placement and Family Preservation Resource Guide.**

The purpose of the Guide is to determine what is driving placements in the State of Maryland, identify children's needs in Maryland and describe how the (placing/referral) agencies plan to meet those needs. The report is submitted annually to the Governor's Office for Children. Data is collected, synthesized and analyzed by key health care thought leaders, agency administrators and other relevant stakeholders.

We reviewed the *FY2014 Out-of-Home Placement and Family Preservation Resource Guide* and attached it to this application in **Exhibit 7.** We have highlighted several areas in the *FY2014 Out-of-Home Placement and Family Preservation Resource Guide*, where the data supports our program model or treatment philosophy. We have listed them here:

- On **page 11**, the one-day snapshot (1/31/14) indicates there were 740 youth in non-community based placements across all placing agencies (which includes RTC/PRTF placements). By agency: DHR =183; DJS=141; MHA=418. DJS also reported 24 placements in "Diagnostic Evaluation Treatment Program" as a separate category under Non Community-Based Placements.
- On **page 15** of this report, the report states, "Another of Maryland's goals for out-of-home placement is for children to remain close to their homes so they can preserve their family, social, educational, and cultural connections during the period of out-of-home placement;"
- On **page 43,** regarding the MD Department of Juvenile Services, the authors note that although DJS "has in recent years increased capacity to serve higher-risk youth who may have in previous years been either placed in out-of-State non-community-based placements or in Maryland non- secure community-based residential programs," the outcomes of those placements were often, "unsuccessful."
- Although there are very few placements in residential care from DHR, the agency recognizes the need to strengthen all services to build a system of trauma-informed care; and the need for more services for older youth (above the age of 17);
- On **page 43** of the report, MD DJS reported the agencies commitment to more structured risk and needs assessment – consistent with our plan to partner more effectively with agency referral partners to deliver well-informed treatment recommendations;
- **On page 46**, regarding secure placement options for committed youth, "A large portion of secure placement options for committed youth continues to be in out-of-State programs." Although the total number of placements has decreased in the past 2 years, Maryland youth in the care of MD DJS are still being sent to out of state programs – Seasons would help the agency meet the legislative mandate to keep youth closer to home;
- MHA reports a very slight decrease of residential placements and utilization over the past 5 years. There is some indication the "Section 1915(c) Home and Community-Based Services Waiver" has helped slightly reduce overall RTC placements.
- On **page 75**, MHA reported an average bed cost per day of **$475 for FY 2014**. The proposed Medicaid rate for Seasons Residential Treatment in **FY 2018 is $410.**
- On **page 75**, MHA suggests there is a continued need for out of state placements for specialized treatment and said, "It would seem desirable to have the Maryland RTCs offer more options for specialized treatment for a small number of Maryland youth."

Gap in Services

According to the *Maryland Department of Juvenile Services: 2013 Residential and Community-Based Services Gap Analysis*, the greatest need for residential placement for Maryland DJS placements is for hardware secure programming for males.

The MD Department of Juvenile Services classifies RTC placements as follows: Level III, hardware secure; Level II, staff secure; and Mental Health Residential Placements, (MHRPs). MHRP's are broadly categorized as public and privately run residential treatment centers (RTCs), diagnostic units, high intensity psychiatric respite, and psychiatric hospitals.

We reviewed the *Maryland Department of Juvenile Services: 2013 Residential and Community-Based Services Gap Analysis*, and highlighted below several areas in the report where the data supports our program model and treatment philosophy:

- On **page 3**, the report states: "There is a shortage in capacity to serve boys in Level III programs. Whereas 135-138 boys are projected to require Level III programming on any given day, there is currently only one hardware secure program in Maryland that serves 48 boys."
- On **page 38** the authors noted: "An assessment of boys' needs indicates that Level III (and residential programming) should address the continuum of behavioral health with emphasis on alcohol and drug use, family functioning, aggression, and mental health.
- On **page 38,** these findings are also supported by an analysis of boys who were placed in programs outside of Maryland in FY 12 and FY 13."

Maryland Youth in Out of State Residential Placement

The Governor's Office for Children indicates there is a clear preference to keep youth who meet the level of care for residential placement in programs in the State of Maryland. Agencies and community programs are encouraged to develop programs to support this initiative, however, the findings of the Maryland Department of Juvenile Services (below) indicates there is work to be done in this area.

According to the *2013 Maryland Department of Juvenile Services Residential and Community-Based Services Gap Analysis, **(Exhibit 6)***, between July 1, 2011 and June 30, 2013, there were 291 **boys** admitted to 26 residential programs outside of Maryland. More than 90% of the boys were African American and the average age was 17 years old. Nine **girls** were placed in five programs and the average age was 16 years.

Additional highlights of the findings for Maryland youth in out of state placement is as follows:

- On **page 36** of *2013 Maryland Department of Juvenile Services Residential and Community-Based Services Gap Analysis, **(Exhibit 6)***, the authors conclude from the above data: "Most of these boys were placed in programs located in Pennsylvania (n=141), followed by Iowa (n=58) and Tennessee (n=36)
- On **page 36**: "A substantial number of boys were placed out-of-state in FY12 and FY13, demonstrating a clear gap in programs that can serve these youth in Maryland. Specifically, the findings point to the need for hardware-secure programming that can accommodate DJS-involved boys in Maryland. In addition, a significant number of youth were served in out-of-state MHRP's, suggesting a potential gap in these in-state services as well
- On **page 30**, "Over half (56%) of these girls were African American, and they were 16 years old on average. The majority (89%) of these girls were classified as high risk for recidivism;

- Most of the girls were indicated as having moderate or high needs for mental health (78%), alcohol and drug use (67%), family functioning (78%), and aggression (78%);
- Overall, a small number of girls were placed out-of-state in FY12 and FY13, but their numbers still represent a gap in programs that can serve these youth in Maryland. The findings *point to the potential need for staff secure programming within Maryland that can accommodate DJS-involved girls* who have behavioral health needs and behavior issues generally.

Seasons Residential Treatment Program would be an option for youth currently placed in out of state programs based on our ability to meet the behavioral, clinical, safety and mental health needs of both male and female residents classified as Level II, Level III and MHRP.

The following tables represent the program location and number of Maryland youth admissions in out of state placement in FY 12 and 13. The average length of stay is not indicated in these data, but the distance of the program often requires greater coordination of care for stakeholders and missed opportunities for family therapy and community resource identification and optimization.

Figure 20. ***Out-of-State Residential Placements for Boys****, FY12 & FY13 Admissions (N=291)*

Residential Program Type/Name	Program	# Boys
Hardware Secure Facility		87 total
Abraxas Residential Services	Pennsylvania	37
Mid Atlantic Youth Services – PA Child Care	Pennsylvania	13
Mid Atlantic Youth Services – Western PA Child Care	Pennsylvania	29
Northwestern Academy (NHS Human Services)	Pennsylvania	8
Hardware Secure Facility with Intensive Mental Health Services		10 total
Turning Point Youth Center	Michigan	10
Staff Secure Facility*		163 total
Abraxas Residential Services	Pennsylvania	15
Bennington School	Vermont	2
Canyon State Academy	Arizona	11
Clarinda Academy	Iowa	33
Glen Mills School	Pennsylvania	22
Lakeside Academy	Michigan	3
Mid Atlantic Youth Services – PA Child Care	Pennsylvania	2
Natchez Trace Youth Academy	Tennessee	36
Summit Academy	Pennsylvania	14
Woodward Academy	Iowa	25
Staff Secure Facility with Intensive Substance Abuse Treatment*		1 total
Foundations for Living	Ohio	1
Residential Treatment Center		29 total
Boys Town	Nebraska	5
Coastal Harbor Treatment Center	Georgia	1
Cottonwood Treatment Center	Utah	1
Devereux Florida	Florida	4
Devereux Georgia	Georgia	8
Devereux Pennsylvania – Children's IDD Services	Pennsylvania	1
Laurel Oaks Behavioral Health Center	Alabama	5
New Hope Carolinas	South Carolina	2
Newport News Behavioral Health Center	Virginia	2
Three Rivers Residential Treatment – Midland	South Carolina	1

*Youth placed in out-of-state staff secure facilities typically present risk levels that would warrant a hardware secure placement within Maryland, with the exception of Glen Mills School.

Figure 16. Out-of-State Residential Placements for Girls, *FY12 & FY13 (N=9)*

Residential Program Type/Name	Program	# Girls
Staff Secure Facility		3 total
Clarinda Academy	Iowa	3
Staff Secure with Intensive Substance Abuse Treatment		3 total
Foundations for Living	Ohio	3
Residential Treatment Center		3 total
Gulf Coast Treatment Center	Florida	1
Newport News Behavioral Health Center	Virginia	1
Laurel Oaks Behavioral Health Center	Alabama	1

Adjacent Market: District of Columbia

Need for PRTF Level Care by all agencies

Unlike the State of Maryland, **all D.C. youth** who meet the level of care for RTC or PRTF placement are sent to out of state programs. The District of Columbia **does not have any** licensed RTC's or PRTF programs. Our strategic location and proximity to the District of Columbia will be a great asset for agencies needing to place tough to treat youth in the District of Columbia.

Referral agencies in the District of Columbia have expressed excitement about the promise of Seasons Residential Treatment Program and our ability to more closely partner with key stakeholders and connect resources to area youth and families. In initial meetings with placing agencies and referral sources, stakeholders are convinced there will be better collaboration and communication because of the proximity of the program and our ability to treat older youth and youth with a history of trauma and assaultive behaviors.

According to an article, published in 2009, *Out of State, Out of Mind: The Hidden Lives of D.C. Youth in Residential Treatment Centers,* "at any given time, the District of Columbia pays for approximately 300 to 550 children...to attend institutions called RTC's." Although this number seems high, it is pretty consistent with the total number of youth placed by the State of Maryland.

In a 2009 report filed with the City Administrator and accessed through the Freedom of Information Act, "515 individuals under the age of 22 were in 96 different RTC's." The report also states, "approximately 35% of these youth were placed more than 300 miles from the District of Columbia." The authors noted that the District of Columbia has the second highest percentage of students in RTC/PRTF level of care. The average length of stay for these youth is approximately 11 months.

The letters of support from agencies in the District of Columbia **(Exhibit 17)** suggest there is a need for this level of programming for youth and families in the District of Columbia.

DC Youth in Maryland programs

Currently, fewer than 15% of youth funded by District of Columbia agencies, are sent to Maryland RTC/PRTF programs. Sources indicate there is a perception (that) Maryland RTC programs often "cannot handle DC youth." There are only two programs in Maryland **certified as "PRTF" by the District of Columbia Department of Behavioral Health** – the State Medicaid agency.

During the last two RFP/solicitation cycles for PRTF level care (specifically targeting programs for tough to treat youth), no Maryland RTC's or PRTF's applied to the District of Columbia Office of Contracts and Procurement for program and placement consideration .

District of Colombia Referral Agencies

Department of Youth Rehabilitation Services (DYRS)

DYRS is responsible for the custody, supervision and care of District of Columbia residents (under the age of 21) charged with offense in either detained or committed capacity.

In 2013, we responded to a solicitation to provide hardware and staff secure residential programming for youth in the District of Columbia to support the needs of youth in the custody of

juvenile services in the District of Columbia. We competed with local hardware secure programs for a contract to deliver services to court involved youth in need of diagnostic and assessment services. The solicitation was limited to residential treatment programs within 50 miles of the District of Columbia.

We were *the only* residential treatment program awarded a contract by the Office of Contracts and Procurement. The **5-year contract/award** was based on the comprehensive plan we proposed to provide short-term treatment and intensive services to male residents between the ages of 13 and 21 **(Exhibit 8).** We expect to realize this contract once we meet all licensing and regulatory standards and requirements by the State of Maryland. The ability to secure this contract *without a licensed facility* supports the need for a strong local program of this type for area youth. While this is not a sole source contract, or guarantee of beds by the District of Columbia, it indicates their support for our program and need for these beds.

According to a report on file with the Mayor's Office in the District of Columbia, *Trends In DYRS Residential Treatment Center Usage,* residential treatment centers (RTCs) and psychiatric residential treatment facilities (PRTF's) play an important role in the continuum of services at the Department of Youth Rehabilitation Services (DYRS).

According to the report, in FY2011, there were a total of 378 DYRS youth placed in RTCs/PRTF's. Although this number has risen since FY2007, this upward trend primarily reflects the significant growth that has occurred in the overall DYRS committed population during the same time. **(Exhibit 9)**

In FY2007, the overall DYRS committed population was 541 youth; by FY2011, this number had increased to 1,269. This overall growth of the committed population helps explain the increase in the number of youth placed in RTCs and PRTF's **(Exhibit 9)**

Although the agency is committed to decreasing the number and need for RTC/PRTF beds, the FY 2012 report indicates in January 2012, more than 200 youth funded by the agency remain in RTC, PRTF, sub-acute or diagnostic placement and 187 youth were in out of state RTC placement (this number includes PRTF placement)**(Exhibit 9)**

DC: Department of Behavioral (Mental) Health

In the District, the Department of Mental Health (DMH) is a cabinet-level agency operating separately from the Department of Health. The Department of Behavioral Health (nee, Department of Mental Health), provides financing and delivery of public mental health services to all Medicaid-eligible District residents. The Department of Behavioral (Mental) Health provides core services, outpatient and inpatient services and community-based supports for residents suffering with mental health and substance abuse challenges.

The Department of Behavioral Health, funds approximately 150 Medicaid-eligible youth in out of state residential programs. Approximately 70% of the youth placed and funded directly by DBH are youth in the custody of the Child and Family Services Agency (CFSA) and (custodial) wards of the District of Columbia. The Department of Behavioral Health manages CFSA placements, assigns and approves "level of care" for residential placements and coordinates post-discharge case

management. All residential placements are referred to out of state providers.

DC: Child and Family Services Agency

The DC Child and Family Services Agency (CFSA) is the public child welfare agency in the District of Columbia responsible for protecting child victims and those at risk of abuse and neglect and assisting their families. The Department of Behavioral Health works closely with CFSA to provide case management and make recommendations for residential placement and treatment.

Neighboring States Data: West Virginia and Virginia

West Virginia

According to the West Virginia Department of Health and Human Resources, Bureau of Children and Families, PRTF level care is broken down in two categories – PRTF Long Term (Residential) and PRTF-Short Term (Acute).

The most recent (April 2015) monthly data for West Virginia DHHR, is attached in **Exhibit 9.** According to the Office of Planning Research and Evaluation, out of state placements, "generally represent more than 50% of PRTF level placements." The most recent data from WV DHHR, indicates 85 youth (58.2%) were placed in out of state PRTF/Long Term programs and 61 were placed in state.

Virginia

Comprehensive agency placement data from the Virginia Governor's Office was not made available at the time of application filing. However, the State of Virginia has several RTC and PRTF programs that serve a broad range of programming and levels of care including residential detox, therapeutic boarding schools and wilderness boot camp programs. The State of Virginia does not require a Certificate of Need to operate a RTC - PRTF certification requires programs meet the federal standards. Due to the number and types of programs available in Virginia every effort is made to keep Virginia youth in state.

Virginia residents with mental illness, substance use disorders, and/or intellectual disability are supported through local Community Services Boards (CSB). The CSB is the public agency that plans, organizes and provides services for people who have mental illness, substance use disorders, and/or intellectual disability. State law requires every jurisdiction to have a CSB. There are more than 40 CSB's throughout the state.

Other referral sources

Parents and guardians with third party insurance

Compared to other areas of the country, this region has a pretty low rate of residents without insurance. For this reason, we expect to treat youth placed by parents and guardians with access to third party insurance including Kaiser, Aetna, Blue Cross and Blue Shield and Cigna plans. We will petition to participate in these plans once we are licensed, certified and approved.

The Kaiser Family Foundation recently compiled national data on the post -Affordable Care Act rate of uninsured for all states. The link to the source and information for all states can be found here: http://wallethub.com/edu/rates-of-uninsured-by-state-before-after-obamacare/4800/

- Maryland will have a significant 5.77% reduction of uninsured, resulting in an uninsured rate of 9.13%.
- West Virginia will decrease the number of uninsured by 10.74, brining the states uninsured rate down to 6.74%.
- Washington, DC will experience a 2.80% reduction, bringing the total percentage of uninsured to 6.29%.
- Virginia will see a reduction of 2.46%, brining the total uninsured to 12.45%.

Military families

The proximity of Seasons Residential Treatment Program to area military bases will allow us to extend services to active duty, dependent, retired and reserve duty service members in need of our care. We plan to participate in TriCare, the health care program of the United States Department of Defense Military Health System.

System of Care and Community Partners

Seasons Residential Treatment Program aligns with the Center for Mental Health Services (CMHS), *Building Bridges Initiative.* The Building Bridges Initiative was launched in 2006 and encourages and promotes partnerships between community service providers and residential treatment programs. We have not been able to establish if any of the residential treatment centers in the State of Maryland use the *Building Bridges Initiative* as part of a system of care or established policy. However, Seasons Residential Treatment Program will follow this program model as an integral part of the care we propose and will actively engage community-based stakeholders in the treatment process for all of our residents.

The Building Bridges Initiative is a critical component of our plan to serve young adults between the ages of 18 and 21. According to data collected from 611 residential treatment centers by the Center for Health Care Strategies and detailed in a report entitled, "*System of Care Approaches in Residential Treatment Facilities Serving Children with Serious Behavioral Health Needs,*" **(Exhibit 18, page 5),** "transition services are especially critical for older youth who are moving into adult service systems, in order to maintain the continuity of care that their conditions require." As one of the few Maryland programs prepared to serve the needs of older youth, we will provide necessary resources to support older youth.

Our parent company, Strategic Behavioral Health, operates nine hospitals in five states and delivers a broad range of intensive services to children, adults and seniors. Our long-range plan is to provide a system of care to complement the work we do in our residential program and employ dedicated staff working between the residential programs and the community.

Ideally, these staff would engage the youth and family in lower levels of care in order to prevent the need for residential placement. For those "stepping down" to lower levels of care from our residential program, staff would be actively involved in the placement of Seasons operated community programs (i.e. therapeutic group homes and community-based outpatient care), to ensure successful and seamless continuity of care.

Standards of clinical care

We believe this project is an opportunity to deliver a comprehensive, clinically solid program using the latest evidence-based research and practices to treat this "difficult" population. We have designed a very clinically focused and integrated program for youth who present with these challenges. Our team believes parent and "family" involvement is critical to the success of the program, integrating discharge resources prior to discharge and providing solid academic and career technical focus are all critical components of a successful reintegration.

All youth will receive round the clock care from an experienced multi-disciplinary team of professionals who understand the need for culturally specific treatment and individualized care. If approved, we would be one of four programs able to: admit male and female youth above the age of 18 ***and*** federally certified as a PRTF in the State of Maryland.

If approved, Seasons Residential Treatment Program is the *only* Maryland PRTF to make public, retrospective outcomes data. Seasons will work in partnership with the University Of North Carolina at Wilmington to follow youth 3 years post-discharge **(Exhibit 5).**

Seasons Residential Treatment Program is appealing to the Maryland Heath Care Commission to view this project as a useful investment that will benefit State of Maryland residents and targeted populations in the surrounding region and around the country. There is currently a shortage of in-patient beds for youth in the southern part of the state and a real need for a program that can support youth and families needs in neighboring states.

Economic Impact in the local community

We are excited about the possibility of hiring, training and retaining staff from across the State of Maryland with a specific focus on qualified staff from Prince George's County. According to the latest unemployment report, Prince George's County has an unemployment rate of 6.7% and Charles County has an unemployment rate of 6.0%. Both are slightly above the State unemployment rate of 5.5% and the national rate of 5.6%. At full census, we will employ approximately 130 FTE's.

COMAR Standard 10.24.07 G (3)(b) Sex Specific Programs

Standard has been revised and is consistent with response in Completeness Letter

Seasons Residential Treatment will serve the psychological, behavioral, physical and emotional needs of youth between the ages of 13-21 years who require focused, comprehensive clinical interventions. Youth admitted to our program will meet the level of care for intensive services and will generally have a history of trauma and multiple out of home placements.

We serve three (3) core populations and have outlined the programmatic goal for each below. Each population will have a separate therapeutic, educational and physical environment consistent with their treatment needs and gender. Our goal for all residents is to return them to a lower level of care as quickly and safely as possible with adequate tools and supports for successful community and family reintegration.

Diagnostic and Assessment Unit

The Seasons Diagnostic and Assessment Unit is a 20-bed unit, divided equally between male and female residents. This program is designed to offer mental health agencies, courts and families a safe, secure and short-term intensive placement option for youth who are exhibiting a wide range of behaviors and struggling at home, in school and in the community. The programming is designed to serve as a short-term intensive treatment option where security and safety are concerns.

This program will be utilized by mental health placement agencies, courts and families to help determine appropriate placements, risk factors, and treatment options. The goal of the program is to help the referral source determine appropriate next level of care and provide clinical support to the receiving provider or family member. The normal length of stay will be 30 days, with a proposed limit of 45 days.

Treatment components/modalities: While youth are in placement, we are able to provide social service agencies and courts psychological assessments and family assessments. The goal of these comprehensive assessments is to provide placing workers and agencies, treatment and long-term placement recommendations/goals. We will provide individual, group and family counseling. Programming is supervised and counseling, both individual and family, is provided by a master's-level family specialist utilizing trauma-based therapy.

Educational services: Youth admitted to our diagnostic and assessment unit will benefit from a partnership with Connections Academy, a Baltimore based, accredited, virtual education program. Connections Academy will allow our special and general education teachers to assist residents with individualized plans including credit recovery, remedial courses and GED course review. The easy to use software can be implemented in a variety of ways and will allow the multi-disciplinary team to more accurately determine next level of care educational placement.

Referral sources: Youth admitted to the Diagnostic and Assessment unit will likely be referred by state mental health agencies (DHR, DHS, CFSA), juvenile services and juvenile courts. Referrals may also come from lower levels of care, including therapeutic group homes and community-based "wrap around" programs. Although there is almost always agency involvement due to the consultative nature of the unit, second tier referral sources may include direct family placement

using third party insurance and private pay resources. Unlike other programs, we will NOT charge a higher per diem rate for residents on this unit.

Projected Distribution: Due to need for assessment beds in the area and the short-term nature of the unit, we project this unit to represent 25% of our census in our first year of operations. The gender distribution will likely be as follows: 65% male and 35% female.

PRTF/RTC Residential Beds

PRTF/RTC unit is a 36-bed unit for youth ages 13-17. The units are designed to accommodate 18 male and 18 female residents. The program will provide intensive therapeutic residential care to both boys and girls with a history of severe emotional disturbances and/or severe trauma. Residents are referred for services because of emotional and/or behavioral problems that are impacting their ability to live in their communities. These youth may also require treatment for co-morbid substance abuse and may have been victims of sex trafficking or exploitation.

Treatment Philosophy and Modalities: Both the male and female will be are rooted in a therapeutic milieu based on evidence-based treatment models. These models will be incorporated into daily activities and will guide the therapeutic approach: Dialectical Behavior Therapy (DBT), Motivational Interviewing (MI) and Trauma Focused Cognitive Behavioral Therapy (TFCBT).

The program will provide an extensive therapeutic assessment and person-centered treatment component to improve a youth's functioning so that s/he can discharge to a less-restrictive community setting.

Services include:

- DBT skill groups focusing on mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance
- Specialized groups including sex trafficking, gender identity and sexually offensive behaviors
- Licensed substance abuse treatment, education and counseling
- Life skills groups
- Recreational activities within the unit and in the community, when appropriate
- Individual therapy a **minimum** of one time per week
- Case management
- Educational support
- On-site 24 hour psychiatric, wellness and nursing services
- Referral for necessary and appropriate medical care
- Community resource consultation, education and treatment for families

The structured milieu will organizes the daily activities of the child, which include: education collaboration; recreation; psychiatric, bio- psychosocial and medical assessment; individual, group and family therapy; religious orientation, as indicated by child or parent; personal hygiene and wellness, including nutrition; supervision; and adequate clothing and shelter.

Discharge planning will begin at intake and every effort will be made to return the child to his/her family as quickly as possible. Our interdisciplinary team, consisting of a psychiatrist, nurse, case manager, therapist and unit supervisor, will work in conjunction with the referring worker and

jurist, to make decisions regarding comprehensive assessment, the need for additional services or assessments, the level of care, treatment planning and coordinating discharge services in the community.

The overall goals are to stabilize the youth, to therapeutically teach the family skills to safely maintain the youth at home, and to coordinate community resources to provide additional supports for the family. Prior to discharge, therapists will work in the home with the parent and the youth to establish rules, consistent discipline, positive and negative consequences, as well as address other barriers to family reunification.

Education Services: Residents on this unit will participate in our education program based on their specific educational needs in accordance with the Maryland Department of Education, IEP (for special education youth) and the referring educational authority.

Projected Distribution: In the first year of operations, we expect this unit to represent 35% of our total census. The gender distribution will likely be as follows: 60% male and 40% female.

Older Male (18-21) Unit

The 18-bed adult male program is an intensive treatment program designed to support residents with a history of significant psychiatric illness and/or behavioral disorders and are unable to function in a less restrictive setting. Their psychiatric problems are exacerbated by other issues, such as problems at school or within the legal system, substance abuse, physical abuse and neglect, trauma, learning deficits, and chaotic family situations.

This program is designed to benefit troubled youth, featuring trauma-informed psycho-educational treatment focusing on the development of sustainable pro-social and independent living skills. Many of the youth will likely come to us in need of academic remediation and have had some involvement with the juvenile justice system. Because of their age, they will likely leave the program without support of their families.

We will provide treatment of co-occurring substance abuse disorder; dialectical behavior therapy for the treatment of persons with history of trauma, behavioral disorders, and self injurious behaviors; psychiatric medication therapy and symptom management; referral and linkage to medical, eye and dental care; nutritional services; support with learning life skills (e.g., food shopping, budgeting/banking, using public transportation, structuring productive daily activity, clothes shopping, etc.); vocational rehabilitation; family and social support development and masters level clinical specialist services to address individual needs.

The goal of this program is to assure our residents leave out-of-home care with a high school diploma; the ability to gain employment and/or acceptable post-secondary education; health care coverage; a savings account; knowledge of community resources; and connections to positive adults and family members.

Education Plan: The young adults on this unit matriculating towards a high school diploma or GED certification will benefit from our partnership with Baltimore-based Connections Academy. Although we will support youth who have already progressed in the GED process, our goal is to

help students attain a high school diploma using the on-line, self-paced tools offered by Connections Academy and supported by our certified teachers.

Connections Academy is an excellent tool for older students in need of academic remediation. Through Connections Academy, we will help young adults obtain credits for courses they have previously taken and have been unsuccessful in completing and will also allow youth who have had previous issues with truancy or multiple out of home placements earn credits towards graduation.

Young adults on this unit will also be eligible to take advantage of our "credit by examination" program to realize another 6.5 educational units (depending on the home state LEA criteria). The credit retrieval program is a computer-guided instruction under the supervision of certified special education and general education teachers.

The program curriculum, courses and certificates are aligned with the Maryland State Department of Education and local state education authorities including the District of Columbia and Virginia. Connections Learning also has an impressive list of local partnerships with Learning Disabled (LD) and Emotionally Disabled (ED), elementary and secondary school programs in the region.

We also plan to partner with Prince George's Community College, the University of the District of Columbia and Northern Virginia Community College, to offer online courses for eligible youth and will support them through the discharge process as part of our continuum of care.

Vocational training: This program will be available to all youth on this unit, who, because of age, will likely benefit from a combination of high school/general education diploma and vocational training. The goal of this track is to concentrate on attainment of basic skills competencies, opportunities for academic and occupational training, and eventual exposure to the job market and the potential for pre-discharge employment through partnerships with local employers. We will provide tutoring services (for H.S. diploma and GED), mentoring and comprehensive guidance and counseling.

Our staff will address risk factors to successful and sustainable employment, including academic failure, alienation and rebelliousness, association with delinquent and violent peers, and low commitment to school. We will focus on a developmental approach to help young people avoid high-risk behavior and promote academic and work-readiness skills as well as the personal attributes employers seek.

Referral sources: Male adults admitted to this unit will likely be referred by state mental health agencies (DHR, DHS, CFSA), juvenile services and juvenile courts. We predict the majority of the young adults on this unit will be referred by juvenile services agencies.

Projected Distribution: Young adult males with severe emotional and behavioral challenges are hard to place because of the need to program and house adults away from children and adolescents. In many cases, they have had multiple placements, have serious academic challenges and are at risk for future delinquent behavior. There are also very specific programming needs for

this population. We project approximately 40% of our census in Year 1 will be young adult males between the ages of 18 and 21.

General Information

Seasons Residential Treatment will also meet this standard in the following ways:

1. Male and female residents will be housed in separate housing units **(see Exhibit 4)**
2. All residents will receive group therapy in their housing units and individual, specific, therapeutic supports;
3. Licensed substance abuse treatment for dual diagnosed youth
4. All nursing staff will be embedded in each of the separate housing units and part of the therapeutic milieu. This allows a true multi-disciplinary clinical approach to care and immediate access should any clinical issues arise.
5. Academic programming and classrooms will be gender specific and each resident will receive individualized and customized educational and vocational tech instruction
6. All three (3) meals will be served in the dining hall according to unit and residential cottage, which guarantees the meal times will also be gender specific. The program is designed to serve no more than 20 residents per designated meal times.

COMAR Standard 10.24.07(3)(c) Special Clinical Needs

Seasons Residential Treatment will admit youth 13-21 years old with a full scale IQ of 70 and above. According to most clinical standards, 70 or below is considered a "low IQ" and qualifies as evidence that cognitive limitations existed prior to the age of 18, and limitations in two or more adaptive areas such as communication and self-help skills are present.

The youth we serve will score closest to the admissions criteria of 70, will likely have some mild cognitive limitations, however, at this time, we will not serve youth with coexisting mental and intellectual developmental disabilities, i.e., disabilities that impairs multiple domains of functioning, or youth who are developmentally unable to function independently in his/her environment.

COMAR Standard 10.24.07(3)(d) Minimum Services

Seasons Residential Treatment will seek federal certification to provide services for youth who require the highest level of care outside of an acute setting. As such, we are committed to delivering a treatment program in a safe, structured setting with appropriate levels of staff and security protocols in place for the youth we serve.

Our program and service delivery model is based on a brief, goal-oriented approach. We believe this approach will help reduce lengths of stays and will maximize the time the youth spends in our care and away from their families.

All clinical and direct care staff will be fully integrated in to every level of the program and will have consistent and constant resident oversight. Our staff to resident ratio will be 1:6 which meets the current State of Maryland and federal standards, however, on first and second shift, the staff to resident ratio is higher and exceeds regulations and standards.

Youth will contribute to their treatment "action plan" and families will be required to participate in their care. Our team will work with the youth and family to move residents through the treatment program in a clinically appropriate manner and will consistently discuss next level of care plans before, during and after the admissions process.

We will partner closely with community-based resources including group home providers, independent living programs, appropriate educational programs and vocational/career training programs to develop long-term solutions for youth and families dealing with decades of trauma, behavioral challenges and mental illness.

We are committed to service excellence and will fully explore all of our community-based clinical partners and will establish MOU's to ensure residents have consistency in their care and treatment. Our goal is to identify resources early in the intake process and to have ongoing and engaging discussions about what tools the youth and family need to become contributing members of the community.

Our model is unprecedented in the level of care and support we will provide and is predicated on the belief youth can succeed with programming which allows them to participate in their care.

Our program goals include:

1) Reconnecting youth to their community and families;
2) Supporting youth as they regain/earn public trust;
3) Helping youth identify and understand behaviors and triggers;
4) Engaging youth and families and encouraging them to fully participate in care;
5) Communicating disease state challenges and discussing how to manage issues during the program and post discharge;
6) Developing sustainable educational and vocational skills leading to direct employment and completion of high school diploma;
7) Providing excellent case management resources

COMAR 10.24.07 G(3)(d)

Follows are the minimum services we will provide to meet this standard:

Pre-Admission

Prior to admissions, our staff will work closely with external stakeholders, including prior placement(s) and providers, to determine if our program is the most appropriate and least restrictive setting for the resident. We will request the most recent and relevant academic, therapeutic and social history to inform a pre treatment plan and establish care goals *before* we accept the youth in our program.

Many programs do not commission a pre-treatment plan and rarely request a therapeutic interview prior to admission, Seasons Residential Treatment will make this a standard request to ensure we are the most appropriate placement and that the youth would not benefit from either a lower level of care, or a different treatment milieu.

Admission Process

Consistent with the standards set forth for PRTF certification, under ***42 C. F.R. Sec. 441.152,*** youth will have 24-hour access to a board-certified psychiatric and licensed, registered nurse upon admission, regardless of the time or day the youth is admitted to our program.

Seasons Residential Treatment will employ at minimum, two (2) board-certified child and adolescent psychiatrists. The assigned psychiatrist will manage the overall care and treatment of each resident and will conduct a comprehensive psychiatric evaluation as part of the admissions process.

All psychiatric evaluations, psychological assessments, social history, medical reports and educational reports (including psycho-educational, transcripts and IEP) will be reviewed by a multi-disciplinary care team under the direction and supervision of our board certified psychiatrist.

All referrals must meet the basic medical necessity criteria for Psychiatric Residential Treatment Services (PRTF) **(Exhibit 10).** Consistent with PRTF level care, youth referred to our program must be referred by a physician, or other licensed practitioner, and should meet least one of the following criteria:

-The child is at immediate risk of psychiatric hospitalization or has been removed from his/her home due to a mental or emotional problem; or
-Exhibits behavior which indicates a high risk of developing disturbances of a severe or persistent nature; or
-Is mentally ill or emotionally disturbed as reflected in a DSM-IV diagnosis and would benefit from specialized residential treatment services.

Upon approval of admission, the contact information for the clinical team will be shared with appropriate stakeholders, including the youth's family.

Seasons will set a new bar and standard for partnering with appropriate external stakeholder, immediately documenting and establishing community and campus resources and working towards an effective discharge plan. Although the plan will be based on preliminary treatment goals, we anticipate this early roadmap to be pretty thorough and extensive.

Our licensed therapists will lead daily client and agency interaction; however, both the psychiatrist and clinical director will have direct weekly input with the family, referral source and potential community resources during the first few weeks of care. The process is designed to establish early expectations and foster support for the multi-disciplinary team.

For residents admitted to either the residential or diagnostic/assessment unit, the treatment team will be identified and assigned within 72 hours of admission. As part of the admissions and intake process, the team will also review and assess prior placement information and documentation, family involvement, educational history, juvenile record (if applicable), presence/history of substance abuse, medical and psychiatric history and will also review risk factors related to care/treatment resistance. All residents will also be assessed, upon admission, for past and current trauma symptoms.

Treatment Planning

Individual treatment plans will be used to identify problem areas, establish goals and objectives, detail treatment options most likely to resolve or ameliorate problems, and establish timelines. The Seasons Residential Treatment team will use this document as a roadmap for improving a patient's status and guideline for team orientation, transcription and information.

Individual Group and Family Counseling

Every resident will have individual, group and family services as part of their treatment at Seasons Residential Treatment. All counseling is viewed within the context of the whole family. Family and community involvement is a cornerstone of our program. Research indicates, one family member experiencing problems can affect other members of the family. The team at Seasons Residential will involve the entire family from planning to treatment.

The issues addressed during the sessions are based on long and short-term goals and a comprehensive treatment plan developed in partnership with the resident, his/her family and the multi-disciplinary treatment team. Specific goals include: discharge planning, family and community reintegration, medication management, education and vocational training, life and independent living skills, and trauma history will be discussed.

General areas of therapeutic support include:

- Behavior and conduct disorder
- Sexual and gender identity
- Sexual and physical abuse
- Family dynamics
- Triggers for behaviors and trauma
- School avoidance/educational challenges
- ADHD, PTSD, Bipolar Disorder, Anxiety, Depression and Mood Disorders
- Understanding of disease state, mental health diagnosis
- Substance Abuse

Individual Therapy

Master's level therapist with experience working in a PRTF setting and with youth who have difficult behaviors and mental health challenges will provide individual therapy. Our individual counseling sessions will meet more often than those traditionally offered (3 times per week) and will allow for problem identification, root cause analysis and problem solving between the patient and his/her therapist.

Upon discharge, we will also work closely with the next level of care provider to coordinate care from our residential setting to the community-based provider. Our therapists will share notes, information and history, as appropriate, to ensure a seamless reintegration process, better therapeutic outcomes and decrease likelihood of recidivism.

Family Therapy
Family counseling at Seasons Residential Treatment involves the entire family. We will make every attempt to engage family members and will include relevant stakeholders the youth indentifies as "family" to help with the treatment process. The goal is to help families work through and/or adjust to issues and challenges affecting the entire family. Family therapy may address specific issues surrounding parenting techniques, family dynamics, community/family reintegration concerns, stress management, foster care support, transitional needs and housing options.

The family therapy program emphasizes family relationships as an important factor in psychological health. We believe involving families in solutions is very beneficial in overall positive outcomes. The family therapy program is designed to help parent and child focus on positive qualities and reinforce the positive youth development model embedded in the residential program. The goal of this component is to give parents constructive behavior management skills and to guide them in developing techniques for how to hear, respect and respond to the youth's feelings.

Group Therapy
Residents are provided group therapy 2- 3 times per week. Group therapy involves a small group of residents (approximately 6-10). The residents meet with highly trained clinical staff to learn to cope with, or adjust to, a variety of challenges. The groups will take a variety of forms. Some focus on a specific topic or problem, while others address a number of different concerns. Under the direction of the group facilitator(s), the group is able to give support, offer alternatives, gently confront and promote healing.

Various modalities will be available including in our group therapy menu including traditional, process-oriented, experiential, and cognitive/behavioral. Core group curriculum includes, but is not limited to: trauma resolution and self-concept, social skills and communication, substance abuse, anger management and frustration tolerance and community reintegration.

Therapeutic/Treatment Modalities
Based on national best practices, clinical standards and proven positive outcomes, we believe the therapeutic modalities most appropriate for the type of youth we wish to serve must be: trauma focused, needs-based, individualized, dynamic, family and community focused, engaging and steeped in positive youth development.

Our general philosophy is consistent with the standards hypothesized by Marsha Lineham, Ph.D. Dr. Lineham, the original developer of the Dialectical Behavior Therapy model. According to Dr. Lineham, comprehensive psychotherapy must meet five critical functions. The therapy must:

1) Enhance and maintain the client's motivation to change;
2) Enhance the client's capabilities;
3) Ensure that the client's new capabilities are generalized to all relevant environments
4) Enhance the therapist's motivation to treat clients while also enhancing the therapist's capabilities;

5) Held in a structured environment so that treatment can take place

We have selected the following evidence-based practices as our principle tools and will incorporate similar tools based on the specific needs of the individual client. Our principal treatments will include: Trauma Focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy (DBT) and a modification of Multi-Systemic Therapy (MST). All treatment modalities will be framed within the Positive Youth Development (PYD) model:

Trauma Focused Cognitive Behavioral Therapy: The cornerstone of our treatment philosophy. All therapists will be required to complete a minimum of 20 hours of web-based training during the first year of employment with Seasons Residential Treatment Program. Our clinical director will monitor and lead the successful completion of the program content from the *National Child Traumatic Stress Network* ***(see Exhibit 10)***

The modules cover a host of experiential and expressive therapy techniques along with best practices for psychiatric intervention, medication management and family therapy and counseling. This program was selected because of its robust research, treatment options/customization and outcomes data. The training program has multiple educational levels, explores the various nuances and specificities of trauma within various communities, cultures and environments, and appeals to a broad clinical education level.

Details about the *National Child Traumatic Stress Network,* including a complete list of treatment interventions, program/training modules and how Trauma -Informed Interventions area applied in different clinical and social settings, can also be found here:
http://nctsn.org/nctsn_assets/pdfs/CCG_Book.pdf

Dialectical Behavior Therapy (DBT): Dialectical Behavior Therapy (DBT) The DBT group focuses on developing a clearer sense of self, learning healthy management of emotions, encouraging acceptance of the highs and lows of life without impulsive action, and creating, improving and maintaining healthy, stable relationships

DBT is a modification of cognitive behavioral therapy (CBT) and has been proven effective in residents with very refractory behaviors and youth who have encountered problems in the application of standard CBT. Clinicians have also found the model to be very effective with clients suffering from substance abuse and dually diagnosed adults and adolescents **(see Exhibit 12)**

Multisystemic Therapy (MST): According to the *Coalition for Evidence-Based Policy,* MST is a treatment primarily used for juvenile offenders. However, it has been used with great outcomes in all youth with refractory behaviors. The treatment uses a combination of empirical treatments (e.g. cognitive behavior therapy, behavioral parent training, functional family therapy) to address multiple variables (i.e. family, school, peer groups) that have been shown to be factors in juvenile behavior. It has proven to be an effective tool by all local juvenile services agencies in the District of Columbia, Maryland and Virginia.

Although MST is primarily used in community settings, the overall goal is to improve the youth's ability to make good decisions when choosing his/her peer group, and petitions the family to

monitor his/her behavior(s). These goals are in direct alignment with our program goals, of early and on-going discharge planning, multi-disciplinary care approach and aggressive community and family reintegration strategy. In order to effectively monitor treatment outcomes, we will ensure the fidelity of this model is well defined and supported by our clinical team.

In the community-based model, masters-level therapists provide MST at the youth's home and community locations (e.g. school, recreation center), we will use the same process and tools in the residential setting and feel it will be easy to replicate based on our program intensity, targeted length of stay and required family/stakeholder involvement. Progression will be carefully monitored and therapist will work closely with the stakeholders to remove obstacles to goal achievement.

As part of family therapy, parents and engaged family members will receive MST to prepare them for the youth's discharge. We will work closely with the placing agency to start MST in the home for qualified youth and families. Upon discharge from Seasons Residential Treatment Program, the therapist will coordinate reports to local juvenile service agencies about the effectiveness of this tool and the responsiveness of the youth to the protocol.

Motivational Interviewing: This innovative approach to therapy developed by Stephen Rollnick, Ph.D., is widely accepted as a best practice approach in mental health as well as general healthcare practice when practitioners are challenged with encouraging clients to change an unhealthy lifestyle. Motivational Interviewing is based on a guiding therapeutic style which uses "listening more than questioning" to evoke from patients how change might be more compatible with the direction they want their lives to go in. This empathic listening technique can be useful in any consultation about change, and is supported by a growing body of research.

Personal Boundaries: The key to ensuring relationships is mutually respectful, supportive and caring is setting personal boundaries. Boundaries set the limits for acceptable behavior for each individual and for those around them. Therapists will work with residents in both the group and individual setting to address this issue.

Anger Management: Anger is a powerful energy that can be a destructive force or a channel for change. These groups discuss how to recognize personal triggers, gain control over angry expressions, develop resolution and communication skills, develop appropriate outlets, and redirect energy.

Substance Abuse Treatment: All youth will be evaluated for individual substance abuse treatment and counseling by our certified substance abuse therapist/counselor and will participate in group substance abuse education as part of the general program. Youth who have been identified as having a co-morbid substance abuse issue, will receive counseling and treatment based on the specific addiction and needs of the resident.

Our substance abuse counselor will have experience completing complex bio-psychosocial assessments, delivering specialized treatment/discharge plans, monitoring client's behavior for

relapse, and has participated in hundreds of treatment and family team meetings. Our general focus will be to provide therapeutic counseling and recommendations of treatment based on American Society of Addiction Medicine (ASAM) criteria. According to the ASAM website:

The ASAM criteria, also known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. The ASAM criteria are required in over 30 states and the District of Columbia.

The ASAM Criteria is an indispensable resource that addiction medicine professionals rely on to provide a nomenclature for describing the continuum of addiction services.

Assessments and Testing

Clinical staff will be required to use the most appropriate assessments and tools available to determine the problem severity and general course of treatment.

The general assessment protocol includes:

1) Review of placement agency recommendations (particularly with court-ordered youth)
2) General review of previous placement reports, in the absence of the most current data and information, we will administer: psychological and psychiatric evaluation and psycho-educational evaluations.
3) Conduct Mental Health and Substance Abuse Needs Assessments including: Child and Adolescent Service Intensity Instrument (CASII), the Massachusetts Youth Screening Instrument (MAYSI 1 and 2), The Trauma Checklist (TSC) and the Substance Abuse Screening Inventory (SASSI)
4) Determine Risk. For youth placed by juvenile services agencies, we will use the Structured Decision Making (SDM) tool to review factors and potential for re-offending and to determine the likely level of supervision the youth requires.

Youth admitted to our Diagnostic and Assessment Unit will likely be court-involved and referred by local juvenile service partners. For these youth, we will likely also use the following assessment tools **within 48 hours of admission:**

The Massachusetts Youth Screening Instrument – 2 (MAYSI-2): This instrument is a 15-minute self-report screening tool. It is easy to use and can be administered by staff with minimal training.

There are 5 subscales that have been validated for both males and females:

1) Alcohol/Drug Use
2) Anger-Irritability
3) Depression-Anxiety
4) Somatic Complaints
5) Suicide Ideation

Case Management/Planning

Our multi-disciplinary team, led by the resident's therapist, will work closely with the placing/referral agency and all stakeholders to coordinate case management, care planning and discharge/community reintegration plans. Through our daily interactions, our team will have substantial opportunities to get to know the needs of the youth and how to best support their program and aftercare treatment. We will have dedicated staff to support discharge planning and care coordination with the referral agency and family. The primary role of this department will be to:

1) Facilitate private stakeholder meetings on campus;
2) Provide videoconferencing hardware (at our expense) to support parent/family meetings and therapy;
3) Coordinate Individual Education Plans (IEPs), Individual Development Plans (IDPs) and Individual Treatment Plans (ITPs);
4) Support Youth and Family Team and Community Support Meetings

Recreational Therapy

Recreation Therapy will encourage patients to accept responsibility for their actions, set goals that challenge them to do their best, appropriately express feelings, improve stress tolerance, learn new approaches for problem solving, develop new leisure interests, and learn how to use leisure in positive and constructive ways.

Recreation therapy will utilize activity-based interventions to improve each child's physical, mental, emotional, and social functioning. Recreation therapy services will be offered daily to all populations and are facilitated by activity therapy staff.

Upon admission, each patient will be carefully assessed, and a recreation therapy plan will be developed to determine how to best meet identified needs through recreation therapy. Interventions are implemented to target specific needs and build upon existing strengths throughout their treatment course. Each resident's recreation therapy plan will be reviewed every 90 days and revised as needed to ensure patients are meeting targeted goals.

The Activity Therapy staff will carefully assess personal hygiene skills. The recreation therapy staff will ensure each patient is provided with all personal hygiene items, and ensure all personal needs are met.

Movement Therapy

The movement therapy program is designed to improve physical abilities, including muscle strength, balance, coordination, and flexibility, as well as provide opportunities to help build confidence and self-esteem by focusing on strengths and developing skills. Other benefits include helping patients gain greater self-reliance, which is essential to independent living skills, and increasing interpersonal skills by encouraging patients to join in activities that nurture social relations and create feelings of peer acceptance. Youth admitted to both our residential and diagnostic/assessment unit will benefit from this service.

Movement therapy will be held in the gym and in other classroom size spaces. We plan to partner with a local non-profit to teach yoga and meditation. We plan to offer a range of structured physical activities to promote wellness and help youth remain active in support of a healthy lifestyle. Wherever possible, we will partner with local non-profit and community organizations to deliver bring these programs on campus.

Level System

Our team will implement a "level" system to observe and document youth behavior. The system will be supportive in its effort to show youth behavioral consequence. This system will be applied uniformly and fairly across the program and discussed during the admissions process. This system will not be punitive, instead, it is positive and supportive, with specific discussions related to behavioral consequences.

All youth will be given a comprehensive overview of the level system and how it is used as a vehicle to promote day-to-day feedback and chart and document their success in various settings. The resident will be observed in all settings and feedback will be shared with the multi-disciplinary team and all external stakeholders as part of the assessment process.

Youth Advisory Board

Youth officers elected by their peers from each unit will serve on an agency board representing their milieu. This board, led by the Resident Advocate will meet monthly to review any safety or quality of care issues and make recommendations directly to senior leadership.

Food Services

Our dining hall is designed to accommodate up to 80 people (staff and residents) for three (3) full meals per day. The dining facility will be available for agency inspection and review at all times. Once the program is operational, we will hire experienced staff to ensure we are in compliance with all OSHA, USDA and all other federal and state regulations and food handling requirements.

We will serve three (3) meals per day to residents and staff; daily snacks will also be served. The meals will be aligned with the new nutrition science and standards and will meet federal food and nutrition standards. All food and health safety standards will be monitored by the director of food services and reported to the senior administrative team. The food services director will be responsible for coordinating special diets due to food allergies and/or religious beliefs.

Transportation

Trained transportation staff will provide secure transportation to/from court, home visits, wellness/medical appointments and admissions/discharge to higher/lower level of care. Our transportation team will also facilitate family and community reintegration planning. The team will transport parents, siblings and other supportive stakeholders to/from the facility to support treatment team meetings, parent/family therapy and other interactions that support positive outcomes and youth development.

Our transportation division is also designed to respond to the needs of our customers. We will transport youth to any next level of care placement via auto, train or air travel including safe and

secure transport through airport security. We strongly believe the service will promote better hand off and drive communication between providers. The transportation service will be available on short notice to accommodate requests 24 hours per day/7 days per week.

Discharge Planning

Discharge planning is a critical part of each resident's treatment and our core values. Discharge plans will be prepared by the clinical staff and will include presenting problems at admission, a summary of the course of treatment, progress toward each treatment goal, identification of remaining treatment issues, and recommendations for aftercare.

Generally, the patient will be recommended for successful discharge when he or she has demonstrated a significant decrease in the symptoms that led to admission and has demonstrated reasonable success in structured community reintegration activities.

Clinical staff will be made available to stakeholders during the transition process to provide on-site/phone consultation to help inform the patient's step-down placement. Clinical and direct care staff will also be available to accompany patients during initial home/community passes and to provide initial consultation following discharge.

Medication Management

Our clinical team will help residents and families understand the importance of medication compliance and management. Our goal is to help families understand:

1) Disease state – symptoms and triggers
2) Medication-related side effects
3) Substance abuse and prescription medication interaction
4) The importance of medication compliance

Transitional Services

Transitional services are offered to ensure each patient has appropriate skills and family support necessary for successful community reintegration. Because we plan to serve young adult residents, our discharge/transitional services will include housing support for youth eligible for independent living settings. We will work with local housing authorities to ensure appropriate adult level services are identified and made available as part of the discharge plan.

COMAR Standard 10.24.07G (3)(e) Treatment Planning and Family Involvement

Treatment Planning:

Seasons Residential Treatment is built on a system of care that is collaborative, accessible and comprehensive. Our multi-disciplinary treatment team will work closely with all internal and external stakeholders before, during and after admission and discharge, to ensure resources are: identified and maximized, treatment plans are measured and structured and results defined and delivered.

All of our academic, therapeutic and residential services and supports will be culturally competent and tailored to the unique values and needs of the youth, their families and the culture with which they identify.

All treatment plans will include therapeutic, academic and treatment goals and objectives that are measurable, meaningful and hold staff and youth accountable. The treatment plan is a road map designed to improve problem-solving abilities, increase communication skills, acquire daily coping abilities and enhance self-esteem.

The treatment plan will focus on returning youth back to their family and community and will be driven by the specific and individual needs of the youth and family. All interventions, benchmarks and services will be coordinated by the treatment team and will include input from relevant internal and external stakeholders.

Internally, the multi-disciplinary team will be led by a licensed, experienced, board-certified psychiatrist and will also include contribution and participation from various levels of professional and direct care staff. At minimum, our multi-disciplinary team will include the youth's unit specific registered nurse, teacher, milieu manager and master's level therapists.

Our treatment philosophy is based on keeping families together and returning healthy youth to their natural environment. Our treatment planning is built around effective family participation and engagement. We strongly believe involving client families in therapy can improve communications, reduce stress, and help with resident recovery.

We understand it may be difficult to consistently engage family members and many are juggling multiple priorities and challenges. Our multi-disciplinary team will focus on how to best encourage active and consistent family involvement by understanding barriers to family participation. We will focus on specific individual and family challenges, treatment goals and family history in order to design the best individual family care plan.

Our family treatment is strength and needs-based and focuses on the current family and youth assets. We will educate the family on the role of positive family functioning and how it relates to overall psychological health, stress management and successful youth/resident outcomes.

Our family treatment is positive, supportive and is prospective in its clinical approach. The treatment team will discuss the youth's current mental health and behavioral health challenges and history of substance abuse (as appropriate). We will also address ways to maximize the Seasons Residential program to ensure long term and sustainable treatment success. Our team will promote an atmosphere of hope in a low-stress, comfortable environment. Our family team meetings and therapy will be conducted in a home-like environment designated for family and youth interaction and therapeutic sessions.

Overall, our program model is designed to help parents and youth focus on positive qualities; give parents constructive behavior management skills; guide them in developing techniques for managing anger and teach parents how to hear, respect and respond to their children's feelings. Our treatment model focuses on rebuilding family and community trust, restoring family functioning and developing effective daily living/coping skills. Although we cannot make family therapy a mandatory part of our treatment plan, we will make every effort to engage family members in the treatment process at least once per month.

We will encourage family participation early and often and will require monthly participation in treatment team and/or family therapy. Our proposed location will allow our team to effectively serve a large percentage of families and engage other supportive stakeholders who may be a part of the youth's circle of support.

We plan to make campus access easy for all. Our transportation team will shuttle family members and other stakeholders from the closest Metro station to our campus.

For families who are unable to participate in person, we will make resources available for tele-medicine and counseling via a HIPAA secure computer video service (hardware and software). The goal of this resource is to facilitate family therapy in the home, agency or local outpatient setting. We are committed to this treatment component and will also provide financial assistance to those families who demonstrate access to capital is a barrier to on campus therapy and visitation.

COMAR Standard 10.24.07 G (3)(f) Education

The primary purpose of educational programming at Seasons Residential Treatment is to help students develop the academic, vocational and technical skills needed to be successful. Our mission is to provide a positive educational experience, by building upon existing academic strengths and improving each student's investment and interest in education. The ultimate goal of the educational program is to prepare each student for "next level learning" and to provide a " dynamic roadmap" which reflects how to best achieve educational and career goals as a component of personal development.

All residents will be required to attend the nonpublic academic program as stated in requirements for licensed Residential Treatment Program and certified Psychiatric Residential Treatment Facilities. The nonpublic school program will meet the needs of Level V and Level VI general and special education students with serious behavioral challenges who need a more structured academic setting. Both our day and residential academic program will support general and special education youth with behavioral and emotional challenges

The non-public school program will be located on the Seasons Residential Treatment campus and will serve both day and residential students. We will support middle and high school-age youth and offer a range of traditional and non-traditional academic programming geared towards general education, special education and job readiness and will use the latest technology and experiential learning modules in concert with the required State of Maryland curriculum. The program will be suitable for students who have been unsuccessful in "traditional" educational settings and those that require highly structured and supportive instruction.

In accordance with the rules outlined in *COMAR 13A.09.10, Educational Programs in Nonpublic Schools and Child Care Treatment Facilities,* COMAR 13A.05.01 and COMAR 13A.09.09 *Educational Programs in Nonpublic Schools and Child Care and Treatment Facilities,* we are petitioning to serve youth in our PRTF facility as a ***Type 1, General Special Education*** **Program**. Due to the refractory nature of the youth we will serve and our goal for PRTF certification, we will also adhere to **COMAR 13A.08.04,** *Student Behavior Interventions.*

CERTIFICATION AND ACCREDITATION

Members of the academic team for Seasons Residential Treatment recently met with members of the *Maryland State Department of Education (DOE), Nonpublic Special Education Section and Division of Educator Effectiveness, Nonpublic School Approval Branch,* to discuss our statement of purpose and proposed non-public residential education program.

We will seek a Certificate of Approval (CofA), from the Maryland State Department of Education Nonpublic School division and follow the Maryland State Curriculum for all Maryland youth. Our school administrator(s) will partner with the certifying agency to make sure we are in compliance with **COMAR 13A.09.09.04** if the CofA is approved.

The academic staff will follow general curriculum standards to meet all local and state education authorities for the youth we plan to serve. The standards set forth in the Maryland State Curriculum are consistent with the core education/curriculum requirements for the region, including certification standards set forth by State Education Authorities (SEA's) in the District of Columbia, Virginia and West Virginia. Non-Maryland general and special education youth required by their home state SEA to take electives and credits outside of the Maryland State Curriculum will be handled on an individual basis through our education vendor, Connections Academy.

Within 12 months of approval from the Maryland State Department of Education, Seasons Residential Treatment will also seek accreditation from ***The Middle States Association of Colleges and Schools***. The Middle States Association of Colleges and Schools is defined as a voluntary, peer-based organization dedicated to educational excellence and improvement through peer evaluation and accreditation of public and private universities, colleges, secondary and elementary schools.

The Middle States Association of Colleges and Schools is one of the six regional accreditation organizations recognized by the United States Department of Education and the Council for Higher Education Accreditation. The website and more information about their accreditation standards can be found here: http://www.middlestates.org/

ASSESSMENT

During the admissions process, all youth will be assessed in areas related to the suspected disability, consistent with **34 CFR §300.304 (c)(4)** and **COMAR 13A.05.01**. Our education team, school administrator and clinical team will determine, document and report the best education plan based on a variety of assessment tools and available documentation from previous academic placement.

The team will also review the goals, education history and discharge plan of each student before a plan is developed. A variety of assessment tools will be used to determine how to best leverage the educational, vocational and career technology resources available at Seasons Residential Treatment and through local community partnerships.

STUDENT POPULATION

General Education Youth

Nonpublic programs provide educational therapeutic and/or residential to students with disabilities. In the continuum of services for eligible students, federal and state laws allow programmatic options for students who may require exceptional educational and/or clinical interventions to meet their needs.

During the admissions process, the education team will determine the appropriate grade placement within the educational program and determine where/if the student has credit unit deficiencies. Students will receive an individual core curriculum plan based on their specific education needs within the guidelines of the standards set forth by their State Education Authority. Course content will be presented in an understandable manner designed to accommodate for various learning styles.

Special Education Youth

In accordance with Maryland State Curriculum and outlined in **COMAR 13A.09.10.17,** the academic program of Seasons Residential Treatment will provide an organized program of English, language arts, mathematics, science, social studies, and other curricular areas as appropriate for youth with special education needs. The academic program will help serve and promote the continuation and improvement of Individualized Education Program (IEP) services for day and residential students with disabilities.

In accordance with **COMAR 13A.09.10**, the academic team will maintain and implement policies and procedures for the admission of a student with special education needs into a general education program and will meet the higher standard for all levels within the program requirements, including: staffing, educational programming, teacher/student ratio, related services, assessments and administrative practices.

Young Adults

Older youth who have earned a high school diploma or GED, will program together as a separate school unit. These youth will receive pre-vocational and vocational instruction, along with life and independent skills development and support. Every effort will be made to coordinate "real world" experiential learning with an approved vendor or contractor as part of an apprentice/internship program.

We also plan to partner with Prince George's Community College, the University of the District of Columbia and Northern Virginia Community College, to offer online courses for eligible youth and will support them through the discharge process as part of our continuum of care.

Day School Students

Al programs and services listed in this section will be available to non-residential day students attending the academic program on the campus of Seasons Residential Treatment. Typically, these youth will be referred to Seasons when the IEP team from the local public school has determined that the services the student needs can only be provided in a nonpublic setting. The public school district then pays the tuition for all special education and related services provided by the nonpublic school program. We will assume all responsibility for the implementation of the IEP and

collect/analyze all data on progress; however, the placing school district is ultimately responsible for making sure the students receive appropriate services.

Through FY 2018, we project a day school population of approximately 12 youth per school year and will limit the program to no more than 15 per academic year. This specialized program is designed to support youth with very refractory behaviors from local education authorities within 40 miles of the campus.

Youth may be referred and admitted to our program according to **COMAR 13A.05.01.16** in the following ways:

- Local School System Placement of a Student with a Disability;
- Parental Enrollment of a Student with a Disability in a Nonpublic School
- Unilateral Placement in a Nonpublic School by a Parent when FAPE is an issue;

ACADEMIC STAFF

The educational program at Seasons Residential Treatment will provide academic, behavioral and emotional supports in a comprehensive learning environment with the goal of helping each child achieve new skills and confidence in order to return to their home school district with the best chance of success.

Staff are trained and encouraged to employ the latest de-escalation techniques and strategies to manage student behaviors. Students are never expelled from educational (or any other) service, and we will only use exclusion, restraint or seclusion after every positive behavioral intervention has been completely exhausted *and* the student is at risk, or poses a serious risk to others.

In the instance where behavioral issues warrant temporary removal from the classroom, students will be provided individual instruction in the residential cottage or other designated areas until behaviors are determined appropriate.

Staff to Student ratio

Youth with special education needs will have a staff to student ratio of 1:7, based on the total special education census and outlined in **COMAR 13A.09.10.17.** Qualified teachers will be supported by a teacher's aide, and will also include a member of the direct care staff.

General education youth will have a staff to student ratio of 1:12. The minimum requirement is not outlined in the COMAR regulations and the requirement is excepted in **COMAR 12A.09.10.09 (2) (c).**

Administrator

In compliance with ***COMAR 13A.09.09.06***, and **COMAR 13A.09.10.18**, *Educational Program Personnel Requirements,* using the most restrictive requirement, we will employ an administrator/executive director with:

- A valid Maryland professional certificate as an elementary or secondary school supervisor or principal; or

- A valid Maryland professional teaching certificate in elementary or secondary education; **and**
- Valid Maryland professional certificate as a special education supervisor or special education principal; or
- Valid Maryland professional teaching certificate in special education

The administrator/school director will lead the day-to-day activities of the academic program, and manage all academic program staff. The administrator will also maintain current personnel files (including certifications and qualifications) for all full time and part time academic staff and will establish and adhere to a written policy stating the qualifications, duties, responsibilities and supervision of all academic staff.

The administrator will also have a separate and specific written policy and process for students admitted with IEP's. The academic team will be responsible for: securing, tracking, reporting, monitoring and complying with the IEP requirements for each youth. The team will partner with all external stakeholders to ensure all aspects of the IEP are consistently implemented and services delivered.

The administrator will determine, record and report the student calendar and schedule of the school day in accordance with the standards set forth in **COMAR 13A.09.10.14**. The administrator will also be responsible for unit of credit approval and will coordinate dissemination of transcripts to the local and state education authorities no later than 72 hours after student discharge. School records will be maintained by the education team and will be the primary responsibility and oversight by the school administrator.

Teachers/Instructors/Aides

All full time and part time teachers, including those providing instruction in GED and pre-GED preparation, will have, at minimum, a bachelor's degree from an accredited college or university. All teachers will be required to participate in family and treatment team meetings to help inform next level of care placement, education and therapeutic decisions.

All teacher aides will receive direct supervision and instruction from the teacher to whom the aide is assigned. The teacher aide will have earned an associates degree (preferred), will have at least one year of teaching/instruction, a high school diploma (required).

Career development and career technology staff will be required to have a minimum of 5 years of trade experience, a high school diploma and (preferably) experience working with students with behavioral challenges.

IEP Coordinator

In addition to working closely with the multi-disciplinary team during weekly treatment team meetings, the IEP coordinator will also be responsible for:

- Coordinating admission paperwork – determining the appropriate program and grade placement within the educational program;
- Partnering with the local school system to develop, adhere and amend IEP's,

- Participating in IEP meetings with local school system;
- Informing placement, education and therapeutic decisions within the lens of IEP requirement;
- Documenting related services and IEP compliance;
- Advocating for access to education rights under **COMAR 12A.05.01** (FAPE)
- Disseminating discharge transcripts as part of our individualized educational assessment and education support process

CURRICULUM

Academic Calendar

Seasons Residential Treatment Program will offer a 12-month school year with four 12-week quarters, separated by one-week classroom breaks. The school year will be 228 days, which exceeds the minimum requirement of *at least 180 days of instruction* **(COMAR 13A.09.10.14 (b)).**

Summer School and Extended Year Services

We also plan to offer a summer program that will qualify the program for Extended School Year benefits as defined by the Maryland State Department of Education.

Students will attend summer school classes in the core subjects as outlined in the Maryland State Curriculum. However, our summer academic program focuses on credit retrieval and enrichment with a hands-on, recreation-based theme. Summer school elective courses include Poetry, Photography, Equine Science, Horticulture, Culinary, Creative Writing, Drawing and Painting, Woodworking, Computer Science, Model Building, Exploring Math and Science through Nature, and Photo Journalism.

Students will also be eligible to receive formal instruction in independent living skills, pre-vocational programming, pre-GED and GED preparation and career development/career technology education programming. All instruction will be delivered on the campus by trained and experienced staff of Seasons Residential Treatment, and/or contracted community partners.

Vocational Program and Workforce Development

The program is designed as an elective for older youth (18-21) who are still matriculating towards a high school diploma (or GED) and those youth in our residential program who have successfully completed their high school diploma or GED.

With the understanding not every youth has the goal of furthering their education upon graduation from high school, our goal is to develop an experiential program we can deliver on campus as part of the vocational training and workforce development program.

Students on this track will receive career and technical education in a classroom setting. Our instructors will focus on high growth sectors such as information technology and healthcare and we will infuse the schedule with opportunities for exposure to careers and work experience in these fields. We will also partner with local organizations to provide opportunities for youth to experience success working in more technical areas such as: horticulture; recreation; graphic arts, culinary arts; carpentry; plumbing; electrical; and landscape maintenance.

Independent Living Skills/Transition Services

Seasons Residential will admit youth up to the age of 21. We will implement an independent living program that prepares young adults for community reintegration. We will provide them with the tools they need for movement into adult roles. The goal of the track is to engage them in their own "futures planning process," as well as providing developmentally appropriate services and supports.

The model involves youth (ages 18-21), their families, and other informal key players in a process that facilitates their movement towards greater self-sufficiency and successful achievement of their goals. They will be encouraged to explore their interests and futures as related to each of the transition domains: employment and career, education, living situation, personal effectiveness/wellbeing, sober living and community-life functioning.

The classroom instruction will be delivered by an experienced teacher and reinforced through small group discussion led by a licensed therapist. The clinical aspect of the program will focus on personal development in the following areas:

- Interviewing and general communication skills
- Determining strengths
- Building confidence and trust
- Developing social skills
- Completing an application/resume
- Managing time
- Developing appropriate work habits and attitudes
- Creating a realistic budget, personal credit and how to open a bank account

Get Credit!

We created this program in partnership with Connections Academy to help youth obtain credits for courses they have previously taken and have been unsuccessful in completing. The partnership with Connectional Learning will allow youth who have had previous issues with truancy or multiple out of home placements, to potentially earn credits towards graduation.

We can also provide youth with the opportunity for credit by examination of up to another 6.5 educational units (depending on the home state LEA criteria). The credit retrieval program is a computer-guided instruction under the supervision of certified staff. The program is interactive and engaging and allows the youth to move at his/her own pace.

This is an excellent tool for youth in our diagnostic and assessment unit and youth who may need the extra support of our hands-on team, easy to use software and structured setting to "get credit" for a class they have been struggling with. This program can be implemented in a variety of ways and will be used in conjunction with full time school instruction.

Therapeutic Recreation

Our Therapeutic Recreation Program will provide opportunities for youth to express their creativity through music, yoga, dance and spoken word (poetry). The staff will encourage youth to develop healthy lifestyles during the program and will pair the physical activities with small group

instruction regarding the benefit of movement as a coping mechanism and outlet.

Instructional Materials and Media Library

We will have a state-of-the-art student computer lab outfitted with the latest computers and technology. All students will receive general computer skills training and have supervised use of the Internet for school research, job skill development, independent living preparation and general school coursework.

We have selected *Connections Academy*, an award-winning software and educational company, to complement the variety, quantity and quality of instructional materials we will provide to our students. The partnership with Connections Academy will greatly expand our school resources and ability to deliver quality education resources to youth with gaps in their educational record due to out of home placement or truancy.

The *Connections Academy* program was developed by educators with experience working with youth who need a more flexible and highly customized curriculum design. Each student will be given an educational assessment within 48 hours of admission and will begin some level of credit recovery and/or academic programming within 72 hours of admission.

The use of the *Connections Academy* program, in conjunction with our in classroom instruction, will allow the education team to offer immediate and comprehensive educational assessments and credit recovery to support our commitment to short-term placement and supporting youth in the least restrictive environment.

The ability to administer credit recovery programs in our diagnostic and assessment unit, will also be very helpful and will allow the multi-disciplinary team to more accurately determine next level of care educational placement.

The program curriculum, courses and certificates are aligned with the Maryland State Department of Education and local state education authorities including the District of Columbia and Virginia. Connections Academy also has an impressive list of local partnerships with Learning Disabled (LD) and Emotionally Disabled (ED), elementary and secondary school programs in the region.

Additional information about the company and related outcomes data can be found here: www.connectionslearning.com/connections-learning/home

DIPLOMA AND CERTIFICATE OF COMPLETION

The secondary school academic program at Seasons Residential Treatment will meet the academic, enrollment, credit and student service requirements outlined in **COMAR 13A.03.02** for the issuance of a Maryland high school diploma or Maryland High School Certificate of Program Completion.

SCHOOL RECORDS

Seasons Residential will maintain permanent attendance records, grades, and transcripts for each student. Students are assigned individual grades by certified teachers and will receive credits

based on recommended grades and coursework completed and in compliance with the student's (home) school district requirements.

COMAR Standard 10.24.07 G(3)(g) Medical Assistance

According to the demographic data from the *FY 2013 State of Maryland Out-Of-Home Placement and Family Preservation Resource Plan*, most of the youth we serve will meet the requirements to receive benefits under the Maryland Medicaid Assistance Program and will likely be enrolled in a local MCO provider prior to admission to our program.

Seasons Residential Treatment will adhere to the federal and state standards established in *The Maryland EPSDT Preventive Health Schedule.* The youth we serve will generally be at a higher risk of health problems compared to the same age group in the general population. Multiple out of home placements, placement in non-local residential programs and general family dysfunction, contribute to the data which suggests this group has a higher incident of preventative care non-compliance.

An integral part of the admissions process is to assess the physical, mental and developmental health of all youth referred to our program. For Maryland youth, this process will include determining when the resident is due for the required periodic screenings and whether the youth has ever participated in the screening program.

The clinical team will work closely with external stakeholders to gather all relevant medical records from local providers. Ideally, we will be able to access information from the youth's current primary care physician, partner with the provider to establish a wellness plan for local dental, auditory, vision and health visits and support a continuum of care that will extend to the community once the youth is discharged from our care.

We will check on the following federally mandated components of the *Maryland Healthy Kids Program*:

- Health and Developmental History
- Presence of a recent comprehensive physical examination
- Appropriate Laboratory Tests/Risk Assessments by Questionnaire
- Immunizations
- Health Education/Anticipatory Guidance

We will schedule additional age-appropriate screenings and follow-up visits, as medically necessary and in compliance with the requirements outlined in the *Maryland Healthy Kids Program.*

Seasons Residential Treatment will also contract with local Maryland Medicaid providers, including a pediatrician, primary care physician and nurse practitioners to conduct on site, emergency and on-call, wellness and physical exams, as part of our comprehensive around the clock medical services. In addition, PRTF certification requires and consistent with the needs of the population we will serve, our registered nursing staff will also be available 24 hours per day.

All patients will receive a comprehensive physical examination upon admission. In addition, patients will receive access to bi-annual dental screenings, vision, speech, and hearing screenings, and access to an on-site medical staff seven days a week for injuries or sick visits. We will also provider medical case management and transportation for routine medical needs.

Seasons Residential will contract with a local 24-hour urgent care center and is conveniently located within 5 miles of a full service medical/surgical hospital. All required immunizations are reviewed and updated upon admission, and during the influenza season, all patients are offered free flu vaccines.

Medications will be supplied by and delivered to our program by a "closed door" pharmacy. The pharmacy is contracted and set up to direct bill all local (MD, DC, VA) Medicaid agencies for all youth receiving Medicaid and third party health insurance benefits. The pharmacy will provide specialized clinical staff training and audit patient medication records.

COMAR Standard 10.24.07 G(3)(h) Staff Training
This section has been revised and is consistent with response in Completeness Letter

Seasons Residential Treatment Program is committed to recruiting, training and retaining the best staff at *all levels* of care. Our program leadership team will be unwavering in their expectation of excellence. In order for us to meet this goal, we must educate and empower staff and support their efforts to deliver exemplary care to a challenging population within a therapeutic framework.

We will embrace an employee culture of inclusiveness, open communication and collaboration at all levels within the organization. Starting with recruitment and "on-boarding" of new employees, our staff training will underscore our commitment to building and maintaining an organizational culture that is: respectful of diversity and difference, collaborative and cooperative, and supportive of all internal and external stakeholders. It is also critical to the success of the program that all staff feels supported and valued and is being coached to explore options with the organization beyond their current role.

The contributions of the direct care and direct service staff is critical to the success of the program. Operationally, the direct care staff (specifically, direct care technicians) will have the most frequent and consistent contact with our residents. In our service delivery model, we designed each unit as a separate community within the campus. Our decision to embed nursing staff and therapist in the residential cottages, furthers the idea (that) we will work together as a team to understand and support the needs of our residents.

All levels of staff will be involved in youth care and program design/improvement. Staff will share information about the resident as directed in treatment team meeting, staff meetings and/or individually with the youth. The direct care staff will be fully integrated with the management team and all will serve to support and encourage youth success. The campus will meet in monthly town hall meetings and will have direct access to all levels of management.

The attached *New Employee Orientation Schedule* **(Exhibit 13)** provides a general schedule of new employee orientation in seven key functional areas. The orientation is 80 hours in length and will be delivered during the first two weeks of employment. Staff will be paid for the orientation prior to assuming full job responsibilities. All levels of staff are required to attend the first week (40 hours) of general orientation. The second week of orientation is spent shadowing and indentifying a work mentor and learning the nuances of their specific job function for direct service staff.

The number of hours devoted to each of the seven functional areas is as follows:

Clinical Philosophy: **12 hours**
- Explanation of Evidence Based treatments
- Stages of Change
- Trauma Informed care and approach
- Clinical Outcomes

Therapeutic Milieu: **12 hours**
- Therapeutic Milieu focus on safety, structure and education
- WhyTry? Resilience Education training
- GEARS Verbal De-escalation initiative
- Stages of Change education and training

Evidence-Based Program Training: **20 hours**
- Six Core Strategies to Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint (Trauma Informed Care)
- Seeking Safety (Trauma Informed Care)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Illness Management and Recovery Model
- Seven Challenges
- Cognitive Behavioral Therapy for Late Life Depression

Suicide Prevention: **12 hours**
- Reviewing high risk populations
- Importance of continuity of care
- Contraband prevention

Abuse and Neglect: **8 hours**
- Clients' rights
- Prevention of abuse and neglect

Therapeutic Boundaries: **8 hours**
- Client and staff boundaries
- Counter/transfer boundaries

Handle With Care: **8 hours**
- Crisis Intervention Training provided by certified trainers

Seasons Residential Treatment will require mandatory training for all new and returning full and part time, paid, unpaid and volunteer staff. The director of human resources will be responsible for maintaining staff training and employment records and ensuring employees and contractors adhere to written policies that detail program management, admissions, living and environment, case management, behavior management and program security.

Training and continuing education requirements and national accreditation standards will be outlined for all employees and will be maintained for stakeholder review and inspection, by the director of human resources. All employee certifications, training and continuing educational requirements will meet national standards and best practices and will also be managed by the human resources administrator.

Continuing Education

As part of our benefits package, Seasons Residential Treatment will support continuing education for all employees with at least 12 months of employment. All levels of professional and clinical staff will be able to take advantage of education reimbursement for approved continuing education courses. The courses must directly support their current role, are consistent with their professional development track and approved by their next level manager/supervisor. The tuition reimbursement benefit covers accredited on line, self-study and live classroom coursework and includes programs required for clinical and state licensure.

Direct service personnel will receive training in a variety of in class and online education. Many of these courses will lead to a certificate of completion or continuing education credit for professional staff. Below is an abbreviated list of courses we will make available to direct service staff in order to deliver best practice service to the youth and families we serve:

Intervention	Endorsed by	Required for	How it meets clinical need
Trauma-Focused Cognitive Behavioral Therapy	SAMHSA's National Registry	All Therapists Discharge Planning Academic Staff Direct Care Staff	The purpose of this training is to assist direct care and therapeutic staff with how to recognize issues of past and current trauma. Staff will learn how to identify clinical ad non-clinical aspects of CBT. Non-clinical staff will be trained to recognize triggers and support youth behaviors that are often aggressive and confrontational. Staff will also learn strategies and best practice de-escalation techniques.
Dialectical Behavioral Therapy (DBT)	SAMHSA's National Registry	All Therapists	DBT is a cornerstone modality therapists will be expected to master this intervention and pass related testing/certification. Non-clinical staff will be given a broad overview of how the

Intervention	Endorsed by	Required for	How it meets clinical need
			treatment should be reinforced and supported in the program.
Multi-Systemic Therapy	SAMHSA;s National Registry	All Direct Service Staff Therapists Discharge Planning Academic Staff	Proven "Evidence-Based Practice" shown to be effective in reducing recidivism for juvenile offenders. Training will include discussions about how this intervention is used in the community and which agencies have services to extend our care. Discharge planners will be expected to discuss and understand how to access this resource and provide this information to family members/stakeholders.
Motivational Interviewing	Best Practice and Evidence Based	All Direct Service Staff Therapists Academic Staff Administrators	Motivational interviewing is applicable to a wide range of behavior change/counseling settings and staff. All staff will be expected to approach youth in a way, which supports Positive Behavior Support (PYB) and this style of motivational interviewing.
Positive Youth Development	Best Practice Model	All Staff: Therapist. Discharge planning, academic, dining hall, milieu staff/direct care, administrators	A cornerstone of our Philosophy. All staff will be trained on how to consistently implement Positive Youth Development as a model in all areas of the program: education, milieu, dining,
Good Lives Model of Offenders Rehabilitation	Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services	Therapist	For youth with very specific, very refractory behaviors and disorders
Human Trafficking Awareness Training	Department of Education; Department of Homeland Security	Therapist/Clinical Staff	General training designed to identify the signs of sexual exploitation.
Handle With Care	Best Practice	All Direct Service Staff	National best practice standards for de-escalation of behaviors and crisis intervention

COMAR Standard 10.24.07 G (3)(i) Staffing

Seasons Residential Treatment Program will employ a competent staff of highly skilled full time and contracted, professional, paraprofessional and support personnel. Our staff will be proficient in the latest principles, goals, and advancement in behavioral health and treatment provision, including the principles of Positive Youth Development (PYD).

Seasons will have a staffing pattern that provides on-site trained staff for twenty-four (24) hour coverage, seven (7) days a week (including holidays) based on the number of youth placed in our care. The overall direct care staff to student ratio will be 1:6, with slightly higher staff to resident ratios during first shift hours.

We are committed to maintaining the highest physical, mental and psychosocial wellbeing of each resident. The level of supervision and oversight will have a direct impact on the safety, security and quality of care we will deliver and the outcomes we will share.

All professional staff will be required to submit updates, changes and challenges to all certifications or licenses required to perform, execute or legally deliver services to youth in our care. The Employee Handbook will clearly state what status changes must be reported immediately and what can/should be reported annually in order for the program to fulfill the proposed treatment goals and remain in good standing with our referral partners, funding sources, etc.

The proposed program will take the following steps to ensure we attract and retain a sufficient number of qualified professionals to meet the needs of the youth we wish to serve:

- -Promote from within – establish a succession planning program consistent with program ideals and culture;
- -Encourage use of tuition reimbursement, clinical certifications and continuing education benefit;
- -Establish career tracks and professional development paths across functional areas and staff levels;
- -Recruit staff through local social service agency relationships and workforce development initiatives including those targeting Veterans and other underserved groups;
- -Partner with local universities to attend career fairs, conferences and on-campus events to recruit graduate-level clinicians and alum. Targeted universities include attracting students from the University of Maryland, George Washington, Howard University and Georgetown University;
- -Provide training programs and internship opportunities to graduate-level students; allow them to shadow/support experienced staff;
- -Create various staffing options for our highest turnover (staffing) category: direct care staff. Options will include: per diem, short-term and temporary shifts;
- -Relocation assistance for qualified senior-level clinical and administrative positions;

COMAR Standard 10.24.07 G(3)(j) State Regulations

By virtue of this application, Seasons Residential Treatment Program intends to apply to all mandated federal, state and local health and safety regulations and applicable licensure and certification standards.

COMAR Standard 10.24.07 G(3)(k) Accreditation and Certification

Upon approval of the Certificate of Need from the Maryland Health Care Commission, Seasons Residential Treatment Program will immediately petition the State of Maryland Department of

Health and Mental Hygiene (DHMH) for a license to operate as a Residential Treatment Center (RTC) in accordance with **COMAR 10.07.04**. The program will be jointly licensed as a Specialty Hospital-Psychiatric Facility as outlined in **COMAR 10.07.01.**

We intend to comply with all federal, state and local requirements to operate as a certified Psychiatric Residential Treatment Facility (PRTF) and will meet or exceed standards to operate as a RTC. As soon as permissible, we will petition for initial *Joint Commission* review and file appropriate supporting documents to certify as a PRTF in the State. The process for PRTF certification requires the facility meet the minimum standards to qualify for federal Medicaid reimbursement and is also certified by the *Joint Commission*. We intend to apply for Medicaid reimbursement prior to *Joint Commission* review.

In addition to the above, the academic program at Seasons Residential Treatment will apply to the Maryland State Board of Education for a license to operate as a ***Type 1, General Special Education* Program.** If approved, we also plan to seek accreditation from *The Middle States Association of Colleges and Schools, Commissions on Elementary and Secondary Schools.* The State of Maryland Board of Education does not require the additional education accreditation; however, it will provide an additional level of credibility and accountability in the community.

COMAR Standard 10.24.07 G(3)(l) Criminal Background Investigations

Seasons Residential Treatment Program will comply with all regulations outlined in **Family Law Article, §5-560 through §568, Annotated Code of Maryland.** Seasons Residential Treatment will review regulations **and update procedures** governing criminal background investigations for all employees (FT and PT). We have extended this requirement to include al contractors, vendors and volunteers.

Authorized Agent process

Seasons Residential Treatment Program qualifies to become an authorized agent to receive criminal background information based on the services we provide to youth under the age of 18. As soon as permissible and before we hire the first employee, we will:

1) Formally petition the State of Maryland Department of Public Safety and Correctional Services Criminal Justice Information Systems Central Repository to become an authorized agent to receive criminal background information;
2) Complete Private Party Petition
3) Designate an administrator to receive employee background information

Process for pre-employment and annual background check

All employees, contractors, vendors and volunteers who pass the initial interview/screening to work for and conduct business with Seasons Residential Treatment, will be extended a conditional pre-commitment "offer." Pursuant to moving forward, the applicant must successfully complete the following steps:

First step: State of Maryland filing

1) Complete and submit an application to the State of Maryland Central Repository and provide identifying information used by the Central Repository to verify and identify the applicant;
2) Submit a complete set of legible fingerprints, taken by a designated law enforcement agency or approved agency, to the Central Repository and FBI

Seasons Residential Treatment will:

1) Pay for the full background check (State of Maryland and FBI)
2) Receive the results directly from the State of Maryland as an authorized agent

Second Step: Outside vendor

Because we are committed to providing effective supervision and treatment of all youth in our care and conducting an orderly and safe facility and program, we will pay for a more comprehensive pre-employment and annual criminal record background check of all applicable staff, volunteers and contractors.

We will retain the services of HireRight a national pre-employment screening services company to provide pre-employment screening above what is required in the standards set forth in **Family Law Article, §5-560 through §568, Annotated Code of Maryland/COMAR 12.15.02.**

HireRight offers flexible, tailored employment screening solutions, encompassing more than 150 different service offerings, including pre-employment drug screening and background checks for medical professionals. Depending on the job responsibility of the potential employee and in compliance with national and local standards for the type of services we provide, Seasons Residential Treatment will ask for additional screening in the following areas:

- County and **National** Background Check (all employees)
- Employment/Resume Verification (all employees)
- Healthcare Crime check (health care staff – malpractice, license revocation)
- I-9/Immigration Status (all employees)
- Motor Vehicle (all employees)
- Drug and Alcohol Screening (all employees)

COMAR Standard 10.24.07 G(3)(m): Security

At Seasons Residential Treatment, we believe a safe, structured, stable and secure program starts with a well-trained staff. As stated in **COMAR Standard 10.24.07(3)(h),** Seasons Residential Treatment Program will provide orientation and training for all staff members with respect to administrative procedures, patient rights, confidentiality of resident records, and all relevant policies, procedures and protocols related to environment and community safety.

The entire program will be both staff and hardware secure to meet the needs of the most refractory residents. We have budgeted for internal and external security cameras. The cameras will be positioned to cover the entire perimeter of the campus and communal areas with the exception of areas of personal hygiene.

All windows and "glass" doors will be shatter proof and all access doors will be secured by fob and key access to control resident movement. All external doors will have a delayed lock system and fob control access to ensure the safety of staff and residents. All cameras will be centrally monitored 24 hours per day, 7 days per week by trained staff.

Each "wing" of the new building will have a dedicated de-escalation room. This room will be used only after alternative options have been considered and attempted and positive behavior supports have been exhausted. The use of this room will follow all federal PRTF regulations **(see Exhibit 3)** and Code of Maryland standards.

The room will be used as an extreme last resort in the following instances:

1) residents who need time to process behaviors with staff, or,
2) when it is deemed necessary by staff *and* clinical personnel to remove residents to increase or decrease targeted behaviors

The de-escalation rooms on the residential units are located within line of sight of both the unit therapist and nursing staff. Direct care staff will continue to process with the resident while they are in the de-escalation room and move the resident to the least restrictive environment as soon as safely possible. Please see **COMAR Standard 10.24.07 G(3)(h) Staff Training**

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY – N/A

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
1. Admissions							
a. ICF-MR							
b. RTC-Residents							
Day Students							
c. ICF-C/D							
d. Other							
e. TOTAL							
2. Patient Days							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
3. Average Length of Stay							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
4. Occupancy Percentage*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
5. Number of Licensed Beds*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
6. Home Health Agencies							
a. SN Visits							
b. Home Health Aide							
c. Other Staff							
d.							
e. Total patients srvd.							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
7. Hospice Programs							
a. SN visits							
b. Social work visits							
c. Other staff visits							
d.							
e. Total patients srvd.							
8. Ambulatory Surgical Facilities							
a. Number of operating rooms (ORs)							
• Total Procedures in ORs							
• Total Cases in ORs							
• Total Surgical Minutes in ORs**							
b. Number of Procedure Rooms (PRs)							
• Total Procedures in PRs							
• Total Cases in PRs							
• Total Minutes in PRs**							

*Number of beds and occupancy percentage should be reported on the basis of licensed beds.
**Do not include turnover time.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
(INSTRUCTION: All applicants should complete this table.)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	2020	2021
1. Admissions				
a. ICF-MR				
b. RTC-Residents				
Day Students	14	12	12	12
c. ICF-C/D				
d. Other (PRTF)	50	101	134	142
e. TOTAL	64	113	146	154
2. Patient Days				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other **(PRTF)**	9,008	18,126	24,042	25,550
e. TOTAL	9,008	18,126	24,042	25,550
3. Average Length of Stay				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other **(PRTF)**	180	180	180	180
e. TOTAL	180	180	180	180
4. Occupancy Percentage*				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other **(PRTF)**	34%	69%	91%	97%
e. TOTAL	34%	69%	91%	97%

Table 2 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	2030	2021

5. Number of Licensed Beds				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other **(PRTF)**	72	72	72	72
e. TOTAL	72	72	72	72
6. Home Health Agencies				
a. SN Visits				
b. Home Health Aide				
c.				
d.				
e. Total patients served				
7. Hospice Programs				
a. SN Visits				
b. Social work visits				
c. Other staff visits				
d. Total patients served				
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)				
• Total Procedures in ORs				
• Total Cases in ORs				
• Total Surgical Minutes in ORs**				
b. Number of Procedure Rooms (PRs)				
• Total Procedures in PRs				
• Total Cases in PRs				
• Total Minutes in PRs**				

*Do not include turnover time

10.24.01.08G(3)(c). <u>Availability of More Cost-Effective Alternatives</u>.

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project that will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

This section has been revised and is consistent with request for more information in Completeness Letter

The Project is a more cost effective alternative for the following reasons:

Higher Standard of Clinical Care

The staff at Seasons Residential Treatment Program plans to exceed the highest level of certification standards for a Psychiatric Residential Treatment Facility (PRTF) and meet all requirements for DHMH licensure. We will also adhere to all Joint Commission and national accreditation standards. Our school program will meet standards for Middle States Accreditation and support older youth who may need credit recovery programming, remedial services and vocational/career technical coursework. We plan to partner with local community providers and Core Service Agencies across the state to ensure we are aligned with the most appropriate supports for the youth we serve.

Standard may reduce incidents of acute hospitalization

Our program model is similar to an inpatient acute treatment facility because of the clinical rigor and treatment modalities we will provide and the type of behaviors we will treat. Acute hospitalization is the next level of care above sub-acute and PRTF level care (RTC is generally below PRTF). Although we will not admit youth who is at risk of harm or harming and should be hospitalized, the knowledge, clinical experience and expertise of our multi-disciplinary staff may prevent behaviors from escalating to the level an acute hospitalization is needed from our diagnostic unit or the residential unit. As a certified PRTF, we will also be required to have licensed medical staff available for resident care at all times.

Standard may reduce the cost of acute hospitalization to the health care community

The average cost for acute hospitalization in the local market is approximately 196% higher than the per diem rate we propose (albeit shorter lengths of stay in acute setting) see **Exhibit 14** for local per diem rates for local acute inpatient psychiatric care. Youth in acute settings often "step down" to a residential program. Wherever possible, we would want to reduce the need for hospital admission. Consistent with our core principle and treatment philosophy, we are strong advocates of appropriate clinical placement and would never treat a youth who would be better served either at a higher or lower level of care.

Treatment Modalities as Best Practice for the Target Population

Seasons Residential Treatment will employ a highly trained and qualified staff. Our evidence-based practices and treatments are proven effective in this target population and our staff is

trained to support the most obstinate youth. We want to serve the unique challenges of these youth and their families and have developed a fully integrated, comprehensive, short-term program to maximize therapeutic services before, during and after residential treatment. Our program model includes tracking and reporting post-discharge data and client outcomes. This commitment to support a solid aftercare plan for youth and families also sets our program apart in the local market.

Program will keep youth connected to natural resources and community

Our ability to treat "tough to place" highly aggressive and assaultive Maryland youth closer to home will help placing agencies in the State of Maryland meet the legislative mandate to keep youth closer to home. By keeping youth closer to home, we will have earlier access to more long-term sustainable resources for the youth and family. Data suggests youth placed far from local resources are at risk for poor family and community reintegration, unsuccessful discharge planning and have a higher rate of recidivism than those placed in the appropriate level of care closer to home.

Viable clinical option for older youth

State of Maryland data suggests one of the reasons many of the youth placed in out of state care were placed far from home was due to the lack of programs to treat older youth (ages 18-21). If approved, we will admit youth up to the age of 21 who would normally be placed in out of state programs.

Greater family access to support reintegration

Seasons Residential Treatment Program is a more cost effective alternative because we will reduce associated travel costs currently required to keep families connected to youth in out of state programs.

We will also reduce the barriers to program access and participation by providing hardware and software to families in order to facilitate program participation for families who cannot make it to our site. Data suggests youth placed far from local resources are at risk for poor family and community reintegration, unsuccessful discharge planning and have a higher rate of recidivism than those placed in the appropriate level of care closer to home.

Intangible benefits: Social costs of "failure"

The population we wish to serve has a history of multiple placements and "failures" in local residential programs, community-based programs and "high-fidelity" wrap around services. The social costs of these failures often lead to escalating behaviors and often result in youth involvement in juvenile services, truancy, or hospitalization. Overall, the costs associated with inappropriate residential placement, missed/masked mental health diagnoses and late onset of adequate clinical resources can be staggering for all stakeholders.

System of Care and Accountability

We are proposing a comprehensive system of care designed to partner with and reinforce the community programs already in place because we predict it will strengthen outcomes and successful reintegration. According to a recent issue brief supported by SAMHSA and the Annie E. Casey Foundation and attached in **Exhibit 18,** although "a comprehensive system of care is not

part of the quality improvement initiatives or financial incentives of RTC's," we believe it is a good way to hold our program accountable.

10.24.01.08G(3)(d). Viability of the Proposal.
For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.
This section has been revised and is consistent with request for more information in Completeness Letter.

Please include in your response:

a. *Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.* **(See Exhibit 16)**

On April 7, 2015, Strategic Behavioral Health, LLC, a Memphis, TN corporation acquired Seasons Residential Treatment Program, a Maryland corporation. Please see the acquisition letter in **Exhibit 16** of this application. Strategic Behavioral Health has nine programs in five states and includes acute and residential programs and a commitment to healing children, adolescents, adults and seniors, strengthening families and building communities. We are excited about our ability to "hit the ground running" under the direction of their experienced leadership team, clinical expertise, evidence-based programming and dedicated use of outcomes tools.

Strategic Behavioral Health brings a host of other tangible and intangible benefits to this market, including tremendous financial resources to improve the physical plant for our residents. The company has a very conservative approach to patient admissions and will allow us to focus on milieu safety and building stakeholder confidence as a primary priority over program profits.

Please see the two year audited financial statements from Strategic Behavioral Health as a testament to their commitment to this market and to Seasons Residential Treatment Program, LLC in **Exhibit 15.**

Seasons Residential Treatment Program has received support from local community providers, referral agencies and related service providers. We have had included letters of support from referral sources and Prince George's County Department of Health and Human Services, in **Exhibit 17.**

b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility. (Not Applicable)

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

Other facilities in the area will be affected in the following ways:

The type of youth we wish to serve are the youth many Maryland programs do not support due to the severity and persistence of behavioral problems or mental health challenges. Agencies are forced to send these youth to out of state programs and regional social and juvenile service agencies do not consider Maryland programs for these youth . There will be minimal impact on the cost and charges of care for similar services for other services in the area if this project is approved. Conversely, the impact on out of state programs currently being used by State agencies for this population will be affected because of the decrease in bed utilization if this project is approved – thereby, saving the State resources in this placement category.

We will also support a length of stay that is the shortest and most effective for the behaviors and mental health challenges we seek to treat. In our diagnostic and assessment unit, this may mean youth who would have been at risk for being sent to the Emergency Department in local hospitals may be able to be observed in our diagnostic and assessment unit for a fraction of the cost of acute hospitalization.

If this project is approved, we may be a viable entity for stakeholders who need an expert clinical assessment for youth who have disrupted in lower levels of care. This will be a valuable asset for referral sources who need to make the most clinically informed decision about next level of care placement and resources.

Lower levels of care (therapeutic group homes, home-based wrap around services), will benefit from our commitment to working closely with community-based programs to help prevent some youth from placement in residential programs. We are committed to the Building Bridges Initiative and a coordinated system of care. This commitment will allow us to partner with providers and stakeholders to ensure we only admit youth who are the most appropriate for our level of care while supporting the lowest level of care placement and the most efficient use of health care dollars in the state and region.

By partnering with lower levels of care, we plan to work with community programs to share resources around program costs and implementation. By sharing costs and providing resources in areas where our population overlaps, both organizations may be able to realize savings.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

List of proposed patient charges by service

Education - $127 (does not change year over year for Year 1-4)
Education/Day School - $263 (does not change year over year for Year 1-4)

Residential Patient Charges: (Please note: Seasons will not charge a higher per diem for older youth or for services provided in Assessment and Diagnostic Unit).

Residential per diem rate by payer as follows:

Payor	FYE 2018	FYE 2019	FYE 2020	FYE 2021
Medicaid	$410	$422	$435	$448
Commercial Insurance	$464	$478	$493	$507
Self-Pay	$464	$478	$493	$507
Other – SEA/LEA	$425	$438	$451	$464
Other – Direct Pay Agency	$435	$448	$461	$475

Reimbursement for education services is based on several factors, including general and special education population mix, length of academic calendar, availability of extended services, type and (behavioral) level of population served and curriculum (i.e.. vocational and career technical courses/certifications). Academic rates are set each year in partnership with the Maryland Department of Education and are generally capped at cost plus 10% for nonpublic school providers.

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility (including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Table 4, "Revenues and Expenses - Proposed Project," is to be completed by each applicant for the proposed project only. Table 5, "Revenues and Expenses (for the first full year of utilization", is to be completed by each applicant for each proposed service in the space provided. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.)

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	20___	20___	20___	20___	20___
1. Revenue							
a. Inpatient services							
b. Outpatient services							
c. Gross Patient Service Revenue							
d. Allowance for Bad Debt							
e. Contractual Allowance							
f. Charity Care							
g. Net Patient Services Revenue							
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue							

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle	20___	20___	20___	20___	20___	20___	20___
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)							
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							

f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies							
j. Other Expenses (Specify)							
k. Total Operating Expenses							
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							
d. Income Taxes							
e. Net Income (Loss)							

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
4. Patient Mix: A. Percent of Total Revenue							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT
(INSTRUCTION: Each applicant should complete this table for the proposed project only)

SEASONS RESIDENTIAL TREATMENT

TABLE 4:REVENUES AND EXPENSES - PROPOSED PROJECT

	Project Years (Ending with first full year at utilization)			
CY or FY (Circle)	FYE 12/31/18	FYE 12/31/19	FYE 12/31/20	FYE 12/31/21
1. Revenues				
a. Inpatient Services	9,08,00	18,126,000	24,042,000	25,550,000
b. Outpatient Services (Day School)	1,080,000	1,200,000	1,200,000	1,200,000
c. Gross Patient Services Revenue	10,088,000	19,326,000	25,242,000	26,750,000
d. Allowance for Bad Debt	(100,880)	(193,260)	(252,420)	(267,500)
e. Contractual Allowance	(4.956.307)	(9.284.627)	(11.815.666)	(12.176.014)
f. Charity Care	-	-	-	
g. Net Patient Care Service Revenues	5,030,813	9,848,113	13,173,914	14,306,486
h. Total Net Operating Revenue	5,030,813	9,848,113	13,173,914	14,306,486
2. Expenses				
a. Salaries, Wages, and Professional Fees				
(including fringe benefits)	4,310,873	5,935,554	6,942,783	7,185,596
b. Contractual Services	84,032	120,336	144,168	150,200
c. Interest on Current Debt	-	-	-	-
d. Interest on Project Debt	290,334	275,413	260,493	245,572
e. Current Depreciation	20,000	40,000	60,000	80,000
f. Project Depreciation	489,286	489,286	489,286	489,286
g. Current Amortization	-	-	-	-
h. Project Amortization	-	-	-	-
i. Supplies	189,168	379,764	504,882	536,550
j. Other Expensess (specify)				
Advertising	18,000	18,000	18,000	18,000
Recruitment	36,000	36,000	36,000	36,000
Travel	96,000	72,000	72,000	72,000
Repairs	9,008	18,084	24,042	25,550
Rent	36,000	36,000	36,000	36,000
Insurance	48,000	48,000	48,000	48,000
Utilities	132,000	132,000	132,000	132,000
Property Taxes	202,000	202,000	202,000	202,000
Other Expenses	12,000	12,000	12,000	12,000
k. Total Operating Expenses	5,972,701	7,814,437	8,981,654	9,268,754
3. Income				
a. Income from Operation	(941,888)	2,033,676	4,192,260	5,037,732
b. Non-Operating Income	-	-	-	-
c. Subtotal	(941,888)	2,033,676	4,192,260	5,037,732
d. Income Taxes	-	-	-	-
e. Net Income (Loss)	(941,888)	2,033,676	4,192,260	5,037,732
4. Patient Mix:				
A. Precent of Total Revenue				
1. Medicare	0%	0%	0%	0%
2. Medicaid	50%	50%	55%	55%
3. Blue Cross	0%	0%	0%	0%
4. Commercial Insurance	2%	2%	4%	4%
5. Self-Pay	3%	3%	3%	3%
6. Other (specify) - SEA/LEA	5%	5%	3%	3%
6a. Other (specify) - Direct Pay Agency	40%	40%	35%	35%
7. Total	100%	100%	100%	100%

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.
To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.
List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1995, and their status.

Applicant has never applied for or received a Certificate of Need from the Maryland Health Care Commission.

10.24.01.08G(3)(f). Impact on Existing Providers.
For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicat existing health cares resources. Describe any special attributes of the project that will demonstrate why th project will have a positive impact on the existing health care system.

This section has been revised to answer questions in Completeness Letter

Does not duplicate existing resources
We believe there is an unmet need and documented "gap" in the services for the type of youth and families we wish to serve and this project will not duplicate existing health care resources. Current existing providers do not serve a significant segment of youth in need of residential treatment services. These youth present with one or more of the following: very refractory, highly assaultive and aggressive behavior, a history of arson and fire setting and emotional disturbances. These youth may also need concomitant treatment for substance abuse and mental health issues. This tough to treat population of youth with specialized needs and behavioral challenges, are not being met in state. The approval of this project will not duplicate existing resources.

This project will mean greater access for older youth
There are very few residential treatment programs (certified as PRTF's) in the State of Maryland with separate programming, staff and therapeutic milieu for older male residents. This project will provide dedicated resources to adult males in need of social, therapeutic and academic skills needed to successfully transition from supportive care. Our program will provide adult males with sustainable tools for independent living. This project does not duplicate existing health care resources and will positively impact the marketplace, because there is an established need for both the treatment and supports for this population.

Resources stay close to home

This project will extend access to Maryland residents who need more specialized care close to home. A large percentage of the youth we wish to serve are currently going out of state to receive care causing a significant burden on the financial resources in the health care system due to higher costs to treat youth in out of state programs. Data from the Governor's Office for Children indicates that although there is a decrease in the number of youth being placed in residential treatment programs, the per diem (bed) rate for out of state programs has increased year over. While agencies are placing fewer residents in out of state programs, the impact on total cost of placement has not kept pace. When you factor in the related cost of travel to out of state programs for agency staff, parents and other stakeholders, sending youth to out of state placements has had a negative financial impact on the health care system.

Youth in out of state programs generally are tougher to treat and have a high recidivism rates and poor reintegration rates leading to multiple placements and/or more restrictive care. Data shows youth with greater access to culturally competent and appropriate supports during treatment have a better outcomes and potential for long-term treatment success. **(see Exhibit 18).** The social and financial cost of sending youth aware from natural resources negatively impacts the health care system. This project would positively impact agency budgets and existing providers who may benefit from stepping youth down from an accessible in state provider.

According to data from the District of Columbia, existing Maryland health care providers are not serving a large percentage of District of Columbia youth. This was also made clear during the solicitation and procurement process for "Awaiting Placement" (Diagnostic and Assessment beds) distributed by the District of Columbia Office of Contracts and Procurement on behalf of the Department of Youth Rehabilitation Services. The fact that Seasons Residential Treatment Program was awarded the contract based on a proposal to launch a residential program for tough to treat youth, speaks to the need, interest and viability of this project. It may also indicate existing Maryland programs are not interested in serving the needs of this population.

District of Columbia youth, regardless of the placing source, are placed in residential programs outside of their home community. This project will allow greater geographic access for youth and families from the District of Columbia, Virginia and West Virginia and will be able to better leverage stakeholder participation and provide better access to after care resources. The impact of this project on youth in neighboring states will be significant as step down and reintegration become more seamless.

Occupancy rates for area providers should not be adversely affected by the introduction of this program. Our target population is primarily youth Maryland providers cannot or do not want to treat. The need for additional hardware secure programs in Maryland has been clearly established by Maryland referral sources. The youth needing this level of care are not being served in the local community. Assets, including jobs and tax dollars are being sent to other jurisdictions because we cannot support Maryland youth in in-state programs.

Although PRTF-level care and certification requires more clinical staffing, clinical oversight, staffing, physical plant specifications and documentation, our per diem costs for our residential and diagnostic and assessment unit will be consistent with agency rates charged by residential

treatment center programs currently licensed in the State of Maryland. Our projected Medicaid rate will be slightly lower than what is currently billed by local providers. We will not charge higher rates for our intensive services and will keep education rates for general and special education students flat during the first four program years.

Our costs and charges will be consistent with existing providers, however, the quality of our program will benefit consumers and the health care delivery system overall. We agree with national thought leaders who feel residential treatment should remain an important component of an organized system of care and should no longer be used as the primary resource to support youth with behavioral problems due to mental health challenges. We plan to grow our program slowly and organically with a focus on appropriate placements and treatment.

Our length of stay goals and treatment objectives are consistent with the principles of local and national industry experts and will have a positive impact on existing providers already part of the continuum of care in Maryland. Our philosophy of communicating, collaborating and cooperating with community stakeholders will set us apart from other programs and providers. Our guiding principles are built around innovation, partnership and collaboration, best in class practices, and long-term positive impact on families and youth suffering from a history of trauma.

Seasons Residential Treatment program is built on a philosophy of care that will support, identify, build and leverage local community-based resources in order to more effectively and efficiently address the serious and specific challenges confronting local youth. By partnering with community-based programs, we can extend the support beyond our campus and reduce the amount of time youth spend away from their natural resources. We want to help shape long-term treatment success. We believe youth are best served in their community with proper stakeholder supports and hope to help shape in-state programs that meet current mental health needs of youth and families.

TABLE 5. MANPOWER INFORMATION (see attached)

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Direct Care					
Support					
				Benefits	
				TOTAL	

(INSTRUCTION: Indicate method of calculating benefits percentage):

Strategic Behavioral Health has acquired Seasons Residential Treatment Program, LLC. Strategic Behavioral Heal currently has a portfolio of acute and residential beds in five states and gross revenues of $83M. The company currently employs more than 3,000 employees. The size and scope of Strategic Behavioral Health will allow us to provide the best benefits options to our employees at the lowest costs. We calculated the benefits percentage for this project at 23.5% based on the average cost for local employers and included a variable cost savings based on our post-acquisition total payroll and total number of employees.

SEASONS RESIDENTIAL TREATMENT PROGRAM

CERTIFICATE OF NEED: TABLE 5

TABLE 5: MANPOWER INFORMATION

Position Title		Proposed /New FTE	Changes in FTE's (+/-)	Average Salary	Employee/ Contractual	Annual Salary Cost	Part time total	Total payroll included in benefits	
Admin									
	Executive Director	1.00	-	135,000	E	$130,000	0	$130,000	
	Director of Finance	1.00	-	85,000	E	$85,000	0	$85,000	
	Dir of Academics/Principa	1.00	-	90,000	E	$90,000	0	$90,000	
	Clinical Director	1.00	-	90,000	E	$90,000	0	$90,000	
	Director of Admissions	1.00	-	75,000	E	$75,000	0	$75,000	
	Director of Human Resour	1.00	-	77,000	E	$77,000	0	$77,000	
	Milieu Mgr/Program Mgr	1.00	-	55,000	E	$55,000	0	$60,000	
	Director of Nursing	1.00	-	92,000	E	$92,000	0	$92,000	
	Psychiatrist	2.00	-	165,000	E	$330,000	0	$330,000	Dept coverage is 24/7/365. Meets PRTF standards/certification
Direct Care									Direct care Dept coverage is 24/7/365; exceeds staff/resident ratio requirements
	Direct Care Staff - AM	6.00	-	45,000	E	$270,000	45,000	$225,000	assumes 2 PT staff
	Direct Care Staff - PM	6.50	-	45,000	E	$292,500	67,500	$225,000	assumes 3 PT staff
	Direct Care Staff - Midnigh	6.00	-	45,000	E	$270,000	0	$270,000	
Education									
	Special Education Teacher	3.00	-	85,000	E	$255,000	0	$255,000	
	General Education Teache	3.00	-	75,000	E	$225,000	0	$225,000	
	Teacher Assistant	1.50	-	45,000	E	$67,500	22,500	$45,000	Assumes .5 FTE/1 PT staff
	IEP Coordinator	1.50	-	55,000	E	$82,500	27,500	$55,000	Assumes .5 FTE/1 PT staff

SEASONS RESIDENTIAL TREATMENT PROGRAM

CERTIFICATE OF NEED: TABLE 5

TABLE 5: MANPOWER INFORMATION

Nursing/Therapeutic Team											RN coverage is 24/7/365; meets PRTF standards and certification
		Nursing - RN		4.00	-	78,000	E	$312,000	78,000	$234,000	
		Nursing - LPN		2.50	-	55,000	E	$137,500	82,500	$55,000	
		Therapist		4.00	-	74,959	E	$299,836	74,959	$224,877	
		Discharge Planner		1.00	-	55,000	E	$55,000	55,000	$0	
Food Services											
		Food Service Manager		1.00	-	55,000	E	$55,000	0	$55,000	
		Line Cook/Food Prep		3.00	-	36,000	E	$108,000	36,000	$72,000	
Support											
		Clinical Dept Secry		1.00	-	50,000	E	$50,000	0	$50,000	
		Marketing/Business Dev C		1.00	-	50,000	E	$50,000	0	$50,000	
		UR/Credentialing/Ins Veri		1.00	-	50,000	E	$45,000	0	$45,000	
		Finance Ops/Admin Asst		1.00	-	39,200	E	$39,200	0	$39,200	
		Receptionist/General		1.00	-	35,000	E	$35,000	0	$35,000	
		Accounts Payable		1.00	-	55,000	E	$55,000	0	$55,000	
		Accounts Receivable		1.00	-	55,000	E	$55,000	0	$55,000	
		Admissions Coordinator		1.00	-	50,000	E	$50,000	0	$50,000	
Maintenance/ Housekeeping											
		Maintenance Mgr		1.00	-	48,000	E	$48,000	0	$48,000	
		Maintenance		2.00	-	36,000	E	$72,000	36,000	$36,000	
		Housekeeping		1.50	-	32,000	E	$48,000	48,000	$0	
									Salary	$3,433,077	
									Benefits (23%)	$806,773	
									Total Salary	$4,239,850	
Contract Staff											
		Security Staff		1.50		30,900	C	$46,350			
		Internist		0.50		37,575	C	$37,575	Benefits (0)	$83,925	
									Total Contract	$83,925	

1. **An assessment of the sources available for recruiting additional personnel;** We are excited about the possibility of hiring, training and retaining staff from across the State of Maryland with a specific focus on qualified staff from Prince George's County. According to the latest unemployment report, Prince George's County has an unemployment rate of 6.7% and Charles County has an unemployment rate of 6.0%. Both are slightly above the State unemployment rate of 5.5% and the national rate of 5.6%. At full census, we will employ approximately 130 FTE's.

Seasons Residential Treatment Program plans to use several resources to attract and retain talented experienced personnel. We plan to partner with all of the area colleges and universities, including: Catholic University, Morgan State University, Georgetown University, Howard University, University of MD, Bowie State and George Washington to attract and retain talent from their extensive alumni and professional networks.

We plan to establish and cultivate relationships with all the relevant graduate and professional programs as part of our normal community outreach. We will develop several paid internships to support research and on campus activities. We will focus our resources and interest primarily in the School of Social Work and Education. We hope to develop a pipeline of talent based on organic relationships and positive program publicity in the local print and broadcast media. We will also leverage social media platforms and industry specific search tools to recruit for specific positions.

Of the many resources the acquisition of Seasons by Strategic provides, is access to "deep and experienced" bench of professionals who are on "standby" at our home office to backfill professional positions if and when the need arises. For all functional areas, there is a corporate staff member at Strategic, who, is responsible for "pitch hitting" until we have hired the right candidate.

We also plan to partner with regional social and human service associations and organizations to support local recruiting efforts. We will also attend and recruit from nursing and allied health career fairs and networking events. Our on line presence will help direct successful recruiting, as all roles will be posted on our website along with job boards (Monster.com, Indeed.com and DCJobs.com). Access to and support for local fraternal and civic organizations will also be used.

We have also engaged several recruiting firms and executive search teams to help us with senior managers and clinical positions that require more discretion and time to fill. Our back office support team at Strategic Behavioral Health in Memphis has a lot of experience hiring and on-boarding staff, their help and discernment will be invaluable.

Our long-term goal is to develop and cultivate a team of per diem employees who can help ensure we are above compliance with staff to resident ratio and support any special events or programs.

2. **Recruitment and retention plan for those personnel believed to be in short supply;**

Recruitment of direct care staff will likely be the most challenging and have the highest turnover, however, we are prepared to offer extensive training, professional certificates, and access to national conferences for continuing education along with competitive salaries, excellent benefits, 401K and quarterly bonus potential. Employees will have a dedicated personal and professional development track and opportunities for significant growth and responsibility. We are confident we will attract a consistent source of top tier candidates. We have an impressive roster of continuing education courses and the most recent and relevant training in various treatment modalities to support allied health and professional (therapist, nursing) certifications.

We have also reached out to several staffing firms, including the Delta-T group, a recruiting firm specializing in placement of mental health care staff to help attract hard to fill staff positions. We also plan to work with local recruiting firms in Prince George's and Charles County to recruit allied health staff, re-entrant workers, veterans and staff who may not have an extensive resume of professional experience. Our recruiting goal is to support qualified candidates from the local market who are eager and committed to working with this tough population.

3. **For existing facilities, a report on average vacancy rate and turnover rates for affected positions, (NA)**

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

This regulation is not required according to Maryland State Health Plan for our project, but, is covered in part, by the answer in **COMAR Standard 10.24.07 G (3)(i) Staffing**.

PART IV - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identify and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

   Tyeaesis Johnson, 1101 30th Street, NW, 4th Floor, Washington, DC 20007

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each facility, including facility name, address, and dates of involvement.

   No

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner or other person responsible for implementation of the Project was not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No

4. Is any facility with which the applicant is involved, or has any facility with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition reached by the applicable governmental authority.

   No

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

   No

ATTESTATION

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project, which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed or existing facility.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

5/12/15
Date

Signature of Owner or
Authorized Agent of the Applicant

Exhibit 1

Per the legislative history below, the bill met final approval and was enacted on July 24, 2012. The bill then became effective on September 10, 2012. This information can also be found on the County's website – Legislative Information System.

Prince George's County Council Agenda Item Summary

Printer friendly version

Meeting Date:	7/24/2012
Reference No.:	CB-029-2012
Draft No.:	3
Proposer(s):	Patterson
Sponsor(s):	Patterson, Davis, Franklin, Lehman
Item Title:	An Ordinance concerning Juvenile Group Residential Facilities for the purpose of permitting group residential facilities in certain residential zones subject to specific requirements in order to implement the important public purpose of protecting the public safety, health, and welfare; providing local reporting requirements for juvenile group facilities in residential zones, providing enforcement provisions, and repealing the requirement that group residential facilities obtain a special exception as a condition to operating in certain residential zones.
Drafter:	Kathleen H. Canning, Legislative Officer
Resource Personnel:	Jacqueline W. Brown, PZED Committee Director Maurene Epps-Webb, Chief Zoning Hearing Examiner

Per the legislative history below, the bill met final approval and was enacted on July 24, 2012. The bill then became effective on September 10, 2012. This information can also be found on the County's website – Legislative Information System.

Prince George's County Council Agenda Item Summary

Printer friendly version

Meeting Date:	7/24/2012
Reference No.:	CB-029-2012
Draft No.:	3
Proposer(s):	Patterson
Sponsor(s):	Patterson, Davis, Franklin, Lehman
Item Title:	An Ordinance concerning Juvenile Group Residential Facilities for the purpose of permitting group residential facilities in certain residential zones subject to specific requirements in order to implement the important public purpose of protecting the public safety, health, and welfare; providing local reporting requirements for juvenile group facilities in residential zones, providing enforcement provisions, and repealing the requirement that group residential facilities obtain a special exception as a condition to operating in certain residential zones.
Drafter:	Kathleen H. Canning, Legislative Officer
Resource Personnel:	Jacqueline W. Brown, PZED Committee Director Maurene Epps-Webb, Chief Zoning Hearing Examiner

LEGISLATIVE HISTORY:

Date Presented:	5/15/2012	**Executive Action:**	
Committee Referral:	5/15/2012 - PZED	**Effective Date:**	9/10/2012
Committee Action:	6/6/2012 - FAV(A)		
Date Introduced:	6/19/2012		
Public Hearing:	7/24/2012 - 10:00 AM		
Council Action (1)	7/24/2012 - ENACTED		
Council Votes:	WC:A, DLD:A, MRF:A, AH:A, ML:A, EO:A, OP:A, IT:A, KT:A		
Pass/Fail:	P		

COUNTY COUNCIL OF PRINCE GEORGE'S COUNTY, MARYLAND
SITTING AS THE DISTRICT COUNCIL
2012 Legislative Session

Bill No. CB-29-2012
Chapter No. 19
Proposed and Presented by Council Member Patterson
Introduced by Council Members Patterson, Davis, Franklin and Lehman
Co-Sponsors
Date of Introduction June 19, 2012

ZONING BILL

AN ORDINANCE concerning

Group Residential Facilities

For the purpose of permitting group residential facilities in certain residential zones subject to specific requirements in order to implement the important public purpose of protecting the public safety, health, and welfare; providing local reporting requirements for juvenile group facilities in residential zones, providing enforcement provisions, and repealing the requirement that group residential facilities obtain a special exception as a condition to operating in certain residential zones.

BY repealing and reenacting with amendments:
Sections 27-107.01, 27-441(b) and 27-515(b),
The Zoning Ordinance of Prince George's County, Maryland,
being also
SUBTITLE 27. ZONING.
The Prince George's County Code
(2011 Edition).

BY repealing: Section 27-360,
The Zoning Ordinance of Prince George's County, Maryland,
being also
SUBTITLE 27. ZONING.
The Prince George's County Code

(2011 Edition).

BY adding: Section 27-445.14,
The Zoning Ordinance of Prince George's County, Maryland,
being also
SUBTITLE 27. ZONING.
The Prince George's County Code
(2011 Edition).

SECTION 1. BE IT ENACTED by the County Council of Prince George's County, Maryland, sitting as the District Council for that part of the Maryland-Washington Regional District in Prince George's County, Maryland, that Sections 27-107.01, 27-441(b) and 27-515(b) of the Zoning Ordinance of Prince George's County, Maryland, being also Subtitle 27 of the Prince George's County Code, be and the same are hereby repealed and reenacted with amendments:

SUBTITLE 27. ZONING.

PART 2. GENERAL.

DIVISION 1. DEFINITIONS.

Sec. 27-107.01. Definitions.

* * * * * * * * * * * * *

(109) **Group Residential Facility**:

(A) A "Dwelling Unit" or "Foster Home," operated by a responsible individual or organization, which has a program designed to provide a supportive living arrangement for five (5) or more individuals (unrelated to the operator by blood, adoption, or marriage) who are members of a service population that, because of age or emotional, mental, physical, familial, or social conditions, needs supervision.

(B) This term includes, facilities for developmentally disabled persons, drug dependent persons, alcoholic persons, juveniles, or persons whose welfare and adjustment within the community are dependent on support from the community.

(C) The term does not include:

[(i) A "Foster Home" where there are four (4) or less persons unrelated by blood, adoption, or marriage to their foster parents;]

[(ii) A "Foster Home" where there are not more than six (6) foster children who are unrelated to their foster parents, but are related by blood or marriage to each other;]

[(iii)] (i) A "Hospital" or "Nursing or Care Home";

[(iv)] (ii) A "Congregate Living Facility"; or

[(v)] (iii) An "Adult Day Care Center."

(D) A "Group Residential Facility" for the "mentally handicapped" for up to eight (8) residents shall be considered a "One-family Detached Dwelling."

(E) When a "Group Residential Facility" is limited to serving a "mentally handicapped" population, this term shall include any individual with a primary disability as a result of mental retardation, mental illness, or mental disorder which impairs the person's cognitive ability to live independently (excluding addictive disorders resulting from substance abuse).

* * * * * * * * * * * * *

Sec. 27-441. Uses permitted.

(b) TABLE OF USES.

USE	ZONE								
	R-O-S	O-S	R-A	R-E	R-R	R-80	R-55	R-35	R-20
(6) Residential/Lodging									
* * * * * *	*	*	*	*	*	*	*	*	*
Group residential facility for more than 8 mentally handicapped dependent persons, or for 5 or more other dependent persons [94]	[SE] P	[SE] P	[SE] P	[SE] P	[SE] P	[SE] P	[SE] P	[SE] P	[SE] P
Group residential facility for not more than 8 mentally handicapped dependent persons	P	P	P	P	P	P	P	P	P
* * * * * *	*	*	*	*	*	*	*	*	*

[94 All State and private operators of juvenile group residential facilities shall register their facilities with Prince George's County on forms provided by the County. The County shall compile the information and make it available to applicable County agencies.]

USE	ZONE							
	R-T	R-30	R-30C	R-18	R-18C	R-10A	R-10	R-H
(6) Residential/Lodging								
* * * * * * * *	*	*	*	*	*	*	*	*
Group residential facility for more than 8 mentally handicapped dependent persons, or for 5 or more other dependent persons [94]	[X] P	[X] P	[X] P	[SE] P	[X] P	[X] P	[X] P	[X] P
Group residential facility for not more than 8 mentally handicapped dependent persons	P	P	P	P	P	[X] P	P	P
* * * * * * * *	*	*	*	*	*	*	*	*

[[94] All State and private operators of juvenile group residential facilities shall register their facilities with Prince George's County on forms provided by the County. The County shall compile the information and make it available to applicable County agencies.]

PART 8. COMPREHENSIVE DESIGN ZONES.

DIVISION 3. USES PERMITTED.

Sec. 27-515. Uses permitted.

(b) TABLE OF USES.

USE	ZONE								
	M-A-C	L-A-C	E-I-A	R-U	R-M	R-S	R-L	V-L	V-M
(7) RESIDENTIAL/LODGING:									
Group residential facility for up to 8 mentally handicapped dependent persons [36]	P	P	[X] P	P	P	P	P	P	P
* * * * * * *	*	*	*	*	*	*	*	*	*

[[36] All State and private operators of juvenile group residential facilities shall register their facilities quarterly with Prince George's County on forms provided by the County. The County shall compile the information and make it available to applicable County agencies.]

SECTION 2. BE IT ENACTED by the County Council of Prince George's County, Maryland, sitting as the District Council for that part of the Maryland-Washington Regional District in Prince George's County, Maryland, that Section 27-360 of the Zoning Ordinance of Prince George's County, Maryland, being also Subtitle 27 of the Prince George's County Code, be and the same is hereby repealed:

SUBTITLE 27. ZONING

PART. 4. SPECIAL EXCEPTIONS.

DIVISION 3. ADDITIONAL REQUIREMENTS FOR SPECIFIC SPECIAL EXCEPTIONS.

[Sec. 27-360. Group residential facility.

(a) A group residential facility for more than eight (8) mentally handicapped dependent persons, or for five (5) or more other dependent persons, may be permitted, subject to the following:

(1) The applicant shall demonstrate that there is a need for the facility;

(2) The premises shall be under supervision at all times; and

(3) The regulations set forth in the zone in which the use is proposed may be waived by the District Council provided that:

(A) The proposed site is of sufficient size to properly accommodate a facility of the type proposed without adversely affecting adjacent land use; and

(B) The waiver is granted in accordance with the requirements and criteria by which variances are granted by the Board of Zoning Appeals (Section 27-230).

(b) A statement shall be submitted explaining:

(1) The character of the facility;

(2) The program's policies and goals, and means proposed to accomplish the goals;

(3) The characteristics of the service population and number of residents to be served;

(4) The operating methods and procedures to be used; and

(5) Any other aspects pertinent to the facility's program.

(c) If the subject property is located within a municipality, the municipality shall be allowed sixty (60) days from the date of referral to forward its recommendation to the District Council.]

SECTION 3. BE IT FURTHER ENACTED by the County Council of Prince George's County, Maryland, sitting as the District Council for that part of the Maryland-Washington Regional District in Prince George's County, Maryland, that Section 27-445.14 of the Zoning Ordinance of Prince George's County, Maryland, being also Subtitle 27 of the Prince George's County Code, be and the same is hereby added:

SUBTITLE 27. ZONING

PART 5. RESIDENTIAL ZONES

DIVISION 5. ADDITIONAL REQUIREMENTS FOR SPECIFIC USES.

Sec. 27-445.14 Group residential facility.

(a) A group residential facility for more than eight (8) mentally handicapped dependent persons, or for five (5) or more other dependent persons, may be permitted, subject to the following:

(1) The applicant shall demonstrate that there is a need for the facility; and

(2) The premises shall be under supervision at all times.

(b) A statement shall be submitted explaining:

(1) The character of the facility;

(2) The program's policies and goals, and means proposed to accomplish the goals;

(3) The characteristics of the service population and number of residents to be served;

(4) The operating methods and procedures to be used; and

(5) Any other aspects pertinent to the facility's program.

(c) All State and private operators of juvenile group residential facilities are subject to a reporting requirement. The Department of Environmental Resources, the Police Department, and the Maryland National Capital Park and Planning Commission shall establish procedures to implement the reporting requirement for juvenile group residential facilities. The procedures shall be submitted to the District Council for approval on or before March 15, 2013. The purpose and intent of reporting by juvenile group residential facilities is to promote the health, safety and welfare of the citizens and residents of the County to prevent or control the detrimental effects of juvenile crime in the County.

SECTION 4. BE IT FURTHER ENACTED that the provisions of this Act are hereby declared to be severable; and, in the event that any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this Act is declared invalid or unconstitutional by a court of competent jurisdiction, such invalidity or unconstitutionality shall not affect the remaining words, phrases, clauses, sentences, subparagraphs, paragraphs, subsections, or sections of this Act, since the same would have been enacted without the incorporation in this Act of any such invalid or unconstitutional word, phrase, clause, sentence, subparagraph, subsection, or section.

SECTION 5. BE IT FURTHER ENACTED that this Ordinance shall take effect forty-five (45) calendar days after its adoption.

Adopted this 24th day of July, 2012.

COUNTY COUNCIL OF PRINCE GEORGE'S COUNTY, MARYLAND, SITTING AS THE DISTRICT COUNCIL FOR THAT PART OF THE MARYLAND-WASHINGTON REGIONAL DISTRICT IN PRINCE GEORGE'S COUNTY, MARYLAND

BY: _____
Andrea C. Harrison
Chair

ATTEST:

_____
Redis C. Floyd
Clerk of the Council

KEY:
Underscoring indicates language added to existing law.
[Brackets] indicate language deleted from existing law.
Asterisks *** indicate intervening existing Code provisions that remain unchanged

GUIDE TO ZONING CATEGORIES

PRINCE GEORGE'S COUNTY, MARYLAND

THE MARYLAND-NATIONAL CAPITAL PARK AND PLANNING COMMISSION
PRINCE GEORGE'S COUNTY PLANNING DEPARTMENT
COUNTY ADMINISTRATION BUILDING
14741 GOVERNOR ODEN BOWIE DRIVE
UPPER MARLBORO, MARYLAND 20772
Phone number 301-952-3195
Web Address: www.pgplanning.org

November 2010

RESIDENTIAL ZONES [1]

R-O-S: Reserved Open Space - Provides for permanent maintenance of certain areas of land in an undeveloped state, with the consent of the property owners; encourages preservation of large areas of trees and open space; designed to protect scenic and environmentally sensitive areas and ensure retention of land for nonintensive active or passive recreational uses; provides for very low density residential development and a limited range of public, recreational, and agricultural uses.

Minimum lot size	-	20 acres*
Maximum dwelling units per net acre	-	0.05

* Except for public recreational uses, for which no minimum area is required.

O-S: Open Space - Provides for areas of low-intensity residential (5 acre) development; promotes the economic use and conservation of land for agriculture, natural resource use, large-lot residential estates, nonintensive recreational use.

Standard lot size	-	5 acres
Maximum dwelling units per net acre	-	0.20

R-A: Residential-Agricultural - Provides for large-lot (2 acre) residential uses while encouraging the retention of agriculture as a primary land use.

Standard lot size	-	2 acres
Maximum dwelling units per net acre	-	0.50

R-E: Residential-Estate - Permits large-lot estate subdivisions containing lots approximately one acre or larger.

Standard lot size	-	40,000 sq. ft.
Maximum dwelling units per net acre	-	1.08
Estimated average dwelling units per acre	-	0.85

---

[1] Definitions:

Minimum or Standard lot size: The current minimum net contiguous land area required for a lot.

Average dwelling units per acre: The number of dwelling units which may be built on a tract--including the typical mix of streets, public facility sites and areas within the 100-year floodplain--expressed as a per-acre average.

Maximum dwelling units per net acre: The number of dwelling units which may be built on the total tract--excluding streets and public facility sites, and generally excluding land within the 100-year floodplain--expressed as a per-acre average.

Exhibit 2

PURCHASE AND SALE AGREEMENT

This PURCHASE AND SALE AGREEMENT ("Agreement") is made effective as of the "Execution Date" determined as provided on the signature page hereto by and between DONALD W. WUERL, ROMAN CATHOLIC ARCHBISHOP OF WASHINGTON, AND HIS SUCCESSORS IN OFFICE ACCORDING TO THE DISCIPLINE OF THE ROMAN CATHOLIC CHURCH, A CORPORATION SOLE ("Seller"), and SEASONS RESIDENTIAL TREATMENT PROGRAM, LLC, a Maryland limited liability company, or its assigns ("Buyer") (sometimes "Buyer" and "Seller" may be referred to individually as "Party" or collectively as the "Parties").

RECITALS

This Agreement is made with reference to the following facts and objectives:

A. Seller is the owner of certain real property and the improvements thereon, if any, containing approximately 16.01 acres of land located on Allentown Road in Fort Washington, Maryland, being more particularly described in **Exhibit A** attached hereto.

B. Seller is willing to sell the above-referenced real property to Buyer, together with all privileges, rights, easements, hereditaments, and appurtenances thereunto belonging; all right, title and interest of Seller in and to any streets, alleys, ramps, passages, abutter's rights and other rights-of-way included therein or adjacent thereto; and all water, mineral and other subsurface rights owned by Seller (collectively the "Property"), and Buyer is willing to buy the Property from Seller under the terms and conditions set forth in this Agreement.

AGREEMENT

NOW THEREFORE, for good and valuable consideration, the receipt and adequacy of which being hereby acknowledged, and in consideration of the mutual promises set forth in this Agreement, the Parties agree as follows:

1. **Definitions and Interpretation**.

1.1 As used in this Agreement:

1.1.1 "Closing" means the consummation of the conveyance of the Property to Buyer and the payment of the Purchase Price to Seller as provided in this Agreement.

1.1.2 "Environmental Contamination" means the existence or release (including sudden or nonsudden, accidental or nonaccidental leaks, spills, disposal, deposit and migration) of, or exposure to, any Hazardous Substance in, into, onto or under the environment (including the air, soil, surface water and ground water).

1.1.3 "Hazardous Substance" means all toxic or hazardous materials, chemicals, wastes, pollutants or similar substances, including Petroleum and Petroleum products, polychlorinated biphenyls, radioactive substances, asbestos insulation and/or urea formaldehyde insulation, and any other substance which has in the past or could in the future constitute a health, safety or environmental hazard to any person or property, including all substances which are regulated, governed, restricted or prohibited by any federal, state or local

law, decision, statute, rule, regulation or ordinance currently in existence or hereafter enacted or rendered, including those materials or substances defined as "hazardous substances," "hazardous materials," "toxic substances" or "pollutants" in the Comprehensive Environmental Response, Compensation and Liability Act of 1980, 42 U.S.C. § 9601, *et seq.*, the Resource Conservation and Recovery Act, 42 U.S.C. § 6901, *et seq.*, the Hazardous Materials Transportation Act, 49 U.S.C. § 1801, *et seq.*, the Toxic Substances Control Act, 15 U.S.C. § 2601, *et seq.*, the Clean Air Act, 42 U.S.C. § 7401, *et seq.*, the Clean Water Act, 33 U.S.C. § 1251, *et seq.*, and any applicable statutes, ordinances or regulations under the laws of the state in which the Property is located, and any rules and regulations promulgated thereunder, all as presently or hereafter amended.

1.1.4 "Net Usable Square Footage" means the total area of the Property less any portions thereof that are considered common areas, wetlands or included in public streets, highways or public right-of-ways, or that are required to be dedicated to any public authority.

1.2 Exhibits attached to this Agreement, amendments made pursuant to Subsection 12.3 below, and documents incorporated by reference are integral parts of this Agreement and references to this Agreement will be deemed to include such documents.

2. **Sale of Property**. Seller agrees to sell, and Buyer agrees to purchase, pursuant to the provisions of this Agreement, all of Seller's right, title, and interest in and to the Property.

3. **Purchase Price**.

3.1 The purchase price for the Property (the "Purchase Price") shall be Four Hundred Seventy Five Thousand and 00/100 Dollars ($475,000.00).

3.2 Deposit. Within five (5) business days after the day on which the latter of the two (2) Parties executes this Agreement (the "Execution Date"), Buyer shall deposit into escrow with Avenue Commercial Title Company, Inc., as agents for Old Republic National Title Insurance Company (the "Escrow Agent/Title Company") the sum of Ten Thousand and 00/100 Dollars ($10,000.00) (together, with all interest earned thereon, the "Deposit").

3.2.1 Investment of Deposit, Etc. Buyer shall pay the Deposit by cashiers or official bank check or a wire transfer of funds for immediate credit. The Deposit shall be held by the Escrow Agent in an FDIC-insured interest-bearing account at a bank, savings and loan association or other financial institution mutually acceptable to the Parties. Interest shall be retained in the account and will accrue for the benefit of and be credited to the Party entitled to receive (or have credited) the Deposit at Closing or upon termination of this Agreement pursuant to its terms.

3.2.2 Return of Deposit. Buyer and Seller acknowledge that the Deposit is being paid on behalf of Buyer by Strategic Behavioral Health, LLC, a Delaware limited liability company ("SBH"). Notwithstanding anything in this Agreement to the contrary, if at any time all or any portion of any Deposit is to be returned to Buyer, such amounts shall instead be returned to SBH, and not to Buyer.

3.3 Payment of Purchase Price. The Purchase Price shall be paid as follows:

3.3.1 Deposit The Deposit, plus interest thereon, shall be applied as a credit against the Purchase Price.

3.3.2 Additional Payment. On the Closing Date, Buyer shall deposit with the Escrow Agent in Good Funds the balance of the Purchase Price, and such other amounts as are set forth in the closing statement prepared by the Escrow Agent and reasonably approved by Buyer.

4. **Title to the Property**.

4.1 Quality of Title. Title to the Property shall be good and marketable, fee simple title and shall be free and clear of all liens, restrictions, easements, and other encumbrances and title objections, except for the exceptions to title as determined in accordance with Subsection 4.2.

4.2 Title Commitment and Survey. Within sixty (60) days of the Execution Date (the "Title/Survey Period"), Buyer shall obtain a commitment for title insurance issued by the Title Company (the "Title Commitment"), together with copies of the documents and instruments upon which the exceptions contained therein are based.

If Seller has a prior survey that can be re-certified, Seller shall, within 10-days after the date of this Agreement, provide the survey to Buyer and Buyer shall have it re-certified at Buyer's expense.

Buyer shall have prepared a survey of the Property by a surveyor licensed in the state where the Property is located. The surveyor shall be selected by Buyer. The surveyor shall also provide the Parties with a certificate of the Net Usable Square Footage of the Property. The Survey shall state the applicable zoning of the Property.

Prior to the expiration of the Title/Survey Period, Buyer shall deliver written notice to Seller ("Buyer's Objection Notice") of all matters reflected in the title Commitment or on the Survey that are disapproved by or unsatisfactory to Buyer in Buyer's sole and absolute discretion (the "Disapproved Items"). If Buyer notifies Seller of Disapproved Items, and any of the Disapproved Items are not cured by Seller to the satisfaction of Buyer, at Seller's expense, prior to Closing, Buyer may terminate this Agreement by giving Seller written notice of termination and, in that event: (a) Buyer and Seller shall execute and deliver to the Escrow Agent escrow cancellation instructions; (b) the Deposit (less One Hundred and No/100 Dollars ($100.00) which shall be paid to Seller as consideration for entering into this Agreement, and less one-half of any escrow fee to be paid to Escrow Agent), together with all interest thereon, shall be returned to Buyer; and (c) except as otherwise provided herein, this Agreement shall be of no further force or effect. If Buyer fails to provide any notice to Seller on or before the expiration of the Title/Survey Period, Buyer shall be deemed to have accepted all matters reflected in the Title Commitment and the Survey.

5. **Closing**. The "Closing Date" shall be the date the Deed, Seller's Instruments, Buyer's Payment and Documents are delivered to the Escrow Agent/Title Company which shall occur on the earlier of: (a) the date which is thirty (30) days after the expiration of the Inspection Period (as the same may be extended) or (b) the date which is thirty (30) days after

the date each of the conditions precedent set forth herein (including the Buyer's Undertakings (as defined below)) are either waived or satisfied by Buyer (as evidenced by Buyer's delivery of a Completion Notice to Seller), but in no event shall the Closing Date be later than the date which is thirteen (13) months after the Execution Date. The sale contemplated by this Agreement shall be consummated as follows:

5.1 Seller's Instruments. Seller shall cause to be deposited with the Escrow Agent, no later than one (1) day prior to the Closing Date, for recordation and delivery to Buyer upon the Closing, the following items:

5.1.1 Deed. A recordable special warranty deed (the "Deed"), in a form reasonably acceptable to Buyer, duly executed and acknowledged by Seller and effective to convey to Buyer fee simple title to the Property as provided for in this Agreement free and clear of all exceptions, except those approved in accordance with Subsection 4.2.

5.1.2 Non-Foreign Status Certificate. A Non-Foreign Status Certificate pursuant to Internal Revenue Code § 1445 duly executed by Seller in a form reasonably acceptable to Buyer.

5.1.3 Title Affidavit. A Title Affidavit in a form reasonably acceptable to Buyer.

5.1.4 Additional Documents. Such additional documents as may be reasonably required by the Buyer or the Escrow Agent to consummate the Closing.

5.2 Buyer's Payment and Documents.

5.2.1 Payment. On or prior to the Closing Date Buyer shall deposit with the Escrow Agent, for payment to Seller upon the Closing, the balance of the Purchase Price and an amount equal to Buyer's costs as set forth in Subsections 5.4 and 5.6. The amount to be paid by Buyer at the Closing shall be set forth in the approved Buyer's closing statement.

5.2.2 Documents. Such documents as may be reasonably required by the Seller or the Escrow Agent to consummate the Closing.

5.3 Seller's Costs. Seller shall before or simultaneously with the Closing pay the following costs (a) one-half (1/2) of all sales, excise, documentary, real estate conveyance, and transfer taxes applicable to the sale which are imposed by any governmental authority, (b) the costs of preparing and recording the Deed, (c) fees and expenses of Seller's counsel, and (d) the Brokers' Commission, as defined herein.

5.4 Buyer's Costs. Buyer shall, before or simultaneously with the Closing pay the following costs: (a) the cost of any Title Policy requested by it, (b) one-half (1/2) of all sales, excise, documentary, real estate conveyance, and transfer taxes applicable to the sale which are imposed by any governmental authority, (c) the Escrow Agent's fees, (d) all costs of recording documents and instruments pertaining to financing, if any, obtained by Buyer, (e) the costs of recording all documents and instruments to be recorded at the Closing (with the exception of the Deed), and (f) the cost of the Survey if applicable, and (f) all fees and expenses of Buyer's counsel.

5.5 Other Closing Costs. Any and all other closing costs not addressed herein shall be paid as is customary in similar commercial transactions in the jurisdiction in which the Property is located.

5.6 Prorations, Adjustments. All real property taxes, rentals, and utilities (if any) shall be prorated and adjusted between the Parties as of the Closing Date. To the extent that the tax statement covers land in addition to the Property, the overall tax amount will be allocated to land and improvements based on the land value and improvements value shown on the tax statement. The portion of the tax amount allocated to land value will then be allocated to the Property based on the area of the Property divided by the area of the entire property covered by the tax statement. Seller and Buyer hereby agree that any of the aforesaid prorations and adjustments which cannot be calculated accurately as of the Closing Date shall be prorated on the basis of the Parties' reasonable estimates, and shall be recomputed sixty (60) days after the Closing and either Party owing the other Party a sum of money based upon such subsequent proration adjustment shall promptly pay such sum to the other Party and, if payment is not made within ten (10) days after delivery of the bill therefor, shall pay interest thereon at the rate of eight percent (8%) per annum from the Closing Date to the date of payment. Buyer acknowledges that the tax value of the Property may be reassessed upon the change of ownership, and that a supplemental tax bill may be issued. If a supplemental tax bill is issued after the Closing Date, Buyer shall be solely responsible for any additional taxes due thereunder.

The obligations of this Subsection shall survive the Closing.

5.7 Bonds, Taxes and Assessments. All bonds, special taxes, improvement taxes and/or assessments, rollback taxes, school taxes, open space taxes, green belt taxes, industrial taxes or any other taxes or deferred taxes relating to the Property and any other deferred tax relating to the Property, if any, shall be paid by Seller at or prior to Closing.

5.8 Possession. Seller shall deliver possession of the Property to Buyer on the Closing Date.

6. **Conditions Precedent to Closing.**

6.1 Closing Conditions. Notwithstanding anything in this Agreement to the contrary, Buyer's obligation to complete Closing under this Agreement is contingent upon the following conditions being satisfied within the time specified below:

6.1.1. Inspection Period.

(a) Buyer shall have evaluated and approved, in Buyer's sole, absolute and unreviewable discretion, the suitability of the Property for its contemplated use, and the availability of all necessary permits and governmental approvals and any and all aspects of the Property. Buyer shall have a period of one hundred twenty (120) days (as the same may be extended under the terms of subsection (d) below) beginning on the Execution Date (the "Inspection Period"). In connection with this evaluation:

(i) Buyer and Buyer's agents, employees and independent contractors, may enter upon the Property at reasonable times for the purpose of inspecting and testing the same and Seller hereby grants Buyer the right to go upon the Property

between the Execution Date and the Closing Date, at Buyer's expense, to make such surveys, tests and other site analyses as Buyer may require. Buyer shall indemnify Seller against all losses, damages, expenses, and claims that may arise by reason of Buyer's entry upon the Property pursuant to this Subsection and shall repair any damage to the Property caused by such entry. This provision shall survive the Closing or the termination of this Agreement.

(ii) Buyer may, in its discretion, retain one or more environmental consultants of its choosing to inspect the Property, including any soils, surface waters, wells, and groundwater on or under the Property and conduct such tests, samples, engineering studies, and examinations upon the Property as Buyer or any such consultants deem appropriate to determine the environmental condition of the Property and the existence or nonexistence of Environmental Contamination or environmental hazards on or about the Property including any past or current generation, storage, release, threatened release, disposal, and presence and location of asbestos, PCB transformers, Petroleum products, flammable explosives, underground storage tanks or other Hazardous Substances. Buyer shall indemnify Seller against all loss, damages, expenses and claims that may arise by reason of Buyer's inspection, testing and examination of the Property pursuant to this Subsection and shall repair any damages to the Property caused by such inspection, testing or examination. Concurrent with the Execution Date, Seller agrees to make available to Buyer any environmental studies or Commitments related to the Property in Seller's possession, Buyer acknowledges and agrees that Seller is not making, and will not make, any representations or warranties of any kind or nature concerning or related to the environmental studies or Commitments made available to it by Buyer, including their accuracy, content, thoroughness of investigation or the competence or ability of the persons or companies preparing the same. This provision shall survive the Closing or the termination of this Agreement.

(iii) In order to assist Buyer in the completion of Buyer's inspections, testing, examinations, and studies during the Inspection Period, the parties acknowledge and agree that Seller has delivered and Buyer has received copies of the those items listed on Exhibit "B" attached hereto on or prior to the Execution Date ("Seller's Materials"). Seller covenants and agrees that if, prior to the termination of this Agreement or the Closing Date, it receives any information or documents amending or supplementing those set forth on Exhibit "B", it will immediately upon receipt provide Buyer with a copy of the same.

(b) Buyer shall have obtained, reviewed and approved the Title Commitment and all other title-related documents to be provided pursuant to Subsection 4.2.

(c) Buyer shall have obtained, reviewed and approved the Survey.

(d) (i) Buyer shall have (1) successfully changed the water and sewer category respecting the Property (from category 5 to category 3) and (2) successfully subdivided the property into a separate lot of record (collectively, "Buyer's Undertakings"). Buyer shall use its good faith, diligent efforts to complete Bnyer's Undertakings, at Buyer's sole cost and expense as soon as reasonably practicable, but in no event later than twelve (12) months after the Execution Date. Seller agrees to reasonably cooperate with Buyer with respect to Buyer's Undertakings, at no or nominal cost to Seller (for example, by signing applications, plats, etc. prepared by Buyer).

(ii) In order to complete Buyer's Undertakings, Buyer shall have the right to extend the Inspection Period described above for one (1) eight (8) month period. In order to exercise such extension option, Buyer shall provide Seller with written notice thereof (the "Extension Notice") prior to the then current expiration date of the Inspection Period. In the event Buyer completes the Buyer's Undertakings prior to the outside date set forth in subsection (d)(i) above, Buyer shall provide Seller with written notice thereof (the "Completion Notice").

(iii) If Buyer, at its option, elects to extend the Inspection Period as set forth in subsection (ii) above, then Buyer shall be deemed to have also agreed to pay eight (8) months of the annual real estate taxes for the Property, as well as eight (8) months of the annual grounds maintenance expenses for the Property, all not to exceed the sum of $7,500 per annum. Accordingly, if Buyer elects to extend the Inspection Period as set forth above, then contemporaneously with its delivery of an Extension Notice to Seller, Buyer shall tender the sum of $5,000 (calculated as 2/3 of the estimated $7,500 cost per annum) to Seller which is intended to reimburse Seller for the estimated real estate taxes and grounds maintenance expenses for the Property for the ensuing 8-month period. All of said sums shall not be credited against the Purchase Price otherwise payable by Buyer, and shall not be refundable to Buyer if Buyer elects to terminate this Agreement under this Section 6.1.1

6.1.2 On or prior to the expiration of the Inspection Period, Buyer may either (i) in its sole, absolute and unreviewable discretion, terminate this Agreement by giving written notice thereof to Seller, at which time Buyer shall be entitled to a refund of the Deposit, less One Hundred and No/100 Dollars ($100.00) which shall be paid to Seller as consideration for entering into this Agreement and less any escrow fee; or (ii) provide Seller with written notice that it is satisfied with the Property and is prepared to proceed to Closing. If no notice is received by Buyer prior to the expiration of the Inspection Period, Buyer shall be deemed to have elected to terminate pursuant to subsection (i) above.

6.1.3 Intentionally omitted.

6.1.4 Additional Conditions Precedent. Buyer's obligation to purchase the Property on the Closing Date is also subject to the satisfaction or waiver by Buyer of the following additional conditions precedent which must be satisfied on or before the Closing Date:

(a) The representations and warranties of Seller set forth in Section 8 shall be true, correct and complete in all material respects on and as of the Closing Date with the same effect as though such representations and warranties had been made as of the Closing Date.

(b) There shall be no effective injunction or restraining order of any nature issued by a court of competent jurisdiction which shall direct that this Agreement or the transaction contemplated herein not be consummated.

(c) Seller shall have fully complied with all of the covenants in this Agreement on its part to be performed on or prior to the Closing Date.

(d) The Property shall have sufficient utilities for development and Buyer's intended use. In the event utilities are not sufficient, Seller shall grant to Buyer the necessary

easements and/or provide for construction of applicable utilities to the Property reasonably requested by Buyer.

(e) The Property being properly zoned for Buyer's intended use as a facility for the provision of behavioral health services for children and young adults with no change in zoning or rezoning required. Buyer shall be satisfied that it can use the Property for its intended use.

6.2 Effect of Failure to Satisfy Conditions. If the conditions precedent set forth in Subsection 6.1 hereof are not satisfied within the respective time periods set forth therein then, in addition to any rights afforded by this Agreement, Buyer shall be entitled to terminate this Agreement and receive back the Deposit and any Additional Deposit.

6.3 Termination of Agreement.

6.3.1 Termination by Buyer. If this Agreement is terminated by Buyer: (a) during the Inspection Period (as may be extended); (b) as a result of the failure to satisfy or waive all conditions and contingencies contained herein; (c) pursuant to Subsections 12.13; or (d) as a result of Seller's breach of this Agreement (each a "Buyer's Termination Event"), then, in any of those events: (i) Buyer and Seller shall execute and deliver to the Escrow Agent escrow cancellation instructions; (ii) except as otherwise provided herein, this Agreement shall be of no further force or effect; and (iii) the Deposit less (a) any escrow fee and (b) one hundred dollars ($100.00) which shall be paid to Seller as consideration for entering into this Agreement and the balance of the amounts paid by Buyer to the Escrow Agent and all interest thereon shall be returned to Buyer.

6.3.2 Seller's Remedies Upon a Breach by Buyer. In the event this agreement is breached by Buyer, including an intentional breach, Buyer and Seller agree that it would be impractical and extremely difficult to estimate the damages Seller may suffer. Buyer and Seller therefore agree that a reasonable estimate of the total net detriment that Seller would suffer in the event of such breach an amount equal to the Deposit , together with all interest thereon, and that this shall be Seller's sole and exclusive remedy (whether at law or in equity). This amount shall be the full, agreed and liquidated damages for a breach hereunder by Buyer, including, but not limited to, intentional breach by Buyer, all other claims to damage or other remedies being herein expressly waived by Seller (except for Seller's rights under Subsection 12.9). The payment of this amount as liquidated damages is not intended as a forfeiture or penalty, but is intended to constitute liquidated damages to Seller. Upon an uncured breach or default by Buyer, neither Party shall have any further rights or obligations under this Agreement, each to the other, except for the right of Seller to collect such liquidated damages and except as otherwise specifically provided in this Agreement. Prior to exercising its right to collect and retain the liquidated damages set forth above as a result of a default of or breach by Buyer, Seller shall give Buyer written notice of any alleged breach and Buyer shall have a period of fifteen (15) days, but not later than the Closing Date, to cure such breach. The Parties agree to execute, within five (5) days following the termination of this Agreement, in accordance with this Subsection, irrevocable written instructions to the Escrow Agent/Title Company containing the provisions of this Subsection, and that no further instructions to Escrow Agent/Title Company shall be necessary to release the Deposit to Seller as liquidated damages. Buyer's right to terminate as provided in this Agreement shall not be considered a breach and shall not entitle Seller to liquidated damages pursuant to this Section.

6.3.3 Buyer's Remedies Upon the Default of Seller. In the event Seller defaults under any of the terms of this Agreement on or prior to the Closing Date (including by failing or refusing to deliver any documents or Information required to be delivered pursuant hereto), Buyer shall be entitled to: (a) compel specific performance of this Agreement, in which event Buyer may also recover its damages incurred as a result of such default, including all of its reasonable costs and attorney fees in seeking such specific performance; or (b) if specific performance is not possible or if Buyer elects not to pursue specific performance, receive a refund of the Deposit, together with all interest thereon and damages, the Parties agreeing that it would be impractical and extremely difficult to estimate the damages Buyer may suffer. Buyer and Seller therefore agree that a reasonable estimate of the total net detriment that Buyer would suffer in the event of such breach is an amount equal to (x) the return of the Deposit, together with all interest thereon, (y) damages in an amount equal to the amount of the Deposit, plus (c) the reimbursement of all verifiable and reasonable costs and expenses (not to exceed $30,000.00) incurred by Buyer in connection with this Agreement and in inspecting and examining the Property, and that this shall be Buyer's sole and exclusive remedy (whether at law or in equity) other than the remedy of specific performance noted above. This amount shall be the full, agreed and liquidated damages for a pre-Closing breach hereunder by Seller, including, but not limited to, intentional breach by Seller, all other claims to damage or other remedies being herein expressly waived by Buyer (except for Buyer's rights under Subsection 12.9). The payment of this amount as liquidated damages is not intended as a forfeiture or penalty, but is intended to constitute liquidated damages to Buyer. Upon an uncured breach or default by Seller, neither Party shall have any further rights or obligations under this Agreement, each to the other, except for the right of Buyer to collect such liquidated damages and except as otherwise specifically provided in this Agreement. Prior to exercising its right to collect and retain the liquidated damages set forth above as a result of a default of or breach by Seller, Buyer shall give Seller written notice of any alleged breach and Seller shall have a period of fifteen (15) days, but not later than the Closing Date, to cure such breach. The Parties agree to execute, within five (5) days following the termination of this Agreement, in accordance with this Subsection, irrevocable written instructions to the Escrow Agent/Title Company containing the provisions of this Subsection, and that no further instructions to Escrow Agent/Title Company shall be necessary to release the Deposit to Buyer. Buyer's right to terminate as provided in this Agreement shall not be considered a breach and shall not entitle Seller to liquidated damages pursuant to this Section.

6.3.4 Waiver of Mutuality of Remedies. The Parties hereby waive mutuality of remedies.

7. **Ongoing Operations**. From the Execution Date through the Closing Date or the earlier termination hereof:

7.1.1 Operation of Property. Seller shall maintain the Property in substantially its current condition and in compliance with all applicable laws and regulations. Except as necessary to comply with the preceding sentence, Seller shall not make any material alterations to the Property or any portion thereof without Buyer's prior written consent. Seller will perform its obligations under all agreements that may affect the Property.

7.1.2 New Contracts. Seller shall not, without Buyer's prior written consent in each instance, amend, terminate, exercise any rights or options under, grant concessions regarding, or enter into any contract or agreement that will be an obligation affecting the Property or binding on Buyer after Closing, except contracts entered into in the ordinary

course of business that are terminable without cause or penalty on 30-days' notice (and Seller shall terminate any such contracts on the Closing Date, unless such contracts are accepted by Buyer.

7.1.3 Listings and Other Offers. Seller will not list the Property with any broker or otherwise solicit or make or accept any offers to sell all or any part of the Property, engage in any discussions or negotiations with any third party with respect to the sale or other disposition of the Property, or enter into any contracts or agreements (whether binding or not) regarding any disposition of all or any part of the Property.

7.1.4 Maintenance of Insurance. Seller shall carry its existing insurance through the Closing Date, and shall not allow any breach, default, termination or cancellation of such insurance policies or agreements to occur or exist.

7.1.5 Maintenance of Permits. Seller shall maintain in existence all licenses, permits and approvals necessary or reasonably appropriate to the ownership, operation or improvement of the Property.

7.1.6 Other Actions. Neither Seller, nor its employees, agents or contractors, shall take or fail to take any action that causes Seller's representations or warranties to become untrue or that causes one or more of Buyer's conditions to Closing to be unsatisfied.

8. **Seller's Warranties and Representations** As a material inducement to cause Buyer to enter into this Agreement, Seller represents and warrants to Buyer that:

8.1 Authority. Seller has the authority and power to enter into this Agreement and to consummate the transactions provided for by this Agreement. Consummation of such transactions will not breach any material agreement to which it is a party.

8.2 Title. Seller has good and marketable fee simple title to the Property and at Closing such title shall be subject only to the encumbrances determined in accordance with this Agreement.

8.3 Service Contracts. There are no written service contracts, art contracts, leasing listing agreements, landscaping contracts, equipment leases, maintenance agreements, open purchase orders and other contracts for the provision of labor, services, materials or supplies to or for the benefit of the Property which will affect or be obligations of Buyer or of the Property or any portion thereof following Closing.

8.4 Agreements Affecting the Property. At Closing, there will be no unrecorded leases, easements, encumbrances, or other agreements affecting the Property except as shown on the Title Commitment, or as otherwise disclosed to Buyer by Seller in writing and approved by Buyer.

8.5 Outstanding Taxes. To Seller's actual knowledge, there are no outstanding ad valorem taxes, including, but not limited to improvement taxes or assessments, rollback taxes, school taxes, open space taxes, green belt taxes, industrial taxes or any other taxes or deferred taxes relating to the Property which will affect or be obligations of Buyer or of the Property or any portion thereof following Closing.

8.6 Information. The Information delivered to Buyer pursuant to this Agreement or in connection with the execution hereof are, and at Closing will be (a) true and correct copies; and (b) in full force and effect.

8.7 No Notices of Violations. Seller has received no notice of any failure of Seller to comply with any applicable governmental requirements in respect of the development, use and occupation of the Property, including environmental, zoning, platting and other land use requirements which have not been heretofore corrected to the satisfaction of the appropriate governmental authority.

8.8 Compliance with Law. To Seller's actual knowledge, the Property and the existing uses of the Property, are in material compliance with all applicable laws, ordinances, rules, regulations, and requirements of all governmental authorities having jurisdiction thereof, including those pertaining to zoning, building, housing, water, use, safety, fire, health and the environment.

8.9 No Litigation or Proceedings. There are no actions, suits, proceedings or investigations pending or, to Seller's actual knowledge, threatened, before any agency, court, or other governmental authority which relates to the ownership, maintenance, development or operation of the Property or which could become a liability of Buyer or the Property or any portion thereof following Closing.

8.10 Condemnation.

8.10.1 Eminent Domain Proceedings. To Seller's actual knowledge, there is no condemnation or eminent domain proceeding affecting the Property or any portion thereof currently pending or threatened.

8.10.2 Takings by Eminent Domain. There have been no takings by condemnation or eminent domain of any land of which the Property was a part and for which compensation has not been paid or for which compensation has been paid within the past three (3) years.

8.11 No Defaults. Seller is not in default and has not received notice of any default or breach by Seller under any covenants, conditions, restrictions, rights-of-way, or easements which may affect Seller in respect to the Property or may affect the Property or any portion thereof and no condition exists that with the passage of time or giving notice or both would constitute such a default.

8.12 Seller Not a Foreign Person. Seller is not a foreign person as defined in Section 1445(f)(3) of the Internal Revenue Code of 1986, as amended. Seller will deliver to Buyer at Closing a Certificate of Nonforeign Status, in a form reasonably acceptable to Buyer certifying the correctness of this Subsection.

8.13 No Attachments. There are no attachments, executions, assignments for the benefit of creditors, or proceedings in bankruptcy or under any other debtor relief laws contemplated by or pending or, to the knowledge of Seller, threatened by or against Seller.

8.14 No Mechanics' Liens. To Seller's actual knowledge, there are no pending or threatened mechanics' or materialmen's liens recorded against the Property.

8.15 Special Assessments. To Seller's actual knowledge, no special or general assessments have been levied on or with respect to the Property that are unpaid by Seller as of the date hereof, or that will be unpaid by Seller as of the date of Closing.

8.16 Zoning. The Property is currently zoned RA.

8.17 Environmental Conditions. To Seller's actual knowledge, no Hazardous Substances are, will be, or have been, stored, treated, disposed of or incorporated into, on or around the Property in violation of any applicable statutes, ordinances or regulations, excepting only normal farming chemicals and nitrates.

8.18 No Fill or Proper Compaction. To Seller's actual knowledge, the Property is not filled or if filled, it has been filled properly and Seller shall provide Buyer with letters of compaction or other information evidencing such to Buyer's satisfaction.

8.19 Association. To Seller's actual knowledge, Seller represents and warrants that there is no association or other private entity or group which has approval or assessment rights against the Property. Seller represents and warrants that it is not in default or received any notice of violation from such association and all dues, assessments or other amounts assessed by said association have been paid in full by Seller.

8.20 Representations To Be Correct at Closing. All of the representations and warranties of Seller contained in this Agreement shall be true and correct as of the Execution Date and as of the Closing.

8.21 No Untrue Statements. None of the foregoing representations and warranties contain any untrue statement or material fact or fails to state any material fact necessary to make such representations and warranties not misleading.

8.22 Corrective Notices; Liability. If after the Execution Date, but prior to the Closing Date, Seller becomes aware that any of Seller's representations set forth herein are no longer true and correct, then Seller shall provide Buyer with written notice stating that Seller believes that such representations are no longer accurate and the general nature of the change. Within ten (10) business days after receipt of such notice, Buyer shall either: (a) terminate this Agreement and the Deposit shall be returned to Buyer (in which event Buyer shall retain its right to recover its actual damages, limited to actual out-of-pocket expenses, incurred by Buyer and determined according to proof, if any, resulting from such inaccuracy); or (b) waive its rights on such account and elect to consummate the transaction herein contemplated, in which event Buyer shall be deemed to have waived all rights and remedies with respect to those matters specifically set forth in such notice. Notwithstanding the foregoing, nothing in this Agreement shall limit Buyer's rights and remedies if such representation or warranty was intentionally or willfully misrepresented by Seller to Buyer as of the Execution Date or if Buyer discovers an incorrect material representation or warranty following the Closing Date which Seller had knowledge of before Closing and failed to disclose to Buyer.

9. **Buyer's Warranties and Representations**.

Buyer represents and warrants to Seller as follows:

9.1 Authority. Buyer is fully authorized to enter into and perform its obligations under this Agreement and any other agreement or instrument necessary to consummate the transaction contemplated by this Agreement.

9.2 No Defaults. To the best of Buyer's knowledge, neither Buyer's execution of this Agreement nor Buyer's performance of its obligations hereunder will violate, or constitute a default under or breach of, any agreement between Buyer and any third party or by which Buyer is bound.

9.3 No Proceedings. There is neither pending nor, to the knowledge of Buyer, any threatened legal action, arbitration or administrative hearing before any governmental authority to which Buyer is a party and which could enjoin or restrict Buyer's right or ability to perform its obligations under this Agreement.

9.4 No Attachments. There are no attachments, executions, assignments for the benefit of creditors, or proceedings in bankruptcy or under any other debtor relief laws contemplated by or pending or, to the knowledge of Buyer, threatened by or against Buyer.

9.5 No Untrue Statements. None of the foregoing representations and warranties contain any untrue statement or material fact or fails to state any material fact necessary to make such representations and warranties not misleading.

9.6 Representations. All representations and warranties contained in this Section shall be deemed made as of the Execution Date, shall be renewed as of the Closing and shall survive the Closing.

10. **Survival of Warranties and Representations**.

Notwithstanding anything to the contrary in this Agreement, all covenants contained in this Agreement which by their nature impliedly or expressly involve performance after Closing and all representations and warranties of Seller contained in this Agreement shall survive Closing for a period of twelve (12) months following the Closing Date. Any inspection of the Property or of Seller's records, by Buyer or its representatives shall not be construed as a waiver of any representation or warranty contained in this Agreement.

11. **Brokers**. Buyer represents that it is not represented by a broker other than Mosaic Realty, LLC ("Buyer's Broker"), who shall be paid a fee of $25,000 in connection with the Closing under this Agreement. Seller represents that it is not represented by a broker and is not responsible for the payment of any commission other than to NAI Michael Companies ("Seller's Broker") in the amount of 5% of the Purchase Price (Seller's Broker and Buyer's Broker may be collectively referred to as "Broker"). Seller agrees to pay at Closing to any and all brokers, including without limitation, Buyer's Broker and Seller's Broker, or any finder or any other party who claims a commission, fees or other cost arising from or related to the sale contemplated by this Agreement (collectively, the "Brokers' Commission"). Seller and Buyer each hereby agree to indemnify and hold the other harmless from all loss, costs, damage or expenses (including reasonable attorney fees) incurred by the other as a result of any claim arising out of the acts of the indemnifying Party (or others on its behalf) for a commission, finder's fee or similar compensation made by any other broker, finder, or party who claims to have dealt with such Party other than Broker. The provisions of this Section shall survive the Closing or termination of this Agreement.

12. **Miscellaneous**.

12.1 Notices. Whenever a Party to this Agreement is required or permitted under this Agreement to provide the other Party with any notice, request, demand, consent or approval ("Notices"), the Notices will be given in writing and will be delivered to the other Party at the address or facsimile number set forth below: (a) personally; (b) by a reputable overnight courier service; (c) by certified mail, postage prepaid, return receipt requested; or (d) by facsimile transmission. Either Party may change its address for Notices by written notice to the other Party delivered in the manner set forth above. Notices will be deemed to have been duly given: (1) on the date personally delivered; (2) one (1) Business Day after delivery to an overnight courier service with next-day service requested; (3) on the third (3rd) Business day after mailing, if mailed using certified mail; or (4) on the date sent when delivered by facsimile (so long as the sender receives electronic confirmation of receipt and a copy of the Notice is sent by one of the other means permitted hereunder on or before the next Business Day).

IF TO BUYER: Seasons Residential Treatment Program, LLC
_____
_____
Attn: Ty Johnson
Telephone:_____
Fax: _____
tyjohnson@seasonsdc.com

With a copy to:
Mike Garone
Director of Development
Strategic Behavioral Health
8295 Tournament Drive, Suite 201
Memphis, Tennessee 38125
Telephone: Office (901) 969-3100
Cell (901) 277-6522
Fax: _____

With a copy to:
David K. West
Principal Broker
Mosaic Realty, LLC
8002 Quill Point Drive
Bowie, MD 20720
(202) 251-7056 direct
Fax: _____

With a copy to:
Laurence Roscher, Esq.
Roscher & Associates, P.C.
7910 Woodmont Avenue, Suite 1320
Bethesda, MD 20814
Telephone: (301) 312-8561
Fax: (301) 312-8579
lroscher@roscherlaw.com

IF TO SELLER: Archdiocese of Washington
Attn: Director of Real Estate
5001 Eastern Avenue
Hyattsville, MD 20782

Telephone: 301-853-4500
Fax: 301-853-5346

With a copy to: Dan Balserak
Archdiocese of Washington
Office of the General Counsel
5001 Eastern Avenue
Hyattsville, MD 20782
Telephone: 301-853-4495
Fax: 301-853-7662

12.2 Assignment. Except as otherwise specifically provided for herein, the Parties shall be entitled to assign their rights and obligations under this Agreement only upon obtaining the other Party's prior written consent, which will not be unreasonably withheld; notwithstanding the foregoing, the Buyer shall have the right to assign this Agreement, without the Seller's consent, to any related or affiliated entity. Unless otherwise agreed by a Party in writing, no such assignment shall release the other Party from its obligations under this Agreement.

12.3 Amendments. This Agreement may be amended or modified only by a written instrument executed by the Party or Parties asserted to be bound thereby.

12.4 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state in which the Property is located without regard to the conflict of laws principles of such state. The federal and state courts within the state where the Property is located shall have exclusive jurisdiction to adjudicate any dispute arising out of this Agreement. All parties hereto expressly consent to:

12.4.1 the personal jurisdiction of the federal and state courts within the county and state within which the Property is located and

12.4.2 service of process being effected upon them by registered mail sent to the addresses set forth in Subsection 12.1.

12.5 Merger of Prior Agreements. This Agreement and the exhibits hereto constitutes the entire agreement between the Parties with respect to the purchase and sale of the Property and supersedes all prior and contemporaneous agreements and understandings between the Parties hereto relating to the subject matter hereof. Each Party acknowledges and agrees that except for the specific representations, warranties and covenants contained in this Agreement, the other Party and its agents have not made any representations, warranties or covenants to it.

12.6 Time is of the Essence. Seller and Buyer hereby acknowledge and agree that time is strictly of the essence with respect to each and every term, condition, obligation and provision hereof.

12.7 No Joint Venture or Third Party Beneficiary. It is not intended by this Agreement to, and nothing contained in this Agreement shall, create any partnership, joint venture or other agreement between Buyer and Seller. No term or provision of this Agreement is intended to be, or shall be, for the benefit of any person, firm, organization or corporation not a Party hereto, and no such other person, firm, organization or corporation shall have any right or cause of action hereunder. Notwithstanding the foregoing, SBH is an intended third party beneficiary of Section 3.2.2, and shall be entitled to enforce such provisions in any court and to obtain any legal or equitable remedy for breach thereof in accordance with applicable law.

12.8 Further Acts. Each Party shall, at the request of the other, execute, acknowledge (if appropriate) and deliver whatever additional documents, and do such other acts, as may be reasonably required in order to accomplish the intent and purposes of this Agreement.

12.9 Professional Fees and Costs. If any legal or equitable action, appeal, arbitration, bankruptcy, reorganization, or other proceeding, whether on the merits, application or motion, are brought or undertaken, or an attorney retained, to enforce this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, then the successful or prevailing Party or Parties in such undertaking (or the Party that would prevail if an action were brought) shall be entitled to recover reasonable attorney and other professional fees, expert witness fees, court costs and other expenses incurred in such action, proceeding or discussions, in addition to any other relief to which such Party may be entitled. The Parties intend this provision to be given the most liberal construction possible and to apply to any circumstances in which such Party reasonably incurs expenses. The provisions of this Section shall survive the Closing or termination of this Agreement.

12.10 Dates of Performance. In the event that any date for performance by either Party of any obligation hereunder required to be performed by such Party falls on a Saturday, Sunday or nationally recognized holiday, the time for performance of such obligation shall be deemed extended until the next business day following such date.

12.11 Counterparts and Execution by Facsimile. This Agreement may be executed in multiple counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument. Delivery of an executed copy of this Agreement by facsimile, telecopy, telex or other means of electronic communication producing a printed copy will be deemed to be an execution and delivery of this Agreement on the date of such communication by the Party so delivering such a copy. The Party so delivering such a copy via electronic communication shall deliver an executed original of this Agreement to the other Party within five (5) business days of the date of delivery of the electronic communication.

12.12 Severability. Any provision of this Agreement which is determined by a court of competent jurisdiction to be invalid or unenforceable shall be invalid or unenforceable only

to the extent of such determination, which shall not invalidate or otherwise make ineffective any other provision of this Agreement.

12.13 Eminent Domain. If prior to the date of the Closing, Seller acquires knowledge of any pending or threatened action, suit or proceeding to condemn or take all or any part of the Property under the power of eminent domain, then Seller shall immediately give notice thereof to Buyer. Upon receipt of such notice, Buyer may terminate this Agreement and this Agreement shall be null and void, whereupon the full amount of the Deposit, minus one-half (½) the escrow cancellation fee, shall be paid by Escrow Agent to Buyer, and all Parties shall thereupon be relieved of all further liability hereunder. If Buyer does not terminate this Agreement, and the Closing occurs, then Buyer shall be entitled to the proceeds of any condemnation award available.

12.14 Development Applications. Seller agrees to cooperate with Buyer in conjunction with any development applications or permit applications which Buyer may desire to submit to governmental authorities while this Agreement is in force, provided that Buyer pays all expenses associated with any of the foregoing documents or processes and that no agreement to be executed by Seller is binding upon Seller or the Property unless and until the Closing.

12.15 No Public Disclosure. Before the Closing, neither Buyer nor Seller shall make any public release of information regarding the matters contemplated herein, except as mutually agreed to in writing by Buyer and Seller. Seller acknowledges and agrees that the transactions contemplated by this Agreement, and Buyer's plans for the Property and matters related thereto, are not otherwise known by or readily available to the public and the plans, persons involved, terms, conditions and negotiations concerning the same shall be held in the strictest confidence by Seller and shall not be disclosed by Seller except to its counsel, and except and only to the extent that such disclosure may be necessary for its performance hereunder. Seller agrees that it shall instruct each of its counsel to maintain the confidentiality of such information. The provisions of this Section shall survive any termination of this Agreement.

(signatures appear on next page)

IN WITNESS WHEREOF, the Parties have signed this Agreement the day and year set forth below. The latest date of execution by the Parties set forth below shall be deemed the "Execution Date" of this Agreement.

SELLER:

ROMAN CATHOLIC ARCHDIOCESE OF WASHINGTON

By: +Paul S. Loverde

Its: Moderator of the Curia and Vicar General

Dated: 4/17/15

BUYER:

SEASONS RESIDENTIAL TREATMENT PROGRAM, LLC, a Maryland limited liability company

By: _____

Its: President

Dated: 4-17-15

EXHIBIT A

LEGAL DESCRIPTION OF PROPERTY

Beginning For the same at an iron pipe set at the Southeast corner of the original tract and thence with the southerly line North 89° 02' 44 West 492.00 feet to a stone found and thence North 17° 05' 20" West 371.79 feet to a cedar stab found and thence North 65° 25' 24" West 781.58 feet to a point in Allentown Road passing over an iron pipe set 20.90 feet from the end of this course and thence with said road North 17° 51' 56" East 470.78 feet to a point and thence with the southerly line of PEPCO 80.00 foot right of way South 64° 19' 19" East 1088.00 feet to an iron pipe set passing over an iron pipe set 11.28 feet from the beginning of this course and thence with the westerly line of the "Crawford" property which is described in Liber 757 at folio 931 among the land records of Prince Georges County, Maryland, the following two courses and distances (1) South 22° 48' 08" East 367.00 feet to a cedar stab found and thence (2) South 07° 47' 44" East 330.00 feet to the point of beginning and containing 16.00334 acres of land more or less.

Assessed as 16.01 acres; Tax Account No. 09-0923334

Exhibit B

SELLER'S MATERIALS

Exhibit 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-15

DATE: **February 16, 2007**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Psychiatric Residential Treatment Facilities (PRTF) Clarification

Memorandum Summary

- Clarifies that a PRTF, as identified at 42 C.F.R. 483.352, is a separate, stand alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician.
- Reinforces that a PRTF resident population must meet all certification of need requirements as identified under 42 C.F.R. Part 441, Subpart D – Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs.
- Reinforces that a PRTF is subject to survey and certification of the entire facility and must meet all requirements under Part 483, subpart G – Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities.

Issue

There has been a recent influx of providers to become certified as PRTFs. Many of these facilities are residential treatment facilities (RTF) or residential treatment centers (RTC) that provide services to children who may need a variety of services, but who may not need the intensive services indicated for those who would be placed in a PRTF. This memo clarifies what is meant by Psychiatric Residential Treatment Facility and the nature of the services it provides for purposes of directing State surveyors.

Historical Development of Psychiatric Residential Treatment Facilities

The Social Security Amendments of 1972 amended the Medicaid statute to, among other things, allow States the option of covering inpatient psychiatric hospital services for individuals under age 21 (Psych under 21-benefit). Originally the statute required that the psych under 21-benefit be provided by psychiatric hospitals. In 1976 final regulations were published implementing the psych under 21-benefit. Section 4755 of the Omnibus Budget Reconciliation Act (OBRA '90) amended section 1905(h) of the Act to specify that the psych under 21-benefit can be provided in psychiatric hospitals that meet the definition of that term in section 1861(f) of the Act "or in another inpatient setting that the Secretary has specified in regulations."

needs of the resident and that according to §441.152 "(2) proper treatment of the resident's psychiatric condition requires services on an inpatient basis under the direction of a physician; and (3) the services can reasonably be expected to improve the resident's condition or prevent further regression so that the services will no longer be needed." As CMS clarified in the 2001 interim final rule (66 FR 28111); payment for inpatient psychiatric services to individuals under age 21 includes the need for room and board as well as the provision of a comprehensive package of services.

PRTF services – who does it serve?

- All PRTF residents according to regulation must need inpatient services to treat his or her psychiatric condition under the direction of a physician and the services provided must be reasonably expected to improve the resident's condition or prevent further regression so that the services will no longer be needed.

- The psych under 21-benefit is an optional Medicaid benefit. States can determine which psychiatric conditions would fall under this benefit and for which the State will reimburse payment for services rendered. For example, such diagnoses may include paranoid schizophrenia, post-traumatic stress disorder, depression, and/or hyperactivity-attention deficit disorder. Although what psychiatric conditions are covered may differ based on State determinations, (see appendix B), the federal requirements that are established in sections 441.150 through 441.156 must be applied consistently across all States.

PRTFs vs. Residential Treatment Facilities (RTFs) or Residential Treatment Centers (RTCs)

There has been a recent influx of RTFs/RTCs who request to become certified as PRTFs. RTFs or RTCs provide a mixed level of service to children who do not need the intensive services of a PRTF. To be certified as a PRTF, the facility must attest to meeting the Conditions of Participation (CoP) found at 42 C.F.R. Part 483 Subpart G, and attest that all its residents meet the certification of need requirements as identified under 42 C.F.R. Part 441, Subpart D – Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs, as discussed above.

The Social Security Act and federal regulations, expressly identify that services under the psych under 21-benefit can be provided in distinct parts found in psychiatric hospitals; however, a PRTF is not identified as a distinct part of another facility.

Any facility that wishes to be certified as a PRTF must adhere to the following:

1. **Survey and Certification review of the entire facility:**
   Based on CMS standards and existing policy under CMS, the survey process described in the State Operations Manual (SOM), section 2714.1, states that:

   The CoPs/Requirements apply to the entire certified provider/supplier and to all patients/residents being served by the certified entity, regardless of payment source unless stated otherwise in the regulations. This means that the surveyors may review the care of private pay patients/residents when surveying a Medicare/Medicaid approved provider or supplier. This policy is based on the premise that it is the provider or supplier

Appendix A: Part 441, Subpart D – Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs, §§ 441.150-441.156.

Sec. 441.150 Basis and purpose.

This subpart specifies requirements applicable if a State provides inpatient psychiatric services to individuals under age 21, as defined in Sec. 440.160 of this subchapter and authorized under section 1905 (a)(16) and (h) of the Act.

Sec. 441.151 General requirements.

(a) Inpatient psychiatric services for individuals under age 21 must be:

(1) Provided under the direction of a physician;

(2) Provided by--

(i) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

(ii) A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.

(3) Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following--

(i) The date the individual no longer requires the services; or

(ii) The date the individual reaches 22; and

(4) Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with Sec. 441.152.

(b) Inpatient psychiatric services furnished in a psychiatric residential treatment facility as defined in Sec. 483.352 of this chapter, must satisfy all requirements in subpart G of part 483 of this chapter governing the use of restraint and seclusion.

Sec. 441.152 Certification of need for services.

(a) A team specified in Sec. 441.154 must certify that--

(1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;

(2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

(b) The certification specified in this section and in Sec. 441.153 satisfies the utilization control requirement for physician certification in Sec. Sec. 456.60, 456.160, and 456.360 of this subchapter.

Sec. 441.153 Team certifying need for services.

Certification under Sec. 441.152 must be made by terms specified as follows:

(a) For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team that--

(a) The individual plan of care under Sec. 441.155 must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

(b) Based on education and experience, preferably including competence in child psychiatry, the team must be capable f--

(1) Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

(2) Assessing the potential resources of the recipient's family;

(3) Setting treatment objectives; and

(4) Prescribing therapeutic modalities to achieve the plan's objectives.

(c) The team must include, as a minimum, either--

(1) A Board-eligible or Board-certified psychiatrist;

(2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

(3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

(d) The team must also include one of the following:

(1) A psychiatric social worker.

(2) A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

(3) An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of xperience in treating mentally ill individuals.

(4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

State	Criteria – Psych under 21-benefit*	Department	Source of Information
Florida	Minimum criteria: 1. Services can be expected to improve or prevent further regression 2. DSM IV diagnosis 3. A serious impairment in functioning compared to others of the same age due to psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self-care) 4. Child must be in good physical health	Agency for Health Care Administration	Medicaid Statewide Inpatient Psychiatric Program (SIPP) Services for Individuals Under 18-RFP
Georgia	Psych under 21-benefit is **not** currently part of State plan **		
Hawaii	Psych under 21-benefit is currently part of State plan – however no information readily available.		
Idaho	Children placed in residential treatment shall meet the CMH (community mental health) eligibility criteria of serious emotional disturbance (SED)	Department of Health and Welfare	Core Services Publication http://www.healthandwelfare.idaho.gov
Illinois	EPSDT	Dept of Children and Family Services	Section 95. Illinois Public Aid Code
Indiana	EPSDT	Indiana Family and Social Services Association	http://www.in.gov/fssa/disability/medicaid/serv.html Online Publication
Iowa	85.3(3) Certification of need of care: 1. Determined by an Independent Team 2. Ambulatory Care services within community not sufficient 3. Care requires supervision by physician 4. Condition is expected to improve or be prevented from further regressing	Department of Human Services	IAC 1/4/06 Chapter 85. Services in Psychiatric Institutions http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents?Rules/441-85.pdf
Kansas	EPSDT	Dept of Social and Rehabilitation Services	Kansas Health Policy Authority Summary of State Plan Amendment Revisions 06.19.06
Kentucky	EPSDT	Cabinet for Health and Family Services	Directory of Services for Children and Youth with Special Health Care, Educational, and Vocational Rehabilitation Needs. Revised May 2005
Louisiana	Psych under 21-benefit is currently part of State plan – however no information readily available.		
Maine	EPSDT	Department of Health and Human Services	Maine Medical Assistance Manual Psychiatric Facility Services 46.03.1
Maryland	Presence of disorder from the DSM-IV-TR codes on applicable Axes(I-V)	Mental Hygiene Administration	Department of Health and Mental Hygiene MD Per- Susan Steinberg SSteinberg@dhmh.md.us

.eferences to **EPSDT** means Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals under ge 21 (42 C.F.R. Part 441 – Subpart B).

** DHHS, CMS source: Medicaid At-A-Glance 2005. (See http://www.cms.hhs.gov/medicaid/stateplans).

State	Criteria – Psych under 21-benefit*	Department	Source of Information
Ohio	EPSDT Also known as Healthchek	Department of Job and Family Services	Publication of Ohio legal rights services, January 2006
Oklahoma	EPSDT	Department of Health and Human Services	http://mentalhealth.samsha.gov/Publications/allpubs/State_Med/Oklahoma.pdf
Oregon	EPSDT	Department of Human Services, Mental Health, and Disability Services	Oregon Administrative Rule 309-031-0200 Mental Health and Developmental Disability Services Division Administrative Rules OAR 309-031-0200 through 309-031-0255
Pennsylvania	EPSDT	Department of Public Welfare	Pennsylvania Code- Ch.1241
Rhode Island	EPSDT	Department of Human Services	Provider Update July 2002, vol 1117
South Carolina	EPSDT	Department of Human Services	South Carolina State Subsidy Plan
South Dakota	Psych under 21-benefit is **not** currently part of State plan **		
Tennessee	EPSDT	Department of Mental Health & Developmental Disabilities Office of Managed Care	TennCare Medicaid Brief Chapter 1200-13-13 Manual for Mental Health Coverage to Uninsured Tennesseans January 2006
Texas	EPSDT determines Medical Necessity	Department of Health and Human Services	Texas Administrative Code Title 25 Ch. 38, Rule 38.4 Children with Special Health Care Needs Services Programs (CSHCN).
Utah	CHEC screening, also known as EPSDT	Department of Health	Scope of Services (Article III) section of Utah's contract with Prepaid Mental Health Plans
Vermont	EPSDT	Department of Health; Agency of Human Services	www.vermont.gov
Virginia	Psych under 21-benefit is **not** currently part of State plan **		
Washington	Psych under 21-benefit is currently part of State plan – however no information readily available.		
West Virginia	PRTFs are long term treatment facilities that treat clients with, severe, complex symptoms, of a significant duration, that have not responded to other level of care. These admissions require pre-approval. They require an MCM-1 and other supportive documentation such as psychiatric evaluations, psychosocial evaluations, social summaries, progress reports, MDT notes, or any documentation that would support why the client needs long term psychiatric residential treatment.		Source: https://secure.wvmi.org/Priorauth/priorauth/_PRTF_Children_under21.pdf
Wisconsin	Psych under 21-benefit is currently part of State plan – however no information readily available.		
Wyoming	Psych under 21-benefit is **not** currently part of State plan **		

* References to **EPSDT** means Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals under age 21 (42 C.F.R. Part 441 – Subpart B).

** DHHS, CMS source: Medicaid At-A-Glance 2005. (See http://www.cms.hhs.gov/medicaid/stateplans).

(1) Includes a physician;

(2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and

(3) Has knowledge of the individual's situation.

(b) For an individual who applies for Medicaid while in the facility of program, the certification must be--

(1) Made by the team responsible for the plan of care as specified in Sec. 441.156; and

(2) Cover any period before application for which claims are made.

(c) For emergency admissions, the certification must be made by the team responsible for the plan of care (Sec. 441.156) within 14 days after admission.

Sec. 441.154 Active treatment.

Inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised individual plan of care, described in Sec. 441.155 that is--

(a) Developed and implemented no later than 14 days after admission; and

(b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

Sec. 441.155 Individual plan of care.

(a) "Individual plan of care" means a written plan developed for each recipient in accordance with Sec. Sec. 456.180 and 456.181 of this chapter, to improve his condition to the extent that inpatient care is no longer necessary.

(b) The plan of care must--

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;

(2) Be developed by a team of professionals specified under Sec. 441.156 in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge;

(3) State treatment objectives;

(4) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and

(5) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.

(c) The plan must be reviewed every 30 days by the team specified in Sec. 441.156 to--

(1) Determine that services being provided are or were required on an inpatient basis, and

(2) Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

(d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for--

(1) Recertification under Sec. Sec. 456.60(b), 456.160(b), and 456.360(b) of this subchapter; and

(2) Establishment and periodic review of the plan of care under Sec. Sec. 456.80, 456.180, and 456.380 of this subchapter.

Sec. 441.156 Team developing individual plan of care.

the latest issuance of the State Operations Manual issued by CMS (CMS Pub. 7).

(h) *State MDS system and database requirements.* As part of facility agency responsibilities, the State Survey Agency must:

(1) Support and maintain the CMS State system and database.

(2) Specify to a facility the method of transmission of data, and instruct the facility on this method.

(3) Upon receipt of facility data from CMS, ensure that a facility resolves errors.

(4) Analyze data and generate reports, as specified by CMS.

(i) *State identification of agency that receives RAI data.* The State must identify the component agency that receives RAI data, and ensure that this agency restricts access to the data except for the following:

(1) Reports that contain no resident-identifiable data.

(2) Transmission of reports to CMS.

(3) Transmission of data and reports to the State agency that conducts surveys to ensure compliance with Medicare and Medicaid participation requirements, for purposes related to this function.

(4) Transmission of data and reports to the State Medicaid agency for purposes directly related to the administration of the State Medicaid plan.

(5) Transmission of data and reports to other entities only when authorized as a routine use by CMS.

(j) *Resident-identifiable data.* (1) The State may not release information that is resident-identifiable to the public.

(2) The State may not release RAI data that is resident-identifiable except in accordance with a written agreement under which the recipient agrees to be bound by the restrictions described in paragraph (i) of this section.

[62 FR 67212, Dec. 23, 1997, as amended at 74 FR 40363, Aug. 11, 2009]

Subpart G—Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

SOURCE: 66 FR 7161, Jan. 22, 2001, unless otherwise noted.

§ 483.350 Basis and scope.

(a) *Statutory basis.* Sections 1905(a)(16) and (h) of the Act provide that inpatient psychiatric services for individuals under age 21 include only inpatient services that are provided in an institution (or distinct part thereof) that is a psychiatric hospital as defined in section 1861(f) of the Act or in another inpatient setting that the Secretary has specified in regulations. Additionally, the Children's Health Act of 2000 (Pub. L. 106–310) imposes procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in facilities, specifically including facilities that provide inpatient psychiatric services for children under the age of 21 as defined by sections 1905(a)(16) and (h) of the Act.

(b) *Scope.* This subpart imposes requirements regarding the use of restraint or seclusion in psychiatric residential treatment facilities, that are not hospitals, providing inpatient psychiatric services to individuals under age 21.

§ 483.352 Definitions.

For purposes of this subpart, the following definitions apply:

Drug used as a restraint means any drug that—

(1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;

(2) Has the temporary effect of restricting the resident's freedom of movement; and

(3) Is not a standard treatment for the resident's medical or psychiatric condition.

Emergency safety intervention means the use of restraint or seclusion as an

occur while the resident is in the program;

(2) Communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;

(3) Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and

(4) Provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).

(d) *Contact information.* The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.

§ 483.358 Orders for the use of restraint or seclusion.

(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for recipients under age 21 be provided under the direction of a physician.

(b) If the resident's treatment team physician is available, only he or she can order restraint or seclusion.

(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(e) Each order for restraint or seclusion must:

(1) Be limited to no longer than the duration of the emergency safety situation; and

(2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.

(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to—

(1) The resident's physical and psychological status;

(2) The resident's behavior;

(3) The appropriateness of the intervention measures; and

(4) Any complications resulting from the intervention.

(g) Each order for restraint or seclusion must include—

(1) The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;

(2) The date and time the order was obtained; and

(3) The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use.

(h) Staff must document the intervention in the resident's record. That documentation must be completed by

VerDate Mar<15>2010 14:23 Jan 03, 2012 Jkt 223185 PO 00000 Frm 00104 Fmt 8010 Sfmt 8010 Q:\42\X42\COPY223185.XXX ofr150 PsN: PC150

(d) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

§ 483.366 Notification of parent(s) or legal guardian(s).

If the resident is a minor as defined in this subpart:

(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

(b) The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

§ 483.368 Application of time out.

(a) A resident in time out must never be physically prevented from leaving the time out area.

(b) Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity or other residents (inclusionary).

(c) Staff must monitor the resident while he or she is in time out.

§ 483.370 Postintervention debriefings.

(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the disussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.

(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of—

(1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;

(2) Alternative techniques that might have prevented the use of the restraint or seclusion;

(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

§ 483.372 Medical treatment for injuries resulting from an emergency safety intervention.

(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

(b) The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that—

(1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

(c) Individuals who are qualified by education, training, and experience must provide staff training.

(d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

(e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.

(g) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

(h) All training programs and materials used by the facility must be available for review by CMS, the State Medicaid agency, and the State survey agency.

Subpart H [Reserved]

LS3P

SEASONS RESIDENTIAL TREATMENT PROGRAM, LLC

OVERALL FLOOR PLAN

SCALE: 1/32" = 1'-0"

NURSE STATIONS *(3)*

PATIENT RESTROOM *(47)*

STAFF RESTROOM *(8)*

1 - BOYS SHORT TERM ASSESSMENT UNIT (10 BED)

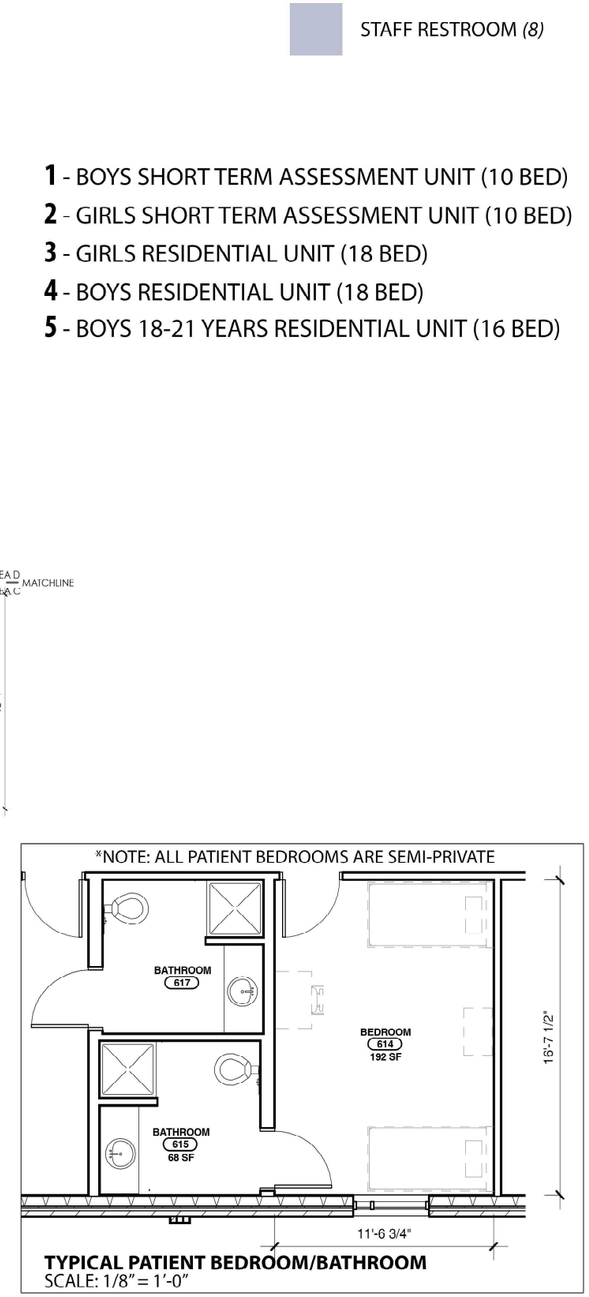
2 - GIRLS SHORT TERM ASSESSMENT UNIT (10 BED)

3 - GIRLS RESIDENTIAL UNIT (18 BED)

4 - BOYS RESIDENTIAL UNIT (18 BED)

5 - BOYS 18-21 YEARS RESIDENTIAL UNIT (16 BED)

*PERIMETER LINEAL FEET = 2,493



TYPICAL PATIENT BEDROOM/BATHROOM
SCALE: 1/8" = 1'-0"

LS3P

SEASONS RESIDENTIAL TREATMENT PROGRAM, LLC

AREA A FLOOR PLAN

SCALE: 1/16" = 1'-0"

NURSE STATIONS

PATIENT RESTROOM

STAFF RESTROOM

SERVICE YARD

KITCHEN 135

OFFICE/STORAGE 139

RISER 140

RECEIVING 135B

RESTROOM 143

LOCKER 142

JAN 141

DISH/ CART SANITIZING 144

ELECT 146

CENTRAL STERILE SUPPLY 145

MECH 147

DINING 134

GYM 148

OFFICE 415

REF

PHARMACY 413

OFFICE 149

STORAGE 414

CORRIDOR 150

BOYS 151

GIRLS 152

MAINT. SUPPLIES & EQUIP 153

MAINTENANCE SHOP 154

CORRIDOR 155

CLASSROOM 156

CLASSROOM 157

DOCTOR 416

DOCTOR 417

CEO OFFICE 128

BUS. OFFICE 129

OFFICE 130

OFFICE 131

ASST. ADMIN 132

ADMISS. 133

OFFICE 127

OFFICE 118

RECORD STORAGE 119

ELECT 120

FILES 121

DATA 122

NERVE CENTER 124

ENGINEER'S OFFICE 125

ADMIS. DIR. 126

CLO. 117

CORRIDOR 174

CORRIDOR 175

HR OFFICE 116

HR OFFICE 115

CONFERENCE 113

MEN 112

WOMEN 111

RESTROOM 109

RESTROOM 108

WAITING 102

SECURE OUTDOOR COURTYARD 173

VESTIBULE 100

RECEPTION 106

LOBBY 101

AREA A

AREA B

CORRIDOR 300A

CORRIDOR 300B

SEASONS RESIDENTIAL TREATMENT PROGRAM, LLC

AREA B FLOOR PLAN

SCALE: 1/16" = 1'-0"

NURSE STATIONS

PATIENT RESTROOM

STAFF RESTROOM

LS3P

SEASONS RESIDENTIAL TREATMENT PROGRAM, LLC

AREA C FLOOR PLAN

SCALE: 1/16" = 1'-0"

- NURSE STATIONS
- PATIENT RESTROOM
- STAFF RESTROOM

LS3P

SEASONS RESIDENTIAL TREATMENT PROGRAM, LLC

AREA D FLOOR PLAN

SCALE: 1/16" = 1'-0"

NURSE STATIONS

PATIENT RESTROOM

STAFF RESTROOM

STRATEGIC
BEHAVIORAL CENTER

3 Year Evaluation Report

2010-2013

Introduction

After three years since the evaluation project at SBC-North Carolina began, sufficient information has been collected to make some definitive conclusions about the program. More than 20% of all the caregivers of residents who were treated during this three year period have been contacted at least once. A comprehensive questionnaire was administered asking about their experience at SBC, and how their children are doing at home and in the community. Attempts were made to call caregivers at one month, six months, and twelve months after discharge. This report shows the outcome of this three year project, illustrating the trends of caregiver opinions about SBC, and how their children have fared since discharge. The following is data provided to and independently analyzed by Dr. Art Frankel, professor at University of North Carolina-Wilmington.

Methodology

Ninety caregivers completed 114 questionnaires through phone calls, some completing more than one questionnaire over time. Each phone interview took from 20-30 minutes. The data was arrayed in SPSS and factored into one month, six month, and twelve month data sets. At the time of intake, all caregivers had to sign a consent form to be part of the ongoing evaluation and agree to be called. Those who did not agree were excluded from the evaluation.

Table 1 *(at end of residential report)*

Over the period of three years, 212 consent forms were received by the evaluation staff, and of that group, 114 were completed by 90 discrete caregivers. 91% of these respondents were family members related to the adolescent resident, of which 56% were mothers. 9% of the respondents were Department of Social Service workers. This group of respondents represents 21.1% of all of the families whose adolescents participated in the SBC residential program over the three year evaluation period. While this sample is not random, it does include the caregivers of one out of every five adolescent residents who participated over one month at the SBC facility. The sample is of sufficient size so that the results can be considered reasonably representative of the entire group of residents who were treated at SBC, particularly at the one month and six month data collection periods. See Tables below including the Recidivism Report.

Recidivism Snapshot

This table shows some of the most important findings over the three year evaluation period. Based on caregiver reports, the average overall re-hospitalization rate for mental health reasons was 7% of the residents who participated in SBC. The rate at one month after discharge was about the same as six months after discharge; at twelve months, none of the children had been re-hospitalized. Since the twelve month rate is smaller, the trend at one and six months is more reliable, showing that less than one in ten children returned to a mental hospital setting over the three year period after discharge from Leland SBC. If an adolescent was re-hospitalized one month after discharge, it was for a longer stay than at six months, where the three re-hospitalized children stayed for only one day each. This would seem to indicate that the highest risk of longer term re-hospitalization occurs with more recently discharged adolescents.

Visiting an emergency room for mental health reasons was a rare event one month and twelve months after discharge. However at six months almost one in ten of the adolescents were brought to an ER.

On the average over the twelve month period after discharge, over 90% of the adolescents were enrolled in school. Most of these children were attending public schools (42%) or alternative schools (44%), with the rest distributed rather evenly across home schooling, private schools, special education, and schools in a facility.

The suspension rate of these children over the year was on the average 13%. It was more likely that if an adolescent was going to be suspended, it would happen in the period from two to twelve months after discharge. At one month, about 1 in 10 children received at least one suspension, while at six and twelve months, almost 1 in 5 was suspended.

Children reportedly left their homes without permission in about 9% of the households in which they were residing; the percentage increased slightly over six months. This outcome indicates that about one in ten of the discharged residents will have at least one AWOL episode within a year from the point of discharge.

On the average, about one in five of discharged residents reportedly had some contact with the police over a year's time from discharge. This percentage increased over time with one third of the adolescents having some police contact at six months, and one fourth at a year after discharge. About 50% of the reasons for police involvement were reported to be for aggression, mostly physical, but some for destroying property. Police were called for children being AWOL 20% of the time. Other reasons made up for the rest of the incidents, including missing court dates, old charges, and pranks. It would seem that the greatest risk for police involvement starts in the period after one month from discharge, and is at a higher risk throughout the rest of the year.

Frequent verbal aggression was reported more often than physical aggression on the average over a year's time. Both verbal and physical aggression was the same at one month--one in ten showing more serious behaviors as reported by their caregivers at that time. It is clear, however, that as time went on, the collective group of adolescents were becoming more verbally aggressive to their family and others. More serious physical aggression also increased at the six month mark, doubling from 10% to 20%, with it calming down close to one month levels at twelve months. Apparently, families were having more trouble communicating with their adolescents as time went on, with a smaller group of these children being more physically aggressive by the six month mark. The decrease at twelve months may not be valid due to the small N, but it is interesting, as we shall see for drug use, that while the 12 month group was far less physically aggressive, their caregivers reported a higher drug problem.

The adolescents' use of drugs reportedly increased over time. If we can believe the twelve month data, given the small N, it would appear that adolescents went from one in ten using drugs at the one month mark, to one in four at twelve months. Regardless, there are sufficient indications in this data set to suggest that drug usage was a increasing problem for some of the children after discharge. However, national studies suggest that up to 35% of high school students are using drugs by the twelfth grade. The former residents from Leland SBC are reportedly using drugs at a much lower level, particularly at one and six months.

As would be expected by national studies, medication compliance reportedly decreased over time. While there are many studies looking at medication compliance, there is some consensus that as time passes, it drops to 50%. The reported high compliance rates at one and six months are well above this, and even at twelve months, it is higher than this national consensus.

One of the most important issues for any organization, be it a business or a social service agency, is that their consumers like the services they have received and are inclined to recommend it to others. 87% of the consumers who were involved in SBC over the three year period indicated they would recommend this residential treatment center to their friends. This recommendation rate was remarkably stable over the year, with a slightly higher percentage of six month responders saying they would recommend the program compared to the one month group. It would appear that the services given to the adolescents at SBC were greatly appreciated by their caregivers.

Based on these caregiver reports, it is evident the great majority of discharged adolescents were doing well. This is especially clear when we view the re-hospitalization rates, the use of the ER, and school enrollment. Given that these children entered Leland SBC with severe emotional and behavioral disorders, these finding are remarkable indeed, as many of these disturbed adolescents had numerous hospitalizations prior to coming to SBC program. However, the data also shows that over time, some of these former residents were beginning to show behavioral problems, such as in their suspension rate, verbal and physical aggression, and their use of drugs. Yet, very few of these increasing behavioral issues caused them to be re-hospitalized a year out from discharge.

It will be up to further evaluation efforts to more clearly establish the benchmarks for what would be successful longitudinal outcomes for seriously emotionally disturbed adolescents who participated in long term residential programs. It is may be that the outcomes reported here will be part of what will be seen as benchmarks for successful long term outcomes.

3 Year Report | Leland SBC

	1 Month	6 Months	12 Months	Total Group
N=	64	34	16	114
% Re-hospitaliztion for MH Reasons	8% (N=5)	9% (N=3)	0%	7% (N=9)
If re-hospitalized, average stay	6 days (1-14 days)	1 day (all 1 day)	0	4.6 days (1-14 days)
% ER use for MH Reasons	3%	9%	0%	3.5%
Child attending Sch	90%	94%	94%	92%
% Suspended	9%	18%	19%	13%
% AWOL	8%	12%	6%	9%
% Police Contact	8%	33%	25%	18%
% Reported Serious Verbal Agg.	10%	33%	43%	21%
% Reported Serious Physical Agg.	10%	21%	7%	13%
% Using Drugs/Alc	10%	16%	27%	14%
% Taking Meds	94%	82%	69%	87%
% Recommending Montevista to Others	85%	91%	87%	87%

Table 2: Outcome Information *(at end of report)*

Following up on the Recidivism Snapshot, Table 2 delves more deeply into the outcomes reported so far. In general, over the years' time, most of the former residents were living with their family, about 60% of them at one, six, and twelve months. Children in foster care seemed to decrease over time, but children who had entered some facility did increase from 19% at one month, to about 30% at six and twelve months. In almost all cases where the child was reported to be in facility, it was a group home, with a small percent in detention.

When adolescents were discharged, 84% of the caregivers reported that step-down services had been arranged, with 81% reporting they actually received them. At the six and twelve month marks, about the same percentage of caregivers remembered that step-down services had been arranged and had been received. At six months, some caregivers reported they were still receiving some of these services, but by twelve months, this dropped to 62%.

The next statistic in Table 1 not reported in the Recidivism Snapshot concerns whether the medications being given to the adolescents were working. Of the 94% of adolescents taking medications at one month, caregivers reported that in 84% of these cases the medications were working. By six months, about the same percentage of caregivers (79%) said the medications were working. At twelve months, it was reported that medications were working only 60% of the time. One might wonder if the decrease in medication compliance and the decrease in medications working could be related to the increase in some behavioral problems over time. Most of the caregivers who reported their children were taking medications said that they had a doctor who was prescribing them, 90-95% at one and six months. However, only 68% of the twelve month group said they were still in contact with a doctor.

The recidivism rate for re-hospitalization was very low. At one month the average stay in days was .4 and it was .1 at six months. This statistic represents the average number of total days spent re-hospitalized for the entire group of adolescents in this sample, N=90. The purpose of this statistic is that it can be reliably compared to other groups should data become available from other evaluation studies.

Caregivers were asked to rate their adolescents' depression on a five point scale, where 5 was very depressed, 1 was no depression at all, and 3 was halfway in-between. The rate of reported depression over the year was pretty much the same, with a slight increase at six months. In any case, these depression ratings meant that caregivers judged their children were a little depressed at times. The rate of suicidal ideation/attempts was reportedly extremely low at one month. However, at six and twelve months, the rate jumped up to about 1 child in 10. Almost all of these reports by caregivers talked about suicidal ideation, which did not result in re-hospitalizations.

Caregivers were also asked to rate on a five point scale a number of other issues. In all of these ratings, 5 equaled feeling very positive, 1 equaled feeling very negative, and 3 meant they felt neutral. When asked how well they were getting along with their adolescent at one month, the caregivers collectively reported a 3.9, which meant they felt positive about their relationship at that time. This rating declined at the six month mark to 3.3 which meant they were feeling more ambivalent about their parent-child relationship, but rebounded at twelve months to 3.6.

They also felt positive about the step-down arrangements they received at one month, 4.2, with similar feelings at six and twelve months out.

When asked of their opinion about their child's school behavior, it started at 3.7, a positive collective response at one month, but began decreasing toward neutrality as time went on.

Table 3: Average Family/Caregiver Satisfaction with SBC

(at end of report)

Up to this point, the status of the adolescents in their home and community has been the focus. Table 2 reports the opinions of the caregivers concerning their views of the SBC program, at one month, six months, and twelve months after discharge. The caregivers were asked a series of questions concerning their experience with SBC, rating each question on a 5 point scale, with 5 equaling great satisfaction, 1 meaning very low satisfaction, and 3 in the middle. The total group averages for these questions can be seen in the Total Group column. In most cases, the caregivers' satisfaction levels for each question remained stable over the year. However, over time, their collective satisfaction level changed for some questions as their perceptions of the program's quality changed. These changes were likely based on factors associated with the passage of time and the experiences they were having with their child when they were contacted.

Viewing the one month and six month responses are likely the most reliable comparisons, since the N for twelve months is small. In all of the ratings to the eight questions, the caregivers gave a 4.0 or better rating out of 5.0, suggesting that overall they were well pleased with the SBC program. Interestingly enough, in six of the eight questions, the ratings were better at six months than at one month. This was also true for those respondents who were contacted twice, the same caregiver being contacted at one and six months. This phenomenon, which was noted in interim evaluations in the last three years, might be called the "absence makes the heart grow fonder" effect. It may be that as time goes on, and caregivers experience the quality and/or intensity of community-based support programs, they have the realization that the SBC residential program was better by comparison than what they originally thought.

In any case, the two factors that maintained ratings stability over the year after discharge was the caregiver's General Opinion of their child's stay at SBC, and their perception the stay at SBC helped their child. The average satisfaction for both of these questions was 4.3, showing good satisfaction with the program. Family sessions were rated at 4.0 at one month, and moved to 4.4 at six months. This finding suggests that over time, caregivers appreciated the family therapy sessions more than when they rated this at one month after discharge. At twelve months, the average ratings returned to the one month satisfaction level.

At SBC, family therapy sessions are conducted on a bi-weekly basis, with some variability of this frequency based on family availability. Some of the families live too far from Leland to attend in person. To facilitate these sessions, about 15% of the caregivers reported they only had family sessions by phone; about 25% were done in-person only; and close to 60% had a combination of both in-person and by phone.

For the next five ratings in the table the initial satisfaction ratings at one month also showed good satisfaction with scores between 4.2 and 4.4: Was the therapist helpful; Did they receive enough information from the staff; Did they have enough phone contact with their child; Did they have enough personal contact with their child; and was their overall decision to put their child in SBC was a good one. For all five of these questions, the caregivers at six months reported more satisfaction, with higher ratings ranging from 4.5 to 4.7, approaching great satisfaction after considering the program six months later. At twelve months, all of these ratings returned to their one month levels.

Tables 4, 5, and 6: Caregiver Comments

While there were many comments recorded throughout each interview, three "forced-answer" questions are perhaps the most representative of what the caregivers were thinking. The first "forced" question was, Table 4, what the caregivers liked about their child's behavior after they were discharged. 71% of the sample answered this question, with the results seen in Table 4.

The caregivers were also asked to tell the interviewer what they thought was the most beneficial part of their child's stay at SBC. 70% of the caregivers gave a statement for this question, and Table 5 shows these results

And finally, the respondents were requested to state what they didn't like about their child's stay at Strategic. Table 6 has these statements. A slightly fewer percentage, 60%, answered this question.

Viewing the statements in Tables 3 and 4, there does seem to be a very positive sense of what was accomplished at SBC. These qualitative comments mirror the positive ratings in Table 3, as well as the high recommendation percentages. The "forced-answer" question asking to state what they didn't like about the program did reveal some dissatisfaction with certain aspects of the program, even for those who rated their experiences very highly. These kinds of answers, when combined with the more positive ones, can support program improvement.

Conclusion

Over a three year period it is clear that many aspects of the SBC program are doing very well, as reported by its consumers. Most importantly, the re-hospitalization rate is extremely low, which is remarkable for a population of very disturbed adolescents, many of whom have experienced prior hospitalizations. There are indications that by six months after discharge some of these former residents are experiencing, or re-experiencing problems in the areas of school suspensions, contact with the police, the use of drugs, and verbal and physical aggression. Even given the severity of the emotional and behavioral problems affecting these children at SBC intake, it is clear from the caregiver reports that one month after discharge they were doing very well as a group. Most were using the step-down services arranged by Strategic staff. As time went on, some adolescents and their families reported more problems over time. It must be clearly noted, however, that a large majority of these adolescents were still reportedly doing well at six and twelve months after discharge.

The fact that so many caregivers were very satisfied with program and its components at SBC seems remarkable, given the nature of the problems that their children presented at intake. By any standard, when a group of consumers shows such positive regard for a service, and is willing to recommend it so highly to others, that service is being perceived as high quality. These high recommendations are grounded by the reported longitudinal positive stability of the home and community behavior for the great majority of these discharged residents.

Table 1: Call Data | August 30, 2010 - June 30, 2013

	Totals
Number of consent forms received	212
Number of questionnaires completed	114
Number of Caregivers Contacted	90
% of total number of Residents enrolled at SBC	21.1

Table 2: *2013 Outcome Information*
3 Year Report | 1, 6 & 12 Months after SBC Discharge

	1 MONTH (N-64)	6 MONTHS (N=34)	12 MONTHS (N=16)	TOTAL GROUP (N=114)
Where is child living now	Family **60%** Facility **19%** FosCare **19%**	Family **58%** Facility **27%** FosCare **15%**	Family **62%** Facility**32%** FosCare 6%	Family **59%** Facility **24%** FosCare 1**6%**
Service Arrange made?	**84%**	**79%**	**75%**	**81%**
Service Arrange Received?	**81%**	**81%**	**62%**	**78%**
Child in Sch	**90%**	**94%**	**94%**	**92%**
Suspended in last 30 days (%)	**9%**	**18%**	**19%**	**13%**
AWOL?	**8%**	**12%**	**6%**	**9%**
Police contact in last 30 days (%)	**8%**	**33%**	**25%**	**18%**
D&A behavior in last 30 days	**10%**	**16%**	**27%**	**14%**
Serious verbal aggression	**10%**	**33%**	**43%**	**21%**
Serious physical aggression in last 30 days (%)	**10%**	**21%**	**7%**	**13%**
Medicated in last 30 days (%)	**94%**	**82%**	**69%**	**87%**
Meds working?	**84%**	**79%**	**60%**	**79%**
Mental Hospital admissions in last 30 Days (%)	**8%**	**9%**	**0%**	**7%**
Mental Hospital average stay	**.4**	**.1**	**0**	**.3**
ER admissions	**8%**	**9%**	**0%**	**7%**
Depression(5 pt.)	**1.7**	**2.2**	**1.8**	**1.7**
Suicide idea/attempt	**3%**	**12%**	**12%**	**6%**
Caregiver relationship rating (5 pt.)	**3.9**	**3.3**	**3.6**	**3.7**
Eval of Step-Down (5 pt.)	**4.2**	**4.3**	**3.8**	**4.1**
Eval of School Behavior (5 pt.)	**3.7**	**3.4**	**3.2**	**3.5**

Table 3: *Average Family/Caregiver Satisfaction with SBC*
3 Year Report | 1, 6 & 12 Months after SBC Discharge
2013 | (5=Very Satisfied; 1=Very Dissatisfied)

	At 1 Month (N=64)	At 6 Months (N=34)	At 12 Months (N=16)	Total Group (N=114)
General opinion of child's stay at SBC	4.2	4.4	4.2	4.3
Did child's stay at SBC help him/her?	4.3	4.3	4.2	4.3
Were family sessions helpful?	4.0	4.4	3.9	4.1
What type of family session?				**Phone 15%** **In Person 25%** **Both 58%** **No sessions 3%**
Was contact with the therapist helpful?	4.2	4.5	4.1	4.2
Did you receive enough information from the staff about your child?	4.2	4.7	4.3	4.3
Did you have enough phone contact with your child?	4.2	4.6	4.4	4.4
Did you have enough personal contact with your child?	4.3	4.7	4.4	4.5
Was your decision to put your child at SBC a good one?	4.4	4.7	4.4	4.5
Would you recommend SBC to another family?	**85%**	**91%**	**87%**	**87%**

Table 4: *What Caregivers liked about their child's behavior after they left Leland SBC*

- A little more compliant
- A little more respectful
- Able to calm down a little more
- Able to process things better
- Attentive and helping out
- Backs down, no escalation
- Better
- Can control his anger better
- Communication a little better
- Compassionate and giving
- Did well for first couple of weeks, followed directions
- Different kid
- Does not get angry like he used to
- Does what asked without arguments
- Doesn't talk back as much
- Easy to get along with since he has been home
- Enjoying him
- Everybody there was so helpful
- Far less mood swings
- Following directions, making connections
- Getting along better
- Good manners
- Has goals for himself now
- Has gone from a bad attitude to a great positive one
- Having fun outdoors with family
- Having her home; behavior is enlightening.
- He accepts responsibility and is more mature
- he apologizes when he is wrong now
- He appears to try to do chores & be positive w/ in family unit. Appears happy.
- He has started talking more easily to everyone.
- He is a different child after leaving strategic
- He is more cooperative
- He is more understanding, he listens to input more and he really talks to me
- He is nicer
- He is polite
- He tries to do the right thing
- Helps at home
- His attitude is better. He is apologizing.
- I love strategic!
- Improved
- Improvement in coping skills
- Just glad she's home and safe
- Learned self-control techniques
- Less self harm
- Manners are back much better behavior
- More open and honest
- More respectful
- Much better attitude
- Much improved
- Much more respectful
- No mouth
- No redirecting needed
- Not always disrespectful
- Not arguing, compliant
- Not outwardly aggressive to siblings anymore... more passive
- Polite
- Quicker to apologize now
- Respectful & pleasant. Open to honest conversation about future
- ROTC is helping give her structure
- Says he feels better
- Seems better
- Seems to be happier
- She loves and communicates so well with us
- She will try to do better
- Showing signs of taking responsibility
- Starting to own up to his behaviors
- Still think strategic was wonderful and changed my child
- Strategic got her on track
- Strategic has been the only good placement
- Strategic was a great program but not the right fit for his drug problem
- Strategic was the best placement she ever had in her life
- Takes his meds
- Talks about feelings
- Talks more
- Temperament better, more control
- Thinking before speaking
- Tolerating behavior
- Turns things around more quickly
- Very pleased

Table 5: *What do you think was the most beneficial part of your child's stay at SBC*

- Learned how to be thankful for what God has given him
- Able to assess and stay on top of things; got him to open up
- Able to get correct diagnosis and help with meds
- Academics went up, behavior turned around (positive), diagnosis was made clear
- All good
- All in one place
- All positive reinforcement--works for positive and not reprimanding him
- Behavior turned around to positive, academics went up
- Being in strategic helped him think about who he needed to be
- Care, external case manager, everybody on the team was trying to do everything possible
- Coping skills
- Coping skills
- Counseling
- Family support, lots of contact w/ therapist
- First time she has shown empathy for other kids at strategic
- Gained empathy for other kids
- Gave her a great attitude
- Gave her leadership skills
- The therapist
- He can work through problems now. More communication now
- He is able to work things out now
- He is doing better
- He was able to talk and trust staff-very positive. The staff was really great.
- Helped anger management
- Helped him talk more
- Helped in so many ways
- Helped with overall attitude
- Helped with school
- Helpful staff & excellent facilities
- Helping him control behavior credit for school
- Her therapist
- I wanted to send him back to strategic
- I will always feel like strategic saved her life
- I wish he could go back long term
- Independent, learned how to deal with problems without thinking he was a terrible person
- Individual therapy and peer groups she always talked about how encouraging they were.
- Her therapist has been the only one to help her at all
- Knowing he was safe & with well trained staff.
- Learned a lot about herself learned to recognize "triggers'
- Learned how to control his temper. Good grades gave him higher self esteem
- Learned not to blame; learned to dial w/ own essence and coping skills
- Learned respect
- Learned to express himself in a positive way better understood himself got to grow up
- Less harm now
- Locked facility
- Made things easier for our family.
- Kept us in the loop even though we were far away
- Made to conform
- Therapist was helpful
- Monitoring
- Opened her eyes that she was not the only one with problems; helped her grow up
- Overall behavior good
- Professionalism of staff, great communication among staff and legal guardian
- Limited his freedom
- She came away with a feeling that she was not alone and can overcome anything
- She is coping much better
- She learned self-control at strategic
- She was safe; she was out of touch with play mates and received good guidance from Jenny
- Social skills he learned
- Staff members and positive reinforcement
- Strategic got him under control
- Strategic has been the best placement ever. He has been in the system since he was two. Strategic has helped so much.
- Strategic helped him find himself and improve his life

Table 5: Continued

- Strategic was a good program to start in
- Structure and guidance
- Structure and access to med checks
- Structured environment and made him want to come home
- Structured, positive environment
- Taught him how to interact and get along
- Taught him respect and rules and natural consequences
- Thank you strategic!!!!!
- The best place ever! Very helpful with medications
- The only helpful person seemed to be the doctor there that diagnosed the developemental delay
- The therapy help have better ways to work through angered him
- Therapy and structure
- Therapy
- Therapy every day, positive place
- Therapy, control of behavior
- They were able to diagnose him and help with meds
- Treatment; plan-ful discharge
- Turned around very bad behavior made him appreciate what he had at home
- We moved here from New Hampshire just for Strategic

Table 6: *What you didn't like about your child's stay at Strategic*

- Case-management issues
- Change in therapist-was not informed; both were good, though.
- Changing therapists was difficult lack of communication with the first one
- Communication
- Could not talk in front of daughter
- Couldn't see him on Christmas
- Couldn't talk to people when she wanted to; did not talk to Dr.; Dr wouldn't return calls
- Did not like some of the other clients; felt like they were very dangerous; threats were made. Did not feel like the staff was professional
- Didn't wash his clothes right
- Discharge was unorganized. Also, wouldn't call school back with things they needed
- Distance
- Distance
- Distance made it difficult to have contact with social worker
- Do not always check ID at the door
- Didn't check ID at entrance; need to be consistent with security when you go in
- A bunch of drug peddler's--drugs changed all the time
- Far away
- Feel like she needed to stay longer
- Got a black eye from a peer; no access to see his environment.
- Belongings destroyed; no one investigated
- Had him on too many meds; almost messed up his liver
- Had some miscommunication
- His discharge prior to completing program.
- I did not believe any information
- Kid had no CM; DSS had to find placement after he left SBC
- Lack of communication by phone
- Lack of communication with the first therapist
- Lack of exercise
- Lack of family sessions
- Long drive and not talking to the doctor
- Medications were changed without contacting me
- Missing him
- More contact phone calls
- Need more individual plans for each child. The second time was the same program
- Need more outside time
- Needed more time there
- No contact with anyone. No answers and no communication; child put through trauma.
- No supervision, not enough contact
- Not being able to call daughter
- Not being able to take a tour of the living area; as a social worker I would like to see it before placement
- Over medicating children
- RNs called frequently, the amount of medication
- Scheduling of treatment team mtgs was not supportive
- Sent her home without meds
- Some of his trauma should have been dealt with more
- Some of the other kids there
- Staff didn't know what was going on. No communication.
- Staff inconsistency
- The distance from home, and the fact that he had to step down before we felt he was ready (due to medicaid funding).
- The distance and inflexibility of the program to address the needs of family
- The first three months, poor organization, little treatment just ward housing
- Too far away
- Too far away
- Too many families in the visiting room; very invasive
- Treatment process not explained clearly at intake, ie points system, earning privileges
- Unhealthy food gained a lot of weight
- Visitation hours were too short. Needed more of a private area for phone conversations
- Wanted to see her living space was not allowed
- Was not allowed to have her music which calms her; almost too strict
- Was not there long enough
- Worried about her physical well-being while at SBC
- Would not individualize the program to suit her

SBC – Acute Clinical Outcomes Report

Summary

CORE (Clinical Outcomes in Routine Evaluation) surveys were conducted at Strategic Behavioral Center from November 2013-February 2014, upon admission and at discharge with 1 month follow-up, for the acute adolescent inpatient unit to measure change during and after treatment (see Table 1). The data analysis and 1 month follow-up was conducted independently by the University of North Carolina at Wilmington. The lowest level of acuity value is a 0 where the most severe symptomology is a 40. A change of 6 or more is considered statistically significant. The CORE-YP (Young Person) measures a composite score of patient symptoms: Anxiety, Risk, and Depression (see Table 2).

Clinical Results

- CORE pre-post experienced clinically significant change on all dimensions.
- 56% overall reduction in acuity from admission to discharge.
- 85% reduction of Risk from admission to discharge.
- Only slight elevation or Risk from discharge to 1 month follow-up.

Table 1:

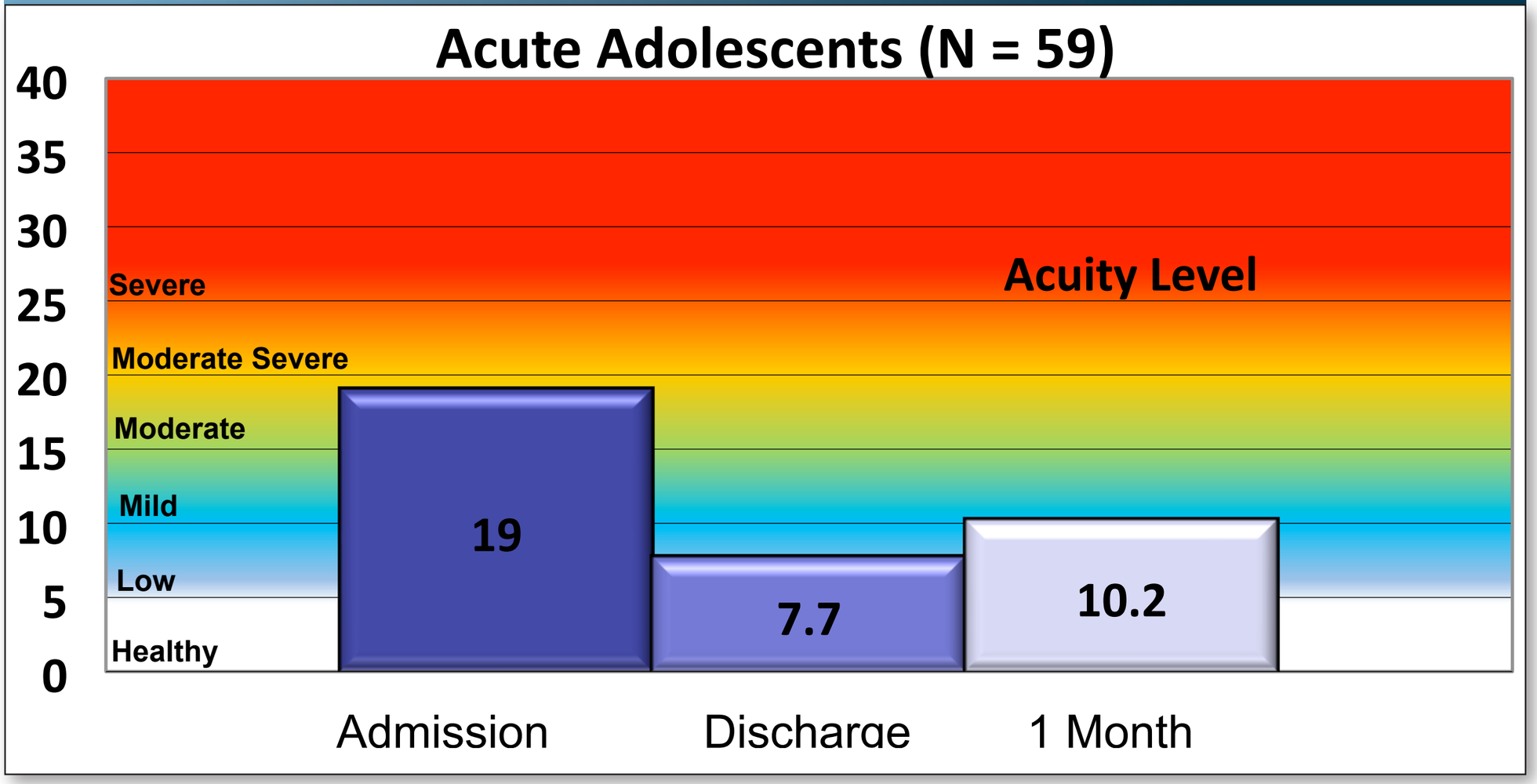
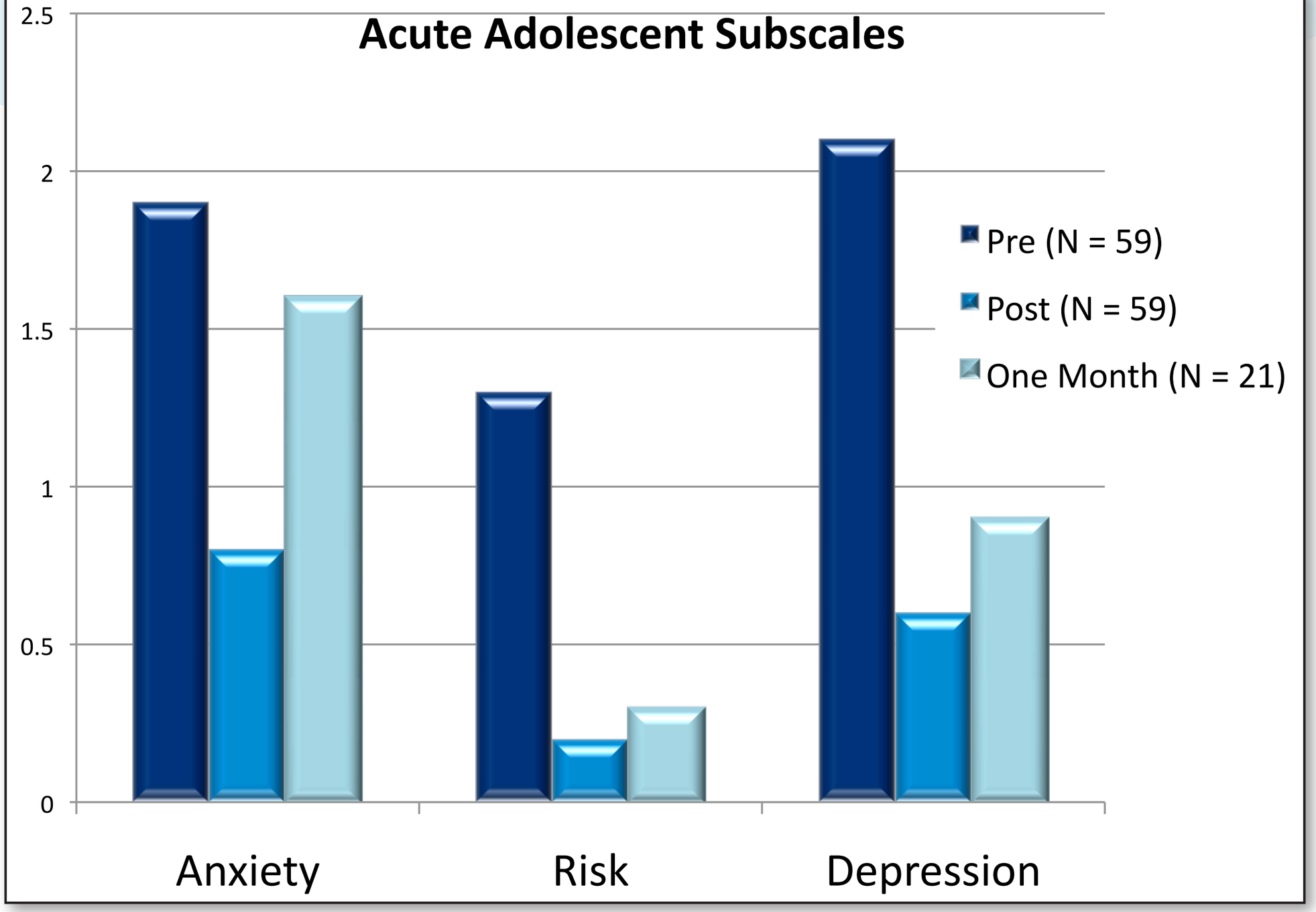


Table 2:


Acute Adolescent Subscales
2.5
2
1.5
1
0.5
0
Anxiety
Risk
Depression
Pre (N = 59)
Post (N = 59)
One Month (N = 21)

STRATEGIC
BEHAVIORAL CENTER

2013

Maryland Department of Juvenile Services Residential and Community-Based Services Gap Analysis

Submitted by the Department of Juvenile Services in partnership with The Institute for Innovation & Implementation

12/31/2013

Contents

Executive Summary

The Department of Juvenile Services (DJS) is responsible for managing, supervising, and treating youth who are involved in the juvenile justice system in Maryland. This report summarizes DJS's current service continuum and data related to the risks and needs presented by girls and boys who are involved with DJS, and provides an assessment of whether the current array of services are sufficient to meet the needs of all youth, with specific focus on girls. A proposed action plan for addressing identified gaps is included at the end of the report.

Community-Based Service Gaps

- Youth in all jurisdictions have access to some form of evidence-based or promising programs that have shown to be effective for girls and boys, including Multisystemic Therapy (MST), Functional Family Therapy (FFT), Family-Centered Treatment (FCT), and High Fidelity Wraparound.
- All jurisdictions reported availability of treatment programming to address mental health and substance use needs; more detailed analyses are needed in each locality to determine whether the existing services are sufficient.
- The following jurisdictions reported having no gender-specific community services for girls, despite having a significant number of girls on probation supervision: Baltimore County (114 girls court-ordered to probation in Fiscal Year 2013 (FY13)), Prince George's County (62), Anne Arundel County (61), and Wicomico County (30).
- A significant number of youth under probation in Anne Arundel and Worcester Counties demonstrated a moderate or high need related to aggression, but these counties did not report access to any services to address this need.
- A significant number of youth under probation in Wicomico and Worcester (boys only) Counties demonstrated a moderate or high education/school need (e.g., truancy, misconduct, poor grades, etc.), but these counties did not report access to any education support services.

Residential Service Gaps for Girls

- Findings from a forecast analysis suggest that DJS has enough capacity to serve girls in Level III/hardware secure residential services through a single DJS-operated program (capacity of 14 girls) for the foreseeable future. An assessment of girls' needs indicates that Level III programming should address mental health, family functioning, aggression, and alcohol and drug use.

- There appears to be a shortage of services available for Level II/staff secure residential programs. On any given day, DJS has approximately eight slots available using two privately-run group homes to serve girls who require a staff secure placement, yet the forecast analysis projects that 16 girls require services at this level. An analysis of girls' needs indicates that programming in Level II programs should focus on alcohol and drug use, in addition to mental health. These findings are also supported by analyses of placement ejections and girls placed outside Maryland.
- There are sufficient resources for Level I/community-based residential programs, with 81 slots available to girls on any given day and 65-67 girls projected for this level of programming. The evidence-based services (EBSs) described above may also be utilized as alternatives to out-of-home placement for these youth, if they are eligible and the youth and caregivers are amenable to treatment.
- There are sufficient resources for mental health residential treatment based on prior utilization, with 47-48 girls projected to need this type of placement, and 51 mental health residential placements (MHRPs) utilized on average. This included 37 residential treatment center (RTC) beds, six beds in diagnostic units, eight psychiatric hospital beds, and one high intensity psychiatric respite bed. Nonresidential services, such as care coordination in the community through the Care Management Entity (CME), may also be appropriate alternatives to residential care for some youth.

Residential Service Gaps for Boys

- There is a shortage in capacity to serve boys in Level III programs. Whereas 135-138 boys are projected to require Level III programming on any given day, there is currently only one hardware secure program in Maryland that serves 48 boys. An assessment of boys' needs indicates that Level III programming should address the continuum of behavioral health needs with emphasis on alcohol and drug use, family functioning, aggression, and mental health. These findings are also supported by an analysis of boys who were placed in programs outside of Maryland in FY12 and FY13.
- There are sufficient services available for Level II programs. On any given day, DJS has approximately 335 slots available using seven staff secure programs, one therapeutic group home, one group home, and three intermediate care facilities for boys who require a staff secure placement. The forecast analysis projects that 269-275 boys require services at this level. An analysis of boys' needs indicates that services in Level II programs should

emphasize alcohol and drug use, family functioning, and aggression/assaultive behavior, and mental health.

- There are sufficient resources for Level I programs, with 240 slots available to boys and 254-260 boys projected for this level of programming on any given day. Some boys may be diverted to one of the in-home EBSs—over three-quarters of the boys were identified as having a moderate or high need related to family functioning and all currently available EBSs are family-based models.
- There is a potential shortage in appropriate mental health residential treatment beds. On the one hand, the forecast analysis indicated that 123-126 boys are projected to need this type of placement, and 130 MHRPs have been utilized on average. These included 77 RTC beds, 12 psychiatric hospital beds, 11 beds in diagnostic units, and one high intensity psychiatric respite bed. And once again, community-based services such as care coordination through the CMEs may also be appropriate alternatives to residential care for some youth. On the other hand, 29 boys have been sent to MHRPs located outside of Maryland over the past two fiscal years, and an additional 11 youth were sent to secure out-of-state programs that provide mental health or substance abuse treatment. These out-of-state placements suggest potential gaps in this type of residential care.

Introduction

The Department of Juvenile Services (DJS or the Department) administers the primary service delivery and supervision functions of the juvenile justice system in Maryland, including intake, detention, probation, commitment, and aftercare services.[1] To accomplish these tasks, DJS operates field offices in each of Maryland's counties, including Baltimore City, as well as detention and residential facilities throughout the state. Operational functions are organized into six Regions: Baltimore City, Central, Western, Eastern Shore, Metro, and Southern (Figure 1).

Figure 1. DJS Regional Map

Most of the youth involved with the juvenile justice system are managed and supervised in the community through pre-court (i.e., informal) or probation supervision. In these cases, youth may participate in community-based services provided directly by DJS or by another agency via a contract with DJS or another funding mechanism (e.g., insurance). A substantially smaller share of youth is committed to DJS by the juvenile court; in these cases, the Department provides services to youth in the least restrictive settings warranted by the youth's risk to public safety. A range of programs is available to committed youth. *Community-based treatment programs* allow youth to continue living at home in their community while they receive treatment. *Residential treatment programs* provide specific types of treatment within a continuum of restrictive environments.

DJS utilizes a broad network of public and privately-run programs to meet the needs of youth involved with the system. These programs vary in terms of size, location, populations served, security level, and

[1] A glossary of terms used in this report is available in Appendix A.

services provided, among other factors, and together they constitute a broad, yet comprehensive service array. The different types of programs are discussed in more detail in subsequent sections of this report.

Service Decisions

Decisions to refer and/or place youth in services and programs involve different stakeholders and processes, depending on the nature of the youth's involvement with the Department. At DJS intake, staff interview the youth and family member(s) and utilize a brief risk assessment to inform service referral decisions. For youth who have been adjudicated delinquent, service and placement decisions involve a social history investigation (SHI) and completion of the MCASP (Maryland Comprehensive Assessment and Service Planning) Assessment, as well as direction from the courts, who ultimately determine whether the youth will be served in the community or in out-of-home care. If the youth is committed to DJS, placement determinations are further guided by the Multidisciplinary Assessment and Staffing Team (MAST). The MCASP Assessment and MAST are briefly described below.

All adjudicated youth are assessed with the MCASP Assessment, which is used to inform supervision and service decisions for youth at disposition and treatment service plans (TSPs). It is typically completed as part of the SHI, which occurs between adjudication and disposition (unless these hearings occur on the same day; in these cases it is completed post-disposition). The MCASP Assessment was adapted from the Washington State Juvenile Court Assessment, a validated risk and need assessment instrument created specifically for a juvenile justice population (Barnoski, 1998). It consists of 106 items, which are grouped into 11 domains related to the youth's risk of recidivism: delinquency history, school/education, use of free time, employment, peer relationships, family, mental health, alcohol and drug use, anti-social attitudes, aggression, and neighborhood safety. The instrument's output provides case managers with two sets of information that are incorporated into their recommendations and decisions: 1) the recommended supervision level, which is based on the youth's overall risk level, current offense severity, and prior offending chronicity; and 2) a risk level for each need domain. The MCASP Assessment is not a clinical assessment instrument, thus findings cannot be interpreted to determine clinical levels of care.[2]

[2] For example, if a youth scores as "high" in the mental health domain, that youth should be further assessed by a licensed clinician.

Youth committed to the custody of DJS are evaluated by the Multidisciplinary Assessment and Staffing Team (MAST), which completes a battery of standardized assessments and evaluations to determine clinical needs and other individual factors that should be considered as part of the placement decision. The MAST's clinical staff convene with the youth's DJS case manager, the case manager supervisor, resource coordinator, education representative, and parents or caregivers to review the findings and recommendations. The review incudes documentation of the youth's current offense, prior offenses, Social History Investigation and Report, MCASP scores, educational records, clinical assessments, and whether any other state agency is involved with the youth. The result of the meeting is a list of recommendations for appropriate programs and services that would best suit the youth's individual risks and needs. DJS then refers the youth's case to the recommended programs for consideration. Programs may accept or reject a youth based on program eligibility criteria and capacity. Once a youth is accepted, services must be authorized by DJS prior to the youth's placement.

To facilitate the identification of appropriate services for youth, the Department has also implemented the DJS Program Questionnaire, a 45-item instrument that is disseminated to all DJS-operated and contracted residential providers, and some nonresidential services, on an annual basis. The purpose of this questionnaire is to gather comprehensive information about the services offered and youth served by the programs. This information is used to describe DJS's service array, to identify gaps in services, and to improve service matching based on youth characteristics, including identified risks and needs.

Programming for Girls

Research demonstrates that the experiences and needs of girls involved in the juvenile justice system are different than boys (e. g., Bright & Jonson-Reid, 2008). "Traditional" delinquency interventions have typically been created for boys involved with the system, and are often ineffective with girls (Chesney-Lind & Shelden, 2004). Thus, gender-responsive services that are tailored to girls' unique needs are necessary to effectively serve them. Bloom and Covington (2000, p.11) define services that are "gender responsive" as: "Creating an environment through site selection, staff selection, program development, content, and material that reflect an understanding of the realities of women's lives and address the issues of the participants. Gender-responsive approaches are multidimensional and are based on theoretical perspectives that acknowledge women's pathways into the criminal justice system. These approaches address social (e.g., poverty, race, class, and gender) and cultural factors, as well as therapeutic interventions. These

interventions address issues such as abuse, violence, family relationships, substance abuse, and co-occurring disorders. They provide a strengths-based approach to treatment and skills-building while emphasizing self-efficacy."

It is a priority for DJS to provide a continuum of services for all youth in residential placements and those who are supervised in the community. While DJS provides some gender-specific programs (both residential and community-based) for girls, it also relies on a broader service array to meet the diverse needs of all youth in its care.

The purpose of this report is to (1) describe the existing service arrays for girls and boys involved with DJS and (2) to determine whether the existing community-based and residential service arrays can meet the needs of these youth. The gap analysis is divided into two primary sections—one that explores gaps in community-based services, with a focus on programming for youth placed on probation,[3] and one that explores the potential gaps in residential services for youth who are committed to DJS. The next section provides an overview of the community-based and residential services utilized by DJS.

The Continuum of Care

Community-Based Services

The service array available to youth in the community varies from county to county across Maryland. In all jurisdictions, services for DJS-involved youth are planned and provided through collaborative efforts with the Local Management Boards, Core Service Agencies, Social Services, Health Departments, Courts, Local Education Agencies, Youth Service Bureaus, and other public and private entities. While the Department contracts with a few community-based programs to ensure access to certain services for their youth population, DJS staff also refer youth to services that may be accessed through insurance or made available through another funding source. The community-based programs discussed in this report are often utilized with youth under probation or aftercare supervision, and in some cases pre-court supervision. Some may also be utilized as diversion from out-of-home placements for committed youth (see *Evidence-Based Services*).

[3] DJS, in partnership with The Institute for Innovation & Implementation, will commence a separate project to examine the availability and utilization of alternatives to detention (ATDs) in the Spring 2014. This analysis will utilize data from the newly implemented Detention Risk Assessment Instrument (DRAI).

Evidence-Based Services

Evidence-based Services (EBSs) are model practices or programs that have proven to be effective in reducing recidivism and achieving positive outcomes for youth and families. For many youth, these programs offer appropriate and effective alternatives to residential care if the youth and family are eligible and amenable to the services. DJS uses EBSs to address the needs of youth who are committed to the Department but may be safely served in their homes. These programs are also used for youth under probation supervision and for committed youth who are returning home from residential placements. In some jurisdictions, EBSs are also offered to youth under pre-court supervision.

Four primary evidence-based or promising practices are offered for DJS-involved youth in Maryland: Functional Family Therapy, Multisystemic Therapy, Family-Centered Treatment, and high-fidelity Wraparound delivered through the Care Management Entity. These programs and services are family-based models that have demonstrated to be effective with juveniles involved with the juvenile justice system. The following is a brief description of each program.

Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is a family-based intervention program for high-risk youth ages 10-18. It is a short-term program, with an average of 12 sessions over a 3-4 month period. FFT is intended for a wide range of youth whose problems range from disruptive behaviors to alcohol and/or substance use. Interventions tend to focus on family interactions, communications, and problem-solving, as well as parenting skills and pro-social activities. Services are conducted in both clinic and home settings, and can also be provided in schools, as well as child welfare agencies, probation offices, and mental health facilities. Participating youth must be psychiatrically stable, capable of participating in a cognitive behavioral intervention, and have a parent or legal guardian willing and able to participate (Sexton & Alexander, 2000; Sexton, 2011).

Multisystemic Therapy (MST)

Multisystemic Therapy (MST) is an intensive family-based treatment program that focuses on addressing all environmental systems that impact chronic and violent juvenile offenders, including their homes and families, schools and teachers, neighborhoods and friends. Youth served are 12 to 17 years of age, psychiatrically stable, living with a primary caregiver, and capable of participating in a cognitive behavioral intervention. Exclusion criteria for MST include youth with a diagnosis of Pervasive Developmental Disorder, such as Autism Spectrum Disorder; youth who are primarily

being referred for sex offending behavior; and/or youth living independently in the community. The therapist meets with the family as often as needed (more than once per week, if necessary) in the home or community, and is available 24 hours a day. Treatment duration is typically 3 to 5 months (Henggeler, 1999; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009).

Family Centered Treatment (FCT)

Family Centered Treatment (FCT) is an evidence-based family preservation model of in-home treatment. The FCT model is multifaceted, and treatment services may include counseling, skills training, trauma treatment, community resource coordination, wraparound services, and other interventions. FCT aims to help at-risk families learn and adopt positive behavioral patterns. It is designed for youth facing out-of-home placements and for those reentering their family home from foster care, juvenile detention, or other institutional settings. The FCT model is flexible and treatment can be personalized to meet a range of needs, including substance abuse challenges, domestic violence trauma, sexually inappropriate behavior (including sex offenses), as well as highly reactive behavior (e.g., Sullivan, Bennear, Honess, Painter, & Wood, 2012).[4]

Care Management Entity (CME)/High Fidelity Wraparound

The Care Management Entity (CME) provides intensive care coordination services to children and youth with intensive behavioral health needs using a Wraparound service delivery model. The services are provided in accordance with the 10 principles of Wraparound,[5] including using a strengths-based team approach to individualized, culturally-responsive, comprehensive, and outcomes-driven care planning. Youth and families are considered critical members of the Child and Family Team, and care coordinators strive to ensure that their voices are fully heard and respected.

Girl-Specific Programs

The programs described above have been shown to be effective or promising programs for girls involved with the juvenile justice system, but they are not gender-specific models. Again, research supports the use of programs that are designed to address the unique needs of girls. Several gender-responsive programs are offered to girls who involved with DJS, though access varies across the state. The Female Intervention Team, Girls Group, and Girls Circle are highlighted below.

[4] See www.ifcsinc.com for more information.
[5] More information on the Wraparound Model is available at www.nwi.pdx.edu.

Female Intervention Team

DJS created the Female Intervention Team (FIT), a probation unit dedicated to females, in response to a substantial increase in girls referred to and served by DJS in the early 1990s. FIT's primary focus has been to keep girls in the community and prevent them from re-offending through the use of case management and access to support services and programs, including FIT-conducted teen parenting, parent support, and substance abuse groups. FIT serves all DJS-involved girls who reside in Baltimore City and have been formally adjudicated and supervised through aftercare, probation, and the violence prevention initiative. Girls receive services through FIT for varying lengths of time, often 6 to 12 months.

Girls Group

Across the state, a number of DJS offices provide their own gender-responsive groups for girls. These groups are led by case managers who have received specific training and resources to supervise girls and to encourage their success. Programming may vary somewhat across jurisdictions but tends to focus on relationships, healthy lifestyles, education and employment preparation, and other issues specific to girls.

Girls Circle

Girls Circle is a structured support group for girls ages 9-18, which integrates relational theory, resiliency practices, and skills training in a specific format designed to increase positive connection, personal and collective strengths, and competence in girls. It aims to counteract social and interpersonal forces that impede girls' growth and development by promoting an emotionally safe setting and structure within which girls can develop caring relationships and use authentic voices.[6] Research has shown that girls who participate in Girls Circle, including those involved with the juvenile justice system, experience significant gains in self-efficacy, body image, and perceived social support (Irvine, 2005).

Residential Services

DJS utilizes a broad array of residential programs for committed youth, ranging from treatment foster care to secure youth centers to facilities operated by the Public Mental Health System (PMHS). To ensure that youth are placed in programs that are consistent with their risk to public safety (i.e., risk for re-offending), DJS classifies these programs (with the exception of PMHS services, see below) as Level I, II, or III, with Level III representing the most secure settings.

[6] See www.onecirclefoundation.org/GC.aspx for more information.

Level III programs are hardware secure residential programs, meaning the program relies primarily on the use of construction and hardware such as locks, bars, and fences to restrict youth's movement. The hardware secure programs are generally designed for youthful offenders who are adjudicated for violent offenses or have a history of violent offending.

Level II programs are staff secure residential programs, meaning a youth's movement is controlled by staff supervision rather than by restrictive architectural features. These programs are typically utilized for more serious, non-violent and/or chronic offenders. Some group homes and therapeutic group homes are also classified as Level II programs, when the program offers school on-site and residents have only supervised access to the community. Intermediate care facilities for addictions (ICFAs; i.e., in-patient substance use treatment) are also included in this level.

Level I programs are community-based residential programs, which serve youth who are committed to DJS but do not require placement in a secure setting and may continue to access school and other activities in the community with structured supervision. This level of services typically includes foster care, treatment foster care, group homes (including high intensity group homes), therapeutic group homes, alternative living units, independent living programs, and transitional living programs.

Additionally, youth who are committed to DJS may be placed in residential programs designed for youth with serious emotional disabilities for diagnostic, stabilization, or longer-term treatment purposes. These programs include public and privately-run residential treatment centers (RTCs), diagnostic units, high intensity psychiatric respite, and psychiatric hospitals. Throughout this report, these programs will be referred to globally as *Mental Health Residential Placements* (MHRPs). Referrals to PMHS services are evaluated by local Core Service Agencies, and must have final authorization for services from the Administrative Service Organization (ValueOptions). PMHS services are funded through Medicaid or through the Mental Hygiene Administration (MHA). See Figure 2 for the residential program classification scheme.

DJS also has per diem contracts (i.e., pay for use) with 38 residential programs located outside of Maryland. These programs are utilized to accommodate youth who require more restrictive settings but are not eligible for programs within Maryland or cannot be adequately served by the in-state programs (e.g., youth with unique health needs). The majority of out-of-state programs are

classified as residential treatment centers[7] (n=16), followed by staff secure programs (n=13) and hardware secure programs (n=8). Almost half of these programs (n=17) are located in Pennsylvania.

Figure 2. DJS Residential Program Levels and Subtypes

Security Level	Residential Program Subtype
Level III – Hardware Secure	– Hardware Secure Facility
Level II – Staff Secure	– Intermediate Care Facility for Addictions – Behavioral Program (e.g., Youth Center) – Group Homes and Therapeutic Group Homes with Schools on-site
Level I – Community-based	– Foster Care, Treatment Foster Care – Group Home/High Intensity Group Home – Therapeutic Group Home – Alternative Living Unit – Independent Living Program – Transitional Living Program
Mental Health Residential Placements	– Residential Treatment Center – Diagnostic Unit – High Intensity Psychiatric Respite – Psychiatric Hospital

Service Gap Analysis

Community-Based Service Gap Analysis

Again, the broader community-based service arrays vary by jurisdiction, and services for DJS-involved youth may be provided by many agencies. In order to establish these arrays, regional DJS staff compiled lists of community-based programs and services for each county/jurisdiction (excluding community-based *residential* programs, which are discussed in the residential sections of this report). For each program, they provided the name, a short description, gender(s) served, and the types of services provided/intervention area(s). The regional and jurisdictional breakdowns of program offerings are summarized by gender in Figure 3. Some jurisdictions listed significantly more programs than others; this may reflect actual differences in the availability of

[7] Out-of-state residential treatment centers may not meet Maryland's definition of a residential treatment center, which is synonymous with the federal definition of a psychiatric residential treatment facility, or PRTF),

services, but then some jurisdictions may have only listed services that are typically used for DJS-involved youth. The majority of programs serve both boys and girls.

Figure 3. Community-Based Programs by Region and County

Region/County	# Girl-Only Programs	# Programs Serving Girls and Boys	# Boy-Only Programs	Total # Programs
Baltimore City	2	41	7	50
Central	5	137	4	146
Baltimore Co.	0	24	0	24
Carroll	1	30	0	31
Harford	2	60	2	64
Howard	2	35	1	38
Western	9	61	1	71
Allegany	3	27	0	30
Frederick	3	13	1	17
Garrett	0	11	0	11
Washington	3	20	0	23
Eastern Shore	7	64	6	77
Caroline	0	20	0	20
Cecil	1	10	1	12
Dorchester	1	8	1	10
Kent	2	10	2	14
Queen Anne	0	10	0	10
Somerset	0	10	0	10
Talbot	1	20	1	22
Wicomico	0	8	0	8
Worcester	2	8	1	11
Southern	3	22	5	30
Anne Arundel	0	10	4	14
Calvert	1	9	2	12
Charles	3	10	2	15
St. Mary's	1	11	2	14
Metro	1	24	2	27
Montgomery	1	11	2	14
Prince George's	0	17	1	18
Statewide	**27**	**349**	**25**	**401**

The community-based service gap analysis is focused on services for youth under probation supervision, with attention paid primarily to girl-specific programming. Many of the programs listed in the service array are also accessed by youth under pre-court and aftercare supervision. Neither of these populations was included in the descriptive analyses below because: 1) DJS does not have similar comprehensive needs data on pre-court youth, and 2) the aftercare population comprises a smaller number of youth and is the focus of the residential service analysis—where gaps exist for probation youth, they also exist for these groups of youth.

To identify the needs of youth placed on probation, each case was matched with his/her most recently completed MCASP Assessment. The needs assessed as part this analysis included: education, use of free time, peer relationships, family functioning, mental health, alcohol and drug use, anti-social attitudes, and aggressive/assaultive behavior. Youth were indicated as having a need in each domain if they scored as moderate or high need in the assessment. In addition, specific types of offenders who have unique treatment needs were identified, including those adjudicated for offenses related to sexual behavior[8] or fire setting.[9]

Potential service gaps were determined by comparing the needs of youth who were court-ordered to probation in FY13 with the service arrays in their respective jurisdictions. Because DJS does not have program capacity and average length of stay (ALOS) information for all of the community-based services in every jurisdiction, the analysis simply examined whether there was an observable need for a certain type of service/intervention (based on the number of probation youth), and whether any programs exist to address that need. The analysis does not establish whether there are enough services, if any exist, to meet the needs of all youth.

Characteristics of Youth on Probation

As summarized in Figure 4, 2,898 youth were adjudicated delinquent and court-ordered to probation with DJS in FY13. The largest share of youth was from Central Region (33%), followed by Metro (18%), Southern (18%), Baltimore City (16%), Eastern Shore (10%), and Western Regions (4%). Overall, 20% of youth ordered to probation in FY13 was female, and the largest proportions of girls were located in Baltimore County (19%), Baltimore City (12%), Prince George's County (11%), and Anne Arundel County (10%).

[8] Sex offenses include Attempted Rape or Sex Offense, Child Pornography, Rape 1st Degree, Rape 2nd Degree, Sex Abuse by Household Member, Sex Offense 1st Degree, Sex Offense 2nd Degree, Sex Offense 3rd Degree, and Sex Offense 4th Degree.

[9] Fire-setting offenses include Arson-Threat, Arson 1st Degree, Arson 2nd Degree, Malicious Burning-Felony, and Malicious Burning-Misdemeanor.

Figure 4. Number of Girls and Boys Court-Ordered to Probation in FY13 (% of State Girl/Boy Total)

Region/County	# (%) Girls	# (%) Boys	Total
Baltimore City	69 (12%)	401 (17%)	470 (16%)
Central	203 (34%)	756 (33%)	959 (33%)
Baltimore Co.	114 (19%)	500 (22%)	614 (21%)
Carroll	17 (3%)	78 (3%)	95 (3%)
Harford	31 (5%)	87 (4%)	118 (4%)
Howard	41 (7%)	91 (4%)	132 (5%)
Western	23 (4%)	103 (4%)	126 (4%)
Allegany	8 (1%)	17 (1%)	25 (1%)
Frederick	1 (<1%)	5 (<1%)	6 (<1%)
Garrett	2 (<1%)	24 (1%)	26 (1%)
Washington	12 (2%)	57 (2%)	69 (2%)
Eastern Shore	71 (12%)	218 (9%)	289 (10%)
Caroline	1 (<1%)	13 (1%)	14 (<1%)
Cecil	16 (3%)	73 (3%)	89 (3%)
Dorchester	6 (1%)	15 (1%)	21 (1%)
Kent	1 (<1%)	8 (<1%)	9 (<1%)
Queen Anne	1 (<1%)	5 (<1%)	6 (<1%)
Somerset	0 (0%)	0 (0%)	0 (0%)
Talbot	7 (1%)	9 (<1%)	16 (1%)
Wicomico	30 (5%)	43 (2%)	73 (3%)
Worcester	9 (2%)	52 (2%)	61 (2%)
Southern	126 (21%)	400 (17%)	526 (18%)
Anne Arundel	61 (10%)	207 (9%)	268 (9%)
Calvert	11 (2%)	46 (2%)	57 (2%)
Charles	27 (5%)	80 (3%)	107 (4%)
St. Mary's	27 (5%)	67 (3%)	94 (3%)
Metro	97 (16%)	431 (19%)	528 (18%)
Montgomery	35 (6%)	170 (7%)	205 (7%)
Prince George's	62 (11%)	261 (11%)	323 (11%)
Statewide	**589**	**2,309**	**2,898**

Figure 5 shows additional demographic characteristics, as well as specific treatment needs and offender types, of all girls and boys who were adjudicated delinquent and court-ordered to probation in Maryland in FY13. Overall, 63% of these youth were African American/Black, 30% were Caucasian/White, and 5% were Hispanic/Latino. They were 16 years old, on average. Youth treatment needs were generally comparable across gender, though there were some notable differences in needs related to alcohol and drug use (35% girls, 46% boys), mental health (41% girls, 32% boys), and aggression (73% girls, 64% boys). The number of programs available for each need/intervention area (as identified by local DJS staff) is also reported. The most frequently reported intervention types included those that address mental health (n=115) and peer

relationships (n=99). Very few programs were reported to address the needs of sex offenders (n=11) and fire-setters (n=4), though very few youth were adjudicated with the relevant offenses in this cohort.

Figure 5. Probation Youth Needs (FY13) and Community-Based Services: Statewide

	Girls	Boys	Total Youth	# Programs
Total	589 (20%)	2309 (80%)	2898	401
Average Age	16.1	16.2	16.2	--
Race/Ethnicity				
African American/Black	67%	63%	63%	--
Caucasian/White	29%	31%	30%	--
Hispanic/Latino	4%	6%	5%	--
Other	1%	1%	1%	--
Treatment Needs/Offender Type				
Education	57%	57%	57%	89
Use of Free Time	26%	21%	22%	81
Peer Relationships	76%	83%	82%	99
Family	50%	43%	44%	89
Alcohol & Drug Use	35%	46%	44%	87
Mental Health	41%	32%	33%	115
Anti-Social Attitudes	58%	60%	59%	87
Aggression	73%	64%	66%	59
Sex Offender	1%	4%	3%	11
Fire Setter	3%	1%	2%	4
Girl-Only Programs	--	--	--	27

Gaps in the Community-Based Service Array

The community-based service gap analysis was conducted by county since most of the child-serving agencies are organized at this level. Appendix B contains summary tables for each jurisdiction, presenting the characteristics of youth court-ordered to probation and the numbers of programs available, in addition to regional maps of the identified service providers. The most notable gaps in the existing community-based services are summarized below.

Overall, most of the jurisdictions reported having access to at least one community-based program to meet the various treatment needs of youth in each major need domain. There were just a few notable exceptions:

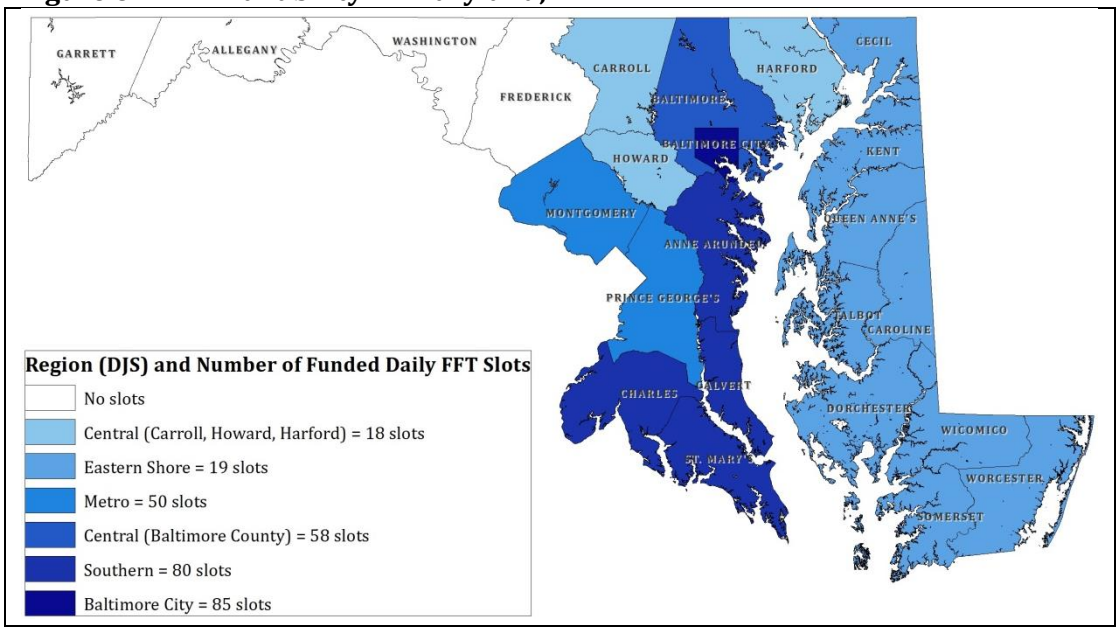
- A significant number of youth under probation in Anne Arundel and Worcester Counties demonstrated a moderate or high need related to aggression, but these counties did not report access to any services to address this need.
- A significant number of youth under probation in Wicomico and Worcester (boys only) Counties demonstrated a moderate or high education/school need, but these counties did not report access to any education support services.

Evidence-Based Services

Youth across Maryland have access to some form of evidence-based or promising programs in the community, although service capacity varies substantially by jurisdiction. The following section summarizes the availability of FFT, MST, FCT, and High-Fidelity Wraparound.

Figure 6 shows where FFT is currently available throughout Maryland. FFT is widely available to DJS-involved youth in Baltimore City, Central, Metro, and Southern Regions, and to a lesser extent in the Eastern Shore Region; it is not available in Western Maryland. DJS provides funding for the majority of these slots, though the Department of Social Services (DSS) provides funding for 18 slots in Baltimore County and the Children's Cabinet Interagency Fund (CCIF) funds 36 slots in Baltimore County and eight slots in Charles County. DJS youth may utilize the slots funded by CCIF, but not those funded by DSS.

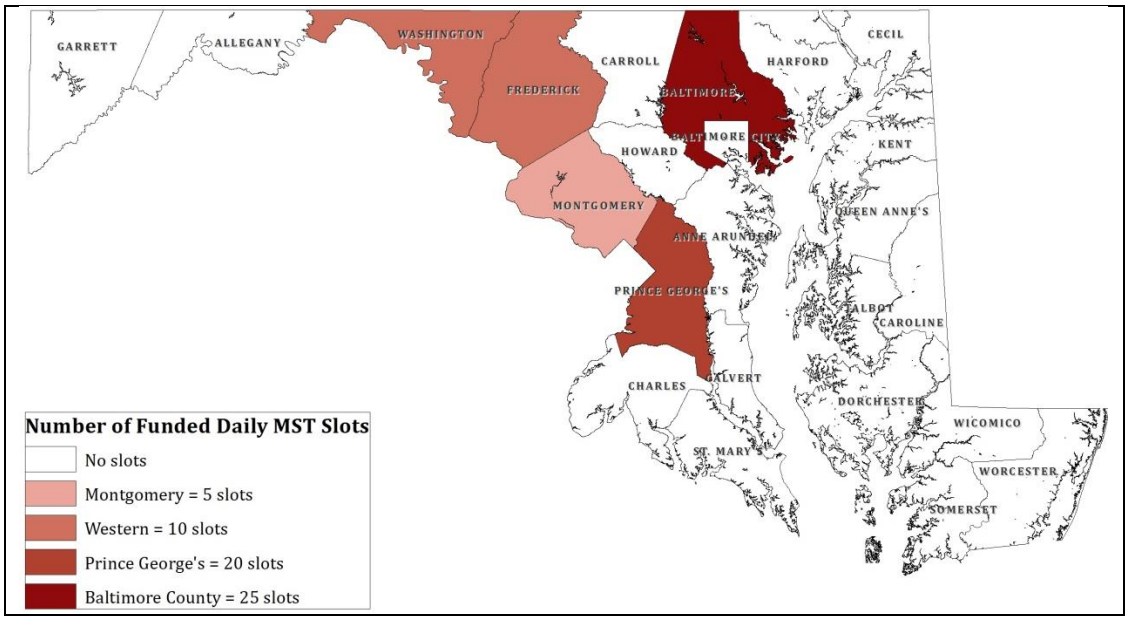
Figure 6. FFT Availability in Maryland, FY14



Note: DSS funds 18 slots in Baltimore County; these are not utilized by DJS youth. CCIF funds 36 slots in Baltimore County and 8 slots in Charles County that may be accessed by DJS youth.

Figure 7 shows where MST is currently available in Maryland. MST is only available to DJS-involved youth in the following five counties: Baltimore, Frederick, Montgomery, Prince George's, and Washington. DJS provides funding for the majority of these slots, though DSS provides funding for 5 slots in Baltimore County, and the CCIF funds 15 slots in Prince George's County. Again, DJS youth may utilize the slots funded by CCIF, but not those funded by DSS.

Figure 7. MST Availability in Maryland, FY14



Note: DSS funds 5 slots in Baltimore County; these are not utilized by DJS youth. CCIF funds 15 slots in Prince George's County that may be accessed by DJS youth.

FCT is available to DJS-involved youth in all regions, except for the Eastern Shore. DJS currently funds 131 slots, which are distributed across Baltimore City (15 slots), Central (27), Western[10] (25), Southern (30), and Metro Regions (34). Slots are funded on a per diem basis.

DJS youth can access services from the CME post-adjudication to divert them from placement in a group home. Currently, the statewide CME, Maryland Choices, has 100 slots funded through the Governor's Office of Children for DJS-involved youth across the state, operated on a first-come, first-serve basis, and available for up to nine months. Youth returning from out-of-home placement to the community may also utilize these slots as part of DJS aftercare supervision. More recently, the CME has been able to serve up to 100 youth statewide through a new Stability Initiative, which includes up to 15 months of Wraparound services for DSS- or DJS-involved youth with a documented Serious Emotional Disturbance (SED). Unlike the other group home diversion program, the Stability Initiative does not require lead agency involvement post-enrollment.

Girl-Specific Programs

The majority of jurisdictions reported access to at least one girl-specific community-based program. Six jurisdictions reported having Girls Groups that are provided directly by DJS staff, including Allegany, Carroll, Charles, Frederick, Harford, and Howard Counties. As mentioned earlier, FIT is available to girls in Baltimore City who have been formally adjudicated and supervised through

[10] FCT is not available in Garrett County.

aftercare, probation, and the violence prevention initiative. Girls Circle is currently offered in Dorchester and Kent Counties. Other girl-specific programs are delivered by local health departments, youth service bureaus, and private providers. The following jurisdictions reported having no gender-specific services for girls, despite having a significant number of girls on probation supervision: Baltimore County (114 girls court-ordered to probation in FY13), Prince George's County (62), Anne Arundel County (61), and Wicomico County (30).

A more detailed examination of each jurisdiction's community-based service array may uncover additional gaps in services; the findings presented here are considered a starting point. Local DJS offices will be provided with the data presented in this report to further assess and address their local needs for services.

Residential Service Gap Analysis

The residential service gap analysis entails different data sources and methods in comparison to the community-based analysis. For one, gaps in residential services are assessed at the state level since most residential programs serve youth from any Maryland jurisdiction and youth are generally placed in the program that can best accommodate their risks and needs. Second, DJS collects more detailed data related to the use of residential programs, allowing for deeper quantitative analysis.

Residential Program Capacity

DJS currently utilizes approximately 104 residential programs for committed youth across the State of Maryland. Figure 8 shows DJS's residential service array by type and gender(s) served. A total of 18 residential programs serve only girls. By comparison, 33 programs serve only boys and 53 programs serve youth of both genders. Figure 8 also shows the number of youth who could be served by each program subtype on any given day. The *total daily capacity* reflects the total number of beds for DJS-run programs and those that serve only DJS youth; for all other programs, the total daily capacity is estimated based on the average daily population (ADP) of DJS-youth served by the program during the past fiscal year (FY13).[11] For programs that serve males and females, these estimates are provided for each gender. Note that capacity estimates based on the ADP are conservative at best, and can be considered the lower parameter for these approximations.

Level III Programs. There are two Level III programs in DJS's in-state residential service array. DJS operates both programs—one for females (J. DeWeese Carter Youth Facility, or Carter) and one for

[11] Capacity for contracted programs that were not utilized for males and/or females during FY13 was set to 1 youth for estimation purposes.

males (Victor Cullen Center). On any given day, these programs can serve 14 girls and 48 boys, respectively.

Level II Programs. Of the 14 Level II programs in DJS's residential continuum, two serve only girls for a total capacity to serve eight girls on any given day. Notably, there is no staff secure facility for girls. Those who require placement in a more restrictive setting, but not a hardware secure facility, may be placed in a staff-secure group home or therapeutic group home.

With regard to staff secure facilities for boys, the Department operates four Youth Centers in Western Maryland; one of these facilities includes a short-term 90-day residential program in addition to the traditional program. DJS also operates a staff secure facility that provides intensive substance abuse services in Baltimore City. The remaining staff secure facility for boys is privately operated (Silver Oak Academy).[12] In addition, to these programs, DJS has contracts with one high intensity group home and one therapeutic group home that provide services for boys in staff-secure settings.

In addition to the gender-specific programs, there are three other staff-secure residential programs that serve both males and females; these programs all specialize in addictions services.

Level I Programs. The majority of the 65 Level I programs are group homes/high intensity group homes and treatment foster care programs. Many, if not all, of these programs also serve youth who are committed to DSS. Note that while there are greater numbers of these programs, they tend to have lower youth capacity than the Level II and III residential settings. Twenty Level I programs serve only boys, 13 programs serve only girls, and 32 serve both genders.

Mental Health Residential Placements. Most of the mental health residential programs serve both boys and girls, including seven staff secure RTCs, three diagnostic units, one high intensity psychiatric respite program, and several psychiatric hospitals. There is also one hardware secure residential treatment program that serves male sex offenders (total capacity of 29 boys), two staff secure RTC programs that serve only boys, and one staff secure RTC program that serves only girls. There is also a female-only diagnostic unit for girls who require a short-term emergency placement.

[12] Silver Oak Academy was recently granted permission by the State of Maryland to expand capacity from 48 to 96 beds, which will occur gradually over the next year.

Figure 8. Frequency of Residential Program Subtypes and Daily Capacity by Gender(s) Served

		Girl-Only Programs		Girl & Boy Programs			Boy-Only Programs	
	Type of Program	# Programs	Total Daily Capacity	# Programs	Total Daily Capacity: Girls	Total Daily Capacity: Boys	# Programs	Total Daily Capacity
Level III	Hardware Secure Facility	1	14	0	0	0	1	48
	Total	1	14	0	0	0	1	48
Level II	Staff Secure Facility	0	0	0	0	0	7	279
	Intermediate Care Facility for Addictions	0	0	3	8	34	0	0
	High Intensity Group Home	1	6	0	0	0	1	16
	Therapeutic Group Home	1	2	0	0	0	1	6
	Total	2	8	3	8	34	9	301
Level I	Alternative Living Unit	0	0	1	1	9	0	0
	Group Home/High Intensity Group Home	7	21	5	10	29	16	124
	Independent Living Program	2	4	6	6	8	0	0
	Therapeutic Group Home	3	16	0	0	0	2	10
	Transitional Living Program	1	1	0	0	0	2	7
	Treatment Foster Care	0	0	20	22	53	0	0
	Total	13	42	32	39	99	20	141
MHRP	RTC-Hardware Secure	0	0	0	0	0	1	29
	RTC-Staff Secure	1	20	7	17	43	2	34
	Diagnostic Unit	1	1	3	5	11	0	0
	High Intensity Psychiatric Respite	0	0	1	1	1	0	0
	Psychiatric Hospital	0	0	7	8	12	0	0
	Total	2	21	18	31	67	3	63
Total		**18**	**85**	**53**	**78**	**200**	**33**	**553**

Figures 9 and 10 show the total daily capacities for programs serving girls and boys committed to DJS by program level. Notably, for girls, most of the residential program capacity is available in Level I/community-based programs, whereas for boys, most of the capacity is within Level II/staff secure programs.

Figure 9. Youth Capacity by Program Level: Girls

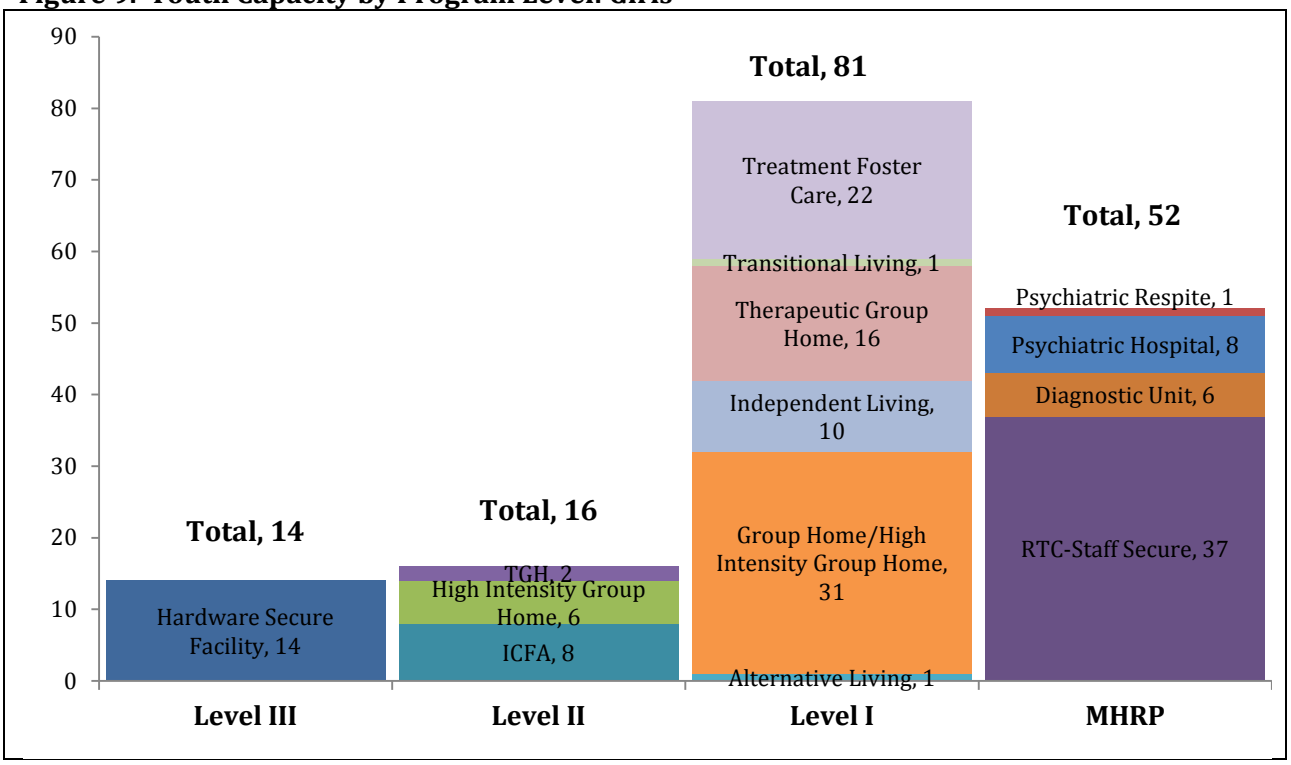
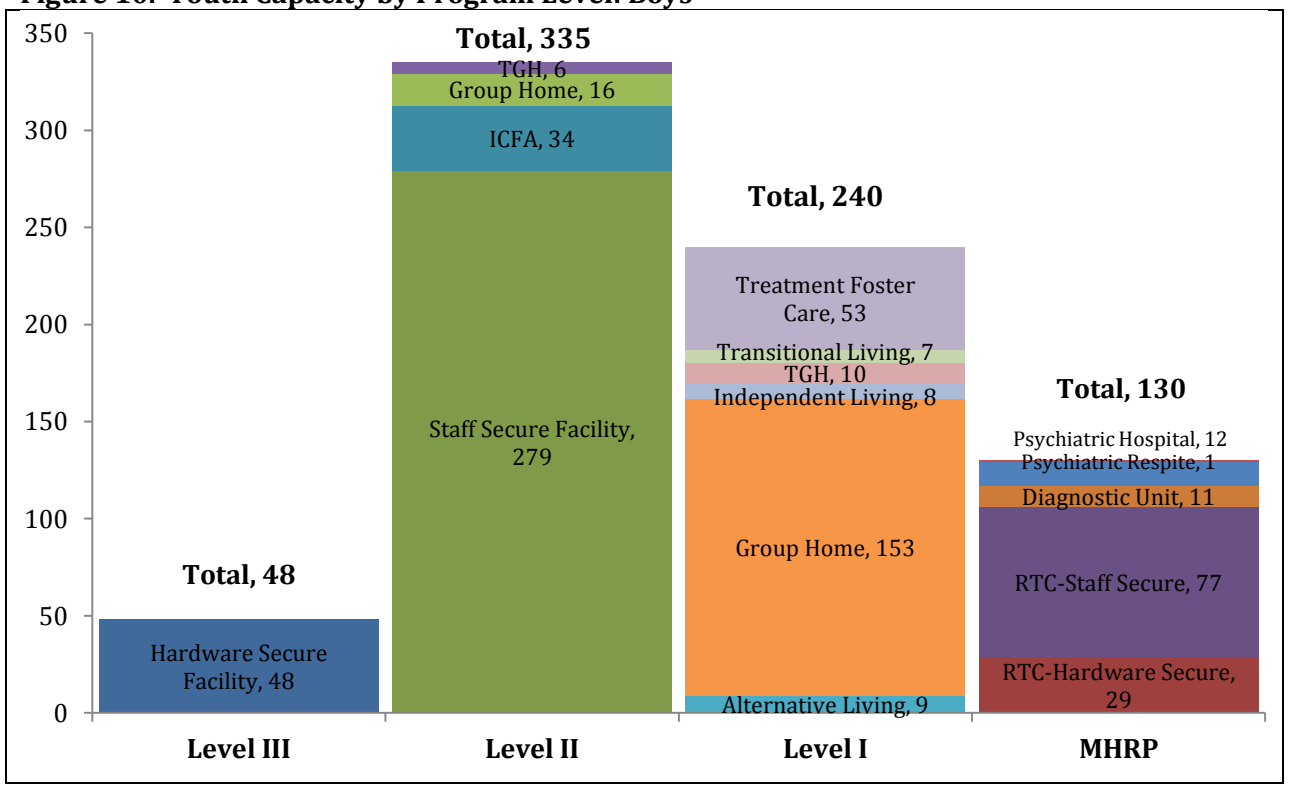


Figure 10. Youth Capacity by Program Level: Boys



Residential Program Locations

The residential programs utilized by DJS are not uniformly dispersed across the state (Figure 11). For instance, the Central Region has seven girl-only Level I programs, while the Eastern Shore Region has one residential program that serves only females—the only Level III program in the State. The rest of the regions only have one or two girl-only residential programs each. On the other hand, the Western Region has the largest number of male-only residential programs (12 total). The Southern Region has the fewest male-only residential programs with just one Level I program.

Figure 11 also shows the distribution of residential programs that serve both genders by DJS Region. Again, a large number of these programs are located in Central Region (13 Level I and 8 MHRPs). The Southern Region has the fewest residential programs that serve both genders, with just one Level I program—in fact, this region has the fewest residential programs overall, with just four total. The Central Region has the most residential programs utilized by DJS (n=36), followed by Western Region (n=25).

Figure 11. Number of Residential Programs by DJS Region

	DJS Region						
	Baltimore	Central	Western	Eastern Shore	Southern	Metro	**Total**
# of Girl-Only Programs	1	9	3	1	2	2	18
Level I	1	7	1	0	2	2	13
Level II	0	0	2	0	0	0	2
Level III	0	0	0	1	0	0	1
MHRP	0	2	0	0	0	0	2
# of Girl-Boy Programs	7	21	10	6	1	8	53
Level I	4	13	6	4	1	4	32
Level II	1	0	2	0	0	0	3
Level III	0	0	0	0	0	0	0
MHRP	2	8	2	2	0	4	18
# of Boy-Only Programs	4	6	12	3	1	7	33
Level I	2	3	5	3	1	6	20
Level II	1	1	6	0	0	1	9
Level III	0	0	1	0	0	0	1
MHRP	1	2	0	0	0	0	3
Total	12	36	25	10	4	17	104

Gaps in the Residential Service Array for Girls

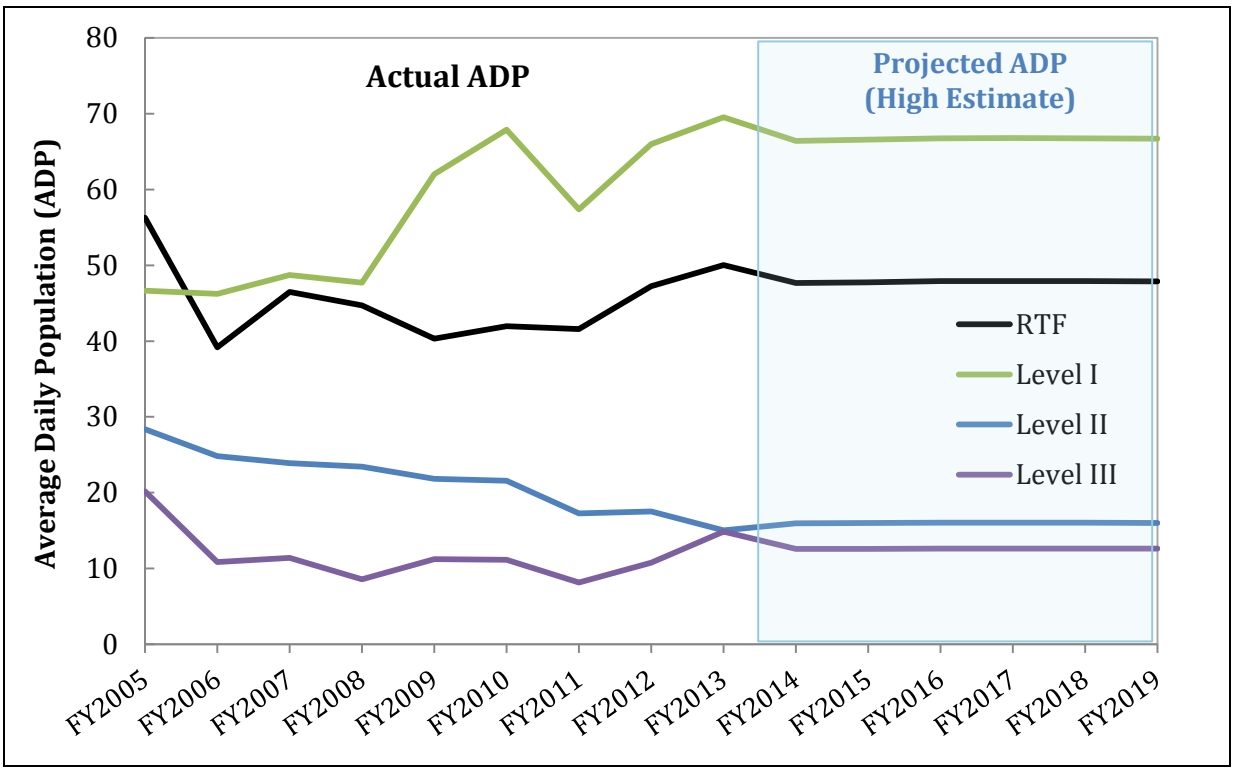
While DJS administers an array of services for youth committed to the Department, the current array does not necessarily meet the diverse needs of all committed boys and girls. The following section summarizes several analyses that focus on identifying the gaps in services for girls, with a subsequent section focused on boys.

Forecast Analysis of Residential Programs for Girls

Projections of Maryland's total committed youth population were developed using a set of statistical techniques known as time-series forecasting.[13] The parameters in the time series model account for the pattern, trend, and seasonal variation and are used to project future population values. For a baseline forecast, such models implicitly assume that current policies and practices will continue into the future. Two projections were developed, providing a low and high scenario. Projections were then disaggregated by gender and program level. To disaggregate the projections, the percentages of the population in each gender/program level category during FY12 and F13 were averaged and the resulting percentages were applied to the projections.

Figure 12 shows the actual ADPs of committed girls from FY05 through FY13 and the projected ADPs through FY19 by program level. The forecast findings indicate that the number of girls to be served at each program level should be relatively constant over the next five years. Approximately 12-13 girls (only the high estimates are shown in Figure 12) are projected for care in Level III programs, 16 girls for Level II programs, 65-67 girls for Level I programs, and 47-48 girls for MHRPs.

Figure 12. Committed Population Projections for Girls by Program Level



[13] We would like to acknowledge Meredith Farrar-Owens for completing the forecast analyses included in this report. A more detailed report of the forecast analysis is currently being completed.

Taking into account the current total daily capacity of services (Figure 8), the findings from the forecast analysis suggest that the Department has enough capacity to serve girls in Level III services with the one hardware secure facility (capacity of 14 girls) for the foreseeable future. On the other hand, there appears to be a shortage of services available for Level II programs; on any given day, DJS has approximately eight slots available using two privately-run group homes to serve girls who require a staff secure placement, yet the forecast analysis projects that 16 girls require services at this level. Conversely, it appears that there are sufficient resources for Level I programs, with 81 slots available to girls on any given day, in addition to the EBSs discussed in the *Community-Based Services* section, and a projected 65-67 girls requiring this level of programming. Finally, there are sufficient resources for MHRP beds, with 47-48 girls projected to need this type of placement and 37 RTC beds utilized on average, as well as six beds in diagnostic units, eight psychiatric hospital beds, and one bed in a high intensity psychiatric respite program. In some cases, in-home evidence-based services, such as the CME, may also be appropriate alternatives to residential care for these girls.

Characteristics of Committed Girls

Figure 13 presents the characteristics of girls who were admitted to residential placements in FY12 and FY13 by program level.[14] On average, the girls were 16 years old. Race/ethnicity varied across program levels—African American/Black was the most frequently identified race/ethnicity within Level I (64%), Level III (77%), and MHRP programs (66%), whereas Caucasian/White was the most frequent for Level II (68%). There were also regional differences in the distribution of girls within each program level—Metro (25%) and Southern Regions (18%) had the highest shares of Level I admissions; Central (26%) and Southern (24%) had the highest percentages of Level II admissions; Metro (33%) and Baltimore City (21%) had the highest percentages of Level III admissions; and Southern had the highest share of MHRP admissions (28%).

To measure the risks and needs presented by this sample of committed girls,[15] each case was matched with the most recently completed MCASP Assessment (prior to admission). Overall, the most frequent adjudicated offenses were misdemeanors and violations of probation (VOP). Girls admitted to Level III programs were the most likely to be adjudicated for a person-to-person offense (43%), followed by those placed in MHRPs (37%). With regard to treatment needs,

[14] Several girls were admitted to one or more programs within or across program levels during the time frame; all cases are included in the descriptive analyses.
[15] Similar criteria were utilized to classify risks and needs as presented in the community-based services analysis.

according to results from the MCASP Assessment, approximately three-quarters of committed girls screened for moderate or high mental health need, and slightly less than two-thirds of girls screened for moderate or high need in the alcohol and drug use domain. Further, the overwhelming majority of committed girls screened as moderate or high need for family functioning (88%) as well as for aggression/assaultive behavior (92%). Despite this latter finding, very few girls were adjudicated for violent offenses[16] (1%) or those related to sexual behavior (<1%) or fire setting (3%).

Figure 13. Characteristics of Girls Admitted to Residential Placements in FY12 and FY13 (N=633)

	Level I	Level II	Level III	MHRP	Total
Average Age	16.6	16.8	16.7	16.0	16.5
Race/Ethnicity					
African American/Black	64%	29%	77%	66%	57%
Caucasian/White	32%	68%	17%	33%	39%
Hispanic/Latino	4%	4%	6%	2%	4%
DJS Region					
Baltimore City	16%	7%	21%	17%	15%
Central	12%	26%	14%	15%	16%
Western	14%	13%	4%	12%	12%
Eastern Shore	16%	17%	15%	13%	15%
Southern	18%	24%	14%	28%	22%
Metro	25%	13%	33%	15%	20%
Offense Type*					
Person-to-Person Felony	3%	2%	14%	5%	4%
Drug Felony	<1%	2%	0%	0%	<1%
Other Felony	11%	8%	12%	6%	9%
Person-to-Person Misdemeanor	20%	17%	29%	32%	23%
Drug Misdemeanor	5%	15%	0%	4%	6%
Other Misdemeanor	38%	32%	20%	39%	36%
VOP	21%	23%	20%	14%	20%
Missing	2%	2%	4%	1%	2%
Treatment Needs/Offender Type*					
Mental Health	74%	58%	76%	90%	75%
Alcohol & Drug Use	61%	82%	59%	52%	63%
Family Functioning	91%	78%	92%	90%	88%
Aggression/Assaultive Behavior	93%	86%	96%	92%	92%
Violent Offender	1%	1%	2%	2%	1%
Sex Offender	<1%	0%	0%	1%	<1%
Fire Setter	4%	1%	2%	3%	3%

*From the MCASP Assessment.

[16] Violent offenses include Attempted Murder, Attempted Rape or Sex Offense, Carjacking, Child Abduction of Individual Under 16, Child Abuse, Kidnapping, Murder 1st Degree, Murder 2nd Degree, Pandering, Poisoning, Prostitution-Bawdyhouse, Rape 1st Degree, Rape 2nd Degree, Sex Abuse by Household Member, Sex Offense 1st Degree, Sex Offense 2nd Degree, Sex Offense 2nd Degree (no force or threat), and Sex Offense 2nd Degree (w/force or threat).

There were some important variations in treatment needs across program levels. Not surprisingly, the majority of girls in MHRPs screened as moderate or high for mental health needs. Notably, the percentage of girls admitted to Level II programs who screened for a moderate or high mental health need (58%) was less than the population of girls admitted to Level I and III programs (74% and 76%, respectively), though the alcohol and drug use need was substantial higher (82% versus 61% and 59%). Taken as a whole, these findings suggest the strong need for behavioral health programming at all program levels, with the greatest need for substance use treatment at the staff secure level.

While the findings from the forecast and descriptive analyses are instructive with regard to programming needs within DJS's residential service continuum for girls, these analyses are limited to the extent that they rely on the use of prior placement data, which poses some drawbacks. For one, it is likely that previous admissions were impacted by the availability of services within each program level; thus, the need for programs within each level may be under or over-estimated. For example, girls who may have been best served in a staff secure setting might have been placed in a Level I or Level III program simply due to the limited availability of programs within Level II for girls. Second, and relatedly, this analysis was based on the assumption that youth were always placed in the most suitable program to meet their needs, which is not always the case as evidenced by ejection data (presented below). With these shortcomings in mind, additional analyses were conducted to assess for potential gaps in the girls' service array using other methods and data.

Analysis of Hardware Secure Placements: Girls

The 46 admissions to the J. DeWeese Carter Youth Facility over the past two years were reviewed individually to determine whether these admissions met the Department's target population for hardware secure settings. The review included an assessment of the girls' histories of offenses, placements, and alerts for AWOL (absent without leave). Only 17 of the 46 girls appeared to have case histories that warranted placement in a hardware secure facility; the remainder of the girls could have been served with an intervention in a less secure setting.

Analysis of Residential Program Ejections: Girls

An analysis of placement ejections also offers information about potential gaps in the girls' residential service array. Youth may be ejected from an out-of-home placement upon determination that he/she failed to comply with the rules and conditions of the program. These cases generally require a new committed placement and are reviewed by DJS's Central Review Committee (CRC). According to data collected by the CRC, the committee reviewed 46 cases of girls

who were facing ejection from residential placements between July 2012 and August 2013 (Figure 14). For the purposes of this analysis, the girls' subsequent placements, if any, were identified using data available in the DJS client database, Automated Statewide System of Information Support Tools (ASSIST). In some cases, youth were detained short-term prior to admission to their next committed residential admission, though only the later placements are indicated.

Figure 14. DJS Girls Ejected from Residential Placements between July 2012 and August 2013 and Their Subsequent Placements (N=46)

Ejected Placement			Subsequent Placement	
	Type	# Girls	Type	# Girls
Level III	Hardware Secure Facility	4	Level I – Group Home	1
			MHRP – RTC	2
			Community/Wraparound Services	1
Level II	Intermediate Care Facility for Addictions (ICFA)	8	Level II – ICFA	2
			Level I – Foster Care	1
			Level I – Group Home	1
			MHRP – Psychiatric Hospital	1
			MHRP – RTC	1
			No Subsequent Residential Placement	2
	Group Home (school on-site)	1	Level I – Treatment Foster Care	1
Level I	Therapeutic Group Home	6	Level I – Group Home	1
			MHRP – RTC	3
			Community/Wraparound Services	1
			No Subsequent Residential Placement	1
	Group Home (school off-site) *Includes 6 youth who were ejected from a Group Home that provides intensive substance abuse services.*	19	Level III – Hardware Secure Facility	5
			Level I – Treatment Foster Care	3
			Level I – Group Home	2
			Level I – Therapeutic Group Home	1
			MHRP – RTC	4
			MHRP – Diagnostic Unit	1
			MHRP – Psychiatric Hospital	1
			No Subsequent Residential Placement	2
	Foster Care	1	Level II – Group Home	1
	Treatment Foster Care	1	No Subsequent Residential Placement	1
MHRP	Residential Treatment Center (RTC)	6	Level III – Hardware Secure Facility	1
			MHRP – RTC	2
			MHRP – Diagnostic Unit	1
			Community/Wraparound Services	1
			No Subsequent Residential Placement	1

Of the 46 girls, the majority had been residing in group homes (including teen mother programs; n=19), IFCAs (n=8), RTCs (n=6), and therapeutic group homes (n=6). Not all ejections resulted in placement in a more restrictive setting. In total, only 7 (15%) of the 46 girls were placed in a more restrictive program post-program ejection, and 16 (35%) were placed in MHRPs. Six (13%) girls were ejected from a Level I or MHRP program and subsequently placed in a hardware secure facility (Carter in all cases). Three girls remained in the community and received services from the CME, and seven did not have any residential programming (or the CME) indicated in ASSIST records. The majority of ejected girls (from any program level) went on to reside in a behavioral health-type placement (27 total, 59%). Of these, the most frequent subsequent placement was a RTC (n=13), followed by treatment foster care (n=4), CME (n=3), diagnostic unit (n=2), psychiatric hospital (n=2), and ICFA (n=2). Notably, four girls were also ejected from the only hardware secure facility for girls, Carter; two of these girls were placed in RTCs and two moved to considerably less restrictive settings.

While these data suggest that the results of the CRC process are very individualized to the circumstances of each girl, it is not clear from the available data whether girls were appropriately placed in their initial placement and simply did not do well in that particular program, or if they should not have been placed there in the first place. This analysis is also impacted by the fact that subsequent placement decisions were constrained by the given service array options. That said, the majority of ejected girls were from Level I placements, 5 of whom were subsequently placed in Carter, likely due to a lack of Level II/staff secure program options. Several of the ejections were also from ICFAs, none of which are operated by DJS. On the whole, these data also support the notion that residential programming for girls should have a strong behavioral health component, and that additional programming may be needed among Level II services.

Analysis of Out-of-State Placements: Girls

Between July 1, 2011 and June 30, 2013, nine girls were placed in out-of-state residential programs (Figure 15). Over half (56%) of these girls were African American, and they were 16 years old, on average. According to their most recent MCASP Assessment, the majority (89%) of these girls were classified as high risk for recidivism, and their adjudicated offenses (as identified in the MCASP Assessment) were diverse. Most of the girls were indicated as having moderate or high needs for mental health (78%), alcohol and drug use (67%), family functioning (78%), and aggression (78%). In four cases, the out-of-state placement was the girl's first committed placement; the remaining

girls had at least one previous admission to a committed residential placement in Maryland and most had several placements, not including stays in detention.

Figure 15. Characteristics of Girls Admitted to Out-of-State Residential Placements in FY12 and FY13

	#/%
Number of Girls	9
Average Age	16.2
Race/Ethnicity	
African American/Black	56%
Caucasian/White	33%
Hispanic/Latino	11%
DJS Region	
Baltimore City	56%
Central	22%
Western	0%
Eastern Shore	11%
Southern	0%
Metro	11%
Offense Type*	
Person-to-Person Felony	11%
Drug Felony	11%
Other Felony	11%
Person-to-Person Misdemeanor	11%
Drug Misdemeanor	0%
Other Misdemeanor	22%
VOP	22%
Missing	11%
Prior DJS Committed Residential Placement	56%
Treatment Needs/Offender Type*	
Mental Health	78%
Alcohol & Drug Use	67%
Family Functioning	78%
Aggression/Assaultive Behavior	78%
Violent Offender	11%
Sex Offender	0%
Fire Setter	11%

*From the MCASP Assessment.

The nine girls were placed in five out-of-state facilities total (Figure 16). Three of the girls were placed at the Clarinda Academy, a staff secure residential facility in Ohio. The rest of the youth were placed in residential treatment centers, including three at Foundations for Living, one at Gulf Coast Treatment Center, one at Laurel Oaks Behavioral Health Center, and one at Newport News Behavioral Health Center.

Overall, a small number of girls were placed out-of-state in FY12 and FY13, but their numbers still represent a gap in programs that can serve these youth in Maryland. The findings point to the

potential need for staff secure programming within Maryland that can accommodate DJS-involved girls who have behavioral health needs and behavior issues generally.

Figure 16. Out-of-State Residential Placements for Girls, FY12 & FY13 (N=9)

Residential Program Type/Name	Program Location	# Girls
Staff Secure Facility		3 total
Clarinda Academy	Iowa	3
Staff Secure with Intensive Substance Abuse Treatment		3 total
Foundations for Living	Ohio	3
Residential Treatment Center		3 total
Gulf Coast Treatment Center	Florida	1
Newport News Behavioral Health Center	Virginia	1
Laurel Oaks Behavioral Health Center	Alabama	1

Gaps in the Residential Service Array for Boys

Forecast Analysis of Residential Programs for Boys

Using the same method described in the analysis for committed girls, a similar forecast analysis is presented for boys. Figure 17 shows the actual ADPs of committed boys from FY05 through FY13 and the projected ADPs through FY19 by program level. The forecast findings indicate that the number of boys projected to be served at each program level should be relatively constant over the next five years. Approximately 135-138 boys (only the high estimates are shown in Figure 17) are projected for care in Level III programs, 269-275 boys for Level II programs, 254-260 boys for Level I programs, and 123-126 boys for MHRPs.

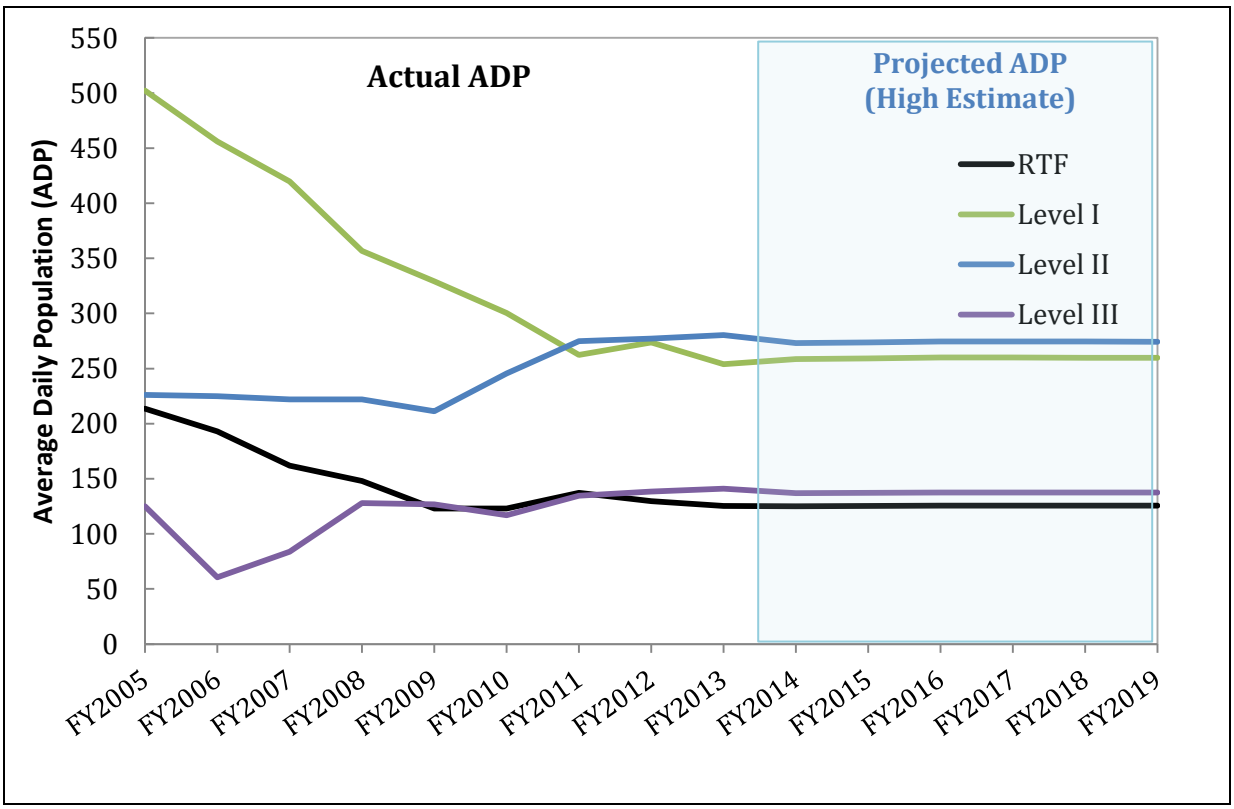
Taking into account the current total daily capacity of services (Figure 8), the findings from the forecast analysis suggest that DJS has a significant shortage in capacity to serve boys in Level III services. Whereas 135-138 boys are projected to require Level III programming on any given day, there is only one hardware secure program in Maryland that provides these services, with a total capacity to serve 48 boys.

On the other hand, there appears to be sufficient services available for Level II programs; on any given day, DJS has approximately 335 slots available using seven staff secure programs, one therapeutic group home, one group home, and three ICFAs to serve boys who require a staff secure placement, and the forecast analysis projects that 269-275 boys require services at this level. It also appears that there are sufficient resources for Level I programs, with 240 community-based

residential slots[17], in addition to the EBSs, available to boys and 254-260 boys projected for this level of programming on any given day.

Finally, there are sufficient MHRP beds, with 123-126 boys projected to need this type of placement, and 130 MHRP beds utilized on average. These included 77 RTC beds, 12 psychiatric hospital beds, 11 beds in diagnostic units, and one bed in a high intensity psychiatric respite program.

Figure 17. Committed Population Projections for Boys by Program Level



Characteristics of Committed Boys

Figure 18 presents the characteristics of boys who were admitted to residential placements in FY12 and FY13 by program level.[18] On average, the boys were 16 years old, though boys admitted to Level III facilities tended to be 17 years old. Race/ethnicity varied across program levels, though African American/Black was the most frequently identified race/ethnicity within each (69%, 70%, 88%, and 57% for Levels I, II, III, and MHRP, respectively). The majority of admissions were from

[17] Note that the estimated 240 slots are based on prior rates of utilization; it is possible for most of these programs to accept additional DJS youth.
[18] Several boys were admitted to one or more programs within or across program levels during the time frame.

Metro and Baltimore City across all levels of placement, together accounting for 51% of admissions overall. This was also the case within each program level, with the exception of MHRPs—the largest share of these admissions was from Southern Region (27%), followed by Eastern Shore (20%) and Metro Regions (20%).

Like the analysis for girls, each case was matched with the most recently completed MCASP Assessment (prior to admission). Among Level I admissions, the most frequently adjudicated offenses were "other" misdemeanors (26%) and person-to-person misdemeanors (20%), compared with "other" misdemeanors (24%) and violations of probation (VOP; 24%) for Level II admissions, person-to-person felony offenses (40%) for youth placed in Level III programs, and person-to-person misdemeanors (30%) and "other" misdemeanors (28%) for MHRP admissions.

Figure 18. Characteristics of Boys Admitted to Committed Residential Placements in FY12 and FY13 (N=3,384)

	Level I	Level II	Level III	MHRP	Total
Average Age	16.8	16.9	17.1	16.0	16.8
Race/Ethnicity					
African American/Black	69%	70%	88%	57%	70%
Caucasian/White	26%	24%	5%	37%	25%
Hispanic/Latino	4%	5%	6%	5%	5%
Asian	<1%	<1%	0%	<1%	<1%
Unknown	<1%	<1%	<1%	<1%	<1%
DJS Region					
Baltimore City	24%	24%	34%	10%	23%
Central	13%	15%	7%	13%	14%
Western	8%	8%	2%	10%	8%
Eastern Shore	15%	9%	3%	20%	11%
Southern	14%	16%	8%	27%	16%
Metro	26%	28%	46%	20%	28%
Offense Type*					
Person-to-Person Felony	12%	11%	40%	9%	14%
Drug Felony	3%	4%	5%	1%	4%
Other Felony	16%	13%	15%	15%	14%
Person-to-Person Misdemeanor	20%	11%	7%	30%	15%
Drug Misdemeanor	7%	12%	5%	5%	9%
Other Misdemeanor	26%	24%	15%	28%	24%
VOP	15%	24%	11%	11%	19%
Missing	1%	1%	1%	0%	1%
Treatment Needs/Offender Type*					
Mental Health	62%	48%	46%	84%	55%
Alcohol & Drug Use	58%	75%	59%	45%	66%
Family Functioning	76%	77%	78%	74%	76%
Aggression/Assaultive Behavior	82%	84%	85%	88%	84%
Violent Offender	2%	1%	6%	4%	2%
Sex Offender	7%	<1%	1%	8%	3%
Fire Setter	1%	1%	3%	3%	2%

*From the MCASP Assessment.

According to results from the MCASP Assessment, treatment needs of committed boys varied by program level. For instance, 62% of boys in Level I programs screened for moderate or high mental health need, whereas just less than half of boys in Level II (48%) and Level III programs (46%) were indicated as such (the majority of boys in MHRPs were indicated for a mental health need). And 75% of boys screened as moderate or high need in the alcohol and drug use domain among those placed in Level II programs, compared with 58% and 59% in Level I and Level III programs. Further, across all levels, approximately three-quarters of committed boys screened as moderate or high need for family functioning and most screened as moderate or high need for aggression/assaultive behavior. Despite this latter finding, very few boys were adjudicated for violent offenses (2%) or those related to sexual behavior (3%) or fire setting (2%), overall.

Once again, these findings are instructive with regard to the type of service needs presented by boys who are committed to DJS. On the other hand, these analyses suffer from the same short-comings as the analyses for girls (i.e., based on prior placements), therefore additional analyses were conducted to assess for potential gaps in the residential service array for boys using other methods and data.

Analysis of Out-of-State Placements: Boys

Between July 1, 2011 and June 30, 2013, 291 boys were placed in out-of-state residential programs[19] (Figure 19). Ninety percent of these boys were African-American, and they were 17 years old, on average. Most of the boys were from Baltimore City (45%) or Metro Region (36%). The most frequently adjudicated offenses (as identified in the MCASP Assessment) were person-to-person felonies for both Level II (25%) and Level III (54%) admissions, and person-to-person misdemeanors (28%) for MHRP admissions.

The boys admitted to Level II programs had slightly higher identified needs relative to those admitted to Level III programs, with a greater share indicating moderate or high needs for mental health (60% vs. 49%), alcohol and drug use (60% vs. 50%), family functioning (85% vs. 74%), and aggression (90% vs. 84%) per the MCASP Assessment. Boys admitted to MHRPs presented even greater needs related to mental health (90%), family functioning (90%), and aggression (96%). In addition, a larger share of boys admitted to Level III programs outside of Maryland were identified as violent offenders (16%), compared with youth admitted to MHRPs (10%) and Level II programs (6%) out of state.

[19] 24 youth were placed out of state twice.

Figure 19. Characteristics of Boys Admitted to Out-of-State Residential Placements in FY12 and FY13

	Level II	Level III	MHRP	Total
Number of Boys	164	98	29	291
Average Age	17.0	17.2	17.5	17.1
Race/Ethnicity				
African American/Black	94%	88%	76%	90%
Caucasian/White	4%	7%	7%	5%
Hispanic/Latino	2%	5%	17%	5%
DJS Region				
Baltimore City	51%	36%	38%	45%
Central	9%	3%	3%	6%
Western	0%	0%	0%	0%
Eastern Shore	4%	1%	3%	3%
Southern	12%	5%	21%	11%
Metro	24%	55%	35%	36%
Offense Type*				
Person-to-Person Felony	25%	54%	14%	33%
Drug Felony	5%	2%	14%	5%
Other Felony	11%	19%	14%	14%
Person-to-Person Misdemeanor	16%	5%	28%	14%
Drug Misdemeanor	11%	5%	3%	8%
Other Misdemeanor	21%	7%	21%	16%
VOP	11%	7%	7%	9%
Missing	0%	1%	0%	<1%
Treatment Needs/Offender Type*				
Mental Health	60%	49%	90%	59%
Alcohol & Drug Use	60%	50%	52%	56%
Family Functioning	85%	74%	90%	82%
Aggression/Assaultive Behavior	90%	84%	96%	89%
Violent Offender	6%	16%	10%	10%
Sex Offender	2%	4%	0%	2%
Fire Setter	2%	5%	3%	3%

*From the MCASP Assessment.

In FY12 and FY13, 291 boys were placed in 26 out-of-state residential programs (Figure 20). The majority were placed in staff secure programs (161 admissions), followed by hardware secure programs (87 admissions) and residential treatment centers (29 admissions). Most of these boys were placed in programs located in Pennsylvania (n=141), followed by Iowa (n=58) and Tennessee (n=36). When considering these findings in relation to in-state service gaps, it is important to note that youth placed in out-of-state staff secure facilities typically present risk levels that would warrant a hardware secure placement within Maryland (with the exception of those placed in Glen Mills School).

A substantial number of boys were placed out-of-state in FY12 and FY13, demonstrating a clear gap in programs that can serve these youth in Maryland. Specifically, the findings point to the need for hardware secure programming that can accommodate DJS-involved boys in Maryland. In addition,

a significant number of youth were served in out-of-state MHRPs, suggesting a potential gap in these in-state services, as well.

Figure 20. Out-of-State Residential Placements for Boys, FY12 & FY13 Admissions (N=291)

Residential Program Type/Name	Program Location	# Boys
Hardware Secure Facility		87 total
Abraxas Residential Services	Pennsylvania	37
Mid Atlantic Youth Services – PA Child Care	Pennsylvania	13
Mid Atlantic Youth Services – Western PA Child Care	Pennsylvania	29
Northwestern Academy (NHS Human Services)	Pennsylvania	8
Hardware Secure Facility with Intensive Mental Health Services		10 total
Turning Point Youth Center	Michigan	10
Staff Secure Facility*		163 total
Abraxas Residential Services	Pennsylvania	15
Bennington School	Vermont	2
Canyon State Academy	Arizona	11
Clarinda Academy	Iowa	33
Glen Mills School	Pennsylvania	22
Lakeside Academy	Michigan	3
Mid Atlantic Youth Services – PA Child Care	Pennsylvania	2
Natchez Trace Youth Academy	Tennessee	36
Summit Academy	Pennsylvania	14
Woodward Academy	Iowa	25
Staff Secure Facility with Intensive Substance Abuse Treatment*		1 total
Foundations for Living	Ohio	1
Residential Treatment Center		29 total
Boys Town	Nebraska	5
Coastal Harbor Treatment Center	Georgia	1
Cottonwood Treatment Center	Utah	1
Devereux Florida	Florida	4
Devereux Georgia	Georgia	8
Devereux Pennsylvania – Children's IDD Services	Pennsylvania	1
Laurel Oaks Behavioral Health Center	Alabama	5
New Hope Carolinas	South Carolina	2
Newport News Behavioral Health Center	Virginia	2
Three Rivers Residential Treatment – Midland Campus	South Carolina	1

*Youth placed in out-of-state staff secure facilities typically present risk levels that would warrant a hardware secure placement within Maryland, with the exception of Glen Mills School.

Conclusion & Recommendations

Summary of Service Gaps

The primary purpose of this report was to identify gaps in services for girls and boys involved with DJS. Several analyses were conducted to determine gaps in the community-

based and residential service continuums, with a focus on gender-specific services. The major findings related to identified service gaps are summarized below:

Community-Based Service Gaps

- The following jurisdictions reported having no gender-specific community services for girls, despite having a significant number of girls on probation supervision: Baltimore County (114 girls court-ordered to probation in FY13), Prince George's County (62), Anne Arundel County (61), and Wicomico County (30).
- A significant number of youth under probation in Anne Arundel and Worcester Counties demonstrated a moderate or high need related to aggression, but these counties did not report utilization of any services to address this need.
- A significant number of youth under probation in Wicomico and Worcester (boys only) Counties demonstrated a moderate or high education/school need, but these counties did not report access to any education support services.

Residential Service Gaps for Girls

- There appears to be a shortage of services available for Level II/staff secure residential programs for girls. On any given day, DJS has approximately eight slots available using two privately-run group homes to serve girls who require a staff secure placement, yet the forecast analysis projects that 16 girls require services at this level. An analysis of girls' needs indicates that programming in Level II programs should focus on alcohol and drug use, as well as mental health.

Residential Service Gaps for Boys

- There is a shortage in capacity to serve boys in Level III programs. Whereas 135-138 boys are projected to require Level III programming on any given day, there is currently only one hardware secure program in Maryland that serves 48 boys. An assessment of boys' needs indicates that Level III programming should address alcohol and drug use, family functioning, and aggression, as well as mental health.
- There is a potential shortage in appropriate mental health residential treatment beds. On the one hand, the forecast analysis indicated that 123-126 boys are projected to need this type of placement, and 130 MHRPs have been utilized on average. These included 77 RTC beds, 12 psychiatric hospital beds, 11 beds in diagnostic units, and one high intensity psychiatric respite bed. And once again, nonresidential services such as CMEs may also provide appropriate alternatives to residential care for some youth. On the other hand, 29

boys have been sent to MHRPs located outside of Maryland over the past two fiscal years, and an additional 11 youth sent to secure out-of-state programs that provide mental health or substance abuse treatment. These out-of-state placements suggest potential gaps in this type of residential care.

Recommendations

The Department of Juvenile Services (DJS) is committed to providing quality care and appropriate services to youth and families involved in the juvenile justice system. DJS operates a system of services delivered in communities and facilities to meet the specific needs of youth and their families without compromising public safety. The DJS recommendations related to the identified service gaps are summarized below:

Community-Based Service Gaps

- **Gender-specific community services for girls in Baltimore County, Prince George's County, Anne Arundel County and Wicomico County.**

DJS is in the process of developing community service programming for girls in Baltimore County, Prince George's County, Anne Arundel County and Wicomico County to meet the needs of girls that are being supervised by DJS in the community. It is anticipated that girl's specific case management or programming will be available in each of the respective counties during 2014.

Additionally, DJS has reached out to a national group to develop training for case managers across the state that will provide appropriate gender responsive techniques to best supervise this population in the community. DJS is also working the State Advisory Board to create a committee to continue to monitor and evaluate DJS's commitment to providing appropriate gender responsive services.

- **Services to address aggression needs in Anne Arundel and Worcester County.**

DJS is reaching out to community partners in Anne Arundel and Worcester County to develop programming for youth in the community that will provide appropriate services to address aggression needs. It is anticipate that this programming will be available during 2014.

- **Education Support Services for boys in Wicomico and Worcester County.**

DJS is continuing to evaluate the need for additional education support services for boys in Wicomico County and Worcester County since each of the above mentioned counties has a truancy court that provides education support services to youth experiencing issues with truancy.

Residential Service Gaps for Girls

- **Level II/staff secure residential programs for girls.**

DJS has recognized a need for a level II / staff secure residential placement for girls. On June 13, 2012, DJS posted an Expression of Interest on eMaryland Marketplace to licensed residential providers to determine if there was interest in developing a Level II/staff secure residential program for girls in Maryland. DJS worked with a provider that was willing to re-purpose an existing program to meet this need, however, due to financial reasons that program was unable to continue in that capacity.

Subsequently, on August 20, 2013 DJS posted another Expression of Interest on eMaryland Marketplace. DJS postponed evaluating responses until the GAP Analysis was complete to ensure that the development of a new program would have all the components necessary to meet the needs of girls that require this level of care. DJS will continue to evaluate responses to the most recent Request for Interest and will work to identify a program that will be able to meet the needs of this population.

Residential Service Gaps for Boys

- **Level III programs/hardware secure residential program for boys.**

The Department of Juvenile Services' Capital Improvement Plan (CIP) includes two (2) male secure treatment centers, Baltimore Regional Treatment Center (BRTC) and Cheltenham Treatment Center (CTC) to address the need for Level III/ hardware secure residential programming.

A brief project/funding synopsis is as follows.

- The Baltimore Regional Treatment Center (BRTC) project is 48-bed hardware secure treatment center to serve male youth in Regions I and II. The project has prior authorized funding for acquisition; anticipated funding for Planning in FY2016, FY2017, and FY2018; and construction funding in FY2018.

- The Cheltenham Treatment Center (CTC) project is a 48-bed hardware secure treatment center to serve male youth in Regions V and VI. The location for CTC is on the grounds of the state-owned Cheltenham Youth Facility. The Department anticipates planning funding in FY2017 and FY 2018.

- **Potential shortage in appropriate mental health residential treatment beds for boys.**

DJS will continue to work with other State agencies to ensure that there is access to appropriate mental health residential treatment beds for boys.

References

Barnoski, R. (1998). *Juvenile Rehabilitation Administration assessments: Validity review and recommendations.* Olympia, WA: Washington State Institute for Public Policy.

Bloom, B., & Covington, S. (2000). *Gendered justice: Programming for women in correctional settings.* Paper presented to the American Society of Criminology, San Francisco, CA.

Bright, C. L., & Jonson-Reid, M. (2008). Onset of juvenile court involvement: Exploring gender-specific associations with maltreatment and poverty. *Children and Youth Services Review, 30,* 914-927.

Chesney-Lind, M., & Shelden, R. G. (2004). *Girls, delinquency, and juvenile justice, 2nd edition*. Belmont, CA: Wadsworth/Thomson Learning.

Henggeler, S.W. (1999). Multisystemic Therapy: An overview of clinical procedures, outcomes, and policy implications. *Child Psychology & Psychiatry Review, 4*, 2-10.

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., & Cunningham, P.B. (2009). *Multisystemic Therapy of Antisocial Behavior in Children and Adolescents.* New York: The Guilford Press.

Irvine, A. (2005). *Girls Circle: Summary of outcomes for girls in the juvenile justice system*. Santa Cruz, CA: Ceres Policy Research.

Sexton, T. L. (2011). *Functional Family Therapy in clinical practice.* New York, NY: Routledge.

Sexton, T. L., & Alexander, J. F. (2000). *Functional Family Therapy*. Juvenile Justice Bulletin, Office of Juvenile Justice and Delinquency Prevention.

Sullivan, M.B, Bennear, L.S., Honess, K.F., Painter,W.E., & Wood, T.J. (2012). Family Centered Treatment—An alternative to residential placements for adjudicated youth: Outcomes and cost-effectiveness. *OJJDP Journal of Juvenile Justice, 2 (1)*, 25-40.

Appendix A. Glossary of Key Terms

Aftercare: Supervision and individualized treatment services provided to youth in the community following discharge from a residential program.

Alternative Living Unit: A residence owned, leased, or operated by a licensee that: (a) provides residential services for children who, because of a developmental disability, require specialized living arrangements; (b) admits not more than three children; and (c) provides 24 hours of supervision per unit, per day.

Average Daily Population (ADP): Daily population of youth in residential placement (state or privately owned) averaged over the number of days in the year.

Average Length of Stay (ALOS): Average total number of days in residential placement between admission and release. Youth detained in more than one facility during a contiguous stay are counted as a single placement.

Case Management Specialist (CMS): DJS staff who provide case management services to youth in community and residential settings. Case managers provide supervision, develop treatment plans, link youth with necessary resources and services, monitor progress, and modify treatment plans as needed.

Certificate of Placement (COP): The document which reflects a youth's placement location, services, and authorizes payment for services.

Commitment versus Admission: A commitment is a court order placing a delinquent youth in DJS' care. The youth is usually placed into an out-of-home program, but may also be provided services at home. An admission occurs when a juvenile physically arrives at a facility and is officially entered into the facility's rolls. An admission may occur days/weeks after the juvenile is committed to DJS (in the interim, a youth is considered to be on "pending placement" status – see Pending Placement). A single admission to an out-of-home program could be the result of multiple commitments (e.g. a juvenile may be committed by more than one court, or have multiple charges with "committed" dispositions). Thus, the number of commitments will not equal the number of admissions to committed programs.

Continuum of Care: The continuum of care spans in-home probation supervision with services, community-based out of home treatment, and state and privately-operated secure programs, all designed to address youth needs, and the factors that led the youth to delinquent behavior. Legislation passed in 2012 authorized DJS to transfer youth directly from one facility/program to another facility/program (of equal or higher security level) without first asking the court to modify the commitment order.

Delinquent: A youth who has been adjudicated for an act which would be a crime if committed by an adult and who requires guidance, treatment, or rehabilitation.

Detention: Temporary, short-term (1-30 days) physically secure housing of youth who are awaiting court disposition and require secure custody for the protection of themselves or the

community and/or to ensure court appearance.

Diagnostic Unit: A short-term residential program, where staff perform physical, social, and psychological evaluations of youth to recommend appropriate therapeutic interventions.

Disposition: The action taken by the juvenile court that outlines whether the youth requires guidance, treatment, or rehabilitation and, if so, the nature of such assistance that an adjudicated youth will receive. (Note: In adult courts, this is known as a "sentence.")

Fiscal Year (FY): The time period measured from July 1st of one year to June 30th of the following year. For example, FY 2013 runs from July 1, 2012 through June 30, 2013.

Foster Care: Continuous 24-hour care and support provided to a youth in a DJS- or DSS-approved family home.

Group Home: A residential program licensed by DHR, DJS or MHA/DHMH to provide 24-hour supervised out-of-home care for 4 or more youth and which provides a formal program of basic care, social work, and health care services.

Hardware Secure Facility: A facility that relies primarily on the use of construction and hardware such as locks, bars, and fences to restrict freedom.

High Intensity Psychiatric Respite: Intensive psychiatric respite services with additional staffing and support services for children with a residential treatment center recommendation.

Independent Living Program: A program implemented by a child placement agency licensed by DHR for youth 15 to 21 years of age. During the program, youth learn about interpersonal skills, money management, job readiness, conflict management, positive leisure opportunities and communication skills. Youth reside in either group homes or supervised apartment units, and must be enrolled in high school, college, vocational training, or be gainfully employed.

Intermediate Care Facility for Addictions (IFCA): A clinically managed low- to high-intensity treatment program that provides a structured environment in combination with treatment directed toward preventing relapse, applying recovery skills, promoting personal responsibility, and reintegration, and ancillary services to support and promote recovery.

Pre-Court (or "Informal") Supervision: An agreement between DJS and a youth and family to enter into counseling and/or DJS monitoring without court involvement.

Probation: Court-ordered supervision of youth in the community requiring youth to meet court-ordered probation conditions (general and case specific), including, for example, school attendance, employment, community service, restitution, counseling, or participation in substance abuse treatment.

Psychiatric Hospital: An inpatient institution that provides evaluation, care, or treatment for individuals who have mental disorders.

Residential Treatment Center (RTC): A mental health facility for children and adolescents with long-term serious emotional, behavioral, and psychological problems. RTCs provide intensive services and should only be considered when therapeutic services available in the community

are insufficient to address a youth's needs. In addition to Maryland RTCs, DJS uses a variety of out-of-state providers including RTCs funded through Medical Assistance, with rates set by the Maryland Interagency Rates Committee, and facilities that are not RTCs and serve moderate-to-high-risk multi-problem youth. These are youth who may be exhibiting moderate psychiatric symptomatology and aggressive behavior, or who have histories of unsuccessful/repeated placements and/or hospitalizations. Treatment models vary depending on the client focus of the program but all provide individualized treatment plans, are comprehensive in services, highly structured, treatment oriented and behaviorally focused.

Respite Care: Short-term care for a child to temporarily relieve the caregiver from the responsibility of providing 24-hour care for a child.

Social History Investigation (SHI): The written study of a youth and his/her family that is presented to the juvenile court. A Social History Investigation emphasizes social and legal histories as well as the domain areas of: family functioning, substance abuse, mental health, somatic health, education, employment, and life skills.

Staff Secure Facility: Residential programs where youth movement is controlled by staff supervision rather than by restrictive architectural features.

Therapeutic Group Home: A small private group home that provides residential child care as well as access to a range of diagnostic and therapeutic mental health services for children and adolescents who have mental disorders.

Treatment Foster Care: 24-hour substitute care program operated by a licensed child placement agency or local Department of Social Services for children with emotional, behavioral, medical, or psychological conditions.

Treatment Service Plan (TSP): A written document identifying treatment objectives, services, and service linkages that address the needs of the youth and family. It also examines the safety and appropriateness of the youth's placement, guides DJS's recommendations to the juvenile court for permanency planning (where appropriate), and monitors level of supervision and services required.

Appendix B. Probation Youth Needs & Community-Based Services

The following tables summarize the characteristics of youth who were adjudicated delinquent and court-ordered to probation in FY13. [20] The tables are organized by region, with summary tables provided for the entire region and the respective counties. In some cases, very few youth were ordered to probation in FY13 and their characteristics may not be representative of treatment needs/offender types more generally; accordingly, these data are not presented for jurisdictions where fewer than five girls or boys were ordered to probation (indicated by an asterisk).

In addition, the community-based service array is summarized for each region/county. Each table shows the number of programs available for each need/intervention area. It is important to note that these programs were identified by local DJS staff, and some counties reported far more programs than others. To some extent, these numbers may reflect actual differences in the availability of programs; but it is also likely that some jurisdictions indicated only their most frequently utilized programs. Further, each section includes a map of the community-based service providers reported by each jurisdiction. Note that some of the service providers administer multiple programs for youth involved with DJS (individual programs are not shown).

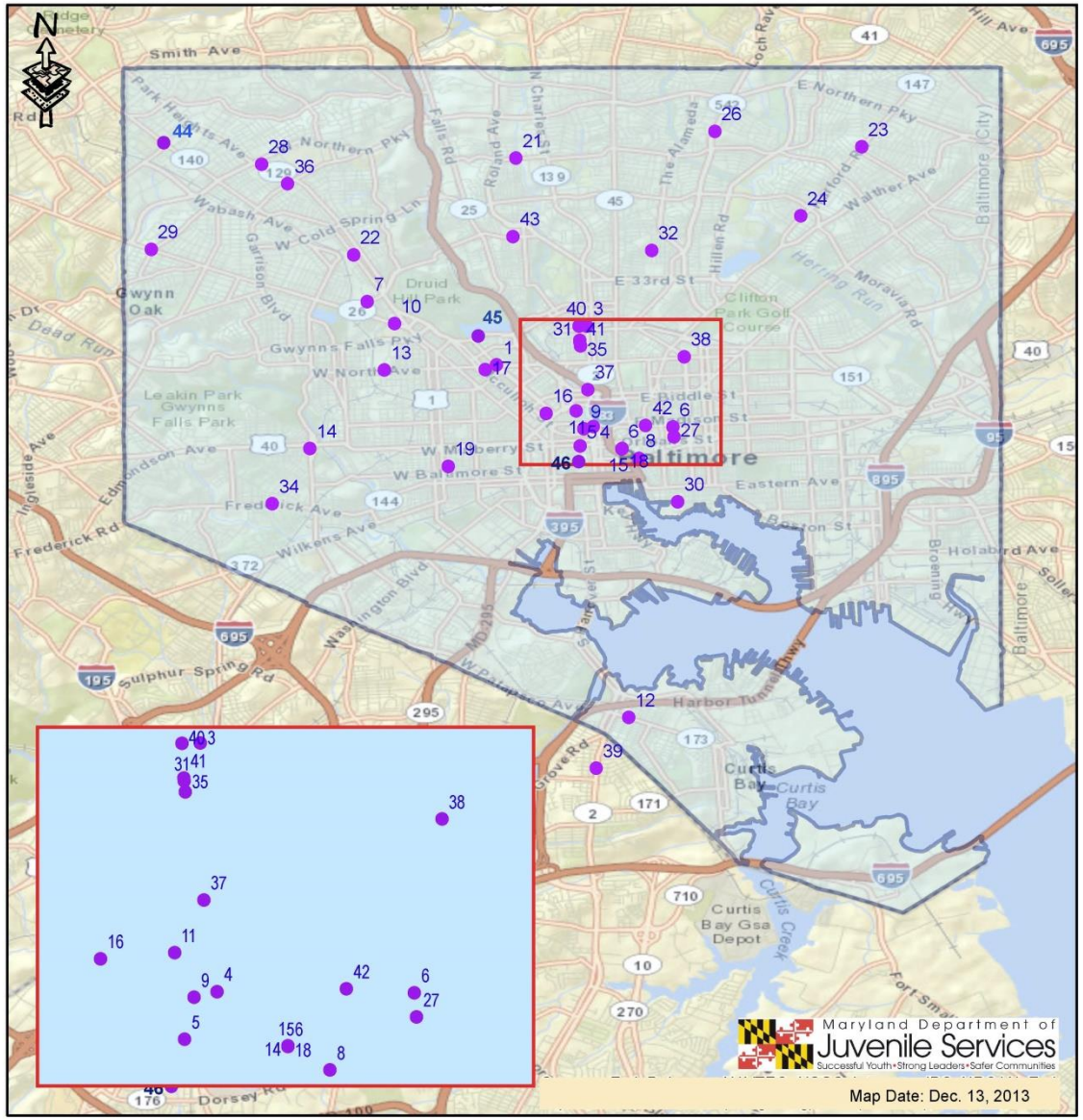
Baltimore City Region

Table 1. Probation Youth Needs (FY13) and Community-Based Services: Baltimore City

	Girls	Boys	Total Youth	# Programs
Total	69 (15%)	401 (85%)	470	50
Average Age	15.7	16.2	16.1	--
Race/Ethnicity				
African American/Black	97%	97%	97%	--
Caucasian/White	3%	2%	2%	--
Hispanic/Latino	0%	<1%	<1%	--
Other	0%	<1%	<1%	--
Treatment Needs/Offender Type				
Education	56%	65%	64%	9
Use of Free Time	14%	24%	22%	2
Peer Relationships	89%	89%	89%	6
Family	58%	49%	51%	8
Alcohol & Drug Use	33%	45%	43%	12
Mental Health	50%	27%	31%	16
Anti-Social Attitudes	72%	66%	67%	2
Aggression	92%	75%	77%	3
Sex Offender	0%	2%	1%	1
Fire Setter	8%	1%	2%	0
Girl-Only Programs	--	--	--	2

[20] Youth under probation supervision who had their relevant adjudication hearing prior to FY13 are not included in these analyses.

Community-Based Services in Baltimore City / Region



Ref No	Provider
1	DRU/Mondawmin Healthy Families, Inc.
2	Advanced Behavioral Health
3	All Walks of Life
4	Young Fathers Responsible Fathers
5	Baltimore Child & Adolescents Response System
6	Baltimore City Health Department
7	Behavioral Interface
8	Black Professional Men, Inc.
9	Boys & Girls Clubs
10	Change Health Systems
11	Chase Brexton Health Care
12	Chesapeake Center for Youth Development
13	Coppin State University
14	DJS-Southern office
15	Baltimore City Drug Court
16	DRU/Mondawmin Healthy Families, Inc.
17	Druid Heights Community Development Corporation
18	E. Baltimore Commty Partnership/The Family League
19	Echo House
20	Epoch Counseling Center
21	Family Solutions of Maryland
22	Harambee Treatment Center
23	Harbel
24	Harford-Belair Community Mental Health Center
25	Institute for Family Centered Services
26	Institute for Life Enrichment
27	Children's Mental Health Center (JHU)
28	King Health Systems
29	Liberty House Shelter
30	Living Classrooms
31	Maryland Choices
32	Mentors for Life
33	Mosaic Community Services
34	Mt. Manor Treatment Center
35	North Baltimore Center
36	Northwest Baltimore Youth Services
37	Quadrant Inc.
38	Roberta's House
39	The Choice Program (UMBC)
40	Treatment Resources for Youth
41	Urban Behavioral Associates
42	VisionQuest
43	Youth Advocate Program
44	DJS-Plaza Office
45	DJS-Day & Evening Reporting Center
46	DJS-Central Office

Central Region

Table 2. Probation Youth Needs (FY13) and Community-Based Services: Central Region				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	203 (21%)	756 (79%)	959	146
Average Age	16.4	16.2	16.2	--
Race/Ethnicity				
African American/Black	63%	55%	56%	--
Caucasian/White	34%	41%	39%	--
Hispanic/Latino	3%	3%	3%	--
Other	0%	1%	1%	--
Treatment Needs/Offender Type				
Education	56%	53%	54%	51
Use of Free Time	30%	23%	25%	47
Peer Relationships	70%	82%	79%	62
Family	39%	40%	39%	44
Alcohol & Drug Use	33%	47%	44%	34
Mental Health	41%	34%	35%	51
Anti-Social Attitudes	58%	61%	60%	51
Aggression	74%	70%	71%	39
Sex Offender	2%	4%	4%	2
Fire Setter	2%	2%	2%	2
Girl-Only Programs	--	--	--	5

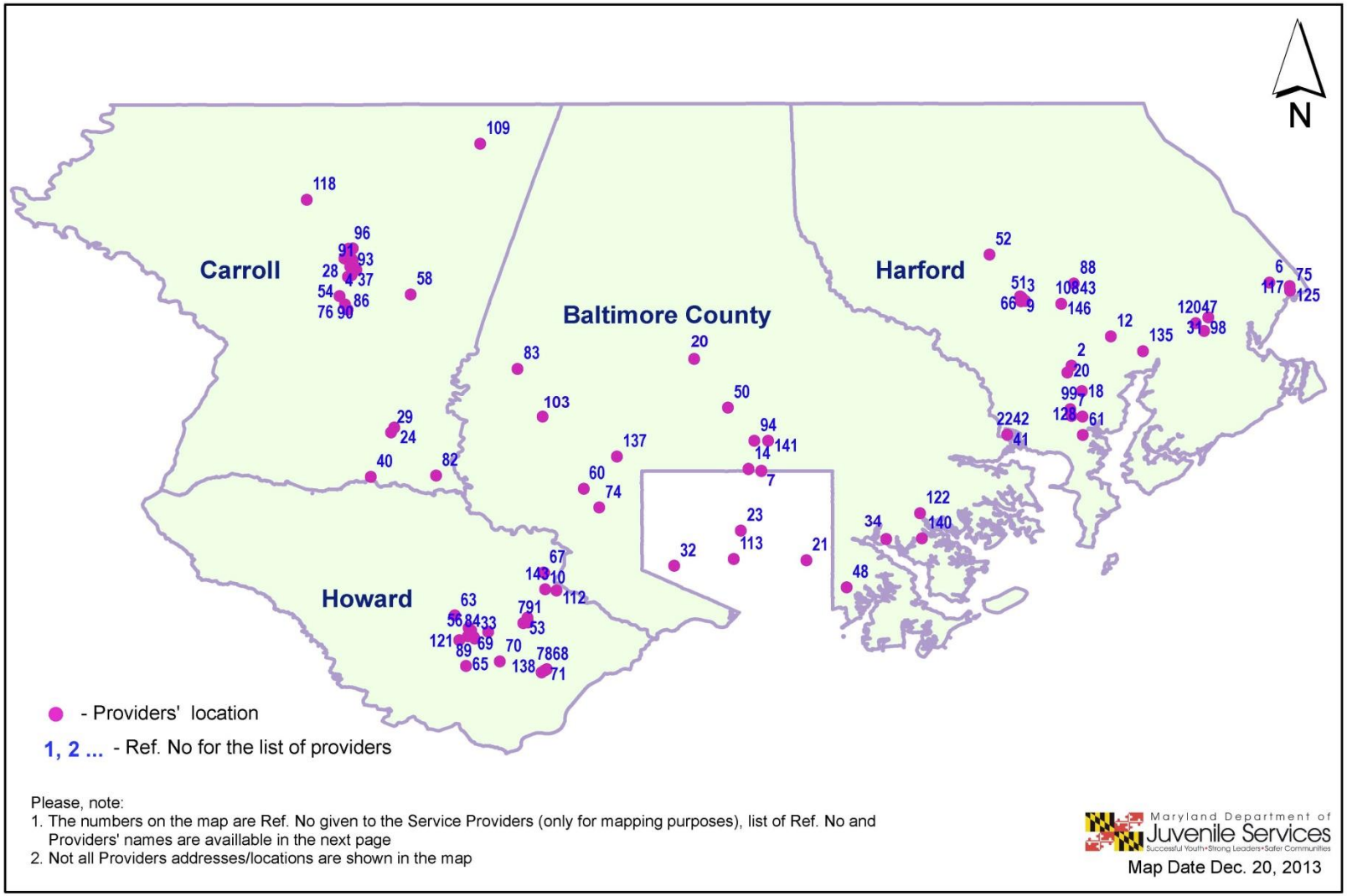
Table 3. Probation Youth Needs (FY13) and Community-Based Services: Baltimore County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	114 (19%)	500 (81%)	614	24
Average Age	16.2	16.2	16.2	--
Race/Ethnicity				
African American/Black	78%	65%	68%	--
Caucasian/White	20%	31%	29%	--
Hispanic/Latino	2%	3%	3%	--
Other	0%	1%	1%	--
Treatment Needs/Offender Type				
Education	52%	57%	56%	6
Use of Free Time	27%	19%	21%	6
Peer Relationships	69%	81%	78%	8
Family	35%	37%	37%	10
Alcohol & Drug Use	30%	45%	42%	4
Mental Health	41%	33%	35%	7
Anti-Social Attitudes	52%	59%	58%	13
Aggression	74%	69%	70%	8
Sex Offender	3%	4%	4%	1
Fire Setter	3%	2%	2%	1
Girl-Only Programs	--	--	--	0

Table 4. Probation Youth Needs (FY13) and Community-Based Services: Carroll County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	17 (18%)	78 (82%)	95	31
Average Age	16.9	16.5	16.6	--
Race/Ethnicity				
African American/Black	12%	9%	10%	--
Caucasian/White	82%	90%	88%	--
Hispanic/Latino	6%	0%	1%	--
Other	0%	1%	1%	--
Treatment Needs/Offender Type				
Education	69%	37%	43%	10
Use of Free Time	13%	27%	25%	10
Peer Relationships	69%	89%	85%	16
Family	38%	49%	47%	14
Alcohol & Drug Use	31%	50%	47%	9
Mental Health	63%	39%	43%	19
Anti-Social Attitudes	69%	58%	60%	12
Aggression	69%	74%	73%	10
Sex Offender	0%	6%	5%	1
Fire Setter	6%	0%	1%	0
Girl-Only Programs	--	--	--	1

Table 5. Probation Youth Needs (FY13) and Community-Based Services: Harford County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	31 (26%)	87 (74%)	118	64
Average Age	16.6	16.0	16.2	--
Race/Ethnicity				
African American/Black	45%	30%	34%	--
Caucasian/White	55%	64%	62%	--
Hispanic/Latino	0%	5%	3%	--
Other	0%	1%	1%	--
Treatment Needs/Offender Type				
Education	87%	65%	71%	21
Use of Free Time	40%	36%	37%	15
Peer Relationships	87%	90%	89%	21
Family	73%	67%	69%	10
Alcohol & Drug Use	43%	63%	58%	7
Mental Health	60%	43%	47%	13
Anti-Social Attitudes	93%	84%	86%	8
Aggression	97%	84%	87%	4
Sex Offender	0%	9%	7%	1
Fire Setter	0%	1%	1%	1
Girl-Only Programs	--	--	--	2

Table 6. Probation Youth Needs (FY13) and Community-Based Services: Howard County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	41 (31%)	91 (69%)	132	38
Average Age	16.6	16.3	16.4	--
Race/Ethnicity				
African American/Black	56%	58%	58%	--
Caucasian/White	34%	30%	31%	--
Hispanic/Latino	10%	9%	9%	--
Other	0%	3%	2%	--
Treatment Needs/Offender Type				
Education	39%	39%	39%	17
Use of Free Time	34%	29%	30%	18
Peer Relationships	59%	73%	68%	23
Family	22%	21%	21%	15
Alcohol & Drug Use	32%	45%	41%	16
Mental Health	24%	26%	26%	15
Anti-Social Attitudes	44%	54%	51%	29
Aggression	63%	54%	57%	19
Sex Offender	0%	0%	0%	1
Fire Setter	0%	3%	2%	2
Girl-Only Programs	--	--	--	2

Community-Based Services in Central Region



Community-Based Services in Central Region

Ref.No	Provider Name
1	A Better Way Counseling Services
2	Alliance
3	School-based Mental Health-Harford County
4	Arrow Children and Family Ministries
5	Associated Catholic Charities (all locations not shown)
6	Baltimore County Dept. of Social Services
8	Baltimore County Drug Court (not shown)
9	Baltimore County Health Dept
10	Baltimore County Police Dept. (additional locations)
11	Big Brothers Big Sisters (not shown on map)
12	Boys & Girls Clubs of Harford County (additional locations)
13	Carroll Counseling Centers
14	Carroll County Community College
15	Carroll County Business & Employment Resource Center
16	Carroll County DJS
17,18	Carroll County Youth Service Bureau
19	Carroll Hospital Center
21	Catoctin Counseling
22	Cedar Ridge Counseling Center
23	Center for Therapeutic Concepts, Inc.
24	Choices of Carroll County
25	Circuit Court for Harford County (Truancy Court)
26	Crisis Intervention Team (Harford County; not shown)
27	Columbia Addictions Center
28	Community Service Office of Drug Control Policy
29	Community Solutions Inc.
30	Congruent and Integrative Counseling
31	Congruent Counseling Services
32	Dads Works
33	Community Conferencing
35	Harford County DJS
37	Dundalk Youth Services Center
38	Extreme Family Outreach
39	Family and Children's Services
40	Family Support and Resource Center
41	Finksburg Counseling Services

Ref.No	Provider Name
42	First Step
43, 44	Grass Roots Crisis Intervention Center
45	Greater Edgewood Education Foundation
46	Greater Excellence in Education Foundation
47	Harford County Boys and Girls Club (not shown on map)
48	Harford County Boys and Girls Club, Edgewood
49	Harford County Dept. of Community Services
50	Harford County Dept. of Social Services
51	Harford County DJS
52	Harford County Drug Court Program
53	Harford County Health Department
54	Harford County Health Department Division of Addictions
55	Harford County Public Schools (all locations not shown)
56	Harford County Public Schools PTAs (all locations not shown)
57	HC Drug Free
58	Howard Co. Dept. of Fire and Rescue Services (Fire Setter Program)
59	Howard County DJS
60	Howard County Health Dept.
61	Howard County Mental Health Authority
62	Howard County Office of Human Rights
63	Howard County Office of Workforce Development
64	Howard County Public Library
65	Howard County Public Schools (all locations not shown)
66	Inner County Outreach
67	Institute for Family Centered Services
68	Johns Hopkins Bayview Medical Center
69	Keystone Service Systems, Inc.
70	LASOS, Inc
71	Main Street Mobile Treatment and Main Street Commty Mental Health Center
72	Maryland Choices
73	Maryland Coalition of Families for Children's Mental Health
74	Maryland Conservatory of Music
75	Mediation and Conflict Resolution Center, Howard Commty College
76	Dr. Michelle Coleman
77	Mosaic Community Services, Inc.

Ref.No	Provider Name
78	Mothers Against Drunk Driving
79	Mountain Manor Treatment Center
80	Mountain Manor Treatment Center - Baltimore
81	MPB Group, Inc.
82	National Association for Shoplifting Prevention (online prog)
83	National Guard (Free State Challenge Academy)
84	New Path Counseling Center
85	Harford County Office of Drug Control Policy
86	Harford County Office of Drug Control Policy, Circuit Court
87	Open Doors Career Center
88	Pastor Reeves & Schools
89	Positive Alternatives to Destructive and Dangerous Driving (PADDD)
90	Psych Associates of Maryland, LCC
91	Sheppard Pratt (Harford County)
92	Sheppard Pratt Health System (Ellicott City)
93	Sheriff's Office (Diversion & Gang Programs)
94	Sheriff's Office and Harford County Public Schools
95	St. Patrick's Catholic Church
96	The Church of Resurrection in Joppatowne
97	The Conflict Resolution Center Of Baltimore Co
98	The Howard Group
99	The Salvation Army Boys & Girls Club of Middle River
100	University of Maryland Shock Trauma Center
101	Upper Bay
102	Upper Bay Counseling
104	Non-Public Educational Placements (locations not shown)
105	Villa Maria (Edgewood Middle School)
106	Villa Maria of Harford County
108	VisionQuest
109	Way Station
110	Westminster YMCA
111	YMCA
112	Howard County Police Dept. (Diversion)
7	Baltimore County DJS-Arbutus Office
20	Baltimore County DJS-Hunt Valley Office
34	Baltimore County DJS-Eastern Office
103	Baltimore County DJS-Garrison Office

Western Region

Table 7. Probation Youth Needs (FY13) and Community-Based Services: Western Region				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	23 (18%)	103 (82%)	126	71
Average Age	15.6	15.8	15.8	--
Race/Ethnicity				
African American/Black	22%	32%	30%	--
Caucasian/White	78%	66%	68%	--
Hispanic/Latino	0%	2%	2%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	67%	66%	66%	10
Use of Free Time	38%	18%	22%	12
Peer Relationships	81%	91%	89%	8
Family	76%	59%	62%	22
Alcohol & Drug Use	48%	40%	41%	11
Mental Health	52%	41%	43%	22
Anti-Social Attitudes	71%	71%	71%	16
Aggression	86%	86%	86%	9
Sex Offender	0%	3%	3%	4
Fire Setter	14%	2%	4%	1
Girl-Only Programs	--	--	--	9

Table 8. Probation Youth Needs (FY13) and Community-Based Services: Allegany County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	8 (32%)	17 (68%)	25	30
Average Age	15.6	15.3	15.4	--
Race/Ethnicity				
African American/Black	25%	18%	20%	--
Caucasian/White	75%	82%	80%	--
Hispanic/Latino	0%	0%	0%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	57%	71%	67%	7
Use of Free Time	43%	24%	29%	4
Peer Relationships	86%	94%	92%	1
Family	86%	65%	71%	8
Alcohol & Drug Use	43%	53%	50%	4
Mental Health	29%	59%	50%	11
Anti-Social Attitudes	57%	82%	75%	5
Aggression	86%	88%	88%	2
Sex Offender	0%	0%	0%	1
Fire Setter	29%	0%	8%	1
Girl-Only Programs	--	--	--	3

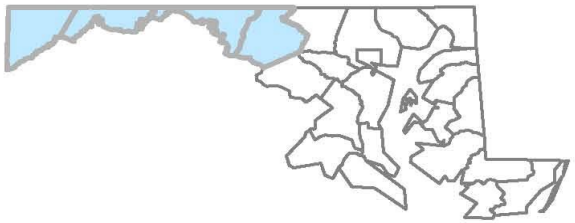
Table 9. Probation Youth Needs (FY13) and Community-Based Services: Frederick County				
	Girls	Boys	Total Youth	# Programs
Total	1 (17%)	5 (83%)	6	17
Average Age	15.9	17.7	17.4	--
Race/Ethnicity				
African American/Black	0%	20%	17%	--
Caucasian/White	100%	80%	83%	--
Hispanic/Latino	0%	0%	0%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	*	40%	50%	0
Use of Free Time	*	40%	33%	6
Peer Relationships	*	80%	83%	6
Family	*	60%	67%	7
Alcohol & Drug Use	*	80%	67%	3
Mental Health	*	80%	83%	2
Anti-Social Attitudes	*	60%	67%	6
Aggression	*	80%	83%	3
Sex Offender	*	0%	0%	1
Fire Setter	*	0%	0%	0
Girl-Only Programs	--	--	--	2

Table 10. Probation Youth Needs (FY13) and Community-Based Services: Garrett County				
	Girls	Boys	Total Youth	# Programs
Total	2 (8%)	24 (92%)	26	11
Average Age	16.3	15.8	15.9	--
Race/Ethnicity				
African American/Black	50%	0%	4%	--
Caucasian/White	50%	100%	96%	--
Hispanic/Latino	0%	0%	0%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	*	50%	46%	1
Use of Free Time	*	4%	4%	0
Peer Relationships	*	96%	96%	1
Family	*	38%	42%	5
Alcohol & Drug Use	*	29%	31%	1
Mental Health	*	17%	19%	5
Anti-Social Attitudes	*	42%	46%	4
Aggression	*	67%	69%	3
Sex Offender	*	13%	12%	1
Fire Setter	*	8%	12%	0
Girl-Only Programs	--	--	--	0

Table 11. Probation Youth Needs (FY13) and Community-Based Services: Washington County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	12 (17%)	57 (83%)	69	23
Average Age	15.5	15.8	15.7	--
Race/Ethnicity				
African American/Black	17%	51%	45%	--
Caucasian/White	83%	46%	52%	--
Hispanic/Latino	0%	4%	3%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	82%	74%	75%	3
Use of Free Time	46%	20%	25%	2
Peer Relationships	73%	89%	86%	1
Family	64%	67%	66%	7
Alcohol & Drug Use	55%	37%	40%	3
Mental Health	64%	43%	46%	8
Anti-Social Attitudes	73%	82%	80%	4
Aggression	82%	94%	92%	3
Sex Offender	0%	0%	0%	2
Fire Setter	0%	0%	0%	1
Girl-Only Programs	--	--	--	1

Community-Based Services in Western Region

Please, note:
1. The numbers on the map are Ref.No given to the Service Providers (only for mapping purposes),
2. Not all Providers address/location are shown in the map



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

Map Date Dec. 20, 2013

Ref No	Provider
1	Allegany County Dept. of Social Services
2	Allegany County DJS
3	Allegany County Health Dept.
4	Allegany County Sheriff's Dept. (Diversion)
5	Alternative Drug/Alcohol Counseling
6	Appalachian Behavioral Health
7	Archway Station, Inc.
8	Christian Counseling Services of Western MD
9	Cumberland City Police Dept. (Safe Streets)
10	DJS-Spotlight on Schools (not shown in the map)
11	Dr. Michelle Colman
12	Family Crisis Resource Center
13	Frederick County Dept. of Social Services
14	Frederick County DJS
15	Frederick County Health Dept.
16	Frederick County State's Attorney's Office (Diversion Prog.)
17	Frederick Police Dept. (Safe Streets)
18	Garrett Co. Health Dept.
19	Garrett College
20	Garrett County DJS
21	Garrett County Health Dept.
22	Girl's Inc.
23	Hartsock Counseling Services
24	Institute for Family Centered Services
25	Jefferson School
26	Lead for Life
27,44	Lead4Life, Inc.

Ref No	Provider
28	Local Churches in Garrett Co. (not shown in map)
29	Local Management Board of Allegany County
30	Maryland Choices
31	Maryland Salem's Trust
32	Meadow Brook
33	Mental Health Authority (Healthy Transitions)
34	Mental Health Center
35	Mental Health Management Agency of Frederick County
36	Mountainside Mediation Center
37	Office of the State Fire Marshal (Fire Setter Program)
38	PADDD Inc.
39	Pressley Ridge
40	Serenity Treatment Centers, Inc.
41	Steve Green Assc.
42	Steve Hartsock
43	Villa Maria
45	Washington Co. Local Management Board
46	Drug Court (Washington County)
47	Washington County Dept. of Social Services
48	Washington County DJS
49	Washington County Health Dept.
50	Way Station Inc.
51	Western Maryland Health System Treatment
52	Western MD Consortium
53	YMCA
54	Zealand Psychological Associates

Eastern Shore Region

Table 12. Probation Youth Needs (FY13) and Community-Based Services: Eastern Shore Region				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	71 (25%)	218 (75%)	289	77
Average Age	15.8	16.0	16.0	--
Race/Ethnicity				
African American/Black	55%	44%	47%	--
Caucasian/White	42%	52%	50%	--
Hispanic/Latino	1%	2%	2%	--
Other	1%	1%	1%	--
Treatment Needs/Offender Type				
Education	77%	70%	72%	8
Use of Free Time	45%	38%	40%	12
Peer Relationships	73%	78%	76%	13
Family	65%	65%	65%	5
Alcohol & Drug Use	28%	48%	43%	16
Mental Health	58%	44%	48%	19
Anti-Social Attitudes	74%	74%	74%	8
Aggression	88%	78%	80%	4
Sex Offender	0%	3%	2%	1
Fire Setter	0%	1%	1%	1
Girl-Only Programs	--	--	--	7

Table 13. Probation Youth Needs (FY13) and Community-Based Services: Caroline County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	1 (7%)	13 (93%)	14	20
Average Age	18.6	16.1	16.3	--
Race/Ethnicity				
African American/Black	0%	15%	14%	--
Caucasian/White	100%	77%	79%	--
Hispanic/Latino	0%	8%	7%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	*	46%	50%	3
Use of Free Time	*	31%	29%	4
Peer Relationships	*	69%	64%	2
Family	*	39%	43%	2
Alcohol & Drug Use	*	31%	29%	5
Mental Health	*	23%	21%	6
Anti-Social Attitudes	*	46%	43%	2
Aggression	*	62%	64%	0
Sex Offender	*	0%	0%	0
Fire Setter	*	8%	7%	0
Girl-Only Programs	--	--	--	0

Table 14. Probation Youth Needs (FY13) and Community-Based Services: Cecil County				
	Girls	Boys	Total Youth	# Programs
Total	16 (18%)	73 (82%)	89	12
Average Age	15.3	15.9	15.8	--
Race/Ethnicity				
African American/Black	31%	33%	33%	--
Caucasian/White	63%	66%	65%	--
Hispanic/Latino	6%	1%	2%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	63%	82%	79%	5
Use of Free Time	56%	52%	53%	3
Peer Relationships	69%	93%	89%	4
Family	75%	82%	81%	2
Alcohol & Drug Use	31%	52%	48%	2
Mental Health	56%	49%	51%	1
Anti-Social Attitudes	69%	85%	82%	4
Aggression	75%	86%	84%	1
Sex Offender	0%	4%	3%	0
Fire Setter	0%	1%	1%	0
Girl-Only Programs	--	--	--	1

Table 15. Probation Youth Needs (FY13) and Community-Based Services: Dorchester County				
	Girls	Boys	Total Youth	# Programs
Total	6 (29%)	15 (71%)	21	10
Average Age	16.1	15.0	15.3	--
Race/Ethnicity				
African American/Black	83%	53%	62%	--
Caucasian/White	17%	47%	38%	--
Hispanic/Latino	0%	0%	0%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	83%	87%	86%	1
Use of Free Time	33%	13%	19%	2
Peer Relationships	100%	89%	91%	4
Family	50%	73%	67%	1
Alcohol & Drug Use	0%	53%	38%	1
Mental Health	67%	60%	62%	3
Anti-Social Attitudes	83%	80%	81%	1
Aggression	100%	93%	95%	1
Sex Offender	0%	0%	0%	0
Fire Setter	0%	0%	0%	0
Girl-Only Programs	--	--	--	1

Table 16. Probation Youth Needs (FY13) and Community-Based Services: Kent County				
	Girls	Boys	Total Youth	# Programs
Total	1 (11%)	8 (89%)	9	14
Average Age	15.1	15.9	15.9	--
Race/Ethnicity				
African American/Black	0%	50%	44%	--
Caucasian/White	100%	50%	56%	--
Hispanic/Latino	0%	0%	0%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	*	25%	33%	2
Use of Free Time	*	50%	44%	3
Peer Relationships	*	25%	22%	3
Family	*	75%	67%	3
Alcohol & Drug Use	*	38%	33%	1
Mental Health	*	25%	22%	3
Anti-Social Attitudes	*	63%	56%	1
Aggression	*	50%	44%	0
Sex Offender	*	0%	0%	0
Fire Setter	*	0%	0%	0
Girl-Only Programs	--	--	--	2

Table 17. Probation Youth Needs (FY13) and Community-Based Services: Queen Anne County				
	Girls	Boys	Total Youth	# Programs
Total	1 (17%)	5 (83%)	6	10
Average Age	18.8	16.7	17.0	--
Race/Ethnicity				
African American/Black	0%	100%	83%	--
Caucasian/White	100%	0%	17%	--
Hispanic/Latino	0%	0%	0%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	*	80%	67%	2
Use of Free Time	*	20%	17%	1
Peer Relationships	*	80%	67%	1
Family	*	80%	67%	4
Alcohol & Drug Use	*	80%	67%	2
Mental Health	*	40%	33%	3
Anti-Social Attitudes	*	60%	50%	1
Aggression	*	80%	83%	0
Sex Offender	*	0%	0%	0
Fire Setter	*	0%	0%	0
Girl-Only Programs	--	--	--	0

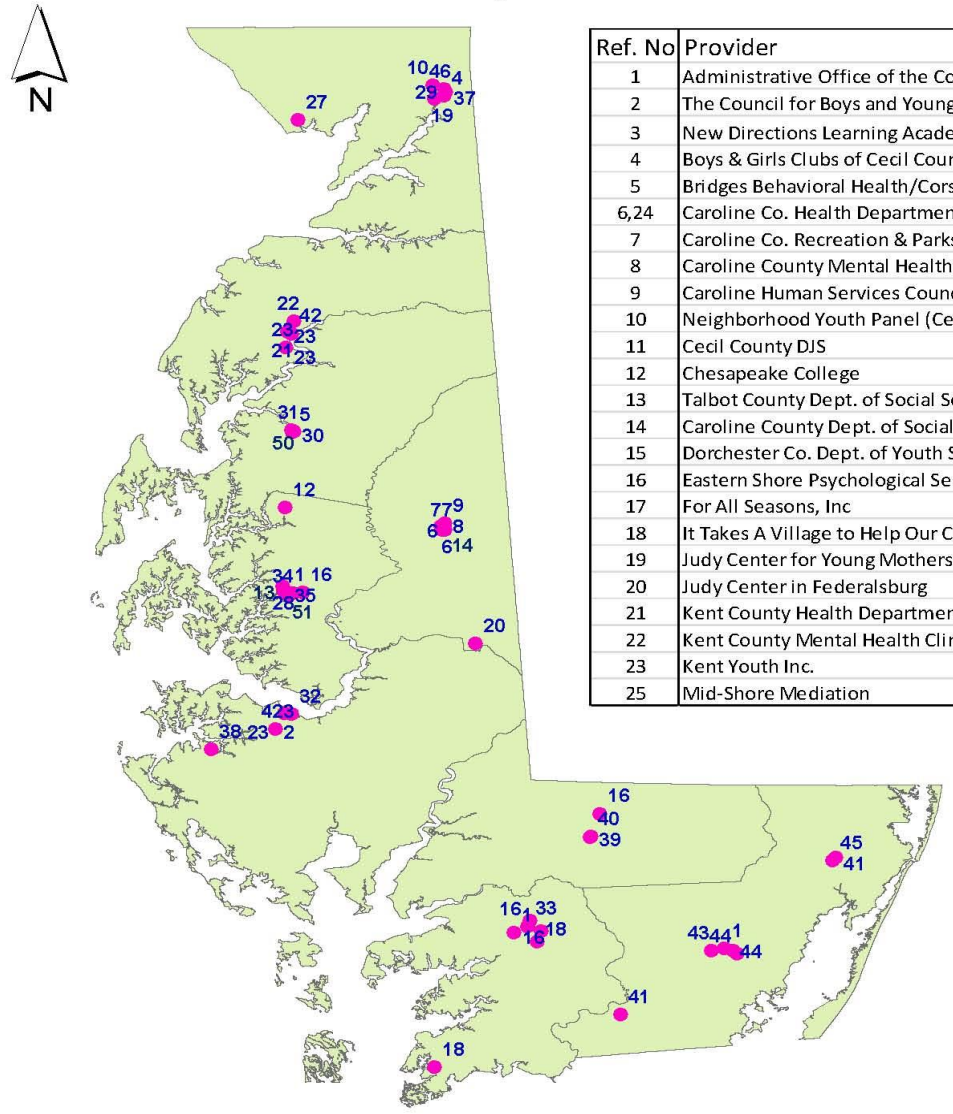
Table 18. Probation Youth Needs (FY13) and Community-Based Services: Somerset County				
	Girls	Boys	Total Youth	# Programs
Total	0	0	0	10
Average Age				--
Race/Ethnicity				
African American/Black	--	--	--	--
Caucasian/White	--	--	--	--
Hispanic/Latino	--	--	--	--
Other	--	--	--	--
Treatment Needs/Offender Type				
Education	--	--	--	1
Use of Free Time	--	--	--	1
Peer Relationships	--	--	--	1
Family	--	--	--	1
Alcohol & Drug Use	--	--	--	3
Mental Health	--	--	--	3
Anti-Social Attitudes	--	--	--	2
Aggression	--	--	--	0
Sex Offender	--	--	--	1
Fire Setter	--	--	--	1
Girl-Only Programs	--	--	--	0

Table 20. Probation Youth Needs (FY13) and Community-Based Services: Talbot County				
	Girls	Boys	Total Youth	# Programs
Total	7 (44%)	9 (56%)	16	22
Average Age	16.5	15.9	16.2	--
Race/Ethnicity				
African American/Black	29%	33%	31%	--
Caucasian/White	57%	56%	56%	--
Hispanic/Latino	0%	11%	6%	--
Other	14%	0%	6%	--
Treatment Needs/Offender Type				
Education	67%	67%	67%	3
Use of Free Time	17%	33%	27%	1
Peer Relationships	83%	100%	93%	1
Family	50%	67%	60%	3
Alcohol & Drug Use	33%	44%	40%	8
Mental Health	67%	78%	73%	7
Anti-Social Attitudes	50%	100%	80%	1
Aggression	100%	89%	93%	1
Sex Offender	0%	0%	0%	0
Fire Setter	0%	0%	0%	0
Girl-Only Programs	--	--	--	1

Table 21. Probation Youth Needs (FY13) and Community-Based Services: Wicomico County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	30 (41%)	43 (59%)	73	8
Average Age	15.5	16.0	15.8	--
Race/Ethnicity				
African American/Black	77%	70%	73%	--
Caucasian/White	23%	30%	27%	--
Hispanic/Latino	0%	0%	0%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	93%	93%	93%	0
Use of Free Time	53%	50%	51%	0
Peer Relationships	77%	80%	79%	1
Family	73%	73%	73%	1
Alcohol & Drug Use	27%	45%	37%	2
Mental Health	57%	48%	51%	3
Anti-Social Attitudes	90%	98%	94%	2
Aggression	97%	100%	99%	1
Sex Offender	0%	3%	1%	1
Fire Setter	0%	0%	0%	1
Girl-Only Programs	--	--	--	0

Table 22. Probation Youth Needs (FY13) and Community-Based Services: Worcester County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	9 (15%)	52 (85%)	61	11
Average Age	15.9	16.5	16.5	--
Race/Ethnicity				
African American/Black	44%	39%	39%	--
Caucasian/White	56%	52%	53%	--
Hispanic/Latino	0%	4%	3%	--
Other	0%	6%	5%	--
Treatment Needs/Offender Type				
Education	50%	39%	41%	1
Use of Free Time	38%	17%	20%	2
Peer Relationships	63%	54%	56%	4
Family	50%	33%	35%	1
Alcohol & Drug Use	50%	48%	48%	4
Mental Health	75%	30%	37%	4
Anti-Social Attitudes	63%	39%	43%	2
Aggression	75%	46%	50%	0
Sex Offender	0%	4%	4%	1
Fire Setter	0%	0%	0%	1
Girl-Only Programs	--	--	--	2

Community-Based Services in Eastern Region



Ref. No	Provider
1	Administrative Office of the Courts (Drug Court)
2	The Council for Boys and Young Men
3	New Directions Learning Academy
4	Boys & Girls Clubs of Cecil County
5	Bridges Behavioral Health/Corsica River MH
6,24	Caroline Co. Health Department
7	Caroline Co. Recreation & Parks
8	Caroline County Mental Health Clinic
9	Caroline Human Services Council, Inc.
10	Neighborhood Youth Panel (Cecil County)
11	Cecil County DJS
12	Chesapeake College
13	Talbot County Dept. of Social Services
14	Caroline County Dept. of Social Services
15	Dorchester Co. Dept. of Youth Services
16	Eastern Shore Psychological Services
17	For All Seasons, Inc
18	It Takes A Village to Help Our Children, Inc.
19	Judy Center for Young Mothers
20	Judy Center in Federalsburg
21	Kent County Health Department
22	Kent County Mental Health Clinic
23	Kent Youth Inc.
25	Mid-Shore Mediation

Ref. No	Provider
26	Mid-Shore Pro Bono
27	Perryville Police Department (Outreach)
28	Planned Parenthood
29	Project Crossroad
30	Queen Anne's Co. Department of Health
31	Queen Anne's County Public Schools (CASASTART)
32	Shore Behavioral Health
33	Somerset County DJS
34	Talbot County Health Dept.
35	Talbot Partnership for Alcohol and Other Drug Abuse Prevention
36	University Of Maryland
37	Upper Bay, Inc.
38	VisionQuest
39	Wicomico County DJS
40	Wicomico County Health Dept.
41	Wocester County Health Dept. & Schools
42	Women in Need Inc. and ADP
43	Worcester County DJS
44	Worcester County Health Department
45	Worcester Youth and Family Counseling Services
46	Elkton Middle School-Out of School Program
47	Caroline County DJS
48	Dorchester County DJS
49	Kent County DJS
50	Queen Anne's County DJS
51	Talbot County DJS

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

Map Date Dec. 20, 2013

Southern Region

Table 23. Probation Youth Needs (FY13) and Community-Based Services: Southern Region				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	126 (24%)	400 (76%)	526	30
Average Age	16.1	16.2	16.1	--
Race/Ethnicity				
African American/Black	60%	49%	52%	--
Caucasian/White	34%	45%	43%	--
Hispanic/Latino	4%	5%	4%	--
Other	2%	1%	1%	--
Treatment Needs/Offender Type				
Education	48%	53%	52%	5
Use of Free Time	15%	14%	14%	1
Peer Relationships	83%	79%	80%	6
Family	46%	32%	36%	3
Alcohol & Drug Use	33%	46%	43%	8
Mental Health	30%	32%	32%	5
Anti-Social Attitudes	49%	55%	53%	1
Aggression	62%	54%	56%	1
Sex Offender	1%	4%	3%	2
Fire Setter	3%	2%	2%	0
Girl-Only Programs	--	--	--	3

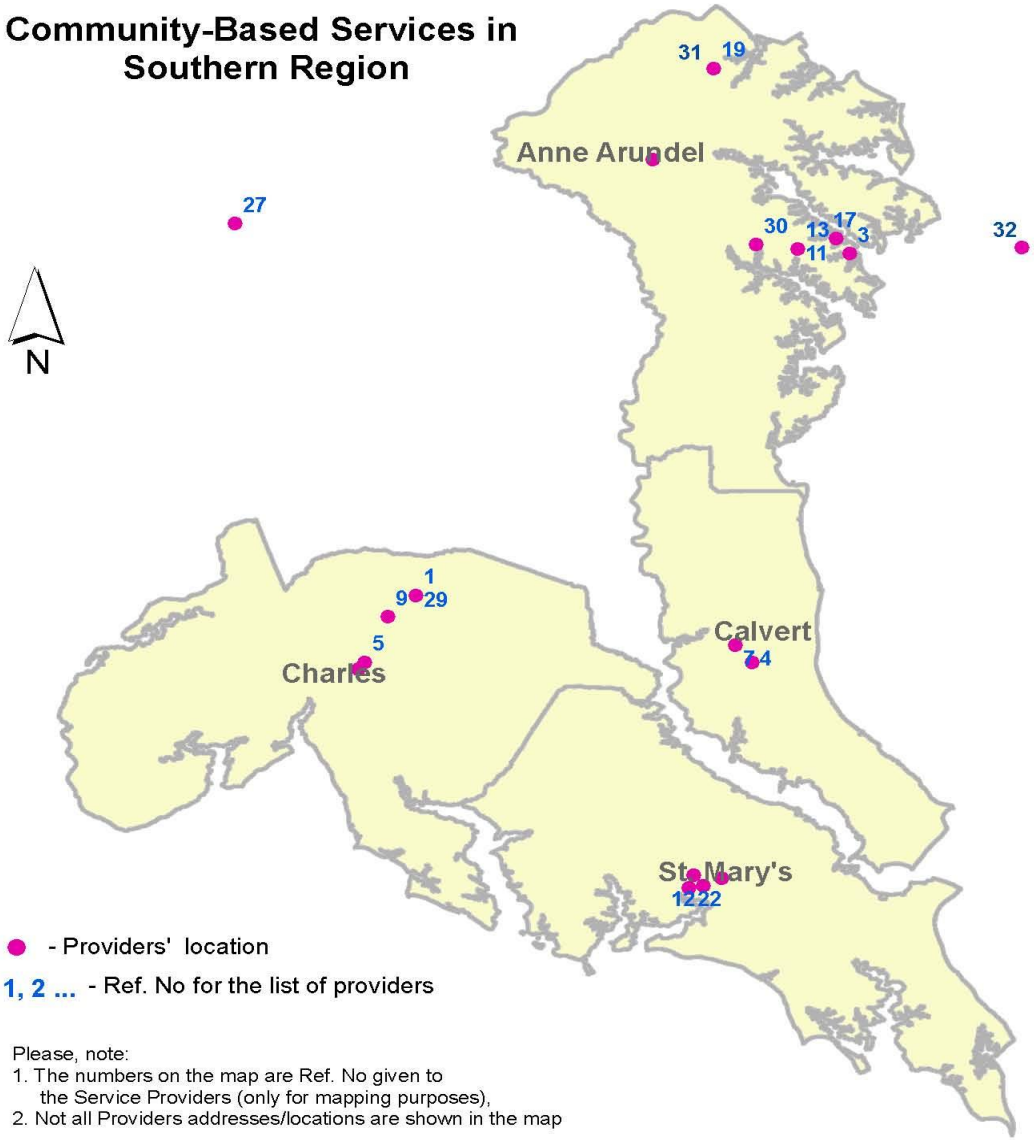
Table 24. Probation Youth Needs (FY13) and Community-Based Services: Anne Arundel County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	61 (23%)	207 (77%)	268	14
Average Age	16.1	16.2	16.2	--
Race/Ethnicity				
African American/Black	56%	50%	52%	--
Caucasian/White	36%	41%	40%	--
Hispanic/Latino	7%	7%	7%	--
Other	2%	2%	2%	--
Treatment Needs/Offender Type				
Education	50%	53%	53%	3
Use of Free Time	24%	22%	23%	1
Peer Relationships	79%	71%	73%	4
Family	38%	30%	32%	3
Alcohol & Drug Use	36%	43%	41%	3
Mental Health	36%	37%	37%	2
Anti-Social Attitudes	53%	57%	56%	1
Aggression	60%	56%	57%	0
Sex Offender	2%	5%	5%	1
Fire Setter	3%	1%	2%	0
Girl-Only Programs	--	--	--	0

Table 25. Probation Youth Needs (FY13) and Community-Based Services: Calvert County				
	Girls	Boys	Total Youth	# Programs
Total	11 (19%)	46 (81%)	57	12
Average Age	16.4	16.0	16.0	--
Race/Ethnicity				
African American/Black	46%	20%	25%	--
Caucasian/White	55%	80%	75%	--
Hispanic/Latino	0%	0%	0%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	55%	52%	53%	2
Use of Free Time	0%	2%	2%	1
Peer Relationships	73%	76%	76%	3
Family	55%	36%	40%	3
Alcohol & Drug Use	36%	50%	47%	1
Mental Health	36%	41%	40%	2
Anti-Social Attitudes	36%	52%	49%	1
Aggression	73%	57%	60%	1
Sex Offender	0%	5%	4%	1
Fire Setter	9%	12%	11%	0
Girl-Only Programs	--	--	--	1

Table 26. Probation Youth Needs (FY13) and Community-Based Services: Charles County				
	Girls	Boys	Total Youth	# Programs
Total	27 (25%)	80 (75%)	107	15
Average Age	15.8	16.3	16.2	--
Race/Ethnicity				
African American/Black	82%	70%	73%	--
Caucasian/White	11%	29%	24%	--
Hispanic/Latino	4%	1%	2%	--
Other	4%	0%	1%	--
Treatment Needs/Offender Type				
Education	41%	58%	53%	2
Use of Free Time	11%	9%	10%	1
Peer Relationships	85%	90%	88%	4
Family	48%	30%	35%	3
Alcohol & Drug Use	26%	53%	46%	2
Mental Health	22%	25%	24%	2
Anti-Social Attitudes	41%	43%	43%	1
Aggression	59%	45%	49%	0
Sex Offender	0%	3%	2%	1
Fire Setter	4%	0%	1%	0
Girl-Only Programs	--	--	--	3

Table 27. Probation Youth Needs (FY13) and Community-Based Services: St. Mary's County				
	Girls	Boys	Total Youth	# Programs
Total	67 (29%)	27 (71%)	94	14
Average Age	16.2	16.1	16.1	--
Race/Ethnicity				
African American/Black	56%	42%	46%	--
Caucasian/White	44%	55%	0%	--
Hispanic/Latino	0%	3%	2%	--
Other	0%	0%	0%	--
Treatment Needs/Offender Type				
Education	48%	45%	46%	2
Use of Free Time	4%	5%	4%	1
Peer Relationships	93%	92%	92%	3
Family	59%	39%	45%	3
Alcohol & Drug Use	33%	45%	41%	2
Mental Health	22%	22%	22%	2
Anti-Social Attitudes	52%	62%	59%	1
Aggression	63%	55%	58%	0
Sex Offender	0%	0%	0%	1
Fire Setter	0%	0%	0%	0
Girl-Only Programs	--	--	--	1

Community-Based Services in Southern Region



Ref No	Provider
1,18, 23,29	Tri-County Youth Service Bureau
2	St. Mary's County Dept. of Social Services
3	Anne Arundel County Dept. of Social Services
4	Calvert County Dept. of Social Services
5	Charles County Dept. of Social Services
6	Anne Arundel County Dept. of Health
7	Calvert County Health Dept.
8	Maryland Choices
9	Charles County Dept. of Health
10	St. Mary's County DJS
11	Anne Arundel County DJS-Annapolis Office
12	Drug Court (St. Marys County)
13	Drug Court (Anne Arundel County)
14	Drug Court (Charles County)
15,20	Center for Children
16	Institute for Family Centered Services
17	Annapolis Police Dept. (JOINS)
19	Anne Arundel Counseling Center
21	DJS-Spotlight On Schools (not shown on map)
22	St. Mary's County Health Dept.
24,25	Charles County DJS
26	Alpha Academy Mentoring Program
27	Boy Scouts of America
28	EMBODI Boys Mentoring and Leadership Program
30	Partnership for Children, Youth and Families
31	Anne Arundel County DJS-Glen Burnie Office
32	Calvert County DJS

Please, note:
1. The numbers on the map are Ref. No given to the Service Providers (only for mapping purposes),
2. Not all Providers addresses/locations are shown in the map

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

Map Date Dec. 17, 2013

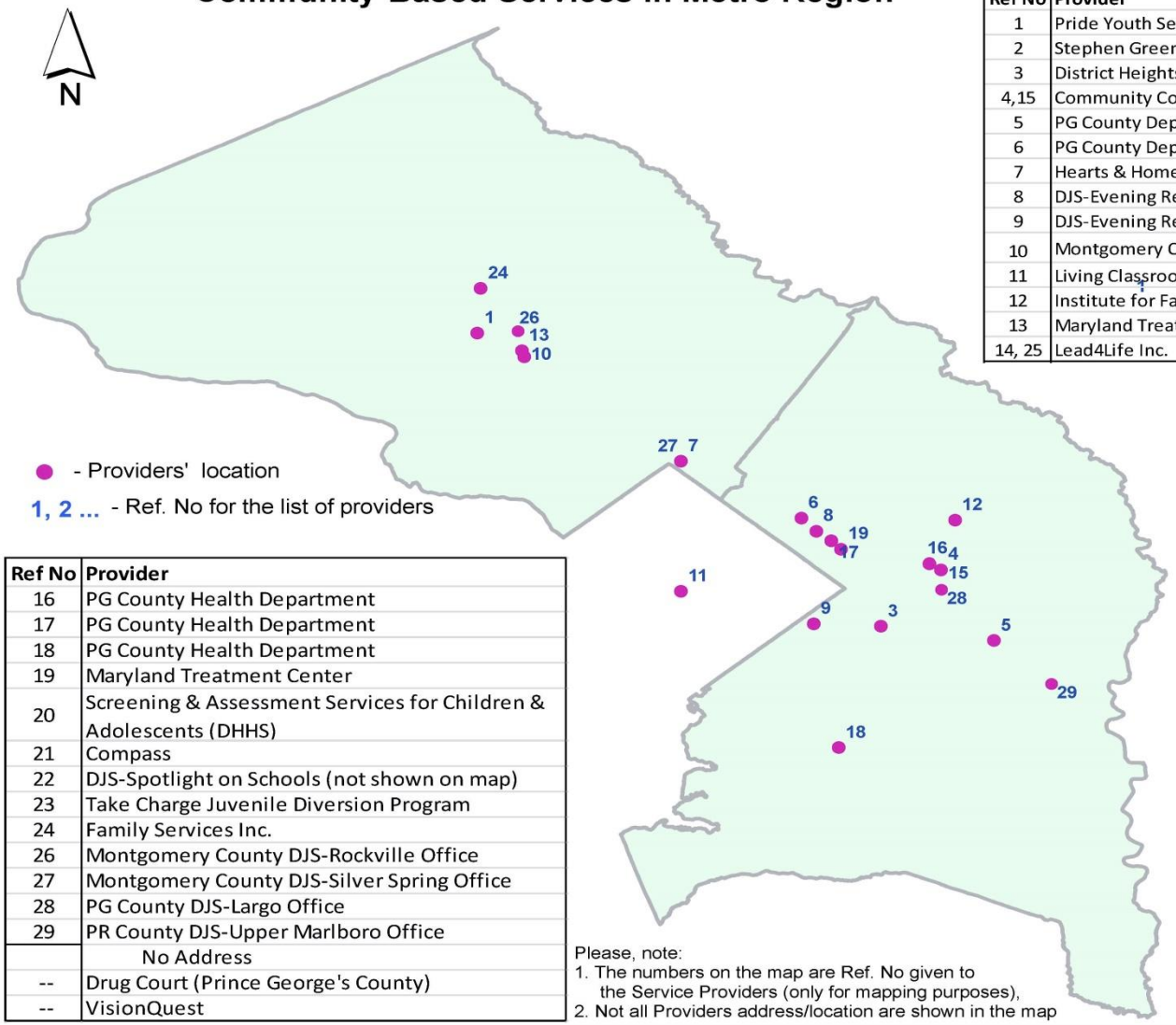
Metro Region

Table 28. Probation Youth Needs (FY13) and Community-Based Services: Metro Region				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	97 (18%)	431 (82%)	528	27
Average Age	16.1	16.3	16.3	--
Race/Ethnicity				
African American/Black	79%	73%	74%	--
Caucasian/White	7%	7%	7%	--
Hispanic/Latino	11%	19%	17%	--
Other	2%	1%	1%	--
Treatment Needs/Offender Type				
Education	55%	50%	51%	6
Use of Free Time	23%	12%	14%	7
Peer Relationships	74%	83%	82%	4
Family	53%	32%	36%	7
Alcohol & Drug Use	47%	43%	44%	6
Mental Health	30%	22%	24%	2
Anti-Social Attitudes	48%	44%	45%	9
Aggression	62%	42%	46%	3
Sex Offender	1%	5%	4%	1
Fire Setter	0%	1%	<1%	0
Girl-Only Programs	--	--	--	1

Table 29. Probation Youth Needs (FY13) and Community-Based Services: Montgomery County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	35 (17%)	170 (83%)	205	14
Average Age	16.4	16.3	16.3	--
Race/Ethnicity				
African American/Black	60%	58%	58%	--
Caucasian/White	14%	12%	12%	--
Hispanic/Latino	20%	29%	27%	--
Other	6%	2%	2%	--
Treatment Needs/Offender Type				
Education	56%	51%	52%	4
Use of Free Time	47%	15%	21%	4
Peer Relationships	82%	85%	85%	4
Family	53%	33%	37%	6
Alcohol & Drug Use	53%	49%	49%	3
Mental Health	29%	28%	28%	1
Anti-Social Attitudes	56%	50%	51%	6
Aggression	74%	51%	55%	2
Sex Offender	3%	7%	7%	1
Fire Setter	0%	1%	1%	0
Girl-Only Programs	--	--	--	1

Table 30. Probation Youth Needs (FY13) and Community-Based Services: Prince George's County				
	Girls	**Boys**	**Total Youth**	**# Programs**
Total	62 (19%)	261 (81%)	323	18
Average Age	15.9	16.4	16.3	--
Race/Ethnicity				
African American/Black	90%	83%	84%	--
Caucasian/White	3%	5%	4%	--
Hispanic/Latino	7%	12%	11%	--
Other	0%	1%	1%	--
Treatment Needs/Offender Type				
Education	55%	49%	50%	4
Use of Free Time	7%	9%	9%	4
Peer Relationships	69%	82%	80%	2
Family	53%	31%	35%	5
Alcohol & Drug Use	44%	40%	40%	2
Mental Health	31%	19%	21%	1
Anti-Social Attitudes	44%	39%	40%	5
Aggression	55%	37%	40%	2
Sex Offender	0%	3%	2%	1
Fire Setter	0%	<1%	<1%	0
Girl-Only Programs	--	--	--	0

Community-Based Services in Metro Region



Ref No	Provider
1	Pride Youth Services
2	Stephen Green Associates
3	District Heights Family & Youth Services Center
4,15	Community Counseling & Mentoring Services
5	PG County Dept of Corrections (Comm. Service Program)
6	PG County Dept of Corrections (Comm. Service Program)
7	Hearts & Homes-Evening Reporting Center
8	DJS-Evening Reporting Center
9	DJS-Evening Reporting Center
10	Montgomery Co. Govt. Family Division
11	Living Classrooms
12	Institute for Family Centered Services
13	Maryland Treatment Center
14, 25	Lead4Life Inc.

Ref No	Provider
16	PG County Health Department
17	PG County Health Department
18	PG County Health Department
19	Maryland Treatment Center
20	Screening & Assessment Services for Children & Adolescents (DHHS)
21	Compass
22	DJS-Spotlight on Schools (not shown on map)
23	Take Charge Juvenile Diversion Program
24	Family Services Inc.
26	Montgomery County DJS-Rockville Office
27	Montgomery County DJS-Silver Spring Office
28	PG County DJS-Largo Office
29	PR County DJS-Upper Marlboro Office
	No Address
--	Drug Court (Prince George's County)
--	VisionQuest

Please, note:
1. The numbers on the map are Ref. No given to the Service Providers (only for mapping purposes),
2. Not all Providers address/location are shown in the map

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

Map Date Dec. 20, 2013

FY2014 State of Maryland Out-of-Home Placement and Family Preservation Resource Plan

Submitted by the

Governor's Office for Children

On behalf of the Children's Cabinet

December 12, 2014

Acknowledgements

The following individuals and agencies provided invaluable assistance with this report:

Department of Health and Mental Hygiene
From the newly named Behavioral Health Administration:
Susan Bradley, Mental Hygiene Administration
Eric English, Mental Hygiene Administration
Ceres Martin, Alcohol and Drug Abuse Administration
Tom Merrick, Mental Hygiene Administration
William Rusinko, Alcohol and Drug Abuse Administration

Department of Human Resources
Debbie Ramelmeier, Social Services Administration
David Ayer, Social Services Administration
Linda Carter, Social Services Administration
Terry Shaw, University of Maryland School of Social Work

Department of Juvenile Services
Michael Ito, Behavioral Health and Victim Services
Michael DiBattista, Fiscal Planning and Management
William Drollinger, Fiscal Planning and Management
John Irvine, Research and Evaluation
Lakshmi Iyengar, Research and Evaluation
Falguni Patel, Research and Evaluation

Governor's Office for Children
Anne Sheridan, Executive Director
Patricia E. Arriaza, Interagency Initiatives
Deborah Donohue, Principal Counsel
Dan Feller, Finance and Operations
Kim Malat, Grant and Contract Administration
Alem Bayou, SCYFIS Database Manager
Christina Church, Interagency Initiatives
Mark Scott, Interagency Initiatives

Maryland State Department of Education
Cynthia Amirault, Division of Special Education/Early Intervention Services
Richard Baker, Division of Business Services
Jeff Miller, Division of Special Education/Early Intervention Services

University of Maryland School of Social Work
Michelle Zabel, Institute for Innovation and Implementation
John Cosgrove, Institute for Innovation and Implementation
Mark Lardner, Institute for Innovation and Implementation

For further information or copies of this report, please visit the Governor's Office for Children's website at www.goc.maryland.gov.

Table of Contents

Introduction & Overview

The State is responsible for linking children in out-of-home care with placements and services that meet their needs. It is imperative that the State conducts ongoing, unified and comprehensive reviews of the placements and services provided to the children placed in its care. The purpose of the Out-of-Home Placement (OOHP) and Family Preservation Resource Plan (Report) is to document the State's capacity for and utilization of out-of-home placements, analyze the costs associated with out-of-home placements, facilitate an evaluation of Statewide family preservation programs, and identify areas of need across Maryland. The Report fulfills the requirement, pursuant to the Maryland Annotated Code, Human Services Article, §8-703, to annually produce a State Resource Plan "in order to enhance access to services provided by RCCPs [(Residential Child Care Programs)]" and the 2014 Joint Chairmen's Report requesting an evaluation of "Maryland's family preservation programs in stemming the flow of children from their homes."

The purpose for the Report is to document what is driving placement decisions in Maryland, identify children's needs in Maryland, and describe how the agencies plan to meet those needs. The Report contains information as reported by the child-serving agencies, including Department of Human Resources (DHR), Department of Health and Mental Hygiene (DHMH), Department of Juvenile Services (DJS) and the Maryland State Department of Education (MSDE). In the Report, these agencies summarize notable details about their out-of-home placements, based on common data elements, and may elaborate on other data presented in the Addendum of each agency's section.

In Maryland, children enter out-of-home care for a variety of reasons and under a number of circumstances. Children may be placed in the care and custody of the State when they are determined to be a Child In Need of Assistance (CINA), a Child In Need of Supervision (CINS), or Delinquent. Children can also enter placement through a Voluntary Placement Agreement (VPA) under which a parent voluntarily places a child in the care of the State. This most often occurs when a child is unable to access funding for needed treatment through any other avenue. The State child-serving agencies and administrations responsible for placing children in out-of-home placements are DHR; DJS; and DHMH, including the Developmental Disabilities Administration (DDA) and the Behavioral Health Administration [which recently combined the former Alcohol and Drug Abuse Administration (ADAA) and Mental Hygiene Administration (MHA)]. Although MSDE funds out-of-home placements made by the Local School Systems (LSS), MSDE is not a placing agency and does not place children out-of-home. Children whose placements are funded by MSDE, either in whole or in part, will be discussed in this Report as well as children placed by other agencies and administrations. These agencies and administrations may fund the placements, or the placements may be funded by Medical Assistance (MA), which is administered through DHMH. Placements may also be co-funded by several State agencies.

Each of these child-placing and funding agencies and administrations operates differently at the local level. DHMH (ADAA and MHA), DHR, and MSDE serve children and families through their

24 local counterparts within each of the State's local jurisdictions - the local Department of Social Services (LDSS), the local Core Service Agencies (CSAs)[1], the local Substance Abuse Councils, and the LSS. DJS and DDA have regional offices, which, in turn, have local offices. For administrative purposes, DJS has six designated regions and DDA has four.

These regions are:

DJS

- Baltimore City
- Central Region (Baltimore, Carroll, Harford, and Howard Counties)
- Metro Region (Montgomery and Prince George's Counties)
- Eastern Shore Region (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties)
- Southern Region (Anne Arundel, Calvert, Charles, and St. Mary's Counties)
- Western Region (Allegany, Frederick, Garrett, and Washington Counties)

DDA

- Central Region (Baltimore City, and Anne Arundel, Baltimore, Harford and Howard Counties)
- Eastern Shore Region (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties)
- Southern Region (Calvert, Charles, St. Mary's, Montgomery, and Prince George's Counties)
- Western Region (Allegany, Carroll, Frederick, Garrett, and Washington Counties)

Data Collection Methodology, Definitions, and Considerations

The data in this Report is aggregate data submitted by each agency for the fiscal years, and the one-day census for each fiscal year. Each agency was given a data request guide along with data collection templates for data reporting and clarification of the information request. GOC also worked individually with each agency to ensure a thorough understanding of reporting requirements and identification of each agency's unique placement process and data collection methods.

[1] One Core Service Agency located on the Eastern Shore serves five local jurisdictions.

Methodology

Each child-serving agency was requested to provide aggregate data using specific templates for children in placement and associated costs for the last three fiscal years. The following information describes the parameters of the requested data:

Reporting Period

This Report features tables and graphs derived from two data sources – "full fiscal year" data and "one-day census" data. This Report differentiates tables using fiscal year data with a shaded background, and graphs using the one-day census with a white, or blank, background.

These are the definitions for each data reporting period:

- *"Full Fiscal Year"* - All placements during the fiscal year including carryover placements from the prior fiscal year(s). The fiscal year periods are as follows:

FY2010: July 1, 2009 through June 30, 2010
FY2011: July 1, 2010 through June 30, 2011
FY2012: July 1, 2011 through June 30, 2012
FY2013: July 1, 2012 through June 30, 2013
FY2014: July 1, 2013 through June 30, 2014

- *"One-Day Census"* - The one-day count date used for each fiscal year is as follows:

FY2010: January 31, 2010
FY2011: January 31, 2011
FY2012: January 31, 2012
FY2013: January 31, 2013
FY2014: January 31, 2014

Age Group

This Report classifies placement for children through their 21st birthday (*i.e.*, to age 20.999) as of the date of admission for new placements, and as of July 1st of the fiscal year for carryover placements. There are two exceptions to this construct: placements that are funded by MSDE include children who are served through the academic year of their 21st birthday, and ADAA placements that end at the child's 18th birthday when they are transitioned to the adult system.

Race

Any child who is characterized in case records as identifying with more than one race is included in the "Bi-Racial/Multiple Race" category. Children who identify as Hispanic are included in the "Other" category if they did not identify as any race but identified as being Hispanic in ethnicity.

Definitions

- *"Bed-Day"* - A unit of measurement that refers to a single day in which one child is provided placement in any out-of-home placement.
- *"Children/Youth"* - The term "youth" is used interchangeably with the term "child" but is often used to describe older adolescents or individuals age 18 or older, and is typically used by agencies that primarily serve these populations. A child is anyone under age 18, but most agencies will serve individuals until their 21st birthday.
- *"One-Day Census"* - The measurement of total population on one day out of the year. January 31st is consistently used because it is about halfway through the State fiscal year. This measurement is used to gauge the total serving capacity of placements on a comparable, specific, single day.
- *"Population Flow"* - The total number of placements at the start of the fiscal year, new admissions within the fiscal year, discharges within the fiscal year, and placements at the end of the fiscal year.
- *"Rate of New Placement Settings"* - The rate of new admissions into a category of out-of-home placement per 1,000 children (aged 0 to 18) within a given geographic population.
- *"Total Served"* – The number of placements at the start of the fiscal year in addition to the number of new placements added during the fiscal year. The placements are counted, and not the number of children, because one child can be placed in more than one category, jurisdiction, or agency in one year. The "total served" encompasses children who may have been placed since the previous year, or before.

Considerations

The FY2014 Report uses a variety of measurements to capture placement dynamics among diverse services, agencies, and jurisdictions. Among those measurements are cost per bed-day, one-day census, population flow, and rate of entry per jurisdiction. These measurements provide a uniform method, based on substantive information, for comparing diverse placements and agencies. Where the data serves as only a partial representation of placement dynamics, or if a particular agency does not calculate data as prescribed by the measurement, the authors of this Report have endeavored to supplement the data and tables with additional information.

Other considerations should be noted as follows:

- **Cost per Bed-Day:** Not all agencies calculate bed-days.
- **One-Day Census:** The totals are derived from a count of all children in placement on one day of the year. This is not the total number of children served in placement during the course of the year. This number is a snapshot in time that demonstrates how many children may be in placement at any given time.

- **Population Flow:** The population flow reflects changes in placements throughout the year. A change is considered to be a discharge or enrollment of any child in a new placement category (*e.g.*, from family home setting to community-based placement), a new jurisdiction (*e.g.*, a transfer from one county to another), or a new placing agency (*e.g.*, a change in custodial responsibility). The population flow counts *placements*, and not *children*, because one child can be placed in more than one category, jurisdiction, or agency in one year. A child may enter a new placement more than once in one year for a number of reasons, including because the child needs to be placed in a more restrictive placement for his or her needs, or because the child has progressed in meeting treatment goals and can be moved to a less restrictive environment. Placement numbers coming from population flow will be higher than the number of children who are actually placed.
- **Rate of New Placement Settings per Jurisdiction:** This shows the trend of children being placed within a jurisdiction. For jurisdictions in which few children are placed each year, the difference of one or two children being placed can exaggerate changes in the trend. The rate of new placement settings comes from the number of new placements (or starts) during the fiscal year, so this number counts placements and not children (see "Population Flow" above).
- **DJS Out-of-Home Placement Information:** The data reported includes only youth who are placed in either in-State or out-of-State committed programs. All committed youth are adjudicated delinquent and committed to the custody of DJS by the juvenile court. A continuum of out-of-home placement options is available for these youth, ranging from placement in a foster care setting to placement in a secure confinement facility. The cost data reported under each section also reflects only youth in committed placements. "Non-committed" DJS youth, who are not adjudicated delinquent or placed by the juvenile court, are not represented in the placement totals and placement costs in this Report.
- **DJS Hospitalization Costs:** When a DJS-committed child is admitted to a psychiatric hospital, DJS pays only the educational portion of the costs, and other entities, such as Medical Assistance or private insurance, pay the remaining costs. This Report includes only educational costs, rather than the total costs.[2]
- **Residential Treatment Center Placements:** These placements are reported by DJS and included in the MHA Residential Treatment Center placements. Because the population flow totals cannot be disaggregated, some placements may be double-counted within the Residential Treatment Center category.
- **MHA Cost Data:** MHA services that are billed through Medicaid can be processed up to one year following the provision of the service, which is the time when MHA receives notice of an expenditure. Costs that were incurred by MHA from the previous fiscal year but that are billed in the current fiscal year are reconciled in the

[2] Prior to 2013, this Report included total costs.

following year. Because of this, current fiscal year costs may be slightly understated and prior fiscal year costs may be higher than reported in the previous year.

- **DHR Cost Data:** Services that DHR bills through Medicaid for its placements are not reflected in the DHR cost tables and primarily include Residential Treatment Center placements. Instead, these costs appear in the MHA section. Additionally, DHR costs are reported by main placement category, but not by placement subcategory (see descriptions below).
- **Unknown and Not Available Placements:** An "Unknown" or "Not Available" placement category is used to describe children who have run away or who cannot be identified in a placement category because an agency's records have not been updated. Differences among the placement subcategories are further explained in each of the placement category descriptions.

Report Overview

This OOHP Report is presented by the Children's Cabinet. The Children's Cabinet coordinates the child and family focused service delivery system by emphasizing prevention, early intervention, and community-based services for all children and families. The Children's Cabinet includes the Secretaries from the Departments of Budget and Management, Disabilities, Health and Mental Hygiene, Human Resources, and Juvenile Services, as well as the State Superintendent of Schools for the Maryland State Department of Education. The Executive Director of the Governor's Office for Children chairs the Children's Cabinet.

The FY2014 Report includes a Statewide summary of all out-of-home placements, five-year trend analyses and recommendations for out-of-home placements by the State agencies that place children or fund children's placements, a description of placements at Maryland's School for the Blind and School for the Deaf, and a discussion of Family Preservation Services.

The Children's Cabinet's objective for the Report is to provide an accurate and precise analysis of each agency's placement trends and future resource development priorities. The Children's Cabinet continues to strengthen, develop, and adopt strategies to serve children in their homes and communities. This Report supports a more comprehensive understanding of the needs of children who require out-of-home placement. The Children's Cabinet agencies seek to improve the tracking and monitoring of placements, and identify meaningful ways to measure progress. These efforts assist the State and local jurisdictions in the planning of effective services and utilizing funding in the most effective and efficient manner.

Placement Categories

There are four categories of out-of-home placement for children in the State of Maryland. These categories fall on a continuum, beginning with the least restrictive setting (Family Home) and moving toward more highly-structured and treatment-oriented setting (Hospitalization).

Family Home	Non-Community-Based
Adoptive Care	Diagnostic Evaluation Treatment Programs
Foster Care	Non-Secure/Non-Residential Treatment Center
Formal Relative (Kinship) Care	Residential Educational Facilities
Restricted Relative (Kinship) Care	Residential Treatment Centers
Treatment Foster Care	Substance Abuse and Addiction Programs
Living-Arrangement – Family Home	Living Arrangement – Non-Community-Based
Community-Based	**Hospitalization**
Independent Living Programs	
Residential Child Care Programs	In-Patient Private
Community Supported Living Arrangement	Psychiatric Hospitalization
Living Arrangement – Community-Based	

Table 1

While there is a range of out-of-home placement types, only DHR and DJS place children in all the placement categories. DHMH and its administrations (MHA, DDA, and ADAA) place children in only one category each. MSDE only funds placements and does not directly place children. Table 2 illustrates overlaps among agencies in placement subcategories, and the subcategories specific to a particular agency.

State Agency Placement Categories: Placement Totals on 1/31/2014																			
	Family Home Placement						Community-Based Placement				Non-Community-Based Placement							Hospitalization Placement	
Placing Agency	Adoptive Care	Foster Care	Formal Relative (Kinship) Care	Restricted Relative (Kinship) Care	Treatment Foster Care	Living Arrangement - Family Home	Independent Living Programs	Residential Child Care Program	Community Supported Living Arrangement	Living Arrangement - Community-Based	Diagnostic Evaluation Treatment Program	Juvenile Detention and Commitment Centers	Non-Secure/Non-RTC	Residential Educational Facilities	Residential Treatment Centers	Substance Abuse and Addiction Programs	Living Arrangement - Non-Community Based	In-Patient Private	Psychiatric Hospitalization
DHR	32	1128	761	326	1541	236	188	611		43					183		89	9	8
DJS		4			86		13	221			24	159	41		141	184			8
MSDE														47					
MHA															418				
DDA								17	68										
ADAA																196			

Table 2

Organization of the Report

Out-of Home Placement Summaries

The out-of-home placement portion of the FY2014 Report consists of summaries from each of the child-placing and funding agencies, as well as a Statewide summary of all placements in Maryland. Each section utilizes the same data metrics to aid comparison between the varying populations served by the agencies, organized under the following headings:

Summary

An overview of the number of children in placement during each year's one-day census and the total number of placements at the beginning of the fiscal year, in addition to the number of placements added during the fiscal year, the population flow during the last five fiscal years, rate of placement by jurisdiction based on one-day census data, total costs, and costs per bed-day.

Recommendations

The agency's or administration's strategies to: address gaps in services, serve children in their home jurisdictions whenever possible, and reduce the length of stay in out-of-home placement programs while increasing the rates of positive discharges to less-restrictive settings or permanent homes.

Addendum

This section includes data on the demographics of children in placement (age, gender, race), out-of-State placement trends, as well as out-of-State demographics for agencies with 10 or more out-of-State placements. The section also includes placement subcategory total costs and costs per bed-day for agencies with more than one placement category (DHR and DJS).

Maryland School for the Deaf and Blind

A brief description of the number of students enrolled and costs (residential and educational) associated with the two schools.

Family Preservation Services

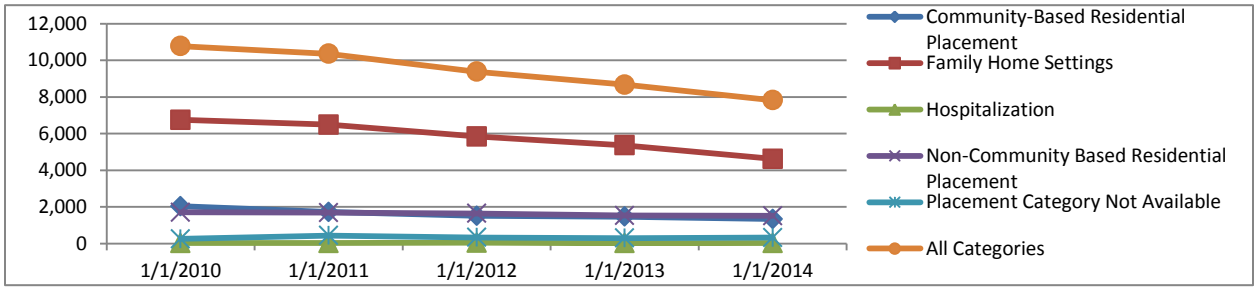
A summary of the outcomes achieved by families participating in Family Preservation Services to prevent the out-of-home placement of children involved with the services.

Appendix: Placement by Jurisdiction

The number of children from each jurisdiction in Maryland who were in out-of-home placements on January 31, 2014 and where they were placed, by out-of-home placement subcategory.

Statewide Summary

The Maryland regulations addressing DHR's out-of-home placement program (COMAR 07.02.11) set forth the requirements of the program to reduce the rate at which children enter and re-enter out-of-home placements; reduce the median length of stay in out-of-home placements; minimize the number of placement changes within 24 months of entering out-of-home placements; increase the percentage of reunifications, guardianships, and adoptions; and decrease the number of children in out-of-home placements.

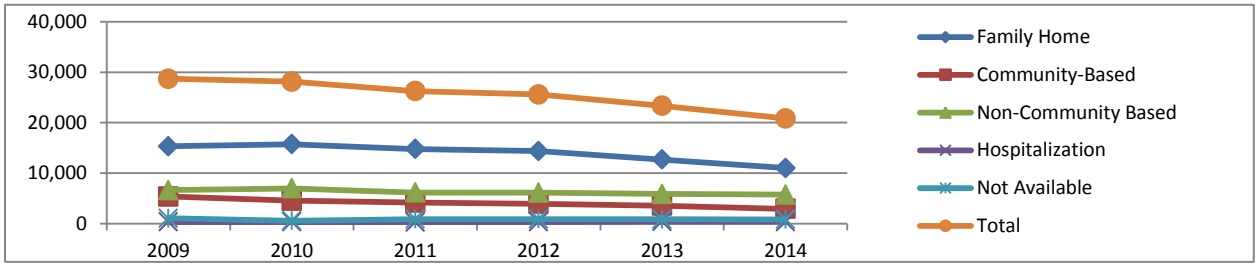


Statewide Placement Trends								
Category	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Community-Based Residential Placement	2,035	1,718	1,514	1,465	1,335	1,161	-10.5%	-13.0%
Family Home Settings	6,755	6,490	5,840	5,359	4,619	4,114	-9.4%	-10.9%
Hospitalization	29	31	43	18	31	25	8.1%	-19.4%
Non-Community Based Residential Placement	1,704	1,686	1,646	1,531	1,514	1,482	-2.7%	-2.1%
Placement Category Not Available	251	435	336	302	324	322	9.4%	-0.6%
All Categories	10,774	10,360	9,379	8,675	7,823	7,104	-8.0%	-9.2%

Table 3

The number of children in out-of-home placements has been steadily decreasing since FY2009. In the last fiscal year, the number decreased by 719.[3] The most significant decrease has been in the Community-Based Placement category, with a decrease of 17.9% from last fiscal year. It is estimated that nearly 8,000 Maryland children are in out-of-home placements on any given day.

[3]The number of non-community-based residential placements is higher than actual placements because DJS Residential Treatment Center placements (included in the number of non-community-based residential placements) are reported by both DJS and MHA. DJS Residential Treatment Center placements are included in Table 60. The numbers are unchanged in Table 3 to ensure consistency between the data based on the Statewide one-day census totals, which are not disaggregated by placement subcategory.



All Agencies Total Served								
Category	2009	2010	2011	2012	2013	2014	Average Change	Last Year Change
Family Home	15,306	15,720	14,772	14,351	12,682	11,015	-6.2%	-13.1%
Community-Based	5,370	4,544	4,161	3,935	3,563	2,925	-11.3%	-17.9%
Non-Community Based	6,637	6,992	6,154	6,115	5,865	5,737	-2.7%	-2.2%
Hospitalization	326	307	292	306	393	337	1.7%	-14.2%
Not Available	1,057	572	887	877	850	832	0.6%	-2.1%
Total	28,696	28,135	26,266	25,584	23,353	20,846	-6.1%	-10.7%

Table 4

The total number of out-of-home placements each fiscal year has decreased, as well, by more than 8,000 in the last five fiscal years. As shown in Table 4, the number of Total Served comes from the number of children in out-of-home placements at the start of the fiscal year and all the new out-of-home placements added until the end of the fiscal year.

All Agencies Placement Population Flow (Placements, Not Children)					
State Fiscal Year	Placements at Start of FY	Starts in FY (New Placements)	Total Served	Ends in FT (Placement Exits)	Placements at End of FY
2010	10,499	17,636	28,135	17,972	10,163
2011	9,635	16,631	26,266	16,871	9,395
2012	9,060	16,524	25,284	17,170	8,414
2013	8,278	15,075	23,353	15,747	7,606
2014	7,337	12,983	20,320	13,562	6,758
Three-Year Change	-23.9%	-21.9%	-22.6%	-19.6%	-28.1%
Average Yearly Change	-8.5%	-6.7%	-7.8%	-6.1%	-9.7%
Recent Year Change	-11.4%	-13.9%	-13.0%	-13.9%	-11.1%

Table 5

The rate of new out-of-home placement has also decreased (Table 6). FY2014 had a less than average rate of new out-of-home placement in the last four fiscal years, with 9.8 per 1,000 in the population of children in Maryland. Fluctuations in the rates can be common in jurisdictions with low populations, but many jurisdictions had significant decreases. New out-of-home placement indicates children initially being placed or being moved from one placement to another. Placement moves may occur when a child is in need of more intensive services or when a child has met placement goals and enters a less restrictive setting.

All Agencies Rate of New Placement Setting By Jurisdiction								
Jurisdiction	2010	2011	2012	2013	2014	Three Year Change	Average Change	Last Year Change
Allegany	13.9	14.3	17.6	19.7	17.4	22%	7%	-12%
Anne Arundel	5.5	4.8	6.1	6.5	5.6	17%	2%	-14%
Baltimore	10.3	9.1	9.2	8.5	7.3	-20%	-8%	-14%
Baltimore City	44.7	42.7	50.7	43	36.4	-15%	-4%	-15%
Calvert	9.0	9.5	8.5	10.5	9.1	-4%	1%	-13%
Caroline	12.7	14.0	13.1	10.1	11.4	-19%	-2%	13%
Carroll	5.3	6.2	7.6	6.4	5.5	-11%	2%	-14%
Cecil	13.0	13.2	15.3	16.1	17.9	36%	8%	11%
Charles	8.1	7.6	7.8	7.4	7.8	3%	-1%	5%
Dorchester	19.5	12.1	11.9	17	11.2	-7%	-8%	-34%
Frederick	8.4	6.9	8.1	7.3	6.3	-9%	-6%	-14%
Garrett	22.0	15.1	24.8	21.1	17.1	13%	0%	-19%
Harford	8.1	8.1	9.8	9.3	9.2	14%	4%	-1%
Howard	2.9	2.9	2.9	3	2.9	0%	0%	-3%
Kent	11.3	9.5	7.7	6.7	8.1	-15%	-7%	21%
Montgomery	5.6	5.1	4.9	4.9	4.2	-18%	-7%	-14%
Prince George's	5.9	5.7	6.9	6.9	6.3	11%	2%	-9%
Queen Anne's	8.5	6.6	7.6	7.6	2.8	-58%	-18%	-63%
Somerset	17.1	14.7	24.3	19.4	18.2	24%	6%	-6%
St. Mary's	8.2	11.5	10.2	8.3	9.1	-21%	5%	10%
Talbot	9.8	11.3	13.7	9.5	7.3	-35%	-4%	-23%
Washington	13.1	13.6	15.1	13	11.1	-18%	-3%	-15%
Wicomico	10.6	10.6	11.8	11.3	10.2	-4%	-1%	-10%
Worcester	14.8	12.3	10.4	8.7	10.5	-15%	-7%	21%
Total	11.6	11.0	12.3	11.2	9.9	-10%	-3%	-12%

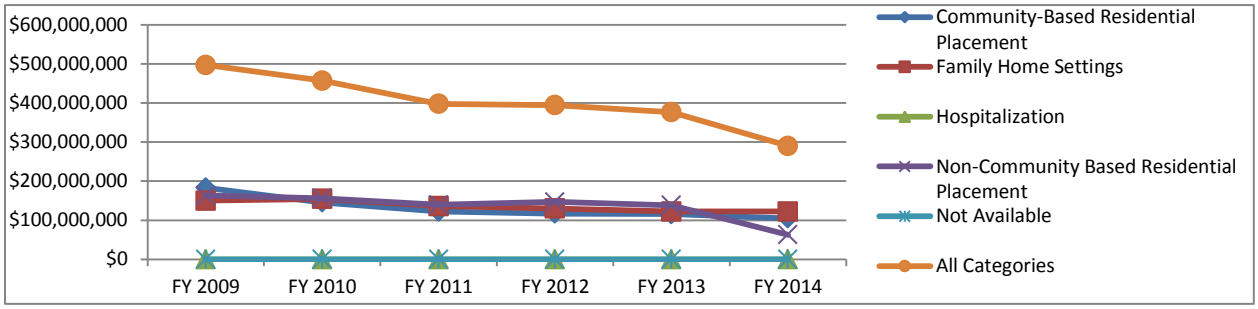
Table 6

Another of Maryland's goals for out-of-home placement is for children to remain close to their homes so they can preserve their family, social, educational, and cultural connections during the period of out-of-home placement. This is not always possible due to the unavailability of resources to suit the child's needs in that jurisdiction or because Kinship and Family Foster Care is available away from the child's home. At least half of the children in out-of-home placement in 10 of Maryland's 24 jurisdictions were placed in their home jurisdiction. Of all the children placed in Maryland, Baltimore City is the location for 36.4% of out-of-home placements, followed by Somerset County with 18.2% of all out-of-home placements in Maryland.

Statewide Placement By Jurisdiction																													
	Jurisdiction Where Children Were Placed																												
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worcester	Out-of-State	Unknown
Allegany	114	1.6%	77	0	2	7	0	0	0	1	0	1	7	6	1	0	0	0	1	0	0	0	0	3	0	0	6	2
Anne Arundel	326	4.6%	19	96	41	48	2	2	13	0	3	8	13	9	4	2	1	11	11	1	2	0	0	12	2	0	22	4
Baltimore	737	10.4%	15	7	387	156	0	3	18	6	0	7	12	13	19	7	1	10	12	0	0	1	0	12	1	0	25	25
Baltimore City	2784	39.3%	12	53	984	1261	2	4	40	1	5	8	26	12	47	26	2	28	75	1	4	0	0	17	6	0	83	87
Calvert	115	1.6%	3	6	13	2	43	2	3	0	11	3	2	5	0	1	0	0	4	1	0	4	0	4	2	0	4	2
Caroline	40	0.6%	1	1	6	0	0	10	0	0	0	5	0	0	0	0	0	0	0	1	0	0	4	0	6	0	4	2
Carroll	88	1.2%	7	0	18	6	0	0	39	0	0	0	5	2	0	1	2	0	0	0	0	0	0	6	0	0	2	0
Cecil	193	2.7%	4	2	27	16	0	3	0	112	0	5	2	1	8	0	2	1	0	0	0	0	0	1	1	0	3	5
Charles	136	1.9%	2	0	12	5	1	1	1	0	80	3	2	3	0	0	1	4	7	0	0	3	0	2	0	0	3	6
Dorchester	54	0.8%	0	0	8	8	0	1	2	0	0	21	2	0	0	0	2	0	0	0	0	0	2	1	1	1	5	0
Frederick	182	2.6%	5	1	19	13	0	2	4	2	0	0	92	0	2	5	0	10	3	0	0	0	0	15	1	0	6	2
Garrett	47	0.7%	4	0	0	3	0	0	0	0	0	0	2	25	0	0	0	0	0	0	0	0	0	6	1	0	2	4
Harford	300	4.2%	6	2	64	20	0	4	5	9	0	4	4	2	140	1	3	6	2	1	0	0	0	7	0	0	11	9
Howard	90	1.3%	2	4	28	17	1	0	0	1	0	0	3	1	0	22	0	2	3	0	0	0	0	2	0	0	4	0
Kent	22	0.3%	3	0	7	1	0	5	0	1	0	0	1	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0
Montgomery	549	7.7%	16	9	47	28	0	5	4	6	2	4	18	4	4	4	1	313	35	0	0	0	0	17	1	0	22	9
Prince George's	738	10.4%	28	11	81	42	8	1	20	4	13	11	25	20	1	15	7	27	335	1	2	0	1	14	4	0	52	15
Queen Anne's	12	0.2%	0	0	1	0	0	4	0	0	0	0	0	0	0	0	0	0	1	4	0	0	0	0	0	0	2	0
Somerset	40	0.6%	2	1	3	1	0	1	0	0	0	5	0	0	0	0	0	2	2	0	11	0	0	0	10	0	2	0
St. Mary's	110	1.6%	3	1	13	4	2	0	1	0	12	1	1	1	2	2	0	1	8	1	1	45	0	1	2	0	6	2
Talbot	38	0.5%	0	0	1	0	0	7	0	0	0	10	5	0	0	0	0	0	0	0	0	0	11	0	3	0	0	1
Washington	191	2.7%	10	0	23	12	0	0	4	0	0	1	7	1	1	0	0	3	3	0	0	0	0	117	0	0	6	3
Wicomico	110	1.6%	6	0	25	10	0	2	2	0	0	13	1	3	0	0	2	6	1	0	0	0	0	0	32	0	7	0
Worchester	28	0.4%	0	0	4	0	0	1	1	0	0	1	0	3	0	0	0	0	0	0	3	0	0	0	12	1	1	1
Out-of-State	48	0.7%	1	0	14	3	1	0	2	0	0	3	2	0	0	0	0	4	0	0	0	0	0	0	2	1	15	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	7092	100.0	226	194	1828	1663	60	58	159	143	126	114	232	111	229	86	28	428	503	11	23	53	18	237	87	3	293	179
% of children from jurisdiction			67.5%	29.4%	52.5%	45.3%	37.4%	25.0%	44.3%	58.0%	58.8%	38.9%	50.5%	53.2%	46.7%	24.4%	18.2%	57.0%	45.4%	33.3%	27.5%	40.9%	28.9%	61.3%	29.1%	3.6%	31.3%	0.0%
% children Statewide in all			3.2%	2.7%	25.8%	23.4%	0.8%	0.8%	2.2%	2.0%	1.8%	1.6%	3.3%	1.6%	3.2%	1.2%	0.4%	6.0%	7.1%	0.2%	0.3%	0.7%	0.3%	3.3%	1.2%	0.0%	4.1%	2.5%

Table 7

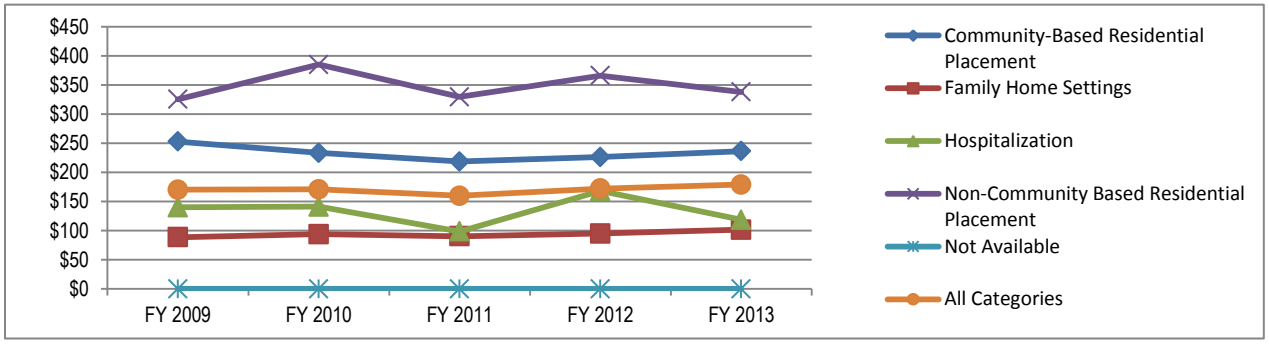
Costs



Statewide Total Costs								
Category	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Community-Based Residential Placement	$183,469,850	$145,760,440	$122,210,854	$117,152,599	$115,749,751	$104,784,520	-10.3%	-9.5%
Family Home Settings	$150,052,028	$154,528,388	$136,152,905	$130,233,996	$122,415,468	$122,192,288	-3.9%	-0.2%
Hospitalization	$110,292	$97,064	$28,977	$14,946	$41,220	$2,082	-9.9%	-94.9%
Non-Community Based Residential Placement	$163,382,867	$156,486,635	$139,430,318	$147,085,835	$138,213,891	$63,113,560	-14.0%	-54.3%
All Categories	$497,015,037	$456,872,528	$397,823,054	$394,487,375	$376,420,330	$290,092,450	-9.9%	-22.9%

Table 8

Placement costs have been driven down each year since FY2009, with a total reduction of more than $205 million since that time. This is mostly due to the decrease in the number of children entering out-of-home placements.



Statewide Costs Per Bed Day								
Category	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Community-Based Residential Placement	$253	$233	$219	$226	$236	$297	3.9%	25.6%
Family Home Settings	$89	$94	$90	$95	$102	$165	15.3%	62.5%
Hospitalization	$140	$141	$99	$168	$118	<$1	NA	NA
Non-Community Based Residential Placement	$325	$385	$329	$366	$338	$340	1.6%	0.6%
All Categories	$170	$171	$160	$172	$179	$227	6.5%	26.9%

Table 9

Statewide Recommendations

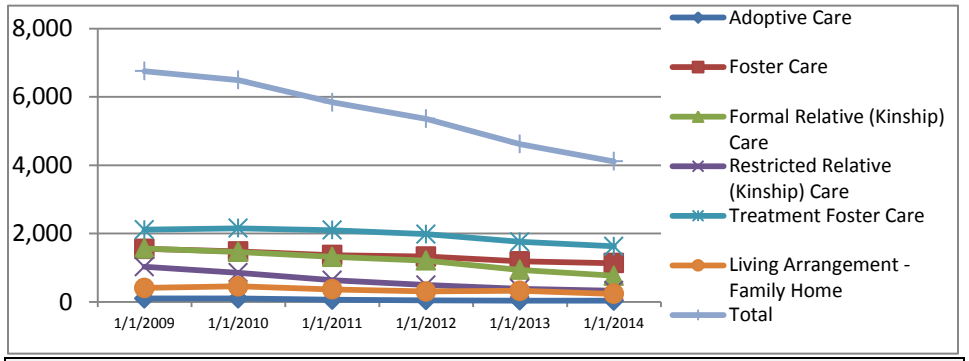
Maryland's State child and family-serving agencies provide a continuum of care to meet an array of needs along a wide spectrum. The purpose of the State Resource Plan is to ensure that the State is doing the best it can to build a multifaceted network that can strengthen the lives of every child in need in Maryland. In the remainder of this Report, State agencies will describe the means by which they meet children's needs and the challenges they face in helping them. The following is a summary of the State agencies' recommendations to improve the efficiency and effectiveness of the State network. Please note that the Interagency Strategic Plan[4] may also be consulted as a resource for in-depth discussion of issues surrounding out of home placement and for further recommendations:

Agency	Recommendations
DHR	• Expand intensive family preservation and post-permanency services. • Create a trauma-informed system that uses standardized assessments to identify services and supports for children and families to prevent out-of-home care and re-entries into out-of-home care as well as to improve well-being. • Support programs such as *Family Connections, Homebuilders, SafeCare, and Functional Family Therapy* to promote family preservation - multi-faceted, community-based programs that work with families experiencing difficulty in meeting the basic needs of their children and at-risk for child emotional and/or physical neglect.
DJS	• Maintain the Continuum of Care statute to ensure that DJS continues to have the ability to quickly move youth as necessary from committed placements that are not working out, without need for further court action. • Support DJS capital projects to ensure that sufficient in-State secure slots are available for high-risk committed youth.
DDA	• Identify youth early before they age out of support systems and transition planning. • Continue to work with other administrations and community resources to allow children to remain in their homes.
MSDE	• Continue working with Maryland providers of services to children with autism through the Autism Waiver. • Continue to support local schools systems to enhance services and supports for students to remain in their community schools. • Support cross-agency collaboration to ensure the development of community-based and residential programs to meet the needs of students typically placed out-of-State and to facilitate the return of these students to Maryland programs and schools.
MHA	Continue efforts to minimize out-of-State placements through the implementation of a 1915(i) Medicaid State Plan amendment providing intensive wraparound services. The feasibility of in-State Residential Treatment Centers offering specialized services such as treatment for fire-setting and sexually offensive behavior should continue to be assessed.

[4]The Interagency Strategic Plan is a collaborative effort by the Maryland Children's Cabinet in partnership with families, communities, and providers to improve the child-family serving delivery system to better anticipate and respond to the needs of youth and families. For more information about the ISP, please visit www.mdchildrenscabinetisp.org.

STATEWIDE Addendum

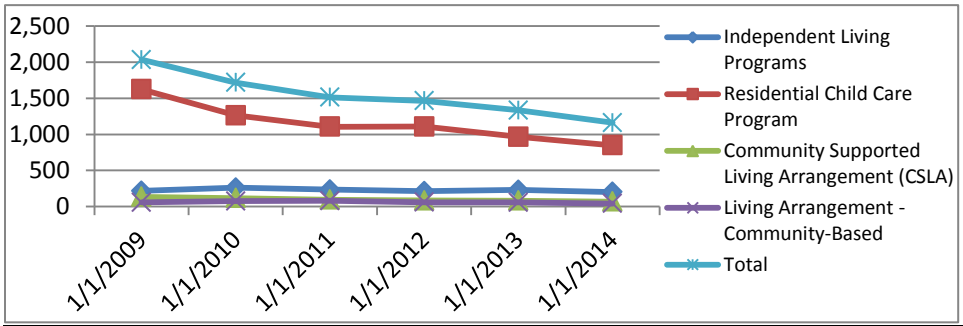
Maryland State Placement Trends by Category



Statewide Family Home Settings Placement Trends

Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Adoptive Care	100	98	60	47	37	32	-19.4%	-13.5%
Foster Care	1,552	1,473	1,365	1,327	1,185	1,132	-6.1%	-4.5%
Formal Relative (Kinship) Care	1,558	1,460	1,316	1,207	936	761	-13.1%	-18.7%
Restricted Relative (Kinship) Care	1,027	854	634	491	382	326	-20.4%	-14.7%
Treatment Foster Care	2,112	2,152	2,100	1,981	1,757	1,627	-5.0%	-7.4%
Living Arrangement - Family Home	406	453	365	306	322	236	-9.1%	-26.7%
Total	6,755	6,490	5,840	5,359	4,619	4,114	-9.4%	-10.9%

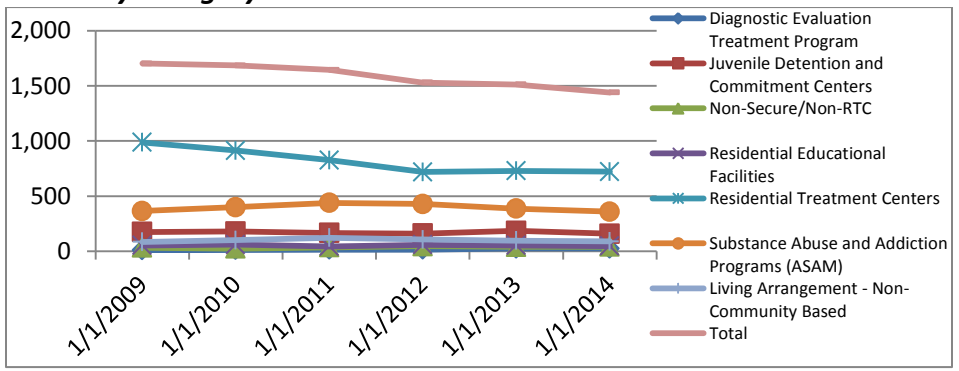
Table 10



Statewide Community-Based Placement Trends

Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Independent Living Programs	217	261	234	213	230	201	-0.7%	-12.6%
Residential Child Care Program	1,625	1,264	1,105	1,108	966	849	-11.9%	-12.1%
Community Supported Living Arrangement (CSLA)	135	117	96	84	81	68	-12.7%	-16.0%
Living Arrangement - Community-Based	58	76	79	60	58	43	-3.7%	-25.9%
Total	2,035	1,718	1,514	1,465	1,335	1,161	-10.5%	-13.0%

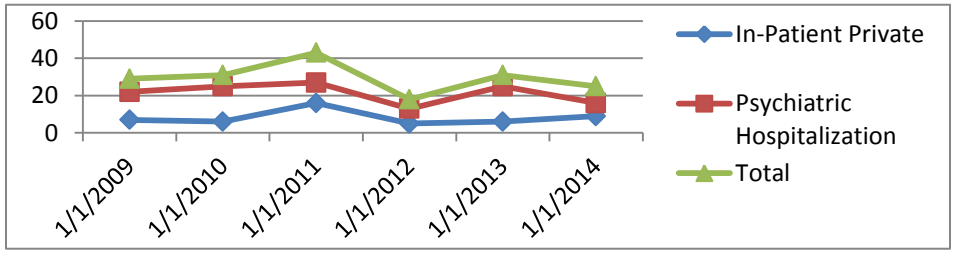
Table 11



Statewide Non-Community-Based Settings Placement Trends

Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	9	12	15	14	25	24	25.2%	-4.0%
Juvenile Detention and Commitment Centers	174	178	166	160	185	159	-1.3%	-14.1%
Non-Secure/Non-RTC	32	23	35	45	39	41	8.9%	5.1%
Residential Educational Facilities	52	59	44	58	53	47	0.0%	-11.3%
Residential Treatment Centers	988	914	826	719	729	722	-5.9%	-1.0%
Substance Abuse and Addiction Programs (ASAM)	365	400	438	429	387	359	0.0%	-7.2%
Living Arrangement - Non-Community Based	84	100	122	106	96	89	2.2%	-7.3%
Total	1,704	1,686	1,646	1,531	1,514	1,441	-3.3%	-4.8%

Table 12



Statewide Hospitalization Trends

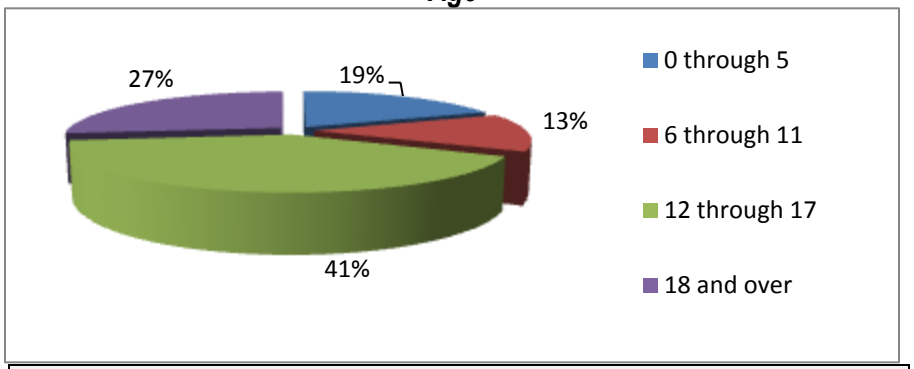
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
In-Patient Private	7	6	16	5	6	9	30.7%	50.0%
Psychiatric Hospitalization	22	25	27	13	25	16	5.2%	-36.0%
Total	29	31	43	18	31	25	8.1%	-19.4%

Table 13

STATEWIDE Addendum

Statewide Demographic Comparisons

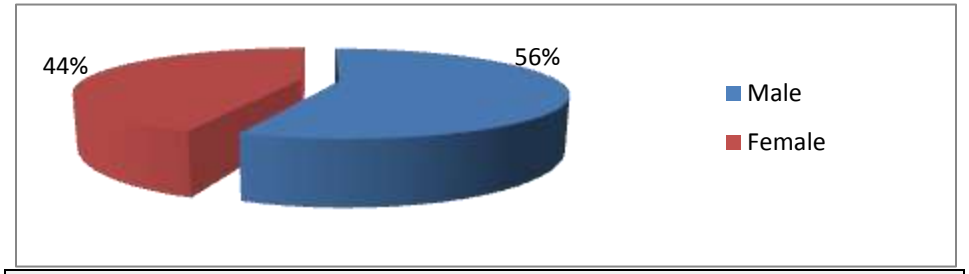
Age



Statewide Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	2,122	1,953	1,647	1,616	1,481	1,346	-26.8%	-9.1%
6 through 11	1,842	1,562	1,306	1,116	1,034	881	-30.7%	-14.8%
12 through 17	4,703	4,481	3,972	3,639	3,201	2,631	-27.3%	-17.8%
18 and over	2,107	2,364	2,454	2,304	2,107	1,891	-19.7%	-10.3%
Total	10,774	10,360	9,379	8,675	7,823	6,749	-26.1%	-13.7%

Table 14

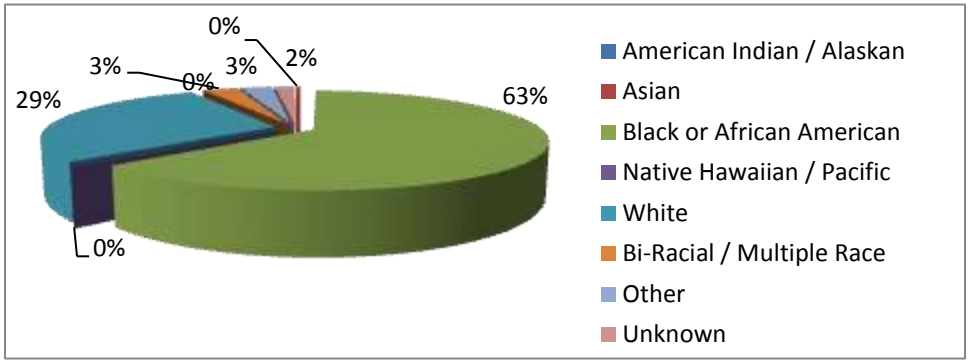
Gender



Statewide Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	6,085	5,766	5,285	4,815	4,370	3,768	-9.1%	-13.8%
Female	4,689	4,593	4,093	3,859	3,453	2,979	-8.6%	-13.7%
Unknown	0	1	1	1	0	2	NA	NA
Total	10,774	10,360	9,379	8,675	7,823	6,749	-8.9%	-13.7%

Table 15

Race

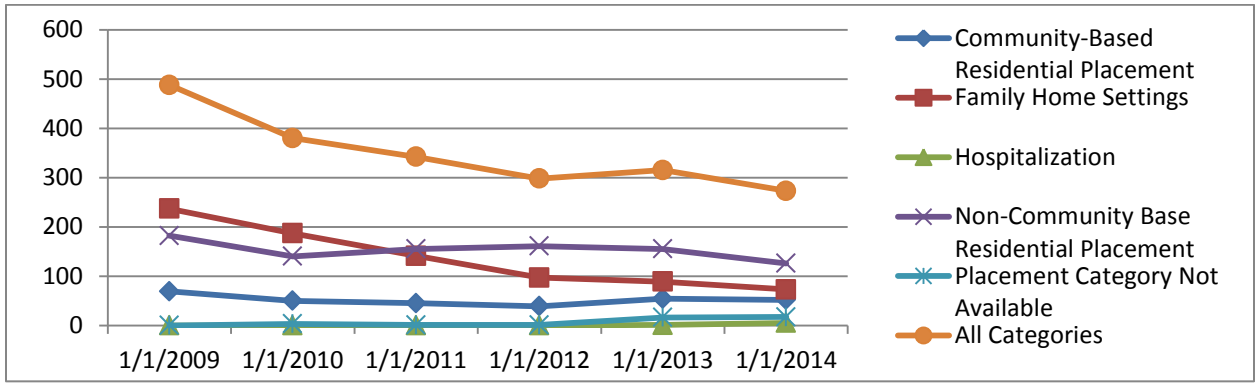


Statewide Race Trends								
Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
American Indian / Alaskan	13	10	7	6	6	7	-16.8%	0.0%
Asian	33	33	33	30	32	34	-0.6%	6.7%
Black or African American	7,482	7,131	6,289	5,643	4,949	4,203	-9.8%	-12.3%
Native Hawaiian / Pacific	3	5	5	5	3	3	6.7%	-40.0%
White	2,602	2,489	2,383	2,388	2,247	1,952	-3.6%	-5.9%
Bi-Racial / Multiple Race	302	309	279	267	236	233	-5.8%	-11.6%
Other	223	252	238	227	220	191	-0.1%	-3.1%
Unknown	116	131	145	109	130	126	4.5%	19.3%
Total	10,774	10,360	9,379	8,675	7,823	6,749	-7.7%	-9.8%

Table 16

STATEWIDE Addendum

Statewide Out-of-State One-Day Comparisons



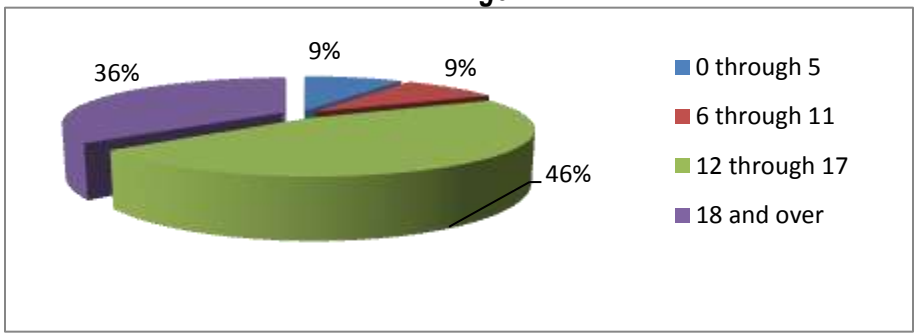
Maryland Out of State Placements								
Category	**1/31/2009**	**1/31/2010**	**1/31/2011**	**1/31/2012**	**1/31/2013**	**1/31/2014**	**Average Change**	**Last Year Change**
Community-Based Residential Placement	69	50	45	39	54	52	-3.2%	-3.7%
Family Home Settings	237	187	141	97	89	73	-20.6%	-18.0%
Hospitalization	0	0	0	0	1	5	NA	400.0%
Non-Community Based Residential Placement	182	140	155	161	155	126	-6.2%	-18.7%
Placement Category Not Available	0	3	1	1	16	17	NA	6.3%
All Categories	488	380	342	298	315	273	-10.5%	-13.3%

Table 17

STATEWIDE Addendum

Statewide Out-of-State One-Day Comparisons

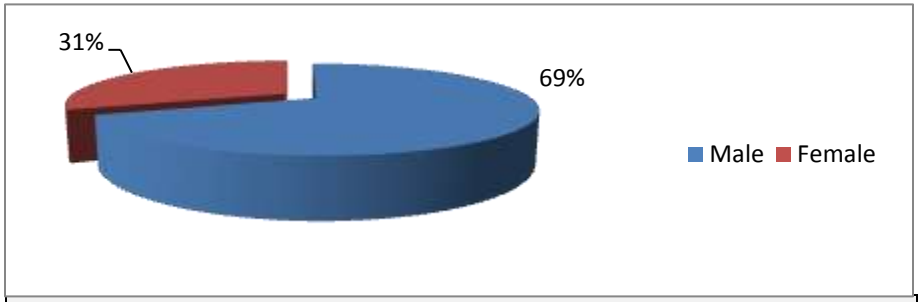
Age



Maryland Out-of-State Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	89	69	44	28	29	39	-11.4%	34.5%
6 through 11	69	44	31	25	28	13	-25.3%	-53.6%
12 through 17	210	154	169	155	146	116	-10.3%	-20.5%
18 and over	120	113	98	90	112	105	-1.8%	-6.3%
Total	488	380	342	298	315	273	-10.5%	-13.3%

Table 18

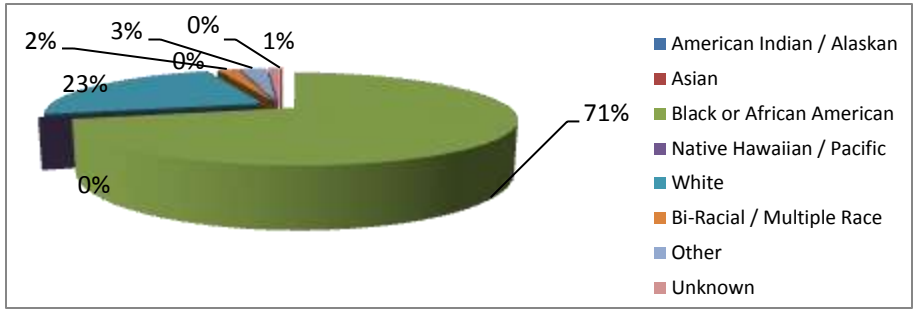
Gender



Maryland Out-of-State Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	323	253	246	221	218	187	-10.0%	-14.2%
Female	165	127	96	77	97	84	-10.9%	-13.4%
Unknown	0	0	0	0	0	2	NA	NA
Total	488	380	342	298	315	273	-10.5%	-13.3%

Table 19

Race



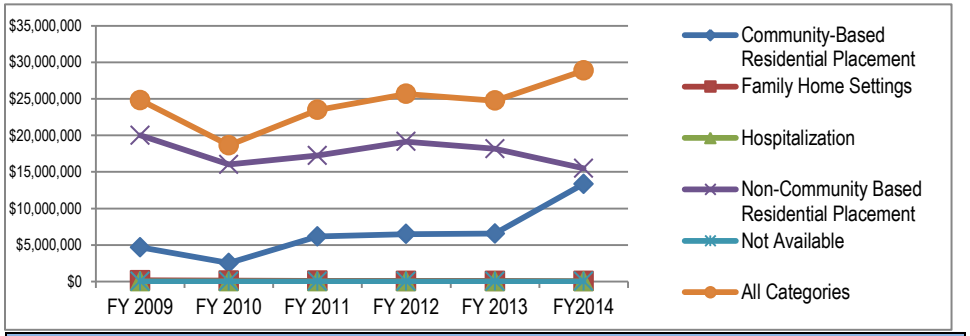
Maryland Out-of-State Race Trends								
Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
American Indian / Alaskan	0	1	0	0	0	0	NA	NA
Asian	4	2	3	0	1	0	NA	-100.0%
Black or African American	295	239	235	216	223	180	-9.0%	-19.3%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	169	121	87	69	74	74	-14.0%	0.0%
Bi-Racial / Multiple Race	9	7	9	6	6	8	1.3%	33.3%
Other	7	6	6	6	8	9	6.3%	12.5%
Unknown	4	4	2	1	3	2	13.3%	-33.3%
Total	488	380	342	298	315	273	-10.5%	-13.3%

Table 20

STATEWIDE Addendum

Statewide Out-of-State Cost Comparisons

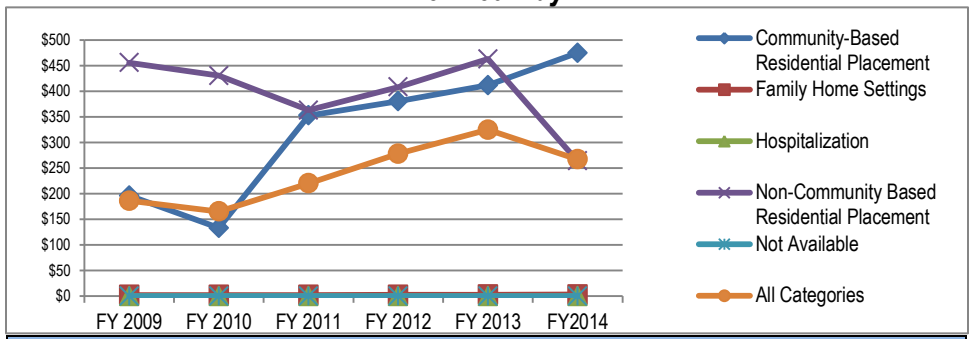
Total Costs



Statewide Out of-State Total Costs								
Category	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY2014	Average Change	Last Year Change
Community-Based Residential Placement	$4,677,421	$2,529,376	$6,167,030	$6,481,015	$6,545,427	$7,710,073	24.4%	17.8%
Family Home Settings	$142,750	$117,590	$87,060	$65,818	$56,033	$47,603	-19.6%	-15.0%
Hospitalization	$0	$0	$0	$0	$0	$0	NA	NA
Non-Community Based Residential Placement	$20,004,852	$16,008,362	$17,242,719	$19,139,903	$18,157,431	$15,490,295	-4.2%	-14.7%
Not Available	$0	$0	$0	$0	$0	$0	NA	NA
All Categories	$24,825,023	$18,655,328	$23,496,809	$25,686,736	$24,758,892	$23,247,971	0.1%	-6.1%

Table 21

Per Bed-Day



Statewide Costs Per Bed Day								
Category	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY2014	Average Change	Last Year Change
Community-Based Residential Placement	$196	$133	$353	$380	$412	$475	32.9%	15.3%
Family Home Settings	$2	$2	$2	$2	$3	$3	6.9%	12.8%
Hospitalization	NA	NA	NA	NA	NA	NA	NA	NA
Non-Community Based Residential Placement	$456	$431	$363	$408	$463	$264	-7.7%	-43.0%
Not Available	NA	NA	NA	NA	NA	NA	NA	NA
All Categories	$186	$165	$220	$278	$325	$267	9.5%	-17.9%

Table 22

Department of Human Resources (DHR) Summary

DHR prioritizes child safety, permanency, and well-being for children and families. DHR is committed to ensuring that children and youth are kept with their families whenever safe and possible. This is one of the central principles of the Place Matters and Family-Centered Practice initiatives. Since the beginning of Place Matters, the number of children in DHR out-of-home (OOH) care has decreased 48% (10,330 in July 2007 to 5,339 in June 2014).[5]

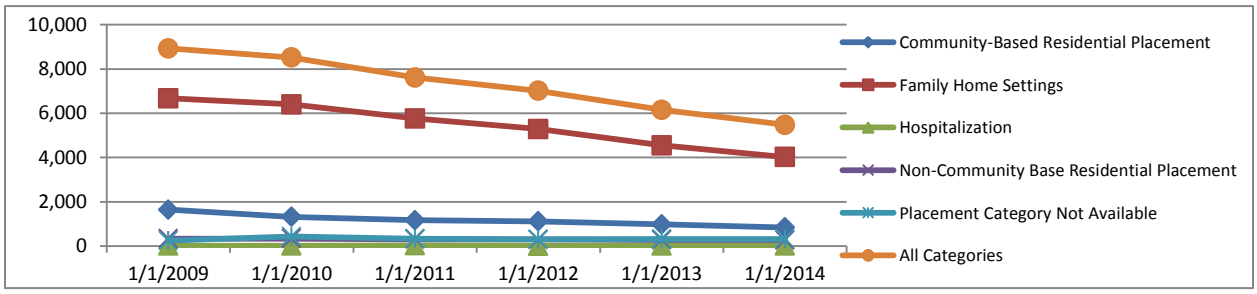
Maryland's Family-Centered Practice model is a fundamental component of DHR's and the local Departments of Social Services' work with families. Workers develop individualized service plans based on comprehensive assessments of the families' strengths and needs, with goals of increasing families' capacities to protect their children. Family Involvement Meetings (FIMs) are also used to engage families in service plan development, especially when safety/risk issues are severe enough that a child may be removed from the home. When OOH placement is necessary, the first choice is always a family home (family foster home or relative placement).

FIMs and other Family-Centered Practice approaches strengthen families by bringing additional resources to families, and helping children stay with their families of origin or relatives. These efforts are designed to reduce risk factors which lead to abuse and neglect, increase safety for children, and avoid OOH placement or reduce time in care.

Most children—an average of 75% over the last six years—in DHR OOH care are in family homes (Table 23). The Family-Centered Practices of child and family inclusion in case planning and decision-making have been crucial in achieving these goals.

DHR 2014 Highlights

The number of children in DHR OOH care is at its lowest point in at least the past 25 years, with a 39% reduction since 2009 and a 48% reduction since 2007 both as an absolute number and as a proportion of children in placement.[6] In 2014, 73% of children/youth in DHR OOH care were in family homes, with another 15% in community-based placements (Table 23).



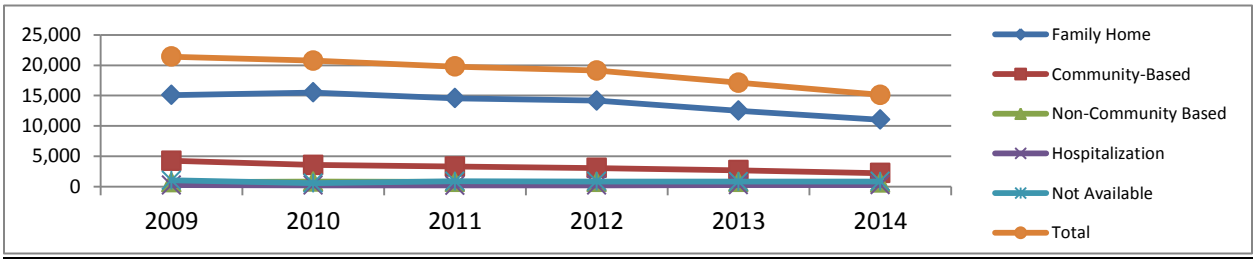
[5] State Stat Place Matters data June 2014; DHR.
[6] State Stat Place Matters data June 2014; DHR.

DHR Placement Trends								
Category	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Community-Based Residential Placement	1,649	1,321	1,170	1,116	978	842	-12.4%	-13.9%
Family Home Settings	6,672	6,397	5,765	5,286	4,548	4024	-9.6%	-11.5%
Hospitalization	21	23	38	11	22	17	16.2%	-22.7%
Non-Community Base Residential Placement	335	339	306	299	279	272	-4.0%	-2.5%
Placement Category Not Available	251	435	336	302	324	322	9.4%	-0.6%
All Categories	8,928	8,515	7,615	7,014	6,151	5,477	-9.3%	-11.0%

Table 23

Across all 24 Maryland jurisdictions, 54% of all children in DHR OOH care are placed in their home jurisdiction. These placements are in alignment with Place Matters and Family-Centered Practice values, which focus on the placement of children close to their families and communities when safe and possible, in order to maintain relationships and facilitate frequent family visitation. Other children may be placed in adjacent jurisdictions or even out of State, which may be closer to a child's home than a location within the same jurisdiction or state. Additionally, relative placements even out of the jurisdiction (or out of State) may be preferable to non-relative placements within the jurisdiction.

Nearly half (46%) of children in DHR OOH care comes from Baltimore City. Another 27% come from Baltimore County, Montgomery, and Prince George's Counties; each of these jurisdictions placed more than 60% of children within their own County as of January 31, 2014. Baltimore City had 48% of its children in care placed within its jurisdiction. Each other local department/jurisdiction had less than 4% each of the total DHR OOH population.



DHR Total Served								
Category	2009	2010	2011	2012	2013	2014	Average Change	Last Year Change
Family Home	15,095	15,510	14,564	14,178	12,498	11,039	-5.9%	-11.7%
Community-Based	4,276	3,592	3,317	3,074	2,719	2,235	-12.1%	-17.8%
Non-Community Based	732	831	794	755	751	675	-1.3%	-10.1%
Hospitalization	253	237	208	232	297	294	4.0%	-1.0%
Not Available	1,057	572	887	877	850	866	1.4%	1.9%
Total	21,413	20,742	19,770	19,116	17,115	15,109	-6.7%	-11.7%

Table 24

DHR Population Flow					
State Fiscal Year	Placements at Start of FY	Starts in FY (New Placements)	Total Served	Ends in FT (Placement Exits)	Placements at End of FY
2010	8,685	12,057	20,742	12,789	7,953
2011	7,953	11,817	19,770	12,261	7,509
2012	7,341	11,775	19,116	12,396	6,720
2013	6,606	10,509	17,115	11,157	5,958
2014	5,919	9,190	15,109	9,811	5,298
Three-Year Change	-25.6%	-22.2%	-23.6%	-20.0%	-29.4%
Average Yearly Change	-7.3%	-5.1%	-6.0%	-5.0%	-7.7%
Recent Year Change	-10.4%	-12.6%	-11.7%	-12.1%	-11.1%

Table 25

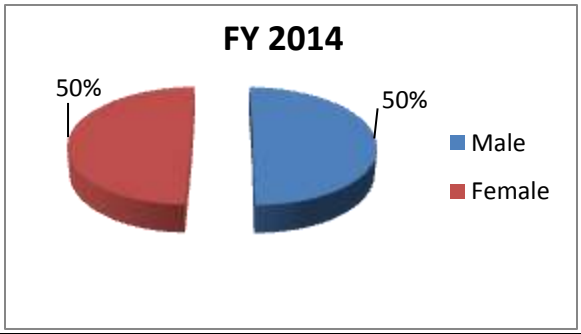
DHR Placement By Jurisdiction																													
	Jurisdiction Where Children Were Placed																												
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worcester	Out-of-State	Unknown
Allegany	81	1.5%	61	0	0	0	0	0	0	1	0	0	0	6	1	0	0	0	1	0	0	0	0	3	0	0	6	2
Anne Arundel	163	3.0%	0	86	19	17	1	2	0	0	3	0	1	0	3	2	0	4	6	1	2	0	0	0	0	0	12	4
Baltimore	561	10.2%	0	7	343	99	0	2	5	6	0	4	6	2	19	7	0	6	12	0	0	1	0	8	1	0	8	25
Baltimore City	2496	45.6%	1	51	922	1186	2	3	10	1	5	2	6	3	47	23	0	15	75	1	4	0	0	5	2	0	45	87
Calvert	87	1.6%	0	5	9	1	41	2	1	0	11	0	0	2	0	1	0	0	4	1	0	4	0	2	0	0	1	2
Caroline	34	0.6%	0	1	4	0	0	9	0	0	0	4	0	0	0	0	0	0	0	1	0	0	4	0	6	0	3	2
Carroll	46	0.8%	0	0	11	2	0	0	29	0	0	0	0	0	0	1	0	0	0	0	0	0	0	3	0	0	0	0
Cecil	158	2.9%	0	1	19	5	0	1	0	111	0	4	0	0	8	0	0	1	0	0	0	0	0	0	0	0	3	5
Charles	103	1.9%	0	0	5	2	0	0	1	0	77	0	0	0	0	0	0	2	7	0	0	2	0	0	0	0	1	6
Dorchester	26	0.5%	0	0	4	0	0	1	1	0	0	12	1	0	0	0	0	0	0	0	0	0	2	0	1	0	4	0
Frederick	123	2.2%	0	0	12	4	0	2	3	1	0	0	67	0	2	3	0	7	3	0	0	0	0	12	1	0	4	2
Garrett	39	0.7%	1	0	0	0	0	0	0	0	0	0	1	25	0	0	0	0	0	0	0	0	0	6	0	0	2	4
Harford	241	4.4%	0	2	52	6	0	3	2	9	0	0	3	0	138	1	0	4	2	1	0	0	0	1	0	0	8	9
Howard	62	1.1%	0	4	23	7	1	0	0	0	0	0	2	1	0	19	0	2	0	0	0	0	0	1	0	0	2	0
Kent	10	0.2%	0	0	2	0	0	3	0	1	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0
Montgomery	391	7.1%	0	6	35	7	0	1	3	3	2	0	14	0	4	4	1	245	32	0	0	0	0	14	0	0	11	9
Prince George's	501	9.1%	1	8	45	16	7	1	3	4	13	1	1	1	1	14	0	15	319	1	2	0	1	1	0	0	31	15
Queen Anne's	9	0.2%	0	0	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	2	0
Somerset	30	0.5%	0	1	2	1	0	1	0	0	0	4	0	0	0	0	0	0	1	0	10	0	0	0	9	0	1	0
St. Mary's	91	1.7%	0	0	11	1	2	0	0	0	11	0	0	0	2	2	0	0	8	1	1	44	0	0	1	0	5	2
Talbot	25	0.5%	0	0	0	0	0	7	0	0	0	4	1	0	0	0	0	0	0	0	0	0	11	0	1	0	0	1
Washington	146	2.7%	2	0	16	3	0	0	2	0	0	0	6	1	1	0	0	0	3	0	0	0	0	103	0	0	6	3
Wicomico	33	0.6%	0	0	4	2	0	0	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	20	0	4	0
Worcester	21	0.4%	0	0	2	0	0	1	0	0	0	1	0	2	0	0	0	0	0	0	3	0	0	0	9	1	1	1
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	5477	100.0	66	172	1541	1359	54	41	60	137	122	37	110	43	226	77	6	301	473	11	22	51	18	159	51	1	160	179
% of children from jurisdiction			75.3	52.8	61.1	47.5	47.1	26.5	63.0	70.3	74.8	46.2	54.5	64.1	57.3	30.6	40.0	62.7	63.7	44.4	33.3	48.4	44.0	70.5	60.6	4.8	0.0	0.0
% children Statewide in all			1.2%	3.1%	28.1%	24.8%	1.0%	0.7%	1.1%	2.5%	2.2%	0.7%	2.0%	0.8%	4.1%	1.4%	0.1%	5.5%	8.6%	0.2%	0.4%	0.9%	0.3%	2.9%	0.9%	0.0%	2.9%	3.3%

Table 26

DHR Demographics

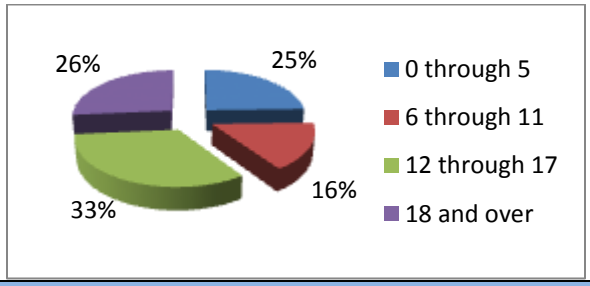
As of January 31, 2014, 25% of children in DHR OOH care were age 5 and younger; 16% were ages 6 to 11; 33% were ages 12 to 17; and 26% were age 18 and older. These percentages are similar to last year's data. Nearly 60% of youth in DHR OOH care are over the age of 11; this has significant implications for placement needs and challenges. Foster parenting skills, therapeutic treatments, and other service needs of older children and youth are different than those of infants, toddlers, and young children.

Although there is still a significant disparity, the percentages of Black/African-American children in DHR OOH care have been decreasing over the past several years. The percentage of White children also has decreased, but by a smaller percentage. In 2009, 72% of children in DHR OOH care were Black/African-American; in 2014, the percentage fell to 63%. In 2009, 21% of children in DHR OOH care were White; in 2014, 28% were White. Gender remains nearly evenly split between males and females.



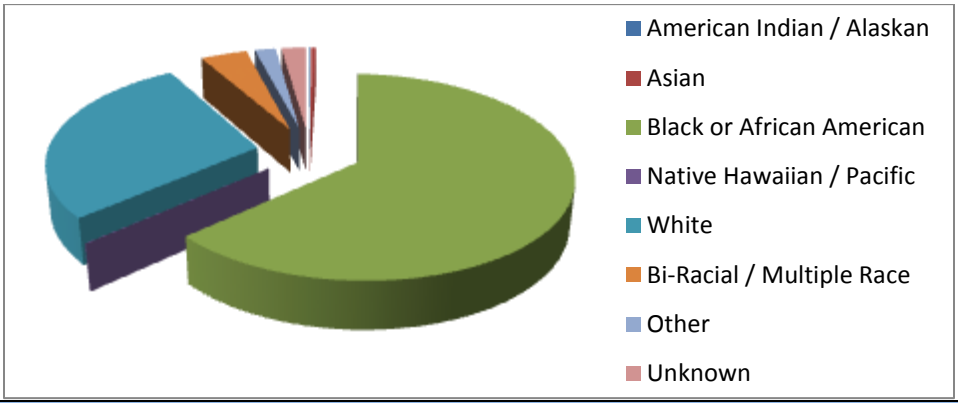
DHR All Categories Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	4,674	4,388	3,922	3,531	3,099	2,754	-10.0%	-11.1%
Female	4,254	4,127	3,692	3,482	3,052	2,721	-8.5%	-10.8%
Unknown	0	0	1	1	0	2	NA	NA
Total	8,928	8,515	7,615	7,014	6,151	5,477	-9.3%	-11.0%

Table 27



DHR All Categories Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	2,121	1,952	1,647	1,615	1,480	1,346	-8.6%	-9.1%
6 through 11	1,773	1,516	1,245	1,058	930	870	-13.2%	-6.5%
12 through 17	3,381	3,201	2,784	2,476	2,046	1,812	-11.6%	-11.4%
18 and over	1,653	1,846	1,939	1,865	1,695	1,449	-2.1%	-14.5%
Total	8,928	8,515	7,615	7,014	6,151	5,477	-9.3%	-11.0%

Table 28



DHR All Categories Race Trends								
Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
American Indian / Alaskan	10	7	4	3	5	5	-6.2%	0.0%
Asian	23	23	24	20	15	23	3.2%	53.3%
Black or African American	6,461	6,085	5,270	4,705	3,988	3,449	-11.7%	-13.5%
Native Hawaiian / Pacific	3	5	3	3	2	3	8.7%	50.0%
White	1,917	1,843	1,792	1,809	1,698	1,543	-4.2%	-9.1%
Bi-Racial / Multiple Race	302	309	278	264	232	229	-5.2%	-1.3%
Other	118	137	139	136	112	103	-2.1%	-8.0%
Unknown	94	106	105	74	99	122	7.9%	23.2%
Total	8,928	8,515	7,615	7,014	6,151	5,477	-9.3%	-11.0%

Table 29

DHR Placement Subcategory Trends

Placement subcategory tables include data on new entries into DHR OOH care, placement changes among children already in DHR OOH care, and children exiting DHR OOH care. Placement changes are counted as both "entries" and "exits." The Total Served, Entries, and Exits numbers are therefore duplicate counts of children in care, representing the number of placements, not children (a child may have multiple placements within a fiscal year, and each placement is counted; therefore a child may be counted multiple times.).

These placement changes are often appropriate and to a lesser level of "restrictiveness" – for example, a child may move from a group home to a family foster home and then to trial home visit with his/her biological parents, in preparation for reunification. Or, a child may need a short-term hospitalization and then be placed into a group home or foster home.

As the total DHR OOH care population has decreased since July 2007, the numbers of family home and community-based placements have correspondingly decreased. There was a total DHR OOH population decrease of 39% from 2009 to 2014; there was a corresponding 40% decrease in family home placements and a higher 49% decrease in community-based placements. The larger decrease in community-based placements is a result of the Place Matters focus on family home placements for children, and the idea that every child deserves a family. There has been a 19% decrease in both hospitalizations and non-community based placements since 2009.

Family homes (for DHR) are defined as placements in a family setting, and include placement categories of:

- Relative/kinship care (paid/restricted/relative and unpaid/formal kinship care);
- Living arrangements (primarily Trial Home Visits with family of origin, but also including own home/apartment);
- Adoptive care (pre-finalized adoptive homes);
- Foster care (emergency, intermediate, regular foster care, and respite care); and
- Treatment foster care (private and public).

Within the family home subcategory, the greatest decreases are seen in adoptive and formal relative (kinship) and restrictive relative (kinship) care placements. Meanwhile, although the raw numbers of foster care, treatment foster care, and living arrangement/family homes (trail home visit or own home/apartment) have decreased, the proportion of children in these placements (out of all DHR placements) has been increasing.

Care must be taken when interpreting Family Home data, if used to analyze private provider usage. Thirty-three percent (33%) of Family Home placements are specific to individual children – meaning, they are relative homes: Formal Relative (Kinship) Care, Restrictive Relative (Kinship Care), or Living Arrangement – Family Home (primarily trial home visits). Meanwhile, another 1% are adoptive homes, 38% are Treatment Foster Care placements (the majority of which are private providers), and 28% are regular foster care which typically are public homes (*i.e.*, licensed by the local Department of Social Services).

Community-based placements constitute DHR's second-most used placement type; an average of 16% of all DHR children/youth are in community-based placements. For DHR, this includes: college, JobCorps, independent living residential programs, and residential child care programs (group homes).

Twenty-six percent of all children/youth in DHR care as of January 31, 2014 were above age 17; college, JobCorps, and independent living placements are age-appropriate for this population, and therefore least-restrictive. Fifty-eight percent of all youth in DHR community-based placements are age 18 and older.

Youth age 18 and over have a choice to remain in DHR OOH care or not; they may choose to remain in care until age 21, but are not legally required to do so. Youth are eligible for independent living programs at age 16.

Less than 1% of children in DHR OOH care are placed in the State's most restrictive placements (hospitalizations), while an average of 4% are in non-community-based placements (Residential Treatment Centers, Correctional Institutions, or Secure Detention). Placements of children/youth in these settings are driven by severe mental health and medical needs, and/or

the juvenile/adult criminal justice system, although past abuse and trauma may contribute to individual children's mental health issues and/or criminal acting-out behaviors.

There has also been an average of 5% of child records with incomplete placement information – this includes children on runaway status, as well as children whose placement data has not been fully entered into MD CHESSIE (DHR's client information system).

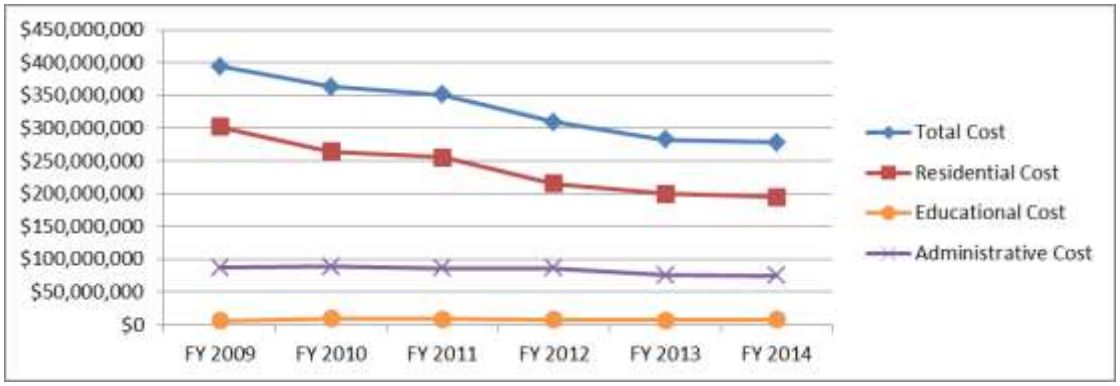
DHR Out-of-State (OOS)

Only 3% of all DHR OOH placements on January 31, 2014 were out-of-State; this is consistent with the percentage in prior years. Of those, the largest number was family home placements, and 66% of children in family homes were placed with family members, adoptive homes, or their own homes. Only one percent of all community-based placements were out-of-State, primarily residential child care (group home) placements but also independent living, college, and JobCorps placements. Residential treatment centers, hospitalizations, and detention and correctional institutions were other out-of-State placements.

DHR Costs

DHR funds only two categories of placements - family home and community-based placements, although not all of these placements require funding. Family foster home placements of trial home placement and formal kinship care placements do not require funding, nor do some types of community-based placements. Hospitalizations are paid for by Medical Assistance, as is the residential portion of residential treatment center placements (non-community based); the other non-community based placements of secure detention or correctional institution are mandated for and paid for by the criminal justice system for youth detained, charged, adjudicated, and/or found guilty of criminal or delinquent behavior.

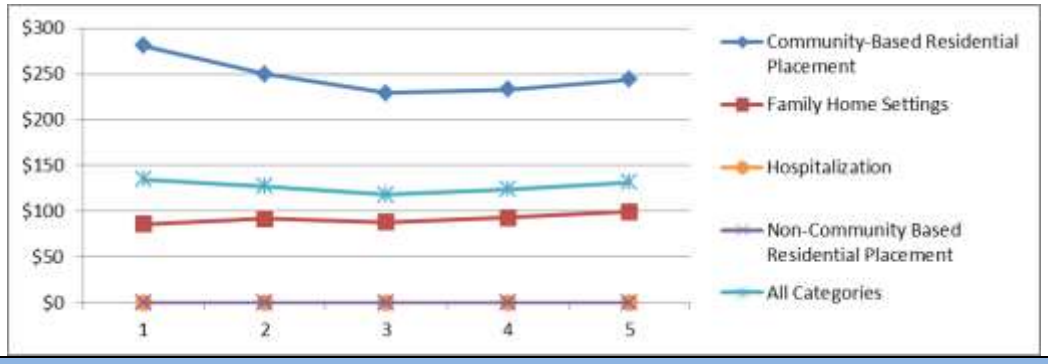
Over the past five fiscal years, DHR's residential costs have continued to decrease, with an average annual decrease of 8%, and an overall decrease of 35% since 2008. In FY2009, the costs were just over $300M. In FY2013, residential costs were slightly under $200M, for the first time in several years; in FY 2014, the costs decreased to just under $195M.



DHR Cost Trends									
Cost Type	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change	2009 - 2014 Change
Total	$394,552,605	$362,826,762	$350,625,684	$309,430,208	$282,614,057	$278,030,287	-7%	-2%	-30%
Residential	$301,566,171	$264,644,544	$255,439,051	$215,361,539	$199,942,040	$194,867,565	-8%	-3%	-35%
Educational	$6,028,754	$9,439,103	$8,972,787	$7,854,822	$6,799,657	$7,966,645	9%	17%	32%
Administrative	$86,957,680	$88,743,115	$86,213,846	$86,213,846	$75,872,360	$75,196,077	-3%	-1%	-14%
% Residential	76%	73%	73%	70%	71%	70%			
% Educational	2%	3%	3%	3%	2%	3%			
% Administrative	22%	24%	25%	28%	27%	27%			

Table 30

Total costs, which include residential as well as education and administrative costs, also continue to decrease. The average annual decrease of total costs is 7%, with an overall decrease of 30% since 2009, to $278M in FY 2014. Education costs, however, have increased from $6M in FY 2009 to $8M in FY 2014, while administrative costs have decreased 14% from $87M in FY 2009 to $75M in FY 2014.[7]



DHR All Categories Cost Per Bed-Day Trends								
Category	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Community-Based Residential Placement	$281	$250	$229	$233	$244	$278	0%	14%
Family Home Settings	$86	$92	$88	$93	$99	$111	5%	12%
Hospitalization	NA	NA	NA	NA	NA	NA	NA	NA
Non-Community Based Residential Placement	NA	NA	NA	NA	NA	NA	NA	NA
Not Available	NA	NA	NA	NA	NA	NA	NA	NA
All Categories	$135	$127	$118	$124	$132	$146	2%	11%

Table 31

Community-based placements continue to have higher per-bed-day costs than family home placements, with a FY2014 average bed-day cost of $278, compared to $111 family home placements (only paid placements were included in these averages). Despite the higher per-bed-day cost, however, community-based placements constitute 40% of all DHR residential placements costs, while family homes constitute 60%; this is due to the larger number of family home placements.

[7] Education and administrative costs were not reported in the last three JCR Reports.

DHR Recommendations

The primary goal of DHR is to prevent maltreatment and out-of-home placement of children and youth—when placement is necessary to protect a child's safety, reunification is the preferred goal; therefore, services that can support these goals are the priority of DHR.

DHR has identified the following critical areas for increased services:

- Services to children ages 0 to 8 and at risk for out-of-home placement;
- Services to youth ages 14 to 17 and at risk for out-of-home placement;
- Older youth in out-of-home care;
- Children/youth exiting out-of-home care and at risk for reentry to out-of-home care; and
- A need to strengthen all services to build a system of trauma-informed care.

In FY 2013, children 0-8 and 14-17 years old represent 81% of all entries into out-of-home placement;[8] 26% of children in DHR's OOH population in FY 2014 were over age 17. Slightly more than 15% of children exiting DHR OOH care re-enter care within 12-months (FY 2013 data).[9] Trauma affects nearly all children in the child welfare system, as well as many parents and caregivers.

DHR has several current initiatives which address these needs:

1. Award of IV-E Waiver Block Grant – DHR was awarded a 5-year, $650 million federal demonstration project from the U.S. Department of Health and Human Services that allows Maryland more flexibility in using federal foster care funds to achieve improved safety, permanency and well-being of vulnerable children. This grant allows funds that could previously only be used as reimbursement for out-of-home placement to be used for in-home supports, prevention services, and other services that keep children at home safely. The project includes an extensive planning process and can begin as early as July 1, 2015.
2. Performance-based contracting for residential congregate care providers (RCCs) (or group homes) increases accountability and quality of community-based out of home care.

[8] *Maryland Department of Human Resources Title IV-E Child Welfare Waiver*, Maryland Department of Human Resources, February 2014, http://www.dhr.state.md.us/documents/Data%20and%20Reports/SSA/Maryland%202014%20IV-E%20Waiver%20Application.pdf.

[9] *Maryland Department of Human Resources Child and Family Services Plan*, *2015 – 2019*, Maryland Department of Human Resources , June 2014.

3. Continuation of Family-Centered Practice and Place Matters initiatives, which focus on child, youth, and family involvement, natural and community supports, and keeping children in their homes and communities whenever safe and possible. Family Involvement Meetings are used to plan services, identify resources, avoid out-of-home placement, and engage the family. Guardianship Assistance Program, Kinship Navigators, and Family Finding are used to avoid out-home-placement and/or help children find permanent homes with relatives.
4. Ready by 21™ is Maryland's initiative to ensure that youth are prepared for the transition into adulthood. Focusing on the five core areas of housing, education, finances, health, and mentoring, Ready by 21 provides a framework and key strategies that are implemented at the local level by the LDSS and their community partners. Ready by 21 is designed to ensure that youth have the necessary skills and resources to integrate back into their homes and communities when they reunify with their families or to be successful if they emancipate from care at age 21.
5. Additional programs such as Youth Matter, Alternative Response, and Tuition Waivers further engage and strengthen youth and families.

DHR is also working to expand additional programs and services, subject to available funding:

1. DHR will expand intensive family preservation and post-permanency service, including both prevention and post-permanency services.
2. DHR proposes to create a trauma-informed system that uses standardized assessments to identify services and supports for children and families to prevent out-of-home care and re-entries into out-of-home care as well as to improve well-being.
3. ***Family Connections*****:** A multi-faceted, community-based evidence-based program that works with families experiencing difficulty in meeting the basic needs of their children and at-risk for child emotional and/or physical neglect.
4. ***Homebuilders*****:** An intensive evidence-based family preservation program that works with the caregivers to provide in-home crisis intervention, counseling, and life skills education over a short-term period.
5. ***SafeCare*****:** An in-home evidence-based parenting model for parents with children ages 0-5 who are at risk for or have a history of child abuse or neglect. SafeCare provides direct skill training with parents using four modules: health, home safety, parent-child/parent-infant interactions, and problem solving and communication.
6. ***Functional Family Therapy (FFT):*** FFT is an evidence-based therapy designed for 11-18 year-olds with behavioral health problems including conduct and substance abuse problems. FFT improves family relationships by teaching families how to promote the safety of their children, improve communication skills and skills for solving family problems.

Additional considerations:

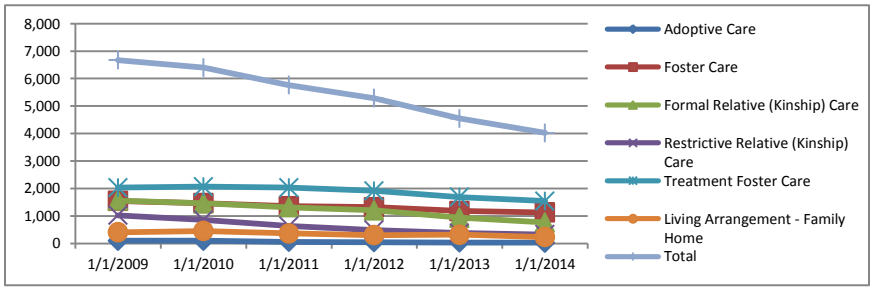
Based on LDSS and stakeholder feedback through advisory committees and the quality assurance process, and SSA analysis, DHR would prioritize the following within available resources:

- Specialized resources and increased awareness for the child victims of human sex trafficking that DHR serves.
- Foster and adoptive parents for teens, sibling groups, medically fragile children, and Spanish-speaking children.
- Community services for biological families – for those involved in child welfare as well as for those not involved — including mental health, substance abuse, anger management and financial management services.
- Transportation in every jurisdiction – both intra- and inter-jurisdictional public transportation, for both parents and older youth.
- Job training, employment opportunities, and low-cost housing for both older youth and families.
- Specialized and intensive services for medically fragile, developmentally delayed children, and children/youth with severe mental health disorders.
- Substance abuse treatment programs that accept parents and children together.

DHR Addendum

Subcategory One-Day Census Totals

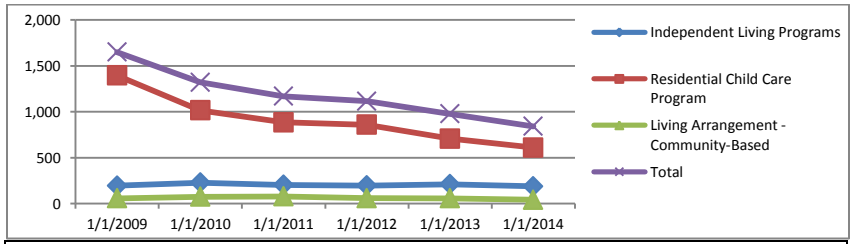
Placement Trends



DHR Family Home Placement Trends

Subcategory	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
Adoptive Care	100	98	60	47	37	32	-19.4%	-13.5%
Foster Care	1,547	1,466	1,358	1,321	1,180	1128	-6.1%	-4.4%
Formal Relative (Kinship) Care	1,558	1,460	1,316	1,207	936	761	-13.1%	-18.7%
Restrictive Relative (Kinship) Care	1,027	854	634	491	382	326	-20.4%	-14.7%
Treatment Foster Care	2,034	2,066	2,032	1,914	1,691	1541	-5.3%	-8.9%
Living Arrangement - Family Home	406	453	365	306	322	236	-9.1%	-26.7%
Total	6,672	6,397	5,765	5,286	4,548	4,024	-9.6%	-11.5%

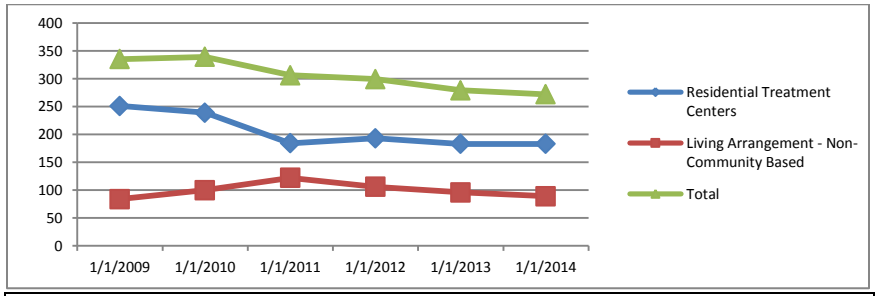
Table 31



DHR Community-Based Placement Trends

Subcategory	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
Independent Living Programs	195	229	205	197	212	188	-0.1%	-11.3%
Residential Child Care Program	1,396	1,016	886	859	708	611	-14.9%	-13.7%
Community Supported Living Arrangement	0	0	0	0	0	0	NA	NA
Living Arrangement - Community-Based	58	76	79	60	58	43	-3.7%	-25.9%
Total	1,649	1,321	1,170	1,116	978	842	-12.4%	-13.9%

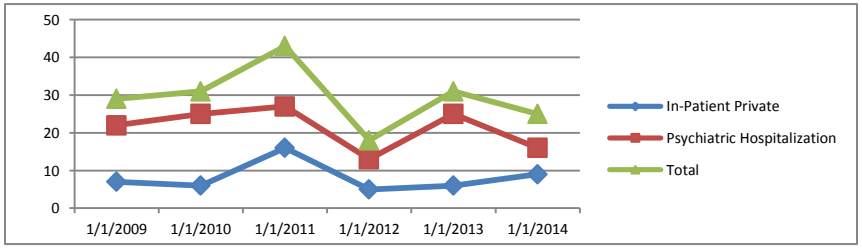
Table 32



DHR Non-Community-Based Placements

Subcategory	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	0	0	0	0	0	0	NA	NA
Juvenile Detention and Commitment Centers	0	0	0	0	0	0	NA	NA
Non-Secure/Non-RTC	0	0	0	0	0	0	NA	NA
Residential Educational Facilities	0	0	0	0	0	0	NA	NA
Residential Treatment Centers	251	239	184	193	183	183	-5.6%	0.0%
Substance Abuse and Addiction Programs (ASAM)	0	0	0	0	0	0	NA	NA
Living Arrangement - Non-Community Based	84	100	122	106	96	89	2.2%	-7.3%
Total	335	339	306	299	279	272	-4.0%	-2.5%

Table 33



DHR Hospitalization Trends

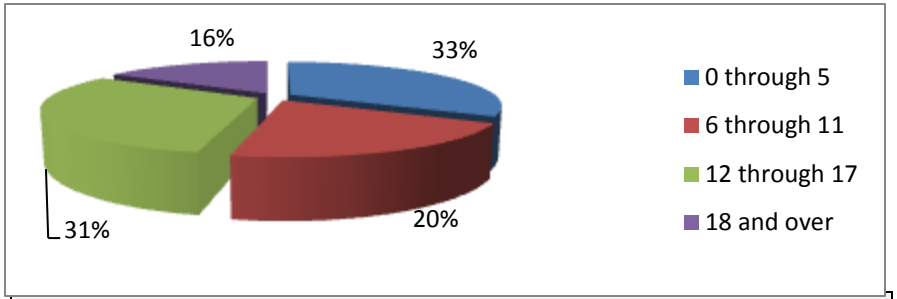
Subcategory	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
In-Patient Private	7	6	16	5	6	9	30.7%	50.0%
Psychiatric Hospitalization	22	25	27	13	25	16	5.2%	-36.0%
Total	29	31	43	18	31	25	8.1%	-19.4%

Table 34

DHR Addendum

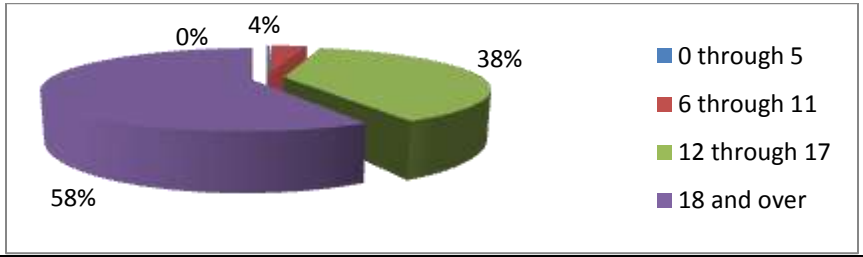
Subcategory Demographic Totals

Age



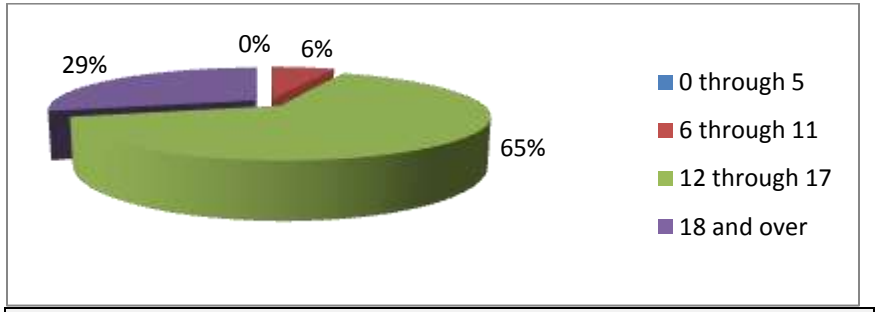
DHR Family Home Settings								
Age	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
0 through 5	2,091	1,892	1,622	1,589	1,461	1,324	-8.7%	-9.4%
6 through 11	1,599	1,386	1,166	984	871	816	-12.5%	-6.3%
12 through 17	2,069	2,140	1,960	1,744	1,377	1,239	-9.4%	-10.0%
18 and over	913	979	1,017	969	839	645	-6.0%	-23.1%
Total	6,672	6,397	5,765	5,286	4,548	4,024	-9.6%	-11.5%

Table 35



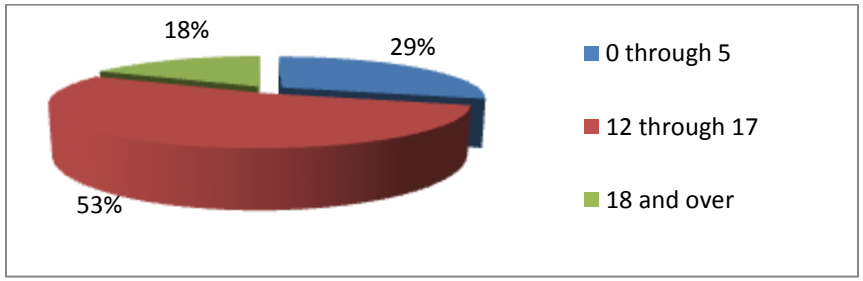
DHR Community-Based Settings								
Age	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
0 through 5	15	4	1	6	5	3	59.0%	-40.0%
6 through 11	116	71	34	36	36	31	-19.8%	-13.9%
12 through 17	914	610	510	475	401	322	-18.4%	-19.7%
18 and over	604	636	625	599	536	486	-4.1%	-9.3%
Total	1,649	1,321	1,170	1,116	978	842	-12.4%	-13.9%

Table 36



DHR Non-Community-Based Settings								
Age	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
0 through 5	0	0	0	0	0	0	NA	NA
6 through 11	30	17	21	27	17	17	-5.7%	0.0%
12 through 17	255	250	193	192	186	176	-6.8%	-5.4%
18 and over	50	72	92	80	76	79	11.5%	3.9%
Total	335	339	306	299	279	272	-4.0%	-2.5%

Table 37



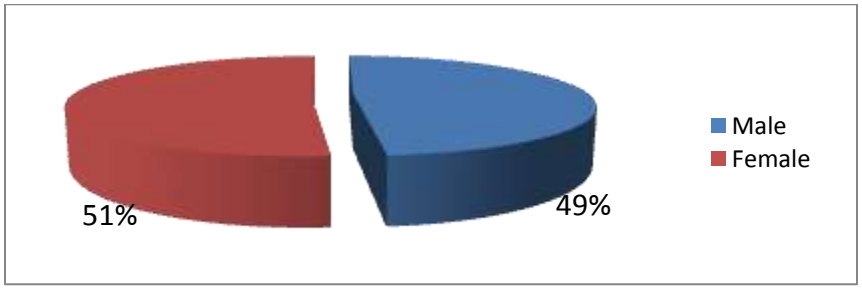
DHR Hospitalizations								
Age	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
0 through 5	2	3	4	5	4	5	22.7%	25.0%
6 through 11	2	0	5	1	0	0	NA	NA
12 through 17	15	16	24	4	12	9	29.7%	-25.0%
18 and over	2	4	5	1	6	3	99.0%	-50.0%
Total	21	23	38	11	22	17	16.2%	-22.7%

Table 38

DHR Addendum

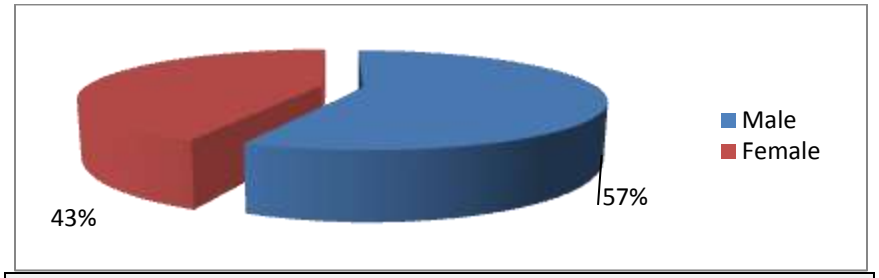
Subcategory Demographic Totals

Gender



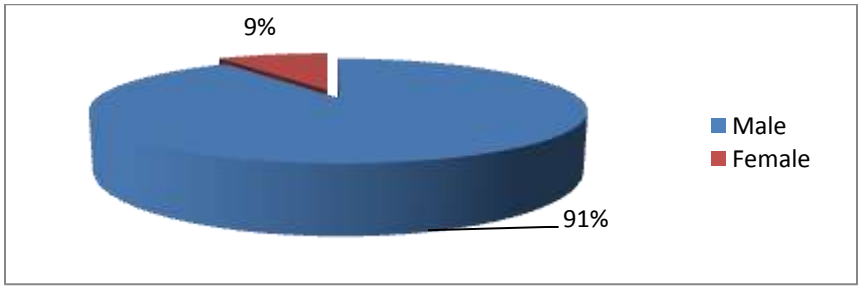
DHR Family Home Settings								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	3,377	3,194	2,853	2,568	2,241	1,954	-10.3%	-12.8%
Female	3,295	3,203	2,911	2,717	2,307	2,068	-8.8%	-10.4%
Unknown	0	0	1	1	0	2	NA	NA
Total	6,672	6,397	5,765	5,286	4,548	4,024	-9.6%	-11.5%

Table 39



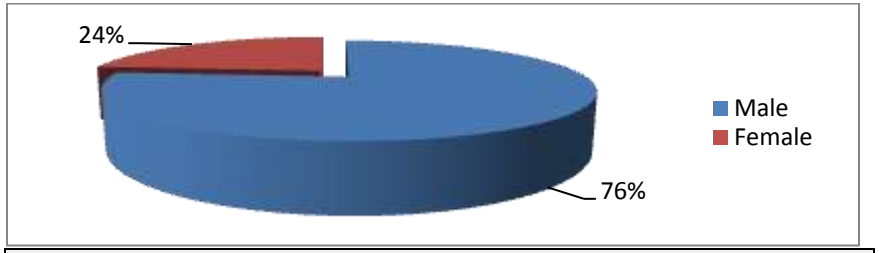
DHR Community-Based Settings								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	969	779	702	647	543	477	-13.1%	-12.2%
Female	680	542	468	469	435	365	-11.4%	-16.1%
Unknown	0	0	0	1	0	0	NA	NA
Total	6,672	6,397	5,765	5,286	4,548	4,024	-9.6%	-11.5%

Table 40



DHR Non-Community-Based Settings								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	107	89	123	130	117	87	-1.7%	-25.6%
Female	5	6	1	2	6	9	57.3%	50.0%
Unknown	0	0	0	0	0	0	NA	NA
Total	112	95	124	132	123	96	-1.4%	-22.0%

Table 41



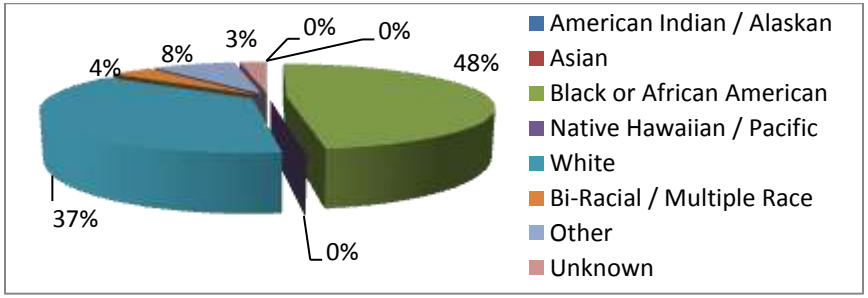
DHR Hospitalization Settings								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	8	8	23	7	10	13	38.2%	30.0%
Female	13	15	15	4	12	4	15.1%	-66.7%
Unknown	0	0	0	0	0	0	NA	NA
Total	21	23	38	11	22	17	16.2%	-22.7%

Table 42

DHR Addendum

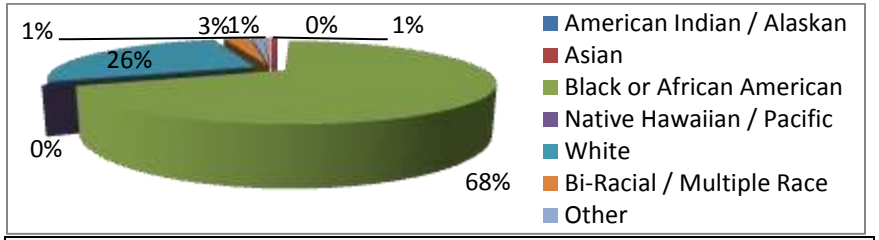
Subcategory Demographic Totals

Race



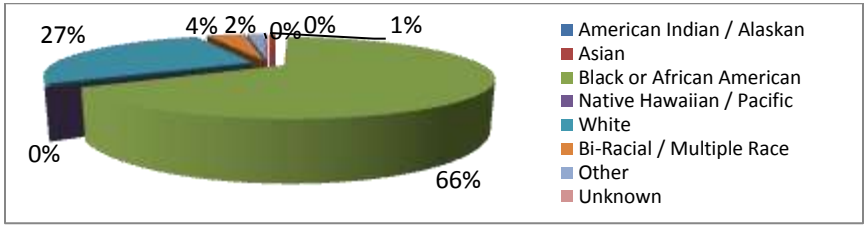
DHR Family Home Settings								
Race	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
American Indian / Alaskan	5	5	1	2	3	2	7.3%	-33.3%
Asian	13	12	14	13	11	14	2.7%	27.3%
Black or African American	4,845	4,588	3,931	3,479	2,866	2,466	-12.5%	-14.0%
Native Hawaiian / Pacific	1	2	2	2	1	3	50.0%	200.0%
White	1,403	1,356	1,384	1,403	1,300	1,155	-3.7%	-11.2%
Bi-Racial / Multiple Race	234	250	227	212	188	188	-4.1%	0.0%
Other	93	113	120	112	86	82	-1.4%	-4.7%
Unknown	78	71	86	63	93	114	11.1%	22.6%
Total	6,672	6,397	5,765	5,286	4,548	4,024	-9.6%	-11.5%

Table 43



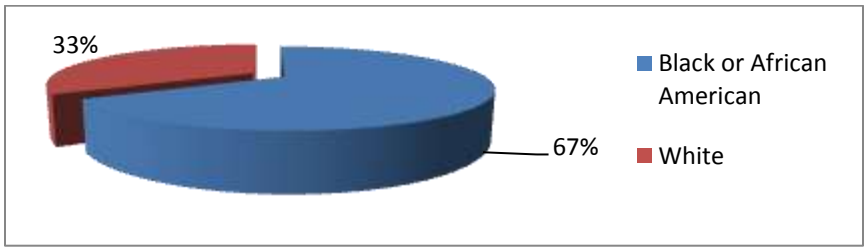
DHR Community-Based Settings								
Race	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
American Indian / Alaskan	2	1	1	0	0	1	NA	NA
Asian	9	8	10	6	3	5	-1.9%	66.7%
Black or African American	1,190	915	841	766	676	575	-13.4%	-14.9%
Native Hawaiian / Pacific	2	2	1	1	1	0	-30.0%	-100.0%
White	369	318	267	284	248	222	-9.3%	-10.5%
Bi-Racial / Multiple Race	42	33	26	35	32	23	-8.9%	-28.1%
Other	20	17	11	17	12	11	-6.7%	-8.3%
Unknown	15	27	13	7	6	5	-9.8%	-16.7%
Total	1,649	1,321	1,170	1,116	978	842		-13.9%

Table 44



DHR Non-Community-Based Settings								
Race	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
American Indian / Alaskan	2	0	1	0	0	0	NA	NA
Asian	1	1	0	0	0	2	NA	NA
Black or African American	216	217	213	200	187	179	-1.5%	-4.3%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	94	107	74	81	75	74	-4.9%	-1.3%
Bi-Racial / Multiple Race	20	13	10	14	9	11	-17.0%	22.2%
Other	2	0	6	3	8	5	NA	-37.5%
Unknown	0	1	2	1	0	1	NA	NA
Total	335	339	306	299	279	272	-3.0%	-2.5%

Table 45



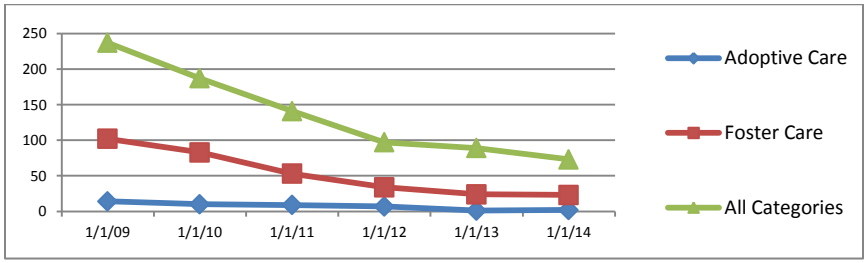
DHR Hospitalizations								
Race	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
American Indian / Alaskan	0	1	0	0	0	0	NA	NA
Asian	0	0	0	0	0	0	NA	NA
Black or African American	10	12	15	5	14	10	26.0%	-28.6%
Native Hawaiian / Pacific	0	1	0	0	0	0	NA	NA
White	8	7	15	5	8	5	11.5%	-37.5%
Bi-Racial / Multiple Race	2	1	7	1	0	2	NA	NA
Other	1	1	0	0	0	0	NA	NA
Unknown	0	0	1	0	0	0	NA	NA
Total	21	23	38	11	22	17	16.2%	-22.7%

Table 46

DHR Addendum

Subcategory Out-of-State One-Day Census Trends

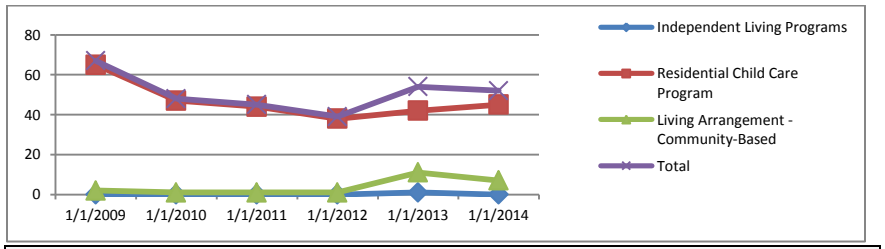
Placement Trends



DHR Out-of-State Family Home Trends

Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Adoptive Care	14	10	9	7	1	2	-9.3%	100.0%
Foster Care	102	83	53	34	24	23	-24.8%	-4.2%
Formal Relative (Kinship) Care	41	22	26	23	27	21	-8.9%	-22.2%
Restrictive Relative (Kinship) Care	70	63	44	25	19	11	-29.9%	-42.1%
Treatment Foster Care	6	9	9	6	2	2	-10.0%	0.0%
Living Arrangement - Family Home	4	0	0	2	16	14	NA	-12.5%
All Categories	237	187	141	97	89	73	-20.6%	-18.0%

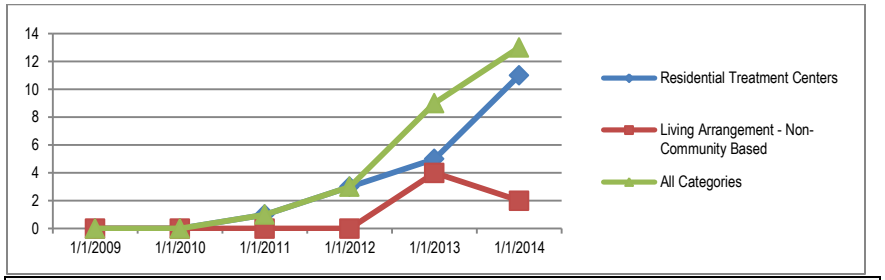
Table 47



DHR Out-of-State Community-Based Trends

Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Independent Living Programs	0	0	0	0	1	0	NA	-100.0%
Residential Child Care Program	65	47	44	38	42	45	-6.0%	7.1%
Community Supported Living Arrangement	0	0	0	0	0	0	NA	NA
Living Arrangement - Community-Based	2	1	1	1	11	7	182.7%	-36.4%
Total	67	48	45	39	54	52	-2.6%	-3.7%

Table 48



DHR Out-of-State Non-Community-Based Trends

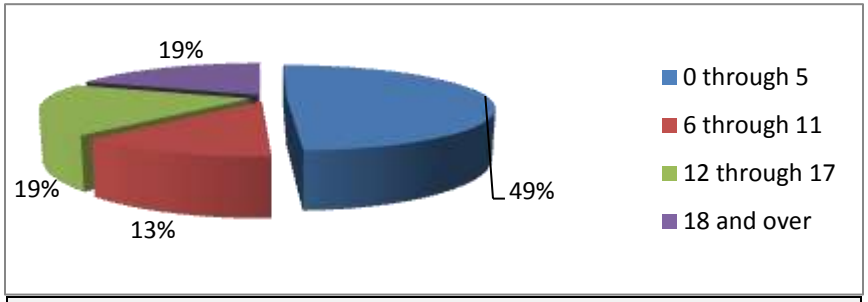
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	0	0	0	0	0	0	0.0%	0.0%
Juvenile Detention and Commitment Centers	0	0	0	0	0	0	0.0%	0.0%
Non-Secure/Non-RTC	0	0	0	0	0	0	0.0%	0.0%
Residential Educational Facilities	0	0	0	0	0	0	0.0%	0.0%
Residential Treatment Centers	0	0	1	3	5	11	3.3%	120.0%
Substance Abuse and Addiction Programs (ASAM)	0	0	0	0	0	0	0.0%	0.0%
Living Arrangement - Non-Community Based	0	0	0	0	4	2	1.0%	-50.0%
All Categories	0	0	1	3	9	13	NA	44.4%

Table 49

DHR Addendum

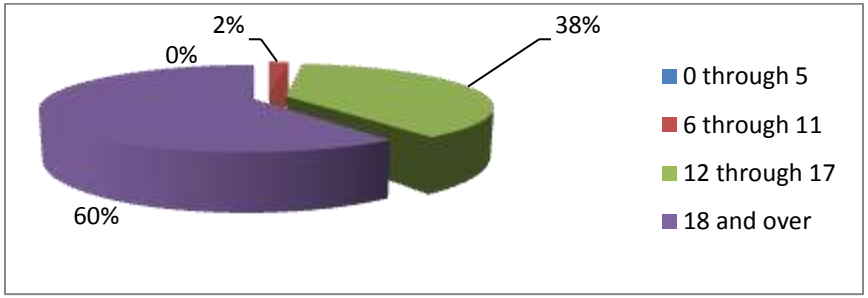
Subcategory Out-of-State Demographic Comparisons

Age



DHR Out-of-State Family Home Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	89	68	44	28	29	36	-13.5%	24.1%
6 through 11	67	42	29	22	24	9	-29.2%	-62.5%
12 through 17	66	64	56	37	23	14	-25.3%	-39.1%
18 and over	15	13	12	10	13	14	0.0%	7.7%
Total	237	187	141	97	89	73	-20.6%	-18.0%

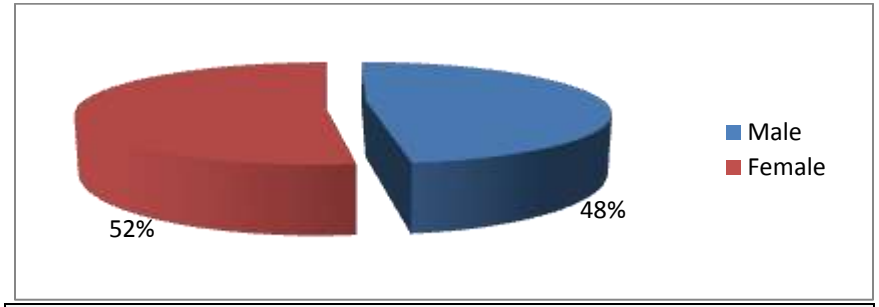
Table 50



DHR Out-of-State Community-Based Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	0	0	0	0	0	0	NA	NA
6 through 11	0	0	1	1	2	1	NA	-50.0%
12 through 17	32	18	23	18	22	20	-4.9%	-9.1%
18 and over	35	30	21	20	30	31	0.9%	3.3%
Total	67	48	45	39	54	52	-2.6%	-3.7%

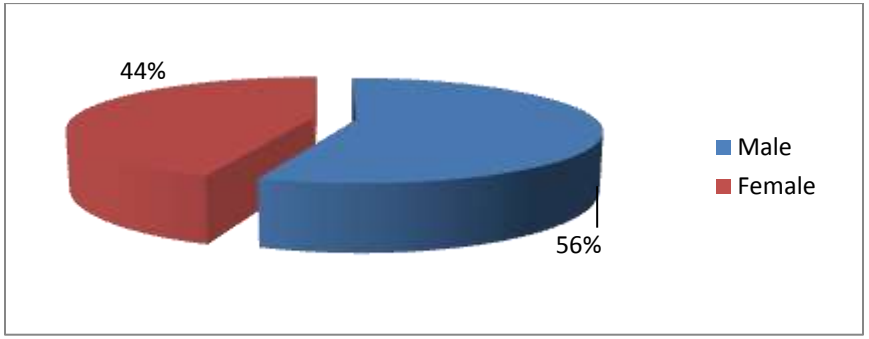
Table 51

Gender



DHR Out-of-State Family Home Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	110	95	70	46	40	35	-20.0%	-12.5%
Female	127	92	71	51	49	38	-21.0%	-22.4%
Unknown	0	0	0	0	0	0	NA	NA
Total	237	187	141	97	89	73	-20.6%	-18.0%

Table 52



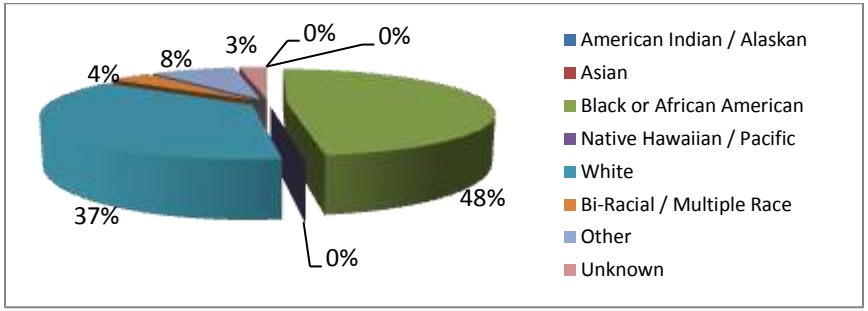
DHR Out-of-State Community-Based Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	44	28	29	25	30	32	-4.0%	6.7%
Female	23	20	16	14	24	20	1.8%	-16.7%
Unknown	0	0	0	0	0	0	NA	NA
Total	67	48	45	39	54	52	-2.6%	-3.7%

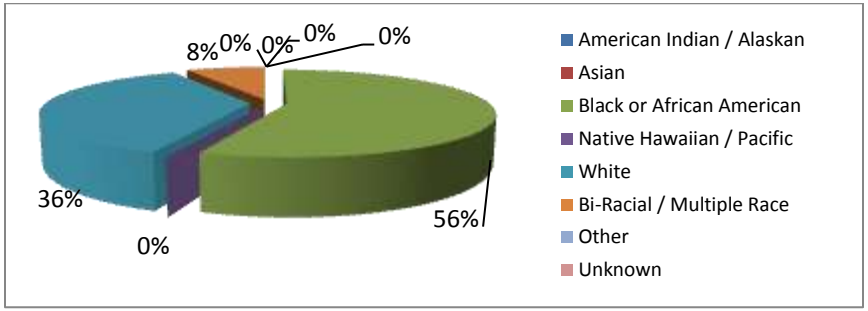
Table 53

DHR Addendum

Subcategory Out-of-State Demographic Comparisons

Race





DHR Out-of-State Family Home Race Trends

Race	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
American Indian / Alaskan	0	0	0	0	0	0	NA	NA
Asian	1	1	1	0	0	0	NA	NA
Black or African American	150	119	92	63	54	35	NA	-35.2%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	75	58	40	28	30	27	-35.3%	-10.0%
Bi-Racial / Multiple Race	5	7	8	4	2	3	-27.5%	50.0%
Other	3	0	0	1	1	6	NA	500.0%
Unknown	3	2	0	1	2	2	NA	0.0%
Total	237	187	141	97	89	73	-33.2%	-18.0%

Table 54

DHR Out-of-State Community-Based Race Trends

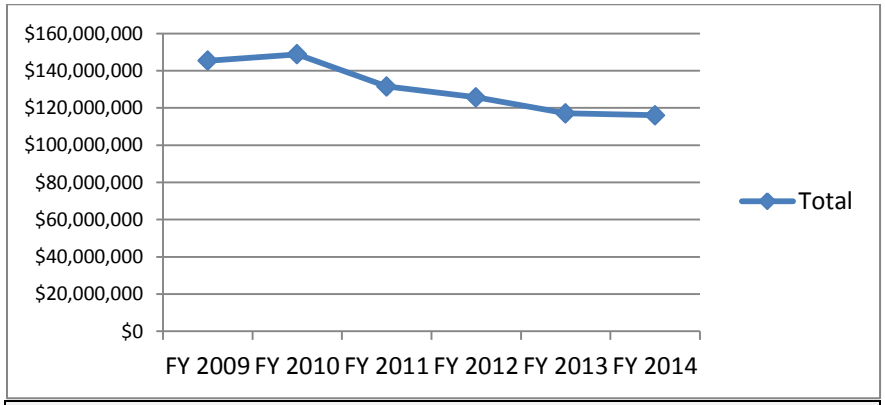
Race	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
American Indian / Alaskan	0	0	0	0	0	0	NA	NA
Asian	1	1	1	0	1	0	NA	-100.0%
Black or African American	26	24	26	21	31	29	4.5%	-6.5%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	34	21	17	16	19	19	-8.9%	0.0%
Bi-Racial / Multiple Race	4	0	1	2	3	4	NA	33.3%
Other	2	0	0	0	0	0	NA	NA
Unknown	0	2	0	0	0	0	NA	NA
Total	67	48	45	39	54	52	-2.6%	-3.7%

Table 55

DHR Addendum

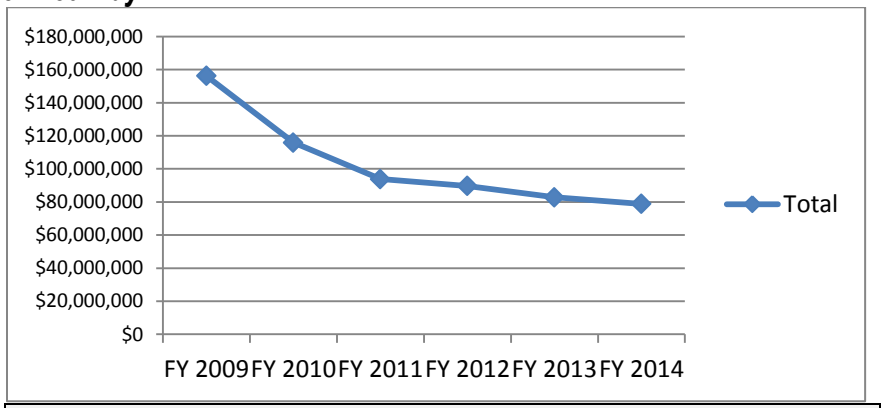
Subcategory Cost Comparisons

Total Costs and Per Bed-Day



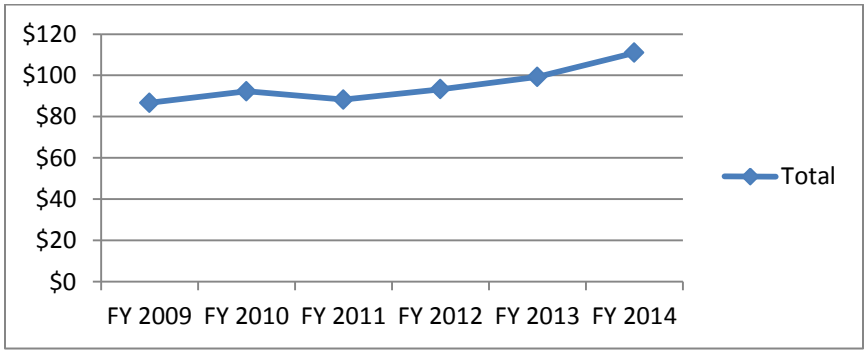
DHR Family Home Total Costs							
FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
$145,335,272	$148,811,233	$131,576,951	$125,716,002	$117,085,829	$116,053,950	-4.3%	-0.9%

Table 56



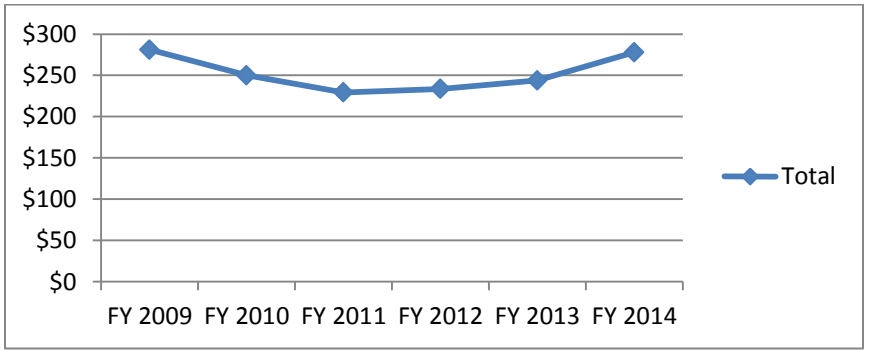
DHR Community-Based Total Costs							
FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
$156,230,898	$115,833,310	$93,862,099	$89,645,537	$82,856,211	$78,813,615	-14.2%	-7.6%

Table 58



DHR Family Home Costs Per Bed-Day (Residential Only)							
FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
$87	$92	$88	$93	$99	$111	5.2%	11.9%

Table 57



DHR Community-Based Costs Per Bed-Day (Residential Only)							
FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
$281	$250	$229	$234	$244	$278	-3.3%	4.3%

Table 59

Department of Juvenile Services (DJS) Summary

DJS has in recent years focused on reducing the time youth who have been committed by the juvenile court to out-of-home placement must stay in detention centers prior to placement. Central to these efforts is making sure that placement decisions are made in a timely, structured, and informed manner, and that youth are ultimately placed into programs meeting both security and treatment needs, to confirm a successful placement that does not result in a removal back to detention. At the same time, DJS has worked to ensure that those placement options are available by increasing the number of in-home slots for lower-risk youth and more secure placement options for higher-risk youth. Initiatives include:

More structured risk and needs assessments

Assessment and treatment planning policies have been refined to better capture the specific treatment needs of each youth, and to structure and guide the placement and case-management processes. The Maryland Comprehensive Assessment and Services Planning (MCASP) has been in place since FY2010 to guide case-forwarding and case-management decisions based on structured risk and needs assessments.

Increased capacity and use of in-home evidence-based programs for lower-risk youth

These programs are meant for youth who are at risk of out-of-home placement, but can be kept at home with intensive family-based services. In prior years such youth may have been placed in group homes or other community-based residential programs, due more to family and home issues than to significant risk to public safety. Since these in-home evidence-based programs (including Functional Family Therapy and Multisystemic Therapy) have been available, DJS use of family home settings (mainly Treatment Foster Care), and community-based residential programs (mainly Group Homes and Therapeutic Group Homes) has declined, as lower-risk youth are kept home.

Increased capacity for non-community-based residential programs for higher-risk youth

DJS has in recent years increased capacity to serve higher-risk youth who may have in previous years been either placed in out-of-State non-community-based placements or in Maryland non-secure community-based residential programs - often with unsuccessful outcomes. These secure placements are available at the State-run Victor Cullen Center, the J. DeWeese Carter Center, the Western Maryland Youth Centers, the William Donald Schaefer House, and the privately-run Silver Oak Academy. Thus, the decline in family home setting and community-based residential placements over the past few years can also be attributed to this increase in more secure slots, as higher-risk youth are more appropriately placed. One of the drivers of pending-placement populations has been the youth who had been placed into non-secure programs, only to be sent back to detention from programs that were not equipped to manage behavior.

Legislative changes allowing for rapid administrative transfer of committed youth

Statutory changes passed during the 2012 legislative session give DJS the ability to move youth from placements that are not working out to different committed programs of either equal or higher security without need for a new court hearing. The Continuum of Care statute[10] now allows DJS (through its new Central Review Committee) to review and, as necessary, quickly move such youth to more secure non-community-based residential programs that are better able to meet the security and treatment needs of the youth. This reduces the need for many youth to be sent back to detention pending a court hearing, and can reduce time in detention for youth that have been ejected. Having more programming capacity at the non-community-based residential placement level is key to the success of this initiative.

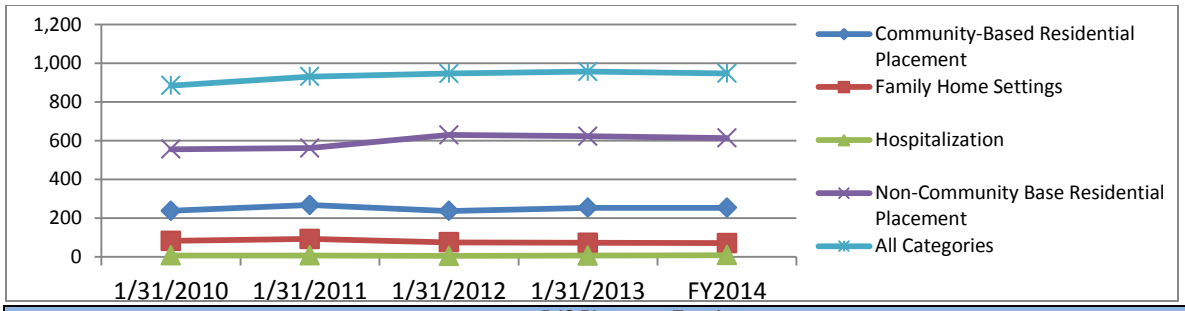
Restructuring the placement decision process for youth at risk of out-of-home placement

The Multi-disciplinary Assessment Staffing Team (MAST) process - an enriched multi-disciplinary process, intended to develop comprehensive individualized plans for youth who are removed from home, and to match youth with the right programs and services so that youth will be successful - was implemented across the State in FY2014. This process has shown initial success at moving youth more quickly through the placement decision process, thus reducing the time youth spend in detention centers prior to placement.

Streamlining placement process for out-of-State placements

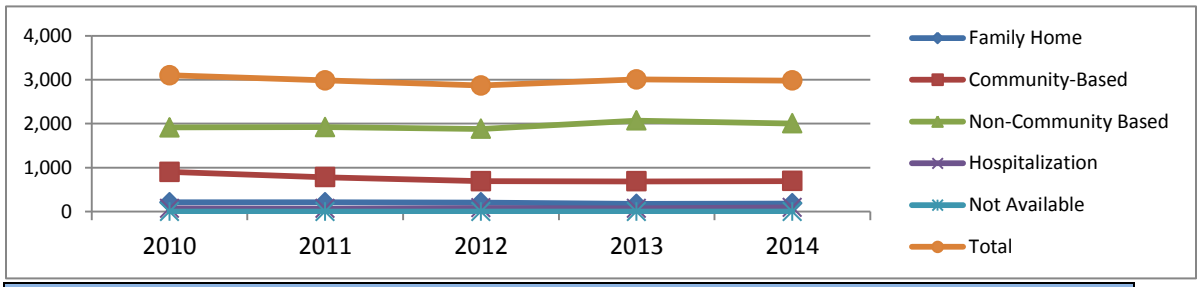
A large portion of secure placement options for committed youth continues to be in out-of-State programs, and the placement process for these youth has often led to long stays in detention for youth requiring secure placement. Youth being placed in out-of-State placements were previously required to be reviewed by the State Coordinating Council (SCC). Following legislation passed in 2011, the SCC has reevaluated and restructured the way it reviews the information on out-of-State placements in accordance with the 2008 Interagency Strategic Plan. The SCC notification form has also been streamlined to ensure that the SCC process does not interfere with placing a youth into the most appropriate placement possible based on individual needs. DJS developed a checklist and tip-sheet for DJS personnel to use which structured and streamlined internal processes. Once it is determined that in-State options have been exhausted, no out-of-State placement for a youth should be delayed due to incorrect or incomplete administrative requirements.

[10] Maryland Annotated Code, Courts and Judicial Proceedings Article, §3-8A-19.



DJS Placement Trends								
Category	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
Community-Based Residential Placement	238	268	237	254	254	258	2.4%	1.6%
Family Home Settings	83	93	75	73	71	90	3.5%	26.8%
Hospitalization	8	8	5	7	9	8	5.0%	-11.1%
Non-Community Base Residential Placement	556	562	630	623	614	525	-1.0%	-14.5%
Placement Category Not Available	0	0	0	0	0	0	NA	NA
All Categories	885	931	947	957	948	881	0.0%	-7.1%

Table 60



DJS Total Served							
Category	2009	2010	2011	2012	2013	2014	Average Change
Family Home	210	210	208	173	184	206	0.1%
Community-Based	902	783	692	688	694	631	-6.7%
Non-Community Based	1,915	1,922	1,883	2,070	2,005	1,592	-3.1%
Hospitalization	73	70	84	74	96	88	5.1%
Not Available	0	0	0	0	0	0	NA
Total	3,100	2,985	2,867	3,005	2,979	2,517	-3.8%

Table 61

DJS Trends in Out-of-Home Placement

Maryland has seen a sharp decline in the number of juvenile cases referred to DJS Intake in recent years. Since FY2009 the number of complaints referred to DJS declined 48%. This reduction in cases coming to the DJS "front door" has slowly rippled through the system in recent years. Detention populations have begun to decline, though at a slower rate than Intakes: down 36% since FY2009. Cases supervised in the community by DJS caseworkers have declined, with probation orders down 48% since FY2009. This declining trend has just begun to be reflected in the committed out-of-home population. Table 62 shows a three-year change in end of Fiscal Year population of 24%. Much of this decline occurred in the final quarter of FY2014. It is too early to tell if this decline will be sustained in FY2015. Declines in committed population, though evenly distributed by gender, are not evenly distributed by race. While the committed population of white youth declined 12.5%, the drop was just 2.9% for youth of color. The Department has recently partnered with the Annie E. Casey Foundation to study the

way youth are committed to out-of-home placements in Maryland, and to better understand how decisions made throughout the juvenile justice system can impact these racial disparities.

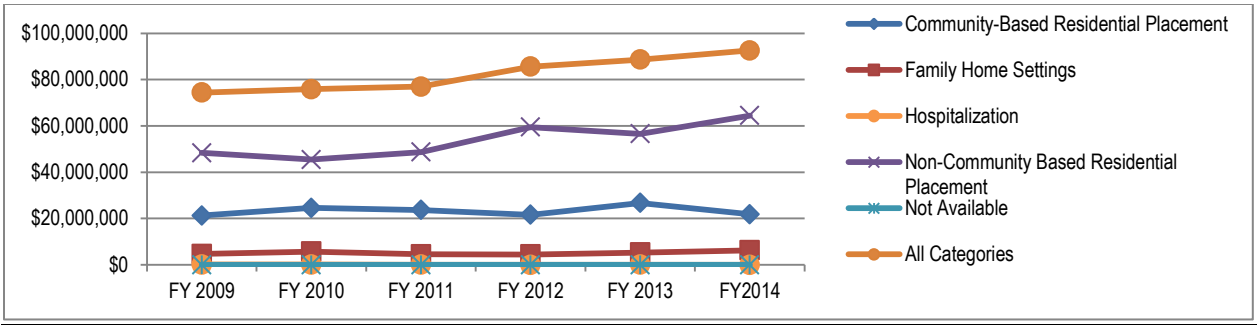
A large portion of secure placement options for committed youth continues to be in out-of-State programs. The population of youth placed out of State has also begun to decline in FY2014, averaging under 100 youth for the first time in five years.

DJS Population Flow (Placements, Not Children)					
State Fiscal Year	Placements at Start of FY	Starts in FY (New Placements)	Total Served	Ends in FT (Placement Exits)	Placements at End of FY
2010	894	2,091	2,985	2,104	881
2011	881	1,986	2,867	1,894	973
2012	961	2,044	3,005	2,039	966
2013	950	2,029	2,979	2,049	930
2014	810	1,707	2,517	1,778	739
Three-Year Change	-8.1%	-14.0%	-12.2%	-6.1%	-24.0%
Average Yearly Change	0.2%	-3.7%	-3.1%	-3.0%	-2.9%
Recent Year Change	-14.7%	-15.9%	-15.5%	-13.2%	-20.5%

Table 62

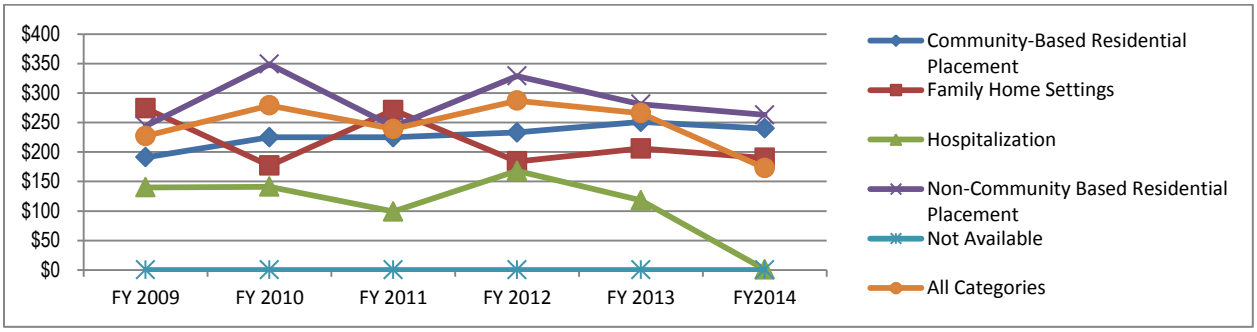
DJS Placement By Jurisdiction																													
	Jurisdiction Where Children Were Placed																												
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worcester	Out-of-State	Unknown
Allegany	19	2.2%	11	0	2	2	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	101	11.5%	10	1	15	12	0	0	11	0	0	4	9	9	1	0	1	6	5	0	0	0	0	6	2	0	9	0	
Baltimore	65	7.4%	9	0	11	5	0	0	4	0	0	1	4	11	0	0	1	3	0	0	0	0	0	3	0	0	13	0	
Baltimore City	164	18.6%	10	0	30	13	0	0	15	0	0	4	16	9	0	3	2	12	0	0	0	0	0	11	4	0	34	0	
Calvert	17	1.9%	2	0	2	0	0	0	1	0	0	1	2	3	0	0	0	0	0	0	0	0	0	2	2	0	2	0	
Caroline	1	0.1%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Carroll	20	2.3%	5	0	2	0	0	0	2	0	0	0	2	2	0	0	2	0	0	0	0	0	0	3	0	0	2	0	
Cecil	13	1.5%	0	0	6	1	0	1	0	0	0	0	2	1	0	0	1	0	0	0	0	0	0	0	1	0	0	0	
Charles	23	2.6%	2	0	5	2	0	0	0	0	0	2	2	3	0	0	1	2	0	0	0	0	0	2	0	0	2	0	
Dorchester	11	1.2%	0	0	2	3	0	0	1	0	0	1	0	0	0	0	2	0	0	0	0	0	0	1	0	0	1	0	
Frederick	18	2.0%	4	0	4	5	0	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	
Garrett	5	0.6%	3	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	
Harford	25	2.8%	2	0	5	5	0	0	0	0	0	2	1	2	0	0	1	2	0	0	0	0	0	5	0	0	0	0	
Howard	14	1.6%	2	0	4	4	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	1	0	0	1	0	
Kent	4	0.5%	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Montgomery	57	6.5%	13	0	6	5	0	0	1	0	0	0	4	4	0	0	0	12	3	0	0	0	0	2	1	0	5	0	
Prince George's	182	20.7%	26	0	24	14	1	0	17	0	0	3	19	19	0	1	7	9	5	0	0	0	0	13	4	0	17	0	
Queen Anne's	2	0.2%	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Somerset	7	0.8%	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	0	0	0	0	1	0	1	0	
St. Mary's	13	1.5%	2	0	1	2	0	0	1	0	0	1	1	1	0	0	0	1	0	0	0	0	0	1	1	0	0	0	
Talbot	7	0.8%	0	0	1	0	0	0	0	0	0	3	1	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	
Washington	24	2.7%	7	0	2	3	0	0	1	0	0	0	0	0	0	0	0	2	0	0	0	0	0	9	0	0	0	0	
Wicomico	57	6.5%	3	0	15	4	0	2	2	0	0	6	0	3	0	0	1	6	1	0	0	0	0	0	12	0	2	0	
Worcester	6	0.7%	0	0	2	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3	0	0	0	
Out-of-State	26	3.0%	1	0	7	3	1	0	1	0	0	1	1	0	0	0	0	2	0	0	0	0	0	0	2	0	7	0	
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Grand Total	881	100.0	115	0	150	84	2	5	58	0	0	29	70	68	1	4	19	59	1	0	0	0	0	61	36	0	96	0	
% of children from jurisdiction			57.9%	1.0%	16.9%	7.9%	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	21.1%	2.7%	0.0%	0.0%	0.0%	0.0%	37.5%	21.1%	0.0%	26.9%	0.0%	
% children Statewide in all			13.1%	0.0%	17.0%	9.5%	0.2%	0.6%	6.6%	0.0%	0.0%	3.3%	7.9%	7.7%	0.1%	0.5%	2.2%	6.7%	1.9%	0.0%	0.0%	0.0%	0.0%	6.9%	4.1%	0.0%	10.9%	0.0%	

Table 63



DJS Total Cost								
Category	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY2014	Average Change	Last Year Change
Community-Based Residential Placement	$21,242,760	$24,592,016	$23,676,804	$21,634,051	$26,725,210	$21,828,389	1.7%	-18.3%
Family Home Settings	$4,679,628	$5,717,155	$4,575,954	$4,517,994	$5,329,639	$6,278,370	7.3%	17.8%
Hospitalization	$110,292	$97,064	$28,977	$14,946	$41,220	$19,652	-1.4%	-52.3%
Non-Community Based Residential Placement	$48,362,284	$45,458,947	$48,695,167	$59,475,243	$56,581,033	$64,467,134	6.5%	13.9%
Not Available	$0	$0	$0	$0	$0	$0	NA	NA
All Categories	$74,394,964	$75,865,182	$76,976,902	$85,642,234	$88,677,102	$92,593,545	4.5%	4.4%

Table 64



DJS Costs Per Bed Day								
Category	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY2014	Average Change	Last Year Change
Community-Based Residential Placement	$191	$225	$225	$233	$251	$235	4.9%	-4.4%
Family Home Settings	$274	$177	$271	$184	$206	$231	-2.0%	-7.8%
Hospitalization	$140	$141	$99	$168	$118	$1	-17.7%	-99.4%
Non-Community Based Residential Placement	$244	$349	$243	$329	$281	$281	5.4%	-6.4%
Not Available	NA	NA	NA	NA	NA	NA	NA	NA
All Categories	$227	$279	$239	$287	$266	$187	-2.7%	-35.0%

Table 65

DJS Recommendations

The Continuum of Care statute should be maintained to ensure that DJS continues to have the ability to quickly move youth as necessary from committed placements that are not working out, without need for further court action. This will permit DJS to continue to leverage current resources and to strengthen the DJS Continuum of Care to best serve youth committed to DJS for treatment and rehabilitation by:

- Eliminating a youth's time in detention when a youth is ejected from a residential placement. Youth do not receive treatment services while awaiting placement in detention.
- Reducing the likelihood a youth will be released from pending placement without the benefit of treatment when s/he remains in pending placement for long periods of time.
- Decreasing the overall length of time the youth stays in committed status with DJS, by allowing DJS to swiftly address treatment concerns and issues without the youth being placed in detention.

The Continuum of Care legislation has a significant impact on DJS operations. The implementation of this legislation has led to a sustained reduction of youth pending placement in detention centers and has improved the youth's ability to receive the required treatment services.

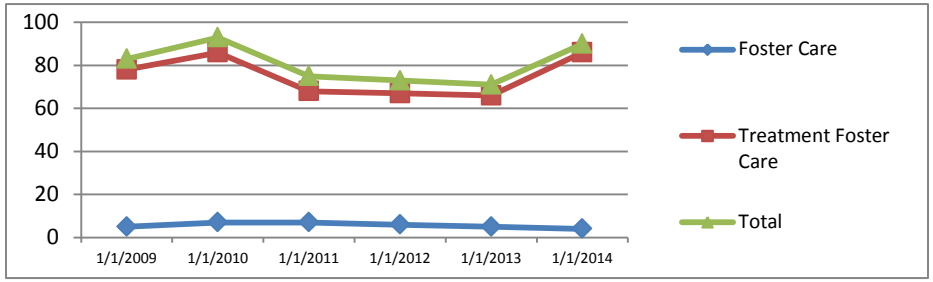
The Legislature should continue to support DJS capital projects to ensure that DJS has access to adequate capacity to serve the diverse needs of the youth that require an out-of-home placement.

DJS is participating on a subcommittee of the Interagency Rate-Setting Committee (IRC) to evaluate the current rate-setting process for residential child care programs. The subcommittee is exploring ways in which the process can: a) allow for flexibility and innovation in order to meet the needs of children placed in out-of-home care; and b) establish a link between the rate and performance-based outcomes of the program and of children served.

DJS Addendum

Subcategory One-Day Census Totals

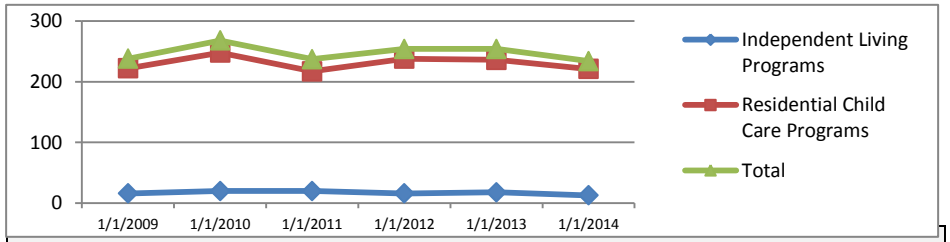
Placement Trends



DJS Family Home Settings Placement Trends

Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Adoptive Care	0	0	0	0	0	0	NA	NA
Foster Care	5	7	7	6	5	4	-2.2%	-20.0%
Formal Relative (Kinship) Care	0	0	0	0	0	0	NA	NA
Restrictive Relative (Kinship) Care	0	0	0	0	0	0	NA	NA
Treatment Foster Care	78	86	68	67	66	86	3.3%	30.3%
Living Arrangement - Family Home	0	0	0	0	0	0	NA	NA
Total	83	93	75	73	71	90	2.8%	26.8%

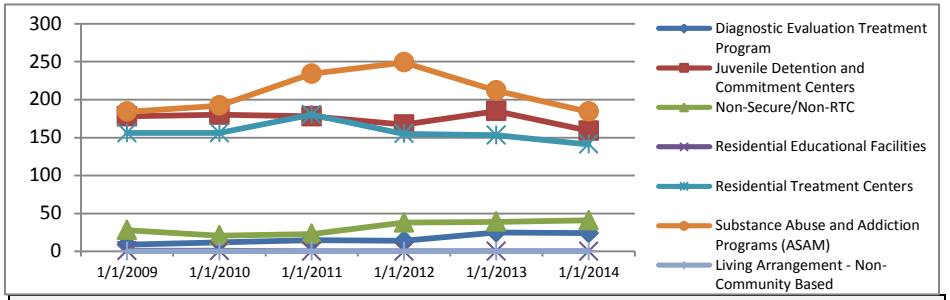
Table 66



DJS Community-Based Trends

Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Independent Living Programs	16	20	20	16	18	13	-2.1%	-27.8%
Residential Child Care Programs	222	248	217	238	236	221	0.3%	-6.4%
Community Supported Living Arrangement (CSLA)	0	0	0	0	0	0	NA	NA
Living Arrangement - CB	0	0	0	0	0	0	NA	NA
Total	238	268	237	254	254	234	0.1%	-7.9%

Table 67



DJS Non-Community Placement Trends

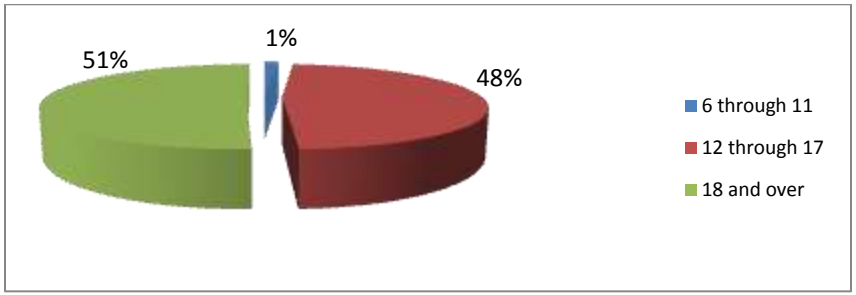
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	9	12	15	14	25	24	25.2%	-4.0%
Juvenile Detention and Commitment Centers	178	180	178	167	185	159	-1.9%	-14.1%
Non-Secure/Non-RTC	28	21	23	38	39	41	11.5%	5.1%
Residential Educational Facilities	1	1	0	0	0	0	NA	NA
Residential Treatment Centers	156	156	180	155	153	141	-1.5%	-7.8%
Substance Abuse and Addiction Programs	184	192	234	249	212	184	0.9%	-13.2%
Living Arrangement - Non-CB	0	0	0	0	0	0	NA	NA
Total	556	562	630	623	614	549	0.0%	-10.6%

Table 68

DJS Addendum

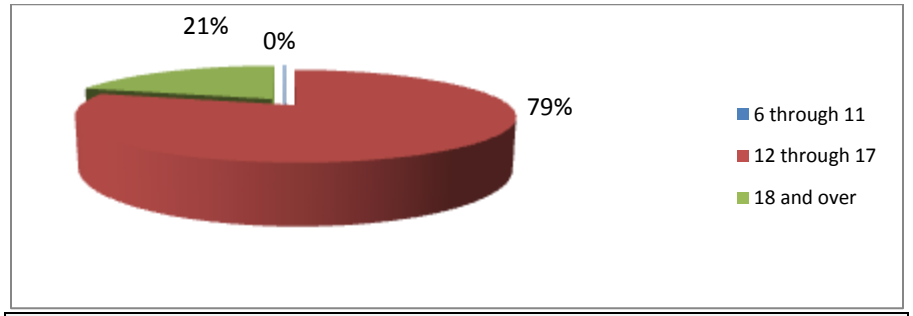
Subcategory Totals Demographic Comparisons

Age



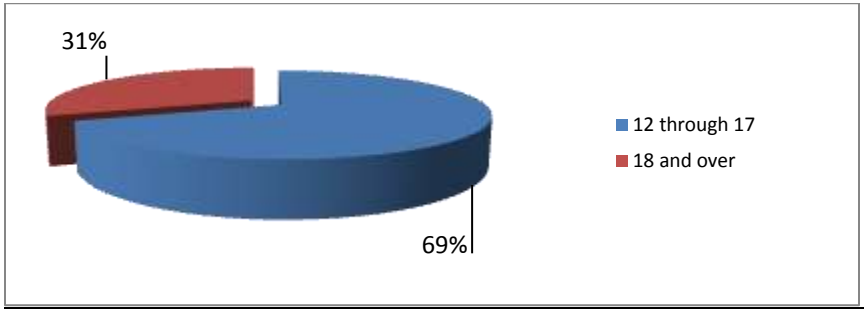
DJS Family Home Settings Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	0	0	0	0	0	0	NA	NA
6 through 11	0	0	0	0	1	1	NA	0.0%
12 through 17	47	60	42	33	34	46	2.9%	35.3%
18 and over	36	33	33	40	36	43	4.5%	19.4%
Total	83	93	75	73	71	90	2.8%	26.8%

Table 69



DJS Non-Community-Based Settings Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	0	0	0	0	0	0	NA	NA
6 through 11	0	1	1	1	3	1	NA	-66.7%
12 through 17	442	428	466	488	482	435	-0.1%	-9.8%
18 and over	114	133	163	134	129	113	1.1%	-12.4%
Total	556	562	630	623	614	549	0.0%	-10.6%

Table 71



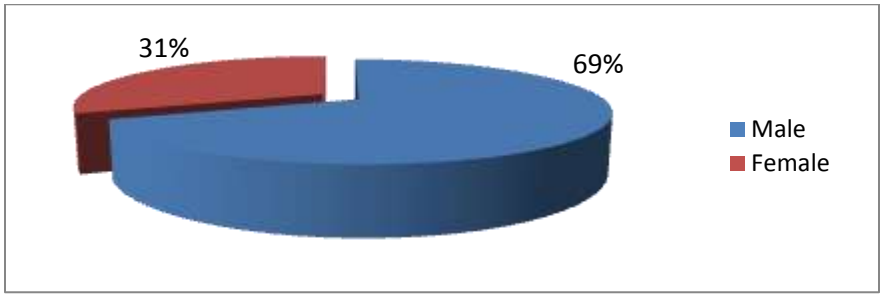
DJS Community-Based Settings Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	0	0	0	0	0	0	NA	NA
6 through 11	0	0	0	0	0	0	NA	NA
12 through 17	192	211	174	196	195	162	1.1%	-0.5%
18 and over	46	57	63	58	59	72	7.1%	1.7%
Total	238	268	237	254	254	234	2.1%	0.0%

Table 70

DJS Addendum

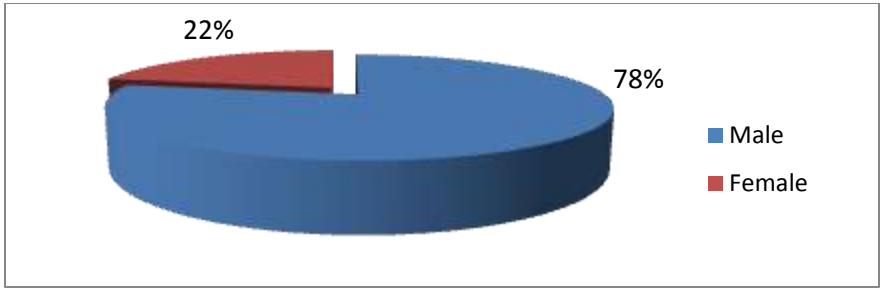
Subcategory Totals Demographic Comparisons

Gender



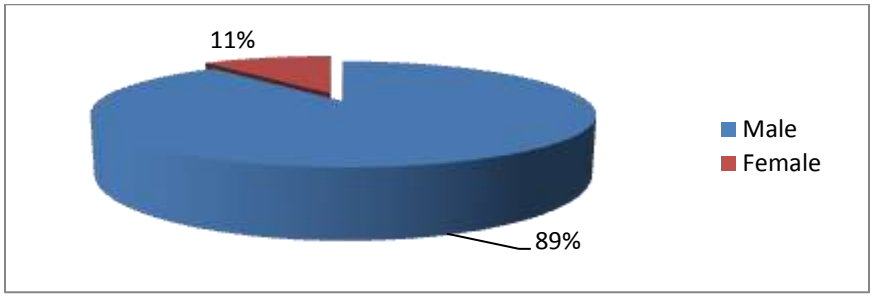
DJS Family Home Settings Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	66	68	57	52	54	62	-0.7%	14.8%
Female	17	25	18	21	17	28	16.3%	64.7%
Unknown	0	0	0	0	0	0	NA	NA
Total	83	93	75	73	71	90	2.8%	26.8%

Table 72



DJS Community-Based Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	191	213	189	197	194	183	-0.5%	-5.7%
Female	47	55	48	57	60	51	2.7%	-15.0%
Unknown	0	0	0	0	0		NA	NA
Total	238	268	237	254	254	234	0.1%	0.0%

Table 73



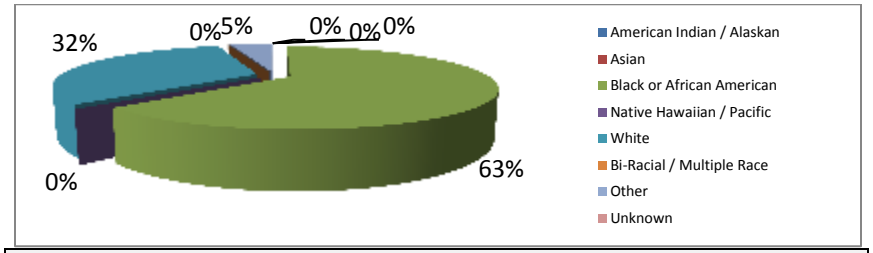
DJS Non-Community-Based Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	502	506	575	565	545	490	-0.2%	-10.1%
Female	54	56	55	58	69	59	2.4%	-14.5%
Unknown	0	0	0	0	0	0	NA	NA
Total	556	562	630	623	614	549	0.0%	-10.6%

Table 74

DJS Addendum

Subcategory Totals Demographic Comparisons

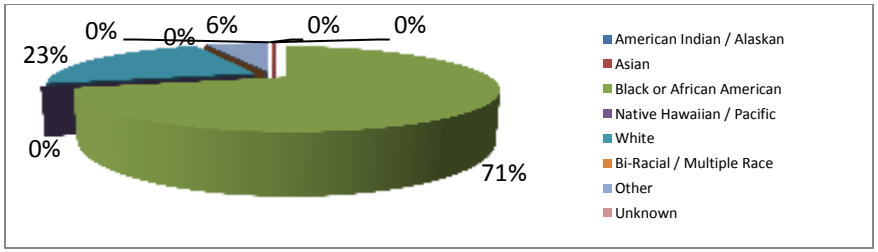
Race



DJS Family Home Settings Race Trends

Race	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
American Indian / Alaskan	0	1	0	0	0	0	NA	NA
Asian	0	0	0	0	0	0	NA	NA
Black or African American	54	62	47	43	37	57	4.4%	54.1%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	24	25	23	25	31	29	4.5%	-6.5%
Bi-Racial / Multiple Race	0	0	0	0	0	0	NA	NA
Other	4	4	5	4	3	4	2.7%	33.3%
Unknown	1	1	0	1	0	0	NA	NA
Total	83	93	75	73	71	90	2.8%	26.8%

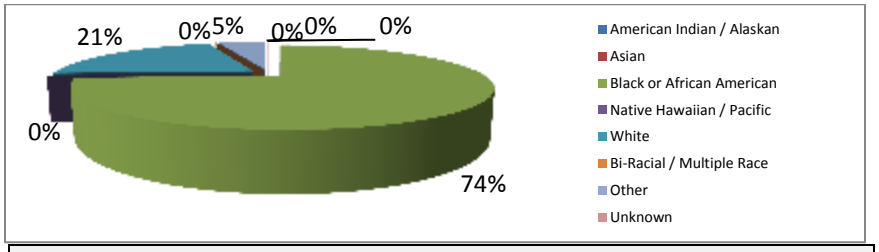
Table 75



DJS Community-Based Settings Race Trends

Race	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
American Indian / Alaskan	1	0	0	0	0	0	NA	NA
Asian	1	1	0	0	2	1	NA	-50.0%
Black or African American	169	205	182	185	168	165	0.2%	-1.8%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	60	54	42	60	66	53	0.2%	-19.7%
Bi-Racial / Multiple Race	0	0	0	0	0	0	NA	NA
Other	7	7	11	9	18	15	24.5%	-16.7%
Unknown	0	1	2	0	0	0	NA	NA
Total	238	268	237	254	254	234	0.1%	-7.9%

Table 76



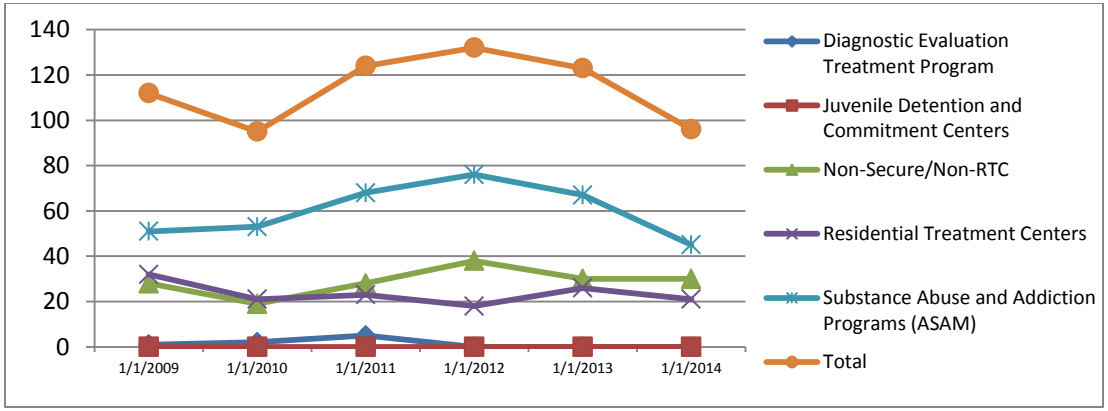
DJS Non-Community Based Settings Race Trends

Race	1/31/ 2009	1/31/ 2010	1/31/ 2011	1/31/ 2012	1/31/ 2013	1/31/ 2014	Average Change	Last Year Change
American Indian / Alaskan	1	1	0	0	0	0	NA	NA
Asian	2	1	3	0	2	1	NA	-50.0%
Black or African American	383	398	456	450	450	399	1.2%	-11.3%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	154	132	143	151	131	113	-5.5%	-13.7%
Bi-Racial / Multiple Race	0	0	0	0	0	0	NA	NA
Other	14	25	24	22	31	27	18.8%	-12.9%
Unknown	2	5	4	0	0	0	NA	NA
Total	556	562	630	623	614	540	-0.3%	-12.1%

Table 77

DJS Addendum

Subcategory Out-of-State One-Day Census Totals



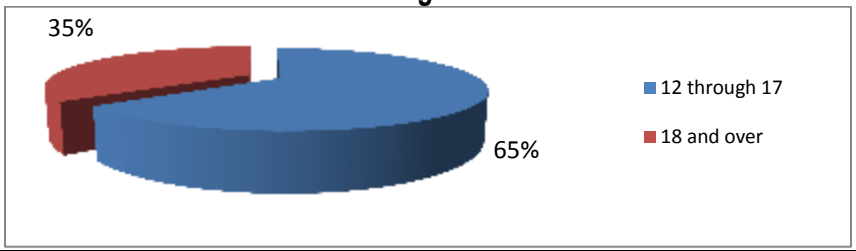
DJS Out of State Non-Community-Based Placement Trends								
Subcategory	**1/31/2009**	**1/31/2010**	**1/31/2011**	**1/31/2012**	**1/31/2013**	**1/31/2014**	**Average Change**	**Last Year Change**
Diagnostic Evaluation Treatment Program	1	2	5	0	0	0	NA	NA
Juvenile Detention and Commitment Centers	0	0	0	0	0	0	NA	NA
Non-Secure/Non-RTC	28	19	28	38	30	30	6.0%	0.0%
Residential Educational Facilities	0	0	0	0	0	0	NA	NA
Residential Treatment Centers	32	21	23	18	26	21	-4.3%	-19.2%
Substance Abuse and Addiction Programs	51	53	68	76	67	45	-0.1%	-32.8%
Living Arrangement - Non-Community Based	0	0	0	0	0	0	NA	NA
Total	112	95	124	132	123	96	-1.4%	-22.0%

Table 78

DJS Addendum

Subcategory Out-of-State Demographic Comparison

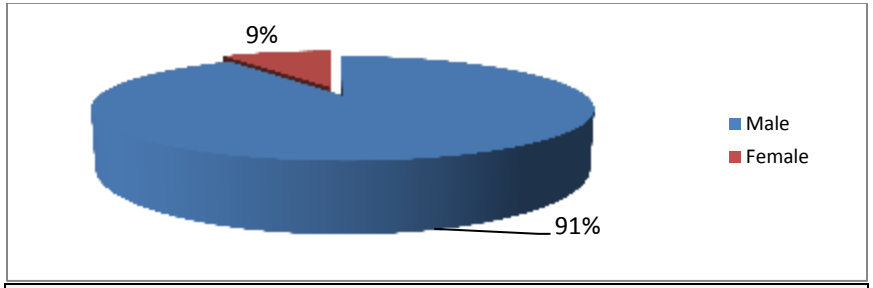
Age



DJS Out of State Non-Community-Based Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	0	0	0	0	0	0	NA	NA
6 through 11	0	0	0	0	0	0	NA	NA
12 through 17	78	59	79	88	79	62	-2.2%	-21.5%
18 and over	34	36	45	44	44	34	1.2%	-22.7%
Total	112	95	124	132	123	96	-1.4%	-22.0%

Table 79

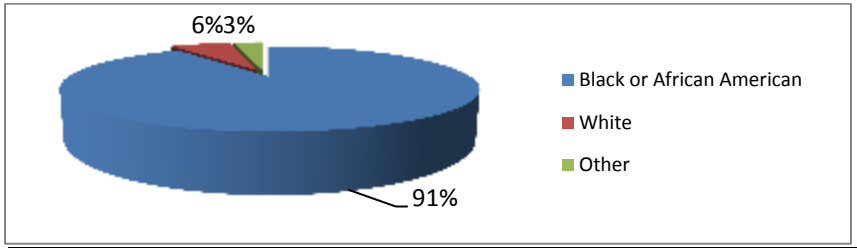
Gender



DJS Out-of-State Non-Community-Based Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	107	89	123	130	117	87	-1.7%	-25.6%
Female	5	6	1	2	6	9	57.3%	50.0%
Unknown	0	0	0	0	0	0	NA	NA
Total	112	95	124	132	123	96	-1.4%	-22.0%

Table 80

Race



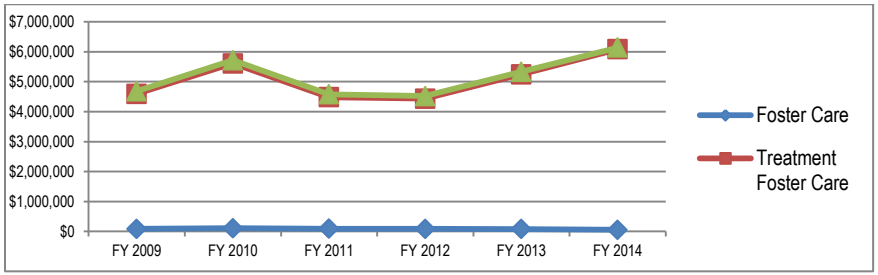
DJS Out-of-State Non-Community-Based Race Trends								
Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
American Indian / Alaskan	0	1	0	0	0	0	NA	NA
Asian	2	0	1	0	0	0	NA	NA
Black or African American	92	78	104	119	107	87	0.8%	-18.7%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	17	12	12	8	10	6	-15.5%	-40.0%
Bi-Racial / Multiple Race	0	0	0	0	0	0	NA	NA
Other	1	4	6	5	6	3	60.7%	-50.0%
Unknown	0	0	1	0	0	0	NA	NA
Total	112	95	124	132	123	96	-1.4%	-22.0%

Table 81

DJS Addendum

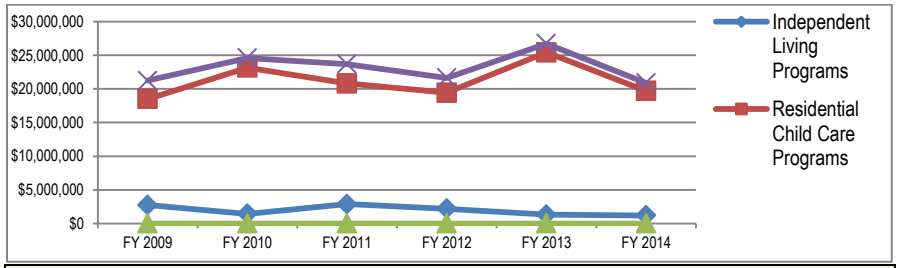
Subcategory Cost Comparison

Total Costs



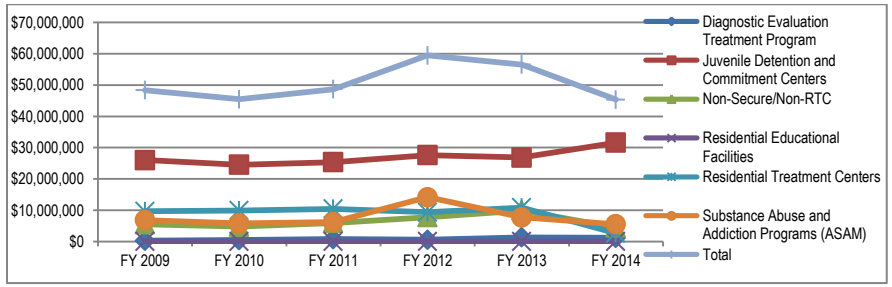
DJS Family Home Total Costs								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Foster Care	$87,217	$108,702	$94,347	$85,937	$83,656	$55,821	-6.7%	-33.3%
Treatment Foster Care	$4,592,411	$5,608,453	$4,481,607	$4,432,057	$5,245,983	$6,082,517	7.0%	15.9%
Total	$4,679,628	$5,717,155	$4,575,954	$4,517,994	$5,329,639	$6,138,338	6.8%	15.2%

Table 82



DJS Community Based Total Costs								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Independent Living Programs	$2,735,959	$1,423,270	$2,879,310	$2,197,844	$1,314,246	$1,187,123	-3.8%	-9.7%
Residential Child Care Programs	$18,506,801	$23,168,746	$20,797,494	$19,436,207	$25,410,964	$19,687,564	3.3%	-22.5%
Community Supported Living Arrangement	$0	$0	$0	$0	$0	$0	NA	NA
Living Arrangement - CB	$0	$0	$0	$0	$0	$0	NA	NA
Total	$21,242,760	$24,592,016	$23,676,804	$21,634,051	$26,725,210	$20,874,687	1.0%	-21.9%

Table 83

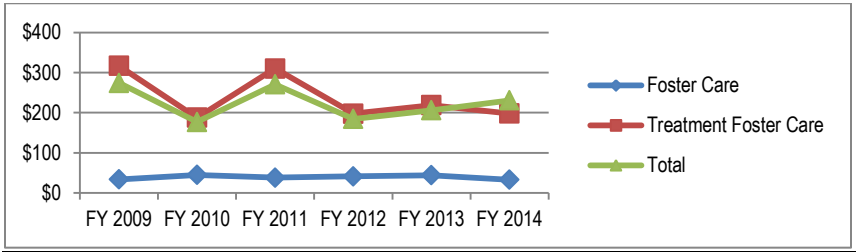


DJS Non-Community Based Total Costs								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	$257,615	$469,239	$772,896	$539,495	$1,303,799	$1,167,096	49.6%	-10.5%
Juvenile Detention and Commitment Centers	$26,032,363	$24,558,746	$25,367,344	$27,630,982	$26,831,507	$31,578,635	4.3%	17.7%
Non-Secure/Non-RTC	$5,536,334	$4,742,328	$5,919,055	$7,787,834	$9,910,700	$4,472,218	2.9%	-54.9%
Residential Educational Facilities	$0	$0	$0	$0	$0	$0	NA	NA
Residential Treatment Centers	$9,674,065	$9,913,715	$10,433,639	$9,344,675	$10,814,084	$2,626,588	-12.5%	-75.7%
Substance Abuse and Addiction Programs (ASAM)	$6,861,907	$5,774,919	$6,202,233	$14,172,257	$7,720,944	$5,526,535	9.2%	-28.4%
Total	$48,362,284	$45,458,947	$48,695,167	$59,475,243	$56,581,033	$45,371,072	-0.3%	-19.8%

Table 84

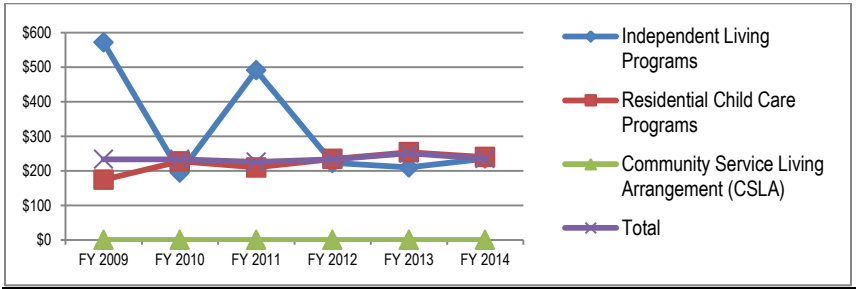
DJS Addendum

Subcategory Cost Comparison Per Bed-Day



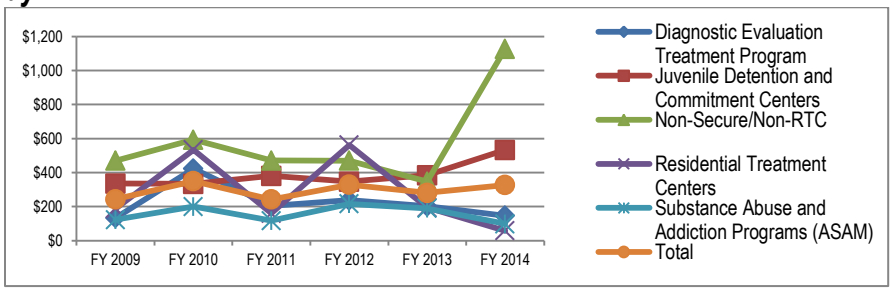
DJS Family Home Costs Per Bed-Day								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Foster Care	$34	$45	$38	$41	$44	$33	1.5%	-25.0%
Treatment Foster Care	$317	$188	$310	$198	$219	$198	-2.1%	-9.5%
Total	$274	$177	$271	$184	$206	$231	1.9%	12.2%

Table 85



DJS Community Based Costs Per Bed-Day								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Independent Living Programs	$571	$195	$491	$223	$210	$235	7.5%	12.1%
Residential Child Care Programs	$174	$227	$210	$234	$254	$240	7.5%	-5.4%
Community Supported Living Arrangement	$0	$0	$0	$0	$0	$0	NA	NA
Living Arrangement - CB	$0	$0	$0	$0	$0	$0	NA	NA
Total	$233	$233	$225	$233	$251	$235	0.3%	-6.4%

Table 86

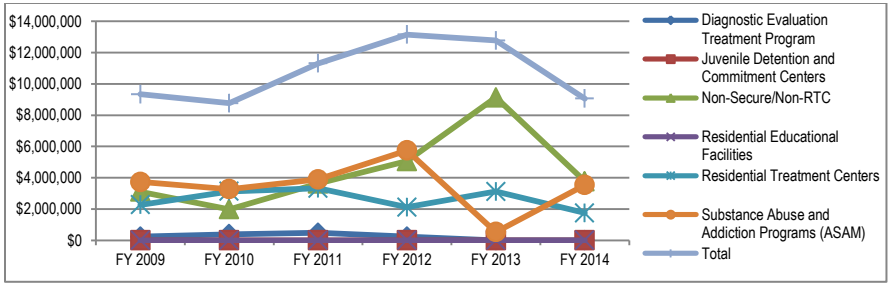


DJS Non-Community Based Costs Per Bed-Day								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	$133	$423	$205	$238	$203	$147	27.9%	-27.4%
Juvenile Detention and Commitment Centers	$335	$334	$380	$347	$384	$533	10.8%	38.6%
Non-Secure/Non-RTC	$470	$593	$471	$470	$347	$1,127	40.8%	225.2%
Residential Educational Facilities	$0	$0	$0	$0	$0	$0	NA	NA
Residential Treatment Centers	$188	$535	$161	$562	$195	$58	45.5%	-70.2%
Substance Abuse and Addiction Programs (ASAM)	$123	$201	$118	$216	$190	$99	8.9%	-47.8%
Total	$244	$349	$243	$329	$281	$327	10.0%	16.2%

Table 87

DJS Addendum

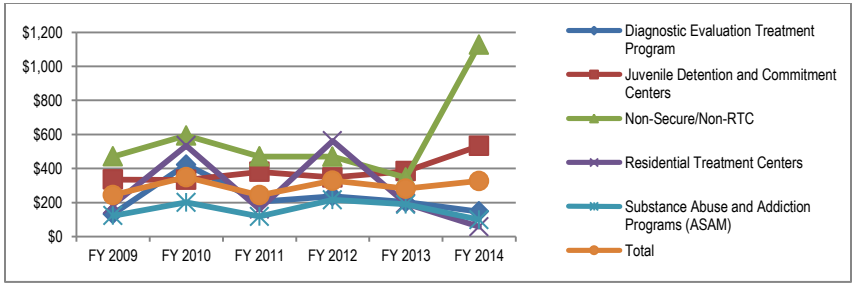
Subcategory Out-of-State Cost Comparison



DJS Out-of-State Non-Community Based Total Costs

Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	$228,038	$390,037	$474,781	$233,070	$0	$0	NA	NA
Juvenile Detention and Commitment Centers	$0	$0	$0	$0	$0	$0	NA	NA
Non-Secure/Non-RTC	$3,111,076	$1,980,475	$3,628,879	$5,062,804	$9,129,507	$4,405,939	21.6%	-51.7%
Residential Educational Facilities	$0	$0	$0	$0	$0	$0	NA	NA
Residential Treatment Centers	$2,271,162	$3,126,830	$3,317,929	$2,115,372	$3,114,182	$2,207,451	2.2%	-2.19%
Substance Abuse and Addiction Programs	$3,729,449	$3,270,341	$3,892,799	$5,748,018	$528,718	$4,206,920	106.6%	569.2%
Total	$9,339,725	$8,767,683	$11,314,388	$13,159,265	$12,772,406	$10,820,310	1.4%	-14.9%

Table 88



DJS Out-of-State Non-Community Based Costs Per Bed Day

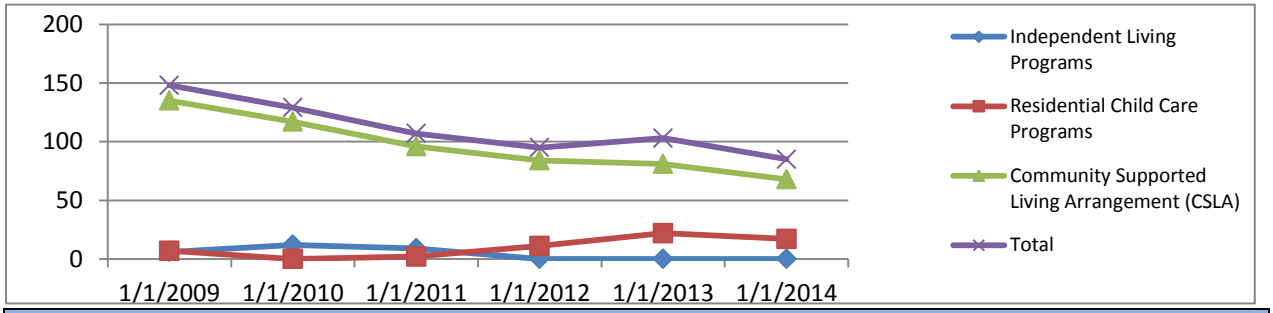
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	$500	$362	$294	$281	NA	NA	NA	NA
Juvenile Detention and Commitment Centers	NA	NA	NA	NA	NA	NA	NA	NA
Non-Secure/Non-RTC	$333	$359	$373	$390	$361	$341	0.6%	-5.5%
Residential Educational Facilities	NA	NA	NA	NA	NA	NA	NA	NA
Residential Treatment Centers	$411	$357	$268	$383	$438	$241	-5.2%	-44.9%
Substance Abuse and Addiction Programs	$196	$180	$192	$232	$240	$210	2.1%	-12.3%
Total	$272	$261	$257	$298	$369	$264	1.2%	-28.4%

Table 89

Developmental Disabilities Administration (DDA) Summary

DDA provides a coordinated service delivery system oriented toward the goal of integrating individuals with intellectual and developmental disabilities into the community. DDA services are provided through a wide array of community-based services delivered primarily through a network of licensed providers. In addition to adults, DDA makes these services available to children residing in out-of-home placements and in their family homes. When children reside in out-of-home placements, they should receive all appropriate entitlement services prior to accessing DDA funds for services. In FY2014, DDA provided funding for out-of-home services to a total of 128 children, a decrease of 14.7% from FY2013.

DDA considers families and caregivers to be the primary supports for children with intellectual and developmental disabilities, and believes they should have an integral role in children's care. DDA recognizes that families and caregivers have unique and varied needs, and may need assistance from both formal and informal networks to provide their children with the support to reach their full potential as they grow up.



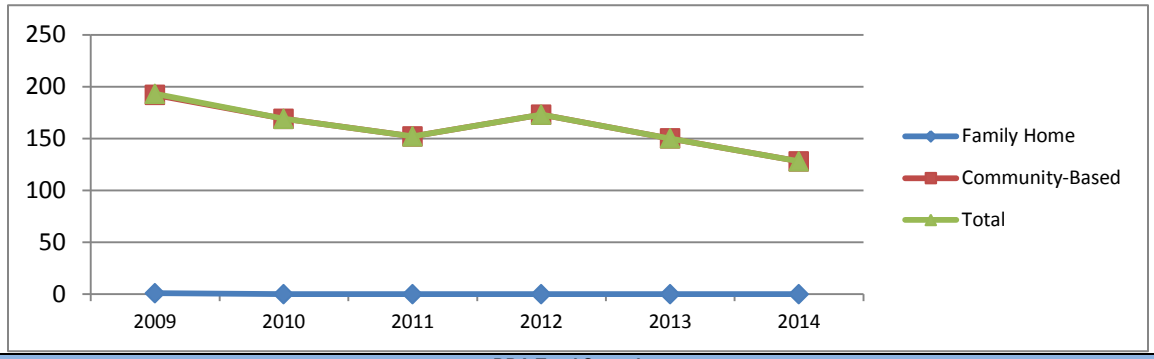
DDA Placement Trends								
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Independent Living Programs	6	12	9	0	0	0	NA	NA
Residential Child Care Programs	7	0	2	11	22	17	NA	-22.7%
Community-Supported Living Arrangement (CSLA)	135	117	96	84	81	68	-12.7%	-16.0%
Living Arrangement - Community Based	0	0	0	0	0	0	NA	NA
Total	148	129	107	95	103	85	-10.0%	-17.5%

Table 90

Table 90 shows a one-day count of DDA's out-of-home placements on January 31st of each year from 2009 through 2014. In FY2014, the one day count of Community-Supported Living Arrangements (CSLA) services decreased by 16.0%, and the one-day count of children receiving DDA Residential Child Care Program (RCCP) services declined by 22.7%. CSLA services are provided for the majority of children (68 of 85 individuals) that DDA serves in out-of-home placements. CSLA services enable individuals to live in their own homes, apartments, family homes, or rental units by providing supervision and other necessary interventions, thus allowing individuals to remain near friends, members of their family, their local areas, and other known supports.

RCCP services are provided by DDA-licensed providers, and include Group Homes and Alternative Living Units. Group Homes are residences owned, leased, or operated by a DDA

licensee that provide specialized residential services to at least 4 but not more than 8 individuals with intellectual and developmental disabilities. Alternative Living Units are residences owned or leased by DDA licensees that provide specialized residential services to no more than 3 individuals with intellectual and developmental disabilities.



DDA Total Served								
	2009	2010	2011	2012	2013	2014	Average Change	Last Year Change
Family Home	1	0	0	0	0	0	NA	NA
Community-Based	192	169	152	173	150	128	-7.2%	-14.7%
Total	193	169	152	173	150	128	-7.3%	-14.7%

Table 91

Table 91 shows the number of children receiving out-of-home services in FY 2014 has decreased by 14.7% from FY 2013.

DDA Population Flow					
State Fiscal Year	Placements at Start of FY	Starts in FY (New Placements)	Total Served	Ends in FT (Placement Exits)	Placements at End of FY
2010	136	33	169	29	140
2011	116	36	152	28	124
2012	102	71	173	34	139
2013	102	48	150	28	122
2014	92	36	128	27	101
Three-Year Change	-20.7%	0.0%	-15.8%	-3.6%	-18.5%
Average Yearly Change	-9.1%	12.2%	-6.1%	-0.8%	-7.2%
Recent Year Change	-9.8%	-25.0%	-14.7%	-3.6%	-17.2%

Table 92

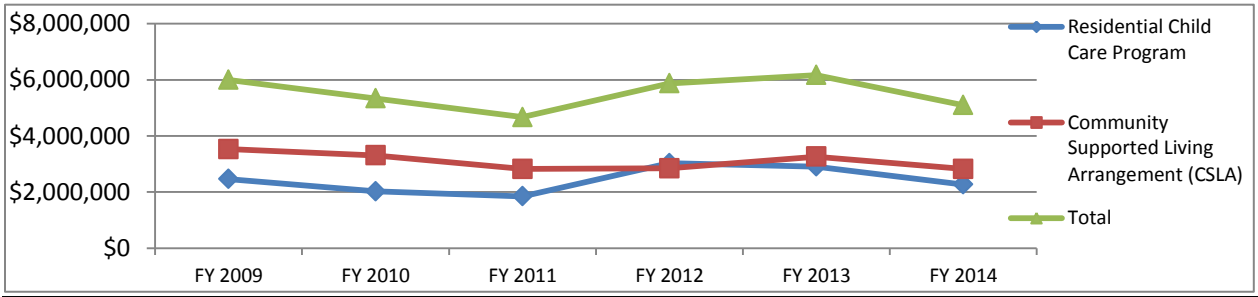
DDA is committed to individualized, flexible, family-centered, and family-directed services, and whenever possible attempts to place children in their home jurisdiction. If placement in the home jurisdiction cannot occur, DDA collaborates with other agencies such as DHR, MSDE, and the DHMH Behavioral Health Administration (BHA), responsible for the welfare of children through interagency and intra-agency boards, coordinating councils, committees, and task forces at the State and local levels. These collaborations help to ensure that services are coordinated and entities utilize all appropriate resources for the children. In addition, arrangements for co-funding of interagency service plans are made for children who qualify for services through multiple agencies in order to maximize available resources.

DDA Placement by Jurisdiction on 1/31/2014																													
			Jurisdiction Where Children Are Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worcester	Out-of State	Unknown-
Allegany	3	4.1%	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	2	2.7%	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	8	11.0%	0	0	6	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore City	3	4.1%	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Calvert	2	2.7%	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	6	8.2%	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	2	2.7%	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	1	1.4%	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	1	1.4%	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	3	4.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	26	35.6%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	26	0	0	0	0	0	0	0	0	0	0	0
Prince George's	11	15.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0	0	0	0	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	1	1.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
St. Mary's	1	1.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	3	4.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0
Wicomico	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worcester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	73	100.0%	3	2	6	4	2	0	7	0	2	0	1	0	1	3	0	26	11	0	1	1	0	3	0	0	0	0	0
% of children from jurisdiction			100.0%	100.0%	75.0%	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			4.1%	2.7%	8.2%	5.5%	2.7%	0.0%	9.6%	0.0%	2.7%	0.0%	1.4%	0.0%	1.4%	4.1%	0.0%	35.6 %	15.1 %	0.0%	1.4%	1.4%	0.0%	4.1%	0.0%	0.0%	0.0%	0.0%

Table 93

As indicated in Table 92, the total number of placements at the start of each fiscal year has declined 20.7% over the past three years. The number of new placements in DDA services from FY2013 to FY2014 decreased by 25%. The total number of placements by DDA in out-of-home placements in FY2014 was 128, 14.7% lower than in FY2013. This table shows the number of placements and not the number of children. In some instances, a child will have more than one placement due to hospitalization, reunification, or move to a new setting.

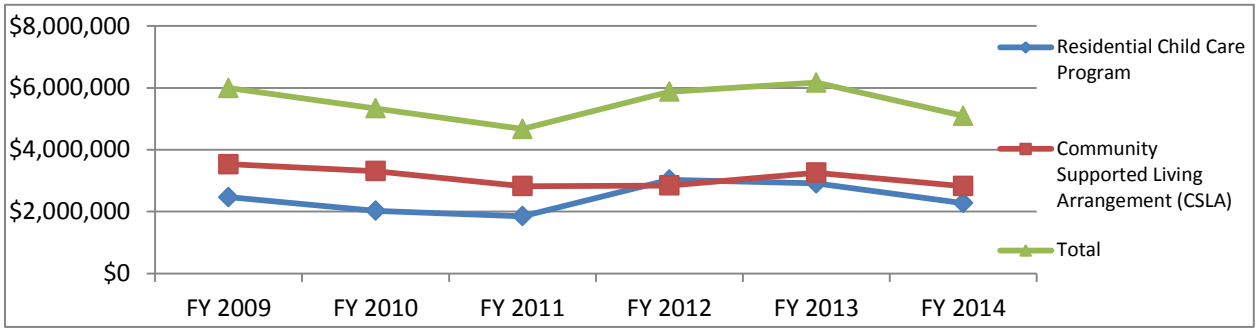
Of the 73 children receiving out-of-home placement services on January 31, 2014, all but two were placed in their local jurisdiction. Jurisdictions with larger percentages of children in out-of-home placements are consistent with the population of those jurisdictions as indicated in Table 93.



DDA Total Cost								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Residential Child Care Program	$2,464,420	$2,027,781	$1,848,389	$3,029,693	$2,908,846	$2,272,657	2.3%	-21.9%
Community Supported Living Arrangement (CSLA)	$3,531,772	$3,307,332	$2,823,561	$2,843,317	$3,259,484	$2,823,561	-3.8%	-13.4%
Total	$5,996,192	$5,335,113	$4,671,950	$5,873,011	$6,168,330	$5,096,218	-2.0%	-17.4%

Table 94

While the cost per bed-day for RCCP services dropped slightly in the past year, it is still over four times more costly than providing out-of-home placement services through CSLA. Over the past six years there has been a slight increase in the cost of CSLA services, but it still remains the more cost-effective model for providing services. The total costs of DDA out-of-home placements have dropped by 17.4%. This is influenced by the decrease in the cost per bed-day as well as the number of children in DDA out-of-home placements.



DDA Cost Per Bed Day								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Residential Child Care Program	$365	$319	$324	$353	$321	$304	-3.3%	-5.2%
Community-Supported Living Arrangement (CSLA)	$68	$73	$72	$87	$95	$72	2.4%	-23.9%
Total	$102	$103	$105	$142	$142	$188	14.1%	32.0%

Table 95

DDA Recommendations

The greatest challenge to the DDA system continues to be the identification and support of children between the ages of 18 and 21 who are aging out of other support systems and agencies within the State. It is critical to identify these children early to allow for thorough, effective transition planning. Incompatible data systems between State agencies and confidentiality issues create barriers to the process. Recent efforts to improve communication and collaboration through inter-agency and intra-agency boards, coordinating councils, committee, and task forces at State and local levels have been helpful in identifying some of these children earlier to allow for smoother transition to adult services. DDA and DHR currently have a comprehensive memorandum of understanding that has enabled DDA to improve the planning process for youth transitioning out of the DHR system.

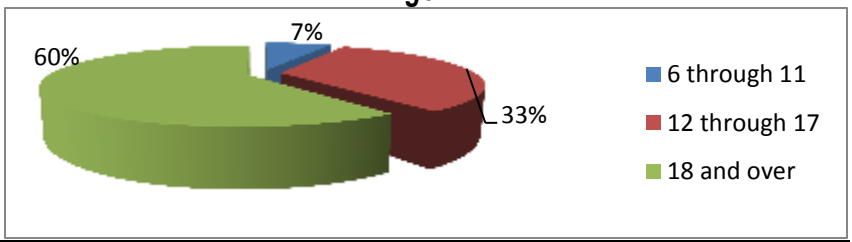
DDA will continue to work with community resources and other State agencies to enable children to remain in their homes. DDA works in conjunction with other State and local agencies to assess the community's capacity to meet the ongoing needs of children with intellectual and developmental disabilities and their families. Ongoing needs may include medical or behavioral services, specialized childcare, respite, and supports for siblings and caregivers.

DDA will continue to explore needs and the development of resources that will allow families to support their children with disabilities in their homes. DDA remains committed to focusing on supporting families.

DDA Addendum

Subcategory Totals Demographic Comparisons

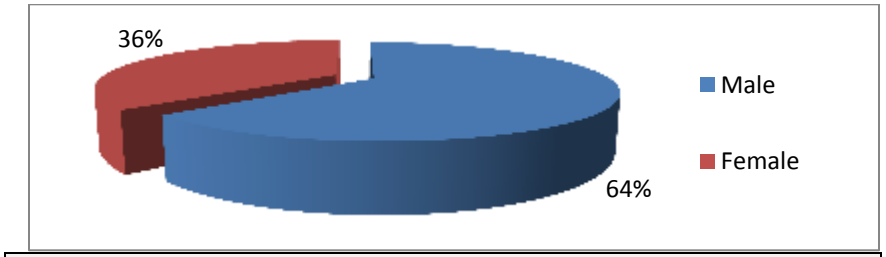
Age



DDA Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	1	1	0	0	0	0	NA	NA
6 through 11	13	9	6	6	10	6	-7.5%	-40.0%
12 through 17	69	53	43	37	30	28	-16.3%	-6.7%
18 and over	65	66	58	52	63	51	-3.8%	-19.0%
Total	148	129	107	95	103	85	-10.0%	-17.5%

Table 96

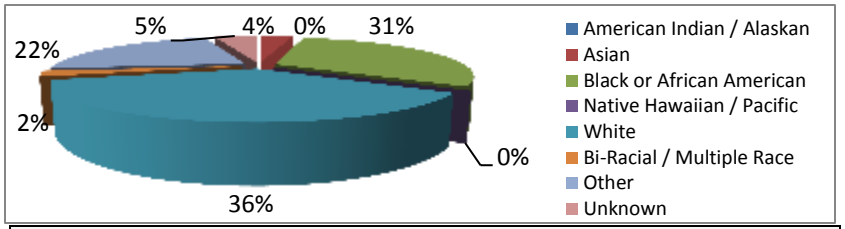
Gender



DDA Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	93	82	65	62	67	54	-9.7%	-19.4%
Female	55	47	42	33	36	31	-10.3%	-13.9%
Unknown	0	0	0	0	0	0	NA	NA
Total	148	129	107	95	103	85	-10.0%	-17.5%

Table 97

Race

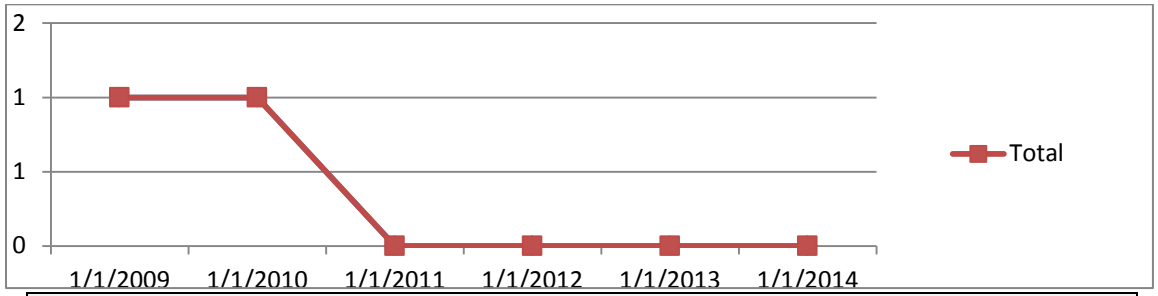


DDA Race Trends								
Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
American Indian / Alaskan	1	0	0	0	0	0	NA	NA
Asian	1	1	1	1	2	3	30.0%	50.0%
Black or African American	32	33	26	21	31	26	-1.2%	-16.1%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	46	32	26	28	35	31	-5.6%	-11.4%
Bi-Racial / Multiple Race	0	0	0	1	2	2	NA	0.0%
Other	50	45	36	25	24	19	-17.1%	-20.8%
Unknown	18	18	18	19	9	4	-20.5%	-55.6%
Total	148	129	107	95	103	85	-10.0%	-17.5%

Table 98

DDA Addendum

Subcategory Out-of-State One-Day Census Totals



DDA OOS								
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Independent Living Programs	0	0	0	0	0	0	NA	NA
Residential Child Care Program	0	0	0	0	0	0	NA	NA
Community-Supported Living Arrangement	1	1	0	0	0	0	NA	NA
Living Arrangement - Community-Based	0	0	0	0	0	0	NA	NA
Total	1	1	0	0	0	0	NA	NA

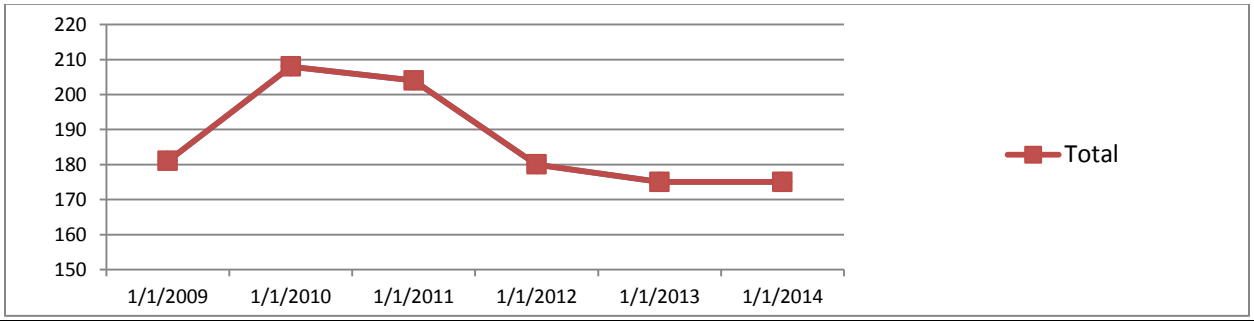
Table 99

Behavioral Health Administration (BHA) Summary

Effective July 1, 2014, within DHMH, the Alcohol and Drug Abuse Administration (ADAA) merged with the Mental Hygiene Administration (MHA) to form the Behavioral Health Administration (BHA). To ensure consistency with previous reports, this year's report will consider placement data from ADAA and MHA separately.

Alcohol and Drug Abuse Administration (ADAA)

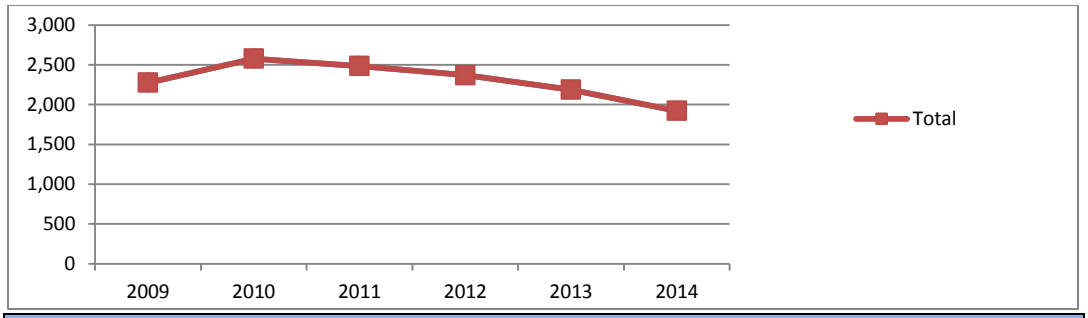
As of January 1, 2015, virtually all data reporting by substance-related-disorder-treatment providers will go through the Administrative Services Organization (ASO), Value Options. In anticipation of that major changeover, some treatment providers became less than completely compliant with SMART[11] reporting requirements. This affects the data reported in the Out-of Home Placement Report in two ways - incomplete reporting of treatment admissions or entries depresses the one-day totals, while incomplete reporting of discharges or exits from treatment tends to artificially inflate one-day totals. Estimated costs were also affected. With these reporting issues, the reporting and analysis for this year's out-of-home placements was more challenging than usual. Next year, all reporting for DHMH behavioral health will be through Value Options and accuracy and completeness should improve.



ADAA Placement Trends								
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	0	0	0	0	0	0	NA	NA
Juvenile Detention and Commitment Centers	0	0	0	0	0	0	NA	NA
Non-Secure/Non-RTC	0	0	0	0	0	0	NA	NA
Residential Educational Facilities	0	0	0	0	0	0	NA	NA
Residential Treatment Centers	0	0	0	0	0	0	NA	NA
Substance Abuse and Addiction Programs	181	208	204	180	175	175	-0.3%	0.0%
Living Arrangement - Non-Community Based	0	0	0	0	0	0	NA	NA
Total	181	208	204	180	175	175	-0.3%	0.0%

Table 100

[11] Strengthening Medicare and Repaying Taxpayers (SMART) Act, H.R. 1845, January 10, 2013.



ADAA Total Served								
	2009	2010	2011	2012	2013	2014	Average Change	Last Year Change
Non-Community Based	2,275	2,577	2,484	2,370	2,188	1,922	-3.0%	-12.2%
Total	2,275	2,577	2,484	2,370	2,188	1,922	-3.0%	-12.2%

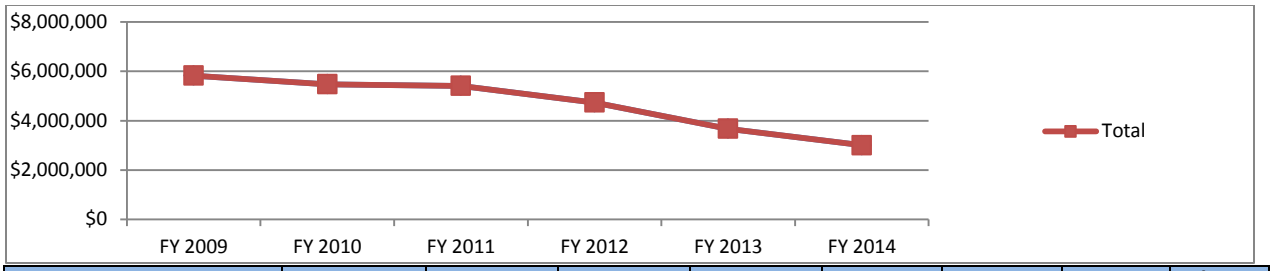
Table 101

ADAA Placement Population Flow (Placements, Not Children)					
State Fiscal Year	Placements at Start of FY	Starts in FY (New Placements)	Total Served	Ends in FT (Placement Exits)	Placements at End of FY
2010	199	2,378	2,577	2,376	201
2011	201	2,283	2,484	2,247	237
2012	187	2,183	2,370	2,171	199
2013	180	2,008	2,188	2,012	176
2014	181	1,741	1,922	1,626	246
Three-Year Change	-10.0%	-23.7%	-22.6%	-27.6%	3.8%
Average Yearly Change	-2.3%	-7.4%	-7.0%	-8.8%	7.5%
Recent Year Change	0.6%	-13.3%	-12.2%	-19.2%	39.8%

Table 102

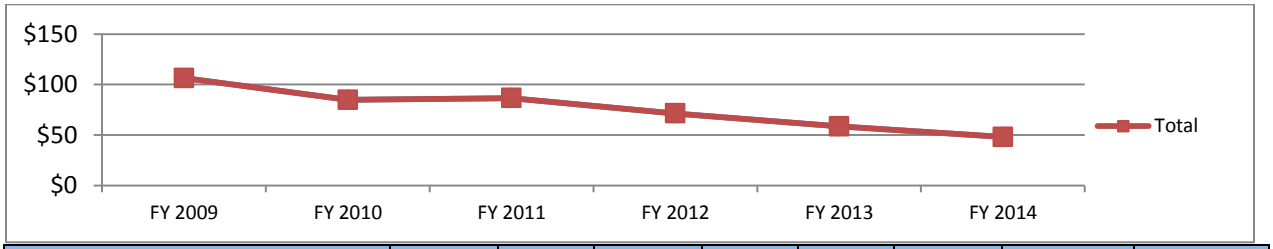
ADAA Placement By Jurisdiction																												
	Jurisdiction Where Children Were Placed																											
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worcester	Out-of-State	Unknown
Allegany	2	1.0%	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	33	16.8%	9	7	7	0	1	0	2	0	0	0	0	0	0	0	0	1	0	0	0	0	0	6	0	0	0	0
Baltimore	27	13.8%	6	0	11	1	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Baltimore City	39	19.9%	1	1	9	11	0	0	15	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0
Calvert	6	3.1%	1	1	1	0	0	0	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	1	0.5%	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	9	4.6%	2	0	2	1	0	0	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	8	4.1%	4	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0
Charles	4	2.0%	0	0	1	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Dorchester	1	0.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Frederick	8	4.1%	1	1	1	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	11	5.6%	4	0	0	0	0	0	3	0	0	0	0	0	1	0	2	0	0	0	0	0	0	1	0	0	0	0
Howard	3	1.5%	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Kent	2	1.0%	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	13	6.6%	3	2	3	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	1	0	0	0	0
Prince George's	4	2.0%	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Queen Anne's	1	0.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	2	1.0%	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	7	3.6%	1	0	3	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0
Wicomico	3	1.5%	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	1	0.5%	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	11	5.6%	0	0	7	0	0	0	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	196	100.0	42	13	50	14	2	0	34	0	2	4	6	0	1	0	3	6	2	0	0	1	0	14	0	2	0	0
% of children from jurisdiction			100.0	21.2%	40.7%	28.2%	0.0%	0.0%	22.2%	0.0%	25.0%	0.0%	50.0%	00.0%	9.1%	0.0%	0.0%	30.8%	0.0%	0.0%	0.0%	0.0%	0.0%	28.6%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			21.4%	6.6%	25.5%	7.1%	1.0%	0.0%	17.3%	0.0%	1.0%	2.0%	3.1%	0.0%	0.5%	0.0%	1.5%	3.1%	1.0%	0.0%	0.0%	0.5%	0.0%	7.1%	0.0%	1.0%	0.0%	0.0%

Table 103



Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Substance Abuse and Addiction Programs	$5,824,947	$5,479,180	$5,412,365	$4,739,245	$3,676,839	$3,003,888	-12.1%	-18.3%
Total	$5,824,947	$5,479,180	$5,412,365	$4,739,245	$3,676,839	$3,003,888	-12.1%	-18.3%

Table 104



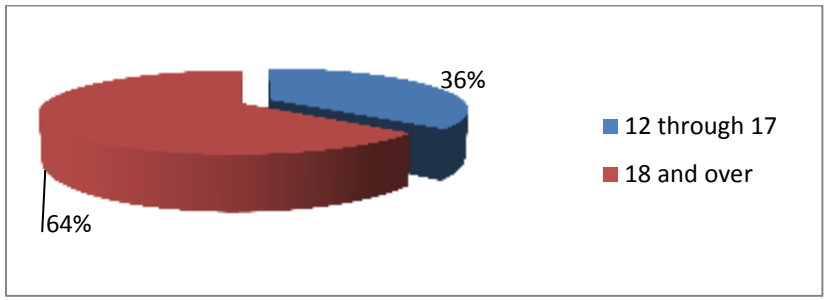
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Substance Abuse and Addiction Programs	$106	$85	$87	$71	$59	$48	-14.4%	-18.0%
Total	$106	$85	$87	$71	$59	$48	-14.4%	-18.0%

Table 105

ADAA Addendum

Subcategory Totals Demographic Comparisons

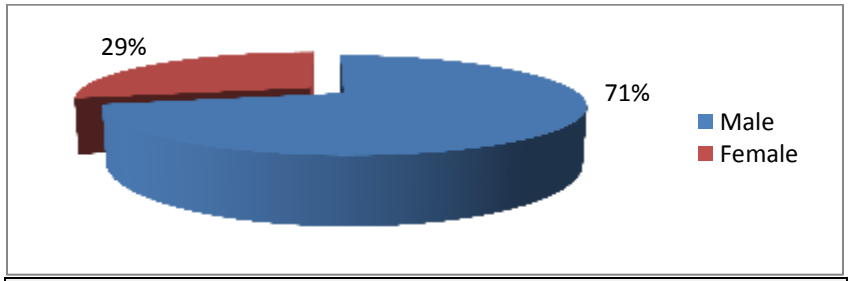
Age



ADAA Non-Community-Based Age Trends								
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	0	0	0	0	0	0	NA	NA
6 through 11	0	0	0	0	0	0	NA	NA
12 through 17	87	83	85	89	82	71	-3.8%	-13.4%
18 and over	94	125	119	91	93	125	8.3%	34.4%
Total	181	208	204	180	175	196	2.1%	12.0%

Table 106

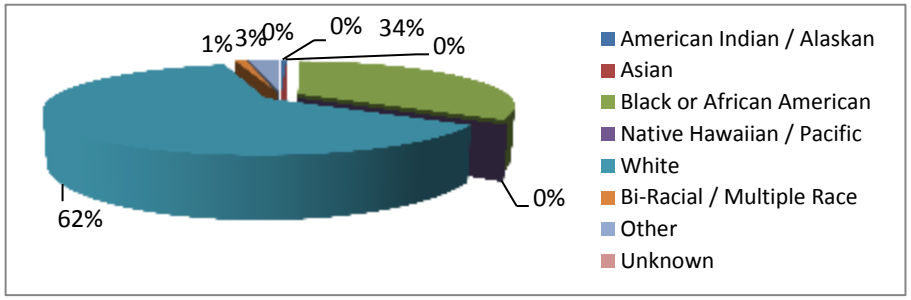
Gender



ADAA Non-Community-Based Gender Trends								
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	144	154	153	129	124	140	-0.1%	12.9%
Female	37	54	51	51	51	56	10.0%	9.8%
Unknown	0	0	0	0	0	0	NA	NA
Total	181	208	204	180	175	196	2.1%	12.0%

Table 107

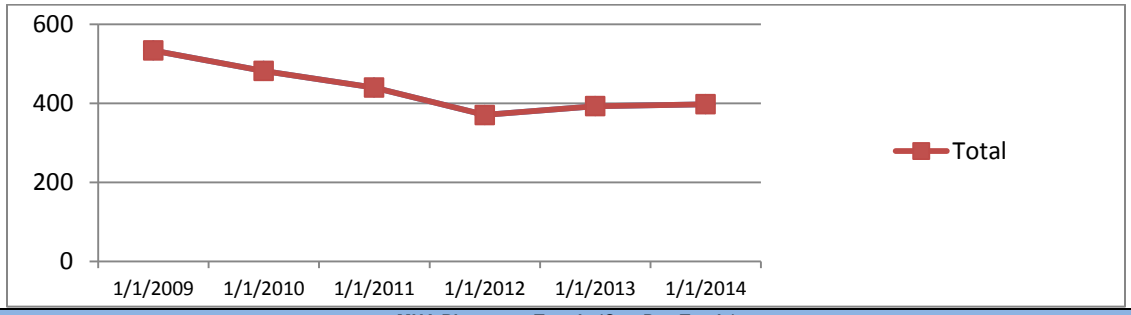
Race



ADAA Non-Community-Based Race Trends								
Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
American Indian / Alaskan	0	1	0	0	0	1	NA	NA
Asian	1	2	1	1	2	0	10.0%	-100.0%
Black or African American	65	53	65	45	49	66	3.4%	34.7%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	111	146	133	127	116	121	2.8%	4.3%
Bi-Racial / Multiple Race	0	0	1	1	1	2	NA	100.0%
Other	4	6	4	6	7	6	13.8%	-14.3%
Unknown	0	0	0	0	0	0	NA	NA
Total	181	208	204	180	175	196	2.1%	12.0%

Table 108

Mental Health Administration



MHA Placement Trends (One-Day Totals)								
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	0	0	0	0	0	0	NA	NA
Juvenile Detention and Commitment Centers	0	0	0	0	0	0	NA	NA
Non-Secure/Non-RTC	0	0	0	0	0	0	NA	NA
Residential Educational Facilities	0	0	0	0	0	0	NA	NA
Residential Treatment Centers	534	482	440	371	393	418	-0.04%	6%
Substance Abuse and Addiction Programs	0	0	0	0	0	0	NA	NA
Living Arrangement - Non-Community Based	0	0	0	0	0	0	NA	NA
Total	534	482	440	371	393	418	-0.04%	6%

Table 109

All MHA non-community placements are funded through Maryland medical assistance, which is a State and federal Medicaid dollar match. "Residential Treatment Centers" is the only placement subcategory utilized by MHA since it is a medical treatment service and, as such, it is the only non-community based placement which is funded by medical assistance.

For clarity in the discussion of MHA data, a residential treatment center may be referred to as an "RTC" or as a "psychiatric residential treatment facility" (PRTF) using federal government nomenclature. Medical assistance is often referred to simply as "MA," or as "Medicaid" using federal government nomenclature. RTCs provide behavioral health treatment to children and youth with high levels of clinical need requiring intensive residential medical services and which cannot be met in typical community placements.

The yearly trend of one-day counts for the "Residential Treatment Centers" category shows an average decrease of about 4% over the last five years. The data, however, shows two trends. There were average *decreases* of 11.4% from FY2009 to FY 2012 and average *increases* of 6.1% from FY 2012 to FY 2014. The decreases from FY 2009 to FY 2012 are largely the result of the State's community-based alternative to residential treatment centers put in place through the federal Medicaid process known as a "Section 1915(c) Home and Community-Based Services Waiver." This was a demonstration waiver of five years duration.

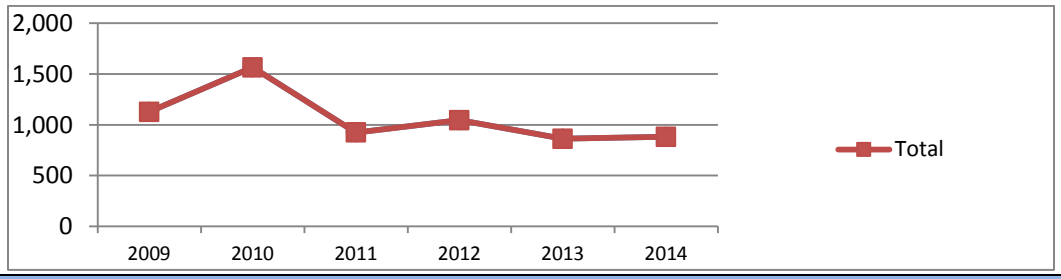
The federal government has specifically encouraged development of alternatives to the standard residential treatment center or "Psychiatric Residential Treatment Facility (PRTF)" in order to promote treatment in the community. The federal government approved Maryland's "RTC Waiver" proposal in FY2009. Maryland began enrolling children and youth into this

community alternative in FY2010. The number of children and youth enrolled in the "RTC Waiver" was 60 in FY2010, 166 in FY2011, and 210 in FY2012. This represents children and youth who were treated in the community through intensive "wraparound" services instead of a physical RTC setting.

All children who required a residential treatment center level of care were eligible to be considered for "RTC Waiver" treatment in the community, up to the number of individuals specified in the waiver, as long as it had been determined that they could be safely treated in the community with an appropriate plan of care (POC) which included all of the necessary "wraparound" community services.

The 1915(c) Psychiatric Residential Treatment Facility demonstration waiver ("RTC Waiver") reached its statutory end on September 30, 2012 when it was not reauthorized by the federal government and new enrollments ceased. The number of Maryland children and youth enrolled in the RTC Waiver population of the Care Management Entity gradually declined throughout FY2013 and FY2014 from approximately 130 to zero in early FY2015 (although new enrollments in the RTC Waiver were not permitted, children and youth already enrolled in the RTC Waiver on September 30, 2012 could continue to be served for a maximum of two years, if eligible). DHMH, however, is planning to offer services to a similar population of children and youth through a 1915(i) Medicaid State Plan amendment that will offer targeted case management and community-based services. The State Plan amendment was recently approved by the Centers for Medicare and Medicaid Services with a retroactive start date of October 1, 2014.

Also contributing to a decrease in the numbers of children in residential treatment centers, the average length of stay in the RTC level of care has declined over the past five years. This has been due primarily to an MHA effort to have children move from the RTCs to community treatment as soon as their clinical needs can safely be met at a lower level of care. MHA has accomplished this through both a process of monitoring their progress in the RTC and providing technical assistance in discharge planning.



MHA Total Served								
	2009	2010	2011	2012	2013	2014	Average Change	Last Year Change
Family Home	0	0	0	0	0	0	NA	NA
Community-Based	0	0	0	0	0	0	NA	NA
Non-Community Based	1,127	1,566	924	1,046	863	907	-0.2%	5.1%
Hospitalization	0	0	0	0	0	0	NA	NA
Not Available	0	0	0	0	0	0	NA	NA
Total	1,127	1,566	924	1,046	863	907	-0.2%	5.1%

Table 110

The MHA "Total Served" numbers of children and youth in residential treatment centers declined since FY2009 and FY2010. As with the one-day counts above, this is the result of the State's community-based alternative to residential treatment centers put in place through the federal Medicaid process known as a "Section 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Waiver." During these years, larger numbers of Maryland children and youth have been served in community placements with wraparound services.

Note: "MHA Total Served" numbers for FY2012 through FY2014 in Table 110 are based on treatment episodes rather than unduplicated numbers of individuals and, so, likely over-represent the annual numbers of *individuals* served since a few individuals may have had more than one RTC admission and discharge during a fiscal year. Although it is difficult to estimate the precise impact of multiple discharges and readmissions, this may account for a small percentage (<3%) of these numbers.

MHA Placement Population Flow					
State Fiscal Year	Placements at Start of FY	Starts in FY (New Placements)	Total Served	Ends in FT (Placement Exits)	Placements at End of FY
2010	517	1,049	1,566	648	918
2011	435	489	924	430	494
2012	441	605	1,046	650	396
2013	407	456	863	496	367
2014	401	480	881	477	404
Three-Year Change	-7.8%	-1.8%	-4.7%	10.9%	-18.2%
Average Yearly Change	-4.7%	-5.9%	-8.6%	-2.0%	-12.7%
Recent Year Change	-1.5%	5.3%	2.1%	-3.8%	10.1%

Table 111

Table 111 represents the flow of admissions and discharges from the in-State and out-of-State residential treatment centers over the course of the fiscal year. It is based on claims for reimbursement for the residential treatment center level of care. When claims are received can slightly affect the numbers of placements at the ending and start of the fiscal year so they are not exactly equal.

The FY2010 figures in Table 111 are calculated differently from other years; however, it is included here for the sake of consistency with past reports. In FY2011, the method for calculating population flow was changed and has been applied in years FY2011-2014. FY2010 will not be included in future reports.

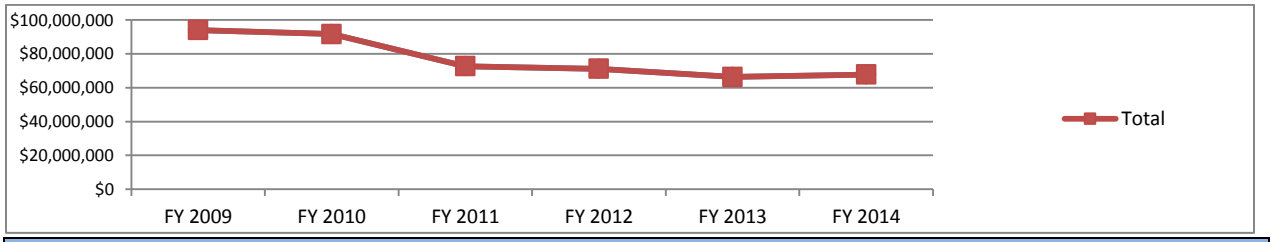
Total Served data for FY2011 through FY2014 show a 13.2% increase from FY2011 to FY2012, a 17.5% decrease from FY2013 to FY2013, and a 3.7% increase from FY2013 to FY2014. The average change from FY2011 to FY2014 is only -0.2%. A least-squares (Pearson correlation) line fitted to the FY2011 to FY2014 data, however, indicates a trend of moderate reduction in total served over the four years. This is due in part from Maryland's community-based "RTC waiver" alternative to residential treatment centers in place from FY2009 through 2014, but the data also suggests a trend of reduction in overall RTC placements.

MHA Placement By Jurisdiction																													
	Jurisdiction Where Children Were Placed																												
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	23	3.7%	0	0	0	19	0	0	0	0	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	58	9.4%	0	0	0	50	0	0	0	0	0	4	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Baltimore	70	11.4%	0	0	16	48	0	0	0	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Baltimore City	31	5.0%	0	0	23	1	0	0	0	0	0	2	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Calvert	1	0.2%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	5	0.8%	0	0	1	3	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	14	2.3%	0	0	3	10	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	3	0.5%	0	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	7	1.1%	0	0	1	5	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	15	2.4%	0	0	2	4	0	0	0	0	0	8	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	24	3.9%	0	0	2	2	0	0	0	0	0	0	18	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0
Garrett	10	1.6%	0	0	0	9	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	15	2.4%	0	0	6	5	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Howard	3	0.5%	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Kent	19	3.1%	0	0	2	16	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	40	6.5%	0	0	3	12	0	0	0	0	0	4	0	0	0	0	0	21	0	0	0	0	0	0	0	0	0	0	0
Prince George's	25	4.1%	0	0	9	0	0	0	0	0	0	7	5	0	0	0	0	1	0	0	0	0	0	0	0	0	0	3	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	3	0.5%	0	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	2	0.3%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Talbot	12	2.0%	0	0	0	6	0	0	0	0	0	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	9	1.5%	0	0	2	4	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Wicomico	13	2.1%	0	0	6	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	11	1.8%	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0	0	0	8	0	0
Unknown	202	32.8%	0	0	0	202	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	615	100.0	0	0	80	399	0	0	0	0	0	44	45	0	0	0	0	27	0	0	0	0	0	0	0	0	20	0	
% of children from jurisdiction			0.0%	0.0%	22.9%	68.6%	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
% children Statewide in all			0.0%	0.0%	13.0%	64.9%	0.0%	0.0%	0.0%	0.0%	0.0%	7.2%	7.3%	0.0%	0.0%	0.0%	0.0%	4.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	0.0%	

Table 112

Although placement within (or near) a youth's jurisdiction is one factor considered in placing a child in a residential treatment center, the primary determinant is the youth's treatment needs, since some types of treatment services are available in some residential treatment centers and not in others (programming, ages and genders served are not identical across facilities), and whether or not a particular program has a vacancy at the time of referral or anticipates one within a reasonable time frame.

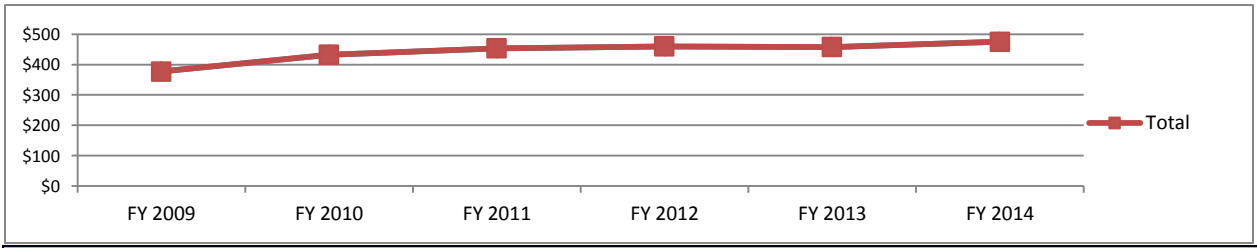
Furthermore, there are 10 RTCs located in five jurisdictions so these are not uniformly distributed throughout the State. Youth from jurisdictions other than these five will necessarily be placed outside his/her jurisdiction. The in-State RTCs are located in Baltimore County (4), Baltimore City (2), Montgomery County (2), Dorchester County (1), and Frederick County (1). Finally, each RTC determines which youth will be admitted, considering programming and vacancy constraints upon admissions.



MHA Non-Community Based Cost Trends								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Residential Treatment Centers	$94,033,805	$91,629,633	$72,649,911	$71,180,664	$66,348,547	$67,700,710	-6.0%	2.0%
Total	$94,033,805	$91,629,633	$72,649,911	$71,180,664	$66,348,547	$67,700,710	-6.0%	2.0%

Table 114

As noted earlier, all MHA non-community based placements are in residential treatment centers. The figures in this Table represent the total medical assistance costs for all residential treatment center placements. These costs vary by the number of youth who are placed, by the specific placements since the programs receive different reimbursement, and these program costs themselves also vary year to year. As the number of youth in RTCs and the length of stay in the RTCs have decreased over the past five fiscal years, however, the cost for the treatment of youth in the RTCs has also decreased over the same period of time.



MHA Non-Community Based Cost Per Bed-Day Trends								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Residential Treatment Centers	$377	$432	$453	$460	$458	$475	4.8%	3.8%
Total	$377	$432	$453	$460	$458	$475	4.8%	3.8%

Table 115

These figures represent the medical assistance costs for all youth placed by MHA in residential treatment centers divided by the number of bed days (the total number of days in residential treatment for all youth placed in residential treatment centers). These bed-day costs can vary due to utilization of residential treatment centers whose costs which may be higher or lower than average due to different programming. RTC costs overall can vary year to year and have increased slightly over the past four years.

MHA Recommendations

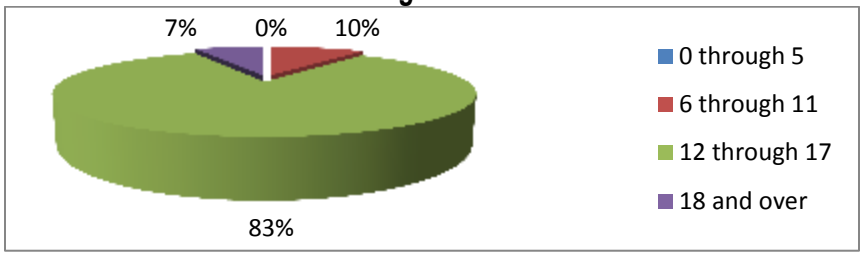
The current capacity of residential treatment centers in Maryland appears adequate to meet the needs of Maryland youth for this level of care for the foreseeable future, based on vacancy rates for the in-State RTCs and plans to serve youth in the community via the 1915(i) State Plan amendment. It would seem desirable to have the Maryland RTCs offer more options for specialized treatment, such as treatment for fire-setting and sexually offensive behavior, especially for youth with low levels of intellectual functioning. At this time, however, it appears unlikely that there would be sufficient numbers of in-State referrals to make financial sense for an in-State RTC to develop such programming.

MHA efforts to minimize the number of Maryland youth in out-of-State placements have been successful and will continue. At the present time, however, it appears likely that for a very small number of Maryland youth with needs for specialized treatment or who are in especially complicated circumstances, an out-of-State placement will continue to be necessary.

MHA Addendum

Subcategory Totals Demographic Comparisons

Age

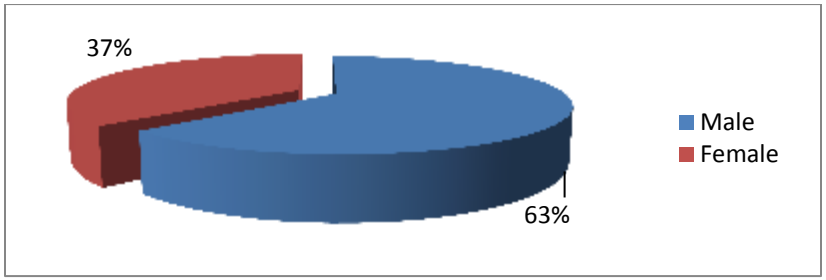


MHA Age Trends

Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	0	0	0	1	1	0	NA	-100.0%
6 through 11	53	32	50	49	88	51	10.4%	-42.0%
12 through 17	443	406	351	285	301	340	-4.4%	13.0%
18 and over	38	44	39	36	3	27	141.0%	800.0%
Total	534	482	440	371	393	418	-4.4%	6.4%

Table 116

Gender

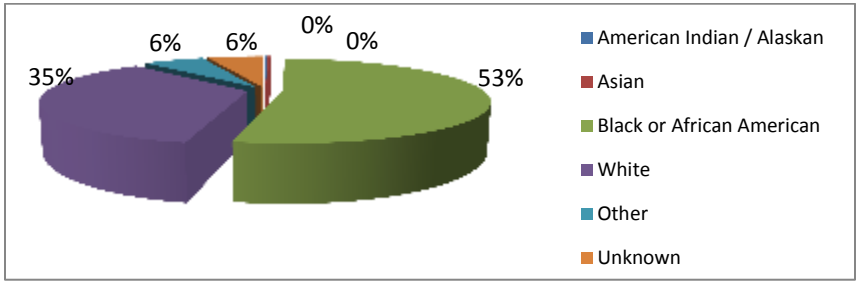


MHA Gender Trends

Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	331	276	272	232	243	269	-3.5%	10.7%
Female	203	205	168	139	150	157	-4.3%	4.7%
Unknown	0	1	0	0	0	0	NA	NA
Total	534	482	440	371	393	426	-4.0%	8.4%

Table 117

Race



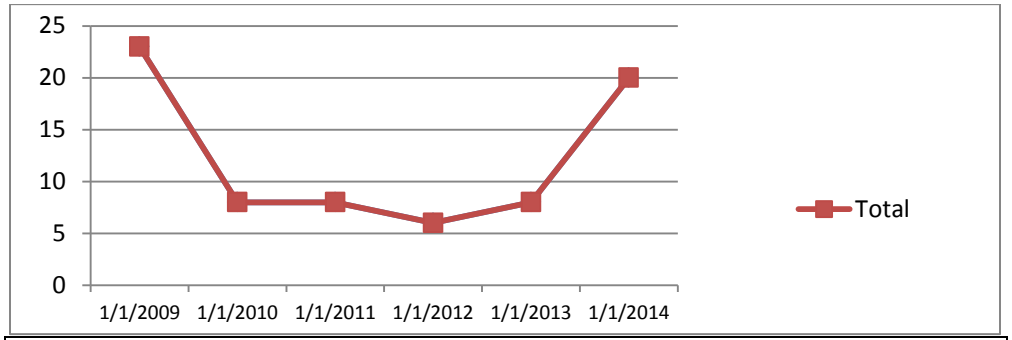
MHA Race Trends

Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
American Indian / Alaskan	0	0	3	3	1	1	NA	0.0%
Asian	2	2	2	3	1	4	56.7%	300.0%
Black or African American	287	263	225	177	208	221	-4.1%	6.3%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	221	193	175	149	137	157	-6.1%	14.6%
Bi-Racial / Multiple Race	0	0	0	0	0	26	NA	NA
Other	23	24	19	24	24	8	-11.4%	-66.7%
Unknown	1	0	16	15	22	1	NA	-95.5%
Total	534	482	440	371	393	418	-4.4%	6.4%

Table 118

MHA Addendum

Subcategory Out-of-State One-Day Census Totals



MHA OOS Placement Trends

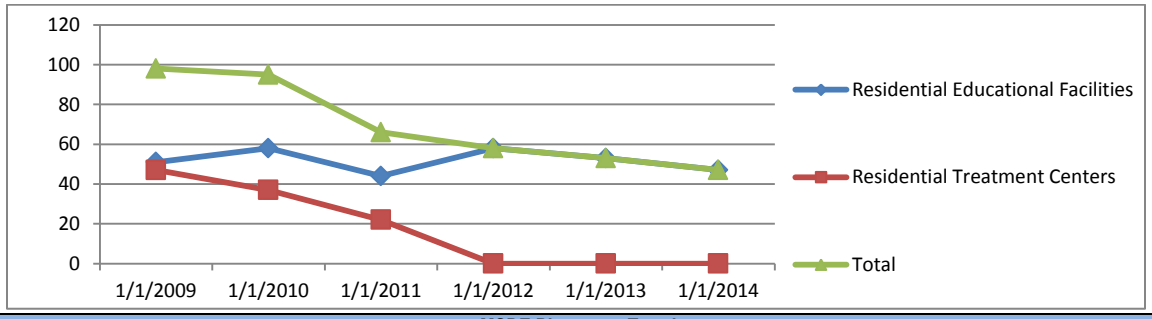
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Residential Treatment Centers	23	8	8	6	8	20	18.6%	150.0%
Total	23	8	8	6	8	20	18.6%	150.0%

Table 119

Maryland State Department of Education (MSDE) Summary

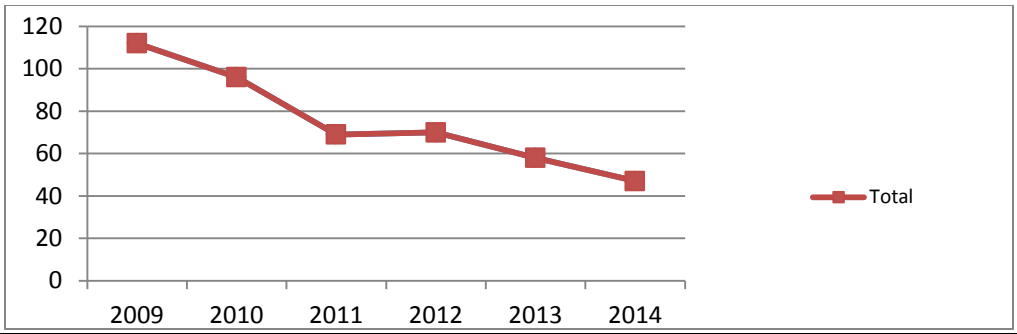
Local School Systems (LSSs) are required to provide a Free and Appropriate Public Education (FAPE) for all students who require special education and related services. Special education and related services for children in residential placements are determined through the Individualized Education Program (IEP) team process. The IEP team, including the parent, determines the services required, the type of program, and identifies the location for the delivery of services. The IEP team is charged with ensuring that the child is demonstrating educational progress in the approved placement and the team may determine at any time that a change in placement is necessary to implement the IEP and to provide a FAPE.

An out-of-home placement only occurs for a student, placed by a LSS, when the team determines that the child requires a residential educational facility. Maryland residential treatment centers are approved for educational purposes as residential educational facilities. The number of students requiring residential settings as a school placement is approximately .0005% of the total population of students with disabilities. The LSSs are experiencing a continued decline in the number of children requiring residential services through the IEP team process. There has been an increase of services at the community level under targeted initiatives such as the Autism Waiver and specific mental health partnerships. As students with severe autism and severe emotional disabilities enter their teen-age and young-adult years, providing educational services for these students may become increasingly challenging because of their age and the exhaustion of community-based services. Older students with residential needs frequently remain in residential schools until they transition to adult services. The LSSs are required to provide special education and related services through the school year in which the child turns 21.



MSDE Placement Trends								
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	0	0	0	0	0	0	NA	NA
Juvenile Detention and Commitment Centers	0	0	0	0	0	0	NA	NA
Non-Secure/Non-RTC	0	0	0	0	0	0	NA	NA
Residential Educational Facilities	51	58	44	58	53	47	0.3%	-11.3%
Residential Treatment Centers	47	37	22	0	0	0	NA	NA
Substance Abuse and Addiction Programs	0	0	0	0	0	0	NA	NA
Living Arrangement - Non-Community Based	0	0	0	0	0	0	NA	NA
Total	98	95	66	58	53	47	-13.1%	-11.3%

Table 120



MSDE Total Served								
Category	2009	2010	2011	2012	2013	2014	Average Change	Last Year Change
Family Home	0	0	0	0	0	0	NA	NA
Community-Based	0	0	0	0	0	0	NA	NA
Non-Community Based	112	96	69	70	58	47	-15.4%	-19.0%
Hospitalization	0	0	0	0	0	0	NA	NA
Not Available	0	0	0	0	0	0	NA	NA
Total	112	96	69	70	58	47	-15.4%	-19.0%

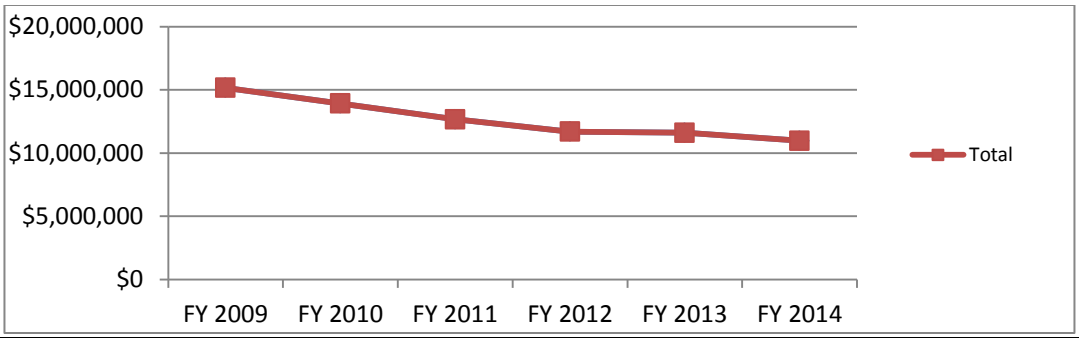
Table 121

MSDE Population Flow (All Placements)					
State Fiscal Year	Placements at Start of FY	Starts in FY (New Placements)	Total Served	Ends in FT (Placement Exits)	Placements at End of FY
2010	68	28	96	26	70
2011	49	20	69	11	58
2012	34	36	70	9	61
2013	33	25	58	5	53
2014	38	15	53	6	47
Three-Year Change	-22.4%	-25.0%	-23.2%	-45.5%	-19.0%
Average Yearly Change	-9.3%	-3.8%	-10.5%	-20.1%	-7.3%
Recent Year Change	15.2%	-40.0%	-8.6%	20.0%	-11.3%

Table 122

MSDE Placement By Jurisdiction																													
	Jurisdiction Where Children Were Placed																												
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worcester	Out-of-State	Unknown
Allegany	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	4	8.5%	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2	0
Baltimore City	4	8.5%	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Calvert	1	2.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Caroline	2	4.3%	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Carroll	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	2	4.3%	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	1	2.1%	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	6	12.8%	0	0	0	0	0	0	0	1	0	0	0	0	0	2	0	1	0	0	0	0	0	0	0	0	0	2	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	3	6.4%	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Howard	1	2.1%	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	2	4.3%	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	18	38.3%	0	0	0	0	0	4	0	3	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	6	0
Prince George's	3	6.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wicomico	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worcester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	47	100.0%	0	0	1	0	0	12	0	6	0	0	0	0	0	2	0	9	0	0	0	0	0	0	0	0	0	17	0
% of children from jurisdiction			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			0.0%	0.0%	2.1%	0.0%	0.0%	25.5%	0.0%	12.8%	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	19.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	36.2%	0.0%

Table 123



MSDE Total Costs								
Subcategory	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Average Change	Last Year Change
Residential Educational Facilities	$15,161,831	$13,918,875	$12,672,875	$11,690,683	$11,607,471	$10,972,899	-6.2%	-5.5%
Total	$15,161,831	$13,918,875	$12,672,875	$11,690,683	$11,607,471	$10,972,899	-6.2%	-5.5%

Table 124

MSDE Recommendations

MSDE Division of Special Education/Early Intervention Services (DSE/EIS) has worked directly with Maryland private day and residential education facilities to build in-State capacity for students requiring intensive services. For the school year 2013-2104, an established Maryland provider became active in serving students with autism for residential placements under the Autism Waiver. MSDE provided ongoing support and technical assistance to this provider and others to build capacity and quality programming for students. During the 2014-2015 school year MSDE, DSE/EIS will continue to support local schools systems to enhance services and supports for students to remain in their community schools.

In addition, MSDE, DSE/EIS increased the number of children directly served under the Autism Waiver. This increase in funding capacity increased the number of children with autism whose needs are supported in their homes and communities.

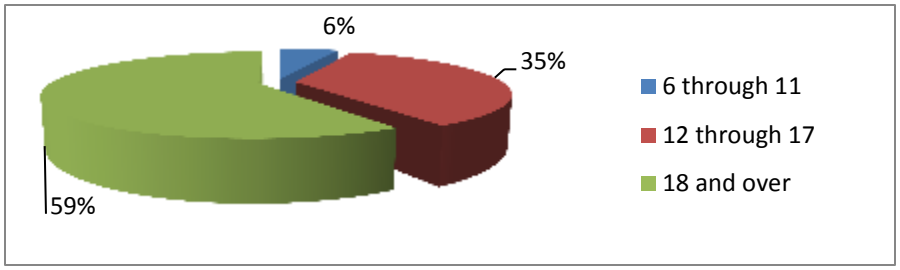
MSDE, DSE/EIS recommends the continuation of direct work with Maryland providers to meet the increasing needs of this population.

MSDE supports cross-agency collaboration to ensure the development of community-based and residential programs to meet the needs of students typically placed out-of-State and to facilitate the return of these students to Maryland programs and schools.

MSDE Addendum

Subcategory Totals Demographic Comparisons

Age



MSDE Non-Community-Based Age Trends								
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	0	0	0	0	0	0	NA	NA
6 through 11	2	1	1	1	1	1	-10.0%	0.0%
12 through 17	19	9	7	6	7	6	-17.4%	-14.3%
18 and over	26	27	14	13	7	10	-10.9%	42.9%
Total	47	37	22	20	15	17	-16.5%	13.3%

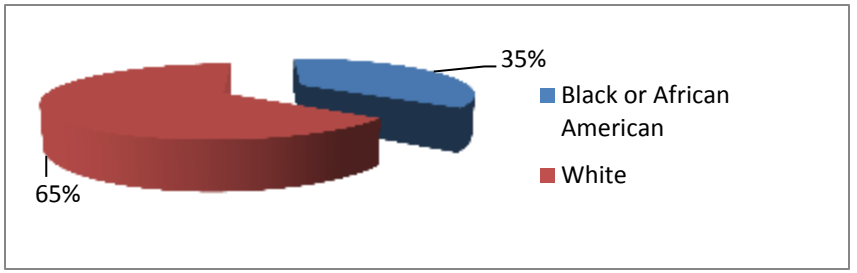
Table 125

Gender

MSDE Non-Community-Based Gender Trends								
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	37	31	15	12	8	11	-16.7%	37.5%
Female	10	6	7	8	7	6	-7.2%	-14.3%
Unknown	0	0	0	0	0	0	NA	NA
Total	47	37	22	20	15	17	-16.5%	13.3%

Table 126

Race



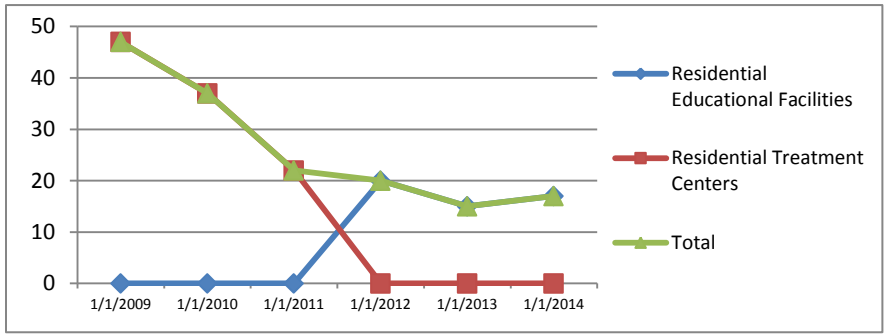
MSDE Non-Community-Based Race Trends								
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
American Indian / Alaskan	0	0	0	0	0	0	NA	NA
Asian	0	0	0	0	0	0	NA	NA
Black or African American	12	10	8	7	6	6	-12.7%	0.0%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	34	25	14	13	9	11	-17.2%	22.2%
Bi-Racial / Multiple Race	0	0	0	0	0	0	NA	NA
Other	1	2	0	0	0	0	NA	NA
Unknown	0	0	0	0	0	0	NA	NA
Total	47	37	22	20	15	17	-16.5%	13.3%

Table 127

MSDE Addendum

Subcategory Out-of-State One-Day Census Totals and Demographic Comparisons

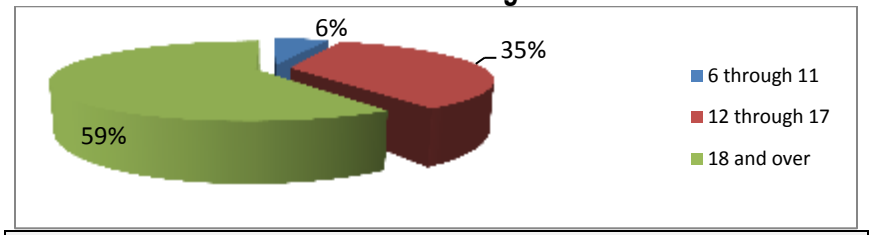
Out-of-State Placement Trends



MSDE Out-of-State Non-Community-Based Trends								
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Residential Educational Facilities	0	0	0	20	15	17	NA	13.3%
Residential Treatment Centers	47	37	22	0	0	0	NA	NA
Total	47	37	22	20	15	17	-1.8%	13.3%

Table 128

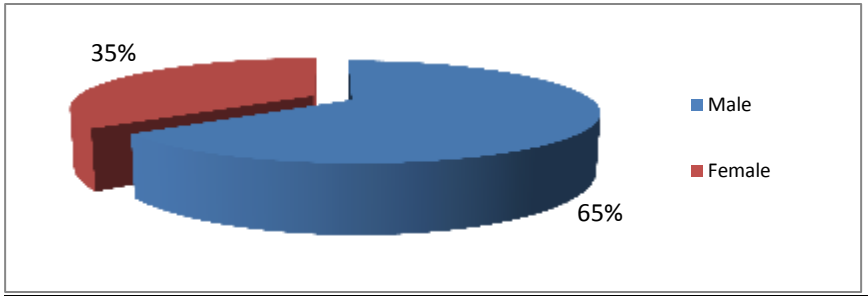
Out-of-State Age



MSDE Out-of-State Age Trends								
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
0 through 5	0	0	0	0	0	0	NA	NA
6 through 11	2	1	1	1	1	1	-10.0%	0.0%
12 through 17	19	9	7	6	7	6	-17.4%	-14.3%
18 and over	26	27	14	13	7	10	-10.9%	42.9%
Total	47	37	22	20	15	17	-16.5%	13.3%

Table 129

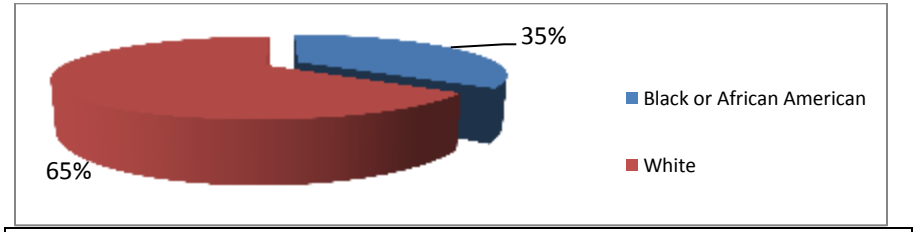
Out-of-State Gender



MSDE Out-of-State Gender Trends								
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
Male	37	31	15	12	8	11	-16.7%	37.5%
Female	10	6	7	8	7	6	-7.2%	-14.3%
Unknown	0	0	0	0	0	0	NA	NA
Total	47	37	22	20	15	17	-16.5%	13.3%

Table 130

Out-of-State Race



MSDE Out-of-State Race Trends								
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	1/31/2014	Average Change	Last Year Change
American Indian / Alaskan	0	0	0	0	0	0	NA	NA
Asian	0	0	0	0	0	0	NA	NA
Black or African American	12	10	8	7	6	6	-12.7%	0.0%
Native Hawaiian / Pacific	0	0	0	0	0	0	NA	NA
White	34	25	14	13	9	11	-17.2%	22.2%
Bi-Racial / Multiple Race	0	0	0	0	0	0	NA	NA
Other	1	2	0	0	0	0	NA	NA
Unknown	0	0	0	0	0	0	NA	NA
Total	47	37	22	20	15	17	-16.5%	13.3%

Table 131

Maryland School for the Blind and Maryland School for the Deaf

The Maryland School for the Deaf (MSD)

MSD is established under §8-304 of the Education Article of the Annotated Code of Maryland. MSDE is required to admit free of charge all students who are Maryland residents and meet the established admissions criteria. Section §8-305 requires each Local School System (LSS) to notify parents or guardians of each hearing-impaired child of the availability of the educational programs offered by MSD. Funding for MSD is established under §8-310.3. MSD is also required to establish and operate a program of enhanced services for deaf students who have moderate to severe disabilities under §8-310.1 with funding provided jointly by the State and the local jurisdiction. The majority of students enrolled at MSD are placed by parents or guardians rather than by a LSS. Children receiving enhanced services are placed by LSSs through the Individualized Education Program (IEP) team process. A small number of students, placed by the IEP team process, live on campus during the school week.

Maryland School for the Deaf Total Costs				
	Total Residential Served	Residential Cost	Educational Cost	Total Cost
FY2010	125	$2,296,579	$5,893,239	$8,189,818
FY2011	111	$2,253,601	$5,031,852	$7,285,453
FY2012	123	$2,476,233	$6,162,792	$8,639,025
FY2013	125	$2,415,309	$5,704,625	$8,119,934
FY2014	125	$2,456,214	$5,877,375	$8,333,589

Table 132

The Maryland School for the Blind (MSB)

MSB is established to provide services for children placed by LSSs through the IEP team process. In accordance with §8-307.1 each LSS in the State shall notify the parents or guardians of each blind or visually-impaired child, including children with multiple disabilities, of the availability of the educational programs and administrative policies of the schools under their jurisdiction. MSB is required to establish and operate a program of enhanced services[12] for students who are blind and have other disabilities. Funding for these services is provided jointly by the State and local jurisdiction. The budget for MSB is submitted annually by the Governor to the General Assembly. The residential program offers a continuum of service options. Students may participate in the program on an extended-day, part-time or full-time, and may reside in a dormitory or in a house on the campus during the school week.

Maryland School for the Blind Total Costs				
	Total Residential Served	Residential Cost	Educational Cost	Total Cost
FY2010	86	$4,760,670	$7,628,494	$12,389,164
FY2011	93	$4,844,775	$8,702,304	$13,547,079
FY2012	89	$4,722,467	$8,316,387	$13,038,854
FY2013	91	$5,043,578	$9,632,009	$14,675,587
FY2014	93	$5,238,222	$9,521,222	$14,760,114

Table 132

[12] Enhanced services allow students to receive educational services in Maryland rather than out-of-State residential programs.

Family Preservation Services

DHR provides family preservation services to children and family at risk of child maltreatment and/or out of home placement. Rooted in the 1980 federal child welfare law to make "reasonable efforts to prevent out-of-home placement," Maryland has provided in-home interventions since the early 1980s. These services are provided by the Local Departments of Social Services (LDSSs) as In-Home or Family Preservation services.

From 1990 to the present, Interagency Family Preservation Services (IFPS) was added in Maryland as an inter-agency approach to preserving families with children at imminent risk of placement from all child-serving Agencies. Until FY2008 IFPS was administered by the Governor's Office for Children (GOC), after which it was integrated into DHR's In-Home services.

Family preservation/In-Home services can be evaluated by examining families' risk levels, and the incidence rates of maltreatment and out of home (OOH) placement. Risk is assessed by the Maryland Family Risk Assessment (MFRA), which is administered by the caseworker at the initiation of services, several times throughout services, and at case closure. Risk data for families served in In-Home services is discussed in this Report.

Maltreatment (child abuse or neglect) is measured by the number of indicated investigation findings of child maltreatment. OOH placement is measured by the number of children entering OOH care. Both measures are analyzed here for incidents of maltreatment or OOH placement among children while they were receiving In-Home services, and for children who had recently received In-Home services.

DHR In-Home services are separated into two (2) categories:

1. Interagency Family Preservation Services (IFPS); and
2. Consolidated In-Home Services – including Services to Families with Children (a short-term service featuring an assessment of family needs) and all other In-Home services.

Data for the two separate categories (IFPS and Consolidated) will be presented, along with data for the two programs combined (Total In-Home Services).

Service Counts for DHR In-Home Services

The table below contains four years of data for Total In-Home services, Consolidated In-Home services, and IFPS. A review of the last four years' information on overall served cases indicates there was a 13% increase in the overall number of families and a corresponding 9% increase in the number of children served in In-Home programs from FY 2011 to FY 2014.

Families and Children Served and Newly Served*						
Total In-Home						
	All Cases Served during FY			New Cases during FY		
	Cases	Children	Child/Case	Cases	Children	Child/Case
FY 2011	7,517	16,425	2.2	5,260	11,396	2.2
FY 2012	8,755	18,799	2.2	6,583	13,935	2.1
FY 2013	8,751	18,836	2.2	6,278	13,391	2.1
FY 2014	8,494	17,836	2.1	6,552	13,463	2.1
Consolidated In-Home Services						
	All Cases Served during FY			New Cases during FY		
	Cases	Children	Child/Case	Cases	Children	Child/Case
FY 2011	6,555	14,173	2.2	4,488	9,593	2.1
FY 2012	7,850	16,633	2.1	5,870	12,237	2.1
FY 2013	7,777	16,508	2.1	5,467	11,481	2.1
FY 2014	7,527	15,643	2.1	5,807	11,797	2.0
Interagency Family Preservation Services						
	All Cases Served during FY			New Cases during FY		
	Cases	Children	Child/Case	Cases	Children	Child/Case
FY 2011	962	2,252	2.3	772	1,803	2.3
FY 2012	905	2,166	2.4	713	1,698	2.4
FY 2013	974	2,328	2.4	811	1,910	2.4
FY 2014	967	2,193	2.3	745	1,666	2.2
**FY 2011 – 2013 data revised*						

Table 133

Total In-Home served and newly-served families increased significantly from FY2011 to FY2012 (12% and 24%, respectively). This was the first substantial increase among In-Home services in several years, and allayed concerns about the downward trends in In-Home services in prior years during a time period in which DHR out-of-home (OOH) placements had been decreasing significantly as well. Among some stakeholders, there had been the belief that if DHR OOH care placements were decreasing, then In-Home services should increase; this argument, however, ignored the increasing impact of DHR's Family-Centered Practice model, which emphasized child and family involvement in case planning and decisions, and utilizes natural and community resources to meet families' needs, which often negates the need for DHR/LDSS intervention.

Analysis of Indicated Findings of Child Maltreatment and Non-Placement Rates

This analysis focuses mainly on the question "Are children better off?" by measuring the absence of the occurrence of indicated findings of maltreatment, and the absence of placement in DHR out of home care.

The goal of In-Home services is to support families in caring for their children, and to remove risk of maltreatment, not the children, from their homes. Families generally want to stay together even when challenges exist, and In-Home staff strives to assist families in reaching that goal. Despite these efforts (by both families and DHR), there are instances of child maltreatment or the need for a child to be removed from the home while in (or after) In-Home services.

An indicated finding of child maltreatment refers to a decision made by a LDSS Child Protective Services (CPS) investigator, upon completion of an investigation, that there is sufficient

evidence, which has not been refuted, of child maltreatment. (There are two other CPS findings, not discussed here, including an "unsubstantiated" finding, meaning that there is not sufficient evidence to support the contention that maltreatment took place, or a "ruled out" finding, meaning that child protective services determined that maltreatment did not take place.)

OOH placements begin with a removal from the home of a child, which occurs when their safety cannot be assured in their home. The date of removal marks the beginning of the OOH placement episode.[13] In this analysis, only DHR OOH placements are discussed—while other Maryland agencies place or fund the placement of children, this section discusses only DHR OOH placement among children who have participated in DHR's In-Home services, as these placements are generally due only to child maltreatment. (A small number of placements exist due to children's severe medical/mental health/developmental needs, through Voluntary Placement Agreements.)

Two measures are used to analyze the effectiveness of In-Home services in preventing child maltreatment and OOH placements:

- Did a CPS investigation result in an indicated finding for children receiving In-Home services?
- Did a DHR OOH placement occur for children receiving In-Home services?

For each of these indicators, data is analyzed for the time period during which a child received services, and then for the one-year time period after the child received services.

Measure	Timeframes	
Did a CPS investigation result in an indicated finding for children receiving services?	*During Services* For each fiscal year listed, the children newly-served in In-Home cases during that fiscal year are considered, and the observation time period for each child is the start of In-Home services to the first of either: • the In-Home service close date; or • 12 months following the start date of In-Home services.	*Within 1 Year of Case Close* For each fiscal year listed, the children considered are those who were newly-served during the fiscal year and whose In-Home cases closed within 12 months of the start date of In-Home Services. In other words, these are the same children as the "During Services" children whose cases closed during the 12-month observation period. The observation time period for each child is the 12-month period beginning on the close date of In-Home services and ending 12 months later.
Did a DHR OOH placement occur for children receiving service?		

Table 134

[13] Not all children found to be the victim of an indicated maltreatment finding are removed, nor have all removed children been the victim in an indicated maltreatment finding. Removal is based on safety issues alone; if an alleged maltreator is no longer in the home and/or an appropriate safety plan is in place, removal may not be necessary. Additionally, safety is assessed continuously, and removal decisions are made based on the current situation while findings to investigations generally take up to two months to finalize. Safety issues may require removal regardless of an investigation finding.

Table 135 displays the counts of cases (families) and children newly-served each fiscal year, along with the counts and proportions of newly-served families whose cases closed within one year. It is evident that the majority of cases close within a year of starting. The child population associated with these cases were observed a year after case closing to determine whether a CPS Indicated Investigation or DHR OOH placement occurred.

For the "During Services" observation period, it is necessary for a year to elapse after the reported fiscal year ends. For the "Within 1 Year of Case Closure" observation period, it is necessary for two years to elapse after the reported fiscal year ends. Therefore, data for events occurring within 1 year of case closure are available for children newly served in FY2012, and data for events occurring during services is available for children who entered In-Home services in FY2013.

Using this construct, this table shows the number children who began In-Home services in FYs 2009-2014, and those that started In-Home services in those years but also completed services within 12 months of their service start date. Although this table includes data on cases (*i.e.*, families), subsequent data on indicated maltreatment and OOH placement will focus on children, not cases.

Total In-Home Cases*						
Fiscal Year	Cases			Children		
	Newly Served Cases	Newly-Served & Closed Within 1 Year	% Closed Within 1 Year	Newly-Served Children	Newly-Served & Closed Within 1 Year	% Closed Within 1 Year
FY2009	6,274	5,528	88%	13,462	11,689	87%
FY2010	5,515	4,784	87%	11,863	10,229	86%
FY2011	5,260	4,568	87%	11,396	9,800	86%
FY2012	6,583	5,827	89%	13,935	12,257	88%
FY2013	6,278	5,551	88%	13,391	11,783	88%
FY 2014	6,552	NA until FY15		13,463	NA until FY15	
**FY2009 – 2013 data revised*						

Table 135

Over the past six fiscal years, the percentage of cases (families) and children that complete services within one year of beginning In-Home services is between 86% and 89%.

Indicated CPS Findings and Foster Care Placement Rates* (Total In-Home Cases)								
Fiscal Year	Indicated CPS Investigation				Out-of-Home Placement			
	During Services		Within 1 Year of Case Close		During Services		Within 1 Year of Case Close	
	Percent	Number	Percent	Number	Percent	Number	Percent	Number
FY2009	2.9%	396	3.3%	383	4.0%	536	2.4%	278
FY2010	3.9%	464	3.9%	401	4.6%	542	2.3%	233
FY2011	4.2%	475	3.3%	326	5.2%	598	2.5%	244
FY2012	2.6%	367	3.2%	397	4.5%	622	2.2%	264
FY2013	2.6%	345	NA until FY15		4.2%	557	NA until FY15	
**FY2009 – 2012 data revised*								

Table 136

Indicated CPS Findings and OOH Care Placement Rates*								
Consolidated In-Home Services								
Fiscal Year	**Indicated CPS Investigation**				**Out-of-Home Placement**			
	During Services		**Within 1 Year of Case Close**		**During Services**		**Within 1 Year of Case Close**	
	Percent	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**
FY2011	4.6%	440	3.4%	277	5.7%	548	2.5%	202
FY2012	2.7%	332	3.3%	354	4.6%	564	2.0%	219
FY2013	2.7%	314	NA until FY 15		4.3%	490	NA until FY 15	
Interagency Family Preservation Services								
Fiscal Year	**Indicated CPS Investigation**				**Out-of-Home Placement**			
	During Services		**Within 1 Year of Case Close**		**During Services**		**Within 1 Year of Case Close**	
	Percent	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**
FY2011	1.9%	35	3.0%	49	2.8%	50	2.6%	42
FY2012	2.1%	35	2.7%	43	3.4%	58	2.9%	45
FY2013	1.6%	31	NA until FY 15		3.5%	67	NA until FY 15	
**FY2011 – 2012 data revised*								

Table 137

Indicated CPS Investigations/Child Maltreatment

During the past five fiscal years, the percentage of children who have experienced an indicated Child Protective Service investigation that resulted in an indicated finding of child maltreatment during In-Home services ranged between 2.6% in FY2012 and 2013, and 4.2% in FY2011. Despite these fluctuations, since FY2009, the average percentage of children not experiencing indicated maltreatment is 96.8%; for FY2013 the percentage was 97.4%.

Within one year of case closure, an average of 3.4% of children experienced an indicated finding of maltreatment within one year of case closure; therefore, since FY2009, an average of 96.6% of children did not experience an indicated maltreatment finding up to one year after finishing In-Home services.

During services and for the one-year period after services, therefore, approximately 97% of children did not experience an indicated finding of maltreatment over the past four to five years. For the past three fiscal years, there has been a lower rate of indicated maltreatment findings among children in IFPS compared to those in Consolidated In-Home services both during and within the year following case closure.

OOH Placement

Although there was a slight increase in FY2011 (to 5.2%), the general rate of OOH placement during In-Home services has ranged from 4.0% to 4.6%, dropping to 4.2% in FY 2013. Overall, an average of 95.5% of children served in In-Home services from FY 2009 to FY 2013 was able to remain with their families during In-Home services, and avoid OOH placement.

OOH placement in the year following In-Home services has been stable between 2.2% and 2.5% for the past four years, with the lowest rate (2.2%) this past fiscal year. For these past four years, an average of 97.7% of children remain in their home and avoided OOH placement within the first year after receiving In-Home services.

For OOH placement, a lower percentage of children in IFPS entered OOH care during services than Consolidated services – in FY2013, 3.5% of children in IFPS services entered OOH care, compared to 4.3% in Consolidated services. After care, however, there is as slightly higher rate among children who had received IFPS than Consolidated (2.9% versus 2.0%, respectively, FY 2012 rates).

Analysis of Maryland Family Risk Assessment (MFRA) for In-Home Services

DHR is in the process of revising and implementing two new risk and service assessment instruments. The Child and Adolescent Needs and Strengths- Family version (CANS-F) was developed, which provides specific caregiver information and is intended to support strengths-based case plans for in-home services. Additionally, a revised Maryland Family Risk Assessment (MFRA) has been designed based on an actuarial model, which will provide increased inter-rater reliability. It is anticipated that these instruments will be implemented in June 2015. Once these instruments are fully implemented, DHR will have a better set of integrated tools for its In-Home workforce to use, and will gain a well-rounded picture of a family's safety, risk, and functioning that will assist with service planning and data reporting.

Data presented here is based on the current MFRA, which offers the advantage of consistency in analyzing data from prior years, and consistency within cases. Workers are trained on the MFRA during pre-service orientation and through ongoing supervision.

DHR In-Home workers are required to complete an MFRA while the family is receiving services. An intake and closing risk assessment is required, as well as additional ratings every six months or when the family situation changes. The assessment is six pages and includes a central section wherein workers score family observations in five risk categories: (a) History of Child Maltreatment; (b) Type and Extent of Current Child Maltreatment Investigation; (c) Child Characteristics; (d) Caregiver Characteristics; and (e) Familial, Social and Economic Characteristics. A four-level risk rating of no-risk, low-risk, moderate-risk, or high-risk is assigned by assessing past incidents or the current incident leading to In-Home services. The final section of the MFRA is the Overall Rating of Risk. Workers enter their summary risk ratings for the five preceding risk categories before assigning an overall rating of risk for the family. Workers use the overall family risk rating to inform their case management decisions including case opening.

MFRA Intake Ratings

Within two weeks of starting an In-Home service case, workers are required to complete a MFRA rating for the family. Data, however, is not available for an average of 18% of In-Home cases for FY2011 - 2014. Two reasons seem most likely for this missing data: first, the MFRA may be completed during the investigation and then shared with the In-Home services team but not made a formal part of the In-Home service record; second, workers may be completing the MFRA in a paper-version but not recording the results in MD CHESSIE. DHR is working on

correcting these issues through a quality assurance system, as well as through improved supervision of case workers.

Safety, not risk, is the decisive factor in determining if children must be removed from their family of origin and placed into OOH care. (Safety is measured in a separate instrument, the SAFE-C.) Although safety and risk are different constructs (safety is concerned with the child's immediate condition), many cases with high risk also have enough immediate safety issues to warrant an out of home removal. Therefore, families with the highest risk may be more often served in OOH services than In-Home services.

Initial Risk based on MFRA Ratings*						
Total In-Home Services						
		Percent				
Fiscal Year	**n**	**None**	**Low**	**Moderate**	**High**	**Missing**
FY 2011	7,517	9%	28%	39%	10%	14%
FY 2012	8,755	15%	29%	33%	8%	16%
FY 2013	8,751	17%	26%	31%	7%	18%
FY 2014	8,494	14%	27%	28%	6%	24%
Consolidated In-Home Services						
		Percent				
Fiscal Year	**n**	**None**	**Low**	**Moderate**	**High**	**Missing**
FY 2011	6,555	9%	29%	38%	9%	14%
FY 2012	7,850	16%	29%	31%	7%	16%
FY 2013	7,776	19%	27%	29%	7%	19%
FY 2014	7,527	15%	28%	26%	6%	25%
Interagency Family Preservation Services						
		Percent				
Fiscal Year	**n**	**None**	**Low**	**Moderate**	**High**	**Missing**
FY 2011	962	4%	21%	48%	17%	103%
FY 2012	905	5%	22%	50%	12%	11%
FY 2013	972	6%	24%	49%	12%	9%
FY 2014	967	6%	23%	44%	13%	14%
**FY 2011 – 2013 data revised*						

Table 138

This table shows initial MFRA ratings. In both Consolidated In-Home Services and IFPS cases over the past four years, the largest proportion of families has moderate risk levels. Families with low risk are the next largest group. Among Consolidated In-Home cases, those with no risk represented a higher proportion of cases than those with high risk in FYs 2012 and 2013, while the reverse is true for IFPS. Overall, over a third of all families in FY2014 (34%) had moderate or high risk at the initial MFRA evaluation.

Family Preservation Summary

DHR In-Home services are a critical component of meeting the needs of thousands of vulnerable children and their families. In FY2014 approximately 17,800 children from 8,500 families received DHR In-Home services.

Among those who had an initial MFRA (risk assessment) in FY2014:

- 34% had moderate to high risk at the initial assessment

Among those served in In-Home services, based on FY2013 entries (most recent year for which data is available):

- 97% of children did not experience an indicated finding for maltreatment during services, and
- 96% remained with their families and were not removed into a DHR OOH placement during services.

Among those children whose In-Home services ended, based on FY2012 entries (the most recent year for which data is available):

- 97% of children did not experience an indicated finding for maltreatment within one year of case closure, and
- 96% remain with their families and were not removed into a DHR OOH placement within one year of case closure.

As of August 31, 2014, there were 5,225 children in DHR OOH care (DHR/SSA State Stat Place Matters file, August 2014 data); this is the lowest number of children requiring removal from their homes in over 25 years. The provision of DHR In-Home services and other community supports are crucial in keeping children in their homes and families.

DHR's Place Matters Initiative has been able to achieve this success for children and families through its Family-Centered Practice model and use of Family Involvement Meetings. Child, youth, and family involvement are essential in DHR's OOH and In-Home practice models, which also rely on community supports and services. Providing In-Home services and other supports to families is necessary to continue to keep children with their families and to strengthen families' abilities to care for their children.

APPENDIX: Placement by Jurisdiction

Family Home, Adoptive

			Jurisdiction Where Children were Placed																									
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	4	12.5%	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	2	6.3%	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore City	5	15.6%	0	0	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Calvert	3	9.4%	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	4	12.5%	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0
Carroll	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	4	12.5%	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	1	3.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	2	6.3%	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Prince George's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	2	6.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	2	6.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wicomico	3	9.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	32	100.0	4	0	4	2	3	1	0	0	4	0	0	0	3	1	0	0	0	0	0	2	0	2	4	0	2	0
% of children from jurisdiction			100.0%	0.0%	50.0%	40.0%	100.0%	25.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%
% children Statewide in all			12.5%	0.0%	12.5%	6.3%	9.4%	3.1%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	9.4%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	6.3%	0.0%	6.3%	12.5%	0.0%	6.3%	0.0%

Family Home, Foster Care

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	29	2.6%	25	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Anne Arundel	52	4.6%	0	45	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	5	1
Baltimore	111	9.8%	0	0	95	6	0	0	3	2	0	0	0	0	2	0	0	0	0	0	0	0	0	1	0	0	1	1
Baltimore City	335	29.6%	0	2	70	242	0	3	0	0	1	0	1	0	2	1	0	0	0	0	0	0	0	0	1	0	7	5
Calvert	26	2.3%	0	0	0	0	24	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	8	0.7%	0	1	0	0	0	5	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	25	2.2%	0	0	1	0	0	0	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Cecil	86	7.6%	0	0	0	0	0	0	0	86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	45	4.0%	0	0	0	0	0	0	0	0	45	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	5	0.4%	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	0
Frederick	44	3.9%	0	0	0	0	0	0	0	0	0	0	42	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	12	1.1%	0	0	0	0	0	0	0	0	0	0	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	67	5.9%	0	0	4	0	0	0	0	1	0	0	0	0	62	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	9	0.8%	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0
Kent	3	0.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0
Montgomery	99	8.7%	0	0	0	0	0	0	0	1	0	0	3	0	0	0	0	95	0	0	0	0	0	0	0	0	0	0
Prince George's	72	6.4%	0	0	1	1	0	0	0	0	0	0	0	0	0	4	0	0	62	0	0	0	0	0	0	0	4	0
Queen Anne's	2	0.2%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0
Somerset	7	0.6%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	5	0	0	0
St. Mary's	23	2.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	0	0	0	0	0	0
Talbot	6	0.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0
Washington	50	4.4%	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	45	0	0	4	0
Wicomico	10	0.9%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0	0	0
Worchester	6	0.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	1	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	1132	100.0	25	48	171	249	24	8	26	90	48	4	47	15	66	16	3	95	62	3	2	23	7	48	21	1	23	7
% of children from jurisdiction			86.2%	86.5%	85.6%	72.2%	92.3%	62.5%	92.0%	100.0%	100.0%	40.0%	95.5%	100.0%	92.5%	100.0%	100.0%	96.0%	86.1%	100.0%	28.6%	100.0%	100.0%	90.0%	100.0%	16.7%	0.0%	0.0%
% children Statewide in all			2.2%	4.2%	15.1%	22.0%	2.1%	0.7%	2.3%	8.0%	4.2%	0.4%	4.2%	1.3%	5.8%	1.4%	0.3%	8.4%	5.5%	0.3%	0.2%	2.0%	0.6%	4.2%	1.9%	0.1%	2.0%	0.6%

Family Home, Relative Care

			Jurisdiction Where Children were Placed																									
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	19	2.5%	15	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2	1
Anne Arundel	12	1.6%	0	8	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Baltimore	26	3.4%	0	2	16	2	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0	0	0	3
Baltimore City	475	62.4%	0	16	127	283	1	0	0	0	2	0	2	0	17	7	0	1	8	0	0	0	0	0	0	0	8	3
Calvert	15	2.0%	0	4	2	0	6	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	1
Caroline	6	0.8%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	2
Carroll	3	0.4%	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	10	1.3%	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Charles	16	2.1%	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	3
Dorchester	3	0.4%	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Frederick	17	2.2%	0	0	0	0	0	0	2	0	0	0	13	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
Garrett	1	0.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Harford	36	4.7%	0	2	10	0	0	0	1	1	0	0	2	0	13	1	0	1	1	0	0	0	0	0	0	0	0	4
Howard	6	0.8%	0	3	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	53	7.0%	0	0	0	0	0	0	0	0	0	0	4	0	2	1	0	41	2	0	0	0	0	0	0	0	1	2
Prince George's	34	4.5%	0	2	1	0	1	0	0	0	3	0	0	0	0	0	0	3	21	0	0	0	0	0	0	0	2	1
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	1	0.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
St. Mary's	16	2.1%	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	10	0	0	0	0	3	0
Talbot	2	0.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0
Washington	8	1.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	1	1
Wicomico	1	0.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Worchester	1	0.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	761	100.0	15	37	160	287	8	0	6	8	17	1	21	0	34	10	0	46	36	1	1	12	5	6	3	0	21	26
% of children from jurisdiction			78.9%	66.7%	61.5%	59.6%	40.0%	0.0%	100.0%	70.0%	68.8%	33.3%	76.5%	0.0%	36.1%	16.7%	0.0%	77.4%	61.8%	0.0%	0.0%	62.5%	100.0%	75.0%	100.0%	0.0%	0.0%	0.0%
% children Statewide in all			2.0%	4.9%	21.0%	37.7%	1.1%	0.0%	0.8%	1.1%	2.2%	0.1%	2.8%	0.0%	4.5%	1.3%	0.0%	6.0%	4.7%	0.1%	0.1%	1.6%	0.7%	0.8%	0.4%	0.0%	2.8%	3.4%

Family Home, Restricted Relative Care

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	3	0.9%	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	24	7.4%	0	1	14	3	0	0	0	0	0	1	0	0	1	4	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore City	233	71.5%	0	5	56	148	1	0	1	0	0	0	0	0	10	1	0	0	1	0	0	0	0	0	0	0	0	8	2
Calvert	6	1.8%	0	1	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	2	0.6%	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	2	0.6%	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Garrett	6	1.8%	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	2	0.6%	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	1	0.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	14	4.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12	1	0	0	0	0	0	0	0	0	1	0
Prince George's	12	3.7%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0	0	0	1	0
Queen Anne's	2	0.6%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0
Somerset	3	0.9%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0
St. Mary's	6	1.8%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	10	3.1%	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	0	0	0	0
Wicomico	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	326	100.0%	3	7	71	151	4	0	3	0	2	1	1	6	12	5	0	13	13	2	3	8	0	8	0	0	11	2
% of children from jurisdiction			100.0%	0.0%	58.3%	63.5%	50.0%	0.0%	0.0%	0.0%	100.0%	0.0%	50.0%	100.0%	50.0%	0.0%	0.0%	85.7%	91.7%	100.0%	100.0%	100.0%	0.0%	80.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			0.9%	2.1%	21.8%	46.3%	1.2%	0.0%	0.9%	0.0%	0.6%	0.3%	0.3%	1.8%	3.7%	1.5%	0.0%	4.0%	4.0%	0.6%	0.9%	2.5%	0.0%	2.5%	0.0%	0.0%	3.4%	0.6%

Family Home, Treatment Foster Care

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	6	0.4%	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Anne Arundel	50	3.1%	0	14	10	9	1	0	0	0	0	0	0	0	0	2	0	3	6	0	2	0	0	0	2	0	1	0
Baltimore	194	11.9%	0	4	107	53	0	0	1	1	0	1	1	1	10	2	0	1	2	0	0	1	0	6	0	0	0	3
Baltimore City	806	49.5%	0	19	348	350	0	0	8	1	0	0	0	0	16	10	0	11	33	0	1	0	0	3	4	0	0	2
Calvert	17	1.0%	0	0	1	0	1	0	1	0	7	0	0	0	0	1	0	0	3	0	0	0	0	2	1	0	0	0
Caroline	8	0.5%	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	1	0	0	1	0	4	0	0	0
Carroll	4	0.2%	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Cecil	25	1.5%	0	1	5	2	0	0	0	6	0	2	0	0	6	0	0	0	0	0	0	0	0	0	1	0	1	1
Charles	12	0.7%	0	0	1	0	0	0	1	0	5	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0
Dorchester	9	0.6%	0	0	0	0	0	0	1	0	0	6	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0
Frederick	17	1.0%	0	0	4	2	0	0	1	0	0	0	1	0	1	0	0	0	0	0	0	0	0	8	0	0	0	0
Garrett	2	0.1%	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	45	2.8%	0	0	14	4	0	0	1	2	0	0	0	0	22	0	0	0	1	1	0	0	0	0	0	0	0	0
Howard	18	1.1%	0	1	7	5	0	0	0	0	0	0	0	0	0	4	0	1	0	0	0	0	0	0	0	0	0	0
Kent	1	0.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Montgomery	85	5.2%	0	2	14	4	0	0	1	0	2	0	0	0	2	3	1	34	15	0	0	0	0	6	1	0	0	0
Prince George's	219	13.5%	1	3	13	7	6	0	3	0	7	1	0	0	0	8	0	3	162	1	0	0	0	1	2	0	0	1
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	14	0.9%	0	1	1	0	0	0	0	0	0	3	0	0	0	0	0	0	2	0	4	0	0	0	3	0	0	0
St. Mary's	24	1.5%	0	0	1	1	1	0	0	0	8	0	0	0	2	2	0	0	6	1	0	0	0	0	2	0	0	0
Talbot	11	0.7%	0	0	0	0	0	5	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3	0	2	0	0	0
Washington	24	1.5%	5	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	16	0	0	0	0
Wicomico	20	1.2%	0	0	2	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	17	0	0	0
Worchester	13	0.8%	0	0	1	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	3	0	0	0	7	0	0	0
Out-of-State	3	0.2%	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	1627	100.0	12	45	532	438	9	7	18	10	29	17	3	3	59	32	2	53	235	4	10	1	5	44	49	0	2	8
% of children from jurisdiction			66.7%	28.0%	55.2%	43.4%	5.9%	12.5%	0.0%	24.0%	41.7%	66.7%	5.9%	50.0%	48.9%	22.2%	100.0%	40.0%	74.0%	0.0%	28.6%	0.0%	27.3%	66.7%	85.0%	0.0%	0.0%	0.0%
% children Statewide in all			0.7%	2.8%	32.7%	26.9%	0.6%	0.4%	1.1%	0.6%	1.8%	1.0%	0.2%	0.2%	3.6%	2.0%	0.1%	3.3%	14.4%	0.2%	0.6%	0.1%	0.3%	2.7%	3.0%	0.0%	0.1%	0.5%

Family Home, Living Arrangement

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	14	5.9%	13	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	21	8.9%	0	14	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	4	0
Baltimore	34	14.4%	0	0	25	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	7
Baltimore City	71	30.1%	0	0	57	4	0	0	0	0	1	0	0	0	1	0	0	0	0	0	1	0	0	1	0	0	3	3
Calvert	2	0.8%	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	1	0.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Carroll	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	4	1.7%	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Charles	3	1.3%	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Dorchester	1	0.4%	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	7	3.0%	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	23	9.7%	0	0	3	0	0	0	0	2	0	0	0	0	16	0	0	0	0	0	0	0	0	0	0	0	1	1
Howard	1	0.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	26	11.0%	0	0	2	0	0	0	1	0	0	0	0	0	0	0	0	16	3	0	0	0	0	0	0	0	1	3
Prince George's	18	7.6%	0	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	7	0	0	0	0	0	0	0	5	3
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	1	0.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
St. Mary's	4	1.7%	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	5	2.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0
Wicomico	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	236	100.0%	13	15	91	4	1	0	1	5	3	2	7	2	18	1	0	16	11	0	2	3	0	6	1	0	14	20
% of children from jurisdiction			92.9%	66.7%	73.5%	5.6%	50.0%	0.0%	0.0%	75.0%	33.3%	100.0%	100.0%	0.0%	69.6%	100.0%	0.0%	61.5%	38.9%	0.0%	100.0%	75.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			5.5%	6.4%	38.6%	1.7%	0.4%	0.0%	0.4%	2.1%	1.3%	0.8%	3.0%	0.8%	7.6%	0.4%	0.0%	6.8%	4.7%	0.0%	0.8%	1.3%	0.0%	2.5%	0.4%	0.0%	5.9%	8.5%

Community, Independent Living

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	5	2.5%	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	3	0	0	0	0	0	0	0	0	0	0	0
Baltimore	20	10.0%	0	0	14	5	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Baltimore City	126	62.7%	0	0	65	54	0	0	0	0	0	0	0	0	0	2	0	1	3	0	0	0	0	1	0	0	0	0	0
Calvert	1	0.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	1	0.5%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	2	1.0%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	3	1.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0
Garrett	1	0.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Harford	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	5	2.5%	0	0	2	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	13	6.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	2	0	0	0	0	0	0	0	0	0	0
Prince George's	22	10.9%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	16	0	0	0	0	0	2	0	0	0	1
Queen Anne's	1	0.5%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wicomico	1	0.5%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	201	100.0%	0	0	86	60	0	0	0	0	0	0	0	0	1	5	0	21	22	0	0	0	0	1	4	0	0	1	
% of children from jurisdiction			0.0%	0.0%	70.0%	42.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	0.0%	84.6%	72.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			0.0%	0.0%	42.8%	29.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	2.5%	0.0%	10.4%	10.9%	0.0%	0.0%	0.0%	0.0%	0.5%	2.0%	0.0%	0.0%	0.5%	

Community, RCCP

Jurisdiction Where Children were Placed																														
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	14	1.7%	6	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	1	0	0	0	0	1	0	0	3	0
Anne Arundel	49	5.9%	0	3	17	8	0	2	0	0	3	0	1	0	3	0	0	2	3	0	0	0	0	6	0	0	1	0
Baltimore	94	11.2%	1	0	36	23	0	2	0	3	0	0	1	1	3	1	0	6	7	0	0	0	0	4	0	0	5	1
Baltimore City	201	24.0%	0	7	51	93	0	0	0	0	1	0	0	0	0	2	1	12	20	0	0	0	0	10	0	0	4	0
Calvert	20	2.4%	1	0	5	1	1	2	0	0	2	0	1	2	0	0	0	0	1	0	0	1	0	2	0	0	1	0
Caroline	3	0.4%	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Carroll	9	1.1%	2	0	3	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	3	0	0	0	0
Cecil	25	3.0%	0	0	12	2	0	2	0	4	0	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	2	0
Charles	17	2.0%	1	0	3	2	0	0	0	0	7	0	0	0	0	0	0	1	0	0	0	0	0	2	0	0	1	0
Dorchester	5	0.6%	0	0	1	0	0	1	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	0
Frederick	30	3.6%	2	0	8	1	0	2	0	1	0	0	2	0	1	0	0	2	3	0	0	0	0	6	0	0	2	0
Garrett	6	0.7%	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	3	0	0	0	0
Harford	46	5.5%	0	0	12	1	0	3	0	3	0	0	0	0	11	0	0	5	0	0	0	0	0	6	0	0	5	0
Howard	23	2.7%	0	0	14	1	1	0	0	0	0	0	0	1	0	0	0	1	2	0	0	0	0	2	0	0	1	0
Kent	6	0.7%	0	0	2	0	0	3	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	73	8.7%	0	3	6	2	0	1	0	2	0	0	2	0	0	0	0	34	9	0	0	0	0	8	0	0	5	1
Prince George's	117	14.0%	4	5	26	11	1	1	0	4	2	0	2	0	1	1	3	9	28	0	0	0	0	13	0	0	6	0
Queen Anne's	6	0.7%	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Somerset	3	0.4%	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
St. Mary's	17	2.0%	0	1	9	0	1	0	0	0	1	0	0	0	0	0	0	1	2	0	0	0	0	1	0	0	1	0
Talbot	3	0.4%	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Washington	36	4.3%	1	0	9	3	0	0	0	0	0	0	1	0	0	0	0	0	3	0	0	0	0	17	0	0	0	2
Wicomico	19	2.3%	0	0	5	2	0	2	0	0	0	0	0	0	0	0	1	6	1	0	0	0	0	0	0	0	2	0
Worchester	4	0.5%	0	0	1	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Out-of-State	11	1.3%	0	0	7	1	1	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	837	100.0	20	19	229	152	5	29	0	19	16	0	10	8	20	5	8	82	80	0	0	1	0	84	1	0	45	4
% of children from jurisdiction			42.9%	6.1%	38.3%	46.3%	5.0%	33.3%	0.0%	16.0%	41.2%	0.0%	6.7%	16.7%	23.9%	0.0%	0.0%	46.6%	23.9%	0.0%	0.0%	0.0%	0.0%	47.2%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			2.4%	2.3%	27.4%	18.2%	0.6%	3.5%	0.0%	2.3%	1.9%	0.0%	1.2%	1.0%	2.4%	0.6%	1.0%	9.8%	9.6%	0.0%	0.0%	0.1%	0.0%	10.0%	0.1%	0.0%	5.4%	0.5%

Community, CSLA

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	3	4.4%	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	2	2.9%	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	8	11.8%	0	0	6	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore City	3	4.4%	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Calvert	2	2.9%	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	6	8.8%	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	2	2.9%	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	1	1.5%	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	3	4.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	25	36.8%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25	0	0	0	0	0	0	0	0	0	0	0
Prince George's	8	11.8%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	1	1.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
St. Mary's	1	1.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	3	4.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0
Wicomico	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	68	100.0	3	2	6	4	2	0	7	0	2	0	0	0	1	3	0	25	8	0	1	1	0	3	0	0	0	0	0
% of children from jurisdiction			100.0%	100.0%	75.0%	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			4.4%	2.9%	8.8%	5.9%	2.9%	0.0%	10.3%	0.0%	2.9%	0.0%	0.0%	0.0%	1.5%	4.4%	0.0%	36.8%	11.8%	0.0%	1.5%	1.5%	0.0%	4.4%	0.0%	0.0%	0.0%	0.0%	0.0%

Community, Living Arrangement

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	4	9.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	2	
Baltimore City	26	60.5%	0	1	7	0	0	0	0	0	0	0	0	2	0	0	0	0	7	0	2	0	0	0	0	0	4	3	
Calvert	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Carroll	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Cecil	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Charles	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Frederick	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Harford	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Howard	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Montgomery	7	16.3%	0	1	5	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	
Prince George's	6	14.0%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	3	0	
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
St. Mary's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Washington	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Wicomico	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Grand Total	43	100.0%	0	2	13	0	0	0	0	0	0	0	0	2	0	0	0	0	9	0	4	0	0	0	1	0	7	5	
% of children from jurisdiction			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
% children Statewide in all			0.0%	4.7%	30.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.7%	0.0%	0.0%	0.0%	0.0%	20.9%	0.0%	9.3%	0.0%	0.0%	0.0%	2.3%	0.0%	16.3%	11.6%	

Non-Community, DETP

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	1	4.2%	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	2	8.3%	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore City	1	4.2%	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Calvert	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	1	4.2%	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	1	4.2%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	1	4.2%	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	2	8.3%	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	2	8.3%	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	3	12.5%	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Prince George's	2	8.3%	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	1	4.2%	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	2	8.3%	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wicomico	2	8.3%	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	2	8.3%	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	1	4.2%	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	24	100.0	0	0	9	14	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
% of children from jurisdiction			0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			0.0%	0.0%	37.5%	58.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Non-Community, Detention

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	2	1.3%	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	11	6.9%	3	0	0	0	0	0	0	0	0	0	3	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	11	6.9%	3	0	0	0	0	0	0	0	0	0	3	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore City	32	20.1%	10	0	0	5	0	0	0	0	0	0	14	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Calvert	3	1.9%	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	4	2.5%	2	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	2	1.3%	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	5	3.1%	1	0	0	1	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	3	1.9%	1	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	1	0.6%	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	1	0.6%	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	2	1.3%	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	1	0.6%	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	18	11.3%	11	0	0	2	0	0	0	0	0	0	4	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Prince George's	49	30.8%	20	0	0	3	0	0	0	0	0	0	15	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	2	1.3%	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	3	1.9%	1	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	3	1.9%	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wicomico	5	3.1%	3	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	1	0.6%	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	159	100.0	65	0	0	15	0	0	0	0	0	0	46	33	0	0	0	0	0	0	0	0	0	0	0	0	0	0
% of children from jurisdiction			50.0%	0.0%	0.0%	15.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			40.9%	0.0%	0.0%	9.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	28.9%	20.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Non-Community, Non-Secure

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	3	7.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2	0
Baltimore	1	2.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Baltimore City	15	36.6%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	14	0
Calvert	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	3	7.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	0
Cecil	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	3	7.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	1	2.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Howard	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	3	7.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Prince George's	8	19.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	4	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wicomico	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	4	9.8%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	41	100.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0	0	0	0	30	0
% of children from jurisdiction			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
% children Statewide in all			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	26.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	73.2%	0.0%

Non-Community, Residential Education

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	4	8.5%	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2	0
Baltimore City	4	8.5%	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Calvert	1	2.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Caroline	2	4.3%	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Carroll	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	2	4.3%	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	1	2.1%	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	6	12.8%	0	0	0	0	0	0	0	1	0	0	0	0	0	2	0	1	0	0	0	0	0	0	0	0	2	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	3	6.4%	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Howard	1	2.1%	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	2	4.3%	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	18	38.3%	0	0	0	0	0	4	0	3	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	6	0
Prince George's	3	6.4%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	1	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wicomico	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	47	100.0	0	0	1	0	0	12	0	6	0	0	0	0	0	2	0	9	0	0	0	0	0	0	0	0	17	0
% of children from jurisdiction			0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	27.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			0.0%	0.0%	2.1%	0.0%	0.0%	25.5%	0.0%	12.8%	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	19.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	36.2%	0.0%

Non-Community, RTC

			Jurisdiction Where Children were Placed																											
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	15	2.0%	0	0	1	7	0	0	0	0	0	1	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	46	6.2%	0	0	4	27	0	0	0	0	0	5	4	0	0	0	0	2	0	0	0	0	0	0	0	0	4	0
Baltimore	123	16.6%	0	0	43	62	0	0	0	0	0	3	7	0	0	0	0	1	0	0	0	0	0	0	0	0	7	0
Baltimore City	137	18.5%	0	0	64	54	0	0	0	0	0	3	8	0	0	0	0	2	0	0	0	0	0	0	0	0	6	0
Calvert	5	0.7%	0	0	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Caroline	5	0.7%	0	0	3	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	15	2.0%	0	0	8	4	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Cecil	22	3.0%	0	0	8	11	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	8	1.1%	0	0	3	1	0	0	0	0	0	1	1	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Dorchester	26	3.5%	0	0	5	8	0	0	0	0	0	10	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Frederick	35	4.7%	0	0	5	8	0	0	0	0	0	0	20	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Garrett	5	0.7%	0	0	0	3	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	37	5.0%	0	0	15	13	0	0	0	0	0	4	1	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0
Howard	15	2.0%	0	0	2	8	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Kent	7	0.9%	0	0	5	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	67	9.0%	0	0	10	20	0	0	0	0	0	4	4	0	0	0	0	29	0	0	0	0	0	0	0	0	0	0
Prince George's	78	10.5%	0	0	27	18	0	0	0	0	0	7	8	0	0	0	0	6	0	0	0	0	0	0	0	0	12	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	6	0.8%	0	0	2	0	0	0	0	0	0	2	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
St. Mary's	4	0.5%	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Talbot	14	1.9%	0	0	1	0	0	0	0	0	0	8	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	24	3.2%	0	0	8	7	0	0	0	0	0	1	4	0	0	0	0	3	0	0	0	0	0	0	0	0	1	0
Wicomico	34	4.6%	0	0	15	5	0	0	0	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	14	1.9%	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	2	0	0	0	0	0	0	0	0	9	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	742	100.	0	0	234	260	0	0	0	0	0	66	79	0	0	0	0	51	0	0	0	0	0	0	0	0	52	0
% of children from jurisdiction			0.0%	0.0%	35.0%	39.4%	0.0%	0.0%	0.0%	0.0%	0.0%	38.5%	57.1%	0.0%	0.0%	0.0%	0.0%	43.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	64.3%	0.0%
% children Statewide in all			0.0%	0.0%	31.5%	35.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.9%	10.6%	0.0%	0.0%	0.0%	0.0%	6.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.0%	0.0%

Non-Community, ASAM

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	2	0.5%	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	67	17.6%	16	7	7	0	1	0	12	0	0	3	5	4	0	0	0	1	0	0	0	0	0	6	0	0	5	0
Baltimore	53	13.9%	11	0	11	1	0	0	12	0	0	1	0	6	0	0	0	0	0	0	0	0	0	1	0	0	10	0
Baltimore City	80	21.1%	1	1	9	11	0	0	30	0	0	4	0	6	0	0	0	1	0	0	0	0	0	1	0	0	16	0
Calvert	11	2.9%	2	1	1	0	0	0	2	0	0	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Caroline	1	0.3%	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	13	3.4%	3	0	2	1	0	0	4	0	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	9	2.4%	4	1	1	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0
Charles	8	2.1%	0	0	1	1	1	0	0	0	1	2	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Dorchester	2	0.5%	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Frederick	11	2.9%	2	1	1	0	0	0	1	0	0	0	5	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	15	3.9%	6	0	0	0	0	0	3	0	0	0	1	1	1	0	2	0	0	0	0	0	0	1	0	0	0	0
Howard	3	0.8%	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Kent	2	0.5%	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	21	5.5%	5	2	3	0	0	0	1	0	0	0	0	3	0	0	0	4	0	0	0	0	0	1	0	0	2	0
Prince George's	39	10.3%	2	0	3	1	0	0	16	0	0	3	0	8	0	0	0	0	0	0	0	0	0	0	0	0	6	0
Queen Anne's	1	0.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Somerset	1	0.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
St. Mary's	6	1.6%	2	0	0	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	8	2.1%	1	0	3	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0
Wicomico	11	2.9%	3	0	0	0	0	0	2	0	0	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Worchester	2	0.5%	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	14	3.7%	0	0	7	0	0	0	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	380	100.0	63	13	50	16	2	0	90	0	2	20	15	35	1	0	3	6	2	0	0	1	0	14	0	2	45	0
% of children from jurisdiction			100.0%	10.4%	20.8%	13.8%	0.0%	0.0%	30.8%	0.0%	12.5%	0.0%	45.5%	0.0%	6.7%	0.0%	0.0%	19.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%
% children Statewide in all			16.6%	3.4%	13.2%	4.2%	0.5%	0.0%	23.7%	0.0%	0.5%	5.3%	3.9%	9.2%	0.3%	0.0%	0.8%	1.6%	0.5%	0.0%	0.0%	0.3%	0.0%	3.7%	0.0%	0.5%	11.8%	0.0%

Hospitalization, Psychiatric

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	2	12.5%	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore City	2	12.5%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Calvert	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	1	6.3%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	1	6.3%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harford	1	6.3%	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	3	18.8%	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Prince George's	4	25.0%	0	0	1	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	1	6.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wicomico	1	6.3%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	16	100.0%	0	0	8	0	0	0	2	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	0	0	2	1	
% of children from jurisdiction			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
% children Statewide in all			0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	6.3%	6.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.3%	0.0%	0.0%	12.5%	6.3%	

Hospitalization, General

			Jurisdiction Where Children were Placed																										
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Anne Arundel	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Baltimore	1	11.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Baltimore City	5	55.6%	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2	0
Calvert	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	1	11.1%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cecil	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dorchester	1	11.1%	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Garrett	1	11.1%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Harford	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Prince George's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Mary's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wicomico	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	9	100.0%	0	0	3	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	3	1
% of children from jurisdiction			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% children Statewide in all			0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	11.1%

Unknown

Jurisdiction Where Children were Placed																														
Home Jurisdiction of Children	# children from jurisdiction in placement	% of children Statewide in placements from jurisdiction	Allegany	Anne Arundel	Baltimore	Baltimore City	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester	Out-of-State	Unknown
Allegany	3	0.9%	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Anne Arundel	4	1.2%	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Baltimore	18	5.6%	0	0	14	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Baltimore City	170	52.8%	0	1	85	10	0	0	1	0	0	1	0	1	1	2	0	0	0	0	0	0	0	0	1	0	5	62
Calvert	3	0.9%	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Caroline	2	0.6%	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	5	1.6%	0	0	1	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Cecil	6	1.9%	0	0	0	0	0	0	0	5	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles	4	1.2%	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Dorchester	1	0.3%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick	4	1.2%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	2
Garrett	11	3.4%	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	2	0	0	0	4
Harford	17	5.3%	0	0	4	0	0	0	0	0	0	0	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	4
Howard	1	0.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Kent	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	15	4.7%	0	1	3	0	0	0	1	0	0	0	1	0	0	0	0	3	1	0	0	0	0	0	0	0	3	2
Prince George's	34	10.6%	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1	18	0	0	0	1	0	0	0	8	3
Queen Anne's	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Somerset	1	0.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
St. Mary's	2	0.6%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Talbot	2	0.6%	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Washington	16	5.0%	0	0	2	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	13	0	0	0	0
Wicomico	3	0.9%	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0
Worchester	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out-of-State	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	322	100.0	2	4	114	10	2	1	6	5	1	2	2	7	12	3	1	5	19	0	0	1	1	17	3	0	17	87
% of children from jurisdiction			33.3%	50.0%	77.8%	5.9%	66.7%	50.0%	60.0%	83.3%	25.0%	0.0%	0.0%	45.5%	52.9%	100.0%	0.0%	20.0%	52.9%	0.0%	0.0%	0.0%	0.0%	81.3%	33.3%	0.0%	0.0%	0.0%
% children Statewide in all			0.6%	1.2%	35.4%	3.1%	0.6%	0.3%	1.9%	1.6%	0.3%	0.6%	0.6%	2.2%	3.7%	0.9%	0.3%	1.6%	5.9%	0.0%	0.0%	0.3%	0.3%	5.3%	0.9%	0.0%	5.3%	27.0%

Exhibit 8

Government of the District of Columbia

HUMAN CARE AGREEMENT

PAGE 1 OF PAGES 30

1. CONTRACT NUMBER	2. REQUISITION/PURCHASE REQUEST NO.	3. EFFECTIVE DATE
DCJZ-2014-H-0007		

4. ISSUED BY	5. ADMINISTERED BY (If other than Item 5):
Office of Contracting and Procurement 441 4th Street, NW, Suite 700S Washington, DC 20001	Department of Youth Rehabilitation Services 8300 Riverton Court Laurel, Maryland 20724

6. NAMES AND ADDRESS OF PROVIDER/PROVIDER(No. Street, county, state and ZIP Code)

Seasons Residential Treatment Program, LLC.
13400 Edgemeade Road,
Upper Marlboro, Maryland 20772
Telephone: 404-433-5205 Fax: E-Mail:

7. PROVIDER/PROVIDERSHALL SUBMIT ALL INVOICES TO:	8. DISTRICT SHALL SEND ALL PAYMENTS TO:
Department of Youth Rehabilitation Services Office of the Chief Financial Officer 8300 Riverton Court Laurel, MD 20724	Seasons Residential Treatment Program, LLC. 13400 Edgemeade Road. Upper Marlboro, Maryland 20772

9. DESCRIPTION OF HUMAN CARE SERVICE AND RATE COST

ITEM/LINE NO.	NIOP CODE	BRIEF DESCRIPTION OF HUMAN CARE SERVICE	QUANITY OF SERVICE REQUIRED	TOTAL SERVICE UNITS	SERVICE RATE	TOTAL AMOUNT
0001	952-95	Short Term Placement Services (Staff Secured)			See Schedule B	
0002	952-95	Short Term Placement Services (Hardware Secured)				
0003	952-95	Educational Services				
					Total	$
					Total From Any Continuation Pages	$
					GRAND TOTAL	$

10. APPROPRIATION DATA AND FINANCIAL CERTIFICATION

LINE	AGY	YEAR	INDEX	PCA	OBJ	AOBJ	GRANT/PH	PROJ/PH	AO1	AO2	AO3	PERCENT	FUND SOURCE	AMOUNT

A. SOAR SYSTEM OBLIGATION CODE:	B. Name of Financial Officer (Typed): Title:	C. Signature:	D. Date:

11. PERIOD OF HUMAN CARE AGREEMENT

Starting Date:	Ending Date:

HUMAN CARE AGREEMENT SIGNATURES

Pursuant to the authority provided in D.C. Law 13-155, this HUMAN CARE AGREEMENT is being entered into between the Provider/Providerspecified in Item No. 7 and Item No. 12 of page 1 of this document. *The Provider/Providerls required to sign this document and return 3 original and signed copies to the Contracting Officer of the Issuing Office stated in Item No.4 of page 1 of this document.* The Providerfurther agrees to furnish and deliver all items or perform all the services set forth or otherwise identified within this Human Care Agreement and on any continuation sheets or appendices for the consideration stated above. The rights and obligations of the parties to this Human Care Agreement shall be subject to and governed by the following documents: (a) this Human Care Agreement, (b) the *STANDARD CONTRACT PROVISIONS FOR USE WITH DISTRICT OF COLUMBIA GOVERNMENT SUPPLY AND SERVICES CONTRACTS*, dated October 1, 1999; (c) Any other provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. This Human Care Agreement between the signatories to this document contummates the final agreement of the parties.

12. FOR THEPROVIDER/ CONTRACTOR		13. FOR THE DISTRICT OF COLUMBIA	
A. Name and Title of Signer (Type or print) Name: Tyeasis Johnson Title: Owner		A. Name of Contracting Officer (Type or print) Joseph Stewart.	
B. Signature of the PROVIDER/CONTRACTOR:	C. DATE 3/11/14	B. Signature of CONTRACTING OFFICER: Joseph Stewart	C. DATE 4/18/14

THE SCOPE OF HUMAN CARE SERVICES

SECTION 1 – HUMAN CARE SERVICES AND SERVICE RATES

1.1 The Government of the District of Columbia, Office of Contracting and Procurement, Department of Youth and Rehabilitation Services, hereafter referred to as the "District," is Contracting through this Human Care Agreement with Seasons Residential Treatment Program LLC, hereafter referred to as the "Provider," for the purchase of human care services pursuant to the Human Care Agreement Amendment Act of 2000, Section 406 of the Procurement Practices Reform Act of 2010, effective April 8, 2011 (D.C. Law 18-371; D.C. Official Code § 2-354.06).

1.2 The District is not committed to purchase under this Human Care Agreement any quantity of a particular service covered under this Agreement. The District is obligated only to the extent that authorized purchases are made pursuant to the human care agreement.

1.3 Delivery or performance shall be made only as authorized by Task Orders issued in accordance with the Ordering Clause. The Provider shall furnish to the District Government, when and if ordered, the services specified in the Price Schedule

1.4 There is no limit on the number of Task Orders that may be issued. The District Government may issue Task Orders requiring delivery to multiple destinations or performance at multiple locations

1.5 This is a Human Care Agreement based on fixed unit rates. The provider shall deliver services in accordance with Section 4.

SECTION 2 PRICE SCHEDULE / FIXED UNIT RATE

2.1 The District is not committed to purchase under this Human Care Agreement any quantity of a particular service covered under this Agreement. The District is obligated only to the extent that authorized purchases are made pursuant to the human care agreement. DYRS is not responsible for the educational costs incurred for special education services for those youth who have a valid IEP. The Provider shall be responsible for submitting invoices for special education services to the Office of the Superintendent of Special Education (OSSE) in the District of Columbia.

2.1.1 Base Year

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
0001	Short Term Placement Services in the Staff secured facility as described in Sections 4.1	Client/Per Day	$ 365.00
0002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	$ 380.00

0003	Educational Services, as described in Section 4.5	Client/Per Day	$ 100.00

2.1.2 Option Year One

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
1001	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	$ 383.00
1002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	$ 399.00
1003	Educational Services, as described in Section 4.5	Client/Per Day	$ 100.00

2.1.3 Option Year Two

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
2001	Short Term Awaiting Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	$ 402.00
2002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	$ 419.00
2003	Educational Services, as described in Section 4.5	Client/Per Day	$ 100.00

2.1.4 Option Year Three

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
3001	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	$ 423.000
3002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	$ 440.00
3003	Educational Services, as described in Section 4.5	Client/Per Day	$ 100.00

2.1.5 Option Year Four

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
4001	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	$ 444.00
4002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	$ 462.00
4003	Educational Services, as described in Section 4.5	Client/Per Day	$ 100.00

SECTION 3 – SCOPE OF HUMAN CARE SERVICES

3.1 The Government of the District of Columbia, on behalf of the Department of Youth Rehabilitation Services, is seeking providers that shall operate staff secured and/or hardware-secured, Short Term Placement, 24-hours, maximum 25-bed facilities to provide services to the DYRS population as specified in Section 4.

3.1.1 Applicable Documents

Item No.	Document Type	Title	Date
1	Court Document	**Jerry M., et al Plaintiffs v. District of Columbia, et al., Defendants Civil No. 1519-85 (IFP) – Synopsis**	7-10-86

		Superior Court of the District of Columbia **Available at:** Bureau of Courts and Community Services Department of Youth Rehabilitation Services 450 H Street, NW Washington, D.C. Telephone: 202-724-5071	
2		Federal Individuals with Disabilities Education Act, 20 U.S.C.A .§ 1400 et seq, Subchapters I and II available at http://fedlaw.gsa.gov or http://www.law.cornell.edu/uscode/	1990
3	Public Law 101-336, July 26, 1990	Americans with Disabilities Act 42 USCA § 12101-102; 12131-134. available at http://fedlaw.gsa.gov or http://www.law.cornell.edu/uscode/	1990
4	D.C. Law Concerning Proceedings Regarding Delinquency, Neglect or Need of Supervision	D.C. Official Code, Section 16-2301-2372 available at http://dccode.westgroup.com	
5		District Personnel Manual Mandatory Employee Drug & Alcohol, Chapter 39 of the District Personnel Regulations	
6	DYRS Document (Policy & Procedures)	**Unusual Incident & After Hours Emergencies Protocol** **Available at:** Division of Courts and Community Services Department of Youth Rehabilitation Services 450 H Street, NW Washington, DC 20001 Telephone: 202-724-5071	
7		Education for All Handicapped Children Act 1975 (P.L 94-142);	

8		DYRS Establishment Act and specifically, D.C. Code § 2-1515.04,	

3.2 Definitions

3.2.1 **Abscondence:** The youth is absent from an approved placement.

3.2.2 **Bio-Psychosocial Assessment:** An assessment that considers biological, psychological, and social factors in evaluating a youth's mental health, social status, and functional capacity.

3.2.3 **Community Placement Agreement:** – Document detailing requirements and conditions for the youth that govern his or her community placement.

3.2.4 **Education support/advocacy:** Services designed to increase the educational skills of youth. These may include individualized approaches as well as use of non-traditional methods and materials, for example, computers, mentors, or tutors.

3.2.5 **IDEA:** Individuals with Disabilities Education Act is a law ensuring services to children with disabilities.

3.2.6 **Individual Education Program (IEP)**: Program designed to meet the unique educational needs of a child who may have a disability.

3.2.7 **Individualized Service Plan (ISP):** Also referred to as Individualized Development Plan (IDP). This is a document that specifically identifies the goals, objectives, strategies, responsible parties and resources to address the assessed strengths and needs of a committed youth and the family. The DYRS case manager designs the plan to ensure that habilitative and rehabilitative services are correlated to the Positive Youth Development Model (PYD) principles which is a comprehensive way of thinking about the development of adolescents and the factors that facilitate their successful transition from adolescence to adulthood. The plan is developed and periodically updated in conjunction with the DYRS case manager, youth, youth's family and designated service providers

3.2.8 **Individual Treatment Plan (ITP):** A document developed by a planning team comprised of Provider clinical staff, youth, youth's family and DYRS case manager. The ITP serves as the single document that integrates all support a youth may receive irrespective of where the youth resides. The ITP presents the measurable goals and objectives as it relates to youth's strengths, needs, diagnosis, and desired outcomes. The ITP also addresses the provision of safe, secure, and dependable support that is necessary for the youth's well-being, independence and social inclusion.

3.2.9 **Qualified Personnel:** Persons holding official credentials, accreditation registration, certification, or licenses issued by their jurisdiction and, for the purposes of providing services to youth. The term shall include administrators, therapists, professional nurses, physicians, psychologists and professional counselors, and social workers. Persons providing direct care to DYRS youth should be suitable for employment pursuant to 29 DCMR 6228.

3.2.10 **MAYSI-2:** The MAYSI-2 is a standardized, 52-item, true-false method for screening every youth of ages 12-17 entering the juvenile justice system, in order to identify potential mental health problems in need of immediate attention

3.2.11 **Trauma-Based Behavioral Health Care**: An evidence-based treatment approach designed to help youth overcome trauma-related difficulties by reducing negative emotional and behavioral responses.

3.3 BACKGROUND

3.3.1 The Department of Youth Rehabilitation Services (DYRS) serves youth up to age 21 who have been committed to its care and custody by the D.C. Superior Court Family Division. DYRS' mission is to improve public safety and give court- involved youth the opportunity to become more productive citizens by building on the strengths of the youth and their families in the least restrictive, most homelike environment. In partnership with the community, this balanced approach to juvenile justice promotes the rehabilitation of delinquent youth toward reforming their behavior in the context of increased accountability, expanded personal competencies, positive youth development and enhanced community restoration. Pursuant to the DYRS Establishment Act and specifically, D.C. Code § 2-1515.04, DYRS is responsible for establishing through contracts, Provider agreements, human care agreements, grants, memoranda of agreement or understanding, or other binding agreements a system of secure and community-based facilities and rehabilitative services with governmental bodies, public and private agencies, institutions, and organizations, for youth that will provide intervention, individualized assessments, continuum of services, safety, and security.

3.3.2 Youth committed to DYRS following a court disposition hearing or youth who are in need of an alternate placement to facilitate treatment may need to be placed in a short term staff secure or hardware secure facility while awaiting placement in a long-term rehabilitative treatment program. Currently, male youth in need of a hardware-secure facility while awaiting placement are housed at the DYRS New Beginnings Youth Development Center and female youth are housed at the DYRS Youth Services Center (YSC). The Provider selected will provide short Term Awaiting Placement services at a staff secured and /or hardware-secured facility for up to 25 youth.

3.3.3 Certain requirements of this solicitation are extremely important to DYRS in carrying out its responsibilities for this recurring need. Such components include a 24-hour staff secure/hardware secure facility that can provide diagnostic and assessment, educational programming, and rehabilitative treatment as mandated by law, DYRS directives, court orders and consent decrees.

A. DYRS is subject to the Jerry M. Consent Decree, a comprehensive mandate which addresses, in part, programmatic and operational objectives. The decree and court orders focus on reform

initiatives associated with the facilities, services and delivery of services to the youth placed in the custody and care of DYRS.

B. DYRS provides enriched, culturally sensitive services, including recreational, rehabilitative, educational, mental health, medical, recreational, aftercare supervision, residential placements, independent living and mentoring/monitoring support in a nurturing and structured environment to the youth in its custody.

SECTION 4 REQUIREMENTS

4.1 The Provider shall operate staff secured /or a hardware-secured, short-term, 24-hour, facility for up to 25 youth to provide services to the DYRS awaiting placement population. The Provider facility shall accommodate youth between the ages of 12 and 21. This facility will provide a safe, highly-structured, stable and secure environment for youth who:

a. Have been committed to DYRS following disposition by the D.C. Superior Court and are awaiting placement at a long-term facility; or

b. Are in noncompliance with the terms of their Community Placement Agreement and will require immediate placement at the proposed 24-hour facility for a prompt risk reassessment, intervention, data tracking and sanctions under the Graduated Responses Matrix for noncompliance.

4.2 The duration of placement for each youth will be assessed on a case-by-case basis, but should generally not exceed 28 days.

4.3 Basic Program Expectations and Services

4.3.1 The Provider shall provide the following services to youth:

1. Intake and diagnostic screening
2. Onsite medical/dental care
3. Trauma-based behavioral health care
4. Individual and group counseling
5. Substance abuse counseling
6. Drug and alcohol testing
7. Onsite education (including special education services)
8. Structured recreation
9. Life skills training
10. Family visits/engagement
11. Transition services
    - a. Discharge summaries/report writing
    - b. Information-sharing with long term placement providers and DYRS
    - c. Secure transportation
        - i. to and from judicial proceedings (court)
        - ii. to and from long-term placement
        - iii. case status review meeting, if applicable
        - iv. Medical and other services rendered in the community.

12. Behavioral health management/incentive system
13. Nutrition/food services
14. Case planning services
    a. Youth and Family Team meetings
    b. Community Status Review hearings
    c. Private meeting areas for attorney visits
    d. Video conferencing
    e. Individual Development Plans (IDP)
    f. Individual Education Program (IEP)
    g. Individual Treatment Plan (ITP)

4.4 Intake and Diagnostic Screening

4.4.1 The Provider shall accept DYRS youth 24 hours a day, seven days a week and shall provide risk assessments, medical screening, and service planning within 72 hours of placement. If a youth, depending upon placement status and initial assessment, will remain at the facility for more than 48 hours, the Provider shall provide additional assessments as determined in conjunction with the DYRS case manager assigned to the youth.

4.4.2 The Provider shall have the capacity to administer the MAYSI-2 within 48 hours of admission.

4.4.3 The Provider shall conduct any risk assessment tool designated by DYRS.

4.4.4 For youth who remain at the facility more than seven days, the Provider shall have the capability to provide a Bio-Psychosocial Assessment to be completed by a clinical social worker.

4.5 Educational Services

4.5.1 If located within the District of Columbia, the Provider shall provide educational services Monday through Friday through a DC Public Schools (DCPS) certified education program. Staff secured facilities located within the District of Columbia may allow residents to attend school within the community. If located outside of the District of Columbia, the Provider shall provide educational services Monday through Friday through a program certified by the jurisdiction in which they are located. Hardware secure facilities and facilities outside the District of Columbia must provide educational services on the grounds of the facility.

Teachers will initially test all youth in mathematics and reading within 72 hours of placement to assess their level of ability. In addition, teachers will assess the youth's education and social history to determine the appropriate individualized daily curriculum for each youth.

4.5.2 The Provider shall ensure that the teacher coordinates with the youth's current school program to coordinate the completion of assignments from that program, or shall develop an acceptable curriculum if the youth is not currently enrolled in a school program. In the event the DYRS youth is being released to the community, the provider shall coordinate with DC Public schools to transition the youth back to his prior school placement or to an alternative school placement within the DC Public School system.

4.5.3 The Provider shall help to coordinate youth's education services with the youth's long term placement and ensure the transfer of information concerning the youth's educational services.

4.5.4 The Provider shall comply with the federal IDEA requirements and ensure that all youth with special education needs receive high quality and appropriate educational services.

4.6.1 **Trained Staff and Education Criteria**

4.6.2 The Contractor's staff shall consist of professional, paraprofessional and support personnel.

4.6.3 Juvenile justice professionals must be highly skilled and experienced with the principles, goals, and the latest advancements of juvenile rehabilitation and treatment provision, including the principles of Positive Youth Development. Direct care staff should preferably have 60 hours of college credit.

4.6.4 The Provider shall have a staffing pattern that provides on-site trained staff for twenty-four (24) hour coverage, seven (7) days a week (including holidays) based on the number of youth placed at the facility, to provide supervision and programming. The Contractor's professional and administrative staff shall consist of, at a minimum:

1. Center Administrator/Director with a Master's level degree;
2. Staff Assistant or equivalent;
3. Case Manager/Treatment Specialist with a bachelor's degree or equivalent to provide services to the youth and coordinate services with DYRS case managers;
4. Certified Addictions Counselor
5. Licensed Social Worker and or Licensed Professional Counselor with a District License
6. Direct Care Staff such as youth counselors or youth development workers to provide supervision and behavior management treatment to meet the treatment needs of the youth and to ensure the safety and security of the facility, youth, and the security of the public.
7. Nurse

4.6.5 The Provider shall have written policies that provide details describing program management, admissions, living and environment, case management, behavior management, program security, program safety, and conditional release. **The Contractor's employee will be trained annually in all agency policies and procedures.** These policies shall include at a minimum:

1. Orientation;
2. Staff training & development;
3. Nnon-discrimination, in accordance with the D.C. Human Rights Act of 1977, as amended, D.C. Official Code § 2-1401.01 *et seq;*
4. Sexual harassment, in accordance with D.C. Mayor's Order 2004-171;
5. Employee performance evaluation;
6. Hours of work;
7. Disciplinary procedures;
8. Terminations;
9. Use of force;
10. Safe crisis management
11. Reporting unusual incidents;

12. Procedures for Reporting allegations of abuse, harm and risks to youth,
13. Employee conduct;
14. Search and seizure of weapons & illegal contraband;
15. Mandatory employee drug and alcohol testing;
16. Confidentiality of youth information;
17. Youth supervision and movement;
18. Suicide prevention;
19. Use of physical restraint;
20. Youth rights & responsibilities;
21. Grievance Process
22. Youth clothing;
23. Emergency preparedness plan (inclusive of sufficient food, water and equipment),
24. Housekeeping and inspection;
25. Youth phone access and visitation;
26. Secure youth transportation;
27. Abscondence; and
28. Positive Youth Development

4.6.6 The Provider shall provide sufficient qualified staff to support the treatment and rehabilitative needs of each youth. Staff shall have the requisite qualifications to provide services to the populations. Staff members responsible for performing professional services, including psychological, psychiatric, medical, social work, nursing, dental and education shall have a professional degree and appropriate license in his or her respective fields from an accredited college or university and current license if required by law.

4.6.7 The Provider shall ensure that staff is competent and sensitive in providing treatment to persons of diverse cultural backgrounds, as well as responsive to the needs of minority individuals.

4.6.8 The Provider shall maintain a complete, confidential individual personnel file for each staff person, contractor or volunteer containing the signed contract, employment or volunteer application, personal and professional references, applicable licenses, credentials and/or certificates, records of required medical examinations, personnel actions including time records, documentation of all training received, notation of any allegations of professional or other misconduct and actions with respect to the allegations and date and reason if terminated from employment or from providing volunteer services, which shall be accessible to the DYRS Contract Administrator (CA).

4.6.9 The Provider shall provide job descriptions for all staff positions to the DYRS CA within thirty (30) days from date of award. Each job description shall accurately describe duties for the position and include, at a minimum: job title, responsibility of the position and the required minimum education and experience. The Provider may use part time personnel in any employment category except for the director or equivalent position. A part-time employee is any employee employed for less than 40 hours per week. Full-time employment is defined as forty hours (40) per week.

4.6.10 The Provider shall provide orientation and training for all staff members with respect to administrative procedures, patient rights, confidentiality of youth records, including treatment records, reporting allegations of abuse and other risks to youth, grievance procedures and other relevant policies, procedures and protocols of DYRS and the Contractor.

4.6.11 The Provider shall maintain a current organizational chart displaying organizational relationships and responsibility lines of administrative oversight and supervision.

4.6.12 All personnel materials, including the individual personnel file, for each employee providing services pursuant to this Statement of Work shall be made available to the DYRS CA for review upon request.

4.6.13 The Provider shall ensure that direct services staff persons maintain certifications annually in Cardio-Pulmonary Resuscitation (CPR) and First Aid.

4.6.14 The Provider shall adhere to the following staff security requirements:

1. In accordance with DC Official Code § 4-1501.01 et seq., the Provider shall conduct routine pre-employment and annually criminal record background checks of the Provider's applicable staff, volunteer, contractor and future staff that will provide services pursuant to this Statement of Work. The Provider shall not employ any staff in the fulfillment of the work pursuant to this Statement of Work unless said person provides the results of a background check, to include FBI, a National Criminal Information Center Report and annual Child Protective Services Report (abuse and neglect). Staff shall not have any convictions of child abuse, child neglect, spousal abuse, a crime against children, including child pornography or a crime involving violence, including but not limited to, rape, sexual assault, homicide and assault for any disqualifying offenses as enumerated in 29 DCMR 6228.

2. After award of the contract, the Provider shall furnish copies of the certified criminal history records of applicable Provider staff, contractor or volunteer to the Contract Administrator upon request. Any conviction or arrest of the Contractor's employees, contractor or volunteer will be reported to the DYRS Contract Administrator within five (5) days of notification from NCIC or FBI, for further review and final determination of eligibility for employment by the D.C. Department of Human Resources (DCHR).

4.6.15 The Contractor's employees, contractors and volunteers shall have a pre-employment drug test and be subject to ongoing random mandatory drug and alcohol testing in accordance with District of Columbia's Mandatory Employee Drug and Alcohol Testing (MEDAT) regulations.

4.6.16 The Provider shall always be responsible for the effective supervision and treatment of DYRS youth and the orderly operation of the facility and shall notify DYRS of any unforeseen circumstance, which may affect the safety, security, or orderly operation of the facility.

4.7 CONTRACTOR'S FACILITY

4.7.1 The orientation and assessment facility shall include, but not be limited to, separate sleeping quarters for each youth, dining area and space for recreation.

4.7.2 The Provider shall provide in the facility internet accessible computer, telephone, fax, scanner, e-mail, and TTY and TDY service. The Contractor's facility shall be in accordance with the following:

1. The Contractor's facility shall have a license in good standing and in compliance with all local and federal regulations.

2. The Provider shall maintain an emergency plan approved by local fire officials that clearly documents emergency preparedness, which includes information about the emergency site arrangements. The Contractor's emergency preparedness plan shall be available for review upon the request of the Contract Administrator and the designated program monitor. The emergency plan shall be reviewed annually, updated as necessary, and redistributed as changes occur.

3. The Provider shall provide, at no additional cost to the District, supplies and services routinely needed for maintenance and operation of the home, such as, but not limited to, security, janitorial services, trash pick-up, laundry or linens.

4. The District reserves the right to inspect the facility prior to placement of youth. The District will conduct periodic, scheduled and unscheduled site visits for the purpose of directly observing the provision of services and discussing performance relative to the terms and conditions of a task order.

5. The Provider shall ensure that the facility meets all licensing, registration and occupancy requirements, building safety, fire, health and sanitation codes and all other required certifications as prescribed by the governing jurisdiction and maintain current all required permits and licenses.

4.8 FOOD SERVICES

4.8.1 The Provider shall provide three (3) meals and a snack a day for youth in accordance with a menu approved by a licensed nutritionist listing for seven (7) days a week.

4.8.2 The Provider shall make arrangements for special diets as required by a youth's physician or dentist.

4.8.3 The Provider shall comply with all regulations pertaining to handling of food in accordance with the regulations set forth by DCRA or state-equivalent and the USDA Model Food Code.

4.8.4 The Provider shall make their food service facility available to DYRS for inspections.

4.9 POLICY AND PROCEDURE MANUAL

The Provider shall conform to DYRS policies and procedures, Program Statements and all DYRS and Court Orders as cited herein, which will be made part of any contract. A copy of these documents can be requested in writing from:

Department of Youth Rehabilitation Services
Management Support Services
8400 River Road
Laurel, MD 20724

4.10 OTHER PROVIDER REQUIREMENTS

1. Adhere to licensing regulations and state requirements in accordance with all existing federal and District of Columbia or state-equivalent laws, rules and regulations.

2. Provide the DYRS Contract Administrator immediate notification of any restriction, suspension or other disciplinary actions taken by your state licensing or regulatory agency.

3. Commit to a philosophy of unconditional care, by agreeing not to eject a youth that have been accepted but rather renegotiate an individual placement with the agency on a particularly difficult referral.

4.11 ADMINISTRATIVE OPERATIONS

The Provider shall, at a minimum, provide or maintain the following administrative operations to support the delivery of extended family or therapeutic services for youth:

1. Provide services 24 hours per day seven days per week. The Provider shall maintain an administrative office, which shall operate at a minimum from 9:00 a.m. to 5:00 p.m., Monday through Friday, except on federal holidays.

2. Report all unusual or critical incidents, including abscondence, involving youth referred by the District in accordance with the policies and procedure as approved by DYRS.

3. **Reports due to DYRS must be submitted to the DYRS case manager and to dyrs.providerreport@dc.gov**

4.12 JUVENILE SERVICES

The Providers shall maintain comprehensive case files for each youth including historical, background, and other relevant information received from DYRS case managers. Case files shall be maintained in a manner that is both organized and representative of the youth's progress based on the youth's prescribed ISP and updates to the ISP. Case files shall include daily progress notes for individual youth. The Provider shall also provide the DYRS case manager with a work plan that details the intensity and frequency of services described in the ISP, within 15 days of receiving the ISP. The work plan shall address, but not be limited to, the following:

1. Supervision and treatment by providing activities designed to provide external constraints for the youth's behavior, monitor the behavior, and strengthen the adherence and acceptance of rules.

2. Provide regularly scheduled recreation/leisure/cultural activities designed to engage, stimulate and expose youth to vocational, artistic and consciousness raising pursuits.

3. Coordinate with the DYRS case manager for clinical services necessary to meet and support the treatment objectives and strategies described in the ISP, including, but not limited to, individual and group counseling that focuses on day-to-day adjustment issues. This may also include formal psychotherapeutic or behavior modification techniques.

4.13 REPORTS

4.13.1 The Provider shall provide the Contract Administrator with quarterly report data that supports DYRS' quality assurance plan used to assess the effectiveness of the Contractor's services. The Quarterly report shall, at a minimum, include the following information:

1. Names and number of youth admitted to the program.

2. Names and number of youth receiving services.

3. Number and content of training for staff (includes list of participants and participant evaluations).

4. Name and position of staff working with DYRS youth.

4.13.2 The Provider shall prepare and submit individual monthly progress reports to the assigned DYRS case manager. The monthly progress report shall, at a minimum, document the youth's progress in each identified area of service as follows:

1. Life skills;
2. Recreation and leisure activities;
3. Academic performance;
4. Individual therapy;
5. Group therapy;
6. Addiction support;
7. Health/medical updates;
8. Unusual incidents;
9. Abscondence reports; and
10. Updated service strategies.
11. Psychiatric/psychological evaluations
12. Medication assessments

C.14 ELIGIBILITY

Eligibility for services under the agreement with DYRS shall be determined and re-determined by the District, as applicable, in accordance with prescribed procedures. The Provider shall be subject to a written determination that it is qualified to provide the services and shall continue the same level of qualifications, subject to a review by the District, according to the criteria delineated in 27 DCMR, Chapter 19, Section 1905.6, as amended.

SECTION 5 DELIVERABLES for Base Year and Option Years 1 through 4 (All Deliverables shall be delivered to the CA specified in Section 17)

5.1 Deliverable for Base Year and Option Years 1 through 4 (All Deliverable shall be delivered to the Contract Administrator specified in Section 16. a)

Contract Line Item Number (CLIN)	Deliverable	Method of Delivery	Due Date
0001 - 0002 1001 – 1002 2001 – 2002 3001 – 3002 4001 - 4002	Initial ITP	1 electronic copy and/or 1 soft copy clearly labeled with the following: - Deliverable Name (Placement) - Youth's Name - Facility Name - Date Completed - Date submitted	The initial ITP shall be completed and submitted within 15 days of placement to the DYRS case manager and dyrs.providerreport@dc.gov
0001 - 0002 1001 – 1002 2001 – 2002 3001 – 3002 4001 - 4002	Updated Treatment Plans and/or Monthly Progress Reports	1 electronic copy and/or 1 soft copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted - Projected Release Date	Updated Treatment Plans and/or Monthly Progress Reports are due the 10th day of each month to the DYRS case manager and dyrs.providerreport@dc.gov
0001 - 0002 1001 – 1002 2001 – 2002 3001 – 3002 4001 - 4002	Transitional Plan	1 electronic copy and/or 1 soft copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted - Scheduled Release Date	Transition Planning Report is due 90 days before the projected discharge date and should accompany the monthly progress report to the DYRS Case Manager. and dyrs.providerreport@dc.gov
0001 - 0002 1001 – 1002 2001 – 2002 3001 – 3002 4001 - 4002	Discharge Package	1 electronic copy and/or 1 soft copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted - Scheduled Release Date	The Discharge package shall be submitted 60 days before the scheduled discharge date to the DYRS Case Manager and dyrs.providerreport@dc.gov

0001 - 0002 1001 – 1002 2001 – 2002 3001 – 3002 4001 - 4002	Emergency Plans	1 electronic copy to clearly labeled with the following: -Deliverable Name -Facility Name -Date of Revision	The Emergency Plan with alternative placement sites is to be submitted to the CA 10 business days after award of a Human Care Agreement to the CA and dyrs.providerreport@dc.gov
0001 - 0002 1001 – 1002 2001 – 2002 3001 – 3002 4001 - 4002	DYRS Unusual Incident Report	1 electronic copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted	All Unusual Incident Reports shall be submitted via email or telephone by the end of the shift in which the incident occurred and followed up with a written report to the CA and DYRS Case Manager within 24 hours and dyrs.providerreport@dc.gov
0001 - 0002 1001 – 1002 2001 – 2002 3001 – 3002 4001 - 4002	DYRS Absconder Report	1 electronic copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted	All Absconder Reports shall be submitted to the CA via email by the end of the shift in which the incident occurred with a copy forwarded to the DYRS case manager and Quality Assurance Unit and dyrs.providerreport@dc.gov

Section 7 District Responsibilities

7.1 The Department of Youth Rehabilitation Services will provide the following: a) written requests for care indicating youth identified as needing psychiatric services b) reasonably quiet, confidential space to see youth; c) access to medical charts; d) Provide training courses in "Safe Crisis Management" and "Suicide Prevention" and CPR; e) develop and implement quality assurance tools to evaluate the provider's performance on responsibilities indicated above; and f) DYRS shall makes payments to the provider on a monthly basis for the services provided during the previous month as invoiced.

Section 8 Monitoring

8.1 a) The Department of Youth Rehabilitation Services shall monitor the quality of services provided; and b) monitoring shall include, but is not limited to, review of documentation in medical charts, monitoring of medications prescribed by the Pharmacy and Therapeutic Committee, and review of labs ordered based on standard baseline labs to be completed for psychotropic medication monitoring.

Section 9 Compliance With Service Rates

9.1 All human care services shall be provided, and the District shall only pay, in accordance with the service rates shown in Section 2, Human Care Services and Service Rates. If any overpayment occurs, the provider shall repay the District the full amount of the overpayment. The Provider shall provide no human care unless the District makes an official referral and issues a task order to the Provider.

Section 10 Method of Delivery of Services

10.1 a) Youth are to be seen face–to-face based on request for care received from the youth, behavioral health staff or medical staff; and

10.2 b) Psychiatric or forensic evaluations are completed based on requests from behavioral health supervisory staff and/or courts.

Section 11 Eligibility

11.1 Eligibility for services under this Human Care Agreement shall be determined and re-determined by the District, as applicable, in accordance with prescribed procedures. The provider shall be subject to a written determination that it is qualified to provide the services and shall continue the same level of qualifications, subject to a review by the District, according to the criteria delineated in 27 DCMR, Chapter 19, Section 1905.6, as amended which is incorporated into this Agreement as Attachment 41.3.

Section 12 Compliance with Laws

12.1 As a condition of the Provider's obligation to perform for the District's under this Agreement, the Provider shall comply with all applicable District, federal and other state and local governmental laws, regulations, standards, or ordinances and, where applicable, any other applicable licensing and permit laws, regulations, standards, or ordinances as necessary for the lawful provision of the services required of the Provider under the terms of this Human Care Agreement.

Section 13 Human Care Service Delivery and Performance

13.1 The term of this Human Care Agreement shall be for a period of one(1) base year and four (4) additional option years subject to an agreement of the parties, subject to the continuing availability of funds for any period beyond the end of the fiscal year in which this Agreement is awarded.

13.2 If the Provider fails to perform its obligations under this Human Care Agreement in accordance with the Agreement and in a timely manner, or otherwise violates any provision of this Human Care Agreement, the District may terminate this Human Care Agreement for default or convenience of the District upon serving written notice of termination to the Provider in accordance with sections 6, 8 or 16 of the Government of the District of Columbia Standard Contract Provisions For Use With District of Columbia Government Supply and Services, dated July 2010, hereafter referred to as "Standard Contract Provisions", which is incorporated into this Agreement by reference.

13.3 The District reserves the right to cancel a task order issued pursuant to this Human Care Agreement upon thirty (30) days written notice to the Provider.

Section 14 Agreement Not A Commitment of Funds or Commitment to Purchase

14.1 This Agreement is not a commitment by the District to purchase any quantity of a particular good or service covered under this Human Care Agreement from the Provider. The District shall be obligated only to the extent that authorized purchases are actually made by purchase order or task order pursuant to this Human Care Agreement.

Section 15 Option to Extend Term of the Agreement

15.1 The District Government may extend the term of this Human Care Agreement for a period of four (4) one (1) year option periods, or fractions thereof, by written notice to the Provider prior to the expiration of the Agreement; provided that the District gives the Provider written notice of its intent to extend at least thirty (30) days before the Human Care Agreement expires. The preliminary notice does not commit the District to an extension. . The Provider may waive the thirty (30) day notice requirements by providing a written notice to the Contracting Officer.

15.2 The service rates for the option periods shall be as specified in Section 2, Human Care Services and Service Rates.

15.3 If the District exercises an option, the extended Human Care Agreement shall be considered to include this option provision.

15.4 The total duration of this Human Care Agreement including the exercise of any options under this clause shall not exceed five (5) years.

Section 16 Contracting Officer

16.1 The Contracting Officer (CO) is the only District official authorized to bind contractually the District through signing a human care agreement or contract, and all documents relating to the human care agreement. All correspondence to the Contracting Officer shall be forwarded to: Joseph Stewart, Contracting Officer, Office of Contracting and Procurement Human Care Services Group 441 4th Street, N.W. Suite 700 South Washington, D.C. 20001 Telephone Number: (202) 724-8759 and E-Mail: Joseph.stewart@dc.gov

Section 17 Contract Administrator

17.1 The Contract Administrator (CA) is the representative responsible for the general administration of this Human Care Agreement and advising the Contracting Officer as to the compliance or noncompliance of the provider with this Human Care Agreement. In addition, the Contracting Officer's Representative is responsible for the day-to-day monitoring and supervision of this Agreement. The Contracting Officer's representative is not authorized or empowered to make amendments, changes, or revisions to this agreement. The CA shall be appointed by the Office of Contracts and Procurement at the time that the Human Care Agreement is awarded to the individual providers.

Section 18 Contact Person

18.1 For information concerning this Human Care Agreement contact: Mr. Dwight Hayes, Contract Specialist, Office of Contracting and Procurement 441 4th St., NW, Suite 706 North Washington, D. C. 20001 Telephone Number: (202) 727-2354 and E-Mail: dwight.hayes@dc.gov

Section 19 Ordering and Payment

19.1 The Provider shall not provide services or treatment under this Agreement unless the Provider is in actual receipt of a purchase order or task order for the period of the service or treatment that is signed by the Contracting Officer.

19.2 All purchase orders or task orders issued in accordance with this Agreement shall be subject to the terms and conditions of this Agreement. In the event of a conflict between a purchase order or a task order and this Agreement, the Agreement shall take precedence.

19.3 The Provider shall forward or submit all monthly invoices for each referral for services to the agency, office, or program requesting the specified human care service and as specified on page one (1) of the purchase order/task order, "Provider Shall Submit All Invoices To: Department of Youth Rehabilitation Services Office of the Chief Financial Officer 64 New York Ave., NE, 6th Floor Washington., D.C. 20002

19.4 To ensure proper and prompt payment, each invoice for payment shall provide the following minimum information: (1) Provider name and address; (2) Invoice date, number and the total amount due; (3) Period or date of service; (4) Description of service; (5) Quantity of services provided or performed (6) Contract line item number (CLIN) , as applicable to each purchase order or task order; (7) Purchase order or task order number; (8) Agreement number; (9) Federal tax identification number (TIN); (10) Any other supporting documentation or information, as required; (11) Name, title and telephone signature of the preparer; (12)Identification of each recipient of chore aide/emergency caretaker service; (13) The recipient's authorization number and census track; (14) The APS supervisor or social worker responsible for the case; (15) The weekly authorization for the number of ours of service that is authorized for each client; (16) The specific dates and the hours for which serve was rendered for each client; (17) The total cost for each client; and (18) The itemized information for all miscellaneous expenditure.

19.5 Payment shall be made only after performance by the Provider under the Agreement as a result of a valid purchase order or task order of the agreement, or the purchase order/task order, in accordance with all provisions thereof.

Section 20 Inspection and Acceptance

20.1 The inspection and acceptance requirements for the resultant agreement shall be governed by the Inspection of Services Clause § 7 of the Government of the District of Columbia 's Standard Contract Provisions for use with Supplies and Services Contracts, dated July 2010, located at www.ocp.dc.gov.

20.2 The Provider shall permit persons duly authorized by the Contracting Officer to inspect any records, papers, documents, facilities, and/or goods and services of the Provider which are relevant to the human care agreement, and/or to interview any program participants and employees of the Provider to assure the District of the satisfactory performance of the terms and conditions of the task order resulting from this human care agreement.

20.3 Following such evaluation, the CA will deliver to the Provider a written report of its findings and will include written recommendations with regard to the Provider's performance of the terms and conditions of the contract.

20.4 The Provider will correct all noted deficiencies identified by the CA within specified period of time set forth in the recommendations.

20.5 Inspection and Acceptance-deficiencies

20.5.1 The Provider's failure to correct noted deficiencies may, at the sole and exclusive discretion of the Contracting Officer, result in any one or any combination of the following:

20.5.2 The Provider being deemed in breach or default of this agreement.

20.5.3 The withholding of payments to the Provider by the District.

20.5.4 The termination of the Agreement for cause.

Section 21 Standard Contract Provisions Incorporated by Reference

21.1 The Government of the District of Columbia Standard Contract Provisions For Use With District of Columbia Government Supply and Services, dated July 2010, hereafter referred to as the "Standard Contract Provisions" are incorporated by reference into this Agreement, and shall govern the relationship of the parties as contained in this Agreement. By signing this Agreement, the Provider agrees and acknowledges its obligation to be bound by the Standard Contract Provisions, and its requirements.

Section 22 Laws and Regulations Incorporated by Reference

22.1 By signing this Agreement, the Provider certifies, attests, agrees, and acknowledges to be bound by the following stipulations, representations and requirements of the provisions of the following laws, acts and orders, together with the provisions of the applicable regulations made

pursuant to the laws, and they are incorporated by reference into this Agreement:

Section 23 Child and Youth, Safety and Health Omnibus Amendment Act of 2004

23.1 The Provider agrees to comply with Title II of the Child and Youth, Safety and Health Omnibus Amendment Act of 2004, effective April 13, 2005 (D.C. Law 15-353; DC Official Code § 4-1501.01 *et seq.*)(2006 Supp.), as amended by Title II of the Omnibus Public Safety Amendment Act of 2006, effective April 24, 2007 (D.C. Law 16-306; 54 DCR 6577) and its implementing regulations at Chapter 5 of 27 DCMR.

Section 24 District of Columbia Interstate Compact

24.1 Youth accepted for placement in facilities outside of the District, who are under the age of 18 will be referred and approved for placement by District of Columbia Interstate Compact for Placement of Children.

Section 25 Confidentiality

25.1 All services or treatment provided by the Provider through referrals by the District to the Provider shall be provided in a confidential manner and the Provider shall not release any information relating to a recipient of the services or otherwise as to the provision of those services or treatment to any individual other than an official of the District connected with the provision of services under this Human Care Agreement, except upon the written consent of the individual referral, or in the case of a minor, the custodial parent or legal guardian of the individual referral.

Section 26 Tax Compliance Certification

26.1 In signing and submitting this Human Care Agreement and the Tax Certification Affidavit, the Provider certifies, attests, agrees, and acknowledges that the Provider is in compliance with all applicable tax requirements of the District of Columbia and shall maintain that compliance for the duration of the Agreement.

Section 27 Amendments

27.1 This Human Care Agreement, including the Provider's CQR (Attachment 39.2.1), applicable documents and attachments incorporated by reference constitutes the entire Agreement between the parties and all other communications prior to its execution, whether written or oral, with reference to the subject matter of this Agreement are superceded by this Human Care Agreement. The Contracting Officer may, at any time, by written order and without notice to a surety, if any, make amendments or changes in the agreement within the general scope, services, or service rates of the Agreement. No amendment to this Agreement shall be valid unless approved in writing by the Contracting Officer, subject to any other approvals required in accordance with the District regulations at 27 DCMR. Except that the Contracting Officer may make purely clerical or administrative revisions to the Agreement with written notice to the Provider.

Section 28 Subcontracts

28.1 The Provider shall not subcontract any of the work or services provided in accordance with this Agreement to any subContractor without the prior written consent of the Contracting Officer. Any work or service that may be subcontracted shall be performed pursuant to a written subcontract agreement, which the District shall have the right to review and approve prior to its execution. Any such subcontract shall specify that the Provider and the sub- Provider shall be subject to every provision of this Human Care Agreement. Notwithstanding any subcontract approved by the District, the Provider shall remain solely liable to the District for all services required under this Human Care Agreement.

Section 29 Provider Responsibility

29.1 The Provider bears primary responsibility for ensuring that the Provider fulfills all its Human Care Agreement requirements under any task order or purchase order that is issued to the Provider pursuant to this Human Care Agreement.

29.2 The Provider shall notify the District immediately whenever the Provider does not have adequate staff, financial resources, or facilities to comply with the provision of services under this Human Care Agreement.

29.3 The Provider's employees shall report all unusual incidents on the Unusual Incident Report, including allegations of abuse or neglect, involving any client that is provided with services by the Provider by telephone to DYRS, and followed up by a written report to DYRS within forty-eight (48) hours of the unusual incident.

Section 30 Publicity

30.1 The Provider shall at all times obtain the prior written approval from the Contracting Officer before it, any of its officers, agents, employees or subcontractors, either during or after expiration or termination of the contract, make any statement, or issue any material, for publication through any medium of communication, bearing on the work performed or data collected under this Agreement.

Section 31 Conflict of Interest

31.1 No official or employee of the District of Columbia or the Federal Government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of this Agreement shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the agreement or proposed agreement. (DC Procurement Practices Act of 1985, D.C. Law 6-85, D.C. Code Section 1-1190.1 and Chapter 18 of the DC Personnel Regulations).

31.2 The Provider represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Provider further covenants not to employ any person having such

known interests in the performance of the agreement.

Section 32 Department of Labor Wage Determinations

32.1 The Provider shall be bound by Wage Determination No. 2005-2103, Revision No.13, dated June 19, 2013, incorporated herein as Attachment 41.6, issued by the U.S. Department of Labor In accordance with the Service Contract Act of 1965, as amended (41 U.S.C. 351). The Provider shall be bound by the wage rates for the term of the contract. If an option is exercised, the Provider shall be bound by the applicable wage rate at the time of the option. If the option is exercised and the Contracting Officer for the option obtains a revised wage determination, that determination is applicable for the option period(s); the Provider may be entitled to an equitable adjustment.

Section 33 Access to Records

33.1 The Provider shall retain all case records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the human care agreement for a period of five (5) years after termination of the human care agreement, or if an audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of the contract.

33.3 Persons duly authorized by the Contracting Officer shall have full access to and the right to examine any of the Provider's human care agreement and related records and documents, regardless of the form in which kept, at all reasonable times for as long as records are retained.

Section 34 Way to Work Amendment Act of 2006-Living Wage Notice

34.1 Available at www.ocp.dc.gov, click on OCP Policies and Procedures under the heading 'e-Library', then click on Way to Work Amendment Act Notice'.

Section 35 Way to Work Amendment Act of 2006-Living Wage Fact Sheet

35.1 Available at www.ocp.dc.gov, click on OCP Policies and Procedures under the heading 'e-Library', then click on 'Way to Work Amendment Act Fact Sheet'.

Section 36 HIPAA Privacy Compliance

36.1 Please reference the HIPPAA Privacy Compliance Policy at www.ocp.dc.gov, click on OCP Policies and Procedures under the heading e-Library, then click on HIPAA Privacy Compliance Policy Clause.

Section 37 CRIMINAL BACKGROUND AND TRAFFIC RECORDS CHECKS FOR CONTRACTORS THAT PROVIDE DIRECT SERVICES TO CHILDREN OR YOUTH

A. A Provider that provides services as a covered child or youth services provider, as defined in section 202(3) of the Child and Youth, Safety and Health Omnibus Amendment Act of 2004, effective April 13, 2005 (D.C. Law 15-353; D.C. Official Code

§ 4-1501.01 *et seq.*), as amended (in this section, the "Act"), shall obtain criminal history records to investigate persons applying for employment, in either a compensated or a volunteer position, as well as its current employees and volunteers. Annually, the provider shall request results of the criminal background checks for all employees, contractors and volunteers working with DYRS youth.

B) Annually, the provider shall also obtain current driver's license and driving records to investigate persons applying for employment, as well as current employees, contractors and volunteers, when that person will be required to drive a motor vehicle to transport children in the course of performing his or her duties.

C) The Provider shall inform all applicants requiring a criminal background check that the results of the applicant's criminal background check must be before the applicant may be offered a compensated position or volunteer position.

D) The Provider shall inform all applicants requiring a traffic records check that a traffic records check must be received on the applicant before the applicant may be offered a compensated position or a volunteer position.

E) The provider shall obtain from each applicant, employee, contractor and volunteer:

1) a written authorization which authorizes the District and National Crime Information Center (NCIC) to conduct a criminal background check;

2) a written confirmation stating that the Provider has informed him or her that the District and National Crime Information Center (NCIC) is authorized to conduct a criminal background check;

3) a signed affirmation stating whether or not they have been convicted of a crime, pleaded nolo contendere, are on probation before judgment or placement of a case upon a stet docket, or have been found not guilty by reason of insanity, for any sexual offenses or intra-family offenses in the District or their equivalent in any other state or territory, or for any of the following felony offenses or their equivalent in any other state or territory:

(i) Murder, attempted murder, manslaughter, or arson;
(ii) Assault, assault with a dangerous weapon, mayhem, malicious disfigurement, or threats to do bodily harm;
(iii) Burglary;
(iv) Robbery;
(v) Kidnapping;
(vi) Illegal use or possession of a firearm;
(vii) Sexual offenses, including indecent exposure; promoting, procuring, compelling, soliciting, or engaging in prostitution; corrupting minors (sexual relations with children); molesting; voyeurism; committing sex acts in public; incest; rape; sexual assault; sexual battery; or sexual abuse;

but excluding sodomy between consenting adults;

(viii) Child abuse or cruelty to children; or

(ix) Unlawful distribution of or possession with intent to distribute a controlled substance;

4) a written acknowledgement stating that the Provider has notified them that they are entitled to receive a copy of the criminal background check and to challenge the accuracy and completeness of the report; and

5) a written acknowledgement stating that the Provider has notified them that they may be denied employment or a volunteer position, or may be terminated as an employee or volunteer based on the results of the criminal background check.

F) The provider shall inform each applicant, employee, and contractor and volunteer that a false statement may subject them to criminal penalties.

G) Prior to requesting a criminal background check, the Provider shall provide each applicant, employee, contractor or volunteer with a form or forms to be utilized for the following purposes:

1) To authorize the Metropolitan Police Department (MPD), or designee, to conduct the criminal background check and confirm that the applicant, employee, contractor or volunteer has been informed that the Provider is authorized and required to conduct a criminal background check;

2) To affirm whether or not the applicant, employee, contractor or volunteer has been convicted of a crime, has pleaded nolo contendere, is on probation before judgment or placement of a case upon a stet docket, or has been found not guilty by reason of insanity for any sexual offenses or intra-family offenses in the District or their equivalent in any other state or territory of the United States, or for any of the felony offenses described in paragraph H.11.5(C);

3) To acknowledge that the applicant, employee, contractor or volunteer has been notified of his or her right to obtain a copy of the criminal background check report and to challenge the accuracy and completeness of the report;

4) To acknowledge that the applicant may be denied employment, assignment to, or a volunteer position for which a criminal background check is required based on the outcome of the criminal background check; and

5) To inform the applicant, contractor, volunteer or employee that a false statement on the form or forms may subject them to criminal penalties pursuant to D.C. Official Code §22-2405.

H) The Provider shall direct the applicant, contractor, volunteer or employee to complete the form or forms and notify the applicant, contractor, volunteer or employee when and where to report to be fingerprinted.

I) Unless otherwise provided herein, the Provider shall request criminal background checks from the Chief, MPD (or designee), who shall be responsible for conducting criminal background checks, including fingerprinting.

J) The Provider shall request traffic record checks from the Director, Department of Motor Vehicles (DMV) (or designee), who shall be responsible for conducting traffic record checks.

K) The Provider shall provide copies of the results of all criminal background and traffic check reports to the Contract Administrator (CA) within one business day of receipt.

L) The Provider shall pay for the costs for the criminal background and traffic record checks, pursuant to the requirements set forth by the MPD and DMV. The District shall not make any separate payment for the cost of criminal background and traffic record checks.

M) The Provider shall make an offer of appointment to, or assign a current employee or applicant to, a compensated position contingent upon receipt from the contracting officer of the CA's decision after his or her assessment of the criminal background or traffic record check.

N) The Provider shall not make an offer of appointment to a volunteer or contractor whose position brings him or her into direct contact with children until it receives from the contracting officer the CA's decision after his or her assessment of the criminal background or traffic record check.

O) The Provider shall not employ or permit to serve as a volunteer or contractor an applicant or employee who has been convicted of, has pleaded nolo contendere to, is on probation before judgment or placement of a case on the stet docket because of, or has been found not guilty by reason of insanity for any sexual offenses involving a minor.

P) Unless otherwise specified herein, the Provider shall conduct annual criminal background checks upon the exercise of each option year of this contract for current employees, contractors and volunteers .

Q) An employee, contractor or volunteer may be subject to administrative action including, but not limited to, reassignment or termination at the discretion of the CA after his or her assessment of a criminal background or traffic record check.

R) The CA shall be solely responsible for assessing the information obtained from each criminal background and traffic records check report to determine whether a final offer may be made to each applicant, volunteer, contractor or employee. The CA shall inform the contracting officer of its decision, and the contracting officer shall inform the Provider whether an offer may be made to each applicant.

S) If any application is denied because the CA determines that the applicant presents a present danger to children or youth, the Provider shall notify the applicant of such

determination and inform the applicant in writing that she or he may appeal the denial to the Commission on Human Rights within thirty (30) days of the determination.

T) The provider shall institute a policy requiring employees and contractors providing direct care services to DYRS youth to submit to mandatory drug and alcohol testing during the pre-employment screening and on a random basis.

U) Criminal background and traffic record check reports obtained under this section shall be confidential and are for the exclusive use of making employment-related determinations. The Provider shall not release or otherwise disclose the reports to any person, except as directed by the contracting officer.

SECTION 38 Insurance

38.1 A. GENERAL REQUIREMENTS. The Contractor shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Contractor shall have its insurance broker or insurance company submit a Certificate of Insurance to the CO giving evidence of the required coverage prior to commencing performance under this contract. In no event shall any work be performed until the required Certificates of Insurance signed by an authorized representative of the insurer(s) have been provided to, and accepted by, the CO. All insurance shall be written with financially responsible companies authorized to do business in the District of Columbia or in the jurisdiction where the work is to be performed and have an Alfred M. Best Company rating of A-VIII or higher. The Contractor shall require all of its subcontractors to carry the same insurance required herein. The Contractor shall ensure that all policies provide that the CO shall be given thirty (30) days prior written notice in the event the stated limit in the declarations page of the policy is reduced via endorsement or the policy is canceled prior to the expiration date shown on the certificate. The Contractor shall provide the CO with ten (10) days prior written notice in the event of non-payment of premium.

1. Commercial General Liability Insurance. The Contractor shall provide evidence satisfactory to the CO with respect to the services performed that it carries $1,000,000 per occurrence limits; $2,000,000 aggregate; Bodily Injury and Property Damage including, but not limited to: premises-operations; broad form property damage; Products and Completed Operations; Personal and Advertising Injury; contractual liability and independent contractors. The policy coverage shall include the District of Columbia as an additional insured, shall be primary and non-contributory with any other insurance maintained by the District of Columbia, and shall contain a waiver of subrogation. The Contractor shall maintain Completed Operations coverage for five (5) years following final acceptance of the work performed under this contract.

2. Automobile Liability Insurance. The Contractor shall provide automobile liability insurance to cover all owned, hired or non-owned motor vehicles used in conjunction with the performance of this contract. The policy shall provide a $1,000,000 per occurrence combined single limit for bodily injury and property damage.

3. Workers' Compensation Insurance. The Contractor shall provide Workers' Compensation insurance in accordance with the statutory mandates of the District of Columbia or the jurisdiction in which the contract is performed.

   Employer's Liability Insurance. The Contractor shall provide employer's liability insurance as follows: $500,000 per accident for injury; $500,000 per employee for disease; and $500,000 for policy disease limit.

B. DURATION. The Contractor shall carry all required insurance until all contract work is accepted by the District, and shall carry the required General Liability; any required Professional Liability; and any required Employment Practices Liability insurance for five (5) years following final acceptance of the work performed under this contract.

C. LIABILITY. These are the required minimum insurance requirements established by the District of Columbia. **HOWEVER, THE REQUIRED MINIMUM INSURANCE REQUIREMENTS PROVIDED ABOVE WILL NOT IN ANY WAY LIMIT THE CONTRACTOR'S LIABILITY UNDER THIS CONTRACT.**

D. CONTRACTOR'S PROPERTY. Contractor and subcontractors are solely responsible for any loss or damage to their personal property, including but not limited to tools and equipment, scaffolding and temporary structures, rented machinery, or owned and leased equipment. A waiver of subrogation shall apply in favor of the District of Columbia.

E. MEASURE OF PAYMENT. The District shall not make any separate measure or payment for the cost of insurance and bonds. The Contractor shall include all of the costs of insurance and bonds in the contract price.

F. NOTIFICATION. The Contractor shall immediately provide the CO with written notice in the event that its insurance coverage has or will be substantially changed, canceled or not renewed, and provide an updated certificate of insurance to the CO.

G. CERTIFICATES OF INSURANCE. The Contractor shall submit certificates of insurance 10 business days after award of notice giving evidence of the required coverage as specified in this section prior to commencing work. Evidence of insurance shall be submitted to:

James A. Webb, Jr.
Contracting Officer
Office of Contracting and Procurement
441 4th Street, NW, Suite 700S
Washington, DC 20001
Telephone: 202-724-4019
E-mail address: james.webb@dc.gov

H. DISCLOSURE OF INFORMATION. The Contractor agrees that the District may disclose the name and contact information of its insurers to any third party which presents a claim against the District for any damages or claims resulting from or arising out of work performed by the Contractor, its agents, employees, servants or subcontractors in the performance of this contract.

Section 39 Access to Records

39.1 The Provider shall retain all case records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the human care agreement for a period of five (5) years after termination of the human care agreement, or if an audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of the contract.

39.2 The Provider shall assure that these records shall be subject at all reasonable times to inspection, review, or audit by Federal, District, or other personnel duly authorized by the Contracting Officer.

39.3 Persons duly authorized by the Contracting Officer shall have full access to and the right to examine any of the Provider's human care agreement and related records and documents, regardless of the form in which kept, at all reasonable times for as long as records are retained.

F.40 Documents Incorporated by Reference and Order of Precedence

A conflict in language shall be resolved by giving precedence to the document in the highest order of priority that contains language addressing the issue in question. The following documents are incorporated into the human care agreement by reference and made a part of the human care agreement in the following order of precedence.

F.40.1 The Human Care Agreement.

F.40.2 Government of the District of Columbia Standard Agreement Provisions for use with the District of Columbia Government Supply and Services Contracts dated March 2007 located at www.ocp.dc.gov.

F.40.3 U.S. Department of Labor Wage Determination No. 2005-2103, Revision 13, dated June 19, 2013.

F.40.4 Living Wage Fact Sheet.

F.40.5 The Contractor Qualifications Record completed by the Provider.

F.40.6 Task Order or Purchase Order

F.41 Attachments

The following attachments are included and incorporated by reference into this Agreement.

1. Human Care Agreement Qualification Record
2. First Source Employment Agreement
3. U.S. Department of Labor Wage Determination No. 2005-2103, Revision 13, dated June 19, 2013
4. *Living Wage Fact Sheet*
5. Living Wage Act of 2006

Exhibit 9

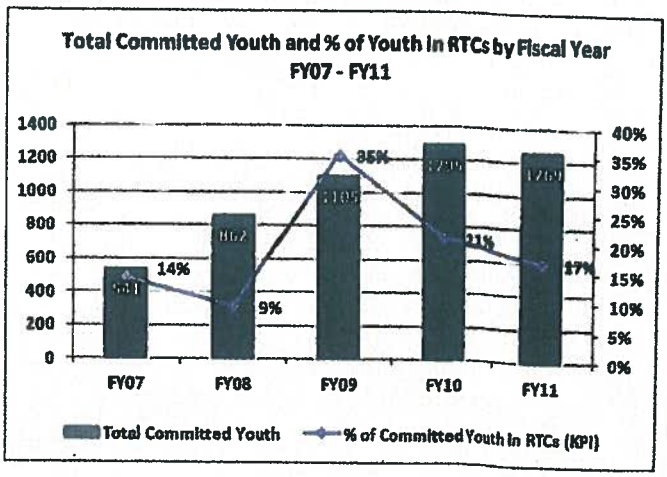
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Youth Rehabilitation Services

TRENDS IN DYRS RESIDENTIAL TREATMENT CENTER USAGE
In Response to the District of Columbia's Behavioral Health Association's
Sensible Budget Choices: Aligning DYRS Dollars to Youth Treatment Needs

Residential treatment centers (RTCs) and psychiatric residential treatment facilities (PRTFs) play an important role in the continuum of services at the Department of Youth Rehabilitation Services (DYRS). Serving DYRS committed youth with specific mental health, behavioral, or substance abuse needs, RTCs and PRTFs provide specialized treatment programs in a secure, structured environment.

RTC/PRTF POPULATION STATISTICS AND TRENDS

During FY2011, there were a total of 378 DYRS youth placed in RTCs/ PRTFs. Although this number has risen since FY2007, this upward trend primarily reflects the significant growth that has occurred in the overall DYRS committed population during that time. In FY2007, the overall DYRS committed population was 541 youth; by FY2011, this number had increased to 1,269.[1] This overall growth of the committed population helps explain the increase in the number of youth placed in RTCs and PRTFs.



On an average day in FY2011, 17% of DYRS committed youth were residing in an out-of-state RTC/PRTF.[2] This rate has decreased noticeably and consistently since FY2009, when 35% of the average daily population of committed youth were in an out-of-state RTC/PRTF. Due to this steady decline, the FY2011 levels are basically aligned with the 14% rate from FY2007.

---

[1] Population figures were obtained using DYRS' case management database and are available in the DYRS FY2011 Annual Performance Report, located at http://dyrs.dc.gov. On February 14, 2012, the District of Columbia Behavioral Health Association (DCBHA) released a report entitled *Sensible Choices: Aligning DYRS Dollars to Youth Treatment Needs* (DCBHA Report). In determining the DYRS population levels and the number of youth in RTCs/PRTFs between FY2007-FY2011, the DCBHA Report makes estimates based on prior DYRS Key Performance Indicator (KPI) data which reflects the number of youth newly committed to DYRS, but not the overall number of youth under the agency's supervision. These estimates inadequately reflect the significant growth that occurred in the overall committed population between FY2007 and FY2011.

[2] The percentage of youth in RTCs/PRTFs is reported in DYRS' KPI data, which is available to the public at http://capstat.oca.dc.gov/PerformanceIndicators.aspx. This figure includes only out-of-state placements because the large majority of RTCs/PRTFs are located outside the Washington, DC metropolitan area, and those that are located within the District are different from typical RTCs/PRTFs in that they largely serve youth who are awaiting placement in another secure facility or who are returning home from facilities with higher levels of supervision.

Population by placement type

On any given day during FY2012, nearly half of all committed youth lived in the community, either at home or in a community-based residential facility, a foster home, or an independent living program.

Placement Types by Average Daily Population, Average Length of Stay, and Gender FY2012

		Average Daily Population	Average Length of Stay (days)	Male	Female
Community-based Placements	Home	256	172	91%	9%
	Community-based residential facility	105	60	95%	5%
	Foster homes	27	179	66%	34%
	Independent living programs	21	144	52%	48%
	Total	**409**			
Non-Community Placements	Detention center or jail	122	119	97%	3%
	RTC	139	189	81%	19%
	Model Unit at New Beginnings	51	218	100%	0%
	YSC/Awaiting Placement	41	24	179%	21%
	Sub-acute care	4	32	63%	38%
	PRTF	20	141	87%	13%
	Total	**377**			

In addition to reductions in the overall residential treatment center population, DYRS youth are being placed in facilities closer to home. Between January 2012 and December 2012, there was an overall 51% reduction in the agency's out-of-state residential treatment center population, with the greatest reductions being in the West (67% decline) and Midwest (67% decline).

DYRS Out-of-State RTC Population January 2012-December 2012

Region	January 2012 Population	December 2012 Population	Percent Decline
West	27	9	-67%
Midwest	60	20	-67%
Mid-Atlantic	80	45	-44%
South	20	18	-10%
Nationwide	187	92	-51%

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bureau for Children and Families
Office of Research and Analysis
350 Capitol Street, Room 730
Charleston, West Virginia 25301-3711
Telephone: (304) 558-0628 Fax: (304) 558-4194

Earl Ray Tomblin
Governor

Karen L Bowling
Cabinet Secretary

REQUEST FOR INFORMATION

May 15, 2015

Via Email

Dear Ms. Johnson,

Thank you for your email request for information regarding PRTF placements in the State of West Virginia. The following table is the most current monthly report regarding West Virginia's children in placement settings.

The state of West Virginia breaks down placements into different levels. The state does not lump placements into one aggregate category of "Residential Treatment Program/Centers." If you are asking specifically about PRTF's the numbers are as follows:

PRTF-Long term (residential program): Placed In-State=61, Placed Out-of-State=85, Total=146
PRTF-Short term (acute psychiatric care): Placed In-State=22, Placed Out-of-State=1, Total=23

I have also attached a copy of the Foster Care Placement Definition Sheet for your information. As you will note from the attached Foster Care Placement Report, the State classifies all youth who are not in their natural homes as "foster care."

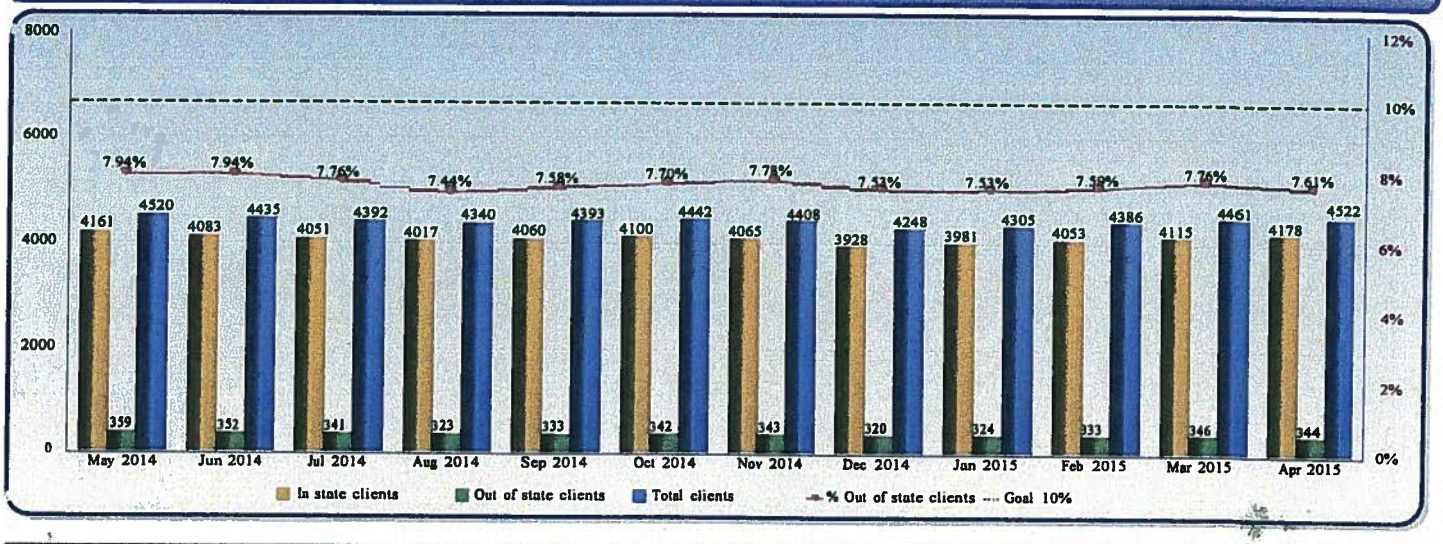
I hope this answers your question. Please feel free to contact us for further assistance.

Sincerely,

Laura Scarberry, M.A.
Office of Planning, Research and Evaluation
Bureau for Children and Families
350 Capitol St, Rm 730
Charleston, WV 25301
(304)356-4563

STATE OF WEST VIRGINIA
Department of Health and Human Resources

Foster Care Placements Report



	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015
In state clients	4161	4083	4051	4017	4060	4100	4065	3928	3981	4053	4115	4178
Out of state clients	359	352	341	323	333	342	343	320	324	333	346	344
Total clients	4520	4435	4392	4340	4393	4442	4408	4248	4305	4386	4461	4522
% Out of state clients	7.94%	7.94%	7.76%	7.44%	7.58%	7.70%	7.78%	7.53%	7.53%	7.59%	7.76%	7.61%

In state and Out of state clients by Provider type for the month of Apr 2015

Provider Type	In state clients	Out of state clients	Total clients	% Out of state clients
Agency Emergency Shelter	176	0	176	0.00%
Agency Foster Family Care	1304	35	1339	2.61%
Department Adoptive Home	163	28	191	14.66%
Detention Centers	39	0	39	0.00%
Group Residential Care	666	171	837	20.43%
Kinship/Relative	641	16	657	2.44%
Psychiatric Facilities (Long Term)	61	85	146	58.22%
Psychiatric Hospital (Short Term)	22	1	23	4.35%
School For Children with Special Needs	2	0	2	0.00%
Specialized Family Care (Medley)	7	0	7	0.00%
Specialized Family Care Home-(Medley)	13	0	13	0.00%
Therapeutic Foster Care	1013	8	1021	0.78%
Transitional Living Client	71	0	71	0.00%
Summary	4178	344	4522	7.61%

Terminology

1. **Agency Emergency Shelter Care**: provide short-term placement during a crisis situation. The purpose is to provide a supportive environment designed to minimize stress and emotional instability.

2. **Department Adoptive Home**: a home that the Department of Health and Human Resources' (DHHR) Bureau for Children and Families has recruited, trained and certified as a potential adoptive placement. These homes serve children who are in the custody of DHHR and whose parent(s)' parental rights have been terminated.

3. **Detention Centers:** Secure residential facility designed to physically restrict the movements and activities of juveniles held in lawful custody.

4. **Agency Foster Family Care**: a family placement designed for children with few problems who can best be served in a family setting pending the development of a permanent living arrangement.

5. **Group Residential Care**: a structured 24-hour group care setting that targets youth with needs that range from adjustment difficulties in school, home, and/or community to those in need of a highly structured program with formalized behavioral programs and therapeutic interventions. These types of settings are referred to in West Virginia as Level I, Level II and Level II Group Residential Care; where Level I serves children with mild behavioral/mental health issues, Level II serves children with moderate issues, and Level III serves children with severe health issues.

6. **Kinship/Relative:** Services provided by any person related to the child by blood or marriage including cousins and in-laws. Persons who the child considers a relative, such as a godparent or significant others whom the child claims as kin may also be considered as a placement resource.

7. **Psychiatric Facility (Long-Term)**: a Psychiatric Residential Treatment Facility (PRTF) provides for children and adolescents under the age of 21 a medically supervised interdisciplinary program of behavior health treatment which addresses the psychiatric needs of each individual and his/her family.

8. **Psychiatric Hospital (Short-Term)**: acute psychiatric inpatient hospitalization lasting 30 days or less and providing intensive, 24-hour psychiatric care, including crisis stabilization and diagnostic assessment.

9. **School For Children With Special Needs:** WV School for the Deaf & Blind in Romney, WV.

10. **Specialized Family Care and Specialized Family Care Home (Medley)**: 24-hour daily care, support, training and supervision (within a family setting) of individuals of all ages, including children with developmental disabilities. The focus of specialized foster care is long-term placement, making it critical to carefully match placements.

11. **Therapeutic Foster Care**: a family placement designed for children with significant treatment needs due to emotional and/or physical problems. Foster parents are professionally trained and supported to aid children in overcoming problems while preparing them for return home or to a less intensive out-of-home setting.

12. **Transitional Living Client**: older youth (17-20 years of age) who are assisted in moving from a foster home or group residential setting to their own community where they establish a household while continuing educational/vocational goals or entering the workforce. A private agency that DHHR has an agreement with provides assistance in career planning, development of employment/job maintenance skills, face-to-face contact and social casework services.

Exhibit 10

948 INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER 22 YEARS OF AGE

948.1 Inpatient psychiatric services for individuals under the age of twenty-two (22) may be provided by:

(a) A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

(b) A psychiatric residential treatment facility (PRTF).

948.2 Inpatient psychiatric services for individuals under the age of twenty-two (22) shall be:

(a) Provided under the direction of a physician;

(b) Provided in a facility or program described in §948.1;

(c) Provided before the individual reaches the age of twenty-two (22), or, if the individual was receiving the services immediately before reaching the age of twenty-two (22), before the earlier of the following:

(i) The date the individual no longer requires the services; or

(ii) The date the individual reaches the age of twenty-two (22).

(d) Certified in writing to be necessary in the setting in which the services shall be provided or are being provided in emergency circumstances in accordance with 42 CFR 441.152; and

(e) Meet the conditions of participation governing the use of restraint or seclusion set forth in 42 CFR 483.350 *et seq.*, if services are provided by a PRTF.

948.3 For each Medicaid beneficiary or applicant who is admitted to a facility or program, the certification required pursuant to §948.2(d) shall be made by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness and has knowledge of the beneficiary's health status. For an individual who applies for Medicaid while in the facility or program, the certification shall be made by the team responsible for the plan of care as described in §948.6 and shall cover any period before application for which claims are made. For emergency admissions, the certification shall be made by the team responsible for the plan of care within fourteen (14) days after admission.

948.4 A PRTF shall:

(a) Be licensed in the state where the facility is located, if required by the state;

(b) Have a current written provider agreement with the District of Columbia Medicaid Program;

(c) Have a written individual plan of care for each patient as described in §948.5, developed by an interdisciplinary team of physicians and other professionals as described in §948.6 in consultation with the patient and his or her parents, legal guardians, or others in whose care the patient will be released after discharge; and

(d) Maintain appropriate administrative and medical records for a minimum of six (6) years beyond the age of twenty-two (22) years and make such records available to officials of the Department of Health Care Finance, the Department of Mental Health, Department of Health, or other governmental officials of District, state, or federal agencies, or their designees.

948.5 Each facility or program shall have a written plan of care for each beneficiary that complies with the requirements set forth in 42 CFR 441.155 and include the following:

(a) A certification of need for services that meets the requirements of 42 CFR 441.152;

(b) An assessment of the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

(c) An assessment of the resources of the beneficiary's family, including parents, legal guardians, or others into whose care the beneficiary will be released after the discharge;

(d) The establishment of treatment objectives; and

(e) The prescribing of therapeutic modalities to achieve the plan's objectives.

948.6 The interdisciplinary team consisting of physicians and other personnel that develops an individual plan of care shall:

(a) Be employed by the facility directly or under contract;

(b) Have demonstrated competency in child psychiatry (for example, residency in child and adolescent psychiatry and experience in inpatient child and adolescent inpatient/residential treatment settings);

(c) Include at a minimum:

(1) A board-certified or board-eligible psychiatrist;

(2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

(3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association; and

(d) Include one (1) of the following:

(1) A psychiatric social worker;

(2) A registered nurse who has specialized training or one (1) year of experience in treating mentally ill individuals;

(3) An occupational therapist who is licensed, if required by the state, and has specialized training or one (1) year of experience in treating mentally ill individuals; or

(4) A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

948.7 Each facility or program shall not admit a District Medicaid beneficiary or applicant unless the admission has been certified as medically necessary by the District of Columbia Department of Mental Health (DMH).

948.8 Each facility or program shall provide active treatment consistent with the requirements set forth in 42 CFR 441.155.

948.9 The written plan of care shall be developed within fourteen (14) days of admission and reviewed at least every thirty (30) days thereafter.

948.10 Each PRTF shall provide to the requesting District child-serving agency the initial plan of care and any subsequent treatment plan adjustments, including all thirty (30) day reviews of the plan of care.

SOURCE: Final Rulemaking published at 37 DCR 6812 (October 26, 1990); as amended by Final Rulemaking published at 50 DCR 7176 (August 29, 2003); as amended by Final Rulemaking published at 57 DCR 1709 (February 26, 2010) and corrected at 57 DCR 1892 (March 5, 2010).

Exhibit 11

NCTSN The National Child Traumatic Stress Network

MUSC MEDICAL UNIVERSITY of SOUTH CAROLINA

Trauma-Informed Interventions:

Clinical and Research Evidence and Culture-Specific Information Project

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Acknowledgments

This project was a collaborative effort between the National Crime Victims Research and Treatment Center in the Department of Psychiatry at the Medical University of South Carolina and the National Center for Child Traumatic Stress. This work was based on previous work on treatment guidelines for the treatment of child physical and sexual abuse conducted by Benjamin E. Saunders, PhD, Lucy Berliner, MSW, and Rochelle F. Hanson, PhD:

Saunders, B. E., Berliner, L. & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment (Revised Report: April 26, 2004).* Charleston, SC: National Crime Victims Research and Treatment Center.

The authors would like to thank all of the treatment developers for taking the time to provide detailed descriptions of their interventions for inclusion in this project and Jo Sornborger, PsyD for extensive project management support. In addition, the authors would like to thank the members of the expert panel who generously gave of their time and talent to contribute to this project. The authors would also like to extend a special thank you to the NCTSN Culture Consortium for participating in the evolution of this project and for providing feedback and guidance along the way.

For information about this project and report, contact:
Susan Ko, PhD
Director, Service Systems
National Center for Child Traumatic Stress
11150 W. Olympic Blvd, Suite 650
Los Angeles, CA 90064
sko@mednet.ucla.edu

This report may be accessed electronically at http://www.nctsn.org/cultureandtraumaresources, or downloaded directly at http://www.nctsn.org/nccts/asset.do?id=1392.

Suggested Citation

de Arellano, M. A., Ko, S. J., Danielson, C. K. & Sprague, C. M. (2008). *Trauma-informed interventions: Clinical and research evidence and culture-specific information project.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Contents

Introduction

The *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* is a collaboration between the National Crime Victims Research and Treatment Center at the Medical University of South Carolina (MUSC) and the National Child Traumatic Stress Network (NCTSN). This project emerged in response to the heavy emphasis on evidence-based practices in the mental health community, a trend that may ultimately affect access to services, as well as policy and funding decisions.

The purpose of this project was to identify trauma-focused interventions that have been developed and utilized with trauma-affected youth populations of various cultural backgrounds and to describe their level of cultural competence. This project also aims to describe the level of clinical and research evidence surrounding the use of specific trauma-informed treatment interventions with diverse cultural groups. Included in the term "diverse cultural groups" are factors of race, ethnicity, sexual orientation, socioeconomic status, spirituality, geographic location, and any other distinguishing factors about a particular group or population.

Goals of the Project

The Project does not intend to provide a subjective value judgment about which interventions are the best. Instead, the primary goals of this project are as follows:

- To collect information on interventions that are currently being used for a broad array of diverse cultural groups of youth affected by trauma;
- To provide descriptions of existing clinical and/or research evidence for each of these interventions;
- To encourage practitioners and intervention developers to summarize practice-based and anecdotal evidence in written form so that treatments can be more widely disseminated and more thoroughly evaluated;
- To create a formal comprehensive report which documents our systematic process and describes the interventions that were identified and submitted by treatment developers. The report can then be used by practitioners when selecting treatments for the diverse communities they serve;
- To develop a web-based, searchable database describing the existing clinical and research evidence for the use of trauma-informed interventions with various cultural groups of youth exposed to trauma. The database will help to facilitate the identification and use of treatments for diverse communities affected by trauma.

Methodology

In 2005, the NCTSN began compiling a list of *Empirically Supported Treatments and Promising Practices*, including interventions being implemented by sites within the NCTSN for traumatized children and their families. Treatment developers were asked to complete an intervention template, which solicited specific information about their interventions (e.g., treatment description, target population, research evidence). Fact Sheets detailing each approach were developed from each completed intervention template, and then posted on the NCTSN website for public use. The interventions and treatments selected span a continuum of evidence-based interventions for use with trauma-affected youth, ranging from rigorously evaluated interventions to promising and newly emerging practices.

In June 2006, revised intervention templates were sent to all developers of the NCTSN's *Empirically Supported Treatments and Promising Practices*. Tailored for the *Trauma Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project*, the questions on these revised intervention templates were designed to elicit information about the cultural competence of an intervention as well as the level of research supporting the treatment. We placed special emphasis on providing this level of detail about the interventions to assist practitioners' selection of which treatment or practice to implement—based not only on their levels of evidence but also on their appropriateness for a given community and target population.

Therefore, the revised intervention templates sent to developers in 2006 included questions designed to evaluate the extent of both clinical and research evidence supporting the use of trauma-informed treatment interventions with trauma-affected youth from diverse cultural groups (as defined by race, ethnicity, sexual orientation, socioeconomic status, spirituality, disability, geographic location and other factors). These questions were intended to elicit information about each of the following categories (see Appendix A, General Information Intervention Template):

- Treatment Description
- Target Population
- Essential Components
- Clinical & Anecdotal Evidence
- Research Evidence
- Outcomes
- Implementation Requirements & Readiness
- Training Materials & Requirements
- Pros & Cons/Qualitative Impressions
- Contact Information
- References

Information gathered from the revised intervention templates replaced the previous Fact Sheets developed by the NCTSN in 2005.

In January 2007, these Fact Sheets on treatment interventions, based on revised intervention templates completed and returned by treatment developers, were sent to members of a nationally represented expert panel. The panel members were asked to meet to discuss the evidence base for the treatment interventions for use with various cultural groups and to determine future directions for this project.

Expert Panel

In February 2007, an expert panel was convened at the NCTSN's annual conference. The panel was asked to review evaluation criteria for treatment interventions, and to evaluate and categorize interventions according to the evidence for their efficacy and effectiveness with various cultural groups. The expert panel members were selected because of their acknowledged expertise and commitment to promoting and developing effective, culturally competent mental health treatments. This nationally represented group consisted of the following members:

Veronica Abney, PhD Private Practice & UCLA School of Medicine	**Larke Huang, PhD** Substance Abuse and Mental Health Services Administration (SAMHSA)
Dolores Subia Bigfoot, PhD Indian Country Child Trauma Center (ICCTC)	**Mareasa Isaacs, PhD** National Alliance of Multi-Ethnic Behavioral Health Associations (NAMBHA)
Ernestine Briggs-King, PhD National Center for Child Traumatic Stress (NCCTS)	**Russell Jones, PhD** Virginia Tech University (VT)
Elissa Brown, PhD Community PARTNERS at St. John's University	**Sheryl Kataoka, MD, MSHS** Department of Psychiatry and Biobehavioral Sciences at UCLA; Los Angeles Unified School District (LAUSD)
Carla Kmett Danielson, PhD Medical University of South Carolina (MUSC)	**Susan Ko, PhD** National Center for Child Traumatic Stress (NCCTS)
Michael de Arellano, PhD Medical University of South Carolina (MUSC)	**Sarah Maiter, PhD** American Professional Society on the Abuse of Children (APSAC)
Chandra Ghosh Ippen, PhD Child Trauma Research Project University of California, San Francisco (UCSF)	**Karen Wyche, MSW, PhD** University of Oklahoma Health Sciences Center (OUHSC)

Expert Panel Meeting

The rating system originally developed for this project was based very closely on the criteria used for *Child Physical and Sexual Abuse: Guidelines for Treatment* (2004). Those guidelines were developed by the Office for Victims of Crime, in collaboration with the National Crime Victims Research and Treatment Center at MUSC and the Center for Sexual Assault and Traumatic Stress at Harborview Medical Center. However, at the February, 2007 meeting, the expert panel concluded that the intervention Fact Sheets did not include enough information to provide a ranking for each treatment's level of cultural competence. Additionally, panel members raised concerns about the classification system, and expressed discomfort with categorizing interventions by assigning numerical ratings and citing inadequate information on specific ways in which the treatments address diverse cultural groups. The panel agreed that, rather than rating interventions based on the level of clinical and research evidence, it would be more helpful to solicit additional information about the degree to which cultural issues are addressed in the treatment intervention. The panel agreed that this would help more accurately capture the "cultural competence" of a given treatment.

As a result of these concerns, the panel decided to create a Culture-Specific Information Intervention Template. The panel spent the remainder of the meeting identifying additional culture-specific questions necessary to help determine the extent to which a particular treatment addresses the needs of diverse cultural groups. The panel decided that, once these Culture-Specific Information Intervention Templates were completed, the project would aim to present Culture-Specific Fact Sheets, alongside General Fact Sheets, in a comprehensive document.

Based on the culture-specific questions generated at the expert panel meeting, the Culture-Specific Information Intervention Template was developed and was sent to treatment developers to complete. This template included questions intended to address the following categories (see Appendix B, Culture-Specific Information Intervention Template):

- Engagement
- Language Issues
- Symptom Expression
- Assessment
- Cultural Adaptations
- Intervention Delivery Method/Transportability & Outreach
- Training Issues
- References

The information collected on the revised General Information Intervention Template as well as the Culture-Specific Intervention Template was used to create General and Culture-Specific Fact Sheets for each intervention. These Fact Sheets were then posted on the NCTSN website.

General and Culture-Specific Fact Sheets for Culturally-Competent, Evidence-Based, Trauma-Focused Interventions

Each General and Culture-Specific Fact Sheet includes all of the information provided by developers of the intervention and has not been substantively altered.[1] Only trauma-informed treatment interventions and practices that have both a General and Culture-Specific Fact Sheet are included in this report. Fact Sheets for each of the following interventions begin on page 23.

- **AF-CBT**: Alternatives for Families–A Cognitive Behavioral Therapy
- **DBT-SP**: Adapted Dialectical Behavior Therapy for Special Populations
- **TAP**: Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway
- **ARC**: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth
- **CARE**: Child-Adult Relationship Enhancement
- **CPP**: Child-Parent Psychotherapy
- **CBITS**: Cognitive Behavioral Intervention for Trauma in Schools
- **CPC-CBT**: Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse
- **CM-TFT**: Culturally Modified Trauma-Focused Treatment
- **IFACES**: International Family Adult and Child Enhancement Services, Heartland Health Outreach
- **ITCT**: Integrative Treatment of Complex Trauma
- **MMTT**: Multimodality Trauma Treatment (aka Trauma-Focused Coping in Schools)
- **PCIT**: Parent-Child Interaction Therapy
- **RLH**: Real Life Heroes
- **Sanctuary Model**
- **SPARCS**: Structured Psychotherapy for Adolescents Responding to Chronic Stress
- **TGCT**: Trauma and Grief Component Therapy
- **TARGET-A**: Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents
- **TF-CBT**: Trauma-Focused Cognitive Behavioral Therapy
- **TG-CBT**: Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief
- **Trauma-Informed Organizational Self-Assessment**
- **TST**: Trauma Systems Therapy

[1] Please note: if a developer left any blanks in a template field, the question from the initial template was not included in the Fact Sheet for that particular intervention.

Conclusion

There is no one treatment intervention appropriate for all children who have experienced trauma. However, there are evidence-supported treatments and promising practices that share core principles of "culturally competent trauma-informed therapy," and that are appropriate for many children and families from diverse cultural groups.

Culturally competent trauma-informed therapies should include some, or all, of the following principles:

- **Engagement with the child, the family, and the community.** For many cultural groups, there may be cultural barriers to accessing treatment. Therefore, the start of treatment should begin with addressing strategies designed to engage children and families. These engagement strategies should be culture-specific. For example, addressing issues of trust may be important when working with refugees. Engagement strategies may also consider the role of other members of the family's immediate community, such as cultural or spiritual leaders, in reaching the child and family.

- **Sensitivity to the family's cultural background when building a strong therapeutic relationship.** Like most forms of therapy, trauma treatment requires the skillful development of a clinical relationship with the child and caregivers. During the process of building the therapeutic relationship, the practitioner must understand the importance of asking questions in order to learn about the child and/or family's cultural background.

- **Consideration of the impact of culture on symptom expression.** Most trauma-informed therapy includes a component that helps the child and caregivers identify and understand normal human reactions to trauma. When assessing reactions to trauma, it is important to consider the impact of culture, since cultural views may have an impact on symptom expression. If it is known that culture impacts symptom expression for a particular cultural group, assessment measures should reflect these differences.

- **Careful use of interpreters, when necessary.** Caregivers are typically powerful mediators of the child's treatment for and recovery from trauma. Involving the parent, resource parent, or other caregiver is a vital element of trauma treatment. Some trauma-informed interventions include a parenting component to give the parent greater mastery of child management skills. Language issues may sometimes arise if the clinician does not speak the parents' language. In such cases, it is very important to consider how the chosen treatment suggests use of interpreters in the absence of bilingual clinicians.

- **Understanding that differences in emotional expression exist among cultures.** To help with emotional regulation, it is typically necessary to teach the child (and sometimes the caregiver) practical skills and tools for gaining mastery of the overwhelming emotions often associated with trauma and its reminders. Again, it is important to assess cultural norms

regarding appropriate levels of emotional expression and with whom it is considered culturally appropriate to share emotions.

- **Assessment of the impact of cultural views on cognitive processing or reframing.** Child trauma can result in serious misunderstandings about personal responsibility. In the aftermath of a trauma, children may assume a great deal of self-blame for the events; or, they may blame someone else for not protecting them—even though protection may have been beyond that person's capacity. Traumatized children may associate the trauma with unrelated events and draw irrational causal relationships. Therapy often helps correct these misattributions. When treating trauma-affected youth from diverse backgrounds, clinicians must be aware that some misattributions may be related to cultural worldviews. A culturally-informed assessment can help to examine how culture affects the child's and family's comprehension of traumatic events. In such cases, cognitive processing and reframing will have to include an understanding of the impact of cultural views on attitudes and behavior.

- **Construction of a coherent trauma narrative using culturally congruent methods.** Successful trauma treatment often includes building the child's capacity to talk about what happened in ways that make sense of the experience without producing overwhelming emotions. Many non-trauma-informed therapists are uncomfortable with this aspect of treatment, which sometimes involves gradual exposure to traumatic reminders while using newly acquired anxiety management skills. Clinicians should consider how trauma narratives can be constructed so that they are congruent with the ways in which specific cultural groups feel comfortable sharing personal or private information (e.g., storytelling).

- **Highlighting ways in which culture may be a source of resiliency and strength.** Trauma treatment often includes strategies that build upon children's strengths. These strategies are designed to give them a sense of control over events and risks. Treatments then often end on a positive, empowering note, giving the child a sense of satisfaction and closure as well as increased competency and hope for the future. It is important to highlight the strengths inherent in children's and families' cultures as part of this process.

The *Trauma Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* aims to promote cultural competence using each of these core principles of culturally competent trauma-informed therapy and to recognize practices that are effectively utilizing these principles. This report provides guidelines for evaluation of the treatments and promising practices that are appropriate for the cultural groups being served. Ultimately, it is the responsibility of clinicians, agencies and consumers to recognize how the needs of the specific cultural group being treated will be addressed by a chosen evidence-based treatment or promising practice.

Future Directions

The purpose of the *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* was to identify trauma-focused interventions that have been developed and applied to trauma-affected youth populations of various cultural backgrounds and to describe their level of cultural competence and the level of clinical and research evidence supporting the treatment. Work on this project has revealed that significant groundwork has been established in this area by clinicians and researchers working directly with trauma-affected culturally diverse populations. However, more work will be required to improve the state of the science for the identification and application of evidence-based interventions with such populations. Advancing the science could be accomplished in a number of ways, as listed below.

First, developers of the interventions described in the Fact Sheets included in this report should seek to bring their respective interventions to the next level of evaluation. This may involve more rigorous collection of pre- and post-treatment outcome data with standardized, culturally appropriate measures. In some cases, assessment approaches may require modification in order to capture this data for a particular population. (See de Arellano & Danielson, 2008, for suggestions on culturally-informed trauma assessment.) For other interventions, developers may consider conducting a more rigorous open pilot trial or a randomized controlled trial. For the limited number of trauma-informed interventions that have been conducted with culturally diverse populations, treatment developers are encouraged to pursue ways in which to measure "real world" effectiveness—perhaps by designing and conducting community-based trials. Appendix C lists criteria for evaluating levels of evidence for interventions' use with specific cultural groups based on those used in previous treatment guidelines projects (Saunders, Berliner & Hanson, 2004) and can help provide suggested next steps for increasing the evidence base for interventions.

Another important future direction for this project may involve collaborations between community-based clinicians and researchers in order to develop a feasible "gold standard" for evaluation of trauma-informed interventions with culturally diverse populations. This pairing of science and practice could help address findings from previous reports that ethnic minority individuals and other culturally diverse youth are less likely to receive empirically-supported, gold-standard mental health interventions (U.S. Department of Health and Human Services, 2001).

Finally, it is hoped that this project will represent a first step in the continually evolving goal of developing a stronger clinical and research base for interventions used with culturally diverse populations. The Fact Sheets provided in this report are a resource that can be used to assist practitioners in the identification of interventions that have demonstrated efficacy in their application with culturally diverse populations. As clinicians continue to use interventions with diverse populations and document their clinical and research outcomes, the information on the effectiveness and efficacy of interventions for specific populations will grow and strengthen. A more formal evaluation of the state of the science, perhaps using the criteria listed in Appendix C, could then be pursued.

References[2]

de Arellano, M. A. & Danielson, C. K. (2008). Assessment of trauma history and trauma-related problems in ethnic minority child populations: An INFORMED approach. *Cognitive & Behavioral Practice, 15,* 53-67.

Saunders, B. E., Berliner, L. & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment (Revised Report: April 26, 2004).* Charleston, SC: National Crime Victims Research and Treatment Center.

U.S. Department of Health and Human Services (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

[2] The reference list does not include references included in each of the Fact Sheets which follow.

Appendix A: General Information Intervention Template

NCTSN The National Child Traumatic Stress Network — GENERAL INFORMATION	**ACRONYM:** Name of Intervention
Treatment Description	**Acronym** *(abbreviation)* **for intervention:** **Average length/number of sessions:** **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)*: **Trauma type** *(primary)*: **Trauma type** *(secondary)*: **Additional descriptors** *(not included above)*:
Target Population	**Age range:** *(lower limit)* ____ to *(upper limit)* ____ **Gender:** ❒ **Males** ❒ **Females** ❒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)*: **Other cultural characteristics** *(e.g., SES, religion)*: **Language(s):** **Region** *(e.g., rural, urban)*: **Other characteristics** *(not included above)*:
Essential Components	**Theoretical basis:** **Key components:**
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ❒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. ____ **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ❒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)*? ❒ **Yes** ❒ **No** **If YES, please include citation:** **Has this intervention been presented at scientific meetings?** ❒ **Yes** ❒ **No** **If YES, please include citation(s) from last five presentations:** **Are there any general writings which describe the components of the intervention or how to administer it?** ❒ **Yes** ❒ **No**

Appendix A: General Information Intervention Template

NCTSN The National Child Traumatic Stress Network — GENERAL INFORMATION	**ACRONYM:** Name of Intervention	
Clinical & Anecdotal Evidence continued	**If YES, please include citation:** **Has the intervention been replicated anywhere?** ☐ Yes ☐ No **Other countries?** *(please list)* **Other clinical and/or anecdotal evidence** *(not included above)*:	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies		
Pilot Trials/Feasibility Trials *(w/o control groups)*		
Clinical Trials *(w/control groups)*		
Randomized Controlled Trials		
Studies Describing Modifications		
Other Research Evidence		
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** **If research studies have been conducted, what were the outcomes?**	
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** **Supervision requirements** *(e.g., review of taped sessions)*? **To ensure successful implementation, support should be obtained from:**	

Appendix A: General Information Intervention Template

NCTSN The National Child Traumatic Stress Network — GENERAL INFORMATION	**ACRONYM:** Name of Intervention
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** **How/where is training obtained?** **What is the cost of training?** **Are intervention materials** *(handouts)* **available in other languages?** ☐ **Yes** ☐ **No** **If YES, what languages?** **Other training materials &/or requirements** *(not included above)*:
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)*? **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)*? **Other qualitative impressions:**
Contact Information	**Name:** **Address:** **Phone number:** **Email:** **Website:**
References	

Appendix B: Culture-Specific Information Intervention Template

NCTSN The National Child Traumatic Stress Network CULTURE-SPECIFIC INFORMATION	**ACRONYM:** Name of Intervention
Engagement	**For which specific cultural group(s)** *(i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas)* **is this treatment tailored? If none, please respond "not specifically tailored."** **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?**
Language Issues	**How does the treatment address children and families of different language groups?** **If interpreters are used, what is their training in child trauma?** **Any other special considerations regarding language and interpreters?**
Symptom Expression	**Is there research or clinical evidence to suggest that the populations served manifest trauma symptoms in differential ways? If so, are there differences in the ways that symptoms are assessed for the various populations?** **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?**
Assessment	**In addition to any differences noted above, are there any differences in assessment measures used across cultural groups? If so, please indicate which measures are used for which cultural groups. Are there normative data available for the populations for which they are being used?** **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** **What, if any, culturally specific issues arise when utilizing these assessment measures?**
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted).* **Has differential drop out been examined for this treatment? Is there any evidence to suggest differential drop out across cultural groups? If so, what are the findings?**

Appendix B: Culture-Specific Information Intervention Template

NCTSN The National Child Traumatic Stress Network CULTURE-SPECIFIC INFORMATION	**ACRONYM:** Name of Intervention
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** **Is this a clinic-based treatment or is the treatment transportable** *(e.g., into home, community)***? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?** **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** **Are these barriers addressed in the intervention and how?** **What is the role of the community in treatment** *(e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)***?**
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** **Has this guidance been provided in the writings on this treatment?** **Any other special considerations regarding training?**
References	

Appendix C: Treatment Protocol Classification System

A primary goal of this project was to establish a clear, criteria-based system for classifying interventions and treatments according to their theoretical, clinical, and empirical support. This system can be applied not only to the interventions presented in this report, but also can be used to judge the utility of other current treatments, as well as treatments to be developed in the future. Therefore, the classification system is a tool that can be used by practitioners and others to make decisions about the appropriateness of certain treatments that are not included in this report. It is helpful to keep in mind that this report reflects the state of knowledge at the time of writing. Hopefully, more research will be conducted testing the efficacy of existing interventions and protocols. As more research is completed, the classifications of treatments will likely change over time. Therefore, this treatment classification system should be viewed as a tool that can be applied to a dynamic area where the body of scientific information is constantly increasing.

The classification system uses criteria regarding a treatment's theoretical soundness, clinical support, professional acceptance, potential for harm, documentation, and empirical support to assign a summary classification score. A lower score indicates a greater level of support for the treatment protocol. The summary categories are:

1 = Well-supported, efficacious treatment for specific cultural groups

2 = Supported and probably efficacious treatment for specific cultural groups

3 = Supported and acceptable treatment for specific cultural groups

4 = Promising and acceptable treatment for specific cultural groups

5 = Innovative or novel treatment for specific cultural groups

6 = Concerning or worrisome treatment for specific cultural groups

Specific criteria for each classification system category are presented below:

1. Well-supported, Efficacious Treatment for Specific Cultural Groups

a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.

b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.

c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.

Appendix C: Treatment Protocol Classification System

d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.

f. At least two randomized, controlled treatment outcome studies (RCTs) have found the treatment protocol to be superior to an appropriate comparison treatment, or no different nor better than an already established treatment when used with child trauma victims and/or their families from specific cultural groups. The RCTs must have focused on the specific cultural group or must have enrolled a sufficiently large number of the target cultural group within their sample to evaluate differential efficacy for that cultural group.

g. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

2. Supported and Probably Efficacious Treatment for Specific Cultural Groups

a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.

b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.

c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.

d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.

f. At least two studies utilizing some form of control without randomization (e.g., matched wait list, untreated group, placebo group) have established the treatment's efficacy over the passage of time; efficacy over placebo; or, found it to be comparable to or better than an already established treatment when used with child trauma victims and/or their families from specific cultural groups. The studies must have focused on the specific cultural group or must have enrolled a sufficiently large number of the target cultural group within their sample to evaluate differential efficacy for that cultural group.

g. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

Appendix C: Treatment Protocol Classification System

3. Supported and Acceptable Treatment for Specific Cultural Groups

a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.

b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.

c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.

d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.

f1. At least one group study (controlled or uncontrolled), or a series of single subject studies suggest the efficacy of the treatment with child trauma victims and/or their families from specific cultural groups, OR

f2. A treatment has demonstrated efficacy with non-trauma-related disorders, has a sound theoretical basis for its use with child trauma victims and/or their families from specific cultural groups, but has not been tested or used extensively with child trauma victims and/or their families from specific cultural groups.

g. If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

4. Promising and Acceptable Treatment for Specific Cultural Groups

a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.

b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.

c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.

d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

Exhibit 12

Dialectical Behavior Therapy Frequently Asked Questions

What is Dialectical Behavior Therapy?

Dialectical Behavior Therapy (DBT) is a treatment designed specifically for individuals with self-harm behaviors, such as self-cutting, suicide thoughts, urges to suicide, and suicide attempts. Many clients with these behaviors meet criteria for a disorder called borderline personality (BPD). It is not unusual for individuals diagnosed with BPD to also struggle with other problems – depression, bipolar disorder, post-traumatic stress disorder (PTSD), anxiety, eating disorders, or alcohol and drug problems. DBT is a modification of cognitive behavioral therapy (CBT). In developing DBT, Marsha Linehan, Ph.D. (1993a) first tried applying standard CBT to people who engaged in self-injury, made suicide attempts, and struggled with out-of-control emotions. When CBT did not work as well as she thought it would, Dr. Linehan and her research team added other types of techniques until they developed a treatment that worked better. We'll go into more detail about these techniques below, but it's important to note that DBT is an "empirically-supported treatment." That means it has been researched in clinical trials, just as new medications should be researched to determine whether or not they work better than a placebo (sugar pill). While the research on DBT was conducted initially with women who were diagnosed with BPD, DBT is now being used for women who binge-eat, teenagers who are depressed and suicidal, and older clients who become depressed again and again.

Why do people engage in self-destructive behavior?

A key assumption in DBT is that self-destructive behaviors are learned coping techniques for unbearably intense and negative emotions. Negative emotions like shame, guilt, sadness, fear, and anger are a normal part of life. However, it seems that some people are particularly inclined to have very intense and frequent negative emotions. Sometimes, the human brain is simply "hard-wired" to experience stronger emotions, just like an expensive stereo is "hard-wired" to produce very complex sounds. Or, it could be that severe emotional or physical trauma causes changes in the brain to make it more vulnerable to intense feeling states. Additionally, sometimes clients have mood disorders – Major Depression or Generalized Anxiety -- that are not controlled by standard medications and thus lead to emotional suffering. Any one of these factors, or any combination of them, can lead to a problem called **emotional vulnerability.** A person who is emotionally vulnerable tends to have quick, intense, and difficult-to-control emotional reactions that make his or her life seem like a rollercoaster.

Extreme emotional vulnerability is rarely the sole cause of psychological problems. An **invalidating environment** is also a major contributing factor. What is an invalidating environment? The "environment," in this case, is usually other people. "Invalidating" refers to a failure to treat a person in a manner that conveys attention, respect, and understanding. Examples of an invalidating environment can range from mismatched personalities of children and parents (e.g., a shy child growing up in a family of extraverts who tease her about her shyness); to extremes of physical or emotional abuse. In DBT, we think that borderline personality disorder arises from the **transaction** between emotional vulnerability and the invalidating environment.

Back to the example of a shy child: If a shy child is teased by his siblings or forced to go into social situations he wants to avoid, he may learn to have tantrums to let others realize that he's scared. If his shyness is only taken seriously when he has an outburst, he learns (without being conscious of it) that tantrums work. He has not been "validated." In this case, forms of validation could have included telling the person that being shy is normal for some people, teaching him that shy people have to work harder to overcome social anxiety, or helping him learn skills for managing shyness so it does not interfere with his life.

Behavioral Tech, LLC • 2133 Third Ave., Ste. 205, Seattle, WA 98121 • Ph. (206) 675-8588 • Fax (206) 675-8590 • www.behavioraltech.org

This is a relatively benign example. Some individuals, however, grow up in situations where they are abused or neglected. They may learn more extreme ways of getting other people to take them seriously. Further, because they are in painful circumstances, they may learn to cope with emotional pain by thinking about suicide, cutting themselves, restricting their food intake, or using drugs and alcohol. A vicious cycle can get started: The person is really sad and scared, she has no one who listens to her, she is afraid to ask for help or knows no help is available, and so she tries to kill herself. Then, when her pain is treated seriously at the hospital, she learns (without being conscious of it) that when she's suicidal, other people understand how badly she feels. Repeated self-injury can result if it is seen as the only means for getting better or achieving understanding from other people.

What kind of therapy do clients receive in DBT?

Clients in standard DBT* receive three main modes of treatment – individual therapy, skills group, and phone coaching. In individual therapy, clients receive once weekly individual sessions that are typically an hour to an hour-and-a half in length. Clients also must attend a two-hour weekly skills group for at least one year. Unlike with regular group psychotherapy, these skills groups emerge as classes during which clients learn four sets of important skills – Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. Clients are also asked to call their individual therapists for skills coaching **prior** to hurting themselves. The therapist then walks them through alternatives to self-harm or suicidal behaviors.

It should be noted that in standard DBT, it is the individual therapist who is "in charge" of the treatment. This means it is the individual therapist's job to coordinate the treatment with the other people – skills group leaders, psychiatrists, and vocational counselors. In collaboration with the client, the therapist keeps track of how the treatment is going, how things are going with everyone involved in the treatment, and whether or not the treatment is helping the client reach his or her goals.

In some situations, DBT clients may also be on medications for problems like major depression bipolar disorder, are transient (short-term) psychotic episodes.

What are the top targets and goals of treatment in DBT?

The most important of the overall goals in DBT is helping clients create "lives worth living." What makes a life worth living varies from client to client. For some clients, a life worth living is getting married and having kids. For others, it's finishing school and finding a life partner. Others might find it's joining a religious or spiritual group and buying a house near a place of worship. While all these goals will differ, all clients have in common the task of bringing problem behaviors, especially behaviors that could result in death, under control. For this reason, DBT organizes treatment into four stages with targets. Targets refer to the problems being addressed at any given time in therapy. Here are the four stages with targeted behaviors in DBT:

Stage I: Moving from Being Out of Control of One's Behavior to Being in Control

Target 1: Reduce and then eliminate life-threatening behaviors (e.g., suicide attempts, suicidal thinking, intentional self-harm).

Target 2: Reduce and then eliminate behaviors that interfere with treatment (e.g., behavior that "burns out" people who try to help, sporadic completion of homework assignments, non-attendance of sessions, non-collaboration with therapists, etc.). This target includes reducing and then eliminating the use of hospitalization as a way to handle crises.

---

* "Standard" refers to outpatient DBT as it is researched and developed at Dr. Linehan's research lab.

Behavioral Tech, LLC • 2133 Third Ave., Ste. 205, Seattle, WA 98121 • Ph. (206) 675-8588 • Fax (206) 675-8590 • www.behavioraltech.org

Target 3: Decreasing behaviors that destroy the quality of life (e.g., depression, phobias, eating disorders, non-attendance at work or school, neglect of medical problems, lack of money, substandard housing, lack of friends, etc.) and increasing behaviors that make a life worth living (e.g., going to school or having a satisfying job, having friends, having enough money to live on, living in a decent apartment, not feeling depressed and anxious all the time, etc.).

Target 4: Learn skills that help people do the following:

a) Control their attention, so they stop worrying about the future or obsessing about the past. Also, increase awareness of the "present moment" so they learn more and more about what makes them feel good or feel bad.
b) Start new relationships, improve current relationships, or end bad relationships.
c) Understand what emotions are, how they function, and how to experience them in a way that is not overwhelming.
d) Tolerate emotional pain without resorting to self-harm or self-destructive behaviors.

Stage II. Moving from Being Emotionally Shut Down to Experiencing Emotions Fully

The main target of this stage is to help clients experience feelings without having to shut down by dissociating, avoiding life, or having symptoms of post-traumatic stress disorder (PTSD). In DBT, we say that clients entering this stage are now in control of their behavior but are in "quiet desperation." Teaching someone to suffer in silence is not the goal of treatment. In this stage, the therapist works with the client to treat PTSD and/or teaches the client to experience all of his or her emotions without shutting the emotions down and letting the emotions take the driver's seat.

Stage III. Building an Ordinary Life, Solving Ordinary Life Problems

In Stage III, clients work on ordinary problems like marital or partner conflict, job dissatisfaction, career goals, etc. Some clients choose to continue with the same therapist to accomplish these goals. Some take a long break from therapy and work on these goals without a therapist. Some decide to take a break and then work with a different therapist in a different type of therapy.

Stage IV. Moving from Incompleteness to Completeness/Connection

Most people may struggle with "existential" problems despite having completed therapy at the end of stage III. Even if they have the lives they wanted, they may feel somewhat empty or incomplete. Some people refer to this as "spiritual dryness" or "an empty feeling inside." Although research on this stage is lacking, Marsha Linehan added it after realizing that many clients go on to seek meaning through spiritual paths, churches, synagogues, or temples. Clients would also change their career paths or relationships.

Although these stages of treatment and target priorities are presented in order of importance, we believe they are all interconnected. If someone kills herself, she won't get the help that she needs to change the quality of her life. Therefore, DBT focuses on life threatening behavior first. However, if the client is staying alive but is neither coming to therapy nor doing the things required in therapy, she won't get the help needed to solve non-life threatening problems like depression or substance abuse. For that reason, treatment-interfering behaviors are the second priority in stage I. But coming to treatment is certainly not enough. A client stays alive and comes to therapy in order to solve the other problems which are making her miserable. To truly have a life worth living, the client must learn new skills, learn to experience emotions, and accomplish ordinary life goals. Therapy is not finished until all of this is accomplished.

How is DBT different from regular Cognitive Behavioral Therapy?

Behavioral Tech, LLC • 2133 Third Ave., Ste. 205, Seattle, WA 98121 • Ph. (206) 675-8588 • Fax (206) 675-8590 • www.behavioraltech.org

DBT is a modification of standard cognitive behavioral treatment. As briefly stated above, Marsha Linehan and her team of therapists used standard CBT techniques, such as skills training, homework assignments, symptom rating scales, and behavioral analysis in addressing clients' problems. While these worked for some people, others were put off by the constant focus on change. Clients felt the degree of their suffering was being underestimated, and that their therapists were overestimating how helpful they were being to their clients. As a result, clients dropped out of treatment, became very frustrated, shut down or all three. Linehan's research team, which videotaped all their sessions with clients, began to notice new strategies that helped clients tolerate their pain and worked to make a "life worth living." As acceptance strategies were added to the change strategies, clients felt their therapists understood them much better. They stayed in treatment instead of dropping out, felt better about their relationships with their therapists, and improved faster.

The balance between acceptance and change strategies in therapy formed the fundamental "dialectic" that resulted in the treatment's name. "Dialectic" means 'weighing and integrating contradictory facts or ideas with a view to resolving apparent contradictions.' In DBT, therapists and clients work hard to balance *change* with *acceptance*, two seemingly contradictory forces or strategies. Likewise, in life outside therapy, people struggle to have balanced actions, feelings, and thoughts. We work to integrate both passionate feelings and logical thoughts. We put effort into meeting our own needs and wants *while* meeting the needs and wants of others who are important to us. We struggle to have the right mix of work and play.

In DBT, there are treatment strategies that are specifically dialectical; these strategies help both the therapist and the client get "unstuck" from extreme positions or from emphasizing too much change or too much acceptance. These strategies keep the therapy in balance, moving back and forth between acceptance and change in a way that helps the client reach his or her ultimate goals as quickly as possible.

THE THREE FUNDAMENTALS OF DBT: CBT, ACCEPTANCE, AND DIALECTICS

1) Cognitive Behavioral Therapy

CBT and DBT therapists do not think that clients can be helped through insightful discussions, although insight can be helpful at times. *Learning new behaviors* is critical in DBT and is a focus in *every* individual session, skills group or phone call (for coaching). "Behavior" refers to anything a person thinks, feels, or does. Cognitive behavioral therapy uses a wide variety of techniques to help people change behaviors that inhibit a "life worth living." In DBT, as in CBT, clients are asked to change. Clients track and record their problem behaviors with a weekly diary card. They also attend skills groups, complete homework assignments and role-play new ways of interacting with people when in session with their therapist. In addition, clients work with their therapist to identify how they are rewarded for maladaptive behavior or punished for adaptive behavior. They expose themselves to feelings, thoughts or situations that they feared and avoided, and they change self-destructive ways of thinking. What we have just described in layman's terms are the four main change strategies: Skills Training, Exposure Therapy, Cognitive Therapy, and Contingency Management.

A great book on one main technique in behavior therapy – contingency management – is Karen Pryor's *Don't Shoot the Dog* (Bantam Books). Karen Pryor is a dolphin trainer who opened Hawaii's first ocean park. The principles an animal behaviorist like Pryor uses to teach animals are the same principles we can use with ourselves to change ourselves and make our relationships better. Karen Pryor's book is fun, humane, and easy to understand. Contrary to popular belief, behavior therapy is not cold and technical. Rather, at its best, it is about learning to change while treating ourselves and each other with respect and kindness. If you read this book (and it can be read in an evening), you'll know a lot more about how one of the main strategies cognitive behavioral therapy works. You can also take a lot of the techniques and apply them to your life at home, work, or school.

2) Validation (Acceptance)

Behavioral Tech, LLC • 2133 Third Ave., Ste. 205, Seattle, WA 98121 • Ph. (206) 675-8588 • Fax (206) 675-8590 • www.behavioraltech.org

As we noted in the above paragraphs, cognitive behavioral therapy techniques were not enough to help clients who were suicidal and chronically self-harming in the context of Borderline Personality Disorder (BPD). It's not that the techniques were ineffective; it's just that as stand-alone interventions, they caused clients a great deal of distress. Clients found the pushing for change *invalidating*. In a simple example, it's as if therapists were saying to someone with severe burns on the soles of their feet, "just keep walking and your feet will get stronger...try not to think about the pain," though each step was excruciatingly painful, and the patient was depressed and had no experience with keeping her mind off severe pain.

Linehan and her research team discovered that when the therapist weaved an emphasis on validation with an equal emphasis on change, clients were more likely to be collaborative and less likely to become agitated and withdrawn. So what is validation? It means a number of things. One of the things it does not mean, necessarily, is agreement. For instance, a therapist could understand that a client abuses alcohol to overcome intensive social anxiety, and yet realize that when the client is drunk, he makes impulsive decisions that may lead to self-harm. The therapist could validate that: a) her behavior makes sense as the only way she's ever gotten her anxiety to go down; b) her parents always got drunk at parties; and c) sometimes when she's drunk and does something impulsive, the impulsive behavior can be "fun." In this case, the therapist can validate that the substance abuse makes sense, given the client's history and point of view. But the therapist does not have to agree that abusing alcohol is the best approach to solving the client's anxiety.

In DBT, there are several levels and types of validation. The most basic level is staying alert to the other person. This means being respectful to what she is saying, feeling, and doing. Other levels of validation involve helping the client regain confidence both by assuming that her behavior makes perfect sense (e.g. of course you're angry at the store manager because he tried to overcharge you and then lied about it) and by treating the other person as an equal (i.e., as opposed to treating her like a fragile mental patient).

In DBT, just as clients are taught to use cognitive behavioral strategies, they are also taught and encouraged to use validation. In treatment and in life, it is important to know what about ourselves we can change and what about ourselves we must accept (whether short term or the long term). For that reason, acceptance and validation skills are taught in the skills modules as well.

There are four skills modules all together - two emphasize change and two emphasize acceptance. For example, it is extremely important that clients who self-harm learn to accept the experience of pain instead of turning to self-destructive behavior to solve their problems. Likewise, clients who cut themselves, binge and purge, abuse alcohol and drugs, dissociate, etc., must learn to simply "be with" reality, as painful as it may be at any given moment, in order to learn that they "can stand it." DBT teaches a host of skills so that clients can learn to stand still instead of running away. DBT also teaches clients how to work to understand why their lives are so hard.

3) Dialectics

"Dialectics" is a complex concept that has its roots in philosophy and science. We won't go into its background here but we will attempt to explain what we mean by dialectics and give examples of thinking dialectically. "Dialectics" involves several assumptions about the nature of reality: 1) every thing is connected to everything else; 2) change is constant and inevitable; and 3) opposites can be integrated to form a closer approximation to the truth (which is always evolving). Here's a brief example about how these assumptions would come into play in a DBT program. Suppose you are silent in groups. The other group members are affected by your silence and they try to get you to talk. You affect them and they affect you. Perhaps the group pushes you so hard that you feel like quitting and you talk even less. Then the other members get tired of your silence and withdraw. Paradoxically, this makes you feel better and causes you to talk a bit more. As you become a true member of the group, the leaders shift the way they run the group in order to manage the tension between you and the other members. In other words, you are all interconnected, influencing each other in each moment.

As time passes in the group, there are inevitable changes. Perhaps the group becomes more skilled at getting you to talk. Perhaps you take some risks and talk more. Maybe a new member enters the group while an older

Behavioral Tech, LLC • 2133 Third Ave., Ste. 205, Seattle, WA 98121 • Ph. (206) 675-8588 • Fax (206) 675-8590 • www.behavioraltech.org

member of the community transitions out and the group struggles to adjust to the new arrangement. You also may become aware that your thoughts and feelings change throughout the group, as does every other group member's. You notice that the group is constantly evolving, constantly readjusting itself. Thinking dialectically means recognizing that all points of view—yours, the other members – have validity and yet all may also be wrong-headed at the same time. If the group is working together dialectically, the group leaders and the members are in constant flux, looking at how opposing points of view can be in play and yet be synthesized. In short, the group is always balancing change and acceptance. Throughout, the group leader and the members would try to hold on to the idea that everyone is doing the best he or she can AND that everyone has got to do better.

DBT also involves specific dialectical strategies to help clients get "unstuck" from rigid ways of thinking or viewing the world. Some of these are traditional Western therapy interventions and others draw on Eastern ways of viewing life. If you read Linehan's (1993a) text, you can read about these strategies in chapter seven and review the examples she gives. But here are two examples. Suppose a client makes a strong initial commitment to do a year's worth of DBT. Rather than simply saying "Hey, that's terrific!" the therapist would gently turn the tables on the client by asking, "Are you sure you want to? It's going to be very hard work." This strategy, called "Devil's advocate," causes the client to argue in favor of why and how she will complete the therapy and not drop out. In this case, the therapist guides the client to strengthen her (the client's) arguments for being accepted into treatment, rather than the therapist trying to convince her to stay. "Making Lemonade out of Lemons," another strategy, also helps the clinician handle similarly tough situations. For instance, a client may complain that she absolutely hates her group therapist and wants to switch skills groups. The therapist might respond with an opposing suggestion: This can be seen as a learning opportunity in handling intense negative emotions towards authority. The therapist could then show the similarity between the client's group therapist and other persons of authority (teachers, bosses, supervisors), and demonstrate this as a chance to tolerate a person one can't stand but has to work with. As these examples illustrate, the point of all dialectical strategies is to provide movement, speed, and flow so that therapist and client do not become stuck in "I will not do that" vs. "Oh, yes you will!"

Suggested Reading

Linehan, M.M. (1993a). Cognitive behavioral therapy for Borderline Personality Disorder. New York: Guilford Press. *This is the published treatment manual for the entire treatment. Many lay-people say this is a difficult read, though very helpful. For that reason, many start by reading the skills manual listed next.*

Linehan, M. M. (1993b). Skills Training Manual for Treating Borderline Personality Disorder. New York: Guilford Press. *This manual gives an excellent overview of DBT and the skills-training in the program.*

Pryor, K. (1993). Don't Shoot the Dog! New York: Bantam Doubleday Dell Pub. *This is a great introduction to principles of learning and behaviorism by a dolphin trainer. Her techniques apply to all of us.*

Behavioral Tech, LLC • 2133 Third Ave., Ste. 205, Seattle, WA 98121 • Ph. (206) 675-8588 • Fax (206) 675-8590 • www.behavioraltech.org

Exhibit 13

New Employ Orientation

Times	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 - 9:00	**Welcome (H/CEO)** Organization Intro President's Message	**Clinical Philosophy (C)**	**Building Bridges Initiative (C)**	**Handle with Care (M)**	**Competency Review (H)** HR Paperwork Preparing for Day 1 Record of Signature Survey
9:00 - 10:00	**Employee Engagement (H)** Health Insurance Compensation	**Therapeutic Services (C)** Behavioral Management Video	**Clinical Program (C)** Admissions Client Rights/IC/AD Crisis Intervention Plan (Seven Challenges)		
	Break	Break	Break		Break
10:15 – 11:15	**Benefits (H)** Team Bonus	**Therapeutic Services** Suicide Prevention-Video Age & Cultural Diversity Common Disorders	**Clinical Program (M)** GEARS Resident Handbook		**Unit Specific Training** / **Time Keeping**
11:15-12:00	**Customer Service (H)** Dress Code-Badge Community Partners Workforce Support				
12:00-1:00	Lunch	Lunch	Lunch	Lunch	Lunch
1:00-2:15	**Compliance (R)** Client Rights QAPI/EMTALA/HIPAA Employee Handbook Code of Conduct Sexual Harassment	**Therapeutic Milieu (M)** Tools to Develop a Milieu	**Clinical Program (C)** Therapeutic Boundaries	**Handle with Care** Verbal	**CPR/First Aid**
2:15-3:15	**Emergency Preparedness (E)** Safety/Security/OSHA SDS/PPE/Waste Emergency Codes/Fire Safety	**Safety (N/M/C)** Abuse & Neglect	**Health (N)** Health & Medication Extrapyramidal SE & TD Nutrition Allergies		
	Break	Break	Break		
3:30-4:30	**Environment of Care (E)** Tour facility	**Safety (N)** S/R Prevention *Debriefing*	**Employee Health (N)** Blood Borne Pathogens *Infection Control*		
4:30-5:00	Daily Competency	Daily Competency	Daily Competency	Daily Competency	Wrap-Up

Facilitator Codes: A-Admissions; C-Clinical; E-Environment of Care; H-Human Resources; M-Milieu; N-Nursing; R-Risk Management

STRATEGIC BEHAVIORAL HEALTH, LLC

New Employee Orientation

Times	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 – 8:30	**Morning Review**	**Morning Review**	**Morning Review**	**Morning Review**	**Morning Review**
8:30 - 10:00	**All Staff** **Behavioral Management** **Video Review** **Language**	**All Staff** Scenarios "Do you smell smoke?"	**All Staff** Scenarios "I thought you did it?"	**Department Training**	**Department Training**
	Break	**Break**	Break	Break	Break
10:15 – 12:00	**All Staff Training** **Schedule Review** **Wake-Up** **Hygiene & Meds** **Breakfast** **Town Hall**	**All Staff Training** **Town Hall** **Dinner** **Psych-Ed** **Transportation**	**Department Training**	**Department Training**	**Department Training**
12:00-1:00	Lunch	Lunch	Lunch	Lunch	Lunch
1:00- 4:30	Education Community Group Lunch Process Group Snack Fitness Journaling	Visitation Phone Call Family Involvement Wrap-Up Hygiene Lights Out Night Shift	**Department Training**	**Department Training**	**Department Training**
4:30-5:00	Wrap-Up	Wrap-Up	Wrap-Up	Wrap-Up	Wrap-Up

Facilitator Codes: A-Admissions; C-Clinical; E-Environment of Care; H-Human Resources; M-Milieu; N-Nursing; R-Risk Management

STRATEGIC BEHAVIORAL HEALTH, LLC

New Employee Orientation

Times	Thursday	Friday
8:00 – 8:30	**Morning Review**	**Morning Review**
8:30 - 10:00	**All Staff** Scenarios "I thought you did it?"	**Nursing Department Training** Chart Review Logs Notes
	Break	Break
10:15 – 12:00	**Nursing Department Training** Admissions Process	Incident Reports Assessment
12:00-1:00	Lunch	Lunch
1:00- 4:30	Medication	Discharge Process
4:30-5:00	Wrap-Up	Wrap-Up

Facilitator Codes: A-Admissions; C-Clinical; E-Environment of Care; H-Human Resources; M-Milieu; N-Nursing; R-Risk Management

STRATEGIC BEHAVIORAL HEALTH, LLC

New Employ[illegible]rientation

Times	Thursday	Friday
8:00 – 8:30	**Morning Review**	**Morning Review**
8:30 - 10:00	**All Staff** Scenarios "I thought you did it?"	**Therapy Department Training** Groups: Process, Psycho-Ed, Individual
		Break
10:15 – 12:00	**Therapy Department Training** Therapist Manual	Family sessions
12:00-1:00	Lunch	**Lunch**
1:00- 4:30	Therapist Manual	Discharge Planning
4:30-5:00	Wrap-Up	Wrap-Up

Facilitator Codes: A-Admissions; C-Clinical; E-Environment of Care; H-Human Resources; M-Milieu; N-Nursing; R-Risk Management

STRATEGIC BEHAVIORAL HEALTH, LLC

New Employee Orientation

Times	Thursday	Friday
8:00 – 8:30	**Morning Review**	**Morning Review**
8:30 - 10:00	**All Staff** Scenarios "I thought you did it?"	**Milieu Department Training** Review
	Break	Break
10:15 – 12:00	**Milieu Department Training** Activity Groups Monitoring: Gym, Outside, Classroom, Halls, Appointments, Visits, Calls Transportation Visitation	Environment set-up for residents Staff work schedule Walkie-Talkie Use & Maintenance Bin Room Contraband Band Laundry
12:00-1:00	Lunch	**Lunch**
1:00- 4:30	Transitions Room Search: Daily & Random Shift Report 15 Minute Checks Levels of Observation	Waste Basket Quiet Areas Safe Rooms Personal Belongings at discharge Room preparation
4:30-5:00	Wrap-Up	Wrap-Up

Facilitator Codes: A-Admissions; C-Clinical; E-Environment of Care; H-Human Resources; M-Milieu; N-Nursing; R-Risk Management

STRATEGIC BEHAVIORAL HEALTH, LLC

Exhibit 14

Acute Psychiatric Hospitals: Bed Rates						
Hospital Name	**Acute Child (under age of 13)**	**Acute Adolescent: 13 to 17)**	**Acute Adult (above age 18)**	**County, State**	**Bed Rate Per Diem**	**Comments**
Meritus Medical Center			X	Washington County, MD	$1,200	Requires admission to ER, psych assessment and clinical services billed as extra; 17 y.o. and above
MedStar Montgomery General		X	X	Montgomery County, MD	$1,416	Charge for admission to unit: $160
Suburban		X	X	Montgomery County, MD	$1,279	Admission through ED = $300 to $600; direct to unit admission: $226, assessment billed separately,
Calvert Memorial		X	X	Calvert County, MD	$1,086	
MedStar Franklin Square		X	X	Baltimore County, MD	$1,477	Admission via ED, assessment in ED is a separate charge. Admission fee: $265;
Carroll Hospital Center		X	X	Carroll County, MD	$1,500	If admitted through the ER, assessment is separate charge
Brook Lane Health Services	X	X	X	Washington County, MD	$1,000	

Acute Psychiatric Hospitals: Bed Rates						
Hospital Name	**Acute Child (under age of 13)**	**Acute Adolescent: 13 to 17)**	**Acute Adult (above age 18)**	**County, State**	**Bed Rate Per Diem**	**Comments**
Adventist Behavioral Rockville	X	X	X	Montgomery County, MD	$1,400	No information on separate related charges. Also has RTC as part of continuum
Sheppard Pratt Hospital System	X	X	X	Baltimore County, MD	$1000/day	No information on separate related charges. Has RTC beds.
Sheppard Pratt: Ellicott City	X	X	X	Howard County, MD	$1,000 per day room and board only	Does not include separate assessments. Several campuses - charges seem to be based on where admitted and if admitted through other programs.
Adventist Eastern Shore	X	X	X	Dorchester County, MD	$1,000	No information on separate related charges, billed separately. Has RTC beds
Children's Medical Ctr	X	X		Washington DC	$2475-$8000/day	Broad range -- based on level of care needed 50% off for self pay also charity care
PIW	X	X	X	Washington, DC	$900	MD costs, medications and assessments are not incldued in this rate.
Virginia Hospital Center		X		Fairfax County, VA	$813	MD costs, medications and assessments are not incldued in this rate.

Acute Psychiatric Hospitals: Bed Rates						
Hospital Name	**Acute Child (under age of 13)**	**Acute Adolescent: 13 to 17)**	**Acute Adult (above age 18)**	**County, State**	**Bed Rate Per Diem**	**Comments**
Snowden Hospital				Spottsylvannia County, VA	$2,000	Could not get additional information about related costs, but, was informed this is "bed rate only."
Yellow: Hospitals outside of the State of Maryland; Grey Highlight: RTC's with inpatient units						

Annual Report on Selected Maryland Acute Care and Special Hospital Services

Fiscal Year 2013

Effective July 1, 2012

MHCC
MARYLAND HEALTH CARE COMMISSION

Annual Report on Selected Maryland Acute Care and Special Hospital Services

Fiscal Year 2013

MHCC | MARYLAND HEALTH CARE COMMISSION

Center for Hospital Services

Table of Contents

Tables and Charts

Tables:

Charts:

Table 1. Licensed Acute Care Beds by Hospital and Service: Maryland, FY 2013

Jurisdiction/ Region	Hospital	Acute Care Services				
		MSGA	Obstetric	Pediatric	Psychiatric	Total
Allegany County	Western Maryland Regional Medical Center	201	9	4	20	234
Frederick County	Frederick Memorial Hospital	240	27	10	21	298
Garrett County	Garrett County Memorial Hospital	24	4	1	0	29
Washington County	Meritus Medical Center*	203	18	6	18	245
WESTERN MARYLAND TOTAL		**668**	**58**	**21**	**59**	**806**
Montgomery County	Holy Cross Hospital of Silver Spring	282	88	26	0	396
	MedStar Montgomery Medical Center	100	11	2	25	138
	Shady Grove Adventist Hospital	250	56	25	0	331
	Suburban Hospital	199	0	6	24	229
	Washington Adventist Hospital	191	21	0	40	252
MONTGOMERY COUNTY TOTAL		**1,022**	**176**	**59**	**89**	**1,346**
Calvert County	Calvert Memorial Hospital	75	8	1	11	95
Charles County	Civista Medical Center	94	12	4	0	110
Prince George's County	Doctors Community Hospital	207	0	0	0	207
	Fort Washington Medical Center	31	0	0	0	31
	Laurel Regional Hospital	53	10	0	14	77
	Prince George's Hospital Center	152	36	8	28	224
	Southern Maryland Hospital Center	180	30	4	25	239
	Total: Prince George's County	*623*	*76*	*12*	*67*	*778*
St. Mary's County	MedStar St. Mary's Hospital	60	12	6	12	90
SOUTHERN MARYLAND TOTAL		**852**	**108**	**23**	**90**	**1,073**
Anne Arundel County	Anne Arundel Medical Center	312	60	8	0	380
	Baltimore Washington Medical Center	265	18	10	14	307
	Total: Anne Arundel County	*577*	*78*	*18*	*14*	*687*
Baltimore City	Bon Secours Hospital	83	0	0	32	115
	James Lawrence Kernan Hospital	9	0	0	0	9
	Johns Hopkins Bayview Medical Center	308	17	10	20	355
	Maryland General Hospital	107	20	0	28	155
	MedStar Good Samaritan Hospital	224	0	0	0	224
	MedStar Harbor Hospital	130	25	5	0	160
	MedStar Union Memorial Hospital	208	0	2	26	236
	Mercy Medical Center	196	32	5	0	233
	Sinai Hospital of Baltimore	344	23	35	24	426
	St. Agnes Hospital	255	23	9	0	287
	The Johns Hopkins Hospital	717	35	140	108	1,000
	University of Maryland Hospital	656	30	58	56	800
	Total: Baltimore City	*3,237*	*205*	*264*	*294*	*4,000*
Baltimore County	Greater Baltimore Medical Center	202	60	8	0	270
	MedStar Franklin Square Hospital	285	37	9	24	355
	Northwest Hospital Center	211	0	0	14	225
	St. Joseph Medical Center	204	20	4	19	247
	Total: Baltimore County	*902*	*117*	*21*	*57*	*1,097*
Carroll County	Carroll Hospital Center	111	20	7	20	158
Harford County	Harford Memorial Hospital	62	0	0	27	89
	Upper Chesapeake Medical Center	166	12	3	0	181
	Total: Harford County	*228*	*12*	*3*	*27*	*270*
Howard County	Howard County General Hospital	189	34	6	20	249
CENTRAL MARYLAND TOTAL		**5,244**	**466**	**319**	**432**	**6,461**
Cecil County	Union Hospital of Cecil County	76	6	3	7	92
Dorchester County	Dorchester General Hospital	30	0	0	16	46
Kent County	Chester River Hospital Center	41	0	1	0	42
Somerset County	Edward W. McCready Memorial Hospital	5	0	0	0	5
Talbot County	Memorial Hospital at Easton	87	17	8	0	112
Wicomico County	Peninsula Regional Medical Center	279	20	8	10	317
Worcester County	Atlantic General Hospital	48	0	0	0	48
EASTERN SHORE TOTAL		**566**	**43**	**20**	**33**	**662**
MARYLAND TOTAL		**8,352**	**851**	**442**	**703**	**10,348**

Source: Maryland Health Care Commission, Acute Care Hospital Inventory (ACHI) FY2013.

Table 27. Licensed Comprehensive Care Facility Beds at Acute Care Hospitals, Maryland, June 1. 2012

Jurisdiction/ Region	Hospital	Licensed Comprehensive Care Facility Beds	Staffed Beds
Garrett County	Garrett County Memorial Hospital	10	10
Western Maryland Total		***10***	***10***
Calvert County	Calvert Memorial Hospital	18	14
Prince George's County	Southern Maryland Hospital Center	24	24
Southern Maryland Total		***42***	***38***
Baltimore City	Johns Hopkins Bayview Medical Center	80	54
	MedStar Good Samaritan Hospital	30	30
	Mercy Medical Center	29	29
Baltimore County	Greater Baltimore Medical Center	25	25
	Northwest Hospital Center	29	29
Central Maryland Total		***193***	***167***
Wicomico County	Peninsula Regional Medical Center	30	30
Eastern Shore Total		***30***	***30***
Maryland Total - Acute Care Hospitals		***275***	***245***

Source: Maryland Health Care Commission, Office of Health Care Quality

Table 28. Licensed Comprehensive Care Facility Beds at Special Hospitals June 1, 2012

Jurisdiction/ Region	Hospital	Licensed Comprehensive Care Facility Beds	Staffed Beds
Wicomico County/ Eastern Shore	Deer's Head Center	80	60
Baltimore City/ Central Maryland	Levindale Hebrew Geriatric Center & Hospital	172	172
Washington County/ Western Maryland	Western Maryland Center	60	23
Maryland State Total		***312***	***255***

Source: Maryland Health Care Commission, Office of Health Care Quality, DHMH, Hospital Management System

Psychiatric Hospital Facilities and Services

In Maryland, two types of hospital-level inpatient psychiatric services are provided; acute psychiatric services and longer-term, continuing care. Most acute inpatient psychiatric care is provided within the acute care general hospital setting at 28 acute care general hospitals. These psychiatric beds are included in the annual "dynamic" licensure process for all acute care beds located in acute care general hospitals in which the licensed acute care bed inventory is based on recorded average daily census. Hospital-level psychiatric inpatient care outside of the acute care general hospital setting can be found in freestanding private hospitals or in state hospitals. The psychiatric beds in these two facility types are licensed as a category of "special hospital" beds under the State's licensing statute. Freestanding private psychiatric hospitals

primarily provide acute psychiatric inpatient services. State psychiatric hospitals primarily provide long-term, continuing care psychiatric inpatient services.

Table 29 provides an overview of the acute psychiatric inpatient service bed capacity and program characteristics of general acute care hospitals. In general, services for children are provided to a patient population under the age of 13 years, adolescent services are provided to patients aged 13 to 17, and adult services are provided to patients aged 18 years and older.

Table 29. Inpatient Acute Psychiatric Services Available at General Acute Care Hospitals: Maryland, FY 2013

Jurisdiction/ Region		Designated FY 2013 Licensed	Acute Adult	Acute Child	Acute Adolescent	Acute Geriatric	Accept Involuntary Patients
Allegany County	Western Maryland Regional Medical Center*	20	√			√	√
Frederick County	Frederick Memorial Hospital	21	√			√	√
	Meritus Medical Center*	18	√		√	√	√
	Western Maryland Total	***59***					
Montgomery County	MedStar Montgomery General Hospital	25	√		√	√	No
	Suburban Hospital	24	√		√	√	No
	Washington Adventist Hospital	40	√			√	√
	Montgomery County Total	***89***					
Calvert County	Calvert Memorial Hospital	11	√		√		√
Prince George's County	Laurel Regional Hospital	14	√			√	No
	Prince George's Hospital Center	28	√			√	√
	Southern Maryland Hospital Center	25	√			√	√
St. Mary's County	MedStar St. Mary's Hospital	12	√				√
	Southern Maryland Total	***90***					
Anne Arundel County	Baltimore Washington Medical Center	14	√				√
Baltimore City	Bon Secours Hospital	32	√				√
	Johns Hopkins Bayview Medical Center	20	√				No
	Maryland General Hospital	28	√				√
	MedStar Union Memorial Hospital	26	√				√
	Sinai Hospital of Baltimore	24	√			√	√
	The Johns Hopkins Hospital	108	√	√			√
	University of Maryland Medical Center	56	√	√		√	√
Baltimore County	MedStar Franklin Square Hospital	24	√		√		√
	Northwest Hospital	14	√			√	√
	St. Joseph Hospital	19	√				No
Carroll County	Carroll Hospital Center	20	√		√		√
Harford County	Harford Memorial Hospital	27	√				√
Howard County	Howard County General Hospital	20	√				√
	Central Maryland Total	***432***					
Cecil County	Union Hospital of Cecil County	7	√			√	√
Dorchester County	Dorchester General Hospital	16	√				√
Wicomico County	Peninsula Regional Medical Center	10	√				√
	Eastern Shore Total	***33***					
	Maryland State Total	***703***					

Source: Maryland Health Care Commission survey of psychiatric services capacity, June, 2012. *Western Maryland Regional Medical Center replaces Braddock Hospital.
Note: Western Maryland Regional Medical Center, Washington County Hospital, and Howard County General report that adolescents (defined as 16+) may be provided services in the same section as adults. Suburban combines adolescents (13+), adults and geriatric in a combined unit. Adult and Geriatric units are combined at Frederick Memorial, Laurel Regional, Prince George's Hospital, Sinai, Northwest, and St. Joseph's Hospital.

Tables 30 and 31 profile psychiatric inpatient service capacity and inpatient program characteristics at Special Hospitals – Psychiatric. Table 30 identifies the licensed bed capacity and the number of reported regularly staffed beds at Maryland's five freestanding private psychiatric hospitals. Table 31 identifies the number of licensed beds and "budgeted" beds, at Maryland's five state-operated psychiatric hospitals. The number of "budgeted" beds provides a more accurate reflection of the bed capacity that is typically set up and staffed at these facilities than the number of licensed beds.

Table 30. Inpatient Services Available at Private Special Hospitals - Psychiatric: Maryland, June 1, 2012

Hospital	Jurisdiction	Region	Licensed Capacity	Staffed Beds	Acute Adult	Acute Child	Acute Adolescent	Acute Geriatric	Accept Involuntary Patients
Brook Lane Health Services	Washington County	Western Maryland	65	42	√	√	√		√
Adventist Behavioral Health Rockville*	Montgomery County	Montgomery County	107	106	√	√	√		√
Sheppard and Enoch Pratt Hospital	Baltimore County	Central Maryland	322	260	√	√	√	√	√
Sheppard Pratt at Ellicott City	Howard County	Central Maryland	92	76	√		√		√
Adventist Behavioral Health Eastern Shore*	Dorchester County	Eastern Shore	15	15		√	√		No
		Maryland State Total	***601***	***499***					

Source: Maryland Health Care Commission Survey: Special Hospitals - Psychiatric, June 1, 2012

* Adventist Behavioral Health Rockville and Adventist Behavioral Health Eastern Shore were previously Potomac Ridge Behavioral Health Center and Potomac Ridge Behavioral Health Center Eastern Shore.

Table 31. Inpatient Psychiatric Services Provided at State Special Hospitals - Psychiatric* Maryland, June 1, 2012

Jurisdiction/ Region	Special Hospital Name	Licensed Psychiatric Beds	Budgeted Psychiatric Beds	Acute Adult	Acute Child	Acute Adolescent	Acute Geriatric	Acute Forensic	Accept Involuntary Patients
Allegany County	Thomas B. Finan Center	80	66					√	√
	Western Maryland Total	***80***	***66***						
Baltimore County	Spring Grove Hospital Center	639	351	√		√	√	√	√
Carroll County	Springfield Hospital Center	522	220	√			√		√
Howard County	Clifton T. Perkins Hospital Center	250	247					√	√
	Central Maryland Total	***1,411***	***818***						
Dorchester County	Eastern Shore Hospital Center	80	60	√			√	√	√
	Eastern Shore Total	***80***	***60***						
	Maryland State Total	***1,571***	***944***						

Source: Maryland Health Care Commission Survey: Special Hospitals - Psychiatric, June 1, 2011. Licensed and budgeted bed totals include both acute and continuing care psychiatric beds.

Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) for psychiatric patients are also provided in the acute care general hospital setting and the special hospital setting. PHPs and IOPs are organized day or night programs providing assessment, treatment, habilitation, or rehabilitation services for persons who do not require psychiatric inpatient care on a 24-hour basis. This may be a structured, ongoing program that the patient typically attends 2 to 5 times a week for 2 to 5 hours per day providing clinical behavioral health services. The plan of care is prescribed by and overseen by a psychiatrist. PHPs may be used as a "step-down" from inpatient care or a "step-up" from less intensive outpatient programming and are sometimes called "day hospital" programs. Services are usually provided in a group setting for at least 4 hours of direct clinical care per day, with additional individual and/or family therapy and medication management as needed. IOPs are a subset of PHPs and would typically involve fewer sessions per week and/or fewer hours per daily session. IOPs may be used as a "step-down" from PHPs or a "step-up" from less intensive outpatient care outside of the institutional setting.

MHCC surveyed the availability of PHPs and IOPs at hospitals, requesting information on the maximum number of treatment "slots" available and the daily program census on four specific dates between September, 2011 and June, 2012. Tables 32 and 33 profile these programs as offered in 23 acute care general hospitals and five freestanding private psychiatric hospitals, respectively. State-operated psychiatric hospitals do not provide PHP or IOP services. [NOTE: Average daily census is

Exhibit 15

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Memphis, Tennessee

Consolidated Financial Statements –
Modified Cash Basis
Years Ended December 31, 2013 and 2012

CONTENTS

HORNE
CPAs & Business Advisors

INDEPENDENT AUDITOR'S REPORT

Members
Strategic Behavioral Health, LLC
Memphis, Tennessee

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Strategic Behavioral Health, LLC and Subsidiaries (the "Company"), which comprise the consolidated statements of assets, liabilities and members' equity on a modified cash basis as of December 31, 2013 and 2012, and the consolidated statements of revenue and expenses, changes in members' equity and cash flows on a modified cash basis for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with the modified cash basis of accounting described in Note 1; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the consolidated financial statements in the circumstances. Management is also responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk

assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the assets, liabilities and members' equity of the Company as of December 31, 2013 and 2012, and its revenues and expenses, changes in members' equity and cash flows for the years then ended in accordance with the modified cash basis of accounting described in Note 1.

Basis of Accounting

We draw attention to Note 1 of the consolidated financial statements, which describes the basis of accounting. The consolidated financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinions are not modified with respect to this matter.

Hayne LLP

Memphis, Tennessee
May 22, 2014

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Assets, Liabilities and Members' Equity -
Modified Cash Basis
December 31, 2013 and 2012

	2013	2012
ASSETS		
Current assets		
Cash and cash equivalents	$ 2,271,076	$ 2,820,508
Patient accounts receivable, net of allowance for doubtful accounts of $2,544,167 at 2013 and $915,540 at 2012	13,593,272	8,195,262
Due from third-party payors	215,868	-
Inventories	86,741	67,931
Prepaid expenses	1,221,325	741,435
Total current assets	17,388,282	11,825,136
Property and equipment	73,426,065	48,843,897
Less accumulated depreciation	(4,331,553)	(2,181,981)
Property and equipment, net	69,094,512	46,661,916
Goodwill	45,326,774	28,616,112
Other assets, net	1,470,620	1,080,521
Total other assets	46,797,394	29,696,633
Total assets	$ 133,280,188	$ 88,183,685
LIABILITIES AND MEMBERS' EQUITY		
Current liabilities		
Current maturities of long-term debt	$ 3,072,422	$ 1,703,039
Accounts payable	3,294,809	923,373
Accrued expenses	4,694,081	2,963,365
Due to third-party payors	-	308,918
Accrued distributions to members	155,942	439,396
Total current liabilities	11,217,254	6,338,091
Long-term debt, less current maturities	65,527,959	40,739,559
Total liabilities	76,745,213	47,077,650
Members' equity		
Members' contributions	45,915,034	36,915,034
Note receivable for members' contributions	(161,878)	(71,616)
Retained earnings	10,781,819	4,262,617
Total members' equity	56,534,975	41,106,035
Total liabilities and members' equity	$ 133,280,188	$ 88,183,685

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Revenues and Expenses -
Modified Cash Basis
Years Ended December 31, 2013 and 2012

	2013	2012
Revenues		
Patient service revenue (net of contractual allowances and discounts)	$ 84,341,797	$ 50,630,683
Provision for bad debts	(3,849,410)	(748,305)
Net patient service revenue, less provisions for bad debts	80,492,387	49,882,378
Expenses		
Salaries and benefits	47,238,842	28,084,047
Professional fees	6,129,697	3,204,772
Supplies	4,669,356	2,632,128
Management and incentive fees	754,517	1,030,560
Depreciation and amortization	2,169,598	1,211,918
Rent	967,683	880,575
Utilities	1,264,783	900,441
Insurance	618,143	409,614
Interest	2,693,906	1,604,292
Property tax	547,463	269,646
Travel	949,598	618,461
Acquisition costs	619,877	51,263
Other expenses	2,903,656	1,752,063
Total expenses	71,527,119	42,649,780
Excess of revenues over expenses - modified cash basis	$ 8,965,268	$ 7,232,598

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Changes in Members' Equity - Modified Cash Basis
Years Ended December 31, 2013 and 2012

	Members' Contributions	Note Receivable for Members' Contributions	Retained Earnings (Deficits)	Total
Balance, January 1, 2012	$ 31,915,034	$ (76,616)	$ (684,519)	$ 31,153,899
Excess of revenues over expenses - modified cash basis	-	-	7,232,598	7,232,598
Contributions	5,000,000	-	-	5,000,000
Payment on note receivable from member	-	5,000	-	5,000
Distributions to members	-	-	(2,285,462)	(2,285,462)
Balance, December 31, 2012	36,915,034	(71,616)	4,262,617	41,106,035
Excess of revenues over expenses - modified cash basis	-	-	8,965,268	8,965,268
Contributions	9,000,000	-	-	9,000,000
Issuance of note receivable from members	-	(103,185)	-	(103,185)
Payment on note receivable from members	-	12,923	-	12,923
Distributions to members	-	-	(2,446,066)	(2,446,066)
Balance, December 31, 2013	$ 45,915,034	$ (161,878)	$ 10,781,819	$ 56,534,975

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Cash Flows - Modified Cash Basis
Years Ended December 31, 2013 and 2012

	2013	2012
Cash flows from operating activities		
Excess of revenues over expenses - modified cash basis	$ 8,965,268	$ 7,232,598
Adjustments to reconcile excess of revenues over expenses (modified cash basis) to net cash provided by operating activities		
Depreciation and amortization	2,169,598	1,211,918
Amortization of debt issue costs	203,496	97,775
Provision for bad debts	3,849,410	748,305
Change in assets and liabilities		
Patient accounts receivable	(6,857,732)	(4,073,999)
Due from third-party payors	(524,786)	(308,918)
Inventories	1,859	3,263
Prepaid expenses	(455,713)	(138,945)
Other assets	(109,971)	-
Accounts payable	2,286,127	(216,607)
Accrued expenses	1,442,932	1,785,559
Net cash provided by operating activities	10,970,488	6,340,949
Cash flows from investing activities		
Acquisitions of property and equipment	(18,613,606)	(16,611,128)
Acquisition of SBH-El Paso, LLC	(24,764,177)	-
Reduction of acquisition price	-	195,501
Net cash used by investing activities	(43,377,783)	(16,415,627)
Cash flows from financing activities		
Debt proceeds received	77,030,626	7,915,203
Repayment of long-term debt	(50,872,843)	(1,334,616)
Cash contributions from members	8,896,815	5,000,000
Payments of debt issuance costs	(482,874)	(416,810)
Proceeds received on members' note receivable for contributions	12,923	5,000
Cash distributions to members	(2,726,784)	(2,377,177)
Net cash provided by financing activities	31,857,863	8,791,600
Net decrease in cash and cash equivalents	(549,432)	(1,283,078)
Cash and cash equivalents, beginning of year	2,820,508	4,103,586
Cash and cash equivalents, end of year	$ 2,271,076	$ 2,820,508
Supplemental disclosure of cash flow information		
Cash paid during the year for interest	$ 2,706,591	$ 1,782,976
Supplemental disclosure of non-cash investing and financing activities		
Accrued distributions to members	$ 155,942	$ 439,396
Purchase of members' contribution by issuance of note receivable	$ 103,185	$ -

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Nature of Business and Significant Accounting Policies

Nature of Business

Strategic Behavioral Health and its subsidiaries (collectively "SBH" or the "Company") provide a variety of services for individuals with psychiatric disorders, including emotional and behavioral disorders. Services provided include but are not limited to therapy, education, nursing and medical services, treatment planning, social skills training and substance abuse counseling.

Strategic Behavioral Health's wholly-owned subsidiaries are as follows:

SBH Wilmington, LLC ("Wilmington") is a 72 bed psychiatric residential treatment facility ("PRTF") and 20 bed acute psychiatric hospital located in Leland, North Carolina. The Hospital is uniquely designed to serve the needs of adolescents ages 12-17 with emotional and behavioral disorders such as ADHD, PTSD, depression, mood, anxiety and oppositional behavioral disorders.

SBH Colorado, LLC ("Peak View") d/b/a Peak View Behavioral Health is a 92 bed acute geriatric psychiatric hospital located in Colorado Springs, Colorado that treats adolescents, adults and seniors with psychiatric disorders.

SBH Raleigh, LLC ("Raleigh") is a 72 bed psychiatric residential and 20 bed acute psychiatric hospital located in Garner, North Carolina. The Hospital is uniquely designed to serve the needs of children and adolescents with emotional and behavioral disorders such as ADHD, PTSD, depression, mood, anxiety and oppositional behavioral disorders.

SBH-Red Rock, LLC ("Red Rock") was formed in 2011 for the purpose of acquiring substantially all the net assets of Red Rock Behavioral Health Hospital in Las Vegas, Nevada. Red Rock Behavioral Health Hospital is a 21 bed acute short-term hospital designed to diagnose and treat the complex mental health and substance abuse problems of people ages 50 and over. The acquisition was completed on January 1, 2012.

SBH-Montevista, LLC ("Montevista") was formed in 2011 for the purpose of acquiring substantially all the net assets of Montevista Hospital in Las Vegas, Nevada. Montevista Hospital is an 90 bed acute psychiatric and chemical dependency hospital providing a full continuum of care for all ages. The land and buildings of Montevista Hospital were acquired on December 30, 2011. The acquisition was completed on January 1, 2012.

SBH Charlotte, LLC ("Charlotte") is a 60 bed psychiatric residential facility in Charlotte, North Carolina, which was opened in the third quarter of 2013. The facility is specifically designed to serve the needs of children/adolescents ages 12-17 with emotional and psychiatric disorders.

SBH El Paso, LLC ("El Paso"), d/b/a Peak Behavioral Health Services, was formed in 2013 for the purpose of acquiring substantially all the net assets of Peak Behavioral Health Services

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

in Santa Teresa, New Mexico. El Paso is a 119 bed psychiatric hospital and residential treatment center specializing in the treatment of children, adolescents, and adults with psychiatric and chemical dependency needs. The acquisition was completed in May 2013.

SBH-College Station, LLC ("College Station") was formed in 2012 and is in the process of building a hospital in College Station, Texas to operate a 72 bed acute psychiatric facility. The Hospital will be specifically designed to serve the needs of children and adults with emotional and psychiatric disorders. The facility was opened in April 2014.

SBH-North Denver, LLC ("Denver"), d/b/a Clear View Behavioral Health was formed in 2013 for the purpose of acquiring land and constructing a new hospital in Denver, Colorado.

SBH-Kingsport, LLC ("Kingsport"), was formed in 2013 for the purpose of acquiring or constructing a hospital in Kingsport, Tennessee. Kingsport has filed for a certificate of need and is awaiting the final determination.

SBH-Mobile, LLC ("Mobile") was formed in 2013 for the purpose of obtaining a certificate of need to operate a psychiatric facility in Mobile, Alabama. The certificate of need was denied and accordingly all related costs were expensed.

The Company's significant accounting policies are summarized below:

Accounting Policy

The Company's policy is to prepare its consolidated financial statements on a modified cash basis of accounting. Except as described below, the Company records amounts due from patients and third-party payors at the time services are rendered and costs and expenses associated with providing services as they are incurred. If an expenditure results in the acquisition of an asset having an estimated useful life which extends substantially beyond the year of acquisition, the expenditure is capitalized and depreciated or amortized over the estimated useful life of the asset. Due to the uncertainty regarding the realization of certain enhanced revenue payments received from governmental payors, these payments are recorded as revenues when the cash is received without considering the potential uncertainties pertaining to any subsequent review by the governmental payors. Additionally, the Company has entered into interest rate swap agreements (see Note 3) with a third party, which are recorded on an accrual basis whereby cash flows are included in interest expense during the period. However, the interest swap agreement is not recorded at fair value at the end of each period as required by accounting principles generally accepted in the United States of America.

Principles of Consolidation

The accompanying consolidated financial statements include SBH and its wholly-owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in the consolidation.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Use of Estimates

The preparation of consolidated financial statements in accordance with the modified cash basis of accounting requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reporting period.

Actual results could differ from those estimates. The amounts recorded as revenues from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

Cash and Cash Equivalents

For purposes of reporting cash flows, SBH considers all cash accounts and all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents.

Accounts Receivable, Net

SBH reports patient accounts receivable at net realizable value after deduction of allowances for doubtful accounts. Management determines the allowance for doubtful accounts based on historical losses, aging of accounts and current economic and regulatory conditions. On a continuing basis, management analyzes delinquent receivables and, once these receivables are determined to be uncollectible, they are written off through a charge against an existing allowance account or against earnings. For receivables associated with services provided to patients who have third-party coverage, SBH analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts predominately based on the aging of accounts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurances and patients with deductible and copayment balances due for which third-party coverage exists for the part of the bill), SBH records a provision for bad debts based on the age of the accounts. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Company's allowance for doubtful accounts was 16 percent and 10 percent of patient accounts receivable at December 31, 2013 and 2012, respectively. The Company has not changed its charity care polices related to discounts for certain uninsured patients during fiscal years 2013 or 2012.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Inventories

Inventories consist primarily of pharmaceutical supplies and are stated at the lower of cost using the first-in, first-out method, or market.

Prepaid Expenses

Prepaid expenses are amortized over the period of benefit using the straight-line method.

Property and Equipment

Property and equipment is stated at cost. Depreciation is computed using the straight-line method over the useful lives of the assets. Assets under capital leases are recorded at the present value of the future minimum rentals at the lease inception and are amortized over the shorter of the lease term or the useful life of the related asset. Amortization of assets under capital lease obligations is included in depreciation and amortization expense.

Debt Issue Costs

Debt issue costs, which include underwriting, legal and other direct costs related to the issuance of debt, are capitalized and amortized to interest expense over the contractual term of the debt using the effective interest method.

Long-Lived Assets

Long-lived assets, such as property and equipment, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable from the estimated future cash flows expected. The Company will recognize an impairment loss when the carrying amount of a long-lived asset is not expected to be recoverable from its undiscounted cash flows. Such a charge is measured by the amount by which the carrying amount exceeds the estimated fair value of the asset. No such impairment losses have been recognized during 2013 or 2012.

Goodwill

The Company's goodwill was recorded as a result of the Company's business combinations. The Company has recorded these business combinations using the acquisition method of accounting. In 2013, the Company recorded the purchase of SBH-El Paso, which resulted in an addition of $16,710,662 to previously existing goodwill. During 2012, the Company recorded the acquisitions of SBH-Red Rock and SBH-Montevista which resulted in $ 28,616,112 of goodwill. The Company tests its recorded goodwill for impairment on an annual basis, or more often if indicators of potential impairment exist. The Company first assesses qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If,

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

after assessing the totality of events or circumstances, the Company determines it is not more-likely-than-not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. Because it was determined that it was not more-likely-than-not that impairment existed, the two-step impairment test was not performed and no impairment loss was recognized during the years ended December 31, 2013 and 2012. Changes to goodwill for 2013 and 2012 are outlined below.

	Balance at 1/1	Additions to Goodwill	Balance at 12/31
2013	$ 28,616,112	$ 16,710,662	$ 45,326,774
2012	$ -	$ 28,616,112	$ 28,616,112

Compensated Absences

SBH employees are granted both vacation and sick leave. Accumulated vacation pay is accrued at the balance sheet date because the employees' right to receive the compensation for the future absences is vested. Sick leave accrues but does not vest; therefore, it is not considered a liability.

Net Revenues

Other than certain enhanced revenue payments received from governmental payors, net revenues are reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered. A summary of the basis of reimbursement with major third-party payors follows:

Medicare

Medicare reimbursement generally is based on the Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS"). Under this methodology, the facility is paid on the basis of a Federal per diem base rate, limited by a specific target amount per discharge, and adjusted annually for such factors as wage index, DRG assignment, rural location and other facility-level adjustments. These annual adjustments are subject to frequent changes and could impact future reimbursement. In addition to the per diem rate, the IPF PPS provides additional payment policies for outlier cases, stop-loss protection, Electroconvulsive Therapy ("ECT") treatments and interrupted stays.

Medicaid

Services rendered to Medicaid beneficiaries are generally reimbursed on a per-diem rate set by each state's division of Medicaid.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Other

SBH has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to SBH under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

The laws and regulations under which the Medicare and Medicaid programs operate are complex and subject to interpretation and frequent changes. As a part of operating under these programs, there is a possibility that government authorities may review SBH's compliance under these laws and regulations. Such reviews may result in adjustments to program reimbursement previously received and subject SBH to fines and penalties. Although no assurance can be given, management believes that it has complied with the requirements of these programs. Due to the uncertainty regarding the realization of certain enhanced payments received from governmental payors, these payments are recorded as revenues when the cash is received. As of December 31, 2013, cost reports for fiscal years 2010 and forward have not been settled.

Charity Care

SBH provides medical care without charge or at a reduced charge to patients that meet certain criteria. Because SBH does not pursue collection of amounts determined to qualify as charity, these charges are not reported as revenue.

Advertising Costs

Advertising costs are charged to operations as incurred. For the years ended December 31, 2013 and 2012, advertising costs totaled approximately $305,000 and $206,000, respectively.

Income Taxes

SBH files a consolidated federal income tax return with its subsidiaries. SBH is structured as a limited liability company and therefore does not incur federal income taxes. The federal taxable earnings are reported by and taxed to the members of SBH individually. SBH also files composite tax returns in several states and makes payments for state income taxes to each of those states on behalf of its members. The state payments are reflected as distributions to members on the accompanying consolidated financial statements. The Company is subject to excise taxes on earnings allocated to the State of Tennessee. The amount of Tennessee excise tax is not considered material and accordingly no deferred or current income taxes are reflected in the accompanying consolidated financial statements.

In accordance with ASC Topic 740, the Company determines if there are any uncertain income tax positions that should be recognized in the Company's financial statements based on tax positions it has taken or is expected to take on a tax return including the entity's status as a pass-through entity. SBH had no significant uncertain tax positions at December 31, 2013 and 2012.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

If interest and penalties are incurred related to uncertain tax positions, such amounts are recognized in income tax expense. Tax periods for all fiscal years 2010 and after remain open to examination by the federal and state taxing jurisdictions to which the Company is subject.

Reclassifications

Certain reclassifications have been made in the 2012 consolidated financial statements to conform with the 2013 presentation. There was no impact in members' equity or changes in members' equity, as previously reported.

Note 2. Long-Term Debt

Long-term debt consists of the following at December 31:

	2013	2012
Credit Facility (See below)		
Term Loan	$ 55,670,000	$ -
Construction Loan	6,126,709	-
Revolver Loan	6,800,000	-
Total Credit Facility	68,596,709	-
Other Debt		
Term loan requiring monthly escalating payments ranging from $21,600 to 29,100 with final balloon payment due on June 30, 2017 (refinanced with Credit Facility)	-	5,386,722
Term loan agreements requiring interest only payments until June 2013 (refinanced with Credit Facility)	-	12,197,190
Term loan requiring monthly escalating payments ranging from $88,000 to $108,000 with final balloon payment due on June 30, 2017 (refinanced with Credit Facility)	-	21,444,000
Construction loan of up to $7.5 million requiring interest only payments until November 2013 (refinanced with Credit Facility)	-	1,400,000

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 2. Continued

	2013	2012
Other Debt - continued		
Revolving loan credit loan of up to $7 million requiring interest only payments with all outstanding principal due on November 30, 2015 (refinanced with Credit Facility)	$ -	$ 2,000,000
Capital lease obligation	3,672	14,686
Total long-term debt	68,600,381	42,442,598
Less current maturities	3,072,422	1,703,039
Long-term debt, less current maturities	$ 65,527,959	40,739,559

In May 2013, the Company entered into an $80 million Credit Facility (the "Credit Facility") with a syndicated group of lenders with a maturity date of May 2018. The Credit Facility consists of an initial Term Loan of $57 million, a Construction Loan (the "Construction Loan") of up to $7.5 million and a Revolving Line of Credit (the "Revolver Loan") of up to $15.5 million. The purpose of the Credit Facility was to fund the El Paso acquisition, as well as to refinance substantially all existing debt. The terms of the Credit Facility are as follows:

Monthly Principal Payments	Term Loan	Construction Loan	Total
From January 31, 2014 through December 31, 2016	$ 237,500	$ -	$ 237,500
From June 30, 2014 through December 31, 2016	$ -	$ 31,250	$ 31,250
From January 31, 2017 through April 30, 2018	$ 285,000	$ 37,500	$ 322,500
Final payment May 20, 2018	$ 42,560,000	$ 4,557,959	$ 47,117,959

The Revolver Loan requires monthly interest only payments through maturity with all principal due at the maturity date of May 20, 2018.

The interest rates on all the loans under the Credit Facility are based on the Funded Debt to EBITDA Ratio as follows:

Funded Debt to EBITDA Ratio	Spread
Less than 2.50	30-Day LIBOR + 275 basis points
Greater than 2.50 but less 3.50	30-Day LIBOR + 300 basis points
Greater than or equal to 3.50	30-Day LIBOR + 350 basis points

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 2. Continued

The interest rate at December 31, 2013 was at 3.75 percent.

The previous debt outstanding at December 31, 2012 required interest on the loans at a variable rate equal to the 30-Day LIBOR plus a certain amount of basis points beginning at 350 (3.114 percent at December 31, 2012).

The Credit Facility is secured by substantially all of the assets of the Company.

The terms of the Credit Facility described above requires certain affirmative and negative debt covenants including the maintenance of a minimum fixed charge coverage ratio and a maximum funded debt to EBITDA ratio. At December 31, 2013 and 2012, SBH was in compliance with all required covenants.

The maturities of long-term debt are as follows:

Year Ending December 31,	Amount
2014	$ 3,072,422
2015	3,225,000
2016	3,225,000
2017	3,870,000
2018	55,207,959
Total	$ 68,600,381

Note 3. Interest Rate Swaps

The Company has entered into various interest rate swap agreements to manage interest costs and risks associated with changes in interest rates. These agreements effectively convert underlying variable-rate debt based on the 30-Day LIBOR to fixed-rate debt through the exchange of fixed and floating interest payment obligations without the exchange of underlying principal amounts.

At December 1, 2013 and 2012, the following interest rate swap agreements were in effect:

	Description	Notional Value	Maturity	Pay Index	Receive Index	Fair Value
Swap 1						
December 31, 2013	Fixed payer	$ 5,069,966	June 2017	4.29%	30-Day LIBOR	$ (530,785)
December 31, 2012	Fixed payer	5,354,366	June 2017	4.29%	30-Day LIBOR	(782,553)
Swap 2						
December 31, 2013	Fixed payer	20,340,000	June 2017	1.06%	30-Day LIBOR	(67,942)
December 31, 2012	Fixed payer	21,444,000	June 2017	1.06%	30-Day LIBOR	(382,300)

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 3. Continued

	Description	Notional Value	Maturity	Pay Index	Receive Index	Fair Value
Swap 3						
December 31, 2013	Fixed payer	$ 6,362,000	June 2017	.87%	30-Day LIBOR	$ 19,585
Swap 4						
December 31, 2013	Fixed payer	5,581,500	June 2017	.87%	30-Day LIBOR	17,162
Swap 5						
December 31, 2013	Fixed payer	19,931,973	June 2017	.90%	30-Day LIBOR	7,790
Swap 6						
December 31, 2013	Fixed payer	45,410,000	May 2018	2.96%	30-Day LIBOR	59,507
					Fair value 2013	$ (494,683)
					Fair value 2012	$ (1,164,853)

Swap 6 is a forward interest rate swap that becomes effective on July 1, 2017.

As a result of the interest rate swap agreements, interest expense increased by $343,003 and $388,381 in relation to the required debt service for the years ended December 31, 2013 and 2012, respectively.

Note 4. Property and Equipment

A summary of property and equipment follows:

	December 31, 2013	December 31, 2012
Land and improvements	$ 8,739,753	$ 7,046,476
Building and improvements	45,839,068	36,139,060
Fixed and major moveable equipment	7,124,183	4,489,785
	61,703,004	47,675,321
Less accumulated depreciation and amortization	(4,331,553)	(2,181,981)
	57,371,451	45,493,340
Construction in progress	11,723,061	1,168,576
Property and equipment, net	$ 69,094,512	$ 46,661,916

Depreciation expense related to these assets for the years ended December 31, 2013 and 2012 amounted to $2,169,598 and $1,211,918, respectively. The amount of interest capitalized by the Company was $223,277 and $276,459 for the years ended December 31, 2013 and 2012, respectively.

At December 31, 2013, the Company had outstanding construction commitments related to construction in progress of $8,152,606.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 5. Other Assets

Other assets at December 31, 2013 and 2012 consisted of the following:

	2013	2012
Debt issue costs, net of accumulated amortization of $313,677 and $110,181 at December 31, 2013 and 2012, respectively	$ 1,229,820	$ 950,442
Other	32,557	-
Deposits	208,243	130,079
	$ 1,470,620	$ 1,080,521

Note 6. Leases

SBH leases certain property and equipment from third parties and related parties under long-term operating leases. Total rental expense for all operating leases for the years ended December 31, 2013 and 2012 was $967,683 and $880,575, respectively. Minimum future rental payments under non-cancelable operating leases having remaining terms in excess of one year as of December 31, 2013 are as follows:

Year Ending December 31,	Amount
2014	$ 601,885
2015	618,165
2016	481,709
2017	186,367
2018	188,434
Thereafter	111,625
Total	$ 2,188,185

Note 7. Patient Accounts Receivable and Net Patient Service Revenue

Patient Accounts Receivable, Net

SBH grants credit without collateral to its patients. The percentage mix of receivables from patients and third-party payors is as follows:

	December 31, 2013	December 31, 2012
Medicare	20%	32%
Medicaid	39	20
Commercial	35	41
Self Pay	6	7
Total	100%	100%

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS - MODIFIED CASH BASIS

Note 7. Continued

A summary of the activity in the allowance for doubtful accounts for 2013 and 2012 is as follows:

	Balance at Beginning of Year	Additions to Allowance	Accounts Written Off, Net of Recoveries	Balance End of Year
Allowance for doubtful accounts year ended December 31, 2013	$ 915,540	$ 3,849,410	$ (2,220,783)	$ 2,544,167

	Balance at Beginning of Year	Additions to Allowance	Accounts Written Off, Net of Recoveries	Balance End of Year
Allowance for doubtful accounts year ended December 31, 2012	$ 264,197	$ 748,305	$ (96,962)	$ 915,540

A summary of net revenue, net of the provision for bad debts, for patient services rendered for the years ended December 31, 2013 and 2012 is as follows:

	2013		2012	
	Amount	Percentage	Amount	Percentage
Medicare	$ 15,839,812	20%	$ 13,402,841	27%
Medicaid	29,150,783	36%	15,748,639	32%
Commercial	33,034,894	41%	17,126,526	34%
Self Pay	788,139	1%	383,151	1%
Other	1,678,759	2%	3,221,221	6%
	$ 80,492,387	100%	$ 49,882,378	100%

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Year Ended December 31, 2013		
	Third-Party Payors	Self-pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 83,515,967	$ 825,830	$ 84,341,797

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 7. Continued

	Year Ended December 31, 2012		
	Third-Party Payors	Self-pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 50,241,784	$ 388,899	$ 50,630,683

Note 8. Charity Care

The Company maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The direct and indirect cost, which includes all operating expenses excluding the provision for bad debts, associated with these services cannot be identified to specific charity care patients. Therefore, management estimated the costs of these services by calculating a ratio of cost to gross charges and multiplying that ratio by the gross charges associated with providing care to charity patients. The estimated direct and indirect cost incurred is approximately $485,000 and $739,000 for the years ended December 31, 2013 and 2012, respectively.

Note 9. Insurance Programs

SBH purchases professional and general liability insurance to cover medical malpractice claims. Management believes that any claims would be substantially covered under its insurance program and would not have a significant effect on the consolidated financial statements. Nevertheless, the future assertion of claims for occurrences prior to year-end is possible and may occur, although not anticipated.

Note 10. Related Party Transactions

Dobbs Management Service, LLC ("Dobbs") is a related party entity due to common ownership by certain members of SBH. SBH's business formation agreement requires a base management fee to Dobbs in an amount not to exceed $5,000 per month. Management fees incurred to Dobbs were $60,000 for each of the years ended December 31, 2013 and 2012.

The business formation agreement also requires that guaranteed payments be made to two of SBH's members. For the years ended December 31, 2013 and 2012, the amounts of guaranteed payments totaled $418,636 and $383,375, respectively, and are included in salaries and benefits on the accompanying consolidated financial statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 10. Continued

Additionally, the business formation agreement requires that an incentive fee equal to 2 and 5 percent of net income be paid to both a member of SBH and Dobbs, respectively. The incentive fees for the years ended December 31, 2013 and 2012 were $754,517 and $709,176, respectively. Accrued incentive fees at December 31, 2013 and 2012 were $58,868 and $58,505, respectively.

SBH has declared certain distributions payable to its members as of December 31, 2013 and 2012 related to income tax distributions. Total accrued distributions to members as of December 31, 2013 and 2012 were $155,942 and $439,396, respectively.

The Company allows members from time to time to transact equity transactions in the form of secured promissory notes. At December 31, 2013 and 2012 outstanding amounts receivable from members were $161,878 and $76,616, respectively. Interest is charged at a variable rate with the principal to be paid at dates in the future. The Company received $12,923 and $5,000 of principal payments related to the notes receivable during 2013 and 2012, respectively. Note receivable balances due from members are presented as a component of members' equity on the accompanying consolidated financial statements.

The Company purchases property, casualty, and malpractice insurance coverage from a company which is owned by Dobbs. During 2013 and 2012, the Company paid insurance premiums of approximately $1,500,000 and $985,000, respectively to this party.

Note 11. Employee Benefits

SBH participates in a multi-employer defined contribution 401(k) plan sponsored by Dobbs for its eligible employees. Contributions by the Company to the plan for the years ended December 31, 2013 and 2012 were $249,221 and $139,399, respectively.

SBH also provides health insurance benefits to its eligible employees. Health insurance benefits provided were $2,972,148 and $1,834,556 for the years ended December 31, 2013 and 2012, respectively.

Note 12. Risks and Uncertainties

SBH is involved in litigation in the normal course of business. Management is of the opinion that likelihood of any financial impact to SBH would be minimal and would be covered by insurance.

The amounts of certain enhanced revenues received from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

SBH maintains cash deposits that are in excess of FDIC insurance limits. The Company has not experienced any losses as a result of this concentration.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 13. Acquisition

On May 19, 2013, the Company entered into an asset purchase agreement with Universal Health Services, Inc. ("UHS") for the purchase of substantially all of the net assets and assumption of certain liabilities of Peak Behavioral Hospital. The Company's acquisition was based on management's belief that the Santa Teresa, New Mexico location is complementary to the Company's existing business and provides a base for further growth. The total original purchase price was $24,000,000.

The Company's acquisition was recorded by allocating the cost of the acquisition to the assets acquired, including intangible assets, and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the cost of the acquisitions over the net amounts assigned to the fair value of the assets acquired, net of liabilities assumed, was recorded as goodwill. The following table summarizes the valuation:

Assets	
Accounts receivable	$ 2,389,688
Inventory	20,669
Prepaid expenses and other assets	24,927
Property and equipment	5,988,588
Goodwill	16,710,662
Assets acquired	25,134,534
Liabilities	
Accounts payable	85,309
Accrued expenses	285,048
Total liabilities	370,357
Net assets acquired	$ 24,764,177

The difference between the original consideration paid of $24,000,000 and assets acquired of $24,764,177 is $764,177 and represents a subsequent working capital adjustment paid to UHS.

On December 30, 2011, the Company entered into an asset purchase agreement with Universal Health Services, Inc. ("UHS") for the purchase of substantially all of the net assets of Montevista Hospital and Red Rock Behavioral Health Hospital. This transaction was not completed until January 1, 2012. The Company's acquisition was based on management's belief that the Las Vegas locations are very complementary to the Company's existing business and provides a base for further growth. The total original purchase price was $43,944,726. As of December 31, 2011, the consideration was remitted by the Company in the form of cash to UHS in the amount $21,444,726 with the additional consideration of $22,500,000 provided to UHS from the proceeds of new debt with a financial institution.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 13. Continued

The Company's acquisition was recorded by allocating the cost of the acquisition to the assets acquired, including intangible assets and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the cost of the acquisitions over the net amounts assigned to the fair value of the assets acquired, net of liabilities assumed, was recorded as goodwill. The following table summarizes the valuation:

Assets	
Accounts receivable	$ 3,200,647
Inventory	45,056
Prepaid expenses	277,864
Property and equipment	12,406,541
Goodwill	28,616,112
Deposits	37,692
Total assets	44,583,912
Liabilities	
Accounts payable	209,874
Accrued expenses	579,183
Capital lease obligation	45,630
Total liabilities	834,687
Net assets acquired	$ 43,749,225

The difference between the original consideration paid of $43,944,726 and net assets acquired of $43,749,225 is $195,501 and represents a subsequent working capital adjustment received from UHS to the final purchase price.

During 2013 and 2012, the Company recorded expenses of approximately $620,000 and $51,000, respectively, related to costs incurred in this and other potential acquisitions. The acquisition costs were primarily related to legal and professional fees and other costs incurred in performing due diligence.

Note 14. Subsequent Events

SBH has evaluated, for consideration of recognition or disclosure, subsequent events that have occurred through May 22, 2014, the date the consolidated financial statements were available to be issued and has determined that no significant events have occurred subsequent to December 31, 2013 but prior to May 22, 2014 that would have a material impact on its consolidated financial statements.

Exhibit 16

FIFTH THIRD BANK

April 15, 2015

Kevin McDonald
Chief, Certificate of Need Division
Center for Health Care Facilities Planning & Development
Maryland Healthcare Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Seasons Residential Treatment Program, LLC - Psychiatric Residential Treatment Facility (the "Project")

Dear Mr. McDonald,

Fifth Third Bank, as Agent for the syndicated Bank Group of Strategic Behavioral Health, LLC ("SBH"), and its affiliates including Seasons Residential Treatment Program, LLC, recently expanded its credit facility and entered into a $130 million dollar syndicated credit facility in December 2014. Under the new credit facility, SBH has a $50 million development loan available to fund future development projects such as this Project.

This letter is to provide assurance that Fifth Third Bank is familiar with the Project being proposed for CON approval to better serve Prince George's County and the surrounding communities.

Fifth Third Bank and the Bank Group have a high degree of interest in financing the proposed Project. We anticipate providing both construction and permanent financing for the Project through a combination of a development line and revolver within the SBH credit facility.

The interest rate on the loan would be based on LIBOR plus an applicable spread. The current variable rate on the loan is approximately 3.69%.

Please feel free to call or email me directly if you have any questions regarding this letter or if you need any additional information. We very much look forward to working with you and SBH on the financing and completion of this Project.

Sincerely,

Todd Vandawater
Vice President
Fifth Third Bank
Phone: (615) 687-8066
Email: todd.vandawater@53.com

April 21, 2015

Kevin McDonald
Chief, Certificate of Need Division
Center for Health Care Facilities Planning & Development
Maryland Healthcare Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Acquisition of Seasons Residential Treatment Program, LLC by Strategic Behavioral Health.

Dear Mr. McDonald,

This letter is in response to your request for additional information regarding the relationship of Strategic Behavioral Health, LLC ("SBH") and Seasons Residential Treatment Program, LLC ("Seasons") and a follow up to the letter addressed to the Maryland Health Care Commission dated April 8, 2015, from Seasons CEO, Ty Johnson.

For the past 10 months, the senior management team at SBH has met with local stakeholders and worked closely with Seasons to determine how to best partner to bring a residential treatment program to the State of Maryland. These discussions culminated on April 7, 2015, when SBH formalized its partnership with Seasons by acquiring 100% of the membership interest of Seasons. Seasons is now a wholly owned subsidiary of SBH and joins a family of behavioral health programs that serve youth and families with challenging behavioral health care needs. Although Seasons is now owned by SBH, Seasons is its own legal entity and will remain the CON applicant and operator.

The acquisition will provide Seasons with significant resources including access to capital, clinical and management expertise and corporate support across all functional areas. Seasons will benefit from a team with experience building, launching and operating new inpatient facilities for difficult patients in diverse markets allowing a smoother market entry. Given the opportunity, stakeholders will immediately benefit from greater efficiencies and access to effective policies, procedures and programming.

Strategic Behavioral Health is a national healthcare company formed in January 2006 and is based in Memphis, Tennessee. SBH is a holding company and has more than eight wholly owned subsidiaries in six states. Each subsidiary is individually licensed and operated to provide psychiatric services to individuals who have a variety of behavioral health disorders. As of December 31, 2014, SBH had consolidated net annualized revenue of approximately $110 million and more than 1,800 employees. Additional information about SBH is available on our company website: http://www.strategicbh.com.

SBH has sufficient capital through its current operations and access to $50 million in funds committed through its existing "development loan" under a credit agreement entered into in December 2014. Future expansion and growth (including the Seasons project) is supported through a commitment from Fifth Third Bank. Specific information regarding our financial commitment to Seasons Residential Treatment Program is outlined in the attached letters from our Chief Financial Officer and Fifth Third Bank.

We are excited about the acquisition of Seasons Residential Treatment Program and the potential to deliver a quality program to the State of Maryland. We look forward to further supporting the efforts of Ty Johnson, our local CEO, and building on the momentum, relationships and trust she has built in the community so far.

Please do not hesitate to contact me if you require any additional information regarding the terms of the acquisition. I can be reached at the number and email below.

Sincerely,

Jim Shaheen,
Founder & President
Strategic Behavioral Health, LLC
(901) 969-3100
Jim.shaheen@strategicbh.com

STRATEGIC
BEHAVIORAL HEALTH, LLC

April 15, 2015

Kevin McDonald
Chief, Certificate of Need Division
Center for Health Care Facilities Planning & Development
Maryland Healthcare Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Seasons Residential Treatment Program, LLC - Psychiatric Residential Treatment Facility (the "Project")

Dear Mr. McDonald,

The Seasons Residential Treatment Program, LLC project will be funded by a combination net cash flows from existing operations and availability under our credit facility. As of April 15, 2015 Strategic Behavioral Health, LLC (parent company of Seasons Residential Treatment Program, LLC) had over $50 million of funds available under its $130 million credit facility syndicated through Fifth Third Bank.

The current borrowing rate under this credit facility is based on LIBOR and is currently at 3.69%.

The combination of availability under the credit facility and net cash flows from existing operations are more than sufficient to provide the funding required for Seasons Residential Treatment Program, LLC to complete the Project.

Please feel free to call me if you have any questions regarding this letter or if you need any additional information.

Sincerely,

James W. Cagle
CFO
Strategic Behavioral Health, LLC

8295 Tournament Drive, Suite 201 • Memphis, TN 38125
P (901) 969-3100 • F (901) 969-3120

PRINCE GEORGE'S COUNTY GOVERNMENT
OFFICE OF THE COUNTY EXECUTIVE

Rushern L. Baker, III
County Executive

May 18, 2015

Mr. Kevin McDonald, Chief
Certificate of Need Division
Center for Health Care Facilities Planning & Development
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. McDonald,

I write in support of the application of Seasons Residential Treatment Program for a Certificate of Need to provide residential treatment for youth between the ages of 13 and 21 with a diagnosis of mental illness.

As part of our overall focus and commitment to providing access to quality and affordable healthcare for Prince George's County residents, we support the need for more mental health services for youth and families and have identified specific goals for at-risk youth with behavioral health challenges. If approved, Seasons Residential Treatment Program would be part of a system of care for youth with severe behavioral problems in need of interventions and treatment superior to what we can provide in our community-based programs.

Currently, there are no residential or secure inpatient assessment beds for adolescents and young adults (under the age of 21), in Prince George's County, or neighboring south counties. Many of our young residents are placed in residential programs and assessment units well beyond a reasonable distance for families to participate in treatment. We strongly believe if Seasons Residential Treatment is approved, the program will extend our ability to provide needs-based services to County residents and will support successful community, school and family reintegration.

We support this application because we believe the program will extend our ability to more effectively and efficiently promote the health, safety and well being of children and families in Prince George's County. Please do not hesitate to contact me if you need additional information in support of this application.

Sincerely,

Betty Hager Francis

Betty Hager Francis
Deputy Chief Administrative Officer
for Health, Human Services and
Education

14741 Governor Oden Bowie Drive, Upper Marlboro, Maryland 20772
(301) 952-4131
www.princegeorgescountymd.gov

PIW

Psychiatric Institute
of Washington

May 26, 2015

Ty Johnson, CEO,
1101 30th Street, NW
4th Floor
Washington, DC 20004

Dear Ms. Johnson :

I am writing to offer my strong support of the Seasons Residential Treatment Program certificate of need application to operate a Residential Treatment Program. This program will help fill a much needed service gap in Washington, DC and Maryland.

Psychiatric Institute of Washington is a short-term, acute care hospital. We provide comprehensive behavioral healthcare for children, adolescents and adults suffering from emotional and addictive illnesses. PIW will work with Seasons, by both providing referrals and receiving their clients into our care, as well as collaborating on projects and initiatives in the community.

It is with much enthusiasm that the Psychiatric Institute of Washington pledges its support of the Seasons Residential Treatment Program application.

Sincerely,

Aarti Subramanian
Exec.Dir. Govt. Affairss and Business Development
Psychiatric Institute of Washington
4228 Wisconsin Avenue, NW
Washington DC 20016
Direct: 202-885-5734
Cell: 703-725-4251

DEPARTMENT OF YOUTH REHABILITATION SERVICES

450 H Street, NW
Washington, DC 20001
(202) 724-1790 (O)
(202) 724-1067 (F)
www.dyrs.dc.gov

4/11/2014

Center for Health Care Facilities Planning & Development,
Maryland Health Care Commission,
4160 Patterson Ave.
Baltimore, MD 21215.

RE: Seasons Residential Treatment Program

To Whom It May Concern:

Please accept this letter of recommendation on behalf of Seasons Residential Treatment Program. As Chief of Committed Services at the Department of Youth Rehabilitation Services, we have struggled to identify local programs that would better serve our youth. Frequently, mental health issues, including substance abuse, have significantly impacted children as well as vulnerable young adults in our community. Major barriers in meeting these needs include available resources in the community and transportation issues. The distance to current residential facilities are out of state and provide great hardship to families. Discharge planning is also more difficult when the providers that will be offering follow up care cannot be directly involved.

Easy access for patients and their families would help in the treatment process as well as improve discharge results due to the availability of close relationships with community providers. The facility would greatly enhance the services we work to provide to youth and families.

It is with great pleasure that I provide a letter of recommendation for Seasons. It is rare to find a provider that truly understands the magnitude of the work we do. They exemplify the meaning of dedication, commitment, honesty and work Ethic.

If you would like to discuss further please feel free to call me directly at 202-352-6328.

Sincerely,

Garine Dalce, LGSW, MBA
Chief of Committed Services
Department of Youth Rehabilitation Services

Community College Preparatory Academy PCS
2405 Martin Luther King, Jr. Avenue, SE
Washington, DC 20020
(202) 610-5780
www.ccprep-academy.org

17 January, 2015

Kevin McDonald
Chief, Maryland Health Care Commission
Center for Health Care Facilities Planning and Development
4160 Patterson Avenue
Baltimore, Md. 21215

Dear Mr. McDonald

I recently learned that the Seasons Residential Treatment Program has begun the process of seeking approval for the development of a mental health facility in your jurisdiction. I have known the founding Director, Ms. Ty Johnson professionally as a result of my 40 year career in the District of Columbia as an educator and Workforce Development specialist. I am also aware of her deep commitment to young people with special needs and the broad range of both experience and knowledge of the field that she brings to such an endeavor.

As the founding Executive Director of a Charter School for adults here in Southeast Washington, I am confronted every day with the young adults for whom adequate and appropriate mental health services have not been provided. As you are no doubt aware, they are a regional challenge because they shift from the East section of the city to Prince Georges' County and back on a regular basis. I can only believe that such a facility has the potential to serve both jurisdictions by providing a responsive and thorough programs and services for young people that resolves learning and socialization barriers early on. Moreover, it provides a bridge to programs like mine.

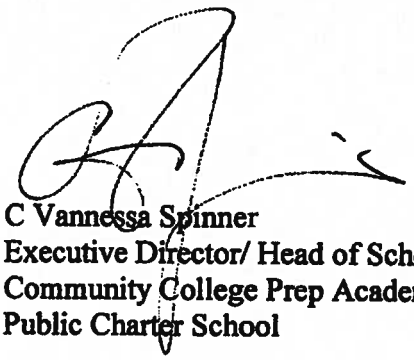
I know that this type of facility could be beneficial to both our communities. Certainly, both communities currently suffer from the lack of appropriate, effective mental health and substance abuse programming that supports young people in re- entering the community with the skills and supports to successfully transition. I am certain that we can both attest to the dire lack of such comprehensive services within our region- particularly focused on minority mental health issues.

As a result of the current referral process, such a nearby center would allow young people from both the county and the city to benefit from placements at a facility that is equipped to meet their

diverse mental, emotional and substance abuse related challenges. Further, such a Center would allow the mental health provider to stay in close contact with families and provide the needed support for effective exit transition. Also, with parent permission, the facility could work with nearby school staff to ensure seamless transition back to school.

I can only see a benefit for the County and the Region from such a facility. As I indicated previously, every day I see the results of ineffective mental health support systems that are often located too far from the area where the client must return- thus making effective transition almost impossible.

I sincerely hope that every consideration will be given approving this unique and much needed resource for both our communities.



C Vannessa Spinner
Executive Director/ Head of School
Community College Prep Academy
Public Charter School

National Collegiate Preparatory
Public Charter High School

August 25, 2014

Kevin McDonald
Chief, Maryland Health Care Commission
Center for Health Care Facilities Planning and Development
4160 Patterson Avenue
Baltimore, Md. 21215

Dear Mr. McDonald:

It has come to my attention that the Seasons Residential Treatment Program has expressed an interest in located a mental health facility in our community. I believe this type of facility could be beneficial to our community. There is a lack of such services within our community which often affects our community in a negative manner. Further, because of the lack of services within the area, often times students need to be transported out of our community for their needed treatment. This creates stress on families because their children are not close enough to visit and it is difficult to bring family together to support the child. If the treatment were available in our community, the mental health provider could stay in close contact with the family and provide the needed support. Also, with parent permission, the facility could work with school staff to help with the transition back to school.

I thank you for the consideration as I believe the Seasons Residential Treatment program would be a true asset to the community.

Best,

Jennifer L. Ross
Founder & Executive Director
National Collegiate Preparatory PCHS

4600 Livingston Road, SE • Washington, DC 20032 • *phone* (202) 832-PREP (7737) • *facsimile* (202) 832-7736
www.nationalprepdc.org

LaFleur Counseling
MSW | LICSW | MBA

JOSEPH W. LAFLEUR

May 12, 2015

Mr. Kevin McDonald
Chief
Certificate of Need Division
Center for Health Care Facilities Planning & Development
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. McDonald,

As a Licensed Independent Clinical Social Worker (LICSW) and former District of Columbia Direct for Beacon Health Strategies, the former Medicaid Behavioral Health Care Organization in Washington, DC. I submit this letter of support to expand local options for safe, secure residential treatment programming for children, young adults and families. Specifically, I support Seasons Residential Treatment Program based on their plan to build a program for youth with severe behavioral and mental health challenges who need a safe and secure therapeutic milieu and intensive community oversight.

I am excited about the proposal to bring a certified Psychiatric Residential Treatment Facility to the area for the following reasons: availability of intensive clinical services, ability to decrease lengths of stay (and related costs) and the possibility of improving community reintegration outcomes.

For more than 10 years, (Program Manager, DC Department of Health Care Finance and Director at Beacon Health Strategies), I worked closely with providers and placement agencies to support federal (Medicaid) funding for District of Columbia youth whose behavioral health care needs exceeded the options available in lower levels of care (i.e., community based interventions, group homes and residential treatment centers).

Very often, youth were placed in programs far from home because there was an absence of available local options for youth who presented with severe trauma and aggressive behaviors. During my tenure, it was not uncommon to see these hard to place youth placed more than 600 miles from the District. If Seasons is certified as a PRTF, the clinical standard and rigor of the therapeutic program will match the clinical need for many "tough to treat" youth in our area.

1700 17th Street NW Suite 201 Washington, DC 20009
www.districtcounseling.com 202.641.5335 joseph@districtcounseling.com

LaFleur Counseling
MSW | LICSW | MBA

JOSEPH W. LAFLEUR

The proximity of Seasons to youth in Maryland, Virginia and Washington, D.C., will allow greater access to families and encourage effective discharge planning early in the treatment process. If the program can identify resources and engage parents and guardians early, I believe we can reduce the amount of time youth spend in this level of care and improve overall clinical outcomes.

As a clinician, I am hopeful the proposed program will also lead to greater collaboration with community-based providers and eventually reduce the overall number of youth in need of this level of care. Until then, I strongly support the need for this program and level of care.

Please do not hesitate to contact me if you need any additional information, or have further questions. I can be reached at 202.641.5335 or through email at joseph@districtcounseling.com.

Sincerely,

Joseph W. LaFleur, MSW, MBA, LICSW

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Youth Rehabilitation Service

May 11, 2015

Mr. Kevin McDonald
Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. McDonald:

I am writing this letter to express my complete support for Seasons Residential Treatment Program, a proposed Psychiatric Residential Treatment Facility (PRTF) in Prince George's County, Maryland.

For fifteen years, I have worked for the Department of Youth Rehabilitation Services (DYRS) in the District of Columbia -- the juvenile justice agency for the District of Columbia. My colleagues and I work closely with court-involved youth to ensure youth are receiving the appropriate level of support and skills to prepare them for successful community reintegration.

My department works with court services, guardians, attorneys, advocates and external agencies to place youth in residential placement after a multi-disciplinary team and juvenile services judge has determined the youth meets the required level of care. A great majority of youth in the care of DYRS requires placement in a residential program that can handle highly aggressive and assaultive behaviors and can admit youth through the age of 21. The program must provide a safe, secure environment and have a strong therapeutic component to address the mental health issues of the youth we place.

Unlike other jurisdictions, the District of Columbia does not have a PRTF, or secure RTC. All youth meeting this level of care must be referred outside of the District of Columbia. Although we are working to keep closer to home, historically, we have placed youth in programs as far away as Colorado, Texas, Florida and Arizona because we have not had options closer to home.

The proximity of Seasons Residential Treatment Program to the District of Columbia and the ability to take older youth will meet a tremendous need in the local market. I am hopeful (that) by keeping youth closer to home we can also shorten lengths of stay, reduce recidivism rates, increase agency collaboration and expand the continuum through community and agency partnerships.

Please feel free to contact me if you need any additional information or have questions about my level of support for this project.

Sincerely,

Jose de Arteaga, JD
Program Manager
DC DYRS

CHCS Center for Health Care Strategies, Inc.

Issue Brief

System of Care Approaches in Residential Treatment Facilities Serving Children with Serious Behavioral Health Needs

Kamala D. Allen, Center for Health Care Strategies; Sheila A. Pires, Human Service Collaborative; and Jonathan Brown, PhD, Mathematica Policy Research

MARCH 2010

Providing an appropriate continuum of mental health services for the estimated one in five children and adolescents in the U.S. who have a mental health disorder is imperative.[1] While it is well established that such services should emphasize community-based care,[2] children and youth with challenging behavioral health problems are often placed instead in residential treatment facilities (RTFs). Those in residential treatment settings can benefit from a system of care approach that facilitates coordination between residential and community-based providers and engages youth and their families as partners in care.

A system of care is a strengths-based approach that recognizes the importance of family, school and community, and addresses the physical, emotional, intellectual, cultural, linguistic and social needs of every child and youth. Through this approach, families and youth work with public and private organizations to design a coordinated network of community-based services and supports — improving functioning at home, in school, and in the community.[3] The federal *Comprehensive Community Mental Health Services Program for Children and Their Families* has funded systems of care for children's mental health in states, tribes and communities across the country, with demonstrated improvements in behavioral and emotional health.[4]

Insufficient home- and community-based options, financial incentives that drive residential placements, and reduced use of inpatient psychiatric care all contribute to increases in the use of RTFs.[5] Accordingly, it is vital to understand how these facilities are delivering mental health services to children and youth to begin to address questions about RTF overuse, lengths of stay, long-term effectiveness, and adoption of evidence-based principles of care.[6]

This paper describes the findings of a national survey of RTFs that serve children and youth with serious behavioral health challenges. The survey sought to identify the extent to which:

- System of care principles are reflected in the policies and practices of RTFs; and
- Residential treatment is providing home- and community-based services and supports in addition to traditional offerings.

Survey findings are particularly relevant to Medicaid and other public purchasers of residential treatment, given the high cost of residential care, its history of overuse, and the potential for home- and community-based services to reduce inappropriate RTF placements and lengths of stay. The findings can also inform child behavioral health policymakers, RTF providers, and child and family advocates seeking promising approaches to better meet the extensive behavioral health needs of children and youth in this country.

The intent is that these findings catalyze discussion among these constituencies to increase incorporation of system of care principles and practices throughout the continuum of care, particularly in RTFs, where they are needed most.

This issue brief is made possible through support from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services and the Annie E. Casey Foundation.

Survey Partnership

While systems of care emphasize home- and community-based services, their growing use has coincided with increased reliance on RTFs — driving tension between advocates of community-based and residential care. The reasons are many, including limited resources, differing philosophies, and a lack of research demonstrating the effectiveness of residential treatment. Based on mutual concern about these issues, the Child and Family Branch of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS), the Annie E. Casey Foundation, and the Center for Health Care Strategies (CHCS) engaged Mathematica Policy Research to conduct this survey.

This effort follows CMHS' *Building Bridges Initiative*, launched in 2006 to create partnerships and improve relationships among residential and community service providers, families and youth. The *Building Bridges Initiative* encourages community-based and residential providers to better communicate and coordinate their services within a system of care framework.[7]

Survey Methodology

Development of the Survey of Residential Treatment Facilities ("RTF survey") was guided by an advisory panel of parents, youth, RTF directors, policymakers, advocates, researchers, and other community-based providers, as well as key-informant interviews. Survey items were designed to gather information on RTF: (1) characteristics; (2) values and principles; (3) treatment and assessment practices; (4) workforce needs; (5) cultural and linguistic diversity; (6) relationships with other providers; and (7) financing.

The RTF survey was distributed from April through June 2009 to individuals (primarily RTF directors) who had completed the 2008 SAMHSA National Survey of Mental Health Treatment Facilities (NSMHTF).[*] The NSMHTF included 741 facilities that provide 24-hour residential treatment to children and adolescents age 17 or younger. For those directors responsible for more than one RTF, one facility was selected randomly to avoid overburdening the respondent and/or over-representing any one organization in the findings. This reduced the number of eligible facilities to 611.

Each RTF director received an email invitation to complete an online survey (a paper version was also available), requiring approximately 30 to 45 minutes to complete. Respondents did not receive compensation or an incentive to complete the survey. Non-respondents received up to four reminder emails and two telephone calls to encourage participation. Sixty-seven individuals (11%) who were invited to complete the survey responded that their facility does not provide residential treatment and/or does not serve children or adolescents. Among those remaining (n=544), 293 (54%) completed the survey. This paper reports on their responses.

NSMHTF data revealed no statistically significant differences between facilities responding and not responding to the RTF survey in terms of the number of children and youth served, type of ownership, religious affiliation, accepted forms of payment, or provision of free treatment. Fifty-six percent of those completing the RTF survey are directors of non-profit facilities, and 44% direct for-profit facilities.

Highlights of Survey Results

Survey results indicate both evidence of and opportunities for improvement in the incorporation of system of care values in RTF policies and practices, and an orientation to community-based care.

[*] RTFs that operate under the auspices of child welfare were only included in the NSMHTF if they offer mental health treatment services.

Most respondents — largely private non-profit or commercial entities — provide a range of residential and non-residential mental health services for children and youth; a few also provide substance abuse services; and many report providing trauma-informed care.[†] The vast majority report mechanisms in place to ensure appropriate residential placement, yet only about half work with referring agencies to determine whether alternative programs might be more appropriate. While nearly all develop individualized treatment plans, the role of youth and families in creating these plans varies greatly, and very few provide family or youth peer support. Staff recruitment and retention is challenging, and only a few respondents believe that their staff has a solid understanding of youth-guided and family-driven principles. RTFs largely report having policies to reduce seclusion and restraint, though most had used the practice in the previous year. About half of RTFs do pre-discharge planning to transition children and youth from their facilities, and a similar proportion assist youth with the transition to adult services. Staff training on the use of culturally competent services and supports is almost universally provided, but application is uneven and some important cultural groups are rarely addressed. Fewer than half of RTFs collect outcomes data, and not for very long following discharge. Additionally, most RTFs surveyed receive Medicaid and child welfare funding, however very few have performance-based contracts.

Detailed Survey Findings[‡]

Description of Facility Types

Survey results reflect the trends of decreasing government ownership of residential beds for children and increasing commercial and non-profit ownership. Eighty percent of reporting RTFs are owned by private partnerships or corporations; only 5% are government-owned.[§] Among non-government owned RTFs, 83% are non-profit or not-for-profit, and 16% are affiliated with a religious organization. Respondents described their primary service area as mental health (68%); substance abuse (4%); a mix of mental health and substance abuse (17%); and other (11%).

Over the past decade, RTFs increasingly have diversified their service offerings,[**] a trend borne out by the survey results. Sixty-six percent of respondents report that they provide both residential and non-residential mental health services. The reporting facilities encompass a range of nine to 100 beds (median=38, mean=48).

Licensing and Accreditation Status

Given the growing federal emphasis on health care quality and accountability, the survey explored facility licensing and accreditation. Most reporting RTFs are licensed by either the state mental health authority (59%) and/or the state department of health (48%), and 79% have some national accreditation. Fifty-three percent are licensed or certified as a psychiatric residential treatment facility according to federal Centers for Medicare and Medicaid Services (CMS) requirements; 13% of respondents do not know whether they are so licensed or certified. Thirty-six percent are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); 32% by the Council on Accreditation for Children and Family Services (COA); 10% by the Commission on Accreditation of Rehabilitation Facilities; and less than 1% by the National Committee for Quality Assurance (NCQA).

Population Served

Population data submitted by respondents are consistent with other studies showing that older children and youth are more likely to be served in RTFs than younger children.[8] Eleven percent of respondents serve children under the age of 6 years, 57% serve children ages 6 to 12, 93% serve

[†]Trauma-informed care treats the consumer in the context of the trauma-inducing situations he or she has experienced and uses that information to inform the approach to care.
[‡]Where the response rate for a given question was less than 90% (263 or fewer), the number of respondents is indicated.
[§]The remaining 15% of respondents reported their facility ownership as "other."
[**]Examples include East Ming Quong in Campbell, CA; Youth Villages in Nashville, TN; and Boysville in Converse, TX.

adolescents ages 13 to 18, and 21% serve adolescents and young adults ages 19 to 25. Respondents estimate that 25% of those served were diagnosed with co-occurring mental health and substance abuse disorders. This contrasts with a recent study finding that at admission, 91% of children and youth in residential treatment had mental health diagnoses and 70% had alcohol/substance abuse diagnoses,[9] suggesting a high level of co-occurring disorders.

During the previous 12 months, the total number of children served by reporting facilities ranged from 10 to 290 (median=83, mean=97). The daily census ranged from 0 to 264 (median=34, mean=45).

Efforts to Ensure Appropriate Placement

How RTFs determine appropriateness of placement and continued stay is an issue of great interest in the children's mental health field. Ninety-two percent of 261 facilities responding report that they consult with staff from a referring agency (e.g., the mental health authority, child welfare, or schools) before a youth enters treatment. Those who do not consult with referring agencies indicate that other agencies do not engage in consultation or lack appropriate records, or that RTFs are not reimbursed for such consultation. Only two respondents believe that information from the referring agency is unnecessary. The majority of RTFs help the referring agency determine bed availability and appropriateness of placement — the latter largely through a review of available records and evaluations (100%), discussion with the referring agency (79%), and/or a formal assessment of the youth's functioning (70%). Of those making functional assessments through a formal evaluation, 59% do so with a widely recognized, standardized instrument, such as the Child and Adolescent Functional Assessment Scale (CAFAS).[10] Staff at 46% of RTFs participate in treatment planning meetings at other agencies to discuss treatment needs of youth who have been or will be referred.

Virtually all respondents (99%) report that they conduct periodic reassessments to determine whether continued residential treatment or a transition to community-based services is appropriate. For 77%, this reassessment is triggered by evidence of the youth's improvement, 71% perform reassessment at every treatment team meeting, and 44% do so upon request of the youth or family.

Respondents use a number of practices to monitor ongoing need for placement. Ninety-six percent assess the youth's therapeutic response to residential treatment, 93% gather information about treatment preferences directly from the youth, and 89% gather it from the family. Other common practices are consulting with community providers to determine appropriateness (63%) or availability (68%) of community-based services. Of the 236 responding, 31% conduct in-home evaluations of the family environment after admission.

Relationship with the Courts

Courts often play a key role in placement of children in RTFs, mandating placements as part of the disposition process. Most of the RTFs (63%) are not legally or contractually required to accept some or all youth referred for placement, including those referred by the courts. Of 261 facilities responding, 79% receive referrals from family courts or the juvenile justice department. The vast majority of these (94%) evaluate the referrals to ensure that appropriate treatment can be provided, and more than half (61%) work with community agencies to determine whether home- or community-based services are more appropriate for a child's needs. Slightly more than one-third (36%) do not conduct further evaluations for court-referred youth, either because they must accept these referrals without further evaluation (14%) or because the court has already determined that residential treatment is required (28%).

Transition from Residential to Home- or Community-Based Services

One of the concerns about out-of-home placements is the extent to which youth and their families receive support for a smooth transition back to more natural living and school environments. Of the 261 RTFs responding, 53% begin working on a client's discharge plan upon admission; 26% prior to

admission; 15% during team meetings immediately following admission; and 6% after the youth shows signs of improvement.

Figure 1: Members of Treatment Planning Teams

Members	RTFs Including*
Treatment facility staff	97%
Youth	94%
Family members	92%
Referring agencies	85%
Natural helpers	40%

*Of those using treatment planning teams.

Almost all respondents (98%) offer some service to facilitate the transition from residential to home- or community-based services. The most common activities reported are consulting with educational institutions to plan for education (76%); referring to natural helpers such as family/youth peer support groups (68%); consulting with other agencies/providers to locate appropriate housing (63%); and accompanying youth to outpatient or other community services (58%). Thirty-four percent consult with employers to identify vocational opportunities, and 31% conduct in-home evaluations of the family or living situation.

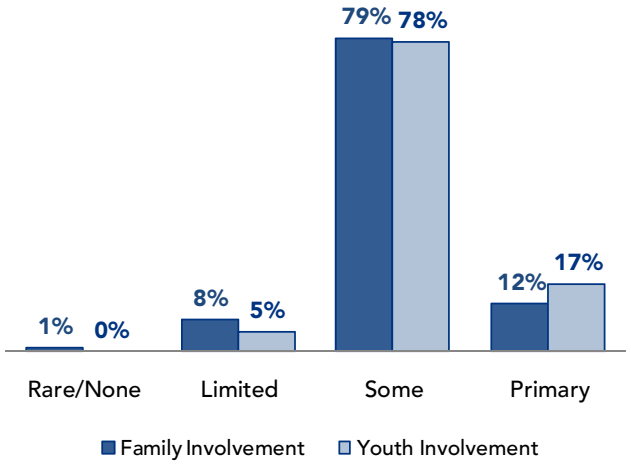
In addition, the majority of respondents (57%) report that there are some services in the community to help youth transition out of residential treatment, but suggest that these are not adequate. About a quarter (24%) indicate that there are very few or no such services, while 19% note that their communities offer a comprehensive range of transition services.

Transition services are especially critical for older youth who are moving into adult service systems, in order to maintain the continuity of care that their conditions require.[11] Of the 258 RTFs responding, 54% provide services to help youth ages 18 to 25 transition to adult services. Eighty-one percent of those provide telephone or written referrals; 79% provide contact information for adult service providers; 75% meet with community-based agencies that help young adults find treatment services, vocational assistance, education, and housing; and 29% provide community-based treatment services.

Individualized Treatment Planning

Individualized treatment plans are a hallmark of systems of care. Virtually all responding RTFs (99%) report that they develop individualized treatment plans for youth. Most incorporate system of care principles including: outcomes reflecting the input of the youth and family; a strengths-based approach to care; an individualized crisis/safety plan; and transition strategies. Sixty-eight percent employ strategies for incorporating natural helpers in the plan of care.

Figure 2: Level of Family and Youth Involvement on Treatment Planning Teams



Ninety-four percent of respondents also indicate that their individualized treatment planning utilizes a team approach incorporating various members (see *Fig. 1*).

While system of care principles stress the importance of family involvement on the treatment planning team,[12] in only 12% of facilities do families play a *primary* role in plan development, and in only 17% do youth (see *Fig. 2*).

Approaches to Behavioral Management

While most facilities (86%) have policies to reduce the use of seclusion and restraint, 83% used these practices within the previous 12 months. Those who did so indicate that they implement standard debriefing and reporting protocols in conjunction with these practices, including staff debriefing (68%), debriefing with the youth and family (72%),

Figure 3: Intervention Strategies for Behavioral Management

Intervention	RTFs Utilizing
Youth-/family-identified supports and interventions	87%
Trauma assessments	73%
Use of other agencies' intervention strategies	67%
Trauma-informed care	64%

recording the incident in the treatment plan (71%), and/or reporting to the youth's physician (65%).

Respondents engage, as well, in other behavior management approaches, including youth-/family-identified supports and interventions, trauma assessments, other agencies' successful intervention strategies, and trauma-informed care (see *Fig. 3*).

Provision of Non-Residential, Community-Based Services

Sixty-two percent of reporting RTFs provide at least one non-residential service (see *Fig. 4*), and 66% are part of organizations that provide both residential and non-residential, community-based services for children and adolescents. However, only half employ staff who provide continuing clinical services to youth in the community.

Use of Family-Driven Practices

A central tenet of a system of care approach is the engagement of families as partners in care, which includes facilitating family visitation and children's visits home. All but one responding RTF allow family visitation. Of these, 59% permit family visits at any time, while 22% do so only after a specified period of time following admission. Eighty-four percent allow home visitation. Seventy-three percent of those permitting visitation do not allow that right to be taken away as a consequence of unacceptable behavior by the child or youth.

Families of children and youth in behavioral health treatment may need support to be effective partners in care. Support provided by respondents (see *Fig. 5*) includes conference calls (the most common), off-site visits, social events for youth and family, reimbursement for meals during visits, reimbursement for transportation to and from the facility, and family-to-family peer support (provided by less than one-quarter). Of those that offer family peer support, more than half do so for all families, about a third based on staff judgment of usefulness, and the remainder to families upon request. Family mentors typically are unpaid.

Figure 4: Non-Residential Services Available to Youth

Service	RTFs Offering
Supported housing	62%
Outpatient mental health counseling*	52%
Integrated co-occurring treatment	48%
Intensive in-home treatment	38%
Crisis intervention	37%
Family preservation and reunification	35%
Multi-Systemic Therapy	38%
Therapeutic foster care	23%
Supported employment	15%
Vocational training	12%
Educational tutoring	10%
Electroconvulsive therapy	1%

*Of those providing outpatient mental health counseling, services include group therapy (95%), cognitive/behavioral therapy (94%), interpersonal psychotherapy (86%), and Functional Family Therapy (44%).[13]

Systems of care also call for family and youth involvement with RTF policy and operations. However, the survey found family involvement with RTF governance and facility operations to be minimal. Only 12% of RTFs involve families in programmatic oversight, most often as peer mentors, board members, or liaisons between other families and staff. Fewer than 25% of RTF directors surveyed believe licensing and accreditation standards should require that family members have a governance role.

Use of Youth-Guided Practices

Engagement of youth as partners and consumer-driven care are key system of care principles. Less than one-third (30%) of respondents offer youth-to-youth peer support; of these, half offer it to all youth, while half do so based on staff judgment of usefulness. Only 12% of RTFs involve youth who have stayed in an RTF in programmatic oversight or operations, most in unpaid

roles. Similarly, few involve youth as legislative advocates, in marketing, to assist in staff training, or as quality reviewers.

Forty-three percent of RTFs have an advisory board or "student council" of youth currently in residential care. Only about one-quarter (26%) of RTF directors believe that licensing or accreditation standards should require youth involvement in governance.

Figure 5: Types of Family Support Offered

Activity	RTFs Offering
Conference calls	94%
Off-site visits	72%
Social events for youth and families	70%
Reimbursement for transportation for visits	56%
Reimbursement for meals during visits	54%
Family-to-family peer support	22%

Culturally and Linguistically Competent Services and Supports

Systems of care stress the importance of a culturally and linguistically competent approach to care — a critical principle for RTFs, as racially and ethnically diverse children tend to be overrepresented in residential care.[14] Of 261 RTFs responding, 86% indicated that they require training on cultural diversity and/or cultural competency for all treatment staff, and 85% have provided such training on a variety of topics in the previous 12 months (see *Fig.* 6).

Only 34% of 258 responding RTFs have procedures for monitoring the cultural competency of services, most commonly through management review with staff (55%), management discussion of needed improvements (51%); a standing committee or team (46%); and/or management meeting with family members or youth (18%).

Of 237 RTFs responding, all have written policies related to the religious practices or faith of residents. The most common of these are provision of time for religious practice (83%); escorting youth to a place of worship in the community (77%); and ensuring that someone is available to talk to youth about their faith and beliefs (59%). A smaller percentage (22%) has dedicated space for religious observance.

Just over half of respondents believe that their staff can meet non-English communication needs of children, youth and families involved in behavioral health treatment, either directly or through a translator.

Staff Training in Family-Driven and Youth-Guided Care Principles

Sixty-five percent of 260 responding RTFs have provided treatment staff with training on how to apply principles of family-driven or youth-guided care, and 71% of 258 RTFs have provided training on its importance. Despite this, only 12% of respondents believe that most of their staff understand and apply principles of family-driven care, and only 19% believe this to be true for youth-guided care (see *Fig.* 7).

Figure 6: Cultural Diversity and Competency Training Offered

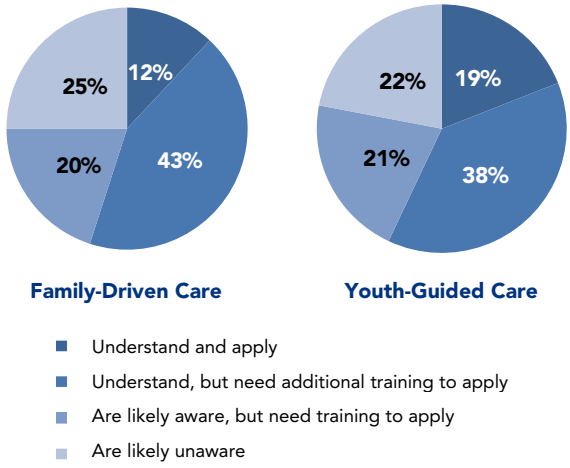
Topic	RTFs Offering
Racial /ethnic views of mental health treatment	79%
Religious diversity and practices	64%
Youth lifestyles	61%
Mental health needs of GLBT* youth	47%
Community resources for GLBT youth	19%
New languages	3%

*Gay, lesbian, bisexual, and transgender

Staff Recruitment and Retention

Sixty-four percent of RTFs report difficulty hiring staff, particularly child care workers and registered nurses, citing a shortage of applicants and the inability to offer competitive salaries. In addition, salary levels hamper staff retention at 56% of facilities. Inadequate staff training may further impede recruitment and retention at these facilities.

Figure 7: Staff Understanding and Use of Family-Driven and Youth-Guided Care Principles



Utilization of Quality Assurance Practices

Federal health care agencies have begun to put greater emphasis on the provision of high-quality care for children.[15] Accordingly, RTFs report having a number of quality assurance practices in place (see *Fig.* 8).

Given the system of care emphasis on using data to improve the quality of care, RTF directors were asked about efforts to monitor outcomes following discharge. Of several categories of information, only satisfaction with residential treatment services is collected by more than half (69%)of RTFs. Less than half monitor contact with the legal system, use of other community-based mental health services, housing stability, employment, use of hospital or residential treatment, clinical and functional status, and/or educational attainment. Among those collecting post-discharge data, most do so for no more than six months, and only about one-third share this data with youth and families at admission.

Description of RTF Financing

Survey data reveal Medicaid's significant role in RTF financing. As reported by 260 respondents, in the past 12 months, RTFs received Medicaid reimbursement for a mean of 69% of youth, and Title IV-E (child welfare) payments for room and board for a mean of 29%. Notably, 19% of respondents did not have knowledge of the extent to which Medicaid is a financing source, and 42% could not report on their facilities' reliance on Title IV-E funding.

Bundled rates are an alternative and typically more flexible financing mechanism for services provided to children and youth with serious behavioral health needs. By removing service constraints that often arise from a single funding source, bundled rates enable a provider to tailor services to a child's needs. Among 250 respondents, 60% receive bundled rates for some or all of their youth; of those, 42% say the mechanism allows sufficient flexibility to meet care needs.

While the health care field has shown an increasing interest in performance-based contracting, this is not reflected in the survey results.[16] Only 21% of 256 reporting RTFs receive financial incentives to reduce lengths of stay. Of these, 72% undergo periodic review of plans of care by state or county officials; in 50%, contracts with the state or county cover specific in-home or community services to help youth transition out of residential treatment; and in another 20%, reimbursement is reduced after a youth has been in residential treatment for a certain period of time.

Figure 8: Use of Quality Assurance Practices

Practice	RTFs Utilizing
Regular case reviews with supervisor	99%
Periodic client/patient satisfaction surveys	97%
Monitored continuing education for staff	94%
Periodic utilization review	91%
Regular case reviews by quality review committee	75%
Client/patient outcome follow-up after discharge	68%

Policy Implications

To varying degrees, the RTFs responding to this survey have adopted some policies and practices informed by system of care principles, and to a lesser extent, have evolved toward greater provision of home- and community-based services. While there are some promising findings herein, there remains room for improvement in these areas.

Reflection of System of Care Principles

Family-Driven and Youth-Guided Care

Overall RTF adoption of family-driven and youth-guided care is limited, and additional staff training in this area appears needed. Nationwide, communities

implementing systems of care are demonstrating effective partnerships with families and youth at direct service, program operations, and governance levels. In addition, many states and communities have strong family- and youth-run organizations that have grown as systems of care have spread – offering valuable lessons. System of care initiatives such as those funded by SAMHSA can reach out to RTFs to help them integrate family-driven and youth-guided principles in their policies and practices. State purchasers such as Medicaid and mental health authorities can include these principles in performance measures, provider capacity-building efforts, and pay-for-performance initiatives.

Cultural and Linguistic Competency

While virtually all facilities recognize the importance of cultural and linguistic competence and have provided some training in these areas, few facilities monitor cultural competency and/or explore related satisfaction levels of diverse youth and families. Federally funded, national technical assistance centers that support systems of care can help RTFs in building their competency in this area. State purchasers that are concerned about health care disparities can address high rates of RTF placement among racially and culturally diverse youth by working with referring agencies to examine racial biases and expand culturally competent home and community alternatives.

Survey results also point to an unmet need to provide culturally competent care beyond language services alone. For example, despite research suggesting that gay, lesbian, bisexual, and transgender (GLBT) youth are at high risk for behavioral health problems, out-of-home placements, and homelessness, low rates of staff training on GLBT issues and community resources were found.[17]

In facilities where staff racial and ethnic backgrounds largely do not reflect the individuals they serve, it is particularly important to provide opportunities for community feedback to the cultural competency of specific services. Given the many varied dimensions of culture — including race, ethnicity, age, gender, religion, and sexual orientation — this is a particular challenge; but if done appropriately, can reduce and/or eliminate barriers to engaging youth and families as partners in care.

Youth with Co-Occurring Mental Health and Substance Abuse Disorders

Despite the high rate of co-occurring substance abuse in children and youth receiving mental health services, only 17% of RTFs reported that their services focus equally on mental health and substance abuse. This is not surprising given that state purchasers of mental health and substance abuse services often operate independently with different licensing, contracting and financing processes. State purchasers can change purchasing and financing approaches to encourage integrated co-occurring treatment, which is critical and more effective than non-integrated treatment for this population.[18]

Home- and Community-Based Services and Supports

Although most facilities discuss appropriateness of placements with referring agencies, it was notable that only about half explore home- and community-based alternatives with these agencies. Furthermore, over one-third of the facilities that accept court-referred youth do so with little discussion of appropriateness. Adoption of strengths-based screening tools and individualized service planning approaches by RTFs, referring agencies and the courts could help to ensure that home and community alternatives are appropriately considered.

Most facilities either provide or are part of larger organizations that provide non-residential, community-based services. While there were promising reports of capacity to provide intensive in-home services, family preservation, crisis services, and evidence-based practices such as Multi-Systemic Therapy and Functional Family Therapy, a minority of reporting facilities provide these services, vocational training or supported employment. State purchasers can address this by including RTFs in efforts to encourage provider adoption of evidence-based and effective practices.

To enhance their provision of system of care informed services and supports, RTFs should consider incorporating related principles into their missions and visions. Frequent staff training that is designed to increase both the understanding and practice of youth-guided and family-driven care is essential given the high turnover rates among RTF staff. Additionally, enabling youth and families to be full partners in treatment planning and goal setting garners their commitment to the plan, and promotes use of informal and natural supports.

Outcomes, Quality, and Financing

Attention to quality of care, the monitoring and reporting of outcomes, and accountability in general are areas warranting more focus by RTFs. Few track outcomes such as clinical and functional measures, recidivism, school or employment status, or housing stability, and with short tracking periods. It is not surprising, then, that few share outcomes data with families and youth at the time of admission.

Despite Medicaid's emphasis on quality and performance measurement, and its role as a major funding source for RTF services, most RTFs reportedly are not bound by performance- or incentive-based contracts tied to desired outcomes (such as reduced lengths of stay) promoted in a system of care. As a result, RTFs do not have strong financial incentives to pursue interventions — such as evidence-informed home and community alternatives — that focus on these outcomes. State purchasers could require RTFs to track and monitor key system-, child- and family-level outcomes as part of their quality improvement initiatives.

The majority of facilities have national accreditation, and nearly all are licensed by their respective states. Those that have national accreditation are most likely to be accredited by JCAHO, which employs a model that is more medically than socially oriented, and/or by COA, which has standards more closely reflecting system of care values. State purchasers could increase the rates of national accreditation — particularly from COA — through contract requirements, purchasing specifications and pay-for-performance measures with RTFs.

Areas for Future Inquiry

There are a number of questions that ideally would have been included in the survey, but were omitted to prevent an undue burden on respondents. For example, given widespread interest among child behavioral health advocates, youth and families, and policymakers in the average length of stay (ALOS) for children and youth in RTFs, it would have been of interest to determine whether greater adherence to system of care principles corresponds to shorter ALOS. Other areas of interest include the primary sources of referrals to RTFs and how those differ by state or region, and the use of evidence-informed practices such as wraparound in RTFs. The current findings and remaining questions suggest that further study is warranted to better understand the approach of RTFs to services and supports for children and youth with serious behavioral health challenges.

Conclusion

While study findings reveal some uptake of system of care principles and practices among RTFs nationally, a greater emphasis on home- and community-based care, youth-guided and family-driven care, and cultural and linguistic competency is warranted.

Federal and state programs addressing the mental health needs of children and youth increasingly are requiring provider attention to these issues — supporting technical assistance and providing grant funding to make them the hallmarks of care. This leadership should guide RTFs seeking an evidence-based approach to sustaining and enhancing their mental health programs for children and youth.

Advancement of systems of care for this population requires that federal, state and local agencies engage RTF providers more effectively. RTFs, in turn, should reach out to entities that are engaged in system of care reform efforts in their states and communities to align and leverage their efforts. Continued dialogue is needed to build a common values base and practice model across the entire service continuum — supporting the best possible outcomes for children and youth with serious behavioral health challenges and their families.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

Related CHCS Resources

Through its *Children in Managed Care* program, the Center for Health Care Strategies (CHCS) works with state child-serving agencies, health plans, and family- and youth-run organizations to improve the delivery of behavioral and physical health services and supports, with a focus on children served by multiple public systems. Visit **www.chcs.org** to for more information on the following resources and initiatives:

Improving Medicaid Managed Care for Youth with Serious Behavioral Health Needs: A Quality Improvement Toolkit - This toolkit details the experiences of a workgroup of nine Medicaid MCOs that collaborated to identify ways to improve care for youth with serious behavioral health needs.

Medicaid Managed Care for Children in Child Welfare - This issue brief examines the complex physical and behavioral health care needs and associated costs for children in child welfare and outlines critical opportunities and challenges within Medicaid to better manage care for this high-risk, high-cost population.

The Use of Psychotropic Medications for Children Involved in Child Welfare - This CHCS webinar presented evidence-based and promising practices related to the use of psychotropic medication among children involved in child welfare and the critical role of families as partners in care. A resource paper presenting these findings will be published this year.

Improving Outcomes for Children Involved in Child Welfare - This national collaborative is working with nine managed care organizations and their child welfare partners to improve the delivery of physical and mental health care to children in child welfare.

References

[1] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD.
[2] Ibid.
[3] http://systemsofcare.samhsa.gov/index.aspx.
[4] http://systemsofcare.samhsa.gov/2008ShortReport.pdf
[5] http://www.cwla.org/programs/groupcare/nationalsurvey.htm.
[6] http://systemsofcare.samhsa.gov/ResourceDir/Comprehensivehome.aspx.
[7] Note: Information about the initiative, including products and activities, can be found at www.buildingbridges4youth.org.
[8] A. Drais-Perillo (2005). *The Odyssey Project: A Descriptive and Prospective Study of Children and Youth in Residential Group Care and Therapeutic Foster Care*, Child Welfare League of America.
[9] Abt Associates, Inc. (2008). *Characteristics of Residential Treatment for Children and Youth with Serious Emotional Disturbances.*
[10] Note: For more information about CAFAS, visit http://vinst.umdnj.edu/VAID/TestReport.asp?Code=CAFAS.
[11] R.C. Kessler, et al. "Age of Onset of Mental Disorders: A Review of Recent Literature." *Curr Opin Psychiatry*, 2007 Jul;20(4):359-64.
[12] B.A. Stroul and R. Friedman (1986). "A System of Care for Children & Youth with Severe Emotional Disturbances." CASSP Technical Assistance Center.
[13] http://www.fftinc.com.
[14] J. McMillen and L. Scott (2005). "Use of Mental Health Services Among Older Youths in Foster Care." *Psychiatric Services*, 55:811-817, American Psychiatric Association.
[15] See the Children's Health Insurance Program Reauthorization Act at http://www.cms.hhs.gov/chipra/.
[16] S.B. Perlman and R.H. Dougherty (August 2006). *State Behavioral Health Innovations: Disseminating Promising Practices.* The Commonwealth Fund.
[17] National Alliance on Mental Illness (June 2007). *Mental Health Risk Factors Among GLBT Youth.*
[18] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (November 2002). *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders.*