DOCUMENT RESUME

ED 304 860 EC 212 557

TITLE Interagency Plan for Children with Special Needs. Progress Report.

INSTITUTION Maryland Governor's Office for Children and Youth, Baltimore.; Maryland State Coordinating Council for the Residential Placement of Handicapped Children, Annapolis.; Maryland State Dept. of Education, Baltimore. Office of Special Education.; Maryland State Dept. of Health and Mental Hygiene, Baltimore.; Maryland State Dept. of Human Resources, Baltimore.

PUB DATE Mar 87

NOTE 64p.; For related document, see ED 280 228.

PUB TYPE Reports - Descriptive (141) -- Viewpoints (120)

EDRS PRICE MF01/PC03 Plus Postage.

DESCRIPTORS *Agency Cooperation; Alcohol Education; Child Abuse; Child Custody; Child Neglect; Child Welfare; *Cooperative Planning; Coordination; *Disabilities, Dropout Prevention; Drug Education; Drug Rehabilitation; Elementary Secondary Education; Handicap Identification; High Risk Persons; Individual Needs; Preschool Education; Prevention; *Social Services; *State Agencies; *State Programs; Student Evaluation; Truancy

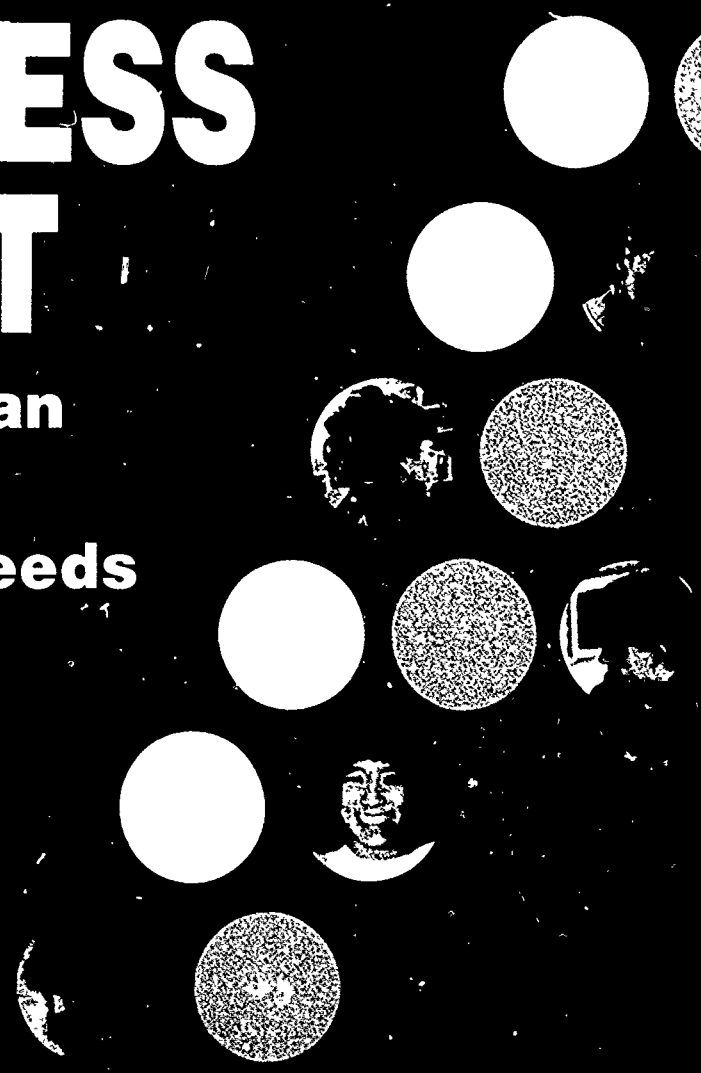
IDENTIFIERS Early Intervention; *Maryland

ABSTRACT

The Interagency Committee for Children was formed by three Maryland government agencies: the Department of Human Resources, Department of Health and Mental Hygiene, and Department of Education. Committee goals are to develop services for children and families and provide a more coordinated service system for special needs children and youth. This progress report summarizes the three Departments' fiscal year 1987 activities. The report recommends the following goals: (1) expand and coordinate a system of prevention/early intervention services for children aged birth to 3 years and their families; (2) strengthen the system of protective services to children at risk of abuse and neglect; (3) ensure that children who are at risk of commitment or who have already been committed to the custody of a state agency receive appropriate services; (4) reduce school truancy, prevent disruptive behavior in school, and encourage students to complete high school; (5) coordinate and expand drug/alcohol abuse education and treatment programs; and (6) establish comprehensive assessment, diagnosis, and evaluation services for special needs children. Progress is described on tasks outlined in the first interagency plan, in the areas of primary prevention; early intervention; evaluation, assessment, and diagnosis; in-home and community services; and substitute care services. (JDD)

PROGRESS REPORT

Interagency Plan for Children with Special Needs



State of Maryland
William Donald Schaefer, Governor

March, 1987

DEPARTMENT OF HUMAN RESOURCES • DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MARYLAND STATE DEPARTMENT OF EDUCATION • OFFICE FOR CHILDREN AND YOUTH
STATE COORDINATING COUNCIL FOR THE RESIDENTIAL PLACEMENT OF HANDICAPPED CHILDREN

PROGRESS REPORT

Interagency Plan for Children with Special Needs

March 1987

State of Maryland
William Donald Schaefer, Governor

DEPARTMENT OF HUMAN RESOURCES • Social Services Administration
DEPARTMENT OF HEALTH AND MENTAL HYGIENE • Alcoholism Control Administration
Developmental Disabilities Administration • Drug Abuse Administration • Juvenile Services Administration
Mental Hygiene Administration • Preventive Medicine Administration
MARYLAND STATE DEPARTMENT OF EDUCATION • Division of Special Education
OFFICE FOR CHILDREN AND YOUTH
STATE COORDINATING COUNCIL FOR THE RESIDENTIAL PLACEMENT OF HANDICAPPED CHILDREN

STATE OF MARYLAND

OFFICE OF THE GOVERNOR

WILLIAM DONALD SCHAEFER
GOVERNOR

March 30, 1987

I am pleased to receive this first Progess Report from the Interagency Committee for children. We can do more to help special needs children and their families when we work together to implement a concrete action plan.

We must work even harder to ensure that our children have a healthy start in life. This requires the kind of collaborative effort of an interagency group which involves state and local government, the judiciary, private philanthropy, the corporate sector, neighborhoods and communities. We in state government must be about helping people and we must use all the rich and creative resources of Maryland to do so.

The Interagency Committee has set an ambitious agenda and you have begun to make it a reality. The effort must continue because Maryland's children depend on us. You have my ongoing support through the Office for Children and Youth as the Special Secretary works with you to develop a united strategy on behalf of Maryland's children.

We must and we will make significant strides if we want a strong workforce as we enter the next century. All of our work, together, can make that happen.

Sincerely,

William Donald Schaefer

Governor

PREFACE

Last year, with the development of the ***Interagency Plan for Children with Special Needs,*** our three Departments made commitments to develop needed services for children and families, and to provide a more coordinated service system for special needs children and youth. We set forth an action stategy with specific tasks and timetables for improving the State's services for children. This strategy was forged by public officials, advocates, and providers working through the Interagency Committee for Children (ICC), which since then has monitored implementation of the Plan.

This first progress report summarizes the three Departments' activities to date during FY 1987. While we are still implementing the first year's activities, we are pleased that already more is being done for children and their families. For example:

- In four new jurisdictions in the State, developmentally disabled children and their families are receiving an array of support services that assist in the prevention of out-of-home placements.

- Over 40 new specialized foster homes are caring for emotionally disturbed and sexually abused children in a home-like environment, rather than in an institutional setting. There will be a total of 60 by the end of FY '88.

- Four therapeutic group homes will enable emotionally disturbed children to remain in community-based settings.

- Two additional family support centers are strengthening parenting skills for adolescent parents, helping these youngsters to remain in school or prepare for a job, and assisting other teenagers to avoid pregnancy.

- A joint specialized foster care effort is being implemented and will provide for the placement of 10 children who are developmentally disabled and multi-handicapped.

- Delinquent youth who are referred for substitute care are receiving comprehensive assessments before placement by a team of professionals who can evaluate mental, physical, social, and educational needs for services.

- Two additional youth centers will provide a smaller group environment for delinquent youth rather than institutionalization.

- There is an increase in the number of community residential alternatives for mentally retarded children and youth and a reduction in the number of State Residential Center beds.

This report also establishes additional goals and recommendations for the three agencies in six critical areas of service. These recommendations, and the tasks associated with them, will become part of the action plan that our three agencies are already carrying out for children. The recommendations are:

- The State should expand and better coordinate a system of preven-

tion early intervention services for children ages birth to three years and their families

• In order to safeguard children at risk of abuse and neglect, the State must strengthen its system of protective services to children and provide ongoing services to families.

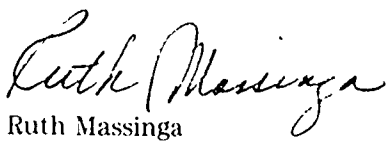
• The State must expedite the development of resources to ensure that children who are at risk of commitment or who have already been committed to the custody of a State agency receive appropriate services.

• The State must expand programs and services designed to reduce school truancy, prevent disruptive behavior in school, and encourage students to complete high school.

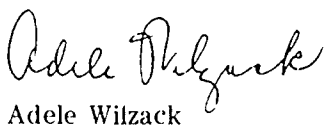
• DHMH and MSDE should continue to coordinate and expand the State's drug and alcohol abuse education and treatment programs.

• The State should establish a pilot program for comprehensive assessment, diagnosis and evaluation services for special needs children to reduce the number of multiple evaluations when appropriate and to plan effectively for services specific to individualized needs.

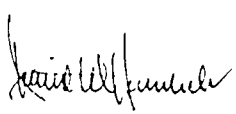
We believe these goals, together with those set forth in the original Interagency Plan, demonstrate the State's deep commitment to the well-being of children and families. We welcome comments and reaction to this report, and invite all parties to work with us toward the goals of assuring healthy development for children and keeping families strong.



Ruth Massinga
Secretary
Department of Human Resources



Adele Wilzack
Secretary
Department of Health and Mental Hygiene



David Hornbeck
Superintendent
Maryland State Department of Education

TABLE OF CONTENTS

INTRODUCTION 1

SECTION I: ACTION RECOMMENDATIONS

Goal #1 5
The State should expand and better coordinate a system of prevention/early intervention services for children ages birth to three years and their families.

Goal #2 9
In order to safeguard children at risk of abuse and neglect, the State must strengthen its system of protective services to children and provide ongoing services to families.

Goal #3 12
The State must expedite the development of resources to ensure that children who are at risk of commitment or who have already been committed to the custody of a State agency receive appropriate services.

Goal #4 16
The State must expand programs and services designed to reduce school truancy, prevent disruptive behavior in school, and encourage students to complete high school.

Goal #5 19
DHMH and MSDE should continue to coordinate and expand the State's drug and alcohol abuse education and treatment programs.

Goal #6 21
The State should establish a pilot program for comprehensive assessment, diagnosis, and evaluation services for special needs children, to reduce the number of multiple evaluations when appropriate and to plan effectively for services specific to individualized needs.

SECTION II: PROGRESS IN 1986

- Primary Prevention Activities 24
- Early Intervention Services 24
- Evaluation, Assessment and Diagnosis Services 25
- In-Home and Community Services 26
- Substitute Care Services 28

CONCLUSION 30

INTERAGENCY COMMITTEE FOR CHILDREN

Officials

Frank Farrow, chairperson: executive director, Social Services Administration, Department of Human Resources

Joy Duva, director; Office of Child Welfare, Social Services Administration, Department of Human Resources

Martha Fields, assistant state superintendent, Maryland State Department of Education

Eric Fine, director, Preventive Medicine Administration, Department of Health and Mental Hygiene

Richard Hamilton, acting director, Juvenile Services Administration, Department of Health and Mental Hygiene

Henry Harbin, director, Mental Hygiene Administration, Department of Health and mental Hygiene

Philip Holmes, director, State Coordinating Council for the Residential Placement of Handicapped Children

Lois Meszaros, director, Developmental Disabilities Administration, Department of Health and Mental Hygiene

Oscar Morgan, acting assistant director, Special Programs, Mental Health Administration, Department of Health and Mental Hygiene

Wendy Sherman, Special Secretary, Governor's Office for Children and Youth

Planners/Advocates

Sharon Nathanson, executive assistant to the Deputy Secretary, Department of Human Resources

Mary Kay Albrittain, branch chief for Pupil Services, Maryland State Department of Education

Beth Carter, Mental Health Law Project

Pat Alt, Office of Policy Analysis and Program Evaluation, Department of Health and Mental Hygiene

Herbert Cromwell, executive director, Mental Health Association of Maryland, Inc.

Doreen Croser, assistant director, Developmental Disabilities Administration, Department of Health and Mental Hygiene

John Farie, director, Office of Program Support, Social Services Administration, Department of Human Resources

Eugene Farrell, acting assistant director for Policy Planning and Information Services, Juvenile Services Administration, Department of Health and Mental Hygiene

Polly Harrison, Child Health Services Division, Preventive Medicine Administration, Department of Health and Mental Hygiene

Barbara Howard M.D., Maryland Early Intervention Work Group

Eleanor Kopchick, Developmental Disabilities Administration, Department of Health and Mental Hygiene

Lydia Kutze, president, Maryland Association of Residential Facilities for Youth

Sandra Leichtman, director, Child and Adolescent Services Unit, Department of Health and Mental Hygiene

Susan Leviton, University of Maryland Clinical Law Program

Gloria Merriam, Alcoholism Control Administration, Department of Health and Mental Hygiene

Marian Monk, licensing specialist, Social Services Administration, Department of Human Resources

Mary Mussman, Medical Assistance Policy Administration, Department of Health and Mental Hygiene

Sally Myers, Maryland Disability Law Center, Inc.

Catherine Raggio, executive director, Maryland State Planning Council on Developmental Disabilities, Department of Health and Mental Hygiene

Margaret Rawle, Social Services Administration, Department of Human Resources

Gail Robinson, director, Office of Planning and Analysis, Department of Health and Mental Hygiene

Daniel Ryan, Juvenile Services Administration, Department of Health and Mental Hygiene

Laura Steele, Office for Children and Youth

Jane Walker, Mental Health Association of Maryland, Inc.

Jerry White, Division of Special Education, Maryland State Department of Education

Karen Wulff, Preventive Medicine Administration, Department of Health and Mental Hygiene

INTRODUCTION

Children need adequate food, shelter, clothing, a safe and healthy environment, the guidance of caring adults, adequate physical and mental health care, and an appropriate education in order to become self-sufficient independent adults. The existence of some factor or combination of factors within the child or the child's environment may make it difficult for the family to meet one or more of these basic needs. A child may be born into extreme poverty, may have a severe physical handicap, live within an unstable, neglectful or abusive environment, have a serious mental or emotional disturbance, or may become dependent on drugs or alcohol. We call these "special needs children." In reality, the "needs" are the same for all children; the existence of a problem requires additional services to ensure that the child's basic needs are met.

The State categorizes children who need special services in a variety of ways. Some of these categories refer to unmet needs — abandoned, abused, neglected. Others are indicative of factors within the child which may make the fulfillment of basic needs more difficult — developmentally disabled, educationally handicapped, mentally disordered/emotionally disturbed, mentally retarded, chemical abuser. Still others represent the point at which a child has come to the attention of a State agency — child in need of assistance (CINA), child in need of supervision (CINS), or the delinquent child.

To meet the basic needs of children and their families, a variety of State and federal programs has been developed. The commitment to public school education is longstanding. Other programs include: Aid to Families with Dependent Children (AFDC), food stamps, Women, Infants, Children Supplemental Food Program (WIC), Early Periodic Screening, Diagnosis and Treatment (EPSDT); and Medical Assistance. Foster Care, Protective Services for abused and neglected children, Juvenile Services, Drug and Alcohol Abuse Prevention and Treatment, and Special Education are among the programs providing special services to children with particular problems. (See *The Interagency Plan for Children With Special Needs*, January, 1986, for a listing of programs offered by the Departments of Health and Mental Hygiene, Human Resources, Education, and other organizations within the State.)

Maryland's commitment to ensuring that the basic educational, health and welfare needs of its children are met is substantial, as is clear from a review of these programs. Unfortunately, there continue to be children in Maryland whose needs are not being met. Some programs are underfunded. There are gaps in services — some children, because of the severity or the multiplicity of their problems require a level or combination of services that is simply not available. Many families are unaware of the services that can be provided to assist them in meeting their children's needs

State officials and children's advocates alike recognize that a narrow focus on discrete health, welfare or educational problems of children will not guarantee that the full array of services is available for children with needs for special services. To ensure the development of the necessary continuum of services, representatives of several agencies within DHMH, the Social Services Administration

within DHR, MSDE, the Office for Children and Youth, the State Coordinating Council for Residential Placement of Handicapped Children, children's advocates, and providers of services began meeting in 1985 to plan for and coordinate future services for children with special needs. This Committee developed an Interagency Plan which was seen as a multi-year commitment by State agencies to achieve the goal of providing a full continuum of services that represents a flexible array of programs geared to individualized strengths and needs. The continuum includes five basic areas: (1) primary prevention activities; (2) early intervention services; (3) evaluation, assessment and diagnosis services; (4) in-home and community services; and, (5) substitute care services.

In each major area of service, the Plan describes the programs presently available, the populations being served, and estimated funding for the programs. It identifies specific short-term and long-term tasks for particular agencies and inter-agency workgroups and sets time frames to ensure that tasks are completed. In addition, the Plan identifies and makes recommendations concerning issues central to the effective management of State agency services. These recommendations also establish specific tasks and time frames for completion.

Since the Plan's publication, the Interagency Committee for Children has continued to meet for the purpose of setting agency goals for the development of children's services and to implement the specific recommendations contained in the Plan. In the following Section I, those areas which the ICC believes to be of immediate urgency for the State's special needs children are identified. In Section II, the State's accomplishments in building the continuum are reviewed in detail

SECTION I

ACTION RECOMMENDATIONS

Karen was 16 and six months pregnant, when a neighbor contacted the Family Support Center.

She had dropped out of school about two months before, and as yet had received no medical attention. She was scared, but there was really no one to whom she could talk. Her parents were angry about the pregnancy, and asking questions always seemed to start a fight. The baby's 18-year-old father was unemployed and unprepared to be a father. A Center staff person contacted Karen at home and convinced her to come to the Center. She responded quickly to the warm atmosphere.

With the aid of a Community Health Nurse, Karen enrolled in an intensive program of pre-natal care at the local health department; the nurse ensured that she kept all appointments and that the pregnancy was proceeding well. At the Center, Karen joined a group of young women who were learning about the needs and care of infants. Center staff also counseled Karen individually, and helped her to get baby clothes and a crib.

Karen delivered a healthy although slightly underweight baby, whom she named David. In the first weeks after delivery, Center staff and the Community Health Nurse visited her at home to check on David and help Karen handle her new responsibilities. They also got to know Karen's mother, who eventually joined Karen in family therapy at the Center.

Over the next few months, Center staff talked with Karen about family planning and helped her locate a part-time job and day care. With their encouragement, Karen also enrolled in a class to prepare for the GED exam. The Community Health Nurse arranged regular checkups for David at the local health department's well-baby clinic, and taught Karen how to monitor the baby's health between visits.

Karen is young to be a parent, but she's responding well to her son's physical, intellectual, and emotional needs. David's weight and development are now in the normal range. He smiles consistently, has an active curiosity, and eats heartily at every oppotunity. Both mother and baby are frequent and welcome visitors at the Family Support Center, where Karen stops by to show off her son, ask a question, or rap for a while with friends or a counselor.

Over 8,000 babies are born to Maryland teens each year, 40 to 50 percent to mothers who received little or no pre-natal care. Children of teens are at serious risk of physical and developmental problems.

Goal #1: *The State should expand and better coordinate a system of prevention/ early intervention services for children ages birth to three years and their families.*

At best, children or youth with special needs receive rehabilitative services that are scarce, costly, and may ameliorate, but not always eliminate, the underlying problem. The cost of the disability, whatever its nature, to the child and the family in terms of frustration, lost opportunities and future limitations cannot be measured. The cost to the State in terms of the potential loss of a contributing adult member of society is also immeasurable. The cost of services later in a child's life, after a problem has developed, can be high. For example, SSA spends approximately $32,000 per child when an institutional placement is required; the projected annual cost for FY 1987 for JSA to maintain a child in the Montrose School is $42,000. For this reason, public policies and programs must seek increasingly to prevent problems rather than merely address them after they occur.

At present, Maryland has a variety of programs that either provide prevention/early intervention services or have the potential for providing such services. Many of these programs are being tested on a pilot basis; others, because of insufficient funding, do not serve the entire population in need; some are limited in the populations they can serve by eligibility requirements. Perhaps most importantly, there is now no central coordination of planning or delivery of services by all the State agencies involved, nor are there comprehensive outreach and referral programs. Existing programs include:

- Early Periodic Screening, Diagnosis and Treatment (EPSDT) DHMH/PMA
- Maternal Health Prenatal Clinics DHMH/PMA
- Women, Infants, Children Supplemental Food Program (WIC) DHMH
- Children's Medical Services (formerly Crippled Children's Services) DHMH/DDA
- Hereditary Disorders Program DHMH/PMA
- Maryland Regional Neonatal Program DHMH/PMA
- Maryland High-Risk Infant Follow-up Program DHMH/PMA
- Family Support Centers DHR/SSA
- Family Support Services DHMH/DDA
- Parent Education Training Program MSDE
- Special Education for Handicapped Infants — MSDE

An increasing number of long-term studies have reported both social and economic benefits from programs of early intervention for infants who need special services and their families. These benefits include better school achievement, less need for special education in later years, lower delinquency and deviance rates, and high projected lifetime earnings. (See, generally, *Benefits of Early Intervention for Special Children*, Bailey and Trohanis, 1984.)

These programs are also cost-effective. The Interact Analysis of cost benefits of early intervention for handicapped children found that participation in preschool programs can save $9,000 to $10,000 in education costs of handicapped children through age 18 when compared with costs of educating handicapped children with no intervention before age six. (See, *Early Intervention for Children with Special needs and Their Families*, WESTAR, Garland, et al., 1981.) These studies emphasize that maximum benefits are obtained when the program includes a range of services, such as an educational experience, related health services, parent education, and parental involvement in planning for the child.

New programs are being added which greatly expand the potential for a comprehensive base of preventive services in Maryland. In October, 1986, Maryland implemented a program of pre-natal and delivery services for women under 21 who are pregnant, poor and have no health insurance.

In addition, DHMH is developing an infant follow-up project using a combination of State, federal, and foundation funding. The program will screen "at risk" infants in newborn intensive care units in Baltimore City and two to three selected counties within the next fiscal year. Infants will be screened according to 24 risk factors, including psycho-social factors (such as infant bonding, history of child abuse in the family). Appropriate services will be provided as needed and cases will be tracked by the community health nurse.

It is possible that Medicaid improvements for maternal and child health care recently enacted at the federal level in the Consolidated Budget Reconciliation Act of 1986 (P.L. 99-272) and the Sixth Omnibus Reconciliation Act (P.L. 99-603) will be a source of federal funding in addition to options presently available.

On October 8, 1986, the federal Education of the Handicapped Amendments of 1986 were signed into law. (P.L. 99-457) The Act authorizes an appropriation of $125 million for FY '87 and '88 to states for a new birth to three program for infants and toddlers who are developmentally delayed, or, at state option, at risk of being developmentally delayed. The legislation requires coordinated provision of services — special education, physical therapy, psychological services, health services, parent and family support services, and social services. It mandates the creation of an early intervention council consisting of representatives of the relevant agencies, consumers, and providers

Together, this expansion of State programs and the changes in federal legislation provide a unique opportunity for the further development of a comprehensive program to promote healthy child development in the first years of life. In order to achieve this goal, the State should take the following steps:

Task #1: DHR, DHMH, and MSDE should develop and implement a "First Years of Life" initiative to ensure that the resources and services of each agency are used collaboratively to promote healthy child development for all children, with special targeting to children known to be at high risk.

This initiative should identify the base of services available to all infants and the special services needed by sub-groups of infants and young children. Emphasis should be placed on ensuring adequate health care, mental health services, and nutrition for all youngsters; connecting high risk children and families to social support programs, such as family support centers; supporting parents' capacity for care of children; and linking existing early identification, health care, family support, and education programs. For example, such linkages can begin by ensuring that pediatricians and other medical care providers have adequate information and knowledge of referral resources.

One agency should be designated as lead for this initiative, with policy oversight by the Secretaries of the three Departments and with coordination and monitoring by the ICC.

Task #2: MSDE, DHMH, and DHR should address the needs of handicapped infants and toddlers and their families, including the "at-risk" population, pursuant to P.L. 99-457.

Recognizing that resource limits may not allow Maryland to extend its definition of "at-risk" under P.L. 99-457 to all children at risk, the ICC recommends that the State, through MSDE, DHMH, and DHR begin identifying priority risk factors other than biological handicaps and developing services to address the needs of these infants.

Task #3: DHR/SSA should expand Family Support Centers and coordinate their services more extensively with the high-risk screening and follow-up services being provided or developed through DHMH/PMA and expanded Medicaid programming.

Recent changes in federal law make it possible to provide prenatal services to more women under 21 and medical services to infants as well as case management services to certain targeted populations. The feasibility of these options needs to be assessed in conjunction with the requirement of the federal Education for Handicapped Amendments that all funding sources be utilized.

Task #5: DHMH, DHR, and MSDE should encourage the development of day care centers, day care homes, and pre-school programs that can serve the special needs of infants and toddlers and their families.

In addition to encouraging the development of programs for special needs infants and toddlers and day care programs in schools for students with infants, the State should encourage the development of effective parenting programs in day care centers and pre-schools. Staff at these centers should be trained to identify children with developmental problems so they can be directed to health care as well as other needed social and educational services.

Tommy's pediatrician reported suspected child abuse when she found welts and bruises during an examination. The injuries, according to Tommy's mother, resulted from a beating by his father. Tommy's mother agreed that he needed to be pur shed, but she admitted concern at the growing severity of the father's actions. However, she already fought so much with her husband that she was afraid to intervene.

A Protective Services worker from the local department of social services visited Tommy's home the next day. He learned that 11-year-old Tommy was misbehaving at home and at school, and could observe that the child was anxious and hyperactive. Tommy's father readily admitted having punished him because Tommy was reprimanded by the school principal. The father also made clear that he felt this was a family matter, and none of the agency's business.

That day, and in succeeding visits, the worker explored in depth the reasons behind the father's abusive treatment of his son. Eventually, the father was able to admit he felt ashamed and guilty about the way he was handling Tommy. He was frustrated, though, at his inability to control Tommy, and at what he felt was a lack of support from his wife in this effort. There were other sources of stress, too. Both parents were working, and Tommy's father had taken an evening job as well to pay off huge debts he had accumulated His wife was unaware of the debts, and felt he had taken the extra job to get away from home.

The children reflected the parents' struggles. Tommy's frequent outbursts were designed to distract his parents' attention and stop the arguments. Instead, they precipitated fighting about discipline.

Tommy's parents began intensive marital counseling, and his father sought individual therapy for his compulsive spending. The worker also continued to visit, helping them talk together about their problems and plan activities that all could enjoy as a family.

In time, Tommy's parents learned to cooperate in handling family issues, including discipline of the children. As the tension eased, Tommy's behavior improved. Tommy and his sisters no longer fear either abuse or the break-up of their family.

Tommy and his family required ongoing counseling and assistance for an extended period of time. There is a monthly caseload of 5,000 children living with their families who are at risk of abuse or neglect, many of whom need similar services.

Goal #2: *In order to safeguard children at risk of abuse and neglect, the State must strengthen its system of protective services to children and provide ongoing services to families.*

Maryland, like many states. is experiencing a dramatic rise in reports of child abuse and neglect. Between 1983 and 1985, reports increased by over 43 percent; in just the past fiscal year, both abuse and neglect reports have risen by approximately 40 percent. Even with this increase, Maryland's rate of abuse reporting (per 100,000 children) is significantly less than other states, and the indication is that the increase being experienced is likely to continue.

The dimensions of this increased reporting are straining the capacities of Maryland's protective services system to respond. Local departments of social services (and local police departments) are required by law to respond to all reports of child abuse and neglect within 24 hours. In order to meet that mandate, local departments of social services are having to redeploy workers just to keep pace with investigations; as a result, continuing services to families, which are key to guarding against further abuse, are reduced. Without adequate staff for investigations, actual caseloads exceed state standards for quality care. The essential base from which a strong, statewide protective services system must be built is adequate staffing for both investigations and continuing protective services functions.

The nature of much of today's child abuse and neglect also challenges current state resources. The incidence of sexual abuse has risen steadily in the past several years as a proportion of all abuse cases. Similarly, local departments of social services have documented very high incidence of alcoholism and substance abuse associated with these cases. Social workers must not

only have training in these dimensions of child abuse and neglect, they must also have available the specialized mental health and other treatment resources necessary to assist in working with abusing and neglecting families.

In view of the changing nature of abuse and neglect in Maryland, the following steps should be taken:

Task # 1: DHR/SSA should expand protective services staff in local departments of social services to meet state protective services caseload standards.

Task # 2: DHR/SSA should expand the availability to local departments of social services of support services in the areas of sexual abuse and substance abuse (alcoholism and drug abuse).

In addition to strengthening referral arrangements and cooperative agreements with local public agencies, SSA should provide local departments of social services with purchase-of-service dollars to secure necessary services from private agencies or to develop services when none exist.

Task # 3: DHR/SSA should develop an expanded training program to ensure that new and ongoing workers receive uniform instruction in State policies and procedures, in the techniques of investigation, and in the purpose and methods of continuing services. DHMH should provide training to protective services workers and other child care professionals in issues relating to abuse and neglect, such as the recognition of substance abuse.

This expansion would supplement or replace the current base of training provided to protective services workers, with particular emphasis on responding to the specialized problems which increasing numbers of protective services cases demonstrate, such as those cited above. Consideration should be given to a certificate program that emphasizes structured, on-going skill building as a mandatory training requirement.

John is 17. He is deaf, metally retarded, and emotionally handicapped. His mother abandoned him as an infant. After a brief stay with relatives, John entered foster care.

At first, John was placed with a foster family. They could handle him despite some behavior problems when he was physically small. As he grew, his behavior worsened, though, and he became less manageable. John moved through a succession of homes, schools, and institutions never staying long in any one.

Eventually, John was placed in Springfield Hospital. He was extremely aggressive and isolated, unable to interact with adults or other children. As a consequence, he was never allowed to leave the hospital. However, there was professional agreement that John didn't need to be hospitalized if an appropriate community placement could be found.

The foster care worker from the local department of social services brought John's case before the local coordinating council (LCC). The LCC has representatives from the social service, health and education systems who review cases of children with special needs. The multiple perspectives were key, because John's needs were too complex for any one agency to address.

Through the LCC, a small agency in a rural part of the state agreed to take John. Its staff, in the admiring words of John's worker, are "effective, caring, and not afraid to be original." The program operates houses in which several residents live with a staff member. The staff member provides supervision and training according to each individual's needs.

Staff worked extensively with John to modify his aggressive behavior, and a counselor from Gallaudet University taught him sign language. John's progress has been remarkable. For the first time, he has friends and is behaving well, no longer needing the reassurance of constant attention. Soon staff will begin helping John learn how to find and keep a job.

Although many residents of the program eventually are able to live independently, John will probably need to remain in one of the program's houses because of the number and severity of his problems. But he will do so as a happy individual settled in a home and functioning to the best of his ability.

Almost 40 percent of the 5,000 children in foster care have diagnosed special needs, including mental retardation, other developmental disabilities, and physical and emotional handicaps.

Goal #3: ***The State must expedite the development of resources to ensure that children who are at risk of commitment, or who have already been committed to the custody of a State agency, receive appropriate services.***

Local departments of social services (DHR/SSA) and the Juvenile Services Administration of DHMH are the primary State agencies to whom children are committed by the juvenile court. One of the powers of the juvenile court is to "order the child, parents, guardian, or custodian of the child to participate in rehabilitative services that are in the best interest of the child and the family." (Md Ann. Code, C&J§3-820 (c)(3)).

Several factors have made it increasingly difficult to provide the most appropriate rehabilitative services for these children and their families. The number of children being committed to the custody of local departments of social services by the courts has increased over the last two years while the number of available foster homes and other out-of-home placements has decreased dramatically. In addition, the foster care population and the needs of that population have changed drastically. Today, over half of the approximately 5,000 children in foster care are teenagers. About 40 percent of the caseload have diagnosed special needs including mental retardation and other developmental disabilities, and physical and emotional handicaps. As efforts to prevent foster care and reunify children in care with their families have been successful, the children who remain in care are those who have come from the most dysfunctional families, who have been most seriously abused, and who have the most severe physical, emotional, or behavioral problems. This has created a crisis situation in certain metropolitan jurisdictions.

JSA has experienced similar difficulties in obtaining appropriate placements for youth committed to its custody. A September 1986 study conducted by DHMH concluded that almost 50 percent of the children committed to the Montrose School did not need institutional care. The study noted that the lack of a continuum of services "contributes to the use of residential and institutional care." Among those services needed were youth tracking and advocacy; case management; in-home crisis intervention; and specialized foster care. The study concluded that, "Providing these kinds of programs in a comprehensive manner is essential to preventing commitment to Montrose and moving youth out of Montrose by giving them the support services necessary to remain in the community."

Much of the data in the Montrose report was based upon findings of a previous study of children committed to the Montrose and Hickey schools conducted by Student and Myhill. Their findings concerning the characteristics of these youth provide valuable assistance in determining the services needed to help this particular group and, more importantly, the services needed to prevent, if possible, the behaviors that result in committment. Of the youth committed to the Montrose and Hickey schools:

- 31 percent had at least one parent with a history of a psychiatric disorder;
- 31 percent had documented histories of physical abuse,
- 5 percent had been sexually molested;
- 60 percent had one or more out-of-home placements

other than JSA detentions and commitments;

- 64 percent had at least one affective disorder (depression, etc);
- 39 percent met the criteria for attention deficit disorders;
- 50 percent met the criteria for a main diagnosis of drug abuse.

In addition, a review of the educational records indicated that 76 percent of the Montrose youth had an IQ of 90 or below.

During the past year, both DHR and DHMH have taken steps to help alleviate this crisis situation. SSA is expanding its specialized foster care program to a capacity of 60 beds in FY 1987. DDA and SSA are jointly planning, developing, implementing, monitoring, and funding an additional ten specialized foster care beds for children who are developmentally disabled; MHA and SSA are in the process of developing a similar agreement. SSA has funded more emergency shelter beds and is pilot-testing a retainer fee system for these beds. DHMH has studied the feasibility of closing Montrose School and alternative uses of that facility. In addition to these efforts, the relevant agencies should take the following actions:

Task # 1: DHR/SSA should restructure its foster care payment levels to pay rates to foster parents that reflect the cost of caring for a child and are adjusted for the special needs of foster children.

SSA has developed a plan for a three-tier structure of foster care home rates which could move Maryland's foster care system over several years to a more professionalized system. Implementation of the system should begin in FY '88.

Task # 2: DHR/SSA should expand the number of specialized foster home beds in FY '88 by 50 beds and develop plans for joint-funded specialized foster homes with MHA.

By the end of FY '87, SSA will have developed a total of 70 specialized foster care beds (ten in collaboration with DDA). This number still falls far short of the estimated need. During the first quarter of FY 1987, the State Coordinating Council has had to place 159 children in out-of-state residential placements. A number of these children could be returned if community living arrangements were available. The total number of specialized foster home beds should be augmented by a minimum of 50 beds in FY '88. In addition, SSA and MHA should proceed with their planning for collaboratively developed and funded specialized foster homes.

Task #3: DHR/SSA, DHMH/JSA and DHMH/MHA should, on a pilot basis, develop service agreements between local departments of social services and regional JSA offices and local mental health programs which target community mental health services to children committed to the State and their families.

The large proportion of children in SSA's and JSA's custody who have mental health problems requires an increased linkage to community mental health services. Full responsiveness of local mental health resources to this need will require expansion of resources, but until that occurs, the agencies should explore, on a pilot basis, greater targeting of existing mental health services for that purpose.

Task # 4: MSDE should develop alternative educational and vocational programs for children who do not meet the requirements for special education but who are not succeeding in school.

As the statistics concerning the youth at the Montrose School indicate, learning difficulties are often among the problems faced by youth at risk of institutionalization. The Individual Educational Plan (IEP) process has proven effective in addressing the needs of handicapped students. A similar approach needs to be developed for those children who do not function well in regular education settings and who require a program of individualized instruction to meet specialized needs.

Task #5: DHMH should continue to expand its family support services programs.

In order to prevent out-of-home placement of developmentally disabled children and youth, DDA should continue to expand the provision of support services on a statewide basis.

Task # 6: DHR/SSA should provide staff to local departments of social services to develop new local resources needed by the Foster Care program and to coordinate resources with other state agencies.

With the growing complexity of the needs of foster children, local departments of social services cannot provide all necessary resources; other services must be provided by state agencies or by private community resources. To promote the development of these resources, SSA should make available resource development staff statewide, with priority given to expanding independent living services for older adolescents, creating linkages to mental health services, recruiting additional foster homes and adoptive homes, and developing additional emergency shelter resources.

Task # 7: DHR/SSA should work with private provider agencies to increase the services these agencies provide to families at risk of foster care and/or to children in foster care.

To expand the base of services available to dysfunctional families at risk of removal of a child from his/her home, SSA, local departments of social services and private family services agencies should develop priorities for services which private agencies could make available (by referral or purchase arrangement). SSA should develop new funding resources or redirect other funding resources for these services as appropriate.

Task #8: DHMH should expand and improve a variety of community-based alternative living arrangements for children and youth as well as facility-based residential services for violent/recidivistic/multiple-problem youth committed to or in need of institution-based services.

There is a need for specialized and regular foster care, alternative living units, and group homes for children who are juvenile delinquents, emotionally/behaviorally disturbed, developmentally disabled, or substance abusers. In addition, there is a particular need for residential placements for seriously emotionally disturbed children under 12.

Task # 9: DHMH, through ACA, DAA, and JSA, should provide coordinated programs and services which address the chemical dependency needs of youth committed to Montrose and Hickey schools.

At 16, Ricky was older than any of his eighth grade classmates, which only added to the frustration he had felt throughout his school career. He had been "held back" three times for poor grades, and was on the verge of being expelled because of his chronic truancy and disruptiveness in the classroom.

As a last resort before expulsion, the director of Pupil Services suggested that Ricky try the area's alternative school. The school offers small classes and teachers with special qualifications. In addition, every child is assigned an advocate from the central office Pupil Services staff. The advocate works closely with the student, even visiting the home if necessary. The advocate then stays in touch with the student once he or she returns to the home school.

Before entering the alternative school, Ricky and his parents met with the director of Pupil Services. They worked out a "contract," specifying what each would do to help Ricky. Ricky's part of the contract was a commitment to attend classes regularly.

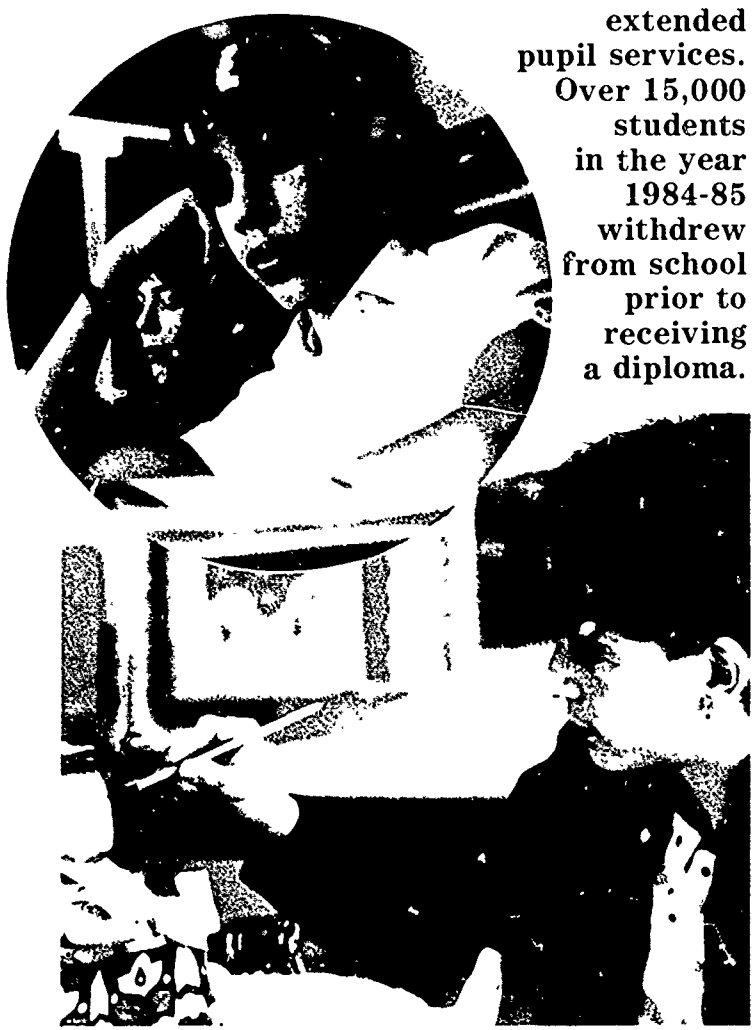
That turned out to be a commitment he could easily keep. Ricky found, as he later wrote in an essay, "teachers who cared and wanted to be there. School was fun. they made me feel like I could succeed." Below the belligerent facade was a sensitive, bright youngster who did well in both the classroom and on tests which had previously indicated below average intelligence. Most important, Ricky regained his sense of self-worth.

Students attend the alternative school for a limited period of time, generally between three months and a year. Returning to their home school is important, a part of learning to cope with and meet normal expectations. The continued support of the advocate helps smooth the transition.

Ricky spent a year at the alternative school. He was reluctant to leave, but agreed to give the regular school "one chance." Shortly after he returned, there were recurrences of the disruptive behavior. The advocate visited the school, working out with Ricky and his teachers a way to handle Ricky's frustration. This negotiation process not only helped Ricky, but brought some of the alternative school's successful techniques into the regular classroom.

Three years later, Ricky graduated from high school and began working at a job. He has already received two promotions from a satisfied boss.

Less than 3,000 of the 57,000 students committing suspension offenses in a year receive direct services in the form of alternative schools or extended pupil services. Over 15,000 students in the year 1984-85 withdrew from school prior to receiving a diploma.



Goal #4: *The State must expand programs and services designed to reduce school truancy, prevent disruptive behavior in school, and encourage students to complete high school.*

The term "students at risk" describes those who, for a variety of health, social and/or economic factors, are often far behind from the beginning of their school careers. The chance of these children being "lost" academically grows throughout their school years until they become at risk of failing to complete their high school education. The following statistics reflect not only some of the types of school failure, but also point towards the kinds of services needed to prevent academic difficulties.

- Over 8 percent of the students enrolled in public school are absent on any given day.
- In the year 1984-85, 4.6 percent of the school population in grades 7 to 12 dropped out of school; the percentage rose to 5.1 percent in the year 1985-86.
- Approximately 9 percent of all Maryland students were suspended during the school year 1984-85
- Approximately 20 percent of the students enrolled in the ninth grade in the years 1981 and 1982 failed to graduate in the years 1985 and 1986.

The social, economic and health factors underlying the statistics cited above are emphasized by the following disturbing facts concerning Maryland's children:

- Twenty-six percent of all first births in Maryland are to women under the age of 20. Seventy-two percent of teenage first births are to unmarried mothers.
- Maryland teenage suicide rates have more than doubled since 1960.
- Ten percent of Maryland's population between the ages of 14 and 18 experienced problems with drugs or alcohol in 1985-86.

Since the passage of Public School Law 7-303 (Special Programs for Disruptive Students) in 1984, the Maryland State Department of Education has received State funds for program development in local education agencies to prevent or remediate student disruption, chronic truancy or students dropping out of school. However, the needs of the students who are at risk of not completing their education far exceed the limits of the available funding.

Given the extent of the problems affecting children in Maryland public schools, the relevant agencies should take the following additional actions to ensure the existence of programs to prevent school failure from the beginning of the child's school experience through high school:

Task # 1: MSDE should expand pre-kindergarten education programs to all four-year-old children attending schools that qualify under Chapter 1.

Results of state and national research demonstrate that high quality early childhood education improves children's chances for success in school and later life. Studies conducted by Weikart and Lazar and MSDE found that pre-school programs reduced the need for children to receive special education or to repeat grades. They also increase the rate at which children participate in talented and gifted programs and contribute to children's higher performance on achievement tests. The Weikart study found a positive relationship between pre-school participation and reduced rates of delinquency, arrests, teen pregnancy, and welfare dependency, and increased rates of employment at age 19.

Task #2: MSDE should make every effort to assist Local Education Agencies in expanding total school intervention programs, at-risk pupil services programs, and alternative education centers to prevent chronic student disruption and to reduce the number of students who leave school prior to graduation as the result of disruptive/truant behavior.

As noted above, the number of student suspensions, absences and dropouts continues to grow. In order to reduce serious student disruption, improve school attendance, and reduce the number of students withdrawing from school, local education agencies must expand all programs and services to these at-risk students.

Task #3: MSDE and DHMH should increase coordinated school health services to all elementary students.

Approximately 283,036 elementary school students receive minimal health or on-site nursing services. There is a need for comprehensive school-based health diagnosis, evaluation, and case management services for all children, and especially for those at-risk students who traditionally may have been lost in the system.

Task #4: MSDE, DHMH and DHR should implement a broad spectrum of programs and services to address the needs of students at risk of teen pregnancy as well as pregnant and parenting teens.

The 1984 statistics for Maryland show that 8,311 births occurred to women under 20. Of these births, 1,525 were repeat pregnancies. As a part of the effort to reduce these numbers, the State should establish school-based health clinics which focus on the total health care of adolescents and teach preventive health care. Additional programs and services directed toward teen pregnancy prevention, teen pregnancy and teen parenting are essential in order to decrease the number of infants who are at risk of congenital defects, developmental delays, child abuse, and poverty as well as to assist pregnant or parenting teenagers in becoming self-sufficient, contributing members of society.

Troy's older brother Jim was an addict, who left home rather than enter a drug treatment program. Troy and his younger brother missed Jim. He'd been the one who looked after them while both parents worked; Mom and Dad always seemed too busy to talk.

With constant fighting about Jim's addiction, it had been rough at home the last couple of years but the loneliness after he left was worse. Troy's grades started to drop and he was suspended from school for fighting. He began to get high on weekends, sometimes with drugs, sometimes with alcohol. He wasn't an addict, not yet, just what is known as an experimental user.

Finally a teacher, frustrated by Troy's disruptions in class, made it clear that Troy would never realize his dream of becoming a Marine if he didn't "clean up his act." The teacher suggested Troy look into a group called Students Helping Other People, or SHOP.

SHOP is a substance abuse prevention program sponsored by the local health department and the county's high schools. SHOP clubs hold regular rap sessions, and organize alcohol/drug free social events. Members are also active in community service projects.The clubs have adult advisors, but are started and led by students. Potential leaders receive special training not only in substance abuse, but also in problem-solving, communication and leadership skills.

Troy joined his school SHOP club after encouragement from club members helped him overcome his initial reluctance. Still early in his flirtation with substance abuse, it wasn't too hard to quit altogether. The friendships he formed at SHOP made up at least a little for Jim's absence, and he realized how important it was to be a role model for his younger brother. His grades and behavior in school returned to normal.

The next year, Troy attended one of SHOP's leadership training conferences, which gave him a new sense of self confidence. In his senior year, Troy chaired the SHOP-sponsored effort to prevent drinking and driving on prom night.

After graduation, Troy entered the Marine Corps. Before he left, he talked to his younger brother about joining SHOP.

By the twelfth grade, 70 percent of all students will have used illegal chemical substances. SHOP programs are effective in preventing drug and alcohol abuse, but are not available on a statewide basis.

Goal #5:
DHMH and MSDE should continue to coordinate and expand the State's drug and alcohol abuse education and treatment programs.

Until recently, drug and alcohol abuse has been neglected as a major problem. Substance abuse is one factor in a broad array of problems affecting special children and youth and their families — from physical abuse and neglect to delinquency and teen suicide. The 1983 Fifth Special Report of the American Psychiatric Association to the U.S. Congress on Alcohol and Health reported that as many as 80 percent of those who attempt suicide had been drinking at the time. In 1984, *U.S. News and World Report* found that 70 percent of teen suicides had alcohol in their systems at the time of death. A review of health status indicators for Maryland adolescents revealed that one in four high school seniors in 1985 used alcohol almost daily, one in eight used marijuana almost daily, and 54 percent had used cocaine, 11 percent almost daily. The Student/Myhill study of youth committed to the Montrose and Hickey facilities found that 70 percent had a substance abuse problem while 50 percent met the criteria for a main diagnosis of drug abuse. A growing number of serious child abuse cases involve substance abuse as well. Maryland's efforts to address this problem require significant expansion

In July 1980, MSDE established the Maryland Alcohol/Drug Action Resource Team (MADART) project to provide leadership teams to selected school systems and their respective communities. Since that time, 30 MADARTS in ten counties have been organized and trained. In addition MSDE has trained 37 peer leadership/counseling teams (Students Helping Other People—SHOP).

Beginning in the 1984-85 school year, Project SMART was implemented in the Prince George's County school system (Self-Management and Resistance Training) by DHMH. The program uses students acting as "skill captains" to encourage others to resist influences leading to experimentation and abuse. With the assistance of a private grant, this program will be expanded to more than 58,000 sixth-graders during the 1987-88 school year.

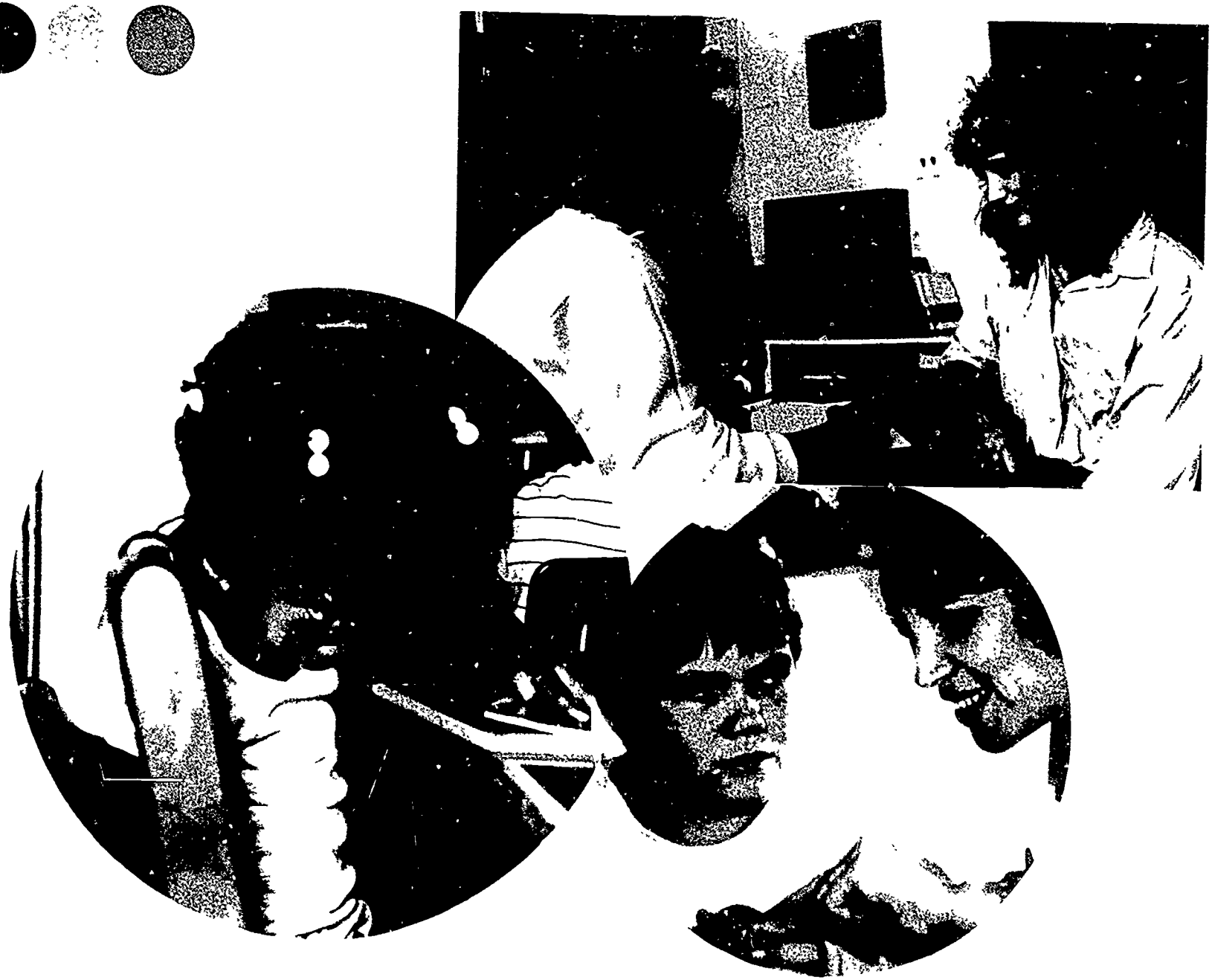
These programs of MSDE and DHMH, however, are not available on a statewide basis. In addition, substance abuse treatment programs are not large enough to meet the existing need. During the past year, increased attention has been focused on substance abuse among adolescents, both in Maryland and at the national level. The federal Drug-Free Schools and Communities Act, signed on October 27, 1986, provides funding for drug education at both the college and public school levels. These additional funds could provide the impetus for expanded drug education programs in the State. The State, however, needs to do the following:

Task #1: DHMH should continue to work collaboratively with MSDE in expanding chemical dependency student assistance programs in the school setting.

In cooperation with MSDE and local agencies, DHMH should develop a comprehensive program of primary prevention, intervention and treatment services designed for troubled students and their families.

Task # 2: MSDE should expand its MADART/SHOP programs to other school systems.

By enlisting community support and through the use of peer counselling, these programs have been effective deterrents to substance abuse.



Goal #6: ***The State should establish a pilot program for comprehensive assessment, diagnosis, and evaluation services for special needs children, in order to coordinate the often separate assessments required or obtained by DHMH, DHR, and MSDE.***

As the special needs of children become more complex, and as a broader array of services is developed by state agencies to meet those needs, the function of assessment, diagnosis, and evaluation becomes increasingly important. A child's problems and abilities, as well as those of his/her family, must be understood in order to match the child to the appropriate service(s).

At present, there are several problems with the way assessment and diagnostic services are provided. First, each agency serving children tends to use different procedures, processes, and forms for obtaining evaluations. With increasing need for families to receive services from several agencies, this lack of uniform procedures too often results in evaluations having differing recommendations for treatment; in conflicting assessments of what a child or family's problems are; and, in general, in an uncoordinated and contradictory base on which to build a service plan.

A related problem with such evaluations is that they often seem to be influenced by the resources available to whichever system is performing the evaluation. For example, evaluations sought by the mental health agency may recommend more intensive mental health services, but not be aware of — and thus not recommend — an array of social support services. Evaluations thus may have a limiting effect on service planning for the child, because they are not done in the context of the full service system.

Given the recurrent problems with the evaluation functions, the ICC believes that state agencies should develop procedures to better coordinate the evaluations sought and received by them, as follows:

> **Task #1: DHMH, DHR, and MSDE should design and implement a coordinated evaluation pilot project in one jurisdiction of the state, to demonstrate the effectiveness of uniform guidelines and procedures for obtaining an evaluation.**

This pilot project should involve the evaluation and diagnostic functions of the LCC, as well as of SSA, MHA, DDA, JSA, and the special education program. The pilot should at least develop coordinated procedures for evaluations and, if possible, implement centralized evaluation procedures, which would encourage multiple agencies to obtain evaluations from the same source.

The SCC should take the lead in developing and implementing the pilot project, with agreements for participation by the agencies referenced above.

SECTION II

PROGRESS IN 1986

Since July, 1986, DHR, DHMH, and MSDE have been implementing the tasks set forth in the first Interagency Plan. This section summarizes progress to date (note that many of the tasks are not due for completion until June, 1987, or later).

PRIMARY PREVENTION ACTIVITIES

Primary prevention services and programs are designed to promote healthy child development and prevent the development of problems which may require extensive special services.

The tasks related to prevention in the first year plan were recognized as only initial steps toward a more extensive, coordinated base of preventive services. Nevertheless, useful progress was made, particularly through the extensive deliberations that went into the Plan for the Prevention of Childhood Disabilities (Task #2 below). The next steps in building preventive services are discussed in Section I of this report

TASK 1: DHMH, through the Medical Assistance Administration and in conjunction with the Preventive Medicine Administration should continue to expand the EPSDT program to ensure coverage of all income-eligible children in the state.

- While the Medical Assistance Administration (MAA) has not yet taken steps to increase utilization of EPSDT statewide, some expansion has occurred On a pilot basis in Baltimore City, EPSDT funds are being used to help finance school nurses and thus increase care to eligible children. Possibilities for even more aggressive outreach through schools are being considered by MAA.

TASK #2: DHMH, through DDA, will prepare a three-year statewide plan focusing on prevention activities related to children's disabilities.

- The task force convened by DDA has drafted a plan entitled "The Maryland Plan for the Prevention of Childhood Disabilities." Among others, the Plan makes recommendations to state agencies on the reduction of environmental hazards, prevention of childhood injuries, and the prevention of substance abuse during pregnancy — activities that could assist in preventing childhood disabilities. DDA will monitor follow-up on the final plan to promote implementation.

TASK #3: DHMH, through JSA, should develop a plan for the expansion of Youth Services Bureaus which provide community-based delinquency prevention services and daily supervised activities for teens.

- At present, JSA funds 21 Youth Services Bureaus and nine Multi-Purpose Centers. JSA will request additional funds for expansion of these programs in FY '89.

EARLY INTERVENTION SERVICES

Early intervention services focus upon screening, diagnosis, and prompt service to ameliorate or eliminate problems before they become more severe. They include health, social service, and child development activities. Examples in Maryland include SSA's family support centers. DDA's family support services, regional neonatal programs, high-risk infant followup programs, and parent education programs. Information and referral services play a vital role in the success of early intervention services (as well as prevention services).

TASK #1: DHMH, through the Mental Hygiene Administration, should expand mental health early intervention programs for children from birth to five years of age who are at risk of psychosocial and developmental dysfunction.

- DHMH's Mental Hygiene Administration has proposed expansion of early intervention programs for these children through: (a) expansion of mental health center staff, enabling more direct service as well as consultation to nurseries, day care programs and other settings which serve this young population; and, (b) expansion

of training for mental health professionals in specialized techniques in working with infants and young children. Contingent on funding, these activities are scheduled to begin in FY '88 and are part of a five-year plan.

TASK #2: The Governor's Office for Children and Youth, in conjunction with MSDE, DHR, and DHMH, should develop a plan to ensure that existing information and referral services reach the families of special needs children.

- OCY has set short-term and long-term goals for this task, working with the public information officers of state and private agencies. Short-term, and to be of immediate benefit, a resource directory is being developed to be used on a pilot basis within the departments for 200 key agency staff. The usefulness of the directory will be evaluated, and it will be modified and updated.

Long-term, this group seeks (a) to establish a single centralized place for I&R services for special needs children and youth, and (b) to have in place a computerized system to provide quick access to appropriate I&R resources. The committee exploring existing I&R resources (such as First Call for Help) to determine whether there needs to be a new state system for centralized I&R resources, or whether it can be added to a current system, at less cost.

TASK #3: DHR, through SSA, will evaluate its pilot program of family support centers which is in its first year of pilot testing in FY 1986. If results of the ongoing evaluation are positive, SSA will plan to increase the size of this program in FY 1987 and FY 1988.

- Initial results of DHR's evaluation of family support centers indicates that these centers have served numerous adolescent parents, other teenagers, and many family members of adolescent parents — a total of 848 people in the first four months of the four centers' operations. As the centers seek to improve parenting and help young parents complete school and obtain employment, they have proved particularly successful in reaching young teens and adolescent fathers. Two additional family support centers will open in FY '87, and two centers are proposed for FY '88 (yielding a total of eight centers by FY 1988).

EVALUATION ASSESSMENT AND DIAGNOSIS SERVICES

Public school systems, local departments of social services, private agencies under contract to the Juvenile Services Administration and mental health clinics all provide evaluations and assessments of children who have particular needs for services. A child may be evaluated by more than one agency because of a multiple need for services. The objectives in this area are to avoid duplication of effort and multiple assessments of the same child.

TASK #1: Each State agency serving children (MSDE, SSA, JSA, PMA, MHA, DDA, ACA/DAA) and their local agencies should have within the agency standardized intake forms which are used consistently throughout the state.

- The State Coordinating Council and DHMH, DHR, and MSDE are designing a pilot project, to be tested in one jurisdiction, which will provide a single, comprehensive assessment and evaluation of children needing the services of more than one agency, using standardized forms as appropriate. (See Section I, Goal #6.)

TASK #2: MSDE (through local education agencies), SSA (through local departments of social services), JSA, DDA, ACA/DAA, and MHA should, to the extent permitted by law, make their written evaluations of specific children available and accessible to other State and local agencies involved in care planning for the child.

- No action has been taken on this task to date. It will be addressed as part of the pilot project, above.

TASK #3: DHMH, through JSA, should develop comprehensive localized assessment capabilities for youth who are referred for substitute care through JSA.

- JSA has already implemented four assessment teams in Baltimore City, Baltimore County, Harford County and Anne Arundel County. An additional assessment team will be initiated in Prince George's County in FY 1988. Five additional assessment teams will be initiated in FY 1989 to serve the remainder of the state.

IN-HOME AND COMMUNITY SERVICES

The State provides a broad array of services designed to support a family living situation for a child who needs special services. These include, but are not limited to, specialized equipment, special medical services, tutoring, vocational education, counseling, out-patient therapy, self-help groups, day care or respite care, and adoption services.

Despite the number and variety of programs offered, many additional resources are required in order to provide adequate services to meet specialized individual needs. The original Plan identified needs for mental health services for children and adolescents, services to prevent teenage pregnancy, respite care services and the development of alternative academic and vocational programs as areas requiring planning and development by interagency groups.

TASK #1: MSDE, working with JSA, SSA, DDA, ACA/DAA, and MHA, will promote the development of appropriate alternative academic and vocational programs for youth who do not function well in regular education settings and who require a program of individualized instruction that meets their specialized needs.

- The development of these programs is a long term project, requiring both leadership from the State as well as commitment and funding on the part of local education agencies. With MSDE leadership, the agencies participating in this task have conducted background research to identify state-of-the-art programs and determine Maryland's future direction in this area.

TASK #2: DHR, through SSA, and DHMH, through DDA, JSA, and MHA, will develop an expansion plan for respite care, day care for special needs children, and personal care/parent aide services.

- Plans for expansion of these services are still under development.

TASK #3: DHMH, through MHA, should expand treatment staff with specialties in child and adolescent mental health in community mental health centers and increase outreach services to emotionally disturbed children and their families, including home-based interventions.

- Expansion of these child and adolescent mental health treatment staff and the development of outreach teams are scheduled to begin in FY '88.

TASK #4: In FY 1987 local mental health centers will enter into

agreements with local departments of social services and locally based JSA intake, probation and aftercare units to make mental health consultation available.

- Of those mental health centers responding to a recent survey, approximately 40 percent have agreements with local departments of social services and juvenile service agencies regarding consultation and/or service delivery. MHA is working to ensure that others develop these agreements. Additionally, MHA will soon issue a policy promoting consultation between all group homes and mental health centers, which will be initially promulgated in FY '87. (At present, seven group homes in the Central Maryland region have shared service agreements with community mental health centers.)

TASK #5: DHMH, through JSA, should take the lead in developing a plan for the expansion of community-based programs for adolescents.

- This general directive has been incorporated into the more specific tasks listed in this section

TASK #6: DHR, through SSA, will continue to expand its family service programs in order to maintain children in their homes and communities rather than in foster care.

- DHR is evaluating its intensive family services program, with plans to expand it in FY '89. In the interim, purchase of service funds for continuing protective services will be increased significantly in FY '88, and SSA will test purchasing these services from private agencies.

TASK #7: DHMH, through DDA, should expand the Family Support Services program in the jurisdictions now participating as well as to the remaining uncovered jurisdictions in the state.

- In FY '86 under community expansion, the DDA funded agencies to provide individual and family support services in Garrett, Howard, Prince George's and Washington counties. These jurisdictions previously were not funded through the Family Support Services program. By the end of FY '86 support services were being provided to individuals and families in a total of 19 jurisdictions.

TASK #8: DHR, through SSA and local departments of social services, will coordinate the development of a core services system to prevent teenage pregnancy and assist adolescent parents, as called for by the report of the Governor's Task Force on Teen Pregnancy.

- Recent changes in federal law present new options to the State for the expansion of case management services to prevent teen pregnancy and support teen parents as well as to provide medical services to pregnant women under 21 and their infants. The proposed core services system must be reviewed in light of these funding options. See Goal #1, Task 4, and Goal #4, Task 4, in Section 1.

TASK #9: DHR, through SSA and working in conjunction with DDA and the Developmental Disabilities Council, will expand adoption opportunities for special needs children with particular emphasis on minority children.

- The "One church, One child" minority recruitment project is now being piloted through SSA in the Baltimore metropolitan area. A part-time recruiter will be hired to work with BARN (Black Adoption Recruitment Network) on this project.

- SSA adoption staff is negotiating with the Developmental Disabilities Council to run a "waiting child" column in their newsletter which is circulated to members as well as employees. The summer issue of this newsletter carried an article on special needs adoption.

SUBSTITUTE CARE SERVICES

When it is not in the best interest of the child to remain at home, an appropriate form of substitute care must be available. These services include emergency and shelter care, foster family care, alternative living units, group homes, semi-independent living arrangements, residential treatment facilities, and psychiatric hospitals. The child who requires out-of-home care may need it for only a short period of time or may require specialized substitute care services to treat severe mental, social, or emotional disorders. The finding of the recent study of youth committed to the Montrose and Hickey schools that 50 percent did not require institutionalization underlines the need to expand the continuum of available community-based residential placements and other support services.

TASK #1: DHMH, through DDA, will continue to implement the FY 1985-1994 Master Facilities Plan for deinstitutionalization by:

a. reducing the number of State Residential Center beds by 37 percent (2,621 to 1,664 available beds); and

b. increasing the number of available community beds from 1,675 at the beginning of FY 1985 to 4,549 by the end of FY 1994.

- (a.) At the end of FY '86, the Average Daily Population (ADP) at DDA's State Residential Centers (SRC) was 1,753; in FY '94 the DDA projects there will be 1,219 available beds at its SRCs, if the extension of the home and community-based waiver is approved by the federal government. If the waiver is not approved, the DDA projects 1,446 available beds at its SRCs.

- (b.) At the end of FY '86, there were 2,353 available community beds; 226 new beds are expected during FY '87.

TASK #2: DHMH, through MHA, will establish four therapeutic group homes in FY 1986-1987 with a total capacity of ten homes by FY 1988.

- Four therapeutic group homes will be established by the end of Fiscal Year 1987. Additional expansion plans will focus on a wider range of community-based alternatives, including specialized foster care and alternative living units, as well as therapeutic group homes.

TASK #3: DHMH, through JSA, will investigate the development of two additional youth centers (one may be on the Eastern Shore) to ease overcrowding at Montrose and the Hickey School.

- With the Doncaster and O'Farrell Youth Centers opening in FY 1987, JSA will have raised its youth center bed capacity from 140 to 250 within a three-year period. Because this capacity is expected to be sufficient to meet the needs of appropriately qualified youth, no additional youth centers will be built. With young males remaining at youth centers for an average of seven months, the increased capacity has raised the number of annual admissions possible from approximately 243 to 435. JSA estimates that, if 250 youth center beds had been available in FY 1986, 45 percent of the committed males between the ages of 15½ and 18 could have been placed in such programs.

TASK #4: DHMH, through JSA, will seek to increase funding for placements in small residential settings.

- In FY 1987, JSA identified approximately $883,000 for community residential placements. It is planning further expansion of residential placements.

TASK #5: DHR, through SSA, will seek to expand beds in emergency shelter facilities or emergency foster homes, with associated diagnostic and assessment facilities, by approximately 40 beds in FY 1987 and FY 1988.

- SSA is expanding the number of emergency shelter beds in FY '87 and plans to pay a stipend to providers of emergency care in order to recruit and retain emergency foster homes.

TASK #6: DHMH, through JSA, should expand from four to five the number of Runaway Youth programs which provide temporary emergency shelter care.

- JSA projects a need for three additional Runaway Youth programs.

TASK #7: DHR, through SSA, will seek to expand the number of specialized or therapeutic foster homes to 60 beds by FY 1987.

- DHR/SSA will have developed a total of 60 specialized foster care beds by the end of FY '87. SSA's report, submitted to the Legislature in October, 1986, indicates that these new homes are successfully meeting the needs of severely emotionally disturbed children.

TASK #8: DHR, through SSA, will take the lead with DDA and MHA in developing a multi-year strategy for more appropriate service for handicapped children requiring long-term care who are not appropriate for the current foster care system, and who have no other avenue for service.

- DDA and SSA have developed a joint specialized foster care project in FY '87 which will provide for the placement of ten children who are developmentally disabled and multi-handicapped.

TASK #9: The State Coordinating Council for the Residential Placement of Handicapped Children (SCC) will identify common needs of out-of-state placements that could support alternative in-state programs.

- The SCC has completed a survey of the needs of children in out-of-state placements, and will make recommendations based upon this data.

TASK #10: DHMH, through MHA, should — by August 31, 1986 — take the lead in developing a plan for bed expansion to accomodate the needs of emotionally disturbed children 12 years old and under with priority given to in-patient care, under 90 days.

- MHA, through its five year plan for children and adolescents, projects a need to provide a 12-bed psychiatric inpatient unit to serve minors under age 12. If funded, these would be established in FY '89. In the meantime, the Maryland Health Resources Planning Commission has authorized the establishment of general acute hospital beds for the birth to age 12 population as follows:

Western Maryland	6 beds
Montgomery County	11 beds
Southern Maryland	16 beds
Central Maryland	29 beds
Eastern Shore	5 beds
Total	67 beds

TASK #11: DHMH, with JSA as the lead agency and with support from MHA and DHR/SSA, will develop a residential treatment program for children on the Eastern Shore.

- When the facility that had been identified for this program proved to be inadequate, planning began for development of a new facility. The program is expected to begin in October, 1989.

CONCLUSION

The Goals set forth in this Progress Report represent consensus among the state agency administrators, advocates, and provider organizations which participated on the Interagency Committee for Children. These goals are intended to be priorities for work during the coming year, in addition to the more comprehensive list of tasks on behalf of children and families which are set forth in the *Interagency Plan for Children with Special Needs* (published in January 1986). Together, these two documents represent an ambitious agenda for children and families, but one to which Maryland's state agencies are committed and, in fact, toward which substantial progress has already been made.

In concluding this report, the members of the Interagency Committee for Children wish to reiterate what we see as the overarching purpose of the ICC. The ICC process is a forum for discussion and for reaching decisions, a vehicle for on-going, coordinated planning, and a method of maintaining accountability for accomplishing important goals for children and families in Maryland. The participating agencies recognize that, in order to address the complex problems encountered by children and families, the best thinking and joint action of both the public and private sectors will be required. Through the separate action of each agency, and through the coordinated efforts such as those cited in this report, Maryland can continue to develop a system of services that strengthens families and promotes the full and healthy development of children.