The Power of Community

Promoting Child Well-Being
Strengthening Families &Communities
Preventing Child Maltreatment

MARYLAND
STATE COUNCIL ON CHILD ABUSE & NEGLECT
ANNUAL REPORT
JANUARY 1, 2015 – DECEMBER 31, 2015

ACKNOWLEDGMENTS

SCCAN is grateful to our public and private partners who work toward the common goal of promoting child well-being and preventing child maltreatment and other adverse childhood experiences (ACEs) *before they occur*. Special thanks this year go to:

- Council Members for sharing their expertise and for the many volunteer hours they have contributed to SCCAN.
- Council Chair, Pat Cronin; Essentials for Childhood/Prevention Committee Co-Chairs, Joan Stine and Margaret Williams and Workgroup Members, Patricia Cronin, Wendy Lane, Deborah Badawi, Patricia Arriaza, Diane Banchiere, Richa Ranade, Linda Robeson; Membership Chair, Ralph Jones and membership interviewees, Joan Stine, Wendy Lane, Pat Cronin, Melissa Rock, and Steve Berry for the many additional hours they contributed to the Council this year.
- Wendy Lane, MD, for her research and writing to support the recommendations for Improvement of Health Care for Children Involved in the Child Welfare System; and, her leadership on the Health Care for Children Involved in Child Welfare Workgroup.
- Council Member agencies for dedicating staff time and expertise to the important work of the Council.
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- Pat Cronin, Executive Director, her staff and the Board of Directors at The Family Tree for its' leadership of SCCAN and the Maryland Partnership to Prevent Child Sexual Abuse (MPPCSA) and the Enough Abuse Campaign (EAC).
- The many other partners, stakeholders and citizens who contribute to moving child maltreatment prevention forward in the state of Maryland.

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State Council on Child Abuse and Neglect (SCCAN)
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June 6, 2016

The Honorable Larry Hogan
Governor of Maryland
State House
100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
State House
100 State Circle, Room H-101
Annapolis, Maryland 21401-1991

The Honorable Michael E. Busch
Speaker of the House
State House
100 State Circle, Room H-107
Annapolis, Maryland 21401-1991

Re: Family – General Article, Annotated Code of Maryland, § 5-7A-09,
State Council on Child Abuse and Neglect (SCCAN) Final Report for 2015

Dear Governor Hogan, President Miller and Speaker Busch:

Preparing Maryland for a prosperous future begins with recognizing that our youngest residents must get what they need today to become the adults who will strengthen our communities and build our economy.

Fortunately, what our children need is not a mystery. Recent advances in the science of early childhood development tell us that the early years are a time when the brain is literally building itself from the ground up, in much the way a house is constructed. And, it is the relationships, experiences and environments that children have early in life that are the building blocks for lifelong health, learning and behavior. When children have stable responsive relationships with caring adults at home and in the community, children get off to a good start with a strong foundation for future development.

When children don't have these experiences, because of child abuse and neglect, untreated parental substance abuse (including opioid addiction), parental incarceration, parental mental illness, intimate partner violence, exposure to violence in communities, or other chronic challenges that produce what is now known as "toxic stress" or adverse childhood experiences (ACEs), children suffer—and we put our future well being as a state at risk. That's why the Maryland State Council on Child Abuse & Neglect (SCCAN) and its' Essentials for Childhood Initiative (EFC) Partners' policy recommendations (pp.8-18) and collective efforts (pp. 20-31) *are* so important. When we support coordinated cross-sector policies that promote safe, stable and nurturing relationships and environments in the home, school and community for children, we are preventing such adverse experiences from becoming toxic.

We know what to do. The question is whether we will approach our challenges with a "can do", not a "can't do" attitude.

These strategies are making a difference here in Maryland and are prime examples of innovating and investing in what works. We must work together to ensure that all children and families have a strong foundation for their lives and approach our challenges with a "Can do!" not a "Can't do" attitude.

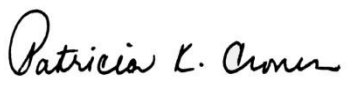
Pursuant to the requirements of Family – General Article, Annotated Code of Maryland, § 5-7A-09 and the federal Child Abuse Prevention and Treatment Act (CAPTA), I respectfully submit on behalf of the State Council on Child Abuse and Neglect (SCCAN) its unanimously adopted Annual Report. The Council makes recommendations for systems changes and improvements through this report that address its' legislative mandates:

1) "*to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities"*
2) to "*report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs"*
3) to *"provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations"*
4) to *"annually prepare and make available to the public a report containing a summary of its activities"*
5) to *"coordinate its activities … with the State Citizens Review Board for Children, local citizens review panels, and the child fatality review teams in order to avoid unnecessary duplication of effort"*

On pages 8-18, the Council recommends several actionable steps to improve Maryland's child and family serving systems in order to protect children and to prevent child maltreatment and other ACEs from occurring in the first place. Specific recommendations are made on prioritizing prevention of ACEs, coordinating the work of child and family serving systems, passing comprehensive child sexual abuse prevention legislation, preventing child abuse and neglect fatalities, improving health care for children involved in child welfare, and improving the state's mandatory reporting system. As you read through the Council's report and recommendations, I hope you will see our deep commitment to the healthy development of every child within our state and the primary prevention of child maltreatment and other ACEs. That dedication extends to the relationships and environments of the child---their parents, their families, their communities and their state.

Failing to support investments in the learning, health and behavior of our youngest children, prevent ACEs, and build resilience, not only impacts individual children and families but also increases state spending on health care, education, child welfare, and juvenile and criminal justice; and, hampers the state's economic productivity. In 2012, the University of Maryland, School of Social Work conservatively estimated that child abuse and neglect costs the taxpayers of Maryland more than 1.5 billion dollars annually. The time for both the executive and legislative branches to set policy that ensures cross-agency concerted effort on behalf of all Marylanders is now. We look forward to working with you to ensure these recommendations become a reality.

Sincerely,



Patricia K. Cronin, Chair
cc: DHR Secretary Sam Malhotra
DHMH Secretary Van Mitchell
DJS Secretary Sam Abed
MSDE Interim State Superintendent, Dr. Jack R. Smith
MDD Secretary Carol A. Beatty
DBM Secretary David R. Brinkley
Children's Cabinet & Governor's Office for Children, Arlene Lee, Chair and Executive Director
Governor's Office of Crime Control & Prevention, V. Glenn Fueston, Jr., Executive Director
SCCAN Members

MARYLAND STATE COUNCIL ON CHILD ABUSE & NEGLECT (SCCAN)
2015 ANNUAL REPORT

EXECUTIVE SUMMARY & RECOMMENDATIONS

Our failure to prevent children's maltreatment (CM) *before it occurs* is conservatively estimated to cost Maryland's economy, businesses and taxpayers over $1.5 billion each year. Investing in child well-being and preventing CM is not only *humane and just*, but *makes good economic sense*. (http://heckmanequation.org/content/resource/why-early-investment-matters) The profound impact that CM and other adverse childhood experiences (ACEs) have on a child's well-being– including short and long-term health, behaviors and development; school success; future employment and earning potential; ability to form positive, lasting relationships and become productive citizens– is well documented. (See, SCCAN's 2012 Annual Report)

Stunning advances in neuroscience, epigenetics, ACEs, and resilience (N.E.A.R. science) provides a strong evidentiary foundation for implementing policies, programs and practices that promote safe, stable and nurturing relationships and environments for children and adolescents, strengthen families, and build caring and responsive communities. Healthy development builds a strong foundation— for kids and for society. Experience shapes the architecture of the brain with more than 700 neurons per second being created in children 0-3. http://developingchild.harvard.edu/ Additionally, research conducted over the past 15 years demonstrates that the adolescent brain undergoes substantial and systematic changes, due both to hormonal changes that influence the brain's major systems and also due to an increase in general neuroplacticity (malleability) during which neurons get reorganized for efficiency. *Steinberg, L. (2014). Age of opportunity: Lessons from the new science of adolescence. New York, NY: Houghton, Mifflin, Harcourt*. Policies should reflect the reality that childhood experiences matter and that we should not treat children and adolescents as if they were adults. Policies that focus on disseminating N.E.A.R. science; supporting parenting; ensuring the healthy development of fetuses, infants and young children (whose brains are highly plastic); and, structuring adolescent parenting, school, and legal policies to promote healthy development of youth as they enter adulthood are essential.

ECONOMIC COSTS OF CHILD MALTREATMENT IN MARYLAND

SOURCE: "An Environmental Scan of Maryland's Efforts to Prevent Child Maltreatment"

DIRECT COSTS	
Child Welfare	**438,887,488**
Law Enforcement	**79,638**
Mental Health	**10,440,979**
Hospitalizations	**85,879,430**
INDIRECT COSTS	
Special Education	**22,325,386**
Juvenile Justice	**52,214,201**
Mental Health & Health Care	**811,135**
Adult Criminal Justice	**323,568,000**
Lost Productivity	**610,457,162**
TOTAL COSTS:	***1,544,663,419***

Prioritizing investments in promotion and prevention efforts and reinvesting gains are critical strategies to ensuring the health, safety, well-being and productivity of Maryland citizens across the lifespan. When Maryland increases its investment in promoting child well-being and preventing ACEs, the many public systems that serve victims throughout their lives (child welfare, law enforcement, special education, juvenile justice mental health and health care, and criminal justice) will undoubtedly see significant cost reductions. In addition, over time, a stronger workforce will increase the tax base, improving social and economic conditions throughout the state.

THE ACE STUDY

"Largest, Most Important Public Health Study You *Never* Heard Of"

The ACE Study examines the social, behavioral and health consequences of adverse childhood experiences *throughout the lifespan*. ACE Study participants (17,337) were members of Kaiser Permanente Medical Care Program in San Diego, California and reflected a cross-section of middle-class American adults. Participants were asked questions regarding ten adverse childhood experiences:

CHILD MALTREATMENT	FAMILY DYSFUNCTION
Physical Abuse	Substance Abuse
Sexual Abuse	Mental Illness
Emotional Abuse	Domestic Violence
Physical Neglect	Divorce/Separation
Emotional Neglect	Incarceration

STUDY FINDINGS:

- ACES are common.
- ACES frequently occur together.
- ACES have a strong and cumulative impact on the health and functioning of adults:

BEHAVIORS	HEALTH
Smoking	Severe Obesity
Alcohol Abuse	Diabetes
Drug Use (Illicit & Prescription)	Suicide
Absenteeism & Poor Work Performance	Depression
Lack of Physical Activity	HIV & STDs
Risky Sexual Behavior	Heart Disease
Teen Pregnancy	Cancer
Instability of Relationships	Liver Disease
Re-victimization Risk	Stroke
	Chronic Lung Disease
	Broken Bones & Other Injuries
	Autoimmune Diseases
	Early Death

More than ***twenty-nine (29) states and D.C. collect state and county specific ACE data*** through the ACE module of their Behavioral Risk Factor Surveillance Study (BRFSS). MD joins these states in 2015. ACE data will be used to measure, analyze and ***inform public policy decision-making*** to improve short and long-term ***health, education, social and workforce***

2014 MARYLAND CHILD MALTREATMENT FACTS AT A GLANCE

CHILD MALTREATMENT

- In FFY 2014, Maryland's child protective services (CPS) received an estimated 51,352 referrals of children being abused or neglected. 44.4% of those referrals were "screened in" and 55.6% were "screened out" by CPS with no investigation.
    - CPS estimated that 15,762 children were victims of maltreatment.
    - Of the child victims, 67.3% were victims of neglect; 27.3 % of physical abuse; 10.1% of sexual abuse; and 0.1% of psychological maltreatment.
- CPS reports are known to underestimate the true occurrence of maltreatment. Non-CPS studies estimate that 1 in 7 U.S. children experience some form of child maltreatment in their lifetimes.
- Current state data sources that could be used to determine the true magnitude of child maltreatment and CM risk and protective factors include:
    - DHR: CHESSIE, CARES, CSES
    - DHMH: Behavioral Risk Factor Surveillance System (BRFSS), National Vital Statistics Systems (NVSS), Maternal & Child Health Pregnancy and Risk Assessment Monitoring System (PRAMS), Youth Risk Behavior Study (YRBS), Behavioral Health, Medicaid, National Child Death Review Case Reporting System (NCDR-CRS), National Violence Death Reporting System (NVDRS), Sudden Unexpected Infant Death (SUID) Case Registry, and the Web-based Injury Statistics Query and Reporting System (WISQARS).
    - MDP: child poverty rates
    - GOCCP: Uniform Crime Reporting (UCR), including the National Incident-Based Reporting System (NIBRS)
    - MSDE: Head Start, Early Childhood Education data, Special Education, Part B

DEATHS & SERIOUS PHYSICAL INJURIES FROM CHILD MALTREATMENT

- In SFY2014, DHR reported that at least 26 Maryland children were reported by CPS as having died with child maltreatment as a contributing factor. At the time of death, 10 of the fatalities had active cases or prior child welfare cases had been closed within the past 12 months.
- 16 (62%)of the child deaths were < 1 year old; 9 (35%) were 1-3 yrs old; and, 1 was 12-15 yrs. old.
- 58% of children were African American; 4% were ial; 23% were Caucasian; and, ace.
-
- In SFY2014, DHR reported that there were 8 serious physical injuries (SPIs) with child maltreatment as a contributing factor. 7 of the SPIs were of children <1 year old; 1< 4 years old.
- Of the SPI cases, 37.5% were African American; 12.5% were bi-racial; 37.5% were Caucasian; and, 12.5% were Hispanic.

RISK FACTORS FOR CHILD MALTREATMENT

- In FFY 2014, 24.93 % of victims were 3 years or younger, with infants younger than 1 year having the highest rate of victimization (16.7 per 1000).
- The rates of victimization per 1000 were 11.3 for boys and 12.0 for girls.
- The 2014 rates of victimizations per 1000 children were 15.2 for African Americans, 3.7 for American Indians/Alaska Natives, 1.8 for Asians, 7.6 for Hispanics, 5.3 for Multiple Races, 9.1 for Pacific Islanders and 9.2 for Whites.
- NCANDs examined two caregiver risk factors in 2014: In Maryland, 1.2 % of Children were reported to have a caregiver with alcohol abuse; and, 3.6% were reported to have a caregiver with drug abuse.
- No 2014 NCANDs data is publicly available for percentage of victims with other known risk factors or protective factors for child maltreatment.

CHARACTERISTICS OF THOSE WHO'VE MALTREATED

- Nationally most victims in 2014 were maltreated by a parent (91.6%). Others who maltreated children include relatives other than parents (5.5%), and partners of parents (2.9%).Maryland specific data was not available.
- In 2014, fewer than 3.9% of those known to have maltreated were < 18 years; 12.1% were aged 18-24 years; 36.2% were 25-34 years; 24.1% were 35-44 years; 10.9% were 45-54 years; 3.9% were 55-64 years; 8.7% 65-75 years; and, 0.2% the age was unknown.
- 43.3% of those who maltreated children in 2014 were men; 51.8% were women; and, 4.8 % gender was unknown.

SOURCES:
- Child Maltreatment 2014, U.S. Children's Bureau
- MD CHESSIE

- Finkelhor D, Turner H, Ormond R, Hamby SL. Violence, abuse, and crime exposure in a national sample of children and youth. Pediatrics 2009;124: 1411-1423.
- Theodore AD, Chang JJ, Runyan DK, Hunter WM, Bangdewala SI, Agans R. Epidemiologic features of the physical and sexual maltreatment of children in the Carolinas. Pediatrics 2005; 115: e331-e337.
- Finkelhor D, Ormrod H, Turner H, Hamby S. The victimization of children and youth: a comprehensive national survey. Child Maltreatment 2005; 10: 5-25.

2015 SCCAN RECOMMENDATIONS
INTERAGENCY FOCUS ON PREVENTION

I. Issue an executive order and/or pass a joint resolution mandating child and family serving agencies participation in collective impact efforts to promote safe, stable & nurturing relationships and environments for children (Essentials for Childhood (EFC)) & preventing ACEs.

A. Clarify authority for ACEs prevention efforts through state law or executive order. Mandate responsibility and the involvement of state and local key agencies.
B. Invite key faith-based communities and Maryland businesses to join in collective impact efforts.
C. Raise awareness about the importance of state, community, family and parental action to ensure the Essentials for Childhood and preventing ACEs.

STATE LEGISLATION:

- 2013 Wisconsin passed Senate Joint Resolution 59. https://docs.legis.wisconsin.gov/2013/related/proposals/sjr59
- 2014 California Legislature, Assembly Concurrent Resolution No. 155, relative to childhood brain development passed.
- 2011 Washington House Bill 1965, passed creating the Washington State ACEs Public Private Initiative.
- 2014 Massachusetts passed a Safe and Supportive Schools Act within their gun violence reduction law:
- 2014 Vermont introduced legislation to require screening for ACEs
- 2015 Minnesota HF 892/ SF 1204 Resolution on childhood brain development and ACEs.
- 2016 Alaska House Resolution 21:

II. Require all state child and family serving agencies and all agencies receiving state funds to train current and future staff to both understand N.E.A.R. Science (Neurobiology, Epigenetics, ACEs and Resilience) and implement strategies to prevent, mitigate (trauma-informed) and build resilience to create safe, stable and nurturing environments for all children.

It is easier to build strong children, than to repair broken men. –Frederick Douglas

- The ever increasing scientific knowledge linking childhood toxic stress to disruptions of the developing immune, cardiovascular, nervous and metabolic systems makes building resilience in children, families, organizations and communities; and, preventing, reducing, and buffering ACEs key to achieving societal goals of improving outcomes in education, health , safety and strengthening the workforce and economy.
- Children who are not identified and treated for sexual abuse can be at risk for acting out sexually. It is especially important that DHR and DJS make every effort to identify and treat sexually abused children within their custody, as they may live with other vulnerable children and youth. Trauma-informed care and treatment must be the norm for children within Child Welfare and Juvenile Justice.

III. Integrate N.E.A.R. Science concepts into the work and publications (websites, press releases, responses to

media requests for response to crises, practices) of all Maryland child and family serving agencies. See 7 Core Concepts below; and, http://www.healthygen.org/sites/default/files/Online%20Version_2014-2015%20Statewide_4-21-15.pdf .

IV. The Governor and General Assembly should convene a public-private stakeholder EFC & ACEs Summit to raise awareness and build cross-agency commitment to the promotion of EFC and prevention of ACEs; including announcing the Executive Order and/or Legislative Resolution and training on ACEs, Prevention, Trauma and Resilience.

STATE EXAMPLES:

- Iowa: http://www.iowaaces360.org/iowa-aces-summit.html
- Montana: http://www.childwise.org/wp-content/uploads/2014/02/Elevate-Montana-Overall-Description-2014.pdf
- Minnesota: http://www.sainta.org/three-day-conference-focuses-on-aces/
- Midwest Regional Summit: http://www.hmprg.org/Events/2015ACEsSummit
- California: http://acestoohigh.com/2014/11/20/children-can-thrive/
- Southeastern Regional Summit: https://sys.mahec.net/ce/aces.aspx

V. Designate an interagency state lead for a statewide collective impact initiative to promote EFC & prevent ACEs.

A. Mandate participation by state leads and invite lead private partners within the following program and service areas:
Home Visiting, Safe Sleep, Shaken Baby Prevention, Home Safety Education & Checks, Parenting Education, Fatherhood Programs, Well-Child Services, Lead Screening, Early Intervention Services for Children with Developmental and Physical Disabilities, Early Childhood Mental Health Services, Head Start/Early Childhood Education, School-Based Programs, Special Education Part B (IDEA), Government Pre-School and Childcare Services, Women, Infant & Children (WIC), Maternal & Child Health Services, Temporary Assistance for Needy Families (TANF), Intimate Partner Violence (IPV) Prevention or Response Programs (including shelters), Injury & Violence Prevention, Maternal Mental Health/Depression Screening, Substance Abuse Recovery for Parents & Expecting Parents, Parenting Support Programs, Healthy Marriage Initiative, Community Violence Prevention Programs, Homeless Shelters, Other Programs for Homeless Families, Stable Housing Programs, Hospital Licensure, Teen Pregnancy Prevention, Ready-by-21, Child Welfare In-Home Services, Foster Care Independent Living Services, the Department of Corrections, Family Planning, Child Sexual Abuse Prevention, Community-Based Child Abuse Prevention (CBCAP), Prevent Child Abuse Maryland, the Maryland Chapter of the American Academy of Pediatrics, Child Advocacy Centers, Sexual Assault Prevention, Children's Trust Fund, and Child Fatality Review Team.

B. Mandate participation by the state leads of the data collection and surveillance systems listed under data sources for child maltreatment (p. 7 above)

ESSENTIALS FOR CHILDHOOD:
SAFE, STABLE & NURTURING
RELATIONSHIPS & ENVIRONMENTS

7 CORE CONCEPTS
SCIENCE OF EARLY CHILDHOOD DEVELOPMENT &
THE IMPACT OF TOXIC STRESS:

1. Healthy Development Builds a Strong Foundation – For Kids and For Society.
2. Experience Shapes Brain Architecture by Over-Production of Connections Followed by Pruning (700 neurons/second are being created in children 0-3.)
3. Brains Are Built from the Bottom Up: Skills Beget Skills.
4. Serve and Return Interaction Builds Healthy Brain Architecture (interactions between the parent and child, as well as, family and non-family members and child literally shapes the architecture of the brain, future relationships, behavior and health outcomes.)
5. Cognitive, Emotional, and Social Development Are Connected: You Can't Do One Without the Other
6. Toxic Stress Damages Developing Brain Architecture.
7. The Ability to Change Brains and Behavior Decreases over Time.

Source: http://developingchild.harvard.edu/

C. Support dissemination of ACE awareness by requiring all child and family serving agencies to participate in the Maryland ACE Interface Master Training Cohort.

D. Collect ACE data and ensure accurate tracking of health outcomes for children under state custody. *See*, recommendations below regarding improving health of children within child welfare. Today's child welfare and juvenile justice children are tomorrow's parents.

VI. Fund the development of a state-wide action & implementation plan to promote EFC and prevent CM and other ACEs.

A. At least 21 states have a CM Prevention Plan. *"Findings from the 2009 Child Maltreatment Prevention Environmental Scan of State Public Health Agencies" CDC.* Maryland does not have a CM or ACE prevention plan.

B. Mandate the integration of Maryland prevention plans for CM, Intimate Partner Violence (IPV), Mental Illness, Substance Abuse, and other ACEs into a supportive and cohesive plan to ensure coordination and avoid duplication of efforts.

VII. Analyze and disseminate state and local level data from the Behavioral Risk Factor Surveillance System (BRFSS) on the prevalence of ACEs on the prevalence of ACEs to build awareness and commitment to preventing, mitigating and reducing ACEs: and, to create a baseline for measuring the impact of promotion and prevention efforts over time.

A. SCCAN commends DHMH for including the CDC's ACE module to Maryland's BRFSS beginning 2015.

B. Data collected should be used to increase public awareness of ACEs and to establish new policies and regulations relating to ACEs and Promoting the Essentials for Childhood. *See,* Washington: http://www.legis.state.wv.us/senate1/majority/poverty/ACEsinWashington2009BRFSSFinalReport%20-%20Crittenton.pdf, Iowa: http://www.iowaaces360.org/iowa-aces-research.html , Wisconsin: http://wichildrenstrustfund.org/files/WisconsinACEs.pdf , California: https://app.box.com/s/nf7lw36bjjr5kdfx4ct9 Minnesota: http://www.health.state.mn.us/divs/cfh/program/ace/content/document/pdf/acesum.pdf

VIII. Establish and fund a robust Children's Trust Fund for Prevention. The National Alliance for Children's Trust & Prevention Funds is available to consult with state leadership on the most successful models across the country.

Maryland's current Children's Trust Fund was established by Sec. 13-2207 of the Maryland Health General Article. While funds initially supported small prevention grants, an ongoing source of income for the Trust Fund was never established. At the same time, many states across the country have developed robust prevention trust funds with combined annual revenues in excess of $100 million dedicated to prevention. Children's Trust Fund Boards actively raise funds to support statewide prevention efforts. This is a gap in Maryland's infrastructure to support prevention.

IX. Pass Comprehensive Child Sexual Abuse Prevention Legislation

Child sexual abuse is a complex problem requiring a comprehensive approach. All adults in child and youth serving organizations play a role in preventing child sexual abuse *before it occurs.* Failing to provide adult-focused training to schools and youth-serving organizations leaves kids vulnerable both before and/or after abuse occurs. Comprehensive Child Sexual Abuse Prevention should include the following components:

A. A clear statement delineating the need for primary prevention (before sexual abuse occurs) efforts, in addition to improving current reporting (after the fact) efforts. RESOURCES: Vermont Act One http://www.leg.state.vt.us/docs/2010/Acts/Act001.pdf and Michigan's Task Force Report, Goal # 1, p. 18 https://www.michigan.gov/documents/dhs/ReportRecommendations_491970_7.pdf

B. Lead with a clear focus on *adult responsibility for preventing child sexual abuse*:

i. **Require participation by all schools (public and private) and youth-serving organizations that are state-operated, state-licensed or state-funded;** RESOURCE: Massachusetts's CSA legislation https://malegislature.gov/Bills/189/Senate/S316

ii. **Educate adults first;** RESOURCE: Prevent Child Abuse America, State and Federal Legislative Efforts to Prevent Child Sexual Abuse: A Status Report, 2015

iii. **Educate *all* adults not just teachers but all employees as well as volunteers;** RESOURCE: Massachusetts's CSA legislation https://malegislature.gov/Bills/189/Senate/S316

iv. **Instruction should help adults:**

1. **recognize sexually offending behaviors in adults, and signs in adults that might indicate they pose a sexual risk to children;** RESOURCE: Massachusetts's CSA legislation
2. **Recognize the difference between normative and non-normative child-on-child sexual behavior; and, appropriately respond to, and prevent sexually inappropriate, coercive, or abusive behaviors among children and youth served by schools, programs and youth-serving organizations;** RESOURCE: Massachusetts's CSA legislation
3. **Recognize behaviors that might indicate a child or youth has been a victim of sexual abuse;** RESOURCE: Massachusetts's CSA legislation
4. **Support the healthy development of students, children and youth by building the protective factors to mitigate against their sexual victimization by adults or by other children or youth (ensuring adults within the system are provided resources (e;g.,http://www.nsvrc.org/projects/child-sexual-assault-prevention/preventing-child-sexual-abuse-resources), training (e.g., http://www.enoughabuse.org/training-workshops.html and http://www.d2l.org/) and standards for promoting healthy social emotional development and relationships (e.g., http://static1.squarespace.com/static/513f79f9e4b05ce7b70e9673/t/56718463a976af3e2f3ecb38/1450280035958/state-scorecard-summary-table-for-k-12-12-16-15.pdf) , sexuality education (e.g., http://www.futureofsexed.org/documents/josh-fose-standards-web.pdf , http://www.uua.org/re/owl/) , focused "boundary" education to reduce child-on-child behaviors appropriately (http://www.nsvrc.org/projects/child-sexual-assault-prevention/preventing-child-sexual-abuse-resources), knowledge of the rules (e.g., school rules) and laws (e.g., age of consent), and creating trauma-sensitive child and youth serving environments (e.g., http://traumasensitiveschools.org/);**
5. **Establish and implement school, program and youth-serving organization policies that support the prevention of and response to sexual abuse through;**
    a. **Ongoing training of staff about adult and child-on-child sexual abuse;** RESOURCE: Massachusetts's CSA legislation
    b. **Comprehensive screening of prospective employees and volunteers;** RESOURCE: Massachusetts's CSA legislation
    c. **The development of codes of conduct to identify inappropriate or boundary-violating behaviors that if left unchecked could escalate to reportable sexual offenses, including methods to interrupt behaviors by school/other personnel**

that don't reach level of abuse; RESOURCES: *State and Federal Legislative Efforts to Prevent Child Sexual Abuse: Status Report*, Jetta Bernier, MA legislation, Keith Kaufman, Missouri Act

d. **The assessment and modification of physical facilities and spaces to reduce opportunities for sexual abuse**
RESOURCES: Keith Kaufman, MA legislation

6. **Respond to disclosures of sexual abuse or reports of boundary-violating behaviors of adults or children in a supportive, trauma-sensitive and appropriate manner and which meets mandated reporting requirements under MD Family Law Code Ann., Sec. 5-704**
7. **Learn about community resources available to assist schools, programs, and youth-serving organizations in the prevention, identification, reporting and referral to treatment of cases involving the sexual abuse or exploitation of children and youth**

v. **Provide resources for parents on how to talk with children about CSA**
RESOURCES: Vermont Act One & Oregon legislation

vi. **Eliminates "passing the trash" among educational institutions and/or other youth serving organizations;**
RESOURCES: PA, MA & MO "SESAME" acts;

C. **Provide developmentally appropriate and trauma-sensitive instruction for children and youth K-12 on healthy social emotional development, healthy relationships, sexuality education, focused "boundary" education to reduce child-on-child behaviors appropriately, knowledge of the rules (e.g., school rules) and laws (e.g., age of consent).**

D. **Provide Evidence-Based Treatment for youth with child sexual behavior problems**
RESOURCES: North Carolina Task Force Report, MA legislation

E. **Include CSA prevention & intervention training in educator preparatory curricula;**
RESOURCE: the New Mexico Law;

F. **Provide a mechanism for evaluation of the implementation of policy change on institutional practices an trainings; and, the implementation of policy, practice and training change on the incidence of CSA;**

G. **Provide a mechanism for quality assurance and enforcement of CSA prevention policies, practices and training at the Maryland State Department of Education;**

X. **Fund and implement a shared services platform to ensure that Maryland's child and family-serving agencies share data on at-risk children and families to improve the quality of decision-making regarding child safety, service provision and case management.**
CPS, law enforcement, public health, behavioral health, schools, Medicaid, child fatality review teams and juvenile services should be linked, at a minimum.

XI. **Ensure accurate determination and counting of child abuse and neglect fatalities (CANF) by requiring that all state data sources on child deaths use the same definition that supports the prevention of child abuse and neglect fatalities and life-threatening injuries to include the following components:**
- **Help to provide real-time information that can inform practice and save lives.**
- **Provide data for research to identify risk and protective factors of CANF and develop innovative programs and practices to reduce CANF.**

IMPROVE HEALTH CARE FOR CHILD WELFARE INVOLVED CHILDREN

The current systems for providing healthcare services to children involved in the child welfare system (abuse/neglect investigations & foster care) are inadequate. Specifically, there is no mandatory oversight to ensure best practices, care coordination, and evidence-based care. Additionally, there is no single system for reimbursement; leaving many services such as court testimony and team meetings unfunded.

Failure to provide appropriate forensic medical assessments jeopardizes the health and well-being of some of our most vulnerable citizens. For children being investigated by CPS for suspected maltreatment, a failure to diagnose existing maltreatment allows maltreatment to continue, and increases the short and long-term costs for physical and mental health care, education, and juvenile justice. In addition, the misdiagnosis of accidental injuries as abusive can have unwarranted and profound repercussions for children who may be faced with removal from their homes or loss of caregiver emotional and financial support. The provision of expert medical evaluations for suspected maltreatment is also a social justice issue. Multiple studies have found that poor and minority children are more likely to have accidental injuries misidentified as abuse, while non-poor and white children are more likely to have abusive injuries misidentified as accidental. This problem may be exacerbated when either health care professionals without child maltreatment expertise or child welfare workers without health care expertise are determining whether a child has been abused or neglected.

Council members urge the Governor to allocate funding and Members of the General Assembly to legislate reforms to ensure that children involved in the child welfare system get appropriate health care coordination to improve their overall health outcomes. The MATCH (Making All the Children Healthy) program instituted in Baltimore City, at least in part due to the L.J. vs. Massinga Consent Decree, has significantly improved health care coordination for children in the care of the Baltimore City Department of Social Services. MATCH's partnership with Baltimore Child Abuse Center and Sinai Hospital has significantly increased the proportion of children receiving timely screening examinations upon entry into foster care. Children in other jurisdictions around the state who are involved in local DSS deserve similar efforts and resources to ensure good health care and coordination.

1. ***Develop a Centralized System for Providing Forensic and Medical Services to Children Involved in the Child Welfare System. Fund each component of the Centralized System as a line item in the Governor's Budget.***
   The following components should be included:

   A. **Management by a physician Health Director at DHR, SSA (either as a DHR employee or contractual position) to**

provide the medical expertise necessary to ensure effective oversight and coordination of the physical, mental, developmental and oral health care needs of children who come in contact with the child welfare system. The physician Health Director's responsibilities should include:

- Lead ongoing efforts to ensure best practice medical review and evaluations in cases of suspected child maltreatment.
- Lead the ongoing development and implementation of the Fostering Connections' Health Oversight & Coordination Plan (HOCP)

- Lead coordination and collaboration efforts between Maryland DHR, DHMH (Medicaid, DHMH Child and Adolescent Health, Behavioral Health, Child Fatality Review), and other health care and child welfare experts to develop a plan for the ongoing oversight and coordination of health needs of children in child welfare. This should include the adoption and implementation of best practice guidelines and evidence-based care in the investigation of suspected child abuse and neglect and provision of health care services to children in foster care.
- Develop policies regarding medical/forensic services for children in the child welfare system.
- Assist with case decision-making when health care issues are involved.
- Raise awareness of complex health and mental health needs of children in child welfare within both child welfare and health care provider communities.
- Monitor and improve state's progress in meeting the schedule for initial screening and follow-up health care services for children in foster care.

LACKING EXPERTISE … MISDIAGNOSIS COMMON

A recent study that reviewed physical abuse medical evaluations found that **when no child abuse expert was involved,** for every 100 children evaluated, **20 had false positive diagnoses and 4.5 had false negative diagnoses**. In Maryland, more than 1500 children with suspected physical abuse received no expert medical evaluation in 2012. Therefore, we can extrapolate that ***at least 300 children with accidental injury are mislabeled as being abused, and 68 children with abusive injury go unrecognized each year in Maryland***.

See below p. 28, SCCAN Report on Health Care for Children Involve in Marvland's Child Welfare System.

B. ***Interagency Child Welfare Health Coordination Expert Panel:*** An ongoing Child Welfare Health Coordination Expert Panel should be established and led by the physician Health Director. A CHAMP physician should act as the lead until a Health Director is hired. The Panel should include representatives from the following agencies and organizations: Maryland Children's Cabinet; Maryland Children's Alliance; Maryland Chapter of the American Academy of Pediatrics; Maryland CHAMP program (CHAMP physician and nurse affiliates); Maryland Forensic Nurses; DHR Out of Home Services; DHR In-Home Family Services; DHR Resource Development, Placement, and Support Services; DHMH, Maternal and Child Health Bureau, Child and Adolescent Health; Medicaid; Behavioral Health; DHR and DHMH representatives with expertise in their agency's child fatality review processes; Maryland State's Attorney's Association; county health departments county DSS agencies, Maryland Legal Aid Bureau, Maryland CASA; and, programs that currently contribute to medical and forensic services funding for children involved in the child welfare system (Maryland Medicaid, DHMH Center for Injury and Sexual Assault Prevention, GOCCP/VOCA).

The Panel's responsibilities should include:

i. Develop regulations and guidelines to ensure that children with suspected maltreatment receive timely, high quality, evidence-based medical assessments.
ii. Develop regulations and guidelines for effective management and oversight of health care services for children in foster care.
iii. Develop a state implementation and oversight plan for the recommended regulations, guidelines and improvements.
iv. Report annually to the Governor and legislature regarding the progress of implementation.

C. ***A system for tracking and improving health outcomes*** for children in the child welfare system;

including fatalities and near fatalities due to child maltreatment.

EXPERT MEDICAL EVALUATION RATES LOW & VARY COUNTY TO COUNTY

The proportion of children who receive medical evaluations varies significantly by county, putting children in some counties at higher risk for erroneous investigation outcomes than in others…. Children with sexual abuse had the highest rates of expert medical evaluation, but rates were still extremely low in some counties. ***In 9 counties, less than one-quarter of children with suspected physical abuse received an expert medical evaluation. No more than 3% of children with suspected neglect received an expert medical evaluation in ANY county***.

See below SCCAN Report on Health Care for Children Involve in Maryland's Child Welfare System.

A. State-wide criteria for which children should receive medical record review and/or medical evaluation should be included in COMAR (see Florida and CHAMP guidelines – Appendix C).
B. State-wide criteria for qualifications of health professionals who conduct maltreatment evaluations should be included in COMAR.
C. Reimburse qualified health providers for maltreatment evaluations (both medical record review and medical evaluation) in order to support a stable trained workforce to provide needed expertise. This includes comprehensive services beyond the initial evaluation to include any follow up of diagnostic studies, multidisciplinary team and Family Involvement meetings, court testimony as needed, and continuing education.
D. Program evaluation and oversight to monitor the percentage of children who receive timely, appropriate and accurate medical evaluations.

3. ***The Interagency Child Welfare Health Coordination Expert Panel should develop and adopt regulations and guidelines for the effective management and oversight of health care services for children in foster care.*** A state oversight plan described in I (above), should be developed as a coordinated and collaborative effort between DHR and DHMH, in consultation with health care experts, child welfare experts, child welfare service recipients and foster parents.

"Recent Maryland data from the Title IV-B report to the federal government indicates that only one-third of children receive their initial health screen in a timely manner, and only 57% receive their comprehensive assessment within 60 days."

Proportion of Foster Youth who Received Timely Health Care Services 2009-2012

State Fiscal Year	New Removals in OOH, in Foster Care > 8 Days	Received Initial Health Screening w/in 5 days	% Receiving Initial Screening w/in 5 days	Medical Provider Assigned w/in 10 days	% Medical Provider Assigned w/in 10 days	Received Compre-hensive Exam w/in 60 days	% Receiving Compre-hensive Exam w/in 60 days
2009	2,477	753	30%	877	35%	1,228	50%
2010	2,557	889	35%	1,210	47%	1,352	53%
2011	2,680	881	33%	1,366	51%	1,098	41%
2012	2,532	865	34%	1,110	44%	1,455	57%

Source: 2013 DHR Title IV-E Report

2. ***The Interagency Child Welfare Health Coordination Expert Panel should develop and adopt regulations and guidelines to ensure that children with suspected maltreatment receive timely, high quality, evidence-based medical assessments***
The following components should be included:

Regulations and guidelines should be included in COMAR and should be consistent with

requirements specified in the Federal Fostering Connections legislation, including:

A. A plan for the ongoing oversight and coordination of health care services for any child in a foster care placement. This plan must include a coordinated strategy to identify and respond to the health care needs of children in foster care, including medical, mental health, developmental, and dental needs. It must be developed by health care experts, including pediatricians, mental health professionals, dentists, and Maryland Medicaid representatives. The plan must include the following elements:
   i. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.
   ii. A process for ensuring that health care needs identified through screenings will be monitored and treated.
   iii. A process for updating and sharing of medical information through an electronic medical record system. These records must be shared with the child's foster parent(s), child welfare worker(s), and biological parents.
   iv. A process for ensuring continuity of health care services, including the establishment of a medical home for every child in care.
   v. A process for physicians working with DHR to provide oversight of prescription medications, including psychotropic medications.
   vi. A process for the Department of Human Resources to consult with health professionals to assess the health and well-being of children in foster care, and to determine the most appropriate medical treatment
   vii. A process for ensuring that all children in foster care obtain health insurance coverage immediately upon entrance into care.
   viii. A process for assessment for, monitoring of, and treatment of emotional trauma associated with the abuse and neglect, as well as, placement into foster care.
   ix. A plan for ensuring ongoing health care services for children who return home or age out of the foster care system.
   x. A coordinated system for tracking service needs and service receipt.

B. Continuing education made available to health care providers and child welfare workers throughout the state on evidence-based guidelines for the health care of children in foster care.

C. Program evaluation and /oversight to monitor the quality of care received and the health status of children in foster care.

D. Inclusion of health care providers in citizen review boards that monitor children in out-of-home placements. Doing so would better ensure that children are receiving timely and effective health care services.

4. **The State of Maryland needs to change the Medicaid eligibility categories to make identification of children in foster care more transparent.**

Currently, the state uses eligibility categories that include subsidized adoption and subsidized guardianship cases to identify the foster care population. In addition, kinship care cases that are receiving TCA are excluded. Medicaid data that the state uses in reports and that could potentially be used to monitor the foster care population is not an accurate reflection of the youth in foster care. Improving or redefining eligibility codes would allow the state to more accurately monitor health care utilization (including psychotropic medication) use for children in foster care. In addition, more transparent eligibility codes will allow programs that use these codes the ability to easily identify youth in foster care. Identification will result in improving coordination with the child welfare agency and will assist the state in providing Medical Assistance to former foster care youth until age 26.

5. In 2014, the Maryland General Assembly passed SB 685, Family Law – Child Abuse and Neglect – Provision of Information to Health Care Practitioners. DHR reads the statute narrowly to mandate sharing of information with a child's health care practitioners *only* during the 60-day period of a CPS investigation. As the ACE Study so clearly illustrates, child abuse and neglect, as well as other ACEs, can have significant lifetime negative health consequences. The child's appropriate health care depends upon *all* of the child's child welfare workers (Alternative Response, CPS and Foster Care) and health practitioners (physical, including dental, and mental health practitioners) sharing information to assist in both diagnosing and mitigating the effects of ACEs. That process goes on throughout the child's involvement with the child welfare agency. **SCCAN respectfully recommends that the General Assembly clarify or broaden the scope of the SB 685 requirement that the Department and local Departments share information regarding the health care needs of "children who are the subject of a report of child abuse or neglect" to include all children served by the child welfare administration and workforce.**

IMPROVE THE STATE'S MANDATORY REPORTING SYSTEM

I. **Reform of Maryland's Reporting System should be comprehensive and be guided by the following "Values Guiding Reform of Maryland's Mandated Reporting System":**

VALUES GUIDING REFORM OF MARYLAND'S CHILD ABUSE & NEGLECT REPORTING SYSTEM

The State Council on Child Abuse and Neglect (SCCAN) shall examine the policies and procedures of Maryland and its local agencies pursuant to Family Law § 5-7A-06 in order to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities. SCCAN believes that preventing child abuse and neglect and protecting children is a shared community responsibility; we all play a role. All children have the right to live in a strong family ensuring a safe, nurturing and healthy connection to encouraged and supported caregivers. Based on an examination of national best practices, the Council has determined that one important step in protecting children in Maryland from child abuse and neglect, is improving Maryland's reporting systems and the education of and information made available to mandated reporters.

PURPOSE OF REFORM:

Ensure that Maryland's child protection laws are "child centered" (rather than perpetrator or system centered) to increase protection for children by:

- Clarifying and/or expanding definitions of child abuse and neglect (CAN), perpetrators, and community members responsible for reporting;
- Streamlining reporting and screening processes;
- Clarifying the roles of those who must report;
- Educating mandated reporters to recognize, report and refer suspected CAN; and,
- Strengthening penalties for failure to report.

VALUES GUIDING REFORM:

1. Maryland's definitions of Child Abuse and Neglect and its' response to Child Abuse and Neglect reports, including a pathway to investigation and services, must be child-centered.

2. Marylanders who work or volunteer directly with children or have access to children must be required to report child abuse and neglect.

3. Maryland reporting laws and strategies should invite and encourage everyone who suspects Child Abuse and Neglect to report.

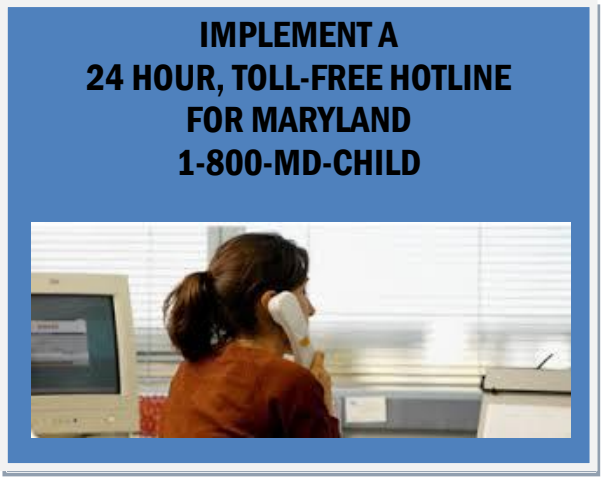
4. Reporting child abuse and neglect – regardless of the type or alleged perpetrator – should be as straight-forward as possible with an emphasis on: believing the child who discloses, maintaining the integrity of the report, cooperating fully with child protective services and law enforcement investigations and discouraging internal investigations.

5. Mandatory reporting requirements must be matched with an expectation of and commitment to high-quality training for all mandated reporters. Recognizing and reporting Child Abuse and Neglect

must be a regular part of continuing education and licensing requirements for all individuals and institutions who work and/or volunteer with or have access to children.

6. A person acting in good faith to report Child Abuse and Neglect should be protected from the retaliation of an alleged perpetrator, employer, or institution.

7. The system for reporting Child Abuse and Neglect should be as easy and straightforward as possible and can be achieved by: the creation of a single state-wide reporting hotline, technology improvements, effective training of staff, adequate staffing, and continuous quality improvement.



II. **Maryland should create a statewide, toll-free, 24 hour, 7 day-a-week Report Child Abuse Hotline, 1-800-MD-CHILD (1-800-632-2443) that will connect reporters to a centralized screening unit or to the appropriate local office or law enforcement to report suspected child abuse or neglect**. Other numbers available in Maryland are 1-800-MD-ABUSE (1-800-632-2873) and 1-888-MD-ABUSE (1-888-632-2873). As The Pennsylvania Task Force on Child Protection recommended in their 2012 Report, the number should ideally be a three-digit number (a service access code (SAC) or N11 number similar to 311 (non-emergency fire and police) and 911 (emergency services)) to report child abuse and neglect. As there are a finite number of N11 numbers and they must be approved by the Federal Communications Commission. 611 is currently unassigned by the FCC (although used broadly by carriers for repair services). Maryland should join Pennsylvania in applying for and supporting a nationwide 611 number to report child abuse and neglect.

III. **DHR and SSA should prominently display a "Report Child Abuse & Neglect" hotlink on its homepage. "Report abuse and neglect" is currently rotating #6.** Hotlinks that are periodically displayed or difficult to find tend to make reporting more cumbersome and potentially less likely. "Report Child Abuse & Neglect" hotlink (including image) should be present on each major DHR webpage.

IV. **SCCAN recommends that DHR make several improvements to its "Report Child Abuse" landing page. SCCAN's specific recommendations for a child abuse reporting landing page are contained in Appendix I.** Council members and staff gathered information from the following resources: DHR's current site, Maryland law, other states, including New Jersey http://www.nj.gov/dcf/index.shtml , Arkansas http://www.arkansas.gov/reportARchildabuse/ Vermont http://dcf.vermont.gov/aboutDCF , and New York http://www.ocfs.state.ny.us/main/ to name examples of several clear, accessible and up-to-date landing pages

V. **Each of the child and family serving agencies represented on the Children's Cabinet as well as GOC and GOCCP should be required to include a "Report Child Abuse & Neglect" hotlink and hotlinks to the Enough Abuse Campaign (Child Sexual Abuse Prevention) on appropriate web pages within their agency.**

VI. **As Maryland requires all citizens to report suspected child abuse and neglect, high-quality online training similar to that in other states should be made available free of charge for all mandated reporters. Recognizing and reporting Child Abuse and Neglect must be a regular part of continuing education and licensing requirements for all individuals and institutions who work and/or volunteer with or have access to children.**

- See, California http://mandatedreporterca.com/ , Delaware http://dpr.delaware.gov/boards/medicalpractice/mandatory_training.shtml , Illinois, https://mr.dcfstraining.org/UserAuth/Login!loginPage.action , New Jersey http://www.state.nj.us/education/students/safety/socservices/abuse/training/ Wisconsin http://wcwpds.wisc.edu/mandatedreporter/ ,

Partners of the Maryland Partnership to Prevent Child Sexual Abuse (MPPCSA) have worked together over the past two years to ensure that

mandated reporters have training available online to recognize and report Child Sexual Abuse.

- Since 2007, the Mid-Atlantic P.A.N.D.A. Coalition has provided mandated reporting training specific to dental professionals; and, successfully advocated for board licensing requirements to include 2 hours of mandated reporter training on family violence to occur every other renewal cycle.
- In 2014, The Maryland Coalition Against Sexual Assault (MCASA) was funded by DHMH, Center for Injury and Sexual Assault Prevention to develop Child Sexual Abuse Online Training for mandated reporters of child sexual abuse.
- In 2015, The Baltimore Child Abuse Center was funded by the Governor's Office of Crime Control and Prevention/Children's Justice Act Committee (CJAC) to develop BCAC Mandated Reporter Training for mandated reporters of child abuse and neglect.

State Council on Child Abuse and Neglect (SCCAN)

AGENCY RESPONSE TO SCCAN's 2014 ANNUAL REPORT

SCCAN requests a written response to its' 2014 & 2015 Annual Reports indicating *whether and how* the state will *incorporate each recommendation*, as required by the 2003 amendments to CAPTA:
"[n]ot later than 6 months after the date on which a report is submitted by the panel to the State, the appropriate State agency shall submit a written response to State and local child protection systems and the citizen review panel that describes whether or how the State will incorporate the recommendations of such panel (where appropriate) to make measurable progress in improving the State and local child protection system."

State Council on Child Abuse and Neglect (SCCAN)
2015 REPORT OF ACTIVITIES & ACCOMPLISHMENTS TOWARD PREVENTION GOALS:

In 2015, SCCAN and its' partners continued working together through Maryland's Essentials for Childhood Initiative (MD EFC) to take a mutually supportive set of actions to promote safe, stable, nurturing relationships and environments (SSNRs&Es), prevent ACEs, and build child, family and community resilience across multiple public and private agencies. Currently, five states (CA, CO, MA, NC, WA) are being funded by the CDC to build statewide infrastructure through a collective impact process to promote SSNRs&Es for children and prevent child maltreatment. In 2014, SCCAN developed a relationship with the Director of the CDC's Essentials for Childhood Initiative and Maryland was offered the opportunity to receive technical assistance as a self-supporting state through the CDC's EFC grant. With the support of Maryland's Center for Injury and Sexual Assault Prevention, SCCAN and its' partners have been participating in the CDC's EFC Initiative since October of 2014. Technical assistance includes monthly phone calls, webinars and annual reverse-site visits for both funded and self-supporting states; access to experts, CDC research and grant-related materials; as well as, tools being used in funded and self-supporting states. *MD EFC efforts will be highlighted as one of eight self-supported states effectively implementing EFC in an upcoming CDC publication to be released in October of 2016.* Maryland's initiative builds the state's capacity to mobilize individuals and organizations across sectors to promote SSNRs&Es for children, prevent child maltreatment and other ACEs, and build resilience through a Collective Impact framework that includes the following five components:

1. ***A common agenda***: MD EFC partners developed a draft common agenda (based on work done in EFC funded states) that helps EFC member organizations to research, share, develop and align activities, programs, policies and funding across Maryland's state and local systems and communities to disseminate the science of the developing brain, promote SSNRs&Es, prevent ACEs, and build resilience. In 2015, the following key actions have been facilitated by Maryland's EFC Initiative (an outgrowth of SCCAN's initial Prevention Committee) to guide vision and strategy.

   ACTIONS:

   - Developed a draft Theory of Change and Maryland EFC Common Agenda from which partners have aligned multiple mutually reinforcing activities (See, Appendix J & K).
   - Developed a draft EFC Governance Structure with workgroups to lead each of the four key statewide strategies: Community Engagement & Public Awareness Workgroup, Programs and Systems Integration Workgroup, Public and Private Sector Policy & Financing Solutions Workgroup, Shared Data & Outcomes Workgroup.(See, Appendix L)
   - Continued to develop a Common/Shared Understanding of the problem, the science and the multiple solutions, as well as the Collective Impact process through the MD EFC Learning to Action Network (see specific actions under 2. Mutually Reinforcing Activities-Raising Awareness and Commitment below).
   - Continued the ongoing analysis, engagement and development of and with organizations, resources, and populations critical to accomplishing EFC goals. (e.g., Maryland Caregiver Support Council, Working Matters Coalition, Johns Hopkins Bloomberg School of Public Health, Urban Health Institute, Maryland Project LAUNCH,

DJS, Office of Behavioral Health, DHMH, MCH-Early Childhood Comprehensive Systems, Mitigating Toxic Stress Initiative, Child Justice, Maryland Safe at Home, Maryland Legal Aid, and BB&T)

- Advocated for resources and technology for the collection and analysis of data to build the case for SSNRs&Es See below, under mutually reinforcing activities-Public and Private Sector Policy & Funding Solutions).

2. ***Shared measurement system (Data & Outcomes):*** The goal of the EFC collective impact initiative is to Improve and enhance Maryland's data management systems that use common measurements to increase accountability for shared indicators and outcomes for families and children. The following key actions have been facilitated by the MD EFC backbone organization/s:

   ACTIONS:

   - Were successful in advocating for the collection of ACE module data in Maryland's 2015 BRFSS.
   - Attended quarterly CDC EFC Evaluator Calls to learn from evaluators in funded EFC states about their decision making process for indicators and chosen indicators of impact.
   - Shared CDC EFC "Indicators of Impact" Document with DHMH, Bureau of Maternal & Child Health and JHU, Bloomberg School of Public Health, Child & Adolescent Health Measurement Initiative (CAHMI), to engage their work in a Shared Data & Outcomes Workgroup to explore shared indicators and outcomes for Maryland.
   - Built a Shared Data & Outcomes Workgroup into the governance structure of Maryland's EFC Initiative.
   - Begun to research how other states have chosen to analyze and disseminate ACE module data in order to promote SSNRs&Es across child and family serving systems.
   - Advocated with EFC partners and aligned coalitions to support the Governor's supplemental budget and DHR Secretary Malhotra's priority to support IT modernization of child and family serving services at DHR.
   - Inventoried data sources in state child and family serving systems. (Environmental Scan of Maryland's Efforts to Prevent Child Maltreatment)
   - Gathered information on how the CDC EFC funded states identified process and outcome indicators for strategies within the EFC common agenda.

3. ***Mutually reinforcing activities:*** Coordinated statewide efforts are essential to expanding the capacity of our state systems to positively support parents, families and communities in developing the social, emotional, cognitive, physical and economic health of our youngest Maryland citizens and their families. EFC partner organizations took the following key actions to ***support aligned activities around the four key statewide strategies in the EFC Common Agenda:***

   Goal 1: Raise Awareness and Commitment Across the State of the importance of the science of the developing brain, the primary prevention of ACEs, the mitigation of toxic stress and build resilience.

   ACTIONS:

- Partner across public and private sectors, disciplines, agencies and with fellow citizens to intentionally build prevention leadership and unite behind EFC common agenda.
- SCCAN and its EFC partners continue to expand the number and deepen the expertise of individuals who have committed to making primary prevention a priority. **The *EFC LEARNING TO ACTION NETWORK*** (an outgrowth of SCCAN's initial Prevention Committee) builds leadership and support within Maryland for promotion and prevention efforts. The following knowledge-building opportunities on public policy advocacy, framing and media advocacy, child maltreatment prevention policies (child abuse and neglect fatalities and child sexual abuse) were offered over the past year at SCCAN and Maryland Partnership to Prevent Child Sexual Abuse (MPPCSA) Meetings:
    - **"Essentials for Childhood Collective Impact Efforts" Webinar**

      Webinar Speaker: FSG

      Audio: available upon request

      Materials: Power Point Presentation available upon request
    - **Policy impacting Social Services to Vulnerable Children & Youth within Maryland's Child & Family Serving Systems: Dustin R**

      Speaker: Mitch Mirviss, Esq.

      Materials: Dustin R. Status & Facts Summary
    - **"National Commission to Eliminate Child Abuse & Neglect Fatalities"**

      Speaker: Commissioner Theresa M. Covington, MPH, National Commission to Eliminate Child Abuse & Neglect Fatalities, Executive Director, National Center for the Review and Prevention of Child Deaths

      Materials: Power Point available upon request, CECANF Draft Policy Recommendations, CECANF Public Disclosure Briefing Document, CECANF Draft Report: Emerging Themes and Recommendations
    - **"Framing, Messaging & EFC Talking Points"**

      Video: Ivan Juzang, founder and President of MEE Productions at the JHU, Bloomberg School of Public Health's 4th Annual Symposium on the Social Determinants of Health, ***Healing Together: Community-Level Trauma—Its Causes, Consequences and Solutions:*** https://www.youtube.com/watch?v=ceyvFsLto2s at 44:31.

      Materials: CDC EFC Framing Tips, CDC Essentials for Childhood Messaging Materials, Maryland Draft EFC Talking Points 1 & 2
    - **"CM Prevention Policies & How EFC Partners Might Align with GOC & DHR Priorities"**

      Speakers: Steven Youngblood, DHR, SSA, Director of Foster Care Policy and Practice; Patricia Arriaza, Governor's Office for Children, Chief of Policy

      Materials: "Exploring policies for the reduction of child physical abuse and neglect" Joanne Klevens, Child Abuse and Neglect Journal; Maryland Children's Cabinet Strategic Planning Summary; Maryland's Governor's Office for Children, Strategic Plan Final; PCA America Status Report on State and Federal Legislative Efforts to Prevent Child Sexual Abuse

- **"CM Prevention Policies: Comprehensive CSA Prevention Legislation"**

  Speakers: Elizabeth Letourneau, PhD

  Materials: "Exploring policies for the reduction of child physical abuse and neglect" Joanne Klevens, Child Abuse and Neglect Journal; PCA America Status Report on State and Federal Legislative Efforts to Prevent Child Sexual Abuse; Summary of PCA America document

- 20+ trainings presented by MPPCSA to educate agencies, providers, advocates and survivors re: Enough Abuse Campaign to prevent child sexual abuse
- EFC's steps to bring ACE Interface to Maryland.
  - EFC Committee initiated conversations with Laura Porter and Rob Anda to bring ACE Interface Training to Maryland
  - Reviewed ACE Interface Curriculum
  - The Family Tree, an EFC co-backbone, secured funding to support ACE Interface in Maryland
  - Interviewed staff candidate to support ACEs Interface in Maryland
  - Next steps: develop interest and recruit master trainers from multiple sectors
- Developed content and design concepts for MD EFC Website
- Raise Awareness through screenings of The Raising of America and Paper Tigers Documentary Screenings by MD EFC Partners:
  - SCCAN showed three supporting episodes of the Documentary Series "The Raising of America" to SCCAN members and partners at its' 2014 SCCAN Retreat: "Are We Crazy About Our Kids?", "Once Upon A Time: When Childcare for All Wasn't Just a Fairytale" and "Wounded Places: Confronting Childhood PTSD in America's Shell-Shocked Cities".
  - SCCAN shared "The Raising of America" with policy makers with the following goals in mind:
    1. Reframe the story about the importance of early experiences for healthy child development to include family, community and societal responsibility for child outcomes;
    2. Foster dialogue and action to strengthen communities and support child and family-friendly initiatives; and,
    3. Advance policies across sectors—early childhood, public health, child welfare, housing, labor, transportation, health care, education, etc.—which reduce ACEs and benefit Maryland's children.
  - DHMH, Maternal & Child Health Bureau, Early Childhood Comprehensive Systems "Mitigation of Toxic Stress in Infancy and Early Childhood" Initiative sponsored five regional summits on "Mitigating Toxic Stress in Infancy and

Early Childhood. EFC participated in planning sessions and shared resources with DHMH.
  - Maryland Family Network, an EFC co-backbone, screened "Once Upon A Time: When Childcare for All Wasn't Just a Fairytale" for members of the early childhood care and education community with the support of Johns Hopkins Bloomberg School of Public Health.
  - Baltimore Child Abuse Center screened "Paper Tigers" and "Raising of America's Wounded Places" in Baltimore City.
  - Thriving Communities Collaborative http://thrivebmore.org/about-us/ screened "Raising of America's Wounded Places" in Baltimore City.

ACTIONS proposed with additional funding:

- Contract to create a Web-based platform tool that is: easily accessible, highly customizable and inexpensive to maintain to facilitate communication, sharing of resources and concrete action steps at all three jurisdictional levels (state, county/city, community).

Goal 2: Identify and use Data to inform actions and recommendations for systems improvement

❖ **Build a partnership to gather & synthesize relevant data:** DHMH, University of Maryland, the Moore Center for the Prevention of Child Sexual Abuse and Child & Adolescent Health Measurement Initiative at Johns Hopkins are interested in partnering with EFC

- **Identify and fill critical data gaps:**
  - Critical data gaps filled:
    - The ACE Module will be included in half of Maryland's 2015 BRFSS surveys. Survey administration began in early January 2015 and will continue through the end of December 2015. Surveys including the ACE module are asked throughout the year. By December 31, 2015, approximately 6,000 surveys will include the ACE module. It is anticipated that the 2015 data will become available in July of 2016.
  - Critical data gaps remain:
    - Data on health outcomes of children in child welfare system: See below, SCCAN's Report on Health Care for Children Involved in Maryland's Child Welfare System; and, http://www.childabusemd.com/foster/health-concerns.shtml
    - It is anticipated that DHR's IT modernization plan will address the health outcome data gaps for children involved in the child welfare system.
- **Use the data to support other action steps:**
  - SCCAN is a founding member of the Maryland's Partnership to Prevent Child Sexual Abuse (MPPCSA) whose mission is to prevent child sexual abuse by engaging adults and mobilizing communities in effective prevention efforts at the state and local levels. With SCCAN's assistance,

the MPPCSA consolidated the information from the Environmental Scan and added partner-known information from local and national sources. After reviewing available data, MPPCSA, including SCCAN, agreed to:

- Organize their actions and recommendations around The National Coalition to Prevent Child Sexual Abuse and Exploitation's Six Pillars of Prevention:

1. **Support Healthy Development of Children**
   It is important to increase adult capabilities to improve child outcomes related to sexual development, as well as, cognitive, social, emotional and physical development. Understanding and ensuring the healthy sexual development of children is an adult responsibility. Resources: http://www.nsvrc.org/sites/default/files/saam_2013_an-overview-of-healthy-childhood-sexual-development.pdf and http://nctsn.org/nctsn_assets/pdfs/caring/sexualdevelopmentandbehavior.pdf
2. **Support Healthy Relationships and Sexuality Education for Children and Youth**
3. **Strengthen Youth Serving Organizations' (YSOs) Sexual Abuse and Exploitation Prevention Capacity,** See, *Enough Abuse Campaign's Gatekeepers for Kids* work below.
4. **End the Demand for Children as Sexual Commodities**
5. **Prevent Initial Perpetration of Child Sexual Abuse and Exploitation**
6. **Develop Sustainable Funding for Prevention**
   See, http://www.preventtogether.org/Resources/Documents/PreventionCoalitionPillarsFinal2015.pdf

- Integrate and highlight MPPCSA and EAC efforts within Maryland's broader EFC Collective Impact effortsSee Shared measurement system (Data & Outcomes) actions above.

Goal 3: Create the Context for Healthy Children and Families through Norms Change and Programs

- Provided for a Programs and Systems Integration Workgroup within collective impact structure.
- Promote the community norm that we all share responsibility for the well-being of Maryland's children.
- Promote community norms about parenting programs and acceptable parenting behaviors through SCCAN's twitter handle and SCCAN Facebook pages
- Promote Implementation of evidence-based and promising programs for parents and caregivers:
  - **Evidence-based Home Visiting:** Support increase in evidence-based home visiting programs.
  - **Circle of Security-Parenting:**

        - Support training and statewide implementation of Circle of Security-Parenting (COS-P)- 3 additional COS-P trainings of 100+ in Maryland
        - Support research of COS-P DVD model in Baltimore City
        - Obtained approval from COS-P developers to train SCCAN Prevention Co-Chair to provide overviews of COS-P to interested public and private agencies within Maryland.
        - Advocated for research & training's in COS-P
        - COS-P overview to Child Welfare, Title IV-E Waiver/ Foster Care Parents, and Children's Mental Health Conference
    - **Enough Abuse Campaign to Prevent Child Sexual Abuse:**
        - Integrated and highlighted MPPCSA and EAC efforts within Maryland's broader EFC Collective Impact efforts.
        - Equipping Maryland adults with valuable skills and resources to prevent CSA before it occurs:
            - Of nine hundred and thirty two (932) adults trained, about 60 completed post assessments revealing that participants improved their knowledge, attitudes and behavior – scoring on average 4.6 on a 5 pt scale.
            - This year we continued to disseminate Straight Talk About Child Sexual Abuse, a prevention guide for parents, which was widely received in our communities.
        - Strengthening Youth Serving Organizations' (YSOs) Sexual Abuse and Exploitation Prevention Capacity:
            - Through a grant from Governor's Office with Children (CJAC), and partnering with the Department of Human Resources, The Family Tree, the MPPCSA lead entity, will provide training on CSA to 250 staff, volunteers, and treatment foster parents from DHR licensed facilities.
        - Advocate for comprehensive CSA prevention policies (See below under IV. Public Policy)
- Disseminate EFC framing and messaging materials to Maryland EFC partners and stakeholders.
- Drafted Maryland EFC and collective impact talking points.
- Shared EFC and Berkley Media Studies resources with DHMH, Behavioral Health, Office of Child & Adolescent Health, Resilience Wellness & Prevention Committee for the Children's Mental Wellness Campaign.
- Participate in Resilience, Wellness & Prevention Committee monthly meetings.
- Participated in and shared resources with ECCS for their Mitigating Toxic Stress and Trauma in Infancy and Early Childhood Initiative
- Assisted with grant writing for ECCS IMPACT Grant

- Submitted EFC & SCCAN letter of support for CDC Core Violence & Injury Prevention Grant
- Supporting Lifespan Respite Care Act Grant application of Maryland Caregiver Coordinating Council
- Participate in Project LAUNCH, State Young Child Wellness Council, Sustainability and Integration Workgroup to identify shared goals, activities and measures between Project LAUNCH, EFC, ECCS, MIECHV, etc.

Goal 4: Create the Context for Healthy Children and Families through Policies

- Created Public and Private Sector Policy & Financing Solutions Workgroup to identify and assess which policies may positively impact the lives of children and families in Maryland communities.
- Disseminated "Exploring policies for the reduction of child physical abuse and neglect" Joanne Klevens, Child Abuse and Neglect Journal to EFC partners in order to frame child maltreatment prevention policy work.
- Incorporated EFC Goals into 2012-2015 SCCAN Annual Reports and disseminated widely
- Participated in the work of multiple coalitions to support child and family friendly policies and funding that are thought to prevent child maltreatment and other ACEs:
    - Coalition to Protect Maryland's Children
    - Maryland Alliance for the Poor
    - Maryland Academy of Pediatrics, Legislative Committee
    - Maryland Caregivers Support Coordinating Council
    - Maryland Coalition Against Sexual Assault
    - Maryland Family Network
    - MD Home Visiting Alliance
    - Maryland Legislative Agenda for Women
    - Maryland Partnership to Prevent Child Sexual Abuse (MPPCSA)
    - Maryland Working Matters Coalition
    - Maryland Working Families Coalition
- Identified coalition specific work that is supportive of EFC Policy Goals
- Tracked legislative bills that were supportive of EFC Policy Goals through coalitions
- SCCAN worked closely with Prevent Child Abuse Maryland Chapter (The Family Tree), the American Academy of Pediatrics (AAP) and the Maryland Coalition to Protect Children, to build a wider base of support for EFC and ACE prevention efforts. The Family Tree, AAP and SCCAN co-sponsored a day in Annapolis, at which advocates visited 188 of our elected officials to share information on ACEs.
- Identified Governor's Executive Priorities & linked to EFC Goals
- Incorporated EFC and ACEs principles into CPMC written testimony on the DHR Budget.

- Provided EFC and SCCAN written testimony to support Maryland Healthy Working Families Act incorporating MD EFC talking points
- Signed on to CPMC Letters of Support Interagency IT Modernization in Governor's Supplemental Budget
- Enough Abuse Campaign-SCCAN, EFC, and the MPPCSA, developed policy recommendations for comprehensive legislation to prevent child sexual abuse. We have had preliminary discussions with legislators regarding strategies to build upon HB72 Erin's Law consistent with SCCAN's review and discussion of national and state laws.
- Provided decision-makers and community leaders with information on the benefits of evidence-based and promising strategies and rigorous evaluation
    - SCCAN's Health Care for Children in Child Welfare Workgroup advocated for adoption of SCCAN's 2013 Recommendations by DHR and DHMH and submits those recommendations again in the 2014 Annual Report.
    - In 2014, the Maryland General Assembly passed SB 685, Family Law – Child Abuse and Neglect – Provision of Information to Health Care Practitioners. The SCCAN executive director, the AAP representative to SCCAN and AAP's lobbyist met with DHR representatives per the statute requirement to "(a) work with relevant stakeholders to 1) identify additional policies, procedures, and systems that can be implemented to improve communication between the Department, local departments, and health care practitioners regarding the health care needs of children who are the subject of a report of child abuse or neglect; and 2) consider the issues relevant to the adoption by the Department of requirements for affirmative communication with health care practitioners; and (b) on or before December 1, 2014, report the outcome of the work conducted under subsection (a) of this section to the Senate Judicial Proceedings Committee and the House Judiciary Committee, in accordance with § 2–1246 of the State Government Article." Both AAP and SCCAN read the statute to require sharing of information between DHR/local DSSs and health care practitioners to all children served by children involved with the child welfare system (CPS and Foster Care). DHR reads the statute narrowly to mandate sharing of information with a child's health care practitioners only during the 60-day period of a CPS investigation. As the ACE Study so clearly illustrates, child abuse and neglect, as well as other ACEs, can have significant lifetime negative health consequences. Child welfare professionals and a child's health care practitioners must work together to ensure abused and neglected children get the appropriate health care and other services they need to begin to heal. The child's appropriate care depends upon *all* of the child's child welfare workers (Alternative Response, CPS and Foster Care) and health practitioners (physical, including dental, and mental health practitioners) sharing information to assist in both diagnosing and mitigating the effects of ACEs. That process goes on throughout the child's involvement with

the child welfare agency. SCCAN respectfully recommends that the General Assembly clarify or broaden the scope of the requirement in SB 685 that the Department and local Departments share information regarding the health care needs of "children who are the subject of a report of child abuse or neglect" to include all children served by the child welfare administration and workforce. ***SCCAN continues to advocate for all child welfare workers to share information to assist in both diagnosing and mitigating the effects of ACEs on children involved with child welfare.***

4. ***Continuous communication:*** Collective impact requires building trust between organizations that may have been or continue to be in competition with one another. In order for EFC to be successful in attaining its common goals, organizations need to feel that their interests are equally valued and protected. Sharing resources and information openly between EFC organizations and uplifting EFC organizations' accomplishments as contribution to the whole is critical to building trust. The following key actions are being facilitated by the EFC co-backbone organizations:
    - Facilitate outreach across multiple state-level public and private agencies working to promote SSNRs & Es, prevent ACEs and promote resilience: Face-to-face meetings have been important to creating trust among the group.
    - **EFC Learning to Action Network:** sharing knowledge, resources, and expertise with partner agency representatives: Growing awareness brain science, impact of trauma and adversity, impact of ACEs on health, connection of health to mental wellness.
    - **EFC Listserv:** notices of EFC meetings work go out to 400+ partner agency representatives. Partners input welcomed and encouraged at EFC and SCCAN meetings.
5. ***Backbone support:*** Ideally, one state backbone organization (seen as neutral by members), would serve as the EFC state level backbone organization providing technical support to the state Leadership Action Team (LAT), Collective Impact Team (CIT) and the Workgroups (Community Engagement & Public Awareness, Programs and Systems Integration, Public and Private Sector Policy & Funding Solutions, and Shred Data and Outcomes) developed around the four key statewide strategies (listed below). In most EFC states, the backbone functions are being coordinated by the public health agency in concert with other in-kind supports from other public or private agencies. Currently in Maryland, the six backbone functions that are provided are being done so by a combination of in-kind supports from The Family Tree, Maryland Family Network, DHMH's Bureau of Maternal & Child Health, and SCCAN, who serve as co-backbones. ACTIONS:
    - Completed a stakeholder matrix to include champions, steering committee (LAT), working groups (collective impact team-CIT) and expert/thought leaders.
    - SCCAN continues to increase the number of strategic partnerships between public and private state-level partners that prioritize promoting safe, stable and nurturing environments for children, strengthening families and preventing child maltreatment and other ACEs.
    - Convened EFC Committee 5 times last year to identify common agenda and key policy goals at the state and local levels
    - SCCAN continues to partner with The Family Tree in leading the Maryland Partnership to Prevent Child Sexual Abuse (MPPCSA) and the partnership's Enough Abuse Campaign in Maryland. MPPCSA efforts have been incorporated into the larger MD EFC Initiative.

- Establish Four Workgroups around which EFC goals are achieved:
    - Community Engagement & Public Awareness Workgroup
    - Programs and Systems Integration Workgroup
    - Public and Private Sector Policy & Funding Solutions Workgroup
    - Shared Data & Outcomes Workgroup
- Focus on building relationships and trust (modeling the basic serve and return relationships we are promoting between adults and children) through continuous communication and developing actions that adults can take at the individual, family, community and state level to promote the healthy development of children 0-3 and beyond.
- Document state level impact of MD EFC efforts via SCCAN Annual Report
- Shared CDC and other national and state resources to encourage and support backbone organizations in local communities. Appendix J illustrates Maryland's EFC theory of change using collective impact. Partners at the community practice and program level, county/system level, and state/system level build awareness of each others' efforts and work in mutually reinforcing ways to promote safe, stable and nurturing relationships and environments, prevent ACEs, and build resilience.
- Maryland's co-backbone organizations, The Family Tree (Maryland's Prevent Child Abuse Chapter), Maryland Family Network (Maryland's Community-Based Child Abuse Prevention Grantee), DHMH, Bureau of Maternal & Child Health and SCCAN, will support the development of state collective impact teams by ensuring that the five key conditions for collective impact (above) are met and reflected in both the approach and structure.

State Council on Child Abuse and Neglect (SCCAN) Report on Health Care for Children Involved in Maryland's Child Welfare System

Finding: The current systems for providing healthcare services to children involved in the child welfare system (abuse/neglect investigations & foster care) are inadequate. Specifically, there is no mandatory oversight to ensure best practices, care coordination, and evidence-based care. In addition, there is no single system for reimbursement; leaving many services such as court testimony and team meetings unfunded.

Background and Supporting Evidence:
Health care providers play many important roles in the evaluation and management of children involved with the child welfare system. The two child welfare programs that have the most contact with children with suspected or proven maltreatment are Child Protective Services (CPS) and Foster Care (FC). Evidence-based guidelines and best practice recommendations are available to guide the appropriate provision of health care services for children in both of these groups. Unfortunately, there is currently no system in place to ensure that evidence-based guidelines and best practice recommendations are implemented in Maryland.

Medical Evaluations for Children Being Investigated for Suspected Abuse or Neglect

Failure to provide appropriate forensic medical assessments jeopardizes the health and well-being of some of our most vulnerable citizens. For children being investigated by CPS for suspected maltreatment, a failure to diagnose existing maltreatment allows maltreatment to continue, and increases the short and long-term costs for physical and mental health care, education, and juvenile justice. In addition, the misdiagnosis of accidental injuries as abusive can have profound repercussions for children who may be faced with removal from their homes or loss of caregiver emotional and financial support because of no-contact provisions or incarceration, and for their families. The provision of expert medical evaluations for suspected maltreatment is also a social justice issue. Multiple studies have found that poor and minority children are more likely to have accidental injuries misidentified as abuse, while non-poor and white children are more likely to have abusive injuries misidentified as accidental. This problem may be exacerbated when health care professionals without child maltreatment expertise are determining whether a child has been abused or neglected.

The Role of Experts: Child maltreatment medical experts play many important roles in the evaluation of children for suspected abuse and neglect. When children with injuries present for medical care, child maltreatment experts assess whether the injuries are accidental or abusive. For children with suspected sexual abuse, experts collect forensic evidence ('rape kits'), test for sexually transmitted infections, and determine whether there are abnormalities on exam that are the result of abuse. When concerns of neglect arise, child maltreatment experts play a number of roles. Examples include

distinguishing whether a medical condition or neglect is responsible for failure to thrive, and determining whether incomplete medical, mental health or dental care rises to the level of medical neglect. For all forms of maltreatment, the expert may identify unmet medical, mental health and dental needs.[1] Child maltreatment experts educate other healthcare, child welfare and law enforcement professionals and make recommendations for follow-up medical, developmental, educational, and mental health services.

Health care professionals without significant experience in the evaluation of children for suspected maltreatment are often uncomfortable making a firm diagnosis of abuse and testifying in court.[2-4] Numerous research studies have demonstrated that lack of expert medical evaluation leads to misdiagnosis, misinterpretation of exam findings, and failure to provide definitive assessments regarding the likelihood of abuse.[5-9] This puts children with accidental injury at risk for being labeled as abused, and may lead to repeated abuse of children who are not identified and protected. Two recent studies have shown that expert evaluation of suspected maltreatment may prevent over and underreporting of child maltreatment to Child Protective Services.[9,10] A study by Anderst and colleagues that reviewed physical abuse medical evaluations found that **when no expert was involved, 67% of evaluations resulted in either no medical opinion about the likelihood of abuse or an incorrect opinion**.[9] For every 100 children evaluated for abuse by a non-child abuse expert, 20 had false positive diagnoses and 4.5 had false negative diagnoses. In Maryland, more than 1500 children with suspected physical abuse received no expert medical evaluation in 2012. Therefore, we can extrapolate that ***at least 300 children with accidental injury are mislabeled as being abused, and 68 children with abusive injury go unrecognized each year in Maryland***. Increasing the percentage of children who receive expert medical evaluation will lead to better protection of children and better use of scarce child welfare funding.

Medical Assessment of Child Maltreatment in Maryland: In Maryland, children who receive a medical evaluation for suspected abuse or neglect may have this evaluation performed at a child advocacy center, a hospital emergency department or inpatient unit, or in a physician's office. Not all children have a medical evaluation, and not all medical evaluations are performed by health care providers with special expertise in the evaluation of physical abuse, sexual abuse, and/or neglect. Further, depending on the type of training and amount of experience, different providers may have very different levels of expertise.

There are three main routes for health care providers in Maryland to become child maltreatment experts. Pediatricians can obtain specialized training in child maltreatment through a 3-year fellowship completed after pediatric residency. Those who complete this fellowship and pass a certifying exam are board certified in Child Abuse Pediatrics. Maintenance of certification is an ongoing process that is monitored by the American Board of Pediatrics. There are 6 board certified Child Abuse Pediatricians practicing in Maryland. Pediatricians and Family Medicine physicians can also gain expertise through shorter and less standardized training from individual physicians or groups. Maryland CHAMP (CHild Abuse Medical Professionals) program

faculty members have trained six physicians who now serve as local experts throughout the state. Another five physicians have received training from other sources.
Registered nurses in Maryland can train to become Forensic Nurse Examiners (FNEs). FNEs are registered nurses that have specialty training and skills to identify, assess and intervene in situations of violence including child maltreatment. Forensic nurse examiners provide assessment and documentation of injuries, evidence collection & preservation including photography, recommendations for medical & forensic testing, referrals for continued care, and testimony as required. Two forensic nurse certifications are available in Maryland. FNE-A certification allows a nurse to evaluate adults and adolescents, while FNE-P certification allows for the evaluation of children <13 years. The regulations set forth by the Maryland Board of Nursing require all FNE-Ps to have completed both training components (FNE-A & FNE-P) to become certified to provide care to children.
Detailed information regarding the training requirements for physician and nurse experts is provided in Appendix A. In addition to their initial training, both physicians and nurses are expected to participate in peer review and continuous quality improvement. Standards for forensic nurses, including expectations for peer review, are published in the "National Training Standards for Sexual Assault Medical Forensic Examiners" published by the U.S. Department of Justice.[11] The Maryland Board of Nursing requires that FNEs participate in peer review, but does not provide specifics about content or process. Standards for pediatricians are published in several peer reviewed journals,[12,13] and the American Professional Society on the Abuse of Children (APSAC) has published peer review recommendations that apply to both physicians and nurses.[14] For a child advocacy center to be certified by the National Children's Alliance (NCA), its medical providers must document participation in ongoing training and peer review (Appendix B).[15] The Maryland CHAMP program was established to provide training and peer review for physicians and nurses who evaluate children with suspected maltreatment. Currently, CHAMP faculty, all CHAMP-trained physicians, and many FNEs participate in CHAMP peer-review. A small number of physicians and nurses do not participate.
CHAMP providers see a very small proportion of the children reported to Child Protective Services (Table 1). There were 26,688 alleged-maltreatment cases investigated between May 2012 and April 2013, of which 16,224 (61%) were indicated or unsubstantiated. CHAMP providers saw approximately 3490 children, accounting for only 13.1% of children investigated for suspected maltreatment. Because the investigation data is not broken down by maltreatment type, it is not possible to determine the percent of children investigated for physical abuse, sexual abuse, and neglect who receive a forensic medical evaluation. However, if the sum of the indicated and unsubstantiated cases is used as a denominator (a crude and low estimate), then nearly all children with sexual abuse receive medical evaluations, but only about half (1599/3108) of children with physical abuse and only 8% (88/11,148) of children with neglect receive forensic expert medical evaluations.

Table 1: Estimated number of children receiving medical evaluations in Maryland*

	Physician Evaluation with Physical Exam	FNE Evaluation with Physical Exam	Physician Evaluation - No Physical Exam	FNE Evaluation - No Physical Exam	Total	Maryland DHR Indicated & Unsubstantiated cases**
Sexual Abuse	1040	417	295	55	1807	1968
Physical Abuse-Inpatient	112	20	0	0	132	3108
Physical Abuse-Outpatient	194	35	1222	12	1463	
Neglect	52	5	31	0	88	11,148
TOTAL					3490	16,224

*Based on survey distributed to physicians and FNE-Ps by the CHAMP program. 17/19 physicians and 24 FNEs provided data. Data not provided for Calvert, St. Mary's and Prince George's counties.
**May 2012-April 2013. No public data available for ruled-out cases by maltreatment type.

The proportion of children who receive medical evaluations varies significantly by county, putting children in some counties at higher risk for erroneous investigation outcomes than in others. County-level variation in the rates of expert medical evaluation for all forms of maltreatment is provided in Table 2 as a proportion of all reports and as a proportion of all investigations. Expert medical evaluation rates range from <1% to 60% of all children being investigated for suspected maltreatment. County-level rates of expert medical evaluation can also be examined by type of maltreatment (Table 3). Children with sexual abuse had the highest rates of expert medical evaluation, but rates were still extremely low in some counties. ***In 9 counties, less than one-quarter of children with suspected physical abuse received an expert medical evaluation. No more than 3% of children with suspected neglect received an expert medical evaluation in ANY county***.

Some limitations of the data in Tables 1-3 should be noted. First, exam data was self-reported by CHAMP providers. Not all providers responded to the data request. We received no data from providers in Calvert, Prince George's or St. Mary's counties. We received responses from 17 of 19 physicians (89%) who evaluate children with suspected maltreatment, and 24 FNEs. We were unable to determine the response rate for FNEs because the total number of FNEs doing pediatric exams fluctuates frequently making it difficult to obtain an accurate denominator. It is possible that children were counted by more than one provider if he/she had multiple exams. Finally, some providers work in more than one county and may have misidentified the county for some children who were examined.

Table 2: County-level variation in rate of expert medical evaluation. Percentage of children reported and children investigated who receive an expert medical evaluation.

County	Total # of Exams	Number of CPS Reports	# of CPS Investigations	% of CPS Reports with Exam	% of CPS Investigations with Exam
Allegany	86	1452	540	5.9%	15.9%
Anne Arundel	326	4608	2244	7.1%	14.5%
Baltimore	1,461	5796	5700	25.2%	25.6%
Baltimore County	281	6132	2616	4.6%	10.7%
Calvert	NO DATA	1092	420		
Caroline	1	528	204	0.2%	0.5%
Carroll	28	2508	708	1.1%	4.0%
Cecil	31	1800	708	1.7%	4.4%
Charles	14	1308	720	1.1%	1.9%
Dorchester	1	528	276	0.2%	0.4%
Frederick	280	2496	1308	11.2%	21.4%
Garrett	7	132	144	5.3%	4.9%
Harford	64	2976	1200	2.2%	5.3%
Howard	62	2148	756	2.9%	8.2%
Kent	1	180	96	0.6%	1.0%
Montgomery	597	5820	2568	10.3%	23.2%
Prince George's	NO DATA	5556	2916	0.0%	0.0%
Queen Anne	28	360	144	7.8%	19.4%
Somerset	35	1224	444	2.9%	7.9%
St Mary's	NO DATA	408	156		
Talbot	93	336	156	27.7%	59.6%
Washington	17	2796	1572	0.6%	1.1%
Wicomico	39	1740	684	2.2%	5.7%
Worcester	3	540	408	0.6%	0.7%
TOTAL	3456	52464	26688	6.6%	12.9%

Table 3: County-level variation in rate of expert medical evaluation by type of maltreatment**

County	Number of Exams			Number of Indicated + Unsubstantiated Reports*			% EXAMS/ (Total Indicated+Unsubstantiated)*		
	SA	PA	Neglect	SA	PA	Neglect	SA	PA	Neglect
Allegany	74	12	0	48	36	408	154%	33%	0%
Anne Arundel	142	183	1	132	144	720	108%	127%	0%
Baltimore City	463	942	56	420	780	2016	110%	121%	3%

Baltimore County	95	182	4	240	372	1296	40%	49%	0%
Calvert				12	48	264			
Caroline	0	1	0	24	24	132	0%	4%	0%
Carroll	16	9	3	24	24	108	67%	38%	3%
Cecil	30	1	0	60	48	492	50%	2%	0%
Charles	5	5	4	48	120	192	10%	4%	2%
Dorchester	0	1	0	24	36	204	0%	3%	0%
Frederick	180	49	9	84	120	480	214%	41%	2%
Garrett	6	1	0	12	0	60	50%	0%	0%
Harford	62	2	0	120	156	528	52%	1%	0%
Howard	49	12	1	48	48	132	102%	25%	1%
Kent	1	0	0	0	0	36	0%	0%	0%
Montgomery	500	97	0	156	264	1248	321%	37%	0%
Prince George's				288	540	972			
Queen Anne/Talbot	97	21	3	36	36	132	269%	58%	2%
Somerset	25	10	0	36	60	144	69%	17%	0%
St. Mary's				24	24	84			
Washington	47	10	2	72	108	924	65%	9%	0%
Wicomico	23	14	2	48	48	252	48%	29%	1%
Worcester	0	3	0	24	72	312	0%	4%	0%
TOTAL	1815	1556	85	1968	3108	11148	92%	50%	1%

*DHR does not report the number of investigations by maltreatment type. The sum of Indicated + Unsubstantiated maltreatment reports is therefore used as an estimate of the number of children investigated for each type of maltreatment. This number is an underestimate, which would partially explain the percentages that are greater than 100%.

**Experts include physicians and forensic nurses hired by child advocacy centers and hospitals to perform medical evaluations of children with suspected abuse and/or neglect.

Pediatricians and other child maltreatment experts have published several evidence-based guidelines for the evaluation of child maltreatment.[11,13] These guidelines address the examination process, who should be examined and in what setting, when specific tests should be ordered, how findings should be interpreted, and the importance of peer review. They also address the importance of multidisciplinary evaluations. The Maryland CHAMP program (CHild Abuse Medical Professionals) faculty offer training and peer review for Maryland physicians and nurses working in this field. We have created Maryland-specific guidelines for which children should have medical evaluations, in what setting, and at what level of urgency (Appendix C).

Unfortunately, while CHAMP leadership can make best practice recommendations, there are no Maryland laws or regulations that stipulate which children need medical evaluations, or that mandate oversight of independent physicians and nurses. Medical experts can recommend to a CPS worker or detective that a child has a medical

evaluation. However, CPS and police serve as gatekeepers for the medical evaluation; if they do not recommend that an exam be done, it usually does not happen. Anecdotal reports suggest that some non-medical professionals consider the medical exam for sexual abuse to be uncomfortable, embarrassing, or too invasive, despite evidence to the contrary.[16] Some non-medical professionals don't understand the value of the medical exam, particularly for sexual abuse and neglect. There is also no state mechanism to ensure that the physicians and nurses who perform these evaluations have adequate expertise and support to do so. CHAMP has established a set of minimum continuing education and peer review criteria to be considered a 'CHAMP Provider' (Appendix D). Unfortunately, CHAMP Provider designation is only valuable if the child welfare and legal system professionals consider it important in establishing expert credentials.

Another major concern in many jurisdictions is that there is no financial support for the time that experts spend in multidisciplinary team meetings, family involvement meetings, individual consultations with CPS workers, police and prosecutors, and civil and criminal court, particularly when children are sent outside the county to receive tertiary medical care services. This situation puts experts in an untenable situation – if they do all that is needed to effectively protect children, it is often at the expense of their other professional responsibilities. If experts opt out of their role, the legal and child welfare systems will have to make their determinations without expert medical input.

Included below are some real-life examples of the work that we do, and the value that we add to the medical care and well-being of children;

(1) A child was hospitalized multiple times for severe abdominal pain – multiple invasive procedures were performed, with no significant abnormalities identified. The child's mother insisted that there was something wrong, and she listed a long history of serious medical problems requiring multiple medications. The child abuse pediatrician spent many hours reviewing old medical records and communicating with other medical providers to corroborate the diagnoses and the need for medication. Ultimately, she discovered that all of the diagnoses were either exaggerated or fabricated, and the mother had been convincing physicians to "renew" prescriptions that had not previously existed. The child abuse pediatrician participated in a Family Involvement Meeting at the local Department of Social Services, which was instrumental in countering the misinformation provided by the child's mother. Without the involvement of a child abuse pediatrician, the child's mother may have continued to seek medical care and invasive medical procedures for her daughter, putting her at risk for adverse outcomes from procedures and medications. With the involvement of a child abuse pediatrician, an expert diagnosis of medical child abuse (also called Munchausen's Syndrome by Proxy) was made, enabling the procedures, doctor shopping, and unnecessary medications to stop, and the child to be protected. In addition, we prevented further unnecessary and inappropriate heath care utilization and cost.

(2) An infant was hospitalized for breathing difficulties and during the course of medical care was found to have several occult (without signs or symptoms) fractures. The hospital child protection team was asked to evaluate the child

because of concerns for physical abuse. The child abuse pediatrician noted that the child had blue sclerae (white part of eyes), and that many relatives had a history of frequent fractures. In consultation with a pediatric geneticist, the child was diagnosed with osteogenesis imperfecta, a rare disease in which abnormal collagen production leads to weakened bones. Because of this correct diagnosis, no child protective services report was made, the family did not have to go through an investigation by CPS and police, and the child received timely care to help prevent additional fractures.

(3) A toddler with a spiral fracture of the femur (bone of the upper leg) was reported to child protective services by an emergency room physician who had been taught that spiral fractures are always the result of abuse. The child abuse pediatrician obtained a detailed history from the family and found that the running child had stepped into a small hole in the yard and had fallen with a twisting motion. The pediatrician was able to explain to the CPS worker and detective how the injury could have occurred accidentally, and they closed their investigations.

Health Care for Children in Foster Care

There are also major gaps in health care services for Maryland foster children. These include the following: (1) Children are not receiving initial and comprehensive medical evaluations in a timely manner; (2) Documentation and sharing of medical information is inadequate, making it impossible to determine whether appropriate and necessary care is being provided; and (3) Oversight and coordination of health care services is not provided in any jurisdiction except Baltimore City.

Receipt of Timely Health Care Services: Maryland state regulations require that all foster children are required to have a screening examination within 5 days of entering foster care, and a comprehensive medical assessment within 60 days. Unfortunately, the state does not appear to be meeting these goals. **Recent Maryland data from the Title IV-B report to the federal government indicates that only one-third of children receive their initial health screen in a timely manner, and only 57% receive their comprehensive assessment within 60 days.** The Department of Human Resources explains these low numbers as reflective of poor data entry rather than children "not receiving needed medical care." (See data for 2009-2012 and explanation in Appendix E). Unfortunately, there has been little change in the numbers during this 4-year period indicating that either there has been little improvement in data entry, children are still not receiving timely medical care, or both.

Table 4: Proportion of Foster Youth who Received Timely Health Care Services 2009-2012

State Fiscal Year	New Removals in OOH, in Foster Care > 8 Days	Received Initial Health Screening w/in 5 days	% Receiving Initial Screening w/in 5 days	Medical Provider Assigned w/in 10 days	% Medical Provider Assigned w/in 10 days	Received Compre-hensive Exam w/in 60 days	% Receiving Compre-hensive Exam w/in 60 days
2009	**2,477**	**753**	**30%**	**877**	**35%**	**1,228**	**50%**
2010	**2,557**	**889**	**35%**	**1,210**	**47%**	**1,352**	**53%**

2011	**2,680**	**881**	**33%**	**1,366**	**51%**	**1,098**	**41%**
2012	**2,532**	**865**	**34%**	**1,110**	**44%**	**1,455**	**57%**

Source: 2013 DHR Title IV-E Report

Documentation and Sharing of Health Information: The federal Fostering Connections legislation requires that each foster child have a written plan that includes regularly reviewed and updated medical records. The *Health Passport* serves as the written health record and plan for Maryland foster children. It should include the child's health and developmental history, copies of health visit reports, and parental consent for receipt of health care and release of medical records. For many reasons the *Health Passport* is often incomplete. The 631-E form that health care providers are asked to complete contains no instructions; providers are often unsure about what specific information to include. Past medical records are often missing, sometimes because a parent hasn't provided consent or a physician's office is worried about breaching confidentiality.

From 2010-2011, the Maryland Chapter of the American Academy of Pediatrics collaborated with DHR and the Maryland Foster Parent Association to complete an assessment of the health care needs of Maryland foster youth. The needs assessment process culminated in a series of recommendations that could improve the system without significant cost. A survey of foster parents and group home providers was completed as part of the needs assessment. It found that many topics of importance to the health of foster youth were not being discussed by primary care providers during well child visits (e.g. adjustment to foster care, developmental and mental health needs). They also received very little health information from the child's primary care provider (Figures 1 & 2).

Figure 1: Physician lack of discussion of healthcare topics as reported by foster parents and group home providers

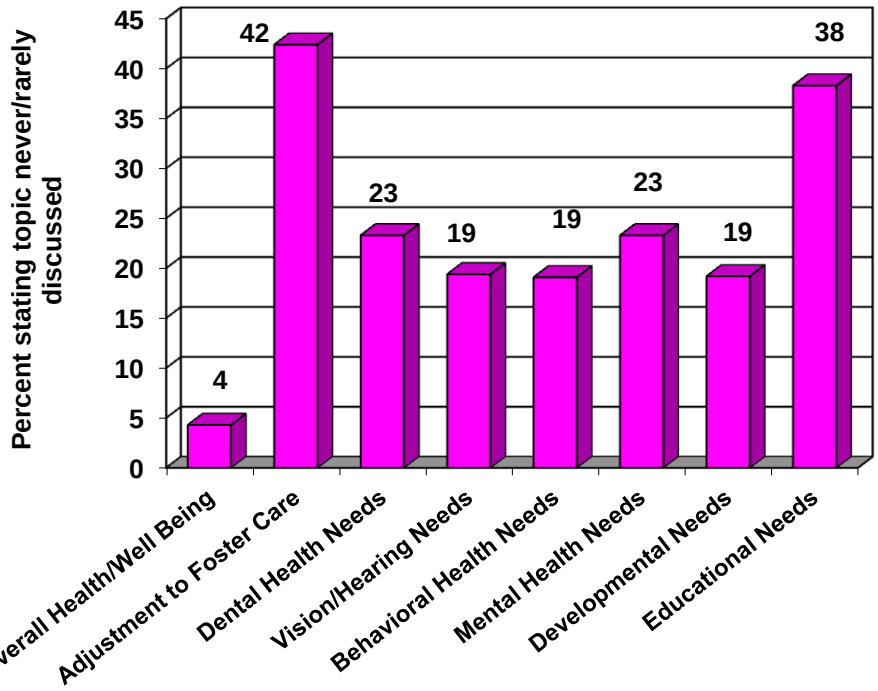
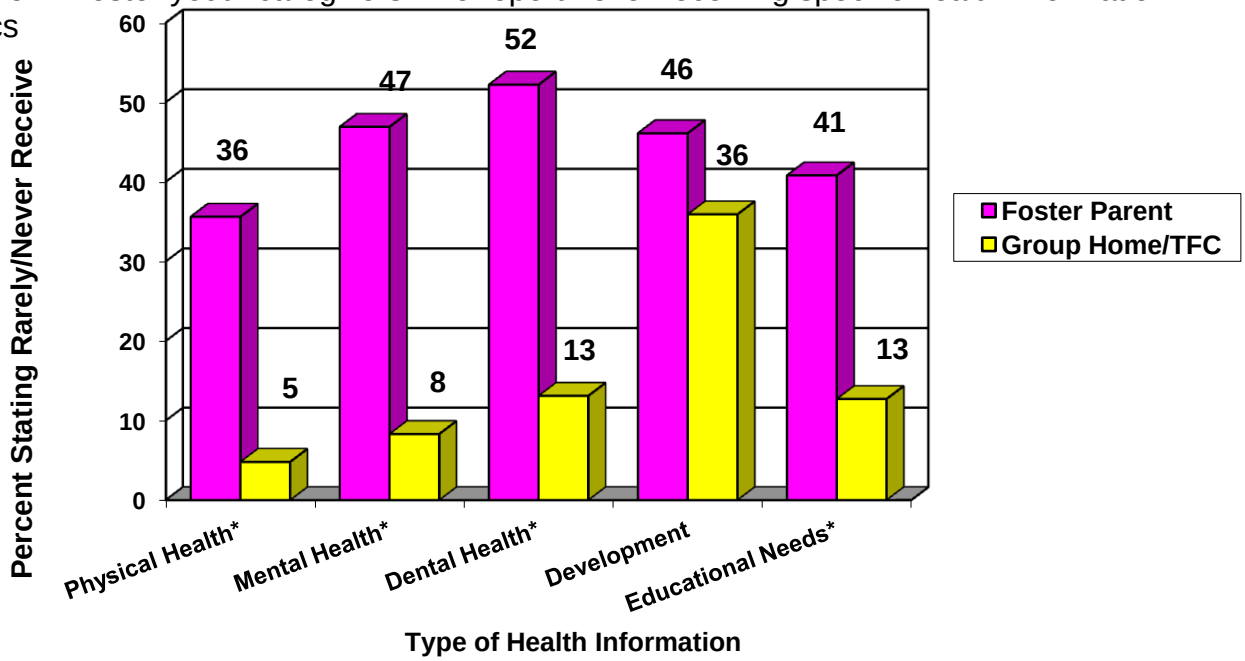


Figure 2: Foster youth caregivers who report never receiving specific health information topics



Based on these and other needs assessment findings, DHR, Maryland AAP, and the Maryland Foster Parent Association (now the Maryland Resource Parent Association) proposed a number of recommendations. Some examples include: (1) policy changes to improve information sharing among DHR, foster parents, and health care providers so that all have information about the child's health needs; (2) Modifications to the DHR Health Visit Report (FORM 631-E) to specify what information should be included (e.g., medication dosages & indications, needed follow-up and referrals with indications, and immunizations provided). It does not appear that any of these recommendations have been implemented.

Oversight and Coordination of Health Care Services: The federal Fostering Connections legislation requires that states develop a plan for ongoing oversight and coordination of health care services for children in foster care. The plan is supposed to be developed and implemented in coordination with the State Medicaid agency. While DHR and DHMH, Mental Hygiene Administration have been working together to address mental health issues including trauma exposure and appropriate use of psychotropic medications, there is no similar initiative for physical health. Children

placed in foster care receive health insurance through the Maryland Medicaid program, which has established standards for preventive care and treatment (Early and Periodic Screening, Diagnosis, and Treatment, EPSDT). However, in most jurisdictions, "**Caseworkers are responsible for ensuring that foster children obtain needed health care and conferring with the physician regarding Medical treatment and follow-up**." (Title IV-B report – Appendix E). Yet most caseworkers do not have any health care training, and they may not even be present at health care appointments. In addition, most primary care providers do not see foster youth on a regular basis, and may not be familiar with the health care needs of foster youth.

It is the responsibility of DHR to ensure that foster youth receive appropriate preventive care, acute and chronic disease management, and mental health and developmental assessment and management. Caseworkers and most primary care providers do not have the expertise to do this. Therefore oversight by a professional who is knowledgeable about child health and familiar with the particular concerns and needs of foster youth is essential.

A number of different models for providing health care to foster youth have been implemented throughout the United States. These typically fall into three different categories: Care coordination, direct services, and specialized Medicaid managed care programs. Most direct service programs are implemented in small catchment areas such as a single city or county in order to ensure that services are accessible. The main advantage of these programs is that care is provided by a team of professionals with expertise in the special needs of foster youth. A major drawback is that children change primary care providers when entering and leaving foster care. Care coordination programs oversee the health care being provided to foster children, but generally do not provide direct care. Children remain with their assigned primary care provider and continuity of care is maintained. Additional, complementary strategies have also been recommended by experts. Some examples include use of standardized screening tools, insurance coverage for intensive care coordination, inclusion of skilled child welfare providers and specialists in Medicaid networks, and ongoing training on the unique needs of the child welfare population and effective practices.

The need for effective oversight has been acknowledged by the Baltimore City Department of Social Services, and led to the development of the MATCH (Making All The Children Healthy) program through HealthCare Access Maryland, Inc. The MATCH program was specifically created to provide health care coordination and to make sure that Baltimore City foster children are receiving appropriate health care services, including behavioral health care services. The program is led by Dr. Rachel Dodge, a Board Certified Pediatrician with expertise in the health care of foster youth. MATCH staff work collaboratively with Baltimore City Department of Social Services caseworkers, foster/kinship care parents, private foster care agencies, and medical, dental, and behavioral health care providers.

MATCH coordinates the mandated health exams for new entrants to foster care to ensure they are completed within the required time frames and from appropriate health care providers. MATCH coordinates and tracks preventive care/EPSDT health services and provides targeted medical and behavioral case management for those children identified as having intensive medical or behavioral health needs. MATCH also provides

Medical assistance program navigation (HealthChoice MCO's, Value Options, and MD Healthy Smiles programs) and ensures active enrollment in the Maryland Medical Assistance program. Finally, MATCH staff develops and monitors a health care plan for each child in foster care that includes information on whether health care needs are being met and recommendations to address any outstanding health needs. Unfortunately, little has been done in the rest of the state to ensure that foster children receive timely and appropriate care. No care coordination is being provided, and there is no medical oversight to ensure that children receive appropriate and necessary care. While the Citizen's Review Board for Children reviews selected case files, they are only determining whether medical services are received. There is no health professional input to determine whether the content and/or quality of the care is appropriate. **Foster youth throughout the rest of Maryland deserve to receive the same level of oversight as those in Baltimore City and deserve to receive what is considered standard of care for foster youth.**

I. Develop a Centralized System for Providing Forensic and Medical Services to Children Involved in the Child welfare System. Fund each component of the Centralized System as a line item in the Governor's Budget.
The following components should be included:

A. Management by a physician Health Director at DHR, SSA (either as a DHR employee or contractual position) to provide the medical expertise necessary to ensure effective oversight and coordination of the physical, mental, developmental and oral health care needs of children who come in contact with the child welfare system. The physician Health Director's responsibilities should include:

- Lead ongoing efforts to ensure best practice medical review and evaluations in cases of suspected child maltreatment.
- Lead the ongoing development and implementation of the Fostering Connections' Health Oversight & Coordination Plan (HOCP)
- Lead coordination and collaboration efforts between Maryland DHR, DHMH (Medicaid, Office of Genetics and People with Special Health Care Needs, Behavioral Health, Child Fatality Review), and other health care and child welfare experts to develop a plan for the ongoing oversight and coordination of health needs of children in child welfare. This should include the adoption and implementation of best practice guidelines and evidence-based care in the investigation of suspected child abuse and neglect and provision of health care services to children in foster care.
- Develop policies regarding medical/forensic services to children in the child welfare system.
- Assist with case decision-making when health care issues are involved.
- Raise awareness of complex health and mental health needs of children in child welfare within both CPS and Health Care Provider Communities.
- Monitor and improve state's progress in meeting the schedule for initial screening and follow-up health care services for children in foster care.

B. ***Interagency Child Welfare Health Coordination Expert Panel:*** An ongoing Child Welfare Health Coordination Expert Panel led by the physician Health Director, once hired; and, a CHAMP physician until that time. The Panel should include representatives from the following agencies and organizations: Maryland Children's Cabinet; Maryland Children's Alliance; Maryland Chapter of the American Academy of Pediatrics; Maryland CHAMP program (CHAMP physician and nurse affiliates); Maryland Forensic Nurses; DHR Out of Home Services; DHR In-Home Family Services; DHR Resource Development, Placement, and Support Services; DHMH Office Genetics and People

With Special Health Care Needs; Medicaid; Behavioral Health; DHR and DHMH representatives with expertise in their agency's child fatality review processes; Maryland State's Attorney's Association; county health departments, county DSS agencies, Maryland Legal Aid Bureau, Maryland CASA; and, programs that currently contribute to medical and forensic services funding for children involved in the child welfare system (Maryland Medicaid, DHMH Center for Injury and Sexual Assault Prevention, GOCCP/VOCA). The Panel's responsibilities should include:

a. Develop regulations and guidelines to ensure that children with suspected maltreatment receive timely, high quality, evidence-based medical assessments.
b. Develop regulations and guidelines for effective management and oversight of health care services for children in foster care.
c. Develop a state implementation and oversight plan for the recommended regulations, guidelines and improvements.
d. Report annually to the Governor and legislature regarding the progress of implementation.

C. ***A system for tracking and improving health outcomes*** for children in the child welfare system; including fatalities and near fatalities due to child maltreatment.

II. The Interagency Child Welfare Health Coordination Expert Panel should develop and adopt regulations and guidelines to ensure that children with suspected maltreatment receive timely, high quality, evidence-based medical assessments

The following components should be included:

E. State-wide criteria for which children should receive medical record review and/or medical evaluation (see Florida and CHAMP guidelines – Appendix C) should be included in COMAR.

F. State-wide criteria for qualifications of health professionals who conduct maltreatment evaluations should be included in COMAR.

G. Reimbursement for maltreatment evaluations (both medical record review and medical evaluation) that supports a stable trained workforce to provide needed expertise. This includes comprehensive services beyond the initial evaluation to include any follow up of diagnostic studies, multidisciplinary team and Family Involvement meetings, court testimony as needed, and continuing education.

H. Program evaluation and oversight to monitor the percentage of children who receive timely, appropriate and accurate medical evaluations.

III. The Interagency Child Welfare Health Coordination Expert Panel should develop and adopt regulations and guidelines Develop regulations and guidelines for the effective management and oversight of health care services for children in foster care. A state oversight plan described in I (above), should be a developed as a coordinated and collaborative effort between DSS and DHMH, in consultation with health care experts, child welfare experts, child welfare service recipients and foster parents.

Regulations and guidelines should be included in COMAR and should be consistent with requirements specified in the Federal Fostering Connections legislation, including:

A. A plan for the ongoing oversight and coordination of health care services for any child in a foster care placement. This plan must include a coordinated strategy to identify and respond to the health care needs of children in foster care, including medical, mental health, developmental, and dental needs. It must be developed by health care experts, including pediatricians, mental health professionals, dentists, and Maryland Medicaid representatives. The plan must include the following elements:
   i. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.
   ii. A process for ensuring that health care needs identified through screenings will be monitored and treated.
   iii. A process for updating and sharing of medical information through an electronic medical record system. These records must be shared with the child's foster parent(s), child welfare worker(s), and biological parents.
   iv. A process for ensuring continuity of health care services, including the establishment of a medical home for every child in care.
   v. A process for physicians working with DHR to provide oversight of prescription medications, including psychotropic medications.
   vi. A process for the Department of Human Resources to consult with health professionals to assess the health and well-being of children in foster care, and to determine the most appropriate medical treatment

vii. A process for ensuring that all children in foster care obtain health insurance coverage immediately upon entrance into care.
viii. A process for assessment for, monitoring of, and treatment of emotional trauma associated with placement into foster care.
ix. A plan for ensuring ongoing health care services for children who return home or age out of the foster care system.
x. A coordinated system for tracking service needs and service receipt.

B. *Continuing education made available to health care providers and child welfare workers throughout the state on evidence-based guidelines for the health care of children in foster care.*

C. *Program evaluation and /oversight to monitor the quality of care received and the health status of children in foster care.*

D. *Inclusion of health care providers in citizen review boards that monitor children in out-of-home placements.* Doing so would better ensure that children are receiving timely and effective health care services.

***A medical home is not a building, house, or hospital. It is a way of providing high quality primary health care for children within their community. A medical home is a partnership between families caring for children and youth and the primary health care providers they trust. Primary health care providers may include pediatricians, family practitioners, and pediatric nurse practitioners. In this partnership, families and primary health care providers work together to identify and access all of the medical and non-medical services needed to help children and their families reach their greatest potential.**

Analysis of Impacts of Implementation

Cost – It is difficult to determine the exact cost to establish and maintain a system for providing medical services to children in Maryland's child welfare system. However, we create some estimates based on current unpaid services, the time spent providing those services, and existing sources of funding.

Current sources of funding – Medical evaluation of children with suspected maltreatment:

The following agencies and funding streams provide financial support for health-related services to all jurisdictions:

(1) DHMH Sexual Assault fund – These funds pay for some costs of the medical evaluation and forensic evidence collection. Funding is limited to adult and child sexual abuse and assault. It cannot be used for medical evaluation and evidence collection for physical abuse or neglect. The reimbursement rate of $80/hour was included in the bill's text when it passed approximately 20 years ago, and the rate has not changed since then.

(2) Medicaid – When Medicaid-insured children with suspected abuse or neglect are hospitalized there is some reimbursement for clinical consultation. The current Medicaid reimbursement for a child maltreatment consultation is $283. Medicaid does not reimburse for many services that are necessary for ensuring child safety. These include discussions and meetings with DSS and law enforcement, preparation for and attendance at family involvement meetings, and preparation for and attendance at civil and criminal court. Because Medicaid billing requires significant administrative time and effort, most child advocacy centers do not participate.

Funding that may be available to and used by individual jurisdictions:

(1) Victims of Crime Assistance (VOCA) funds – These funds are provided to Maryland by the U.S. Department of Justice to assist crime victims. The Maryland Governor's Office on Crime Control and Prevention distributes these funds via a grant application process. VOCA funds pay for some health-related services in selected counties.

(2) Local funding – Some child advocacy centers receive funding through the county budget or through the local health department or department of social services.

(3) Charitable giving – some child advocacy centers are incorporated as 501c3 not-for-profit organizations and can receive charitable contributions.

Current sources of funding – Care coordination for Baltimore City DSS foster youth:

This program is currently funded by Baltimore City DSS and Health Care Access Maryland.

Cost Estimate– Medical Evaluation of Children with Suspected Maltreatment: Over the past two years, CHAMP faculty have surveyed CHAMP providers to obtain estimates of the number of consultations provided, the time involved in conducting these consultations, and the costs not covered by existing funding. The estimates of total cost/case were calculated based on provider documented average time spent per case and average provider salary. Costs include physician and social work effort. Time spent in CINA hearings (Child in Need of Assistance Adjudications) was included. Time

spent on criminal prosecutions was not. The total number of cases was estimated based on a survey of CHAMP physicians. Unpaid costs per case are costs not covered by DHMH sexual assault funds or by Medicaid.

Table 5: Estimated Total Cost and Unpaid Cost of Medical Evaluation by Child Maltreatment Physician Experts

	Unpaid Cost/case*	Total Cost/case**	# of cases¥	Total Cost	Unpaid Cost
Inpatient Physical Abuse	$605	$888	112	$99,456	$67,788
Outpatient Physical Abuse	$279	$279	194	$54,126	$54,175
Outpatient sexual abuse	$32	$112	1040	$116,480	$32,825
Non-F2F Physical & Sexual Abuse	$122	$122	1517	$185,074	$184,857
TOTAL COST PA & SA				$455,136	$339,645

*Not covered by Medicaid or DHMH Sexual assault funds.

**Data based on physician recorded average time per case and average hourly wage, plus team social worker average time per case and average hourly wage. Costs include medical evaluation, communication with DSS and law enforcement, and civil court testimony time (e.g. for CINA hearings). Time spent testifying in criminal court is NOT included in these estimates.

¥Includes only cases evaluated by CHAMP physicians. Does not include cases evaluated by FNE-Ps, by experts not participating in CHAMP, or by health care providers without child maltreatment expertise.

It is important to note that the number of cases used in this calculation includes only those children who were referred for and received a medical evaluation for physical or sexual abuse. The number of children who would benefit from a medical evaluation is likely much higher. We are currently working on getting estimates from states with centralized programs on the proportion of reported children who receive medical evaluations.

A number of other costs were not included in these calculations:

- Services provided by FNE-Ps (because of incomplete salary information).
- Program administrative costs including office space and salary for program leadership and administrative assistant
- Costs associated with the establishment and maintenance of a follow-up clinic, including rental of space, medical supplies, administrative support, and nursing support.
- Cost to conduct program evaluation

An increase in the percentage of children who have an expert medical evaluation could provide some cost savings to DHR, DHMH, and the State of Maryland. Better identification of abusive and accidental injuries would reduce the number of unnecessary and potentially time-consuming investigations of children with accidental injury. Accurate identification of children who have been abused may prevent repeated episodes of abuse with further costs to the medical and child welfare systems.

Cost Estimate – Care coordination for foster youth in the custody of DSS agencies outside of Baltimore City: Because 43% of Maryland foster children are in the custody

of Baltimore City DSS, the cost to provide services to children in the remainder of the state may be comparable to Baltimore City costs. Some higher costs could be incurred because of additional time needed to navigate multiple local DSS agencies and many additional community-based service providers.

Funding Source – Because the medical evaluation is primarily used to assess and assure child safety, we believe that this program should be funded by the Department of Human Resources or through the Governor's Office for Children. State child welfare agencies in Florida, New Jersey, Washington, North Carolina, South Carolina, and Texas partially or fully support medical programs in those states. DHMH already provides some support by funding CHAMP provider training and peer review. Funding for time spent preparing for and testifying in criminal court should be paid by local state's attorney's offices or by DHR.

Staffing – Social Services Administration would need to hire a Physician Medical Director and provide staff support to the Director.

Existing Regulations and Other Laws – COMAR regulations, as noted within specific recommendations.

Operational Impact – Program funding would help stabilize programs led and staffed by both physicians and FNE-Ps. Currently many FNE programs are only able to support on-call and casual employment, limiting participation in peer review, training, and multidisciplinary team meetings, and leading to frequent staff turnover. Likewise, some hospital child protection teams have been forced to limit their consultation services due to lack of financial support. Stable funding would allow experienced physicians and nurses to continue using their experience to provide thoughtful and accurate medical assessments.

Some Maryland FNE programs function fairly autonomously, with little physician oversight. While the Maryland Board of Nursing requires that all FNE-P programs have available a qualified physician resource, many ED physicians lack expertise in forensic medical evaluations and may defer assessment and clinical decision making to the FNE. FNE programs that have little physician oversight and do not participate in CHAMP training and peer review may be reluctant to be evaluated by other professionals. However, collaboration with other child abuse experts may be more palatable if it also leads to stable program funding.

Health and Social Impact – We anticipate better health outcomes for foster youth, and better use of resources for child abuse investigations.

References

1. Giradet R, Giacobbe L, Bolton K, Lahoti S, McNeese M. Unmet health care needs among children evaluated for sexual assault. Archives of Pediatrics & Adolescent Medicine. 2006;160:70-73.
2. Flaherty EG, Jones R, Sege R. Telling their stories: primary care practitioners' experience evaluating and reporting injuries cause by child abuse. Child Abuse & Neglect. 2002;28:939-945.
3. Flaherty EG, Sege R, Binns HJ, Mattson CL, Christoffel KK. Health care providers' experience reporting child abuse in the primary care setting. Pediatric Practice Research Group. Archives of Pediatrics & Adolescent Medicine. 2000;154:489-493.
4. Lane WG, Dubowitz H. Primary care pediatricians' experience, comfort and competence in the evaluation and management of child maltreatment: Do we need child abuse experts? Child Abuse & Neglect. 2009;33:76-83.
5. Adams JA, Starling SP, Frasier LD, et al. Diagnostic accuracy in child sexual abuse medical evaluation: Role of experience, training, and expert case review. Child Abuse & Neglect. 2012;36:383-392.
6. Botash AS, Galloway AE, Booth T, Ploutz-Snyder R, Hoffman-Rosenfeld J, Cahill L. Continuing medical education in child sexual abuse: Cognitive gains but not expertise. Archives of Pediatrics & Adolescent Medicine. 2005;159:561-566.
7. Makoroff KL, Brauley JL, Brandner AM, Myers PA, Shapiro RA. Genital examinations for alleged sexual abuse of prepubertal girls: Findings by pediatric emergency medicine physicians compared with child abuse trained physicians. Child Abuse & Neglect. 2002;26:1235-1242.
8. Starling SP, Heisler KW, Paulson JF, Youmans E. Child abuse training and knowledge: A national survey of emergency medicine, family medicine, and pediatric residents and program directors. Pediatrics. 2009;123:e595.
9. Anderst J, Kellogg N, Jung I. Is the diagnosis of physical abuse changed when Child Protective Services consults a Child Abuse Pediatrics subspecialty group as a second opinion? Child Abuse & Neglect. 2009;33:481-489.
10. Wallace GH, Makoroff KL, Malott HA, Shapiro RA. Hospital-based multidisciplinary teams can prevent unnecessary child abuse reports and out-of-home placements. Child Abuse & Neglect. 31:623-629.
11. U.S. Department of Justice Office on Violence Against Women. A National Protocol for Sexual Assualt Medical Forensic Examinations Adults/Adolescents, 2nd Ed. Washington: D.C.: U.S. Department of Justice, April 2013.
12. Jenny C, Crawford-Jakubiak JE, and Committee on Child Abuse and Neglect. The evaluation of children in the primary care setting when sexual abuse is suspected. Pediatrics. 2013;132:e558.

13. Adams JA, Kaplan RA, Starling SP, et al. Guidelines for medical care of children who may have been sexually abused. Journal of Pediatric and Adolescent Gynecology. 2007;20:163-172.
14. Frasier LD. Peer review and telehealth in child abuse medical evaluation. APSAC Alert. 2013;25:15-17.
15. National Children's Alliance. Ongoing Training and Peer Review, NCA Membership Standards. 2009. Online at: www.nationalchildrensalliance.org/index.php?s=76&item=99. Accessed January 6, 2014.
16. Robbins CL, Fortenberry JD, Roth AM, Ott MA. Premenarchal girls' genital examination experiences. Journal of Adolescent Health. 2012;51:179-183.

APPENDIX A
TRAINING REQUIREMENTS FOR CHILD ABUSE MEDICAL EXPERTS

Board Certification in Child Abuse Pediatrics

Physicians who are Board Certified in Child Abuse Pediatrics have had extensive training in the medical evaluation of child abuse, and the care of children who have been maltreated. In addition to four years of medical school, Child Abuse Pediatricians must complete 3 years of residency in General Pediatrics and a 3 year fellowship in Child Abuse Pediatrics. Fellowship training includes clinical care as well as clinical research, public policy, and advocacy training. During the first 4 years of subspecialty recognition by the American Board of Pediatrics, pediatricians could become board certified if they demonstrated at least 5 years of experience in child abuse pediatrics and passed the subspecialty certifying exam.

Child Abuse Pediatricians must pass an initial certifying exam in General Pediatrics and then a certifying exam in Child Abuse Pediatrics. To maintain certification, physicians must participate in continuing medical education, complete periodic quality assurance projects, and take a recertification exam every 10 years.

The American Board of Pediatrics Content Outline for certification in Child Abuse Pediatrics lists all of the topics that physicians are expected to know for subspecialty certification:

https://www.abp.org/abpwebsite/takeexam/subspecialtycertifyingexam/contentpdfs/chab.pdf

Board Certification in General Pediatrics or Family Medicine with Additional Child Maltreatment Training

Some physicians who provide medical care for children with suspected abuse or neglect have completed residency training in General Pediatrics or Family Medicine, and have received some additional child maltreatment training. The extent of additional training is quite variable, as there are no specific standards or requirements for such training in Maryland. Some physicians may have received all of their training through clinical experience and observation, others have taken courses lasting from a few days to several weeks or months. The CHAMP program has developed a training program consisting of approximately one week of didactic training and one week of supervised clinical child abuse work.

Maryland Board of Nursing Forensic Nurse Examiner Training Requirements

More complete information can be found at the Maryland Board of Nursing website:
http://www.mbon.org/main.php?v=norm&p=0&c=adv_prac/wccm_rn-fne.html

To become a Maryland Forensic Nurse Examiner, one must be a registered nurse with a Maryland license. FNE training is run by the Maryland Board of Nursing. FNE-A (Adult/Adolescent) training includes 40 hours of didactic training and 40 hours of clinical training. Clinical training includes at least 12 hours of experience in performing evidentiary forensic examinations, 4 hours of observation at a sexual assault center, rape recovery center or Sexual Assault Response Team, 8 hours of criminal court experience (e.g. observing testimony, meeting with victim advocate), 8 hours of experience performing vaginal speculum exams (minimum of 10 exams), 4 hours learning from police, and 4 hours learning from crime lab staff.

Pediatric Forensic Nurse Examiner (FNE-P) certification requires initial FNE-A certification followed by additional didactic (30 hours) and clinical (32 hours) training. Clinical training includes observing or performing at least 4 pediatric forensic exams, observing 4 hours of activities at a child advocacy center (e.g. forensic interviews, case reviews, meetings with staff), 4 hours observing law enforcement activities related to child sexual abuse, 4 hours observing forensic interviews, and 4 hours observing child protective services work with sexual abuse and assault investigations.
License renewal requires 400 hours of FNE practice and 8 hours of continuing education in the past year.

COMAR Regulations Defining the Practice of the Registered Nurse – Forensic Nurse Examiner

10.27.21.04 Scope and Standards of Practice.

A. An RN-FNE may perform the following tasks and functions with respect to the age group for which the RN-FNE is certified under Regulation .03 of this chapter:

(1) Perform forensic evidentiary examinations on victims and alleged perpetrators in connection with physical, sexual, or domestic assaults, whether chronic or acute;

(2) Before the forensic evidentiary examination, obtain consent from the individual being examined, from the parent or guardian of a minor individual, or from the proper authority for photographing and evidence collection;

(3) Prepare and document the assault history interview;

(4) Perform the forensic evidentiary physical assessment;

(5) Complete the physical evidence kit provided by law enforcement;

(6) Gather, preserve, handle, document, and label forensic evidence, including but not limited to:

(a) Labeling evidence collection containers with the patient's identifying data per local jurisdiction requirements;

(b) Placing evidence in the evidence collection container and sealing the container;

(c) Signing the evidence collection container as the collector of the evidence;

(d) Taking photographs; and

(e) Obtaining swabs, smears, and hair and body fluid samples;

(7) Maintain the chain of custody;

(8) Provide immediate health interventions using clinical practice guidelines;

(9) Obtain consultations and make referrals to health care personnel and community agencies;

(10) Provide immediate crisis intervention at the time of the examination;

(11) Provide discharge instructions;

(12) Participate in forensic proceedings including courtroom testimony;

(13) Interface with law enforcement officials, crime labs, and State attorney's offices; and

(14) Assist the licensed physician in performing a forensic evidentiary examination.

B. Clinical Practice Guidelines. An RN-FNE may practice only in a clinical setting in which clinical policy and practice guidelines:

(1) Have been approved by the facility's medical and nursing departments;

(2) Designate the availability of qualified physician resources;

(3) Identify the department in which an RN-FNE shall function; and

(4) Designate a program coordinator who has experience in forensic evidentiary examinations to administer the RN-FNE training program.

C. The program coordinator:

(1) Is responsible for obtaining Board approval of the curriculum before conducting a training program;

(2) Has responsibility for oversight and administration of the facility's RN-FNE training program and the practice of the facility's RN-FNE's;

(3) Verifies the qualifications and certifications of any RN-FNE practicing in the facility;

(4) Administers and manages the RN-FNE practice;

(5) Approves practice protocols and standards of care for RN-FNE practice;

(6) Shall develop a peer review process that includes, but is not limited to:

(a) Coordinating the peer review of cases;

(b) Ensuring that the peer review is consistent with the standardized data collection process;

(c) Ensuring that a peer reviewer meets the qualifications in Regulation .05 of this chapter; and

(d) Using the standardized form for peer review that is required by the Board;

(7) Interfaces with law enforcement, the State's attorney, and community resource groups;

(8) Implements the facility's Board-approved RN-FNE curricula; and

(9) Facilitates reimbursement for RN-FNE services by cooperating with the facility's billing department and interacting with the State reimbursement system.

D. An RN-FNE shall comply with all State and federal statutes and regulations related to the RN-FNE practice.

10.27.21.05 Standards for Training Programs.

A. The Board shall approve two RN-FNE standardized curricula as follows:

(1) An RN-FNE-Adult curriculum for the examination of adults and individuals 13 years old or older; and

(2) An RN-FNE-Pediatric curriculum for the examination of children who are younger than 13 years old.

B. The RN-FNE training programs shall:

(1) Teach the Board-approved curriculum in forensic nurse practice and forensic evidentiary examinations; and

(2) Submit the qualifications and curriculum vitae of each faculty member to the Board for review before implementation of the training program.

C. The successful completion of the RN-FNE-Adult training program shall be a prerequisite to admission to the RN-FNE-Pediatric training program.

D. The RN-FNE-Adult training program shall include a minimum of 80 clock hours that includes:

(1) A minimum of 40 clock hours of theory; and

(2) A minimum of 40 clock hours of clinical experience with adults and individuals 13 years old or older.

E. The RN-FNE-Pediatric training program shall include a minimum of 62 clock hours that includes:

(1) A minimum of 30 clock hours of theory; and

(2) A minimum of 32 clock hours of pediatric clinical experience.

F. All clinical requirements for an FNE training program shall be completed within a 12-month period.

G. Faculty Qualifications.

(1) An RN-FNE educator who meets the requirements of this section or a physician whose credentials demonstrate experience in the skills required in forensic evidentiary examinations is qualified to teach both theory and clinical portions of the curriculum and may serve as clinical preceptor for the clinical practicum of the training program.

(2) An RN-FNE educator who teaches in an RN-FNE training program or is the clinical preceptor of the training program shall:

(a) Possess at least:

(i) 2 years experience as an RN-FNE or as a SANE, if from another state; or

(ii) 1 year experience with ten forensic examinations performed;

(b) Have experience teaching the adult learner;

(c) Possess broad knowledge and experience in the multidisciplinary treatment approach to family or sexual interpersonal violence, including intervention techniques; and

(d) Have either:

(i) Qualified as a forensic nurse examiner expert witness in a criminal proceeding; or

(ii) Obtained trial preparation experience with the State's attorney's office.

(3) The clinical preceptor for the clinical practicum of the training program shall document the clinical competency of the RN-FNE candidate at the completion of the clinical practicum.

H. The Board shall approve all changes, additions, or deletions to the course before implementation.

APPENDIX B

PEER REVIEW STANDARDS ESTABLISHED BY PROFESSIONAL ORGANIZATIONS

National Children's Alliance. Standards for Accredited Members- Revised. Effective 2017. Updated 8/20/15.
http://www.nationalchildrensalliance.org/sites/default/files/NCAAccreditationStandards201708202015.pdf

Standard: "The CAC and/or MDT provide opportunities for those who conduct medical evaluations to participate in ongoing training and peer review.
The medical provider should be familiar and keep up-to-date with published research studies on findings in abused and non-abused children, sexual transmission of infections in children, and current medical guidelines and recommendations from national professional organizations such as the American Academy of Pediatrics Committee on Child Abuse and Neglect and
the Centers for Disease Control and Prevention.

The provider should have a system in place so that consultation with an established expert or experts in sexual abuse medical evaluation is available when a second opinion is needed regarding a case in which physical or laboratory findings are felt to be abnormal. An advanced medical consultant is generally accepted to be a physician or advanced practice nurse who has
considerable experience in the medical evaluation and photodocumentation of children suspected of being abused, and is involved in scholarly pursuits which may include conducting research studies, publishing books or book chapters on the topic, and speaking at regional or national conferences on topics of medical evaluation of children with suspected abuse.

The above must be demonstrated through the following *Continuous Quality Improvement* Activities:

- Ongoing education in the field of child sexual abuse consisting of a minimum of 3 hours per every 2 years of CEU/CME credits
- Photodocumented examinations are reviewed with advanced medical consultants. Review of all exams with positive findings is strongly encouraged."

Other Professional Peer Review Recommendations

U.S. Department of Justice, Office on Violence Against Women. A National Protocol for Sexual Abuse Medical Forensic Examinations - Pediatric. April, 2016. NCJ #249871. https://www.justice.gov/ovw/file/846856/download.

Adams JA, Kellogg ND, Farst KJ, Harper NS, Palusci VJ, Frasier LD, Levitt CJ, Shapiro RA, Moles RL, Starling SP. Updated guidelines for the medical assessment and care of children who may have been sexually abused. J Pediatr Adolesc Gynecol. 2016;29(2):81-87.

APPENDIX C
CRITERIA FOR CHILD PROTECTION TEAM REFERRALS AND MEDICAL EVALUATIONS

Mandatory Criteria For Child Protection Team Referral – State of Florida

Child abuse, abandonment and neglect reports that must be referred by child protective investigators to child protection teams include cases involving:

1) Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age
2) Bruises anywhere on a child five years of age or younger
3) Any report alleging sexual abuse of a child
4) Any sexually transmitted disease in a prepubescent child
5) Reported malnutrition or failure to thrive
6) Reported medical neglect
7) Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected
8) A sibling or other child remaining in a home where one or more children have been pronounced dead on arrival or have been injured and later died as a result of suspected abuse, abandonment, or neglect.

Maryland CHAMP
Maryland Child Abuse Medical Professionals

Child Maltreatment Medical Consultation – Abridged Referral Guidelines

These guidelines are intended to assist in deciding when to seek medical consultation for suspected child abuse and neglect. They serve only as guidelines and careful judgment is needed in every situation.

SEXUAL ABUSE/ASSAULT

If there is suspicion that a child has been sexually abused or assaulted with direct physical contact, an evaluation by a child abuse medical specialist is recommended.

Urgent evaluations: In the following situations**,** the child should be evaluated **immediately**.

- The last suspected abuse or assault occurred recently (within past 72 hours for children under age 13 or within past 120 hours for those age 13 and over)
- The child is reporting genital/anal pain or bleeding
- The child is exhibiting significant mental health concerns (e.g., self-harm, suicidal behavior)

The urgent medical evaluation should include consideration of the possible need to gather forensic evidence. The evaluation should be done at the closest center with experience in evaluating acutely (or recently) sexually abused/assaulted children.

Non-urgent evaluations: outside of the above time frames or serious conditions, evaluations should occur at the most experienced, child friendly environment within the community. Typically, this is the local child advocacy center. The timing for these evaluations should be the next available appointment.

Sexual abuse/assault evaluation center locations can be found at: http://mdchamp.org/resources/locating-champ-providers.

PHYSICAL ABUSE

A child's medical and mental health status, aside from possible forensic concerns, may require an immediate medical evaluation. In addition, there may be forensic reasons to gather evidence as soon as possible.

Urgent evaluations: In the following situations**,** the child should be evaluated **immediately**.

Any indication of physical injury and suspected child abuse should be evaluated **immediately** at the nearest emergency department. Below is a partial list of such conditions:

- Any sign of a possible head injury (e.g., lethargy, irritability, change in consciousness, difficulty walking or talking)
- Recent burns
- Possible broken bones
- A child with abdominal pain, abdominal bruising, or other reason to suspect abdominal trauma
- A child with a recent ingestion of a toxic or illicit substance

Non-urgent evaluations: In the following situations**,** the child should be evaluated **within 48 hours, preferably by a child abuse medical expert*:**

- Any bruising in an infant who cannot "cruise" (walk holding onto objects)
- A concerning or absent explanation for an injury
- Pattern bruise marks (e.g., loop marks)
- Any other suspicious bruises
- Healing burns (eg, from a cigarette, iron)

*If unable to refer directly to a child abuse medical expert, a physician with expertise in evaluating suspected child abuse or neglect, photographs should be obtained for later review. Information on locating child abuse medical experts in Maryland can be located at: http://mdchamp.org/resources/locating-champ-providers.

CHILD NEGLECT

There are many circumstances when the assessment and management of child neglect can be enhanced with medical consultation by a physician specialist in child abuse and neglect.

Unless a child demonstrates an altered mental status or a clearly urgent medical condition, an assessment by a physician expert is usually not urgent. The following are circumstances for which expert medical consultation is recommended:

- CPS report for medical neglect (e.g., failure/delay to seek medical care, failure to adhere to recommendations for evaluation or treatment)
- Neglect in children with a chronic disease or condition
- Neglect in children with a disability or mental health problem
- Supervisory neglect related to injuries, ingestions, fatalities
- Growth concerns – e.g. failure to thrive, severe obesity
- Concerns of dental neglect

- For assistance or questions, please contact CHAMP Program Manager, Richa Ranade, MPH: richa.ranade@maryland.gov or 410-767-3702, or visit: www.mdchamp.org.

Maryland CHAMP
Maryland Child Abuse Medical Professionals

Maryland CHAMP Membership Guidelines

Faculty Guidelines

CHAMP Faculty Credentials

CHAMP Faculty Pediatricians shall:

- Be licensed to practice medicine in Maryland
- Be board certified in child abuse pediatrics
- Have at least five years of experience conducting child abuse evaluations
- Be currently active in child abuse medical evaluations in Maryland

CHAMP Faculty Nurses shall:

- Be licensed as a registered nurse in Maryland
- Be certified as a nurse practitioner or RN-FNE-A/P in Maryland
- Have at least five years of experience conducting child abuse medical evaluations
- Be currently active in child abuse medical evaluations in Maryland

Maintenance of CHAMP Faculty designation

In order to maintain Faculty designation, CHAMP Faculty shall:

- Maintain required certification and licensure in Maryland
- Provide at least ten child abuse evaluations per year
- Attend at least fifty percent of all CHAMP faculty meetings each year
- Actively participate in a minimum of 4 CHAMP educational or training activities per year. Examples include: Providing a topic presentation, case review session, or Tele CAM instruction at a CHAMP training; providing an educational offering on a child abuse-related topic at other venues reaching Maryland providers, such as the Child Welfare Academy, the Maryland Children's Alliance annual conference, outreach to health care organizations and agencies (hospitals, clinics, Federally Qualified Health Centers, MCOs, etc.); developing an online CHAMP CME/CEU training module.
- Review a minimum of 10 cases on TeleCAM per year.
- Submit required case data and data on CHAMP educational and training activities quarterly

Network Provider Guidelines
CHAMP Network Provider Credentials

CHAMP Network Providers shall:

- Be physicians board certified in their respective field and licensed in the state of Maryland OR certified nurse practitioners, physician assistants, or RN-FNE-A/Ps l licensed to practice in the state of Maryland
- Complete a core training curriculum developed by the CHAMP Faculty
    - Completion of the core curriculum will be waived for pediatricians board certified in child abuse pediatrics
    - Providers who have significant prior experience in providing child abuse medical evaluations will be considered by the faculty for exemption from completion of the core curriculum on a cases by case basis
- If new to the field, must agree to have all cases seen during the first two years of CHAMP membership reviewed by CHAMP faculty. Questions regarding what constitutes "new to the field" will be resolved together with faculty, and be approached on a case by case basis.
- Be currently active in child abuse medical evaluations in Maryland

Maintenance of CHAMP Network Provider designation

In order to maintain Network Provider designation, CHAMP Providers shall:

- Maintain required certification and licensure in Maryland
- Evaluate at least 6 children under age 18 for maltreatment per year, three of which must be below age 13
- Submit all cases with questionable findings or findings indicative of abuse to TeleCAM
- Participate in eight hours of CME/CEU child maltreatment related training annually
- Submit required data quarterly

.

APPENDIX E

2013 TITLE IV-B REPORT
DRAFT – MAY 2013 and FINAL JUNE 2013
(with footnoted comments and questions)
MAY 2013 DRAFT

E. PLAN FOR HEALTH CARE SERVICES FOR CHILDREN IN FOSTER CARE

Below is Maryland's plan for health care services for children in foster care.

Initial and Follow-up Health Screenings and Treatment, Medical Home and Documentation

Each child in foster care is enrolled into a Managed Care Organization (MCO) through their enrollment into Medical Assistance. This MCO establishes their medical home. Each child is assigned a primary care physician within 10 days of entering care. Maryland's regulations and policy require that all children in foster care must have the following:

- Initial health screening within 5 days of placement
- Initial mental health screening within 5 days of placement
- A comprehensive health examination within 60 days of placement, which includes satisfaction of the required EPSDT components of Maryland Healthy Kids Program.
- Follow up medical appointments as indicated by the physician.
- Annual physical and dental examinations.

Data is presented on the number of children entering OOH care, the number/percentage of children receiving initial health screenings within 5 days, the number/percentage of children with an assigned medical provider within 10 days, and the number/percentage of children receiving comprehensive examinations within 60 days.

The Health Plan Advisory Committee (HPAC), which is discussed fully on page 65 of this report, will be developing a Health Care Services handbook [1]. This handbook will be available for local department staff, providers and stakeholders outlining all of the available health care services.

Caseworkers are responsible for taking foster children to all initial appointments and conference with the physician regarding medical treatment and follow-up.

DATA, 10.1, David Ayer

State Fiscal Year	Number New Removals in OOH, in Foster Care > 8 Days	Number Received Initial Health Screening w/in 5 days	Percent Receiving Initial Screening w/in 5 days	Number Medical Provider Assigned w/in 10 days	Percent Medical Provider Assigned w/in 10 days	Number Received Compre-hensive Examina-tion w/in 60 days	Percent Receiving Compre-hensive Examina-tion w/in 60 days
2009	**2,477**	**753**	**30%**	**877**	**35%**	**1,228**	**50%**

[1] As DHR had decided not to move forward with the Health Plan Advisory Committee, it is not clear whether DHR will still be developing the Health Care Services handbook.

2010	**2,557**	**889**	**35%**	**1,210**	**47%**	**1,352**	**53%**
2011	**2,680**	**881**	**33%**	**1,366**	**51%**	**1,098**	**41%**
2012	**2,532**	**865**	**34%**	**1,110**	**44%**	**1,455**	**57%**

Source: MD CHESSIE – derived by the University of Maryland Baltimore

Although the number of children entering OOH care has increased over the past three years, the percent receiving initial screenings within 5 days remains stable, between 30% and 35%. The percentage of children with an assigned medical provider had increased to 51% in SFY 2011 but has decreased to 44% in SFY 2012, while the percentage of children receiving a comprehensive examination had fallen to 41% in SFY 2011 but has increased to 57% in SFY 2012. It is believed that these low numbers and percentages reflect poor data entry, rather than children not receiving needed medical care.

In order to address data entry issues, DHR/SSA will utilize a data clean-up model that has worked for well for other indicators: Exception reports will be developed, with worker and supervisor identified, of cases where health data has not been entered into MD CHESSIE, and local departments will be expected to update the missing data. The development of exception reports has started and the anticipated release for these reports is during the summer of 2013.

Additional feedback will be given to the local departments of social services (LDSS) through the Quality Assurance process on MD CHESSIE documentation of the initial medical exam (within 5 days), mental health assessments within 60 days, annual medical and dental exams, and ongoing medical/dental/mental health care.

Expectations for the actual percentage should not be significantly different than the sample case review data used in a 2007 report on the quality of casework practice (Child Welfare Accountability, Annual Report of Maryland Performance Indicators, December 2007):

- Percent of OOH Children receiving Initial Screening within 5 days was 91.1% (4% margin of error)
- Percent of OOH Children receiving Comprehensive Examination within 60 days was 90.5% (5% margin of error)

The "provider assigned within 10 days" statistic was not included in that report, nonetheless, Maryland remains committed both to assuring that foster children receive both timely and appropriate health assessments and care, and that foster care workers continue in their efforts to document these events correctly in MD CHESSIE.

Caseworkers are responsible for ensuring that foster children obtain needed health care and conferring with the physician regarding Medical treatment and follow-up.[2]

All components of the child's health care are documented in Maryland's Health Passport. Every child in foster care receives a Health Passport. The caseworker and/or caregiver accompany the child on subsequent visits during which the physician consults with the caseworker and/or caregiver regarding the child's health and completes the Health Passport. Maryland physicians must complete the Health

[2] DHR has not described how caseworkers will be trained to determine whether children's health care needs are being met.

Passport forms each time they examine a foster child.[3] The Passport includes the following:

- Medical Alert
- Child's Health History
- Developmental Status (ages 0-4 or child with disability)
- Health Visit Report
- Receipt of Health Passport
- Parent Consent to Health Care and Release of Records

The child's health needs and treatment are also documented in MD CHESSIE in the health screens, providing caseworkers and supervisors the ability to monitor and track the health care needs of the child.[4]

In determining appropriate medical treatment for children in Out-of-Home placements, standards are outlined and described in: Maryland's regulations (COMAR); The Maryland Healthy Kids/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Standards for the Healthy Kids Program are developed through collaboration with key stakeholders such as the Maryland Department of Health and Mental Hygiene (DHMH), Family Health Administration, the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland Dental School, and the Maryland Department of the Environment. Under EPSDT, Medicaid covers all medically necessary services for children in out-of-home placements.

The Healthy Kids Annual screening components include:

- Health and Developmental History
- Height and Weight
- Head Circumference
- Blood Pressure
- Physical Examination (unclothed)
- Developmental Assessment
- Vision
- Hearing
- Hereditary/Metabolic Hemoglobinopathy
- Lead Assessment
- Lead-Blood Test
- Anemia hematocrit (Hct) / hemoglobin(Hgb)
- Immunizations
- Dental Referral
- Health Education/Anticipatory Guidance

[3] Health care providers do not complete all Health Passport forms – they only provide an updated Health Visit Report. As previously noted, providers often do not know what information to include on the form as there are no instructions. In addition, no one is responsible for summarizing the child's medical needs into a useful care plan. Yet care plans are vital to ensuring appropriate care for children with complicated medical histories.

[4] Health information included in CHESSIE is not summarized or organized into a care plan. This makes it difficult, if not impossible to monitor and track a child's health care needs.

These components represent the program's minimum pediatric health care standards. The State of Maryland uses board certified physicians[5] to provide medical services to children in foster care. DHMH is responsible for oversight of all physicians and the collection of medical data on each child and working closely with DHR/SSA for implementation.[6]

There are challenges to being in compliance with the required screenings as described above. Currently a small percentage of children are receiving screenings within the defined timeframes (see table above). Monitoring of the timeliness of screenings and examinations are incorporated into the QA reviews and will be provided in monthly data reports to local departments.

Consultation with Physicians and other Medical Professionals

The Department of Human Resources continues to consult and collaborate with sister agencies such as the Department of Health and Mental Hygiene (DHMH), the Maryland Chapter of the American Academy of Pediatrics,[7] the University of Maryland Dental School and the Maryland Department of the Environment around issues relating to health care for children in Out-of-Home placement. DHR/SSA has a Health Coordinator who collaborates with DHMH on issues involving consultation or lack of consultation by physicians.[8] This staff person also coordinates with Maryland's Managed Care Organizations (MCO) and Local Department of Social Services health coordinators to ensure effective service delivery.

Headed by Medical Director Dr. Rachel Dodge, MD., M.P.H., the Making All The Children Healthy (MATCH) program continues to provide medical case management and health care coordination for children and youth in the Baltimore City foster care system. In addition to coordinating medical and dental care, the program assures the completion of a mental health assessment of youth upon entry to foster care and completes referrals and follow up for mental health treatment. The program continues to work on a monitoring system that is based on the child's current functioning and complexity of psychotropic medication regimen. A child psychiatrist consultant continues to review the medical records of youth with designated "red flag" to identify youth whose regimen warrants further evaluation based on poor treatment response, complexity of regimen, safety concerns, or treatment that is not consistent with current standards of care. The MATCH program oversees the health care of 2,911 children in foster care, which represents 47% of youth in foster care statewide.[9]

Over the several months SSA has been meeting with DHMH/Mental Hygiene Administration (MHA), University of Maryland School of Pharmacy, Peer to Peer program and community Child and Adolescent Psychiatrist to fine tune SSA's statewide draft policies regarding the Oversight and Monitoring of Psychotropic Medication and Informed Consent and Assent process. The plan is to release documents after supervisors and case workers at the local level have received training on psychotropic medication. SSA is partnering with DHMH/MHA and John Hopkins Child and

[5] And Nurse Practitioners

[6] The Maryland Board of Physicians, part of DHMH, is responsible for physician licensing. However, DHMH does not provide specific review or oversight of the medical care provided to foster youth.

[7] While DHR has consulted with Maryland AAP members regarding health care for children in out-of-home placement, recommendations to address system-related issues have not been followed.

[8] This DHR staff person is a social worker. She does not have professional training in health care.

[9] No case management services are provided to the other 53% of foster youth.

Adolescent Psychiatry to develop and provide comprehensive training about psychotropic medications. The training will include, but not limited to, an overview of the different classes of medications, side effects, what should happen prior to prescribing psychotropic medications, and the American Academy of Child and Adolescent Psychiatry (AACAP) basic principles regarding psychiatric and pharmacologic treatment of children in state custody. In addition, DHR/SSA is in the process of collaborating with DHMH/Mental Hygiene Administration and the Peer to Peer program to develop an automatic process for authorization and monitoring of psychotropic medication for all children in Out-of-Home placement. In April, 2013 the University of Maryland School of Pharmacy, DHMH/MHA, and Johns Hopkins will meet with the Assistant Directors of the Local Department of Social Services to discuss statewide evaluation, outreach and training.

Children placed in Out-of-Home (OHP) continue to be assessed for trauma, using the Child and Adolescent Needs Assessment (CANS). The CANS is completed within 60 days of entry into Out-of-Home care and for children already in care, the CANS in completed when the child requires a higher level of care, during a permanency plan change, and at the reconsideration period. The two sections, in the MD-CANS, that assess trauma are the Trauma Experiences and Trauma Stress Symptoms. The Trauma Experience section allows the assessor to rate the youth's exposure to traumatic events including child maltreatment and removal. There are 13 items in the Trauma experiences section. The Trauma Stress Symptoms allows the assessor to rate whether the youth needs an intervention to address any of the six Trauma Stress Symptoms (Grief/Separation, Re-Experiencing, Avoidance, Numbing, Affect Dysregulation, and Dissociation). These items were developed by the National Child Traumatic Stress Network.

The assessor is also able to provide a rating for each youth that communicates whether any of the youth's functioning problems are related to prior trauma exposure (Adjustment to Trauma). The assessment results will be used in the development of a treatment plan for each child to address the identified needs. The youth’s progress will be monitored through the service plan and the bi-annual CANS assessment score.

SSA continues to work with local departments to increase their awareness of the benefits and availability of evidence based Trauma-Focused Cognitive Behavioral Therapy. The assistant directors recommended targeting transitional age youth and voluntary placements for the initial implementation. As a first step, an overview of trauma informed practice will be included in the expanded pre-service training tracks slated to begin in July 2013. Local departments will be invited to pilot the curriculum developed by the Child Welfare Academy in consultation with the Trauma Academy at the Kennedy Krieger Family Center. The training will highlight the trauma experienced by youth involved in the child welfare system and planning to develop strategies to offer enhanced support for youth transitioning from care.

DHR and the Department of Health and Mental Hygiene (DHMH) are committed to ensuring that Section 2004 of the Affordable Care Act is implemented within the state of Maryland. Section 2004 creates a new mandatory Medicaid eligibility category for

former foster care children.[10] Under the new provision, Medicaid must cover any child under age 26 who:

- was in foster care under the responsibility of the State when he or she turned 18 (or a higher age designated by the State);
- was enrolled in Medicaid under the State plan or a waiver while in foster care; and,
  due to income or other criteria, does not qualify for Medicaid under another mandatory eligibility category (except for the category added by ACA to cover formerly ineligible adults under 65 with incomes up to 133 percent of the Federal Poverty Level (FPL).

Former Maryland foster care children will be eligible to receive comprehensive health care coverage, *i.e*., all services covered under the Medicaid State Plan. These eligibility changes take effect January 1, 2014.

Next Steps

DHR/SSA will continue to consult with and collaborate with sister agencies such as the Department of Health and Mental Hygiene (DHMH), the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland Dental School, University of Maryland School of Pharmacy, John Hopkins University, and the Maryland Department of the Environment around issues relating to health care for children in Out-of-Home placement. Currently, DHR/SSA is in the process of identifying community and State stakeholders to invite to be a part of the Health Plan Advisory Committee (HPAC). The goal of HPAC is to provide further consultation regarding the development of a statewide comprehensive medical service delivery model for children in out-of-home placement as well as to provide recommendations regarding effective long-term strategies that will improve health care outcomes for children in foster care. It is anticipated that the first HPAC meeting will be held the fall of 2013.

JUNE REVISION OF 2013 REPORT

Next Steps

Consultations and collaborations will be continued with sister agencies such as the Department of Health and Mental Hygiene (DHMH), the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland Dental School, University of Maryland School of Pharmacy, Johns Hopkins University, and the Maryland Department of the Environment around issues relating to health care for children in Out-of-Home Placement.

Currently, the Department participates on several committees and workgroups that address improving health care outcomes for children in out-of- home placement; therefore the need for the Health Plan Advisory Committee (HPAC) is being re-assessed.

[10] The state has identified an eligibility category in which to place foster youth between 18 and 26 years of age. However, they have not yet publicized how they will identify youth who should be placed in this eligibility category. In addition, there is no automatic enrollment process. Former foster youth must apply for medical assistance and answer a question about foster care history. Unfortunately, this question is not currently present on the consumer website or the short enrollment form. Furthermore, there is no clear direction from DHMH or DHR regarding how former foster youth status will be verified in the system.

APPENDIX F
MODIFIED HEALTH PASSPORT FORM 631-E

Name of Health Care Provider:	Child's Name:	Worker's Name and ID#:
Facility (Name and Address):	Child's DOB:	Worker's Telephone#:
Telephone #:	Date of Visit:	LDSS:

INSTRUCTIONS TO HEALTH CARE PROVIDER: This form will be used to identify additional medical, dental, mental health, developmental, or educational services for the above named child. Please complete legibly and in lay terms so that foster care workers and foster parents can follow the recommendations. **Please also attach a copy of your visit record from today's visit any available immunization records, problem list, or medication list.**

TYPE OF VISIT (See Back of Form for Instructions about Visit Types):

☐ Initial Health Screen/Placement
☐ Dental Exam
☐ Comprehensive Medical Exam/EPSDT/Well Child Exam
☐ Mental Health Visit
☐ Sick/Emergency Exam

VISIT INFORMATION:

DIAGNOSIS (Please attach a problem list if all current diagnoses are included):

ASSESSMENT:

MEDICATIONS (Please attach medication list if all new medications or medication changes are indicated):

Check if New Medication	Check if Dosage Change	Medication Name	Reason for Medication	Dosage/Frequency

IMMUNIZATIONS:

RECOMMENDATIONS:

Recommendation/Referral/Follow-Up	Reason	Expected Timeframe

_____ _____

Health Care Provider's Signature **Date**

TYPE OF VISIT INSTRUCTIONS:

Initial Health Screen/Placement Exam: To be completed within 5 business days of entering foster care. This exam should be considered an exam **to determine the need for acute care management.** Components of the exam should include growth parameters, physical exam of all body surfaces to identify signs of abuse and/or neglect, identifying and treating infectious/communicable diseases, acute dental issues, acute mental health issues, and evaluating status of known chronic medical conditions. Recommendation for follow-up should include acute medical needs.

Comprehensive Medical Exam/EPSDT/Well Child Exam: A comprehensive medical exam is to be completed within 60 days of entering foster care regardless of when the child's last well child exam was completed. This exam should be considered a well-child exam or complete physical that meets EPSDT standards. Well child exams should be completed according to the preventive health care periodicity schedule. Recommendations for follow-up should include acute medical needs as well as routine follow-up recommendations.

Follow-Up/Sick/Emergency Exam: Recommendations should include acute medical needs and follow up with primary care provider.

Dental Exam: Dental exams should be completed according to the EPSDT standards. Recommendations should include acute dental needs as well as routine dental follow-up.

Mental Health Visit: Mental health visits may include counseling, medication management, or psychiatric care. Recommendations should include necessary follow-up. **This form does not replace documentation of a comprehensive mental health assessment.**

APPENDIX G
Health Care for Foster Youth Needs Assessment: Summary of Key Findings and Recommendations

Part I: Health Care Provider Surveys

Key Findings from Health Care Providers:

1. **Mental health providers estimate that about 2/3 of foster children that they evaluate had chronic mental health concerns prior to initiating treatment with them.**
2. Many foster children seen by psychologists had not previously received mental health treatment (estimate 39% had not previously received therapy).
3. Most foster children seen by psychiatrists had some mental health services prior to entering care (estimate 75% very or somewhat likely to have received therapy before).
4. **On average, primary care providers estimate that about ¼ - ½ of their patients in foster care have chronic mental health issues and/or chronic medical problems.**
5. **Most primary care providers felt that it is somewhat or very difficult to access qualified therapists for foster youth (79% of Nurse Practitioners, 80% of pediatricians, and 100% of family physicians said it was somewhat or very difficult to access qualified therapists for foster youth).**
6. Children often stay with their primary care provider after placement into foster care (~ 80-100% of primary care providers believe that patients who are placed in foster care often stay in their practice). However, it is less common for children to stay with their dentist (57% of dentists said that children placed in foster care did not often stay in their practice)
7. More than ½ of psychologists believe that clients who are placed in foster care very or somewhat often remain in treatment with them after placement. Most (71%) of psychiatrists believe that clients who are placed in foster care often remain in treatment with them after placement.
8. Primary care providers believe that many foster youth enter their practice only after foster care placement. 80% of pediatricians, 60% of nurse practitioners, and 50% of family physicians felt that foster youth often entered their practices only after placement.
9. Dentists also believe that many foster youth enter their practice only after foster care placement. 76% of dentists felt that foster youth often entered their practices only after placement.

10. Mental health providers also believe that many foster youth enter their practice only after foster care placement. ~70% of psychologists and 62% of psychiatrists felt that foster youth often began treatment with them only after foster care placement.
11. **Getting information about foster childrens' medical and mental health history is difficult. ~80% of pediatricians, 75% of family physicians, and 48% of nurse practitioners state that they rarely or not very often receive medial or mental health information.**

12. Dentists are more likely to have a past dental history. 60% of dentists stated that they very or somewhat often are given information about a foster youth's dental history.
13. Most health care providers believe that the foster youth who enter their practice only after placement frequently have unmet medical needs. ~77% of pediatricians, 73% of nurse practitioners, 50% of family physicians, 77% of dentists, 90% of psychologists, and 62% of psychiatrists believe that foster youth often have unmet health care needs at the time of placement.
14. Dentists believe that many children entering foster care have severe dental problems that could have been prevented or treated earlier. 68% of dentists felt that between ¼ and ¾ of foster youth had preventable dental problems.

Things that work well:

- Enrollment in and payment from Medical Assistance
- Dedicated and persistent case workers and foster parents

Things that could be improved:

- Better access to dental and mental health care, including having more providers accept payment from Medical Assistance.
- More training, education and support for caseworkers and foster parents
- Better access to medical history

Recommendations:

- Provide medical and dental home for foster youth
- Develop policies and systems that allow for improved sharing of medical information among and between biologic families, foster families, health care providers, DSS, and schools. This could include a statewide health registry or health exchange for immunizations, growth charts, developmental screens, etc.
- Work with DSS and Medical Assistance programs in other states to allow for use of health care providers in those states.
- Identify ways to increase the number of health care providers who accept Medical Assistance.

Part II: Foster Parent and Kinship Care Provider Surveys

Key findings from foster parents and kinship care providers:

1. Most foster parents report few or no problems accessing medical care for foster youth (85% say this is usually easy or never a problem).
2. When there are difficulties accessing medical care, this is most often because of long waiting times for appointments (35%), providers not accepting Medical Assistance (33%), or providers not accepting new Medical Assistance patients (31%). Other concerns include long travel times to nearest health care provider (22%), no health care provider in the community (20%), and providers not willing to provide care for foster youth (18%).
3. Health care providers often address foster youth overall health and well-being (79% of foster parents say that this was often addressed). Development and educational needs are also addressed often. However, **34% of foster parents said that their**

child's health care provider rarely or never addressed the child's adjustment to foster care placement. Other topics that were rarely or never addressed included dental needs (25% of respondents said that this was never or rarely addressed), behavioral concerns (19%), and mental health needs (19%).

4. In general, most foster parents said that the health care provider included them in plans for addressing physical, dental, and mental health needs, as well as developmental and educational needs.
5. Many foster parents responded that service plans for children did not include information about physical health needs (20% said this was never or rarely included), dental needs (26%), and mental health needs (20%).
6. **When foster parents were asked what health care issues they would like to learn more about, behavioral issues were at the top of the list**. The topics cited most frequently included: behavior management strategies (56%), behavior problems and discipline (55%), aggressive behaviors (53%), ADHD (43%), and supporting children through transitions to and from visitation (42%).
7. **Transfer of health care information from one placement to another was identified as a major problem.** 36% of foster parents stated that they never or rarely received information about the child's physical health needs, 47% stated that they never or rarely received information about mental health needs, 52% said that they never or rarely received information about dental needs, 46% stated that they never or rarely received information about developmental needs, and 41% said that they rarely or never received information about educational needs.

<u>Things that Work Well:</u>

- Accessing providers
- Conveniently located health care providers
- Continuity of care
- Case workers

<u>Things that could be improved:</u>

- Access to providers
- Better mental health providers who address foster parents' concerns, and work well with children.
- Getting insurance card quickly
- Long waits for appointments
- Dental and mental health coverage
- Increasing the number of providers who accept medical assistance
- Getting health care information from case workers, parents, and previous placements

<u>Recommendations:</u>

- Screen children for medical and mental health concerns upon foster care entry and change in placement
- Find ways to increase the willingness of therapists to accept medical assistance for payment
- Provide training to mental health care providers regarding the special concerns and needs of foster youth

- Find better ways to track health information for foster youth.

Part III: Group Home Provider Surveys

Key findings from group home providers:

1. About half of group home providers (53%) felt that it is extremely or somewhat difficult to access medical care for foster youth. The most common problems included providers not accepting medical assistance (cited by 50%), long wait times for appointments (45%), long waiting times to get children on medical assistance (34%), and providers not accepting new medical assistance patients (32%).
2. Most group home providers felt that health care providers frequently addressed children's overall health and wellbeing (87% of respondents stated that this was often addressed), dental needs (59% said this was often addressed), and vision and hearing needs (53% said this was often addressed). Forty-one percent of respondents stated that the health care provider rarely or never addressed the child's adjustment to placement.
3. Group home providers were generally able to access dental and mental health care for their foster youth. However, it was more difficult for them to access services for educational concerns, such as psychoeducational testing and or Individualized Education Plans (IEP).

4. Most group home providers felt that they were often included in plans for addressing physical, mental, and dental health needs.
5. About half of respondents said that physical, mental, and dental health needs were often included in foster youth service plans.
6. **When group home providers were asked what health care issues they would like to learn more about, behavioral issues were at the top of the list**. The topics cited most frequently included: aggressive behaviors (81%), ADHD (77%), behavior management strategies (68%), behavior problems and discipline (68%), depression (68%), oppositional defiant disorder (66%), post-traumatic stress disorder (66%), anxiety disorders (64%), bipolar disorder (64%), learning problems/school problems (62%), stealing (60%), conduct disorder (60%), supporting children through transitions to and from visitation (60%), and talking with teens about health (60%). All of the listed topics were identified by at least 25% of respondents as information that would be helpful to provide to group home staff.
7. Group home providers seemed to receive more health care information than foster parents. Almost all respondents stated that they sometimes or often received medical, mental health, and dental information about their residents.

Things that work well:

- Caring, compassionate health care providers.
- Partnership between local DSS, medical assistance, and group home
- Availability of therapists, crisis counselors

Things that could be improved:

- Availability of medical specialists, dentists, mental health providers, orthodontists.
- Changes in placement leading to disruptions in continuity of care

- Increased provider acceptance of medical assistance
- Need more mental health providers who have training in issues of trauma, attachment, and maltreatment
- Problems with authorization for services from medical assistance, especially when placement changes

Recommendations

- More training of mental health providers on mental health problems commonly seen in foster youth (e.g. trauma, attachment, maltreatment)
- Find ways to increase the number of providers who will see patients with medical assistance

Part IV: DSS Attorney Surveys

Key findings from DSS Attorneys:

1. **Most DSS attorneys state that ~25-50% of the foster youth in their caseload have unmet medical needs, dental needs, mental health needs and/or chronic medical problems**.
2. More than half of respondents stated that medical care is not very often or rarely mandated by the court. When DSS attorneys request medical services, the request is rarely denied, and the mandate is often met (92%) by foster families or the foster care agency.
3. Respondents felt that mental health care is mandated by the court more often than medical care. 59% of respondents stated that mental health services were mandated somewhat or very often. When mental health services are requested by DSS attorneys, the request is rarely denied, and all respondents said that the mandate is very or somewhat often met by foster families or the foster care agency.
4. Respondents felt that dental care was not often mandated by the court. 73% of respondents felt that dental care was not very often or rarely mandated by the court. When dental services are requested by DSS attorneys, the request is rarely denied, and the mandate is often met by foster families or the foster care agency.
5. In general, respondents felt that most children's medical needs were met within 3-6 months of placement. Mental health needs and dental needs were more likely to be unmet.
6. **DSS attorneys often lack adequate information to determine a child's health care needs. 47% of respondents stated that they very or somewhat often did not have adequate information to determine a child's health care needs**.

Things that work well:

- Having physicians under contract with local DSS
- Having caseworkers who identify medical needs and communicate the need for medical services with foster parents

Things that could be improved:

- Better access to dental care, orthodontics, and mental health care
- Need for providers to better document information about their evaluations

- Sharing of information by the school system

Recommendations:

- Compacts between medical assistance agencies in different states to allow children to receive services out-of-state if needed.
- Improving the system for getting medical assistance for children entering foster care, including ensuring that the medical assistance transfers from the parent to DSS.
- Provide trainings to school systems about the educational needs of foster youth.
- Partner with DHMH to better ensure access to mental health services.

Part V: Court Appointed Special Advocate (CASA) Supervisor Surveys

Key findings from CASA supervisors:

1. **It is common for the foster youth that CASA workers assist to have unmet health care needs, and chronic mental health problems.** 86% of respondents indicated that more than half of their clients have unmet mental health needs.
2. **Unmet dental needs are also common.** 60% of respondents indicated that more than half of their clients have unmet dental needs.
3. When CASA workers ask the court to mandate medical care or mental health care, this request is usually granted.
4. When CASA workers ask the court to mandate dental care, this request is usually granted. However, **21% of CASA supervisors said that the court very often or somewhat often denies requests to mandate dental services**.
5. CASA supervisors believe that most children have their health care needs met within 3-6 months after placement. **However, the majority of CASA supervisors believe that about 25-50% of children still have unmet mental health needs 3-6 months after placement. Additionally, most CASA supervisors believe that more than 25% of children have not had their developmental needs met by this time point.**
6. **26% of CASA supervisors very or somewhat often lack adequate information to determine a child's health care needs.**

Common Themes

1. Obtaining and sharing of health care information is a major problem. Caregivers and professionals often do not have the information they need to make health care decisions for foster youth.
2. Access to mental health services and dental care is often difficult. Access to medical care is less problematic, but still an issue for some children. Access issues are due, in large part, to providers not accepting medical assistance. Another issue is the inability to use out-of-state providers because of medical assistance rules.

3. Many health care providers are not meeting the needs of foster youth. For example, health care providers rarely address foster youth adjustment to foster care placement.

Also, mental health providers often are not trained to address issues common among foster youth such as traumatic stress, attachment issues, and maltreatment concerns.
4. While judges often mandate services when requested by child advocates, they do not always do this without a request. Some judges may also refuse to mandate specific health care services, despite a request by the child's advocate.

Initial Recommendations

1. A better system for obtaining and sharing health information for Maryland foster youth must be put into place.
2. While DHR cannot change Medicaid reimbursement rates or identify ways to allow for receipt of medical services in bordering states, DHR should work with Medicaid to examine ways to improve access to health care for foster youth.
3. Many professionals would benefit from additional training to better address the needs of foster youth. For example, mental health professionals may benefit from additional training in trauma-based therapy. Judges may benefit from training in regarding the health care needs of foster youth.
4. Foster parents and group home providers could also benefit from additional training and education. Foster parents and group home providers are most in need of training to address behavioral and mental health concerns.

APPENDIX H:

WEBSITES FOR SELECTED STATEWIDE CHILD MALTREATMENT MEDICAL EVALUATION PROGRAMS

TEXAS: http://ped1.med.uth.tmc.edu/divisions/general-medicine/Child-Abuse-Pediatrics.html
WASHINGTON STATE:
http://www.dshs.wa.gov/pdf/ca/MedicalConsultationContactSheet.pdf
SOUTH CAROLINA: https://www.sccamrs.org/
NORTH CAROLINA: http://info.dhhs.state.nc.us/olm/manuals/dss/csm-60/man/CS1422.pdf
FLORIDA: http://www.floridahealth.gov/alternatesites/cms-kids/families/child_protection_safety/child_protection_teams.html

APPENDIX I:

1. On main DHR page at top (http://www.dhr.state.md.us/blog/).
   - Make information easy to find for reporter/visitor to site

REPORT/PREVENT CHILD ABUSE OR NEGLECT
Source: http://ocfs.ny.gov/main/

2. "REPORT/PREVENT CHILD ABUSE" on the main DHR page would be the hypertext used to link to main Reporting Abuse and Neglect page.

3. Reporting Abuse and Neglect main page:

Do You Suspect Abuse or Neglect?

Report It Now!

Act to protect a child by calling the 24 hour, 7 day-a-week statewide toll free hotline:

1-800-xxx-xxxx

If you are deaf or hard of hearing, call TDD/TTY at

1-800-xxx-xxxx

or have your Video Relay System provider call

1-800-xxx-xxxx

If you believe that a child is in **immediate danger**,
call **911** or your local police department.

Who is required to Report Abuse and Neglect?

Reporting child abuse is everyone's responsibility. Maryland law requires every citizen to report suspected child abuse and neglect. Md. Code Ann. Fam. Law § 5-705 YOU may be a child's only advocate at the time you report the possibility of abuse or neglect. Children often tell a person with whom they feel safe about abuse or neglect. Remember, you do not need to make a decision about whether abuse or neglect occurred; you are reporting your concerns.

You do NOT need PROOF that abuse or neglect has occurred before reporting. Incidents are to be reported as soon as they are suspected. Waiting for proof may involve grave risk to the child and impede services to the family. Proof may be long in coming, witnesses to child abuse and neglect are rare, and the child's testimony may be disbelieved or inadmissible.

How do I respond to the child?

Tell the child that you believe them and that you are going to contact people who can help. Respect the privacy of the child. The child will need to tell their story in detail later, so don't press the child for details. Remember, you need only suspect abuse to make a report. Don't display horror, shock, or disapproval of parents, child, or the situation. Don't place blame or make judgments about the parent or child. Believe the child if she/he reports sexual abuse. It is rare for a child to lie about sexual abuse.

4. CHILD ABUSE REPORTING FORM (DHR/SSA 180) AND INSTRUCTIONS (hyperlink)

5. Questions on side of Reporting Abuse and Neglect main page:

- What is child abuse or neglect?
- What are possible warning signs of child abuse or neglect?
- What warning signs that an adult *may* pose a risk to a child?
- What are possible warning signs of child sex trafficking?
- How do I report suspected child abuse or neglect?
- When do I report suspected child abuse or neglect?
- Mandated Reporters
- What is Child Protective Services?
- What Happens after Reporting to CPS
- Will I be Identified as the Reporter?
- Appealing Child Protective Services Findings
- Child Protective Services Background Search The Central Registry
- Child Protective Services Background Clearance Form

- Addresses and Phone Numbers
- Contact Us

6. Content of questions.

- **What is child abuse or neglect?**

    - Physical Abuse: the child's sustaining of a physical injury by a parent, caretaker (a person who has permanent or temporary care or custody or responsibility for supervision of a child), or by any household or family member, under circumstances that indicate that the child's health or welfare is harmed or at substantial risk of being harmed.

    - Sexual Abuse: any act that involves sexual molestation or exploitation, whether injuries are sustained or not, including incest, rape, sexual offense in any degree, sodomy, and unnatural or perverted sexual practices by a parent, caretaker (a person who has permanent or temporary care or custody or responsibility for supervision of a child).

    - Mental Injury: the observable, identifiable, and substantial impairment of a child's mental or psychological ability to function caused by an act of commission of a parent, caretaker (a person who has permanent or temporary care or custody or responsibility for supervision of a child), or by any household or family member, under circumstances that indicate that the child's health or welfare is harmed or at substantial risk of harm.

    - Mental Injury–Neglect: the observable, identifiable, and substantial impairment of a child's mental or psychological ability to function caused by an omission or failure to act by any parent or other person who has permanent or temporary care or custody or responsibility for supervision of the child.

    - Child Neglect: the failure to give proper care and attention, including the leaving of a child unattended, by any parent or other person who has permanent or temporary care or custody or responsibility for supervision of the child, under circumstances that indicate that the child's health or welfare is harmed or at substantial risk of harm.

      Md. Code Ann. Fam. Law § 5-701

- **What are possible warning signs of child abuse or neglect?**

    - Physical Abuse:
        - Includes non-accidental physical injuries such as bruises, broken bones, burns, cuts, missing teeth, abrasions in the shape of an instrument, bite marks, fingernail marks, or other injuries; these injuries may be constantly attributed to a child being accident-prone or clumsy and the explanation does not seem to fit a child or caregiver's explanation

- Child is always watchful and "on alert", as if waiting for something bad to happen
- Child has injuries that appear to have a pattern such as marks from a hand or belt
- Child shies away from touch, flinches at sudden movements, or seems afraid to go home
- Child wears inappropriate clothing to cover up injuries, such as long-sleeved shirts on hot days
- Child is frequently late to or absent from school without a plausible explanation
- Child may have difficulty walking due to painful injuries

- Sexual Abuse:
  - Child sexual abuse can include both **touching** and **non-touching** behaviors and its victims can include infants, toddlers, young children, and teens.
  - **Examples of abusive touching behaviors** include: fondling of a child's genitals, buttocks or breasts; intercourse; and, penetration of the child's mouth, anus, or vagina with an object for the sexual gratification of the offender. Coercing a child to fondle him/herself, the offender or another child is also abusive.
  - **Examples of abusive non-touching behaviors** include: exposing oneself to a child; viewing and violating the private behaviors of a child or teen (e.g. while undressing, bathing, etc); taking sexually explicit or provocative photographs of a child; showing pornography to a child; or talking in sexually explicit ways to children in person, by phone, or on the Internet.
  - Child has trouble walking or sitting
  - Child makes strong efforts to avoid a specific person, without an obvious reason
  - Child doesn't want to change clothes in front of others or participate in physical activities
  - Child has an STD or becomes pregnant, especially if under age 14
  - Child runs away from home

  - Children under 3 may exhibit:
    - Fear or frequent crying
    - Vomiting
    - Feeding and bowel problems
    - Problems sleeping

  - Children up to age 9 can exhibit:
    - Fear of certain people or places
    - Feelings of guilt or shame
    - Withdrawal from family and friends
    - Sleep disturbances and frequent nightmares
    - Victimization of others

- Older children can exhibit:
  - Depression or suicidal gestures
  - Promiscuity
  - Poor school performance
  - Running away from home
  - Substance abuse
  - Aggression
  - Eating disturbances

- Neglect:
  - Child wears clothes that are ill-fitting, filthy, or inappropriate for the weather
  - Child has consistently poor hygiene is (un-bathed, matted and unwashed hair, noticeable body odor)
  - Child has untreated illnesses and or physical injuries
  - Child is frequently unsupervised, [or] left alone, or allowed to play in unsafe situations and environments
  - Child is frequently late or missing from school

- Mental Injury:
  - Mental injury of a child is evidenced by severe anxiety, depression, withdrawal or improper aggressive behavior as diagnosed by a medical doctor or psychologist, and caused by the acts or omissions of the parent or caretaker.
  - Child may be excessively withdrawn, fearful or anxious about doing something wrong
  - Child shows extremes in behavior; may either be extremely passive or extremely aggressive
  - Child may not be very attached to his or her caregiver
  - Child may inappropriately act like an adult (ex. taking care of other children) or inappropriately act like an infantile (ex. throwing tantrums)

- **What warning signs that an Adult *may* pose a risk to a child?**
  - Doesn't appear to have a regular number of adult friends and prefers to spend free time interacting with children and teenagers who are not his own;
  - Finds ways to be alone with a child or teen when adults are not likely to interrupt, e.g. taking the child for a car ride, arranging a special trip, frequently offering to baby sit, etc.;
  - Ignores a child's verbal or physical cues that he or she does not want to be hugged, kissed, tickled, etc.;
  - Seems to have a different special child or teen friend of a particular age or appearance from year to year;
  - Doesn't respect a child's or teen's privacy in the bathroom or bedroom;
  - Gives a child or teen money or gifts for no particular occasion;
  - Discusses or asks a child or teen to discuss sexual experiences or feelings;
  - Views child pornography through tapes, photographs, magazines or the Internet. (In addition to being an important behavioral sign, possessing, viewing and/or selling child pornography is a criminal offense and should be reported.)

Please see the Enough Abuse Campaign in Maryland to learn more about signs of child sexual abuse and *what you can do* to prevent it.

- **What are possible warning signs of child sex trafficking?**
  - Shows evidence of mental, physical, or sexual abuse
  - Cannot or will not speak on own behalf
  - Is not allowed to speak to you alone; is being controlled by another person
  - Does not have access to identity or travel documents or documents appear fraudulent
  - Works long hours
  - Is paid very little or nothing for work or services performed
  - Has heightened sense of fear or distrust of authority
  - Gaps in memory
  - Someone else was in control of migration to U.S. or movement into Maryland
  - Lives at workplace/with employer, or lives with many people in confined area
  - Is not in school or has significant gaps in schooling
  - Has engaged in prostitution or commercial sex acts
  - Any mention of a pimp/boyfriend
  - Any child working where "pay" goes directly towards rent, debt, living expenses/necessities, fees for their journey
  - Exploitation on the internet, online ads
  - Threats of traffickers reporting child to police/immigration
  - Threats to child's parents, grandparents, siblings, or own minor children
  - Methods of control that leave no visible, physical signs of abuse
  - Sleeping/living separately from the "family" (in garage or on the floor instead of bedroom)
  - Forced to sell drugs, jewelry, magazines on the street
  - Excess amount of cash
  - Hotel keys
  - Chronic runaway/homeless youth
  - Lying about age/false ID
  - Inconsistencies in story
  - Unable or unwilling to give local address or information about parents
  - Presence of older male or boyfriend who seems controlling
  - Injuries/signs of physical abuse
  - Inability or fear to make eye contact
  - Demeanor: fearful, anxious, depressed, submissive, tense, nervous
  - Is not enrolled in school
  - Does not consider self a victim
  - Loyalty, positive feelings toward trafficker
  - May try to protect trafficker from authorities.

❖ Warning signs do not automatically mean a child is being abused. However, such signs may draw your attention to the child and the child's situation and reveal additional warning signs.

- **How do I report suspected child abuse or neglect?**
    - Call **Maryland Child Abuse and Neglect Hotline at 1-800-xxx-xxxx**
    - You may also report suspected abuse or neglect to a local department of social services or local law enforcement agency.

      Click here for a list of addresses and phone numbers of social services offices across the state.
    - If you are a mandated reporter (health practitioner, educator, human service worker or a police officer) you are required to report both *orally* and in *writing* any suspected child abuse or neglect. Md. Code Ann. Fam. Law § 5-704
    - Oral reports should be made immediately and written reports must be made within 48 hours of contact which disclose the suspected abuse or neglect.
    - If possible, a report should include:
        - The name and home address of the child and the parent or other individual responsible for the care of the child
        - The present location of the child
        - The age of the child
        - Names and ages of other children in the home
        - The nature and extent of injuries or sexual abuse or neglect of the child
        - When and where the alleged abuse or neglect occurred
        - Any information relayed by the individual making the report of previous possible physical or sexual abuse or neglect
        - Information available to the individual reporting that might aid in establishing the cause of the injury or neglect
        - The identity of the individual or individuals responsible for abuse or neglect
        - Whether the alleged perpetrator has access to the child.
        - *If reporting abuse or neglect of a child involving mental injury, a description of the substantial impairment of the child's mental or psychological ability to function that was observed and identified and why it is believed to be attributable to an act of maltreatment or omission of proper care and attention.*
    - All reports of abuse must be made to the local departments of social services and the appropriate law enforcement agency. To initiate prompt handling of the report of suspected child abuse or neglect, employees of a local department of social services must make a report to the protective services unit.

- **When do I make a report of suspected abuse or neglect?**
    - A report should be made when any person, who reasonably believes that a child under 18 has been abused, neglected, exploited or abandoned. A report of suspected abuse, neglect, exploitation or abandonment is only a request for an investigation. The person making the report does not need to prove the abuse.
    - Investigation and validation of child abuse reports are the responsibilities of child protective service (CPS) workers.
    - If additional incidents of abuse occur after the initial report has been made, make another report.
    - A person is obligated to make a report even when the victim is now an adult or the alleged abuser is dead.

      Md. Code Ann. Fam. Law § 5-705

- **Mandated Reporters**
    - (*Content that is currently on DHR site*)

- **What is Child Protective Services?**
    - *(Content that is currently on DHR site)*

- **What Happens after Reporting to CPS**
    - (*Content that is currently on DHR site*)

- **Will I be Identified as the Reporter?**
    - CONFIDENTIALITY

Information contained in records or reports concerning child abuse or neglect is sensitive and personal. Federal and State law narrowly restricts the circumstances under which information contained in reports or records may be disclosed. It is essential that health care professionals and institutions comply with the Maryland confidentiality law (article 88 a & b) of the Annotated Code of Maryland) when asked to disclose information contained in records concerning child abuse and neglect.

Confidentiality provisions states that:

- The name of the reporter may only be revealed under a court order. However, if the reporter is a professional, he or she may give written permission for his or her identity to be revealed.
- The identity of any other person whose life or safety is likely to be endangered by disclosing the information must not be disclosed. *This is extremely important when*

sharing information with parents or the person who is suspected of child neglect or abuse.

- Information should only be disclosed when doing so would be in the best interest of the child who is the subject of the report.
- Professional discretion should be exercised to disclose only that information which is relevant for the care or treatment of the child.

In 1986, the Maryland confidentiality law was amended to permit the disclosure of information concerning abuse and neglect to licensed practitioners or an institution providing treatment or care to a child who is the subject of a report of child abuse or neglect. Maryland law also permits information to be shared with members of a multidisciplinary case consultation team who are investigating or providing services in response to a report of suspected abuse or neglect.

- **Appealing Child Protective Services Findings**
  - (*Content that is currently on DHR site*)

- **Child Protective Services Background Search The Central Registry**
  - (*Content that is currently on DHR site*)

- **Child Protective Services Background Clearance Form**
  - (*Content that is currently on DHR site*)

- **Addresses and Phone Numbers**
  - (*Content that is currently on DHR site*)

- **Contact Us**
  - (*Content that is currently on DHR site*)

What Else Can I do to Protect Children?

<u>SUPPORT VICTIMS:</u>

Be a trusted adult that a child can speak to about what he or she has endured. Ensure the child that the abuse was *not* the child's fault by any means. Support those organizations that are dedicated to helping child victims of abuse.

<u>EDUCATE:</u>

- Yourself and your loved ones about how to PREVENT child abuse and neglect *before it occurs*. Child abuse can be prevented.
- Other adults in your community about the nature and scope of the epidemic; providing them with useful and specific skills to confront child maltreatment. Caring and supportive adults in the community are critical to every family's ability to raise safe and healthy children.

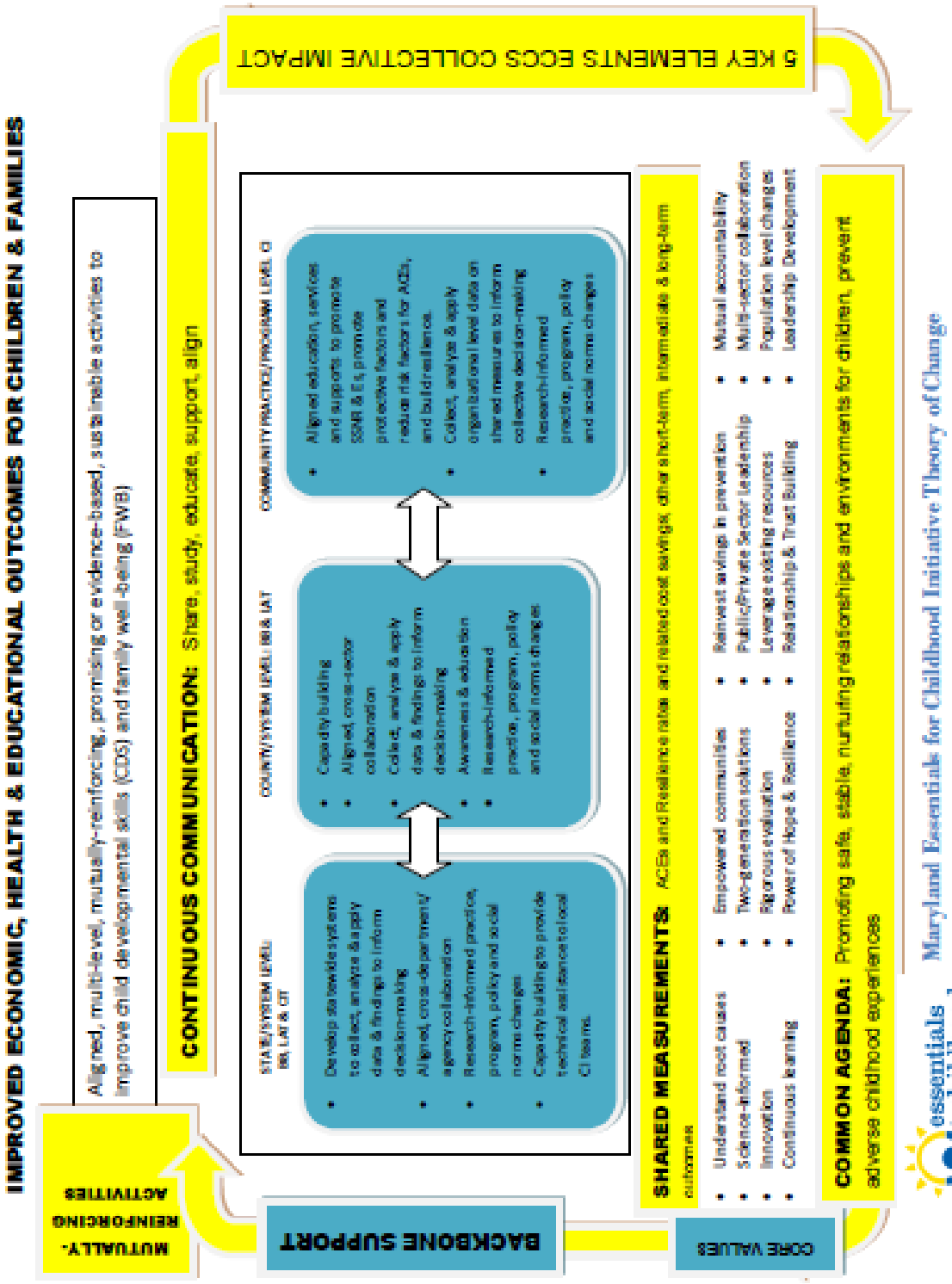
ADVOCATE:

- To policy makers for a wide range of policies, funding and training that can protect children by strengthening the circle of safety around them. It shouldn't hurt to be a child.
- Encourage public and private schools and other child and youth serving organizations to develop programs to educate employees and volunteers to recognize the signs of abuse and respond appropriately.

REPORT:

YOU are legally obligated to report any suspicions of child abuse and neglect. You could be the only person that has the knowledge and capability to report the abuse and **save this child's life.** Every statistic is a child who needs help.

APPENDIX J:


IMPROVED ECONOMIC, HEALTH & EDUCATIONAL OUTCOMES FOR CHILDREN & FAMILIES
MUTUALLY-REINFORCING ACTIVITIES
Aligned, multi-level, mutually-reinforcing, promising or evidence-based, sustainable activities to improve child developmental skills (CDS) and family well-being (FWB)
CONTINUOUS COMMUNICATION: Share, study, educate, support, align
5 KEY ELEMENTS ECCS COLLECTIVE IMPACT
BACKBONE SUPPORT
STATE/SYSTEM LEVEL
COUNTY/SYSTEM LEVEL
COMMUNITY/PRACTICE/PROGRAM LEVEL
SHARED MEASUREMENTS: ACEs and Resilience rates and related cost savings, other short-term, intermediate & long-term outcomes
CORE VALUES
COMMON AGENDA: Promoting safe, stable, nurturing relationships and environments for children, prevent adverse childhood experiences
essentials for childhood
Maryland Essentials for Childhood Initiative Theory of Change

Maryland Essentials for Childhood Initiative
DRAFT Common Agenda

VISION

All Maryland children, youth, and their families thrive in safe, stable, nurturing relationships and environments

PROPOSED MISSION

To develop a common agenda across multiple agencies and stakeholders to align activities, programs, policies, and funding so that all Maryland children, youth and their families have safe, stable, nurturing relationships and environments.

PROPOSED GUIDING PRINCIPLES

1. Ensuring all children and families have Safe, Stable, Nurturing Relationships and Environments will strengthen families, prevent and reduce child maltreatment, promote healthy child growth and well-being, and allow children to meet their full potential as happy, self-sufficient, socially engaged and productive citizens.

2. Solving large scale, complex social problems requires a highly effective level of sustained collaboration across multiple sectors aligned to a broad common agenda and conducting strategic and mutually reinforcing activities (e.g. "collective impact" approach)

3. Accomplishing Safe, Stable, Nurturing Relationships and Environments requires changes in multiple systems with a focus on broad social and economic determinants, social norms, and governmental and institutional policies, as well as individual and family level

4. Service systems and programs should be based on the best available evidence (i.e., research, experiential and contextual), and should strive for continuous quality improvement

5. Service Systems and programs should be culturally and linguistically appropriate for the audiences

6. Efforts to make improvements in overall child health and well-being should include actions to address and reduce inequalities/disparities which are avoidable, unjust and preventable

GOALS

Identify, align and enhance the Maryland Essentials for Childhood Initiative partners' and their stakeholders to:

1. Build upon families' assets to strengthen their knowledge, skills, to provide safe, stable and nurturing relationships and environments for their children

2. Achieve the highest level of well-being for families and children, with special attention to those who have experienced socioeconomic disadvantage and historical injustice, including vulnerable communities and culturally, linguistically, and geographically isolated communities

3. Prevent child maltreatment and other childhood traumas and implement trauma informed policies and practices throughout public and private organizations and systems

4. Improve the quality of and expand the accessibility to programs and services supporting families and children

5. Enhance the integration of systems and networks that support families and children to improve communication, services, accountability and outcomes

6. Engage communities and strengthen their capacity to act and take leadership roles in creating safe and stable environments that support families and children

7. Build public support and commitment (or "public commitment and political will") for policies and programs that promote safe, stable and nurturing relationships and environments for families and children

8. Embed and incorporate families and children as priorities in public policies

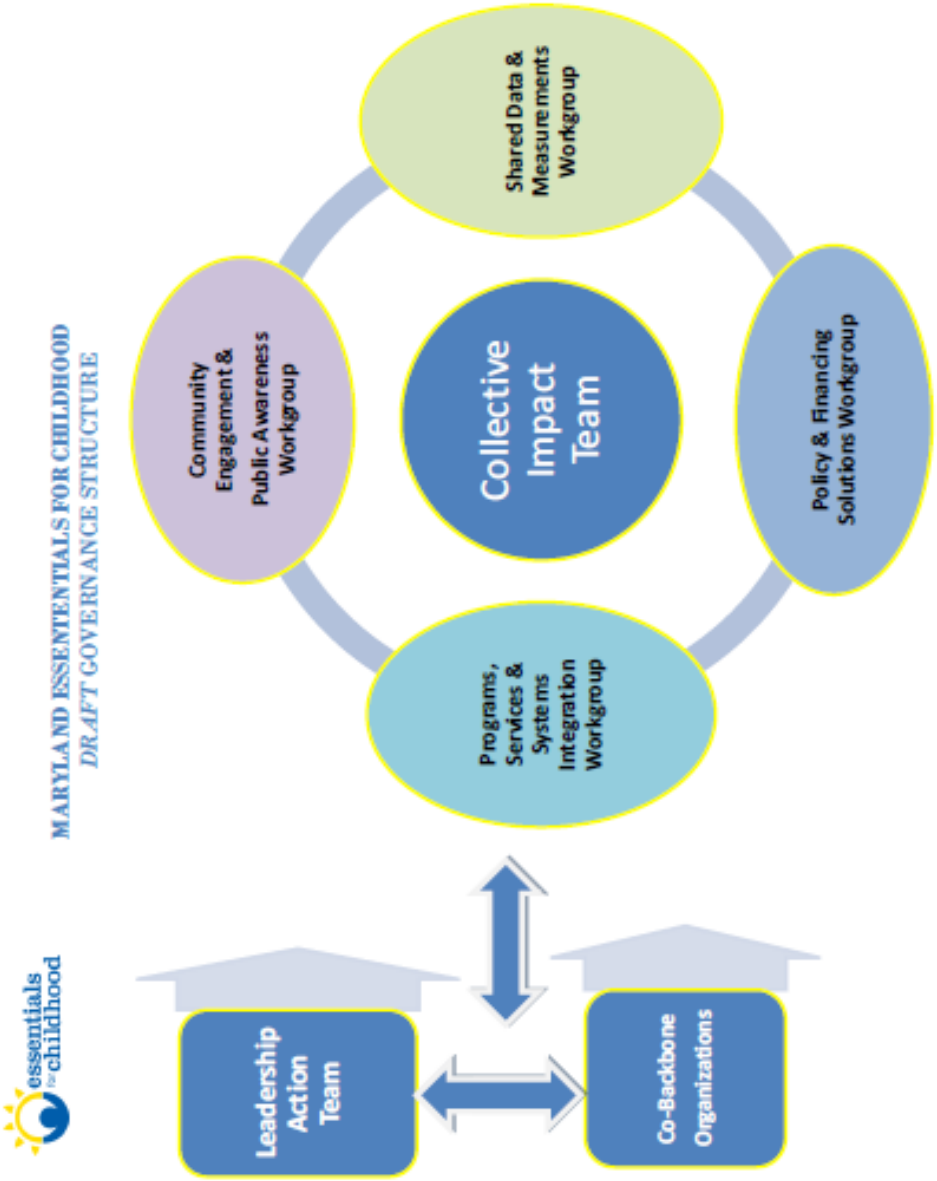
9. Increase the number and scope of private sector policies and practices that support families and children

10. Improve and enhance data management systems that use common measurements to increase accountability for shared indicators and outcomes for families and children

WORK GROUPS

- Community Engagement and Public Awareness
- Programs and Systems Integration
- Public and Private Sector Policy & Financing Solutions
- Shared Data and Outcomes

APPENDIX L:


MARYLAND ESSENTIALS FOR CHILDHOOD
DRAFT GOVERNANCE STRUCTURE
essentials for childhood
Shared Data & Measurements Workgroup
Community Engagement & Public Awareness Workgroup
Collective Impact Team
Policy & Financing Solutions Workgroup
Programs, Services & Systems Integration Workgroup
Leadership Action Team
Co-Backbone Organizations

State Council on Child Abuse and Neglect (SCCAN)

The State Council on Child Abuse and Neglect is one of three citizen review panels **(1)** required by the Federal Child Abuse Prevention and Treatment Act (Title 42, Chapter 67, Subchapter I), known familiarly as CAPTA. The Maryland Legislature established SCCAN and elaborated on its Federal responsibilities in the Maryland Family Law Article (Section 5-7A).

Who we are

SCCAN consists of up to twenty-three members, most of whom are private citizens appointed by the Governor of Maryland, including representatives from professional and advocacy groups, private social service agencies, and the medical, law enforcement, education, and religious communities. At least two members must have personal experience with child abuse and neglect within their own families or have been clients of the child protective services system.

Nine members of SCCAN are designated representatives of their respective organizations including the Maryland Senate, Maryland House of Delegates, Department of Human Resources, Department of Health and Mental Hygiene, Department of Education, Department of Juvenile Services, Judicial Branch, State's Attorneys' Association and Maryland Chapter of the American Academy of Pediatrics.

What we do

What we do is defined in Federal and State law. CAPTA charges SCCAN and all citizen review panels "*to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities"* **(2)** and to *"provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations*. **(3)** The Maryland Family Law Article reiterates the CAPTA requirements and specifically charges SCCAN to "*report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs".* **(4)**

Why we do it

Child abuse and neglect have known detrimental effects on the physical, psychological, cognitive, and behavioral development of children (National Research Council, 1993). These consequences range from minor to severe and include physical injuries, brain damage, chronic low self-esteem, problems with bonding and forming relationships, developmental delays, learning disorders, and aggressive behavior. Clinical conditions associated with abuse and neglect include depression, post-traumatic stress disorder, and conduct disorders.

Beyond the trauma inflicted on individual children, child maltreatment also has been linked with long-term, negative societal consequences such as low academic achievement, drug use, teen pregnancy, juvenile delinquency, and adult criminality (Widom, 1992; Kelly, Thornberry, and Smith, 1997). Further, these consequences cost society by expanding the need for mental health and substance abuse treatment programs, police and court interventions, correctional facilities, and public assistance programs, and by causing losses in productivity.

NOTES:

1) The other two panels are the Citizens' Review Board for Children and the State Child Fatality Review Team.
2) Section 5016a (c) (4) (A)
3) Section 5016a (c) (4) (C)
4) Section 5-7-09A (a)

APPENDIX N:

SCCAN and Maryland Law
Family Law Article
As amended by HB 264

§5–7A–01.

(a) There is a State Council on Child Abuse and Neglect.

(b) The Council is part of the Department of Human Resources for budgetary and administrative purposes.

§5–7A–02.

(a) The Council consists of up to 23 members including:

(1) one member of the Senate of Maryland appointed by the President of the Senate;

(2) one member of the House of Delegates appointed by the Speaker of the House;

(3) a representative of the Department of Human Resources, appointed by the Secretary of Human Resources;

(4) a representative of the Department of Health and Mental Hygiene, appointed by the Secretary of Health and Mental Hygiene;

(5) a representative of the Maryland State Department of Education, designated by the Superintendent;

(6) a representative of the Department of Juvenile Services, designated by the Secretary;

(7) a representative of the Judicial Branch, designated by the Chief Judge of the Maryland Court of Appeals;

(8) a representative of the State's Attorneys' Association, designated by the Association;

(9) a pediatrician with experience in diagnosing and treating injuries and child abuse and neglect, who shall be appointed by the Governor from a list submitted by the Maryland chapter of the American Academy of Pediatrics;

(10) members of the general public with interest or expertise in the prevention or treatment of child abuse and neglect who shall be appointed by the Governor and who shall include representatives from professional and advocacy groups, private social service agencies, and the medical, law enforcement, education, and religious communities; and

(11) at least two individuals who have personal experience with child abuse and neglect within their own families or who have been clients of the child protective services system who shall be appointed by the Governor.

(b) (1) The term of a member appointed under subsection (a)(9), (10), or (11) of this section is 3 years.

(2) An appointed member may serve up to two consecutive 3–year terms.

(3) In case of a vacancy, the Governor shall appoint a successor for the remainder of the unexpired term.

(c) All other members of the Council shall continue in office so long as they hold the required qualification and designation specified in subsection (a)(1) through (8) of this section.

§5–7A–03.

The Governor shall select a chairperson from among the members of the Council.

§5–7A–04.

(a) The Council shall meet not less than once every 3 months.

(b) Members of the Council shall serve without compensation, but may be reimbursed for reasonable expenses incurred in the performance of their duties in accordance with the Standard State Travel Regulations and as provided in the State budget.

(c) The Council may employ a staff in accordance with the State budget.

§5–7A–05.

(a) The Council shall operate with one standing committee.

(b) The federal Children's Justice Act Committee is established in accordance with the requirements of the federal Children's Justice Act, Public Law 100–294. It shall review and evaluate State investigative, administrative, and judicial handling of child abuse and neglect cases, and make policy and training recommendations to improve system response and intervention. The Committee shall include representatives of the State judiciary with criminal and civil trial court docket experience, law enforcement agencies, the Maryland Public Defender's Office, State's Attorneys, the Court Appointed Special Advocate (CASA) Program, health and mental health professions, child protective services programs, programs that serve children with disabilities, parent groups, and attorneys who represent children.

(c) In addition to the Children's Justice Act Committee, the Council may establish other ad hoc committees as necessary to carry out the work of the Council.

§5–7A–06.

(a) In addition to any duties set forth elsewhere, the Council shall, by examining the policies and procedures of State and local agencies and specific cases that the Council considers necessary to perform its duties under this section, evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities in accordance with:

(1) the State plan under 42 U.S.C. § 5106a(b);

(2) the child protection standards set forth in 42 U.S.C. § 5106a(b); and

(3) any other criteria that the Council considers important to ensure the protection of children, including:

(i) a review of the extent to which the State child protective services system is coordinated with the foster care and adoption program established under Part E of Title IV of the Social Security Act; and

(ii) a review of child fatalities and near fatalities.

(b) The Council may request that a local citizens review panel established under § 5-539.2 of this title conduct a review under this section and report its findings to the Council.

(c) The Council shall coordinate its activities under this section with the State Citizens Review Board for Children, local citizens review panels, and the child fatality review teams in order to avoid unnecessary duplication of effort.

(d) The chairperson of the Council may designate members of the Children's Justice Act Committee as special members of the Council for the purpose of carrying out the duties set forth in this section.

§5–7A–07.

(a) The members and staff of the Council:

(1) may not disclose to any person or government official any identifying information about any specific child protection case about which the Council is provided information; and

(2) may make public other information unless prohibited by law.

(b) In addition to any other penalties provided by law, the Secretary of Human Resources may impose on any person who violates subsection (a) of this section a civil penalty not exceeding $500 for each violation.

§5–7A–08.

A unit of State or local government shall provide any information that the Council requests to carry out the Council's duties under § 5-7A-06 of this subtitle.

§5–7A–09.

(a) The Council shall report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs that require the attention and action of the Governor or the General Assembly.

(b) The Council shall annually prepare and make available to the public a report containing a summary of its activities under § 5-7A-05 of this subtitle.

APPENDIX O:

State Council on Child Abuse and Neglect (SCCAN)

VISION STATEMENT

"All children in Maryland are loved, happy, safe, secure, healthy and nurtured by caring families and supportive communities."

MISSION STATEMENT

"Since child abuse and neglect is a critical problem in Maryland requiring an urgent response, the State Council on Child Abuse and Neglect (SCCAN) shall promote the development and implementation of optimal strategies for detection, prevention, intervention and treatment."

SCCAN shall encourage all Marylanders to become involved in efforts to ensure the well-being and safety of children.

APPENDIX P:

State Council on Child Abuse and Neglect (SCCAN)

SCCAN Membership

15 MEMBERS APPOINTED BY THE GOVERNOR

Name	Representing	Jurisdiction	Email	Phone	Address
Patricia K. Cronin, LCSW-C **(SCCAN Chair)**	Executive Director The Family Tree (Maryland Chapters of Prevent Child Abuse America and Parents Anonymous)	Baltimore County	pcronin@familytreemd.org	Work: 410-889-2300	The Family Tree 2108 North Charles Street Baltimore, MD 21218
Alison J. D'Alessandro	Director, Office of Child and Youth Protection, Archdiocese of Baltimore	Baltimore County	adalessandro@archbalt.org	Work: 410-547-5348	Office of Child and Youth Protection Archdiocese of Baltimore 320 Cathedral Street, #1 Baltimore, MD 21201
Aldene M. Ault, RN	Former Chief of Child Health Services in the Maternal and Child Health Division of Prince George's County Health Department (Nurse Home Visitor)	Prince George's County	medault@verizon.net	Work: 301-593-2438	600 Symphony Woods Road, Silver Spring, MD 20901
Jena K. Cochrane	Personal experience	Anne Arundel County	jena_geb@verizon.net	Work: 410-451-0149	1700 Basil Way, Gambrills, MD 21054
Robin Davenport	Executive Director, CASA of the Mid-Shore	Talbot, Dorchester, Queen Anne's	rd@casamidshore.org	Work: 410-822-2866	CASA of the Mid-Shore, Inc. 1 South

Name	Representing	Jurisdiction	Email	Phone	Address
		and Kent Counties		Ext. 1	Washington Street, #2 Easton, MD 21601-3029
Janice Goldwater, LCSW-C	Executive Director, Adoptions Together	Montgomery County	jgoldwater@adoptiontogether.org	Work: 301-422-5125	4061 Powder Mill Road Suite 320 Calverton, MD 20705
Pamela Holtzinger, RN	Forensic Nurse Examiner SAFE Program Coordinator Washington County Hospital	Washington County	cenfne@aol.com	Work: 301-790-8352	Frederick County Child Advocacy Center 520 North Market Street Frederick, MD 21701-5243
Wendy Lane, MD, MPH	Clinical Associate Professor, University of Maryland (Epidemiology & Public Health, Pediatrics)	Baltimore County	wlane@epi.umaryland.edu	Work: 410-706-7865	11 Paladia Way, Pikesville, MD 21208
Elizabeth Letourneau, PhD	Director, The Moore Center for the Prevention of Child Sexual Abuse, Johns Hopkins University, Bloomberg School of Public Health	Baltimore City	eletourn@jhsph.edu	Work: 410-955-9913	Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe Street Baltimore, MD 21205
Melissa Rock, Esq	Director, Child Welfare, Advocates for Children & Youth (ACY)	Baltimore City	mrock@acy.org	Work: 410-547-9200 Ext. 3024	Advocates for Children & Youth 1 North Charles St., Suite 2400 Baltimore, MD 21201
Adam C. Rosenberg, Esq.	Executive Director, Baltimore Child Abuse Center	Baltimore County	arosenberg@bcaci.org	Work: 410-396-6147	Baltimore Child Abuse Center 2300 N Charles St # 400

Name	Representing	Jurisdiction	Email	Phone	Address
					Baltimore, MD 21218-5158
Samantha Simpore	Personal experience, National Youth Advocate Behavior Specialist Social Emotional Counselor, Maya Angelou Public Charter School	Baltimore City	ssimpore@seeforever.org	Cell: 202-361-0487	9 Sulky Court, Apt. T3, Randallstown, MD 21133
Danitza Simpson	Director, Adelphi/Langley Family Support Center	Prince George's County	Dsimpson@pgcrc.org	Work: 301-431-6210 Ext. 1103	Adelphi/Langley Family Support Center 8908 Riggs Road Adelphi, Maryland 20783
Joan Stine	Former Director, Center for Health Promotion Maryland Department of Health and Mental Hygiene	Baltimore County	stinejg@yahoo.com	Cell: 443-690-5539	2614 Liter Court Ellicott City, MD 21042-1729
Margaret Williams	Executive Director, Maryland Family Network (Maryland's CBCAP lead agency)	Baltimore City	mwilliams@friendsofthefamily.org	Work: 410-659-7701 Ext. 121	Maryland Family Network 1001 Eastern Avenue, 2nd Floor Baltimore, MD 21202-4325

8 POSITIONS FILLED BY DESIGNATION OF THEIR ORGANIZATIONS

Name	Representing	Email	Phone	Address
Steven K. Berry	Manager, In-Home Services, Social Services Administration Maryland Department of Human Resources	Sberry@maryland.gov	Work: 410-767-7018	Maryland Department of Human Resources Social Services Administration,

Name	Representing	Email	Phone	Address
				5th Floor 311 W. Saratoga St. Baltimore, MD 21201
Karen Pilarski, Esq.	State's Attorney Association	kpilarski@baltimorecountymd.gov	Work: 410-887-6598	Baltimore County State's Attorneys Office 401 Bosley Avenue Towson, MD 21204-4420
Delegate Susan K.C. McComas	Maryland House of Delegates	susan_mccomas@house.state.md.us	Work: 410-841-3289	Maryland House of Delegates 9 West Courtland Street P.O. Box 1204 Bel Air, MD 21014
Ralph Jones	Director, Child Advocacy Unit, Maryland Department of Juvenile Services	Ralph.jones@maryland.gov	Work: 410-230-3126	Director - Hickey, Maryland Department of Juvenile Services Child Advocacy Unit One Center Plaza 120 W. Fayette St. Baltimore, MD 21201
VACANT	Representative of the Judicial Branch appointed by the Chief Judge of the Maryland Court of Appeals			
John McGinnis	Pupil Personnel Specialist, Maryland Department of Education	John.mcginnis@maryland.gov	Work: 410-767-0295	Pupil Personnel Specialist Maryland Department of Education

Name	Representing	Email	Phone	Address
				200 West Baltimore St. Baltimore, MD 21201
Deborah Badawi, MD	Medical Director, Office of Genetics & People with Special Health Care Needs, Bureau of Maternal & Child Health, Department of Health and Mental Hygiene	Deborah.badawi@maryland.gov	Work: 410-767-5592	Medical Director, Office of Genetics & People with Special Health Care Needs, Bureau of Maternal & Child Health, Department of Health and Mental Hygiene, 201 W. Preston Street Baltimore MD 21201
VACANT	Maryland Senate			

SCCAN EXECUTIVE DIRECTOR

Name	Relevant Background	Email	Phone	Address
Claudia Remington, Esq.	Attorney, Mediator and CASA volunteer	Claudia.remington@maryland.gov	Office: 410-767-7868 Cell: 410-336-3820	311 W. Saratoga Street, Room 934-A Baltimore, MD 21201

APPENDIX Q:

State Council on Child Abuse and Neglect (SCCAN)
By-Laws
As revised May 2011

I. BACKGROUND

A. Authorizing Legislation

The State Council on Child Abuse and Neglect (SCCAN), (formerly, the Governor's Council on Child Abuse and Neglect), was originally established on April 29, 1986 by Executive Order 01.01.1986.07 and amended by 01.01.1986.13. The Maryland Legislature established SCCAN as part of the Office for Children, Youth and Families for budgetary and administrative purposes in Family Law Article § 5-7A-01 through § 5-7A-09 in 1999. The Department of Human Resources assumed responsibility for budgetary and administrative support of SCCAN in early 2006. In addition, the Federal Child Abuse Protection and Treatment Act (CAPTA) requires each State to which a CAPTA grant is made to establish citizen review panels. SCCAN is one of three operating in the State of Maryland**.** The other two citizen review panels are the Citizens Review Board for Children and the State Child Fatality Review Team.

B. Purpose

The Council shall, by examining the policies and procedures of State and local agencies and specific cases that the Council considers necessary to perform its duties under this section, evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities (1).
The Council shall provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations (2).
The Council shall coordinate its activities under this section with the State Citizens Review Board for Children, local citizens review panels, and the child fatality review teams in order to avoid unnecessary duplication of effort (1).

II. ORGANIZATION STRUCTURE

A. Membership

1. The Council consists of *up to 23 members (1).* Members are persons either formally designated to SCCAN by their organizations or formally appointed to SCCAN by the Governor.

2. Fifteen members are appointed by the Governor and may *serve up to two consecutive 3-year terms. In case of a mid-term vacancy, the Governor shall appoint a successor for the remainder of the unexpired term (1).*
3. *The Governor shall select a chairperson from among members of the Council.* The Council may select a Vice-Chairperson to chair regular meetings in the absence of the Chair.
4. The Council may recommend to the Appointing Authority nominees for the Governor's appointment of new SCCAN members and the SCCAN Chair.
5. The remaining eight members are designated by their respective organizations and may *hold office so long as they hold the required designation (1).*

B. Committees

1. The Council operates with the following standing Committee described below:

> *The Federal Children's Justice Act Committee (CJAC) is established in accordance with the requirements of the Federal Children's Justice Act, Public Law 100-294. It shall review and evaluate state investigative, administrative and judicial handling of child abuse and neglect cases, and make policy and training recommendations to improve system response and intervention. The committee shall include representative of the State judiciary with criminal and civil trial court docket experience, law enforcement agencies, the Maryland Public Defender's Office, State's Attorney's, the Court Appointed Special Advocate (CASA) program, health and mental health professionals, child protective services program, programs that serve children with disabilities, parents groups, and attorneys who represent children (1).*

2. *The Council may establish Ad Hoc committees as necessary to carry out the work of the Council (1).*
3. The CJAC chairperson, or their designee, serves as a liaison and attends regular meetings of SCCAN.

III. DUTIES AND RESPONSIBILITIES

A. Council

1. *The Council shall report and make recommendations no less than annually to the Governor and the General Assembly on matters relating to the prevention, detection, assessment, prosecution and treatment of child abuse and neglect, including policy and training needs that require the attention and action of the Governor of the General Assembly (1).*
2. *The Council shall annually prepare and make available to the public a report containing a summary of its activities (1).*

3. *The Council may request that a local citizens review panel established under § 5-539.2 of this title conduct a review under this section and report its findings to the Council (1).*

4. *The Council shall coordinate its activities under this section with the State Citizens Review Board for Children, local citizens review panels, and the child fatality review teams in order to avoid unnecessary duplication of effort (1).*

B. Members

1. Council members are expected to attend scheduled meetings of the full Council, as required by state statute. (3) Members shall notify the Chair or Staff in advance of expected absence from scheduled meetings.
2. Council members who fail *to attend at least 50% of the* (regular) *meetings during any consecutive 12-month period shall be considered to have resigned. If the individual has been unable to attend meetings for reasons satisfactory to the Governor, the Governor may waive the resignation if the reasons are made public.* (3)
3. Council members are expected to fulfill consensus decision-making responsibilities of members listed under Section V below.
4. Council members are expected to serve on at least one standing or ad hoc committee of SCCAN.
5. Council members *may not disclose to any person or government official any identifying information about any specific child protection case about which the Council is provided information (1).*
6. As referenced in their appointment letters and in accordance with the Maryland Public Ethics Law, Council members must disclose for exemption any employment, professional relationships or other interests that may pose a conflict with their service on the Council.

C. Chair

1. The Chair, in coordination with the SCCAN Executive Director, shall develop the meeting agenda with input from the SCCAN members.
2. The Chair shall determine the site of the meetings until a permanent location is designated.
3. The Chair may invite special guests and presenters to regular meetings.
4. The Chair determines quorum.
5. The Chair leads, and, the Executive Director facilitates, each regular and special meeting of the Council.
6. The Chair may call a special meeting for important matters that need immediate attention and cannot wait for a regular meeting.
7. The Chair may direct assignments to SCCAN Committees, members and staff with instruction, guidance, assumptions and timeframes.

8. The Chair fulfills consensus decision-making responsibilities of the Chair listed under Section V below.
9. *The chairperson of the Council may designate members of the Children's Justice Act Committee as special members of the Council for the purpose of carrying out the duties set forth in this section (1).*

IV. MEETING PROTOCOLS

A. Regular Meetings

SCCAN shall hold regular meetings *not less than once every three months (1).*

B. Meeting Agenda

The order of business shall be as follows when the final agenda is approved:

1. Opening of the meeting
2. Approval of the meeting notes of the previous meeting.
3. Chair report and Committee reports
4. Special reports/presentations
5. Unfinished Business
6. New Business
7. Announcements
8. Adjourn

C. Meeting Notices

1. SCCAN meetings shall be scheduled and notice given to members as far in advance as possible. The Staff shall be responsible for issuance of the meeting notices and agenda for the next regular meeting not less than five working days before the scheduled meeting.
2. As a public body within State government, SCCAN is required to *"give reasonable advance notice of the session … by publication in the Maryland Register."* (4) SCCAN staff is responsible for reasonable advance notice.

D. Quorum

The quorum necessary to transact official business of the Council shall be no less than 50% of the members**.** Decisions made by members attending a regular meeting of SCCAN who constitute less than a quorum may be confirmed at the next regular meeting for which there is a quorum. In instances where more immediate action is required, the Chair may call for confirmation via an email response from members.

E. Meeting Notes

1. Staff shall be responsible for preparing meeting notes for SCCAN regular meetings and mailing the draft notes to SCCAN members within ten working days of the meeting.
2. SCCAN members should review the notes and communicate to staff within five working days any comments, additions or objections to that which is

recorded in the notes. Objections or conflicting opinions on the draft meeting notes shall be resolved at the next SCCAN meeting, or if necessary, by the Chair in the interim.

V. CONSENSUS DECISION MAKING (5)

A. Governing Interactions Between Participants

1. **Only one person will speak at a time**. And no one will interrupt when another person is speaking.
2. Each person agrees to candidly identify **the interests of the constituency she represents**.
3. Each person will **express his own views**, rather than speaking for others at the table or attributing motives to them.
4. Each person will **avoid grandstanding** (i.e., making extended comments or asking repeated questions), so that everyone has a fair chance to speak and to contribute.
5. **No one will make personal attacks**. Participants agree to challenge ideas, not people. If a personal attack is made the chair will ask the participants to refrain from personal attacks. If personal attacks continue, the Executive Director may ask the group to take a break to "cool off."
6. Each person will make every effort to **stay on track with the agenda** and to move the deliberations forward.
7. Each person will seek to **focus on the merits of what is being said**, making a good faith effort to understand the concerns of others. Clarifying questions are encouraged; rhetorical questions and disparaging comments are discouraged.
8. Each person will seek to follow a **"no surprises"** rule – voicing her concerns whenever they arise. In this way, no one will be taken off-guard late in the deliberations when someone suddenly raises an objection.
9. Each person will seek to **identify options or proposals that represent common ground**, without glossing over or minimizing legitimate disagreements. Each participant agrees to do his best to take account of the interests of the group as a whole.
10. Each person **reserves the right to disagree** with any proposal and **accepts responsibility for offering alternatives** that accommodates her interests as well as the interests of others.
11. Each person agrees to **keep the constituencies he or she represents informed** about the issues and options under discussion and to **seek their input and advice on any recommendations** that emerge.
12. Each person will **speak to the media about only his own views**. No member will speak on behalf of other participants or the group as a whole.

B. Governing Group Decision Making

1. Each person agrees to fully and consistently **participate in the process unless that person withdraws**. If participants are thinking of withdrawing, they agree to explain their reasons for doing so and to give the others a chance to accommodate their concerns.
2. **Consensus is reached** when the participants agree that they can "live with" the package being proponed. Some participants may not agree completely with every feature of the package as proposed, but they do not disagree enough to warrant opposition to the whole package.
3. The following scale will be used periodically by the chair to test whether consensus has been reached. **Using straw votes**, participants would express their level of comfort and commitment by indicating:
    a. Wholeheartedly agree
    b. Good idea
    c. Supportive
    d. Reservations – would like to talk
    e. Serious concerns – must talk
    f. Cannot be part of the decision – must block it
4. If the stakeholder **representatives cannot reach consensus**, they agree to document the agreements they have reached, clarify the reasons for disagreeing, and indicate how the remaining disagreements might be resolved.
5. The participants will consider their **"fallback" option if no agreement can be reached**, including mechanisms that provide incentives for the participants to continue trying to reach agreement. Fallback options include:
    a. identifying issues requiring further research and suspending deliberations until that research has been completed;
    b. agreeing to switch to a super-majority voting rule (e.g., something like a 75-percent or 80-percent majority would be required);
    c. seeking a recommendation from an independent expert regarding possible ways of resolving their remaining disagreements. This might provide a "reality check" that encourages one or more parties to come back to the table with more realistic expectations;
    d. including a minority report;
    e. letting an authorized decision maker impose a decision.

VI. OFFICIAL RECORD KEEPING

A. The Council shall keep official records of all its activities, including annual reports, conference files, minutes and reports of all meetings.

B. On behalf of the Council, the SCCAN Executive Director shall be the custodian of the files and records.

C. SCCAN shall keep records of all expenditures and revenues, regardless of source, that relate in accordance with a schedule to be developed pursuant to the Maryland Department of General Services Records Management Handbook (as revised January 1993).

VII. AMENDMENTS

These by-laws may be amended, at any meeting of the Council by a vote of not less than 2/3 of SCCAN members, provided that written notice of the proposed amendment and a copy of the amendment have been sent to all Council members at least five working days prior to the meeting. Provided that this written notice is met, and the quorum requirement cited in Section IV.D. is met, the amendment requirement of 2/3 may be met through email confirmation by members not in attendance.

References:

(1) Family Law Article § 5-7A-01 through § 5-7A-09

(2) Child Abuse Protection and Treatment Act, Title 42, Chapter 67, Subchapter I, § 5106a

(3) State Government Article § 8-501

(4) State Government Article § 10-506

(5) Excerpted from Lawrence E. Susskind and Jeffrey L. Cruikshank, Breaking Robert´s Rules, Appendix B (Oxford University Press 2006).

APPENDIX R:

STATE COUNCIL ON CHILD ABUSE AND NEGLECT
PUBLIC POLICY ADVOCACY GUIDELINES

I. GENERAL STATEMENT

In order to achieve its mission, SCCAN engages in advocacy activities, including public policy advocacy. SCCAN advocates policies, practices and programs that encourage our state policy makers to, in the words of our mission statement, "*promote the development and implementation of optimal strategies for detection, prevention, intervention and treatment of child abuse and neglect, and . . . encourage all Marylanders to become involved in efforts to ensure the well-being and safety of children.*"

SCCAN is an advisory body to the Governor and Legislature and consists of up to twenty-three members, most of whom are private citizens appointed by the Governor of Maryland. Members are representatives of professional and advocacy groups, private social service agencies, and the medical, law enforcement, education, and religious communities. At least two members have personal experience with child abuse and neglect within their own families or have been clients of the child protective services system. Nine members of SCCAN are designated representatives of their respective organizations including the Maryland Senate, Maryland House of Delegates, Department of Human Resources, Department of Health and Mental Hygiene, Department of Education, Department of Juvenile Services, Judicial Branch, State's Attorneys' Association and Maryland Chapter of the American Academy of Pediatrics.

As an advisory body, SCCAN follows Council and Commission Legislative Protocol set out in Office of the Attorney General Opinions. SCCAN does not support or oppose candidates for public office or political parties and only acts on issues related to SCCAN's federal and state mandates and its current public policy framework. SCCAN works with both political parties in making and implementing public policy and in all legislative matters.

Perhaps the most valuable role SCCAN plays in the public policy arena is as expert advisor to the Governor and Legislature.

Public policy positions will be taken only after thorough deliberation and open dialogue among SCCAN members, who must reach consensus on any position taken. SCCAN therefore will not take action on new issues that need a response within a short time frame.

II. CRITERIA FOR PUBLIC POLICY POSITIONS

SCCAN will take positions on public policy issues that meet at least one of these criteria:

A. Affects SCCAN's ability to work toward its mission *and* falls under the current priority issue(s);

B. Affects SCCAN's budget and staffing.

III. PROCESS TO DETERMINE POSITIONS ON PUBLIC POLICY ISSUES

A. In July of each year, SCCAN's Executive Director will survey the membership of the Council to develop a list of suggested public policy priorities for the upcoming legislative Session. Members wishing to propose a public policy priority will complete the SCCAN Annual Report Findings & Recommendations form and provide information about the issue, known supporters and opponents of the recommendation, and arguments for and against it. Based on input that will be solicited from members, partners, and stakeholders, the Executive Committee will identify "priority issues" with recommendations and rank them in order of importance. These priority issues will be submitted to the Council at its September meeting for members' consideration. There must be a consensus of the Council to adopt the recommended issues and their priorities. What is approved becomes SCCAN's public policy agenda for the upcoming Session.

B. All advocacy activities must align with SCCAN's current strategic direction. Decisions made by the Council will take into consideration SCCAN's available resources, including knowledge, skills, and infrastructure for engagement in public policy advocacy. If SCCAN takes on an issue, it wants to be successful, realizing that effective public policy advocacy builds respect and credibility among policy makers and other stakeholders, including the public.

C. In addition to the annual process of priority issue identification by all Council members, members of SCCAN's Executive Committee, who are appointed by the Council Chair, may at any time identify issues of interest or concern and determine if such issues should become subjects for advocacy by SCCAN. A majority of Executive Committee members is needed to include a specific issue as a "priority issue."

D. Only the Council Chair and/or the Executive Director may speak or take action on public policy issues -- local, state, or federal -- on behalf of SCCAN.

E. The Executive Director will organize and facilitate communication among all parties in SCCAN's public policy advocacy work.

IV. PARTICIPATION IN COALITIONS

A. SCCAN may work with coalitions such as the Coalition to Protect Maryland's Children in pursuit of its policy agenda. This is often an effective advocacy strategy.

B. SCCAN may take part in the advocacy work of a coalition, association, network, or governmental agency provided the work is not in conflict with SCCAN's mission and current public policy priorities.

STATE COUNCIL ON CHILD ABUSE AND NEGLECT

SCCAN PROCESS FOR DEVELOPING ANNUAL REPORT FINDINGS AND RECOMMENDATIONS

1. Anyone can propose a **FINDING** for consideration by SCCAN and/or its Committees. This includes Council members, staff, and members of the public. For the sake of consistency this should be done using the attached template to document a proposed Finding, and to provide a short background statement and factual basis to support and/or justify the proposed Finding.

2. Findings should be submitted electronically to Council staff (cremingt@dhr.state.md.us) so that they may be logged in for tracking purposes, and assigned to the appropriate committee for consideration.

3. If a majority of the committee agrees to consider a proposed Finding, the committee should develop one or more **RECOMMENDATION(S)** for consideration by the full Council for forwarding to the Governor and General Assembly in the SCCAN Annual Report, including an analysis of the potential impacts of implementing the Recommendation(s).

4. The committees are responsible for identifying Findings and forwarding proposed Recommendations to the full Council. They may also choose to assign working groups, committee members, and/or staff, with Council Member input, to develop the impact analysis of implementing Recommendations. (Please see the attached Findings and Recommendations.)

5. Findings and Recommendations are submitted to the Governor and General Assembly on a calendar year. Proposed Findings and Recommendations should be received no later than December 1st to allow time for Council consideration and inclusion in the report of that calendar year.

STATE COUNCIL ON CHILD ABUSE AND NEGLECT

Date Received:
Submitted by:
Forwarded to:
Process and Template Approval Date:

FINDING AND RECOMMENDATION(S)

Submitted by:_____

Finding: (*Please describe conclusions reached after investigation and/or evaluation of the facts*)

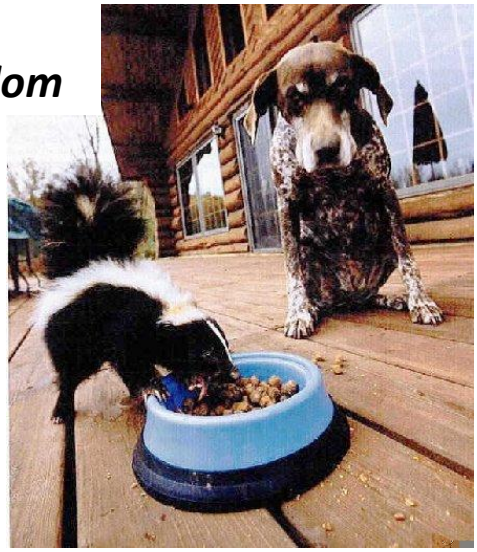
Background and Supporting Evidence: *(A short statement justifying the Finding and describing desired outcome(s); usually no more than half a page.)*

Recommendation(s) *(Based upon an analysis of the Finding, the following recommendation(s) should be made to the Governor and General Assembly):*

Impacts of Implementation: *(The implementation of any Recommendation is likely to have specific impacts. Consider potential consequences related to each of the following areas)***:**

Analysis of impacts on the following factors is REQUIRED (Best Estimate):
☐ Cost
☐ Funding source
☐ Staffing
☐ Existing regulations and/or laws
Analysis of impacts on the following factors is OPTIONAL:
☐ Operational
☐ Social
☐ Political
☐ Policy
☐ Health and Safety
☐ Environmental
☐ Interagency

Two of the greatest virtues in life are patience and wisdom



The Council recognizes the importance of patience and wisdom in catalyzing systems and social norms changes necessary to effectively promote safe, stable and nurturing relationships and environments for children and families, prevent ACEs before they occur, and build resilient children, families and communities. As we are passionate about the need for these significant changes, we persistently pursue our goal: proactive and connected systems that together use the best science, policies and practices available to promote child well-being, to strengthen families and communities; and, to prevent child maltreatment and other ACEs before they occur.