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, 2017 – DECEMBER 31, 2017

ACKNOWLEDGMENTS

With tremendous gratitude, we acknowledge the many individuals and organizations who share their time, experience, expertise and passion for 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, Wendy Lane and Maryland Essentials for Childhood (EFC) Committee Chair, Joan Stine for their leadership.

- Council Member agencies for dedicating staff time and expertise to the important work of the Council and Maryland Essentials for Childhood.

- The Family Tree Board, with special thanks to Presidents, Jeanne Aarsand and Charles Roebuck, for funding the ACE Interface Project & hosting the ACE Interface Reception for policy makers to ensure that Maryland becomes a Brain Science-Informed State.

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- The Maryland policy makers and leaders in business, faith-based, and philanthropic communities who attended the ACE Interface Reception to learn about and support brain science, ACEs, and resilience education in Maryland, including: Delegates Adrienne Jones, CT Wilson, and Mary Washington; Secretary of DHS, Lourdes Padilla, and Secretary of State John Wobensmith; Dr. Nancy Grasmick; The Honorable Anne Albright, William Tucker and David W. Young; Executive Directors, Clay Stamp, Opioid Operational Command Center, Glenn Fueston, GOCCP, and, Rebecca Jones Gaston, DHS, SSA; Dr. Michael Ito and Betsy Tolentino, DJS; Donna Gugel and Clifford Mitchell, MDH; Major William Davis, and Captain Jim Eyler; Brian Duley, Donald Fry, Tricia Issenock, Andrew Michael, and Dr. Mohan Suntha; Nicole P. Glick, Jen Grossman, and Betsy Patcher; Stephanie Adler, Franklyn Baker, Mary Jean Herron, Brooke Hisle, Karen Kreisberg, Betsy Krieger, Dr. John Meyerhoff, Tom O'Neil, Rachel Rueben, Betsy and George Sherman, Missy Sinwell Smith, and Xandy Waesche; as well as, many other partners who made the evening a huge success.

- Secretary of DHS, Lourdes Padilla for her leadership in procuring copies of the documentary *Resilience: The Biology of Stress and the Science of Hope* to share with policy makers; and, for screening the film for her Executive Leadership Team.

- Governor's Office of Crime Control and Prevention, Executive Director, Glenn Fueston, for providing an opportunity for Child Advocacy Centers (CACs) to view *Resilience* and providing grant funding opportunities for CACs developing ACEs Initiatives throughout the state.

- Executive Director, Rebecca Jones Gaston for sharing the film *Resilience* at SSA Regional Supervisory Meetings throughout the state; and providing a copy to each local DSS and two copies for the use of the Maryland Foster Care Court Improvement Project.

- The ACE Interface Master Trainer Cohort: Dorinda Adams, MSW, LGSW, M. Saida Agostini, Ulysses Archie, Jr., Delegate Vanessa Atterbeary, Christina Bethell, PhD, Wendy C. Blackwell, Pamela M. Brown, PhD, Kay Connors, LCSW-C, Patricia Cronin, LCSW-C, Robin Davenport, Amber Guthrie, Joyce Harrison, MD, David Humphries, Lauren Jenkins, Frank Kros, MSW, JD, Naketta Lowery, CFLE, COS, Sarah Manekin, Lt. Veto Mentzell, Cathy Meyers, LCPC, Deborah Nelson, PhD, NCSP, Ruby Parker, Kathy Powderly, Claudia Remington, JD, Steve Rohde, Diane Shannon, LCSW-C, Teresa Simmons, MSW, LCSW-C, Joan Stine, MHS, MS, Honorable William Tucker, D'Lisa Worthy, M.Ed, and Steven Youngblood, LCSW-C.

- Pat Cronin, Executive Director of The Family Tree, her staff, and Board of Directors for co-backbone support, with SCCAN, of the Maryland Essentials for Childhood Initiative.

- Delegate CT Wilson for sponsoring and tirelessly advocating for three bills (HB 1072, HB 1571 & HB 1582) based on SCCAN's recommendations.

- Jetta Bernier, the Executive Director of MASS Kids, founder of the Enough Abuse Campaign, and author of the valuable resource: State and Federal Legislative Efforts to Prevent Child Sexual Abuse: A Status Report for her continued support of child sexual abuse prevention efforts in Maryland.ve.

- Wendy Lane, MD, MPH, 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 Medical Director Legislation Workgroup.

- Medical Director Legislative Workgroup: Wendy Lane, Mitch Mirviss, Denise Wheeler, Rachel Dodge, Irnande Altema, Erica LeMon, Rebecca Seltzer, Erik Weber, Liz Oppenheim, Rachel White, Rowan Powell, Jamie Shepard, Kevin Keegan, and Joan Stine.

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- Child Sexual Abuse Prevention Legislative Workgroup: Elizabeth Letourneau, Jennifer Alvaro, Rowan Powell, Rachel White, Joyce Lombardi, Joan Stine, Liz Oppenheim, Stephanie Neal, Rebecca Fix, Janis Sartucci, Kevin Keegan, and Wendy Lane.

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- Maryland Child Abuse & Neglect Fatality (MCANF) Workgroup: Rich Lichenstein, Wendy Lane, Cathy Costa, Vernice McKee, Joan Stine, Melissa Rock, Veto Mentzell, Hillary Shankman, Denise Wheeler, Pam Dorsey, Cathy Meyers, Ed Kilcullen, Jennifer Herrera, and Claudia Remington.

- Maryland Essential for Childhood Workgroup Chairs: Pat Cronin, Claudia Remington, Kay Connors, D'Lisa Worthy, Diane Banchiere, Joan Stine, Melissa Rock, Cathy Costa and Wendy Lane.

- Maryland ACEs Connection Community Managers, Erik Weber, Ruby Parker, Ros Williams, Genevieve Polk, and Claudia Remington

- The many other partners, stakeholders and citizens who contribute to moving SCCAN recommendations and Maryland Essentials for Childhood efforts forward.

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State Council on Child Abuse and Neglect (SCCAN)
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June 18, 2018

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 2017

Dear Governor Hogan, President Miller and Speaker Busch:

I would like to begin with a heartfelt word of thanks for your support of several State Council on Child Abuse and Neglect (SCCAN) legislative initiatives during the 2018 Maryland State legislative session. With your support, two bills strongly recommended by SCCAN passed unanimously in both the Maryland State Senate and House of Representatives. HB 1582 will require a Medical Director for Child Welfare to be hired by the Department of Human Services. It will also require the development of an electronic health passport to enable better sharing for health information for children placed in foster care. HB 1072 will require that all school personnel receive education on preventing and identifying child sexual abuse, including identifying grooming behavior toward children. Both of these bills will help ensure the health, safety, and wellbeing of Maryland children.

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"*

As the SCCAN mandates are quite broad, the Council must choose priorities on which to focus each year. For 2017, we have chosen to focus on the primary prevention of child maltreatment, health care for children involved in the child welfare system, and child abuse and neglect fatalities. On pages 52-62, 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 Adverse Childhood Experiences (ACEs) *from occurring*. Specific recommendations are made to prioritize prevention of ACEs, coordinate the work of child and family serving systems, pass comprehensive child sexual abuse prevention legislation, prevent child abuse and neglect fatalities, and improve health care for children involved in child welfare. As you read through the Council's report and recommendations, I hope you will see our deep commitment to the healthy growth and 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 children ---their parents, their families, their communities and their state.

Sincerely,

Wendy Lane, MD, MPH,
SCCAN Chair

cc: DHS Secretary Lourdes R. Padilla
MDH Secretary Robert R. Neall
DJS Secretary Sam Abed
MSDE State Superintendent of Schools, Dr. Karen B. Salmon, PhD
MDD Secretary Carol A. Beatty
DBM Secretary David R. Brinkley
DPSCS Secretary Stephen T. Moyer
DLLR Secretary Kelly M. Schulz
Children's Cabinet & Governor's Office for Children, Jaclin Warren Wiggins, Acting Chair and Executive Director
Governor's Office of Crime Control & Prevention, V. Glenn Fueston, Jr., Executive Director
SCCAN Members

Executive Summary

SCCAN's 2017 Annual Report to the Governor and General Assembly provides a framework for a seismic shift in how we as a state address child abuse and neglect, along with related adverse childhood experiences (ACEs). Child physical, sexual, and emotional abuse and child neglect are traditional foci; to these more obvious forms of abuse, we now add other adverse events shown to disrupt the healthy development of children, including family dysfunction, parental mental illness, parental substance abuse, domestic violence, parental incarceration, divorce and separation, experiencing racism, witnessing violence, living in an unsafe neighborhood, living in foster care, and peer violence and bullying. Individually and particularly when experienced in combination, these ACES lead to poor child health and educational outcomes and also reduce public safety and economic productivity *at an immense cost to children and taxpayers.* We support Governor Hogan's vision of economic opportunity for all of Maryland's children, youth, and families and urge him and the General Assembly to develop and refine policy in ways that leverage the exciting advances in the science of the developing brain, ACEs, and Resilience to reach that vision.

SCCAN's recommendations set out specific policies, strategies, and training that build the individual and collective knowledge and skills of Marylanders in our child and family serving agencies and communities to provide the safe, stable and nurturing relationships and environments that children need to grow into healthy and productive citizens. In responding to feedback on prior SCCAN reports, some recommendations are addressed specifically to the Governor, the General Assembly or one or multiple child and family serving agencies. At the same time, implementation of many of these recommendations will require leadership support and the hard but attainable work of collaboration and coordination across child and adult serving agencies that strive now more than ever to integrate themselves and their missions toward this shared vision.

Building infrastructure to disseminate the science and support collective statewide and community efforts is essential. SCCAN facilitated Maryland's participation in the U.S. Centers for Disease Control's Essentials for Childhood (EFC) Framework Statewide Implementation technical assistance program. The Essentials for Childhood program is helping us find ways to promote relationships and environments that help children grow up to be healthy and productive citizens so that *they*, in turn, can build stronger and safer families and communities for *their* children (a two generation approach). Maryland Essentials for Childhood includes public and private partners from across the state; and, receives technical assistance from the U.S. Centers for Disease Control. Participating in this program allows Maryland to learn from national experts and leading states. When people learn the brain science and ACEs, they understand the interconnection of many of the social problems that confront our state; and, begin learning and working together to innovatively solve these problems. SCCAN's Annual Report includes the following:

- A brief background of SCCAN's mandate, focus, and efforts
- An overview of the science of the developing brain, ACEs, and theories about resilience
- A discussion of Maryland data on the magnitude of the problem
- SCCAN & Maryland EFC 2017 Actions & Accomplishments toward Four Strategic Goals
- A description of how brain science can serve as a strong foundation for Governor Hogan's vision of economic opportunity, human capital development, and self-sufficiency, as well as a streamlined and efficient state government that supports the frontline work in local communities and ensures excellent customer service.
- Recommendations to the Governor, General Assembly and Agencies

Key Recommendations for the Governor, General Assembly, and Agencies[1]:

1. Take meaningful action to raise awareness of brain science, adverse childhood experiences (ACEs) and resilience and build community commitment to prevent, reduce and respond to ACEs by launching an ACEs Initiative similar to Governor Bill Haslam's Building Strong Brains Tennessee's ACEs Initiative or First Lady Tonette Walker's Fostering Futures in Wisconsin.

2. Review Maryland's 2015 baseline ACE Module Behavioral Risk Factor Surveillance System (BRFSS) data (pp. 21-35 below); continue to collect BRFSS ACE data every three years; and, collect resilience data, as is being done in Wisconsin, beginning in 2018 in order to understand the magnitude of this public health epidemic and to begin to reduce the numbers and impact of ACEs.

3. Embed Brain Science, ACEs, and Resilience into the Children's Cabinet Three-Year Plan. Start by providing ACE training to all Children's Cabinet members. When creating future plans, consider how each recommendation might reduce ACEs or the effects of ACEs, and how it might improve resilience.

4. Offer free screenings and time to view the film *RESILIENCE: The Biology of Stress & The Science of Hope* to introduce staff from all state agencies to the Brain Science, ACEs and Resilience and trauma-informed systems. Provide opportunity for dialogue on how it might be used to provide better customer service within child and family serving agencies.

6. As level II of the Governor's G.O.L.D. Standard Customer Service Training Initiative, offer ACEs Interface trainings (brain science, ACEs, resilience) to all state employees who work with the public; begin with leadership and supervisors.

7. Explore ways to increase awareness of the brain science and the impact of ACEs on the people your agency serves. Integrate the science into agency and cross agency work by:
   - Partnering in Maryland Essentials for Childhood Initiative to ensure cross-agency coordination.
   - Screening clients for ACEs and resilience factors
   - Providing pre-service and in-service training to all staff on brain science, ACEs and resilience
   - Identifying a standard of care that includes assessing for and responding to ACEs, to be integrated into contracts as performance measures
   - Embedding the science into strategic planning with local agencies and connect to funding
   - Ensuring organizational policies and regulations reflect the science
   - Ensuring practice models reflect the science
   - Investing resources in evidence-based trauma interventions; and, creating a trauma-informed agency
   - Using communication efforts to connect the dots between state child and family serving programs as a response to the science. Developing an umbrella message and integrating it into messaging across agencies and programs, including websites and press releases regarding child and family serving policies and programs.

8. Require state and local child and youth serving agencies and child and youth serving organizations receiving state funding to institute Comprehensive Child Sexual Abuse training, policies and guidelines.

9. Establish an ongoing Child Welfare Health Coordination Expert Panel led by the Child Welfare Medical Director to ensure communication and coordination between the multiple agencies that provide health services to children with the child welfare system.

[1] A comprehensive list of SCCAN Recommendations by Agent/Agency begins at page 52-62.

Background

SCCAN has its historical origins in the 1983 Governor's Task Force on Child Abuse and Neglect, appointed at the request of the General Assembly. The Task Force "found that child abuse, especially sexual abuse was far more widespread than originally estimated; [and,] the problems of child abuse and neglect require long term efforts for the implementation and monitoring of programs for the prevention, detection, and treatment of victims and offenders." In light of the task force findings, on April 29, 1986, the task force became the Governor's Council on Child Abuse and Neglect created by Executive Order. In 1999, the Maryland General Assembly established The State Council on Child Abuse and Neglect as one of three citizen review panels[2] required by the Federal Child Abuse Prevention and Treatment Act (Title 42, Chapter 67, Subchapter I), known familiarly as CAPTA, and elaborated on its Federal responsibilities in the Maryland Family Law Article, Section 5-7A.

SCCAN consists of up to twenty-three members, most of whom are private citizens appointed by the Governor of Maryland, including representatives from the Maryland Chapter of the American Academy of Pediatrics, 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. Eight members of SCCAN are designated representatives of their respective organizations including the Maryland Senate, Maryland House of Delegates, Department of Human Services, Department of Health, Department of Education, Department of Juvenile Services, Judicial Branch, and the State's Attorneys' Association.[3]

SCCAN's mandate 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"* [4]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*."[5] 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".*[6]

Prevention as a priority

For several years now, the Council has focused its research, advocacy and collective energies on activities to raise awareness of the science of the developing brain and adverse childhood experiences (ACEs) and build cross-sector collaboration to advocate for systems reform to promote child well-being and prevent child maltreatment and other adverse childhood experiences (ACEs) *before they occur*. The profound impact that child maltreatment and other (ACEs) have on a child's well-being-- including short and long-term health, behavior and development; school success; future employment and earning potential; ability to form positive, lasting relationships and become productive

[2] The other panels are the Citizens' Review Board for Children and the State Child Fatality Review Team.
[3] See Appendix D for current members.
[4] Section 5016a (c) (4) (A)
[5] Section 5016a (c) (4) (C)
[6] Section 5-7-09A (a)

citizens-- is well documented. Historically, most national, state and local funding streams and responses to the problem of child maltreatment are directed at a case-by-case approach to detecting, investigating, prosecuting and providing CPS or court supervised services to the "perpetrators" of abuse and neglect; and, to protecting children who have already been abused or neglected from future abuse and neglect by providing services to families or placing children in foster care. In describing our current "casework approach" and "criminal justice approach" to solving the problem of child maltreatment and other ACEs (parental: substance abuse, mental illness, domestic violence, separation/divorce, and incarceration), one of the principal investigators of the Adverse Childhood Experiences Study (ACEs), Robert Anda, MD aptly noted that:

> "Our society has treated the abuse, maltreatment, violence, and chaotic experiences of our children as an oddity that is adequately dealt with by emergency response systems—child protective services, criminal justice, foster care, and alternative schools—to name a few. These services are needed and are worthy of support—but they are a dressing on a greater wound. [We continue to buy] into a set of misconceptions. Here are a few: *[Child maltreatment and other] ACEs are rare and they happen somewhere else. They are perpetrated by monsters. Some, or maybe most, children can escape unscathed, or if not, they can be rescued and healed by emergency response systems. Then these children vanish from view… and randomly reappear—as if they are new entities*—in all of [our] service systems later in childhood, adolescence, and adulthood as clients with behavioral, learning, social, criminal, and chronic health problems."

A broader public health approach is needed to prevent child maltreatment *before it occurs.* The public health approach extends our criminal justice and case-based approaches by fostering a better understanding of the complex causes of child maltreatment in order to more effectively and pre-emptively intervene at all levels of the socio-ecological model (individual, family, community and societal). Current prevention programs, policies and practices in Maryland are fragmented across public and private agencies; and, vary both qualitatively and quantitatively from jurisdiction to jurisdiction. While many states, including Tennessee, Wisconsin, Iowa, Minnesota, Washington, Colorado, California, North Carolina, Massachusetts, among others are developing a coordinated approach to addressing childhood adversity and its impacts, **Maryland has no state agency that is specifically mandated to focus on primary prevention of child maltreatment. With the absence of mandated leadership, there is no formal cross-sector statewide strategy for promoting child well-being and preventing child maltreatment and other ACEs *before they occur*; and, current prevention efforts are fragmented across agencies.** That is why SCCAN and its partners joined together to form Maryland Essentials for Childhood Initiative, a statewide collective impact[7] initiative that promotes safe, stable, nurturing relationships and environments for children and prevents, mitigates ACEs, and builds resilience in children, families and communities.

[7] Channeling Change: Making Collective Impact Work, Stanford Social Innovation Review, https://ssir.org/articles/entry/channeling_change_making_collective_impact_work

THE SCIENCE OF THE DEVELOPING BRAIN, ACEs & RESILIENCE: A Strong Case for a Prosperous Maryland[7]

1. Healthy Development Builds a Strong Foundation – For Kids and For Society

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. When Maryland invests wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship.

2. Experiences Build Brain Architecture

Fortunately, what our children need is not a mystery. Recent advances in the science of early childhood development tell us that the basic architecture of the human brain is constructed through an ongoing process that begins before birth and continues into adulthood. Like the construction of a home, the building process begins with laying the foundation, framing the rooms and wiring the electrical system in a predictable sequence. Early experiences literally shape how the brain gets built, establishing either a sturdy or a fragile foundation for all of the learning, health and behavior that follows. A strong foundation in the early years increases the probability of positive outcomes. A weak foundation increases the odds of later difficulties. Getting things right early on is easier than trying to fix them later.

3. Serve & Return Interactions Shape Brain Circuitry

The interactive influences of genes and experience shape the developing brain. The active ingredient is the "serve and return" relationships children have with their parents and other caregivers in their family or community. Like the process of serve and return in games such as tennis and volleyball, young children naturally reach out for interaction. This process starts in infancy – with facial expressions and babbling-- and continues throughout the early years. If adults do not respond with the same kind of vocalizing and gesturing back to them-- or if the responses are unreliable or inappropriate-- the brain's architecture does not form as expected. This has negative implications for later learning and behavior. But when children develop in an environment of relationships that are richly responsive, with back-and-forth interactions, these brain-building experiences establish a sturdy architecture on which future learning is built.

4. Brains are Built from the Bottom Up, Skills Beget Skills

Just as a rope needs every strand to be strong and flexible, child development requires support and experiences that weave cognitive, emotional, and social capacities together. These capacities are inextricably intertwined throughout the life course. Emotional well-being and social competence provide a strong foundation for budding cognitive abilities, and together they comprise the foundation, the bricks and mortar, of human development. Science therefore directs us away from debating which capacities children need most, and toward the realization that they are all intertwined.

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[7] The common language used in this section comes from a combination of sources: Harvard Center for the Developing Child, Frameworks Institute, CDC Essentials for Childhood and Tennessee's Building Strong Brains: ACEs Initiative.

5. The Biology of Toxic Stress or Adverse Childhood Experiences (ACEs) Derails Healthy Development

Toxic stress or chronic, unrelenting stress in early childhood derails development by permanently setting the body's stress response system in high alert, weakening brain architecture, and impairing the development of all-important executive function skills. In the absence of the buffering protection of adult support, toxic stress becomes built into the body by processes that shape the architecture of the developing brain. These changes can lead to lifelong difficulties in learning, behavior, and physical and mental health.

6. Positive Stress Aids Healthy Development, Toxic Stress Impedes It

Learning to deal with stress is an important part of healthy development. Challenges, like learning to tie their shoes or to get along with new people or in new environments, set off a temporary stress response that helps children be more alert while learning new skills. But truly adverse childhood experiences – severely negative experiences such as the loss of a parent through illness, death or incarceration; the experience of abuse or neglect; or witnessing violence – – can lead to a toxic stress response in which the body's stress systems go on "high alert" and stay there. This haywire stress response releases harmful chemicals into the brain that impair cell growth and make it harder for neurons to form healthy connections, damage the brain's developing architecture and increase the probability of poor outcomes. This exaggerated stress response also affects health, and is linked to chronic physical diseases such as heart disease and diabetes.

7. The Presence of Responsive Adults at Home & in the Community Lessens the Impact of Toxic Stress

Science tells us that many children's futures are undermined when stress damages the early brain architecture. But the good news is that potentially toxic stressors can be made tolerable if children have access to stable, responsive adults – home visitors, child care providers, teachers, coaches, mentors. The presence of good serve-and-return acts as a physical buffer that lessens the biological impact of severe stress.

Communities play a big role in supporting a child's healthy development and buffering the impact of abuse, neglect, or other ACEs. A child's wellbeing is like a scale with two sides; one end can get loaded with positive experiences, while the other end can get loaded with negative experiences. Supportive relationships with adults, sound nutrition and quality early learning are all stacked on the positive side. Stressors such as abuse, witnessing violence, neglect or other forms of toxic stress are stacked on the other. This dynamic system shows us two ways we can achieve positive child outcomes: to tip to the positive side, we can pile on the positive experiences, or we can offload (or prevent) weights from the negative side. Children who have experienced several ACEs are carrying a heavy negative load. Innovative states and communities design high-quality programs for children to prevent Adverse Childhood Experiences from occurring in the first place and to effectively respond to adverse events with strong, nurturing supports to ameliorate their impacts when they can't be prevented. These programs have solved problems in early childhood development and shown significant long-term improvement for children.

8. Childhood Experiences Build the Foundation for a Skilled Workforce, a Responsible Community & a Thriving Economy: Executive Function & Self-Regulation Skills are Critical for Learning & for Life

Science has identified a set of skills that are essential for school achievement, for positive behavior, for good relationships, for preparation and adaptability of our future workforce, and for avoiding a wide range of health and relational problems. In the brain, the ability to hold onto and work with information, focus thinking, filter distractions, and switch gears is like an air traffic control system to manage the arrivals and departures of dozens of planes on multiple runways. Scientists refer to these capabilities as executive function and self-regulation—a set of skills that relies on three types of brain function: working memory, mental flexibility, and self-control.

9. These Essential "Air Traffic Control Skills" are Built in Relationships and the Place in which Children Live, Learn, and Play

Children are not born with these skills; they are born with the ability to develop them. These skills begin to develop in early childhood and mature through early adulthood. The quality of interactions and experiences provided in our families and communities either strengthens or undermines these budding skills.

10. Rethinking Our Policies

As Marylanders understand the impact of Adverse Childhood Experiences, they will realize that the future economic development and prosperity of the state depends on rethinking our policies in health, education, public safety, justice, public assistance, child welfare, and juvenile justice. To bring about population level change for children facing adversity and stem the tide of ever-more-costly social problems, focusing on building healthy brain architecture for every child and coordinating our efforts across all our child and family serving systems will prove to be key. We should focus on preventing these ACEs whenever possible; and, on wrapping services around children, families, and communities when they can't be prevented. This requires strong collaboration across disciplines, departments, agencies and communities, with a focus on the infrastructure of services and supports that make a difference. With coordinated efforts focused on related topics including child abuse and domestic violence prevention, home visiting, mental health and substance abuse services for parents, and a variety of other early intervention services and supports we can achieve a comprehensive and transformative preventive system that improves child development. This kind of sound investment in our society's future is confirmed by brain science. It improves outcomes for children now, and is a significant foundation for solutions to many of the long-standing and nagging challenges we face as a state in our health, mental health, social services, child protection, and juvenile and criminal justice systems.

All children and parents (especially those with high ACE scores) need someone in their corner. The shift from "What is wrong with you, or why are you a problem?" to "What has happened to you, and how can we support you and help you heal from these experiences?" will result in a more effective, more empathetic service delivery system and a healthier, socially and economically stronger Maryland.

Magnitude of the Problem in Maryland

Important to addressing any problem is understanding of its scope. There is considerable need for improvement in providing comprehensive data and analysis of childhood adversity for both individual case determinations and systems improvement decision-making. In 2016, the Council and its' partners supported the Governor's supplemental budget request to create a shared services platform into which all the human service agencies could integrate their data systems. The proposal also provided for replacing the three legacy data systems within DHS – CARES (for public assistance); CSES (for child support enforcement); and MD CHESSIE (for child welfare). The Council and partners are hopeful that this ground-breaking project, MD THINK, will bring needed accuracy, efficiency, data analysis capabilities, and tracking of critical outcomes for children across child and family serving agencies. Many key data points are either not regularly and systematically collected or are not readily accessible; and, therefore not analyzed (e.g., ACEs of children involved in child welfare: parental substance abuse, parental incarceration, parental mental illness within child welfare). *We hope that MD THINK will provide critical technology to give us a clearer picture of not only how well children are doing within the child welfare system, but how those same children and families are faring in sister child and adult serving systems and across Maryland.*

CPS reports are known to underestimate the true occurrence of maltreatment. Non-CPS studies estimate that 1 in 4 U.S. children experience some form of child maltreatment in their lifetimes.[8] It is important to look at multiple sources of data to understand the true scope of the problem. To give the reader some perspective on the problem in Maryland, the Council considers data from two Maryland sources below: Maryland CPS Data (incidence) and Behavioral Risk Factor Surveillance System ACE Module data (retrospective prevalence).

CHILD WELFARE DATA, CHILD ABUSE AND NEGLECT REPORTS, PATHWAYS & SERVICES PROVISION:

Figure A below illustrates the number of referrals (alleging suspected maltreatment), reports (screened-in referrals), their pathways (investigation or alternative response, risk of harm), dispositions, and service provision.

- During FFY 2016, DHS, SSA received 49,919 referrals of suspected child abuse or neglect. Of those, 21,152 reports (involving 30,972 children) were referred for a CPS response.
- During FFY 2016, 13,637 investigations were completed. Of this total, 3,811 (27.94%) were indicated for abuse or neglect. The 3,811 indicated referrals represent 7.42% of the total abuse and neglect reports. Once there is an indicated referral, children are considered victims of child abuse/neglect.
- 18,740 reports (36.5% of total reports) received an alternative response.
- Data was not readily available to indicate what, if any, services were offered to and

[8] Finkelhor D, Turner HA, Ormond R, Hamby SL. Violence, crime, and abuse exposure in a national sample of children and youth: an update. JAMA Pediatr 2013; 167(7):614-621. doi:10.1001/ jamapediatrics.2013.42.

accepted by children and their families. This is unfortunate as many of the children referred to child welfare experience significant risk factors (multiple types of maltreatment, parental mental illness, substance abuse, incarceration, domestic violence) that result in poor short and long-term outcomes. ***It is unclear from available data the extent to which children and families are not only referred for services, but linked and provided those services.***

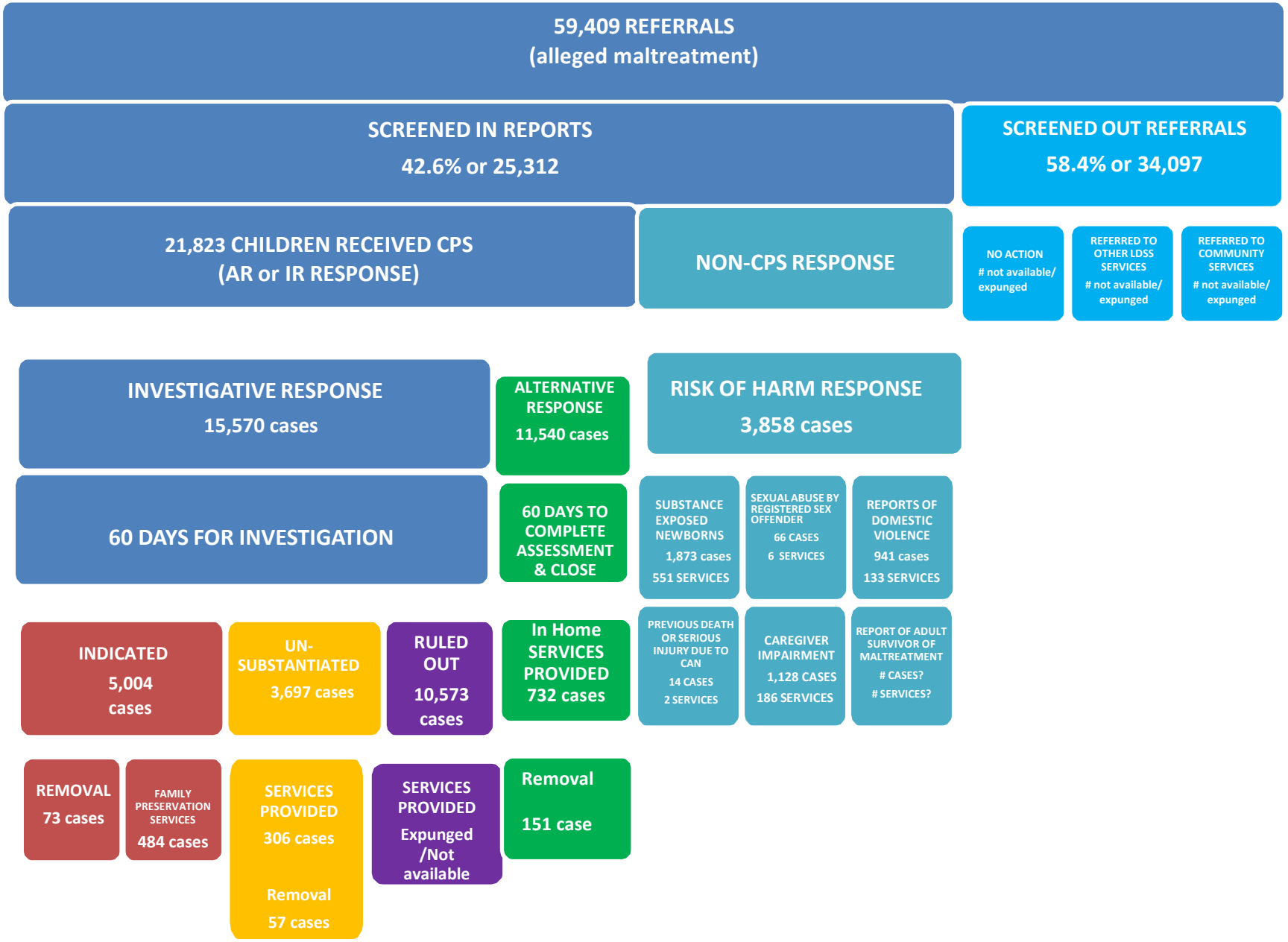
- Of particular concern to both SCCAN and the Citizen's Review Board for Children is the absence of data to verify the extent to which children are receiving necessary health and mental health services and care coordination. Lack of accurate tracking and reporting of these services and their outcomes is particularly troubling as children involved with child welfare face complex challenges of chronic and extreme stress that threaten their long-term health and well-being:

> Children who experience abuse or neglect have abnormally high levels of cortisol, a hormone associated with the stress response, even after they are removed from maltreating caregivers and placed in safe circumstances. Such continuously high cortisol levels adversely affect stress responsiveness, emotion, and memory (National Scientific Council on the Developing Child, 2005). Studies have also shown that heightened stress impairs the development of the prefrontal cortex, the brain region that is critical for the emergence of abilities that are essential to, "autonomous functioning and engagement in relationships" (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p.11). These "executive functions" include planning, focusing, self-regulation, and decision-making. Executive functions are necessary to successfully managing school, work, and healthy relationships.[9]

Data from SCCAN's 2013-2016 Annual Reports emphasized the importance of tracking health services and outcomes for children involved with child welfare. Gathering and analyzing this data should be a high priority for ensuring our state's appropriate care of these our *most* vulnerable children. Because children and families involved in child welfare are often involved in multiple public systems-- public health, behavioral health, primary care, Medicaid, child welfare, juvenile and criminal justice, education, public assistance, child support enforcement—**it is essential that these systems work in unison and share data effectively to meet these children's health care needs**. Brain science and the ACE Study indicate that leaving these needs unmet leads to poor behavioral, health, educational, employment and relational outcomes in the future.

[9] U.S. Department of Health and Human Services, Administration for Children and Families, Information Memorandum, ACYC-CB-IM-12-04. April 17, 2012, p. 4.

Figure A: 2016 CHILD MALTREATMENT *REFERRAL, PATHWAYS,* & SERVICES

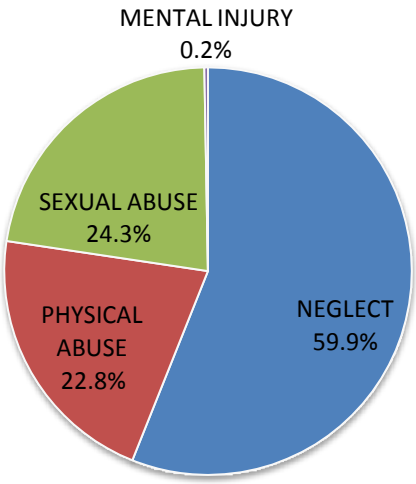


Child Maltreatment by Type:

- Neglect is the largest category of child abuse/neglect at 59.9 percent, followed by sexual abuse at 24.3%, physical abuse at 22.8% and mental injury at 0.2%. (The total is greater than 100% due to poly-victimization, i.e., a child may have suffered more than one type of maltreatment). See Figure B below.

- Chronic neglect is given less attention in policy and practice, however can be associated with a wider range of damage than active abuse. Science tells us that young children are especially vulnerable to poor physical and mental health outcomes of neglect. A broad range of developmental impairments can occur, including cognitive delays, stunting of physical growth, impairments in executive function and self-regulation skills, and disruptions of the body's stress response.[10]

Figure B: MARYLAND
2016 CHILD MALTREATMENT BY TYPE



Caregiver Risk Factors for Child Maltreatment:

Caregiver risk factors are characteristics of a caregiver that may increase the likelihood that their children will be victims of abuse and neglect. Parental drug and alcohol abuse is a documented risk factor. However, the extent of the problem in Maryland is challenging to ascertain because different data sources provide very different statistics. The U.S. Department of Health and Human Services, Administration for Children and Families *Child Maltreatment 2016* indicates that 5.4% of child maltreatment victims in Maryland had a caregiver with substance abuse.[11] Maryland data for this document is obtained from the Maryland Department of Human Services. In contrast, the data DHS collected for Maryland's IV-E Waiver indicates that parental substance abuse was a factor in the

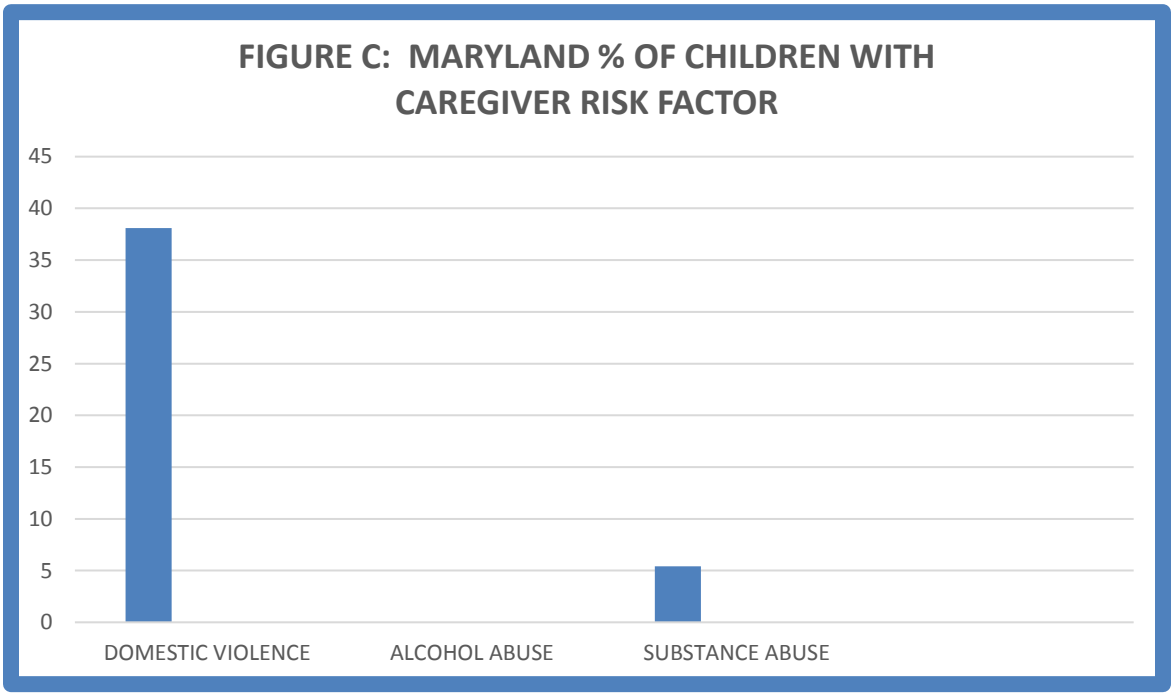
[10] *In Brief, The Science of Neglect*, Harvard Center on the Developing Child.

[11] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2017), *Child Maltreatment 2016*; https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf

removal decision for 29% of all children removed from their homes in FY 2012-2014,[12] and Maryland BRFSS data indicate that 27% of adults lived with someone with substance abuse problems when they were growing up. Knowledge and experience of SCCAN members suggest that 5.4% is a huge underestimate of the burden, and the other data sources are more accurate. In contrast, existing data for another key child maltreatment risk factor, Domestic Violence, is more reliable. Both NCANDS and ACE data identify similar rates of IPV exposure.

Risk Factors from NCANDS data:

- 38.1% of child victims had a caregiver risk factor for domestic violence
- Maryland did not report on the number of child victims who had a caregiver risk factor for alcohol abuse
- 5.4% of child victims had a caregiver risk factor for drug abuse



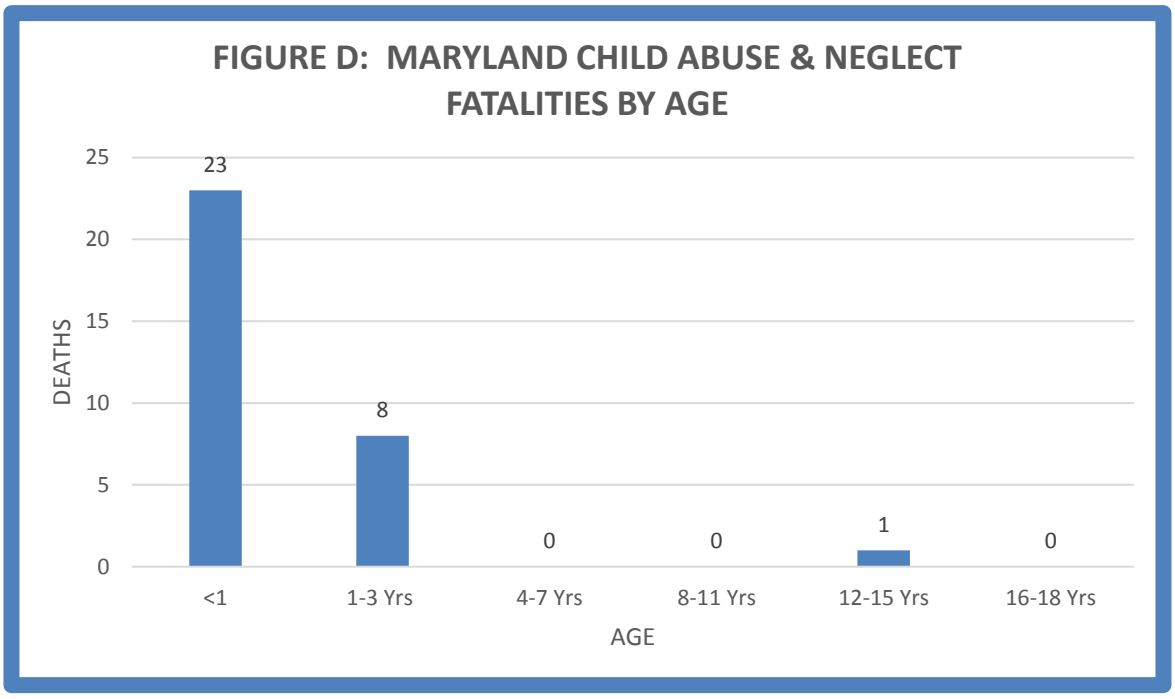
Given the strong likelihood that NCANDS data – obtained from DHS child welfare data – grossly underestimates the risk of parental substance abuse, we are concerned that parental risk factors may not be accurately identified by trained child welfare workers, and therefore can go undocumented in child welfare data systems. It is also possible that child welfare workers are identifying parental risk factors, but this information never gets recorded in the CHESSIE database.

[12] http://www.dhr.state.md.us/blog/wp-content/uploads/2015/01/MARYLAND-data-packet-3-6-15.pdf, p. 10.

Child Abuse & Neglect Fatalities:

DHS Reported:

- In CY2016, DHS reported to NCANDs that at least 32 Maryland children had died with child maltreatment as a contributing factor. This was an increase from 28 the prior year. It was reported that of those 32 children, only 1 child's family had received Family Preservation Services within the previous 5 years. None had been removed from their families within the previous 5 years.
- 23 (71.9%) of child deaths were < 1 years old; 8 (25%) were 1-3 year olds; 1 (3.1%) was between 12-15 years old.
- 17 children (53.1%) of children were African American; 1 child (3.1%) was Asian; 1 child (3.1%) was bi-racial; 10 children (31.3%) were Caucasian; and, 3 children (9.4%) were of unknown race.
- In CY2016, DHS reported that there were 13 serious physical injuries (SPIs) with child maltreatment as a contributing factor. 3 of the SPIs were of children <1-year-old; 6 were 1-3 years old; 3 were 4-7 years old; and, 1 was 8-11 years old. Three (3) of the 13 SPIs had an active case or prior child welfare case which had been closed within the past 12 months.
- Of the SPI cases, 4 were African American; 0 were bi-racial; 5 were Caucasian; 0 were Hispanic; and, 2 were of unknown race.



Maryland Child Abuse & Neglect Fatality (MCANF) Review:

Maryland Child Abuse and Neglect Fatality (MCANF) Workgroup is a joint effort of the State Council on Child Abuse & Neglect (SCCAN), the State Child Fatality Review Team (CFRT), and the Citizens Review Board for Children (CRBC). The effort grew out of a review by SCCAN of the National Commission to Eliminate Child Abuse & Neglect Fatalities Report, Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities and fact sheet with its findings and recommendations published in March 2016. SCCAN, CFRT and CRBC are Maryland's three Child Abuse Prevention and Treatment Act (CAPTA) citizen review panels mandated by federal and state law to examine policies, practices, and procedures of the state and local agencies responsible for child protection, including specific cases. The panels make recommendations for improving child and family serving systems annually to the Governor and General Assembly. The purpose and focus of the MCANF Workgroup is to:

- Review the multiple agency processes in place throughout Maryland to identify, report, respond to and prevent child fatalities and near fatalities related to child abuse and neglect.
- Review Maryland's unexpected/unexplained child deaths under the age of 5 from CY2015, as most child abuse and neglect fatalities and near fatalities in Maryland (and throughout the country) occur to children under 5 years of age.
- Compile accurate, cross-system, aggregate data to develop an understanding of the root causes (i.e., risk factors such as- parental substance abuse, domestic violence, mental illness, etc.) of these fatalities.
- Make recommendations to link the data and its analysis to implementation of improved policies, programs, practices and training within *all* child and family serving agencies (OBs, hospitals, pediatricians, WIC, Early Care and Learning, parental mental health and substance abuse services, law enforcement, CPS, schools, etc.) to prevent child abuse and neglect and the related fatalities and near fatalities.

In July 2016, Maryland began participation in the Three Branches Institute on Improving Child Safety and Preventing Child Fatalities. SCCAN and SCFRT are participants in that work (which is now being organized under the Family Blossoms reorganization at DHS, SSA), sharing information about fatality review processes in Maryland and the current reviews of the MCANF Workgroup.

As most child abuse and neglect fatalities & near fatalities in Maryland (and throughout the country) occur to children *under* 5 years of age, the Workgroup is focusing on reviewing all "unusual and unexpected" fatalities statewide of 0-4 year olds in CY2015 to determine: 1) whether or not the death was related to abuse and neglect; and, 2) what systems improvement recommendations could prevent future deaths. The state-level review is anticipated to finish in May of 2019. MCANF has completed reviewing all child fatalities in Baltimore City, Anne Arundel and Washington Counties and has made the following preliminary observations:

- Child victims were primarily infants and toddlers.
- Many of the deaths were sleep-related, though frequently other family risk factors were also present
- Based on the available data, many of the children and their caregivers had high

ACE scores (involvement as a child in child welfare, juvenile justice, corrections and school dropout and failure) and were struggling with substance use, mental health disorders, and intimate partner violence.

- While mothers may have had prior parenting services, i.e., infant safe sleep, home visiting, etc., the fathers and/or partners who were caregivers when the children died often had not been offered nor received these services.
- Most of the children and families had not had prior CPS contact[13], although the parents may have been involved in child welfare as children themselves.
- The majority of families had been in contact with multiple non-CPS systems, including Temporary Cash Assistance (TCA), Medical Assistance (MA), Health Care Access Maryland (HCAM), SNAP, WIC, substance abuse and mental health treatment, within the 12 months prior to the child's death.
- Lack of safe child care options was identified as an issue in a number of cases.

[13] Until October 1, 2016, Maryland law required all records of CPS "screened out" reports, as well as all records of investigations in which abuse and neglect was ruled out, to be expunged within 120 days.

COLLECTING ACE DATA in MARYLAND:

Background: <u>The Adverse Childhood Experiences Study</u>

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. The study is an ongoing collaboration between Kaiser Permanente and the CDC that began with two-waves of participants beginning in 1995 and 1997. Participants were asked questions regarding ten adverse childhood experiences which included all forms of child maltreatment and five indicators of family dysfunction: substance abuse, parental separation/divorce, mental illness, domestic violence, and/or criminal behavior within the household.

KEY FINDINGS of the ACEs Study published in peer-reviewed scientific journals*:

- **ACEs are COMMON:** Two thirds of study participants reported having at least one ACE. More than one fifth reported having three or more ACEs.

CHILD ABUSE & NEGLECT		**FAMILY DYSFUNCTION**	
TYPE	***% within population***	***TYPE***	***% within population***
Physical Abuse	28 %	Substance Abuse	27 %
Sexual Abuse	21 %	Parental Separation/Divorce	23 %
Emotional Neglect	15 %	Mental Illness	17 %
Psychological Abuse	11 %	Battered Mother	13 %
Physical Neglect	10 %	Criminal Behavior	6 %

- **ACEs are RARELY FOUND IN ISOLATION/ACEs TEND TO OCCUR IN CLUSTERS**:

The cumulative impact of ACEs is captured in the "ACE Score." If an individual has experienced one ACE, they are likely to have multiple. An individual's ACE score likely captures the neuro-developmental consequences of traumatic stress.

ACE SCORE	**PREVALENCE**
0	33 %
1	26 %
2	16 %
3	10 %
4 or More	16 %

- **ACEs are *STRONG* DETERMINANTS OF ADOLESCENT & ADULT SOCIAL WELL-BEING & HEALTH:** ACE-related problems have a strong, graded relationship to numerous health, learning, social and behavioral problems *throughout a person's lifespan*. As the number of ACEs increase in the life of an individual, there is an increased likelihood of the following risky behaviors and chronic physical and mental health conditions.

BEHAVIORS	PHYSICAL & MENTAL HEALTH
SMOKING	SEVERE OBESITY
ALCOHOL ABUSE	DIABETES
DRUG USE (ILLICIT & PRESCRIPTION)	DEPRESSION
MISSED WORK & PERFORMANCE IN THE WORKFORCE	SUICIDE
LACK OF PHYSICAL ACTIVITY	HIV & STDs
RISKY SEXUAL BEHAVIOR	HEART DISEASE

Collecting ACE Data through the Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is a CDC supported, state-administered random-digit-dial (landline and cell phone) survey conducted in all 50 states, the District of Columbia, and three U.S. territories that collects data from non-institutionalized adults regarding health conditions and risk factors. The purpose of the BRFSS is to assess the population prevalence of chronic health conditions, risk factors, and the use of preventative services.

Since 2009, states have been collecting ACEs data through their BRFSS. In 2013, SCCAN Recommended adding the ACEs module to Maryland's BRFSS and successfully advocated in 2014 for inclusion of the module in the 2015 BRFSS. The BRFSS ACE module collects data on eight of the original ten ACEs, and excludes physical and emotional neglect. Maryland BRFSS surveyed 12,000 non-institutionalized adults aged 18+ in 2015. 6,000 of those surveyed were administered the ACE module.

More than 32 states across the U.S. have collected at least one year of ACE data to serve as baseline data to measure population-level prevalence over time. In Maryland we hope to learn about the prevalence of ACEs in Maryland, populations most at risk by demographic characteristics, prevalence of ACEs by risk factors/health behaviors and the prevalence of ACEs by health outcomes.

Maryland ACE Questions:

The Maryland BRFSS ACEs module asked the following questions:

Physical Abuse	"Before the age of 18, how often did a parent or adult in your home ever hit, beat, kick or physically hurt you in any way? Do not include spanking." Response options: Never, Once, More than once.
Emotional abuse	"Before age 18, how often did a parent or adult in your home ever swear at you, insult you, or put you down?" Response options: Never, Once, More than once.
Sexual abuse	"Before the age of 18, how often did anyone at least 5 years older than you or an adult ever touch you sexually?" "Before the age of 18, how often did anyone at least 5 years older than you or an adult ever

	make you touch them sexually?" or "Before the age of 18, how often did anyone at least 5 years older than you or an adult ever force you to have sex." For analysis Maryland classified an adult to have been sexually abused if they answered once, or more than once to at least one of these questions. Response options: Never, Once, More than once. Responses of "once" or "more than once" to one or more of these questions were classified as sexual abuse.
Household Mental Illness	"Now, looking back before you were 18 years of age, did you live with anyone who was depressed, mentally ill, or suicidal?"
Household Substance Abuse	"Before you were 18 years of age, did you live with anyone who was a problem drinker or alcoholic?" or "Before you were 18 years of age, did you live with anyone who used illegal street drugs or who abused prescription medications?"
Divorce & Separation	"Were your parents separated or divorced?" Response options: Yes, No, Parents not married. Responses of "parents not married" were excluded from analysis due to small numbers (<2% of sample).
Household Incarceration	"Before you were 18 years of age, did you live with anyone who served time or was sentenced to serve time in a prison, jail or correctional facility?"
Witnessing Domestic Violence	"How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?" Response options: Never, Once, More than once.

PREVALENCE OF ACEs IN MARYLAND ADULTS:

Maryland is in the preliminary stages of analyzing its ACEs data. Important insights into prevalence of ACEs can be gained by examining the following characteristics of those impacted by ACEs:

- Social, Emotional, and Cognitive Impairment
- Adoption of Health-Risk Behaviors
- Disease, Disability, and Social Problems

Limitations to the Data

- BRFSS data does not survey adults living in institutions such as nursing facilities, group homes, or prisons. These populations may be disproportionately affected by ACEs and their exclusion may result in an underestimate of the true prevalence.
- Data do not indicate the severity or frequency of abuse. The data only estimates whether it occurred or didn't occur.
- Data do not indicate the temporality of ACEs. The data only estimates that it happened, not when it happened. Because these data are cross sectional, we can only say the ACEs happened before the age of 18.
- In some instances the sample size is small. This can increase variance and corresponding confidence intervals, thereby decreasing the precision of estimates. It can also limit the ability to look at prevalence of other state-added questions, such as sexual orientation by abuse type, as this stratification would further reduce the number of individuals in each category, making estimates even less precise.
- Perhaps most importantly, BRFSS data does not indicate causality. We are merely looking at associations, which could be tied to other things such as socio-economic status, for example.

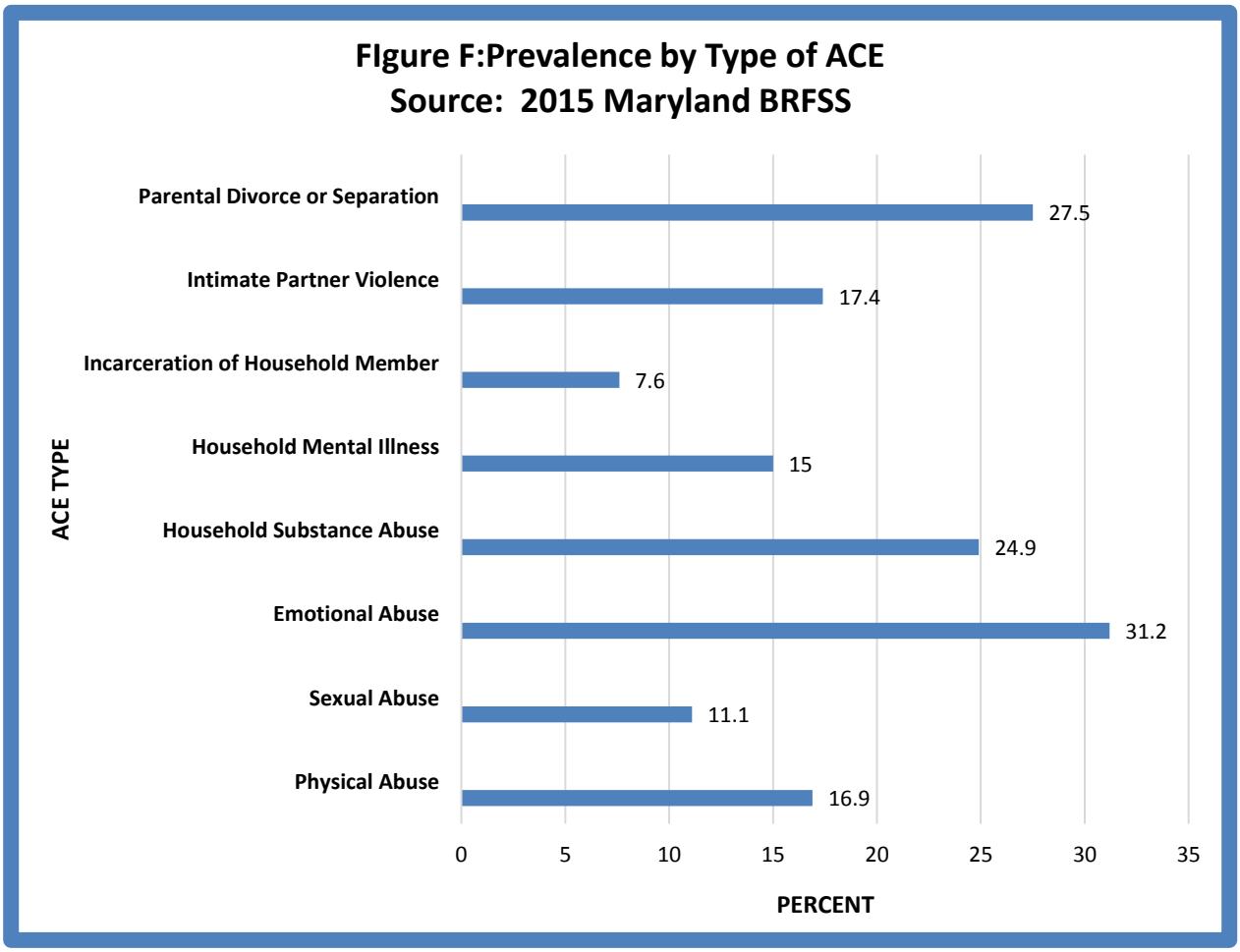
KEY FINDINGS in MARYLAND:

- **ACEs are COMMON:** Three fifths of the 6000 BRFSS participants who completed the ACE module in Maryland in 2015 reported having at least one ACE at some point during their childhood. Approximately 24%, almost a quarter, reported three or more ACEs.

Prevalence by Type of ACE

CHILD ABUSE & NEGLECT		**FAMILY DYSFUNCTION**	
TYPE	***% within population***	***TYPE***	***% within population***
Physical Abuse	16.9 %	Substance Abuse	24.9%
Sexual Abuse	11.1 %	Parental Separation/Divorce	27.5 %
Emotional Neglect	Not asked in BRFSS	Mental Illness	15.0%
Emotional Abuse	31.2 %	Intimate Partner Violence	17.4%
Physical Neglect	Not asked in BRFSS	Incarcerated Household Member	7.6%

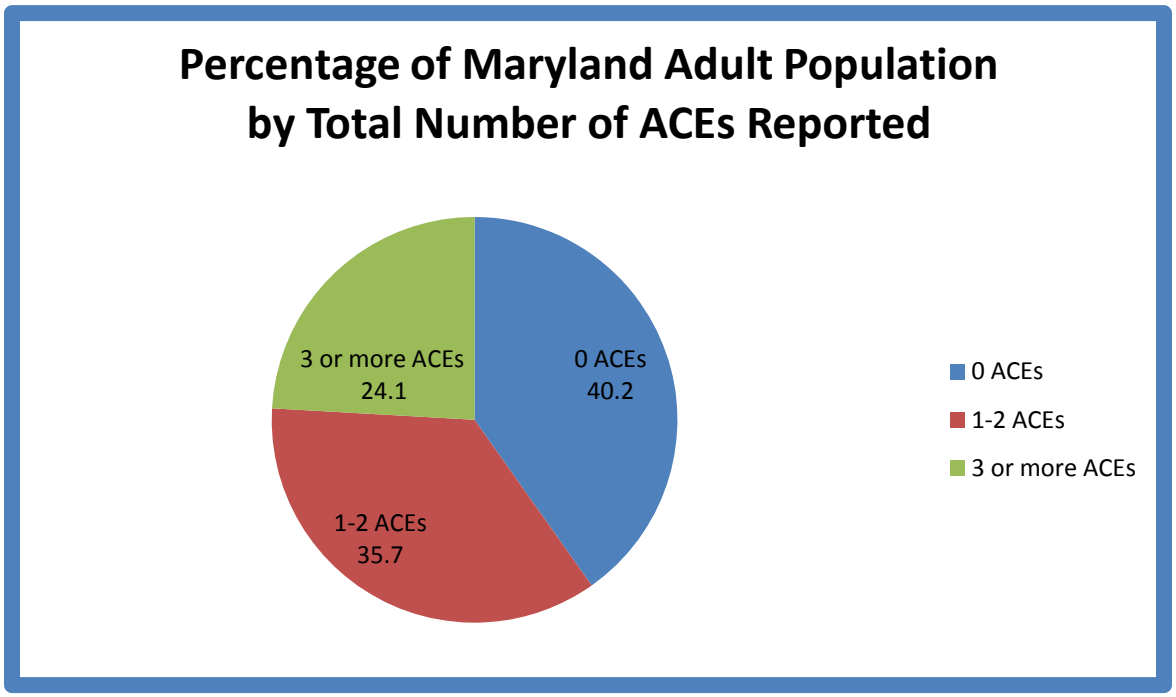
The percentage of respondents who reported experiencing each of these types of ACEs at least once are indicated in the table above. The types of ACEs with the highest prevalence include "parents who were separated or divorced" and "emotional abuse." See Figure F below.



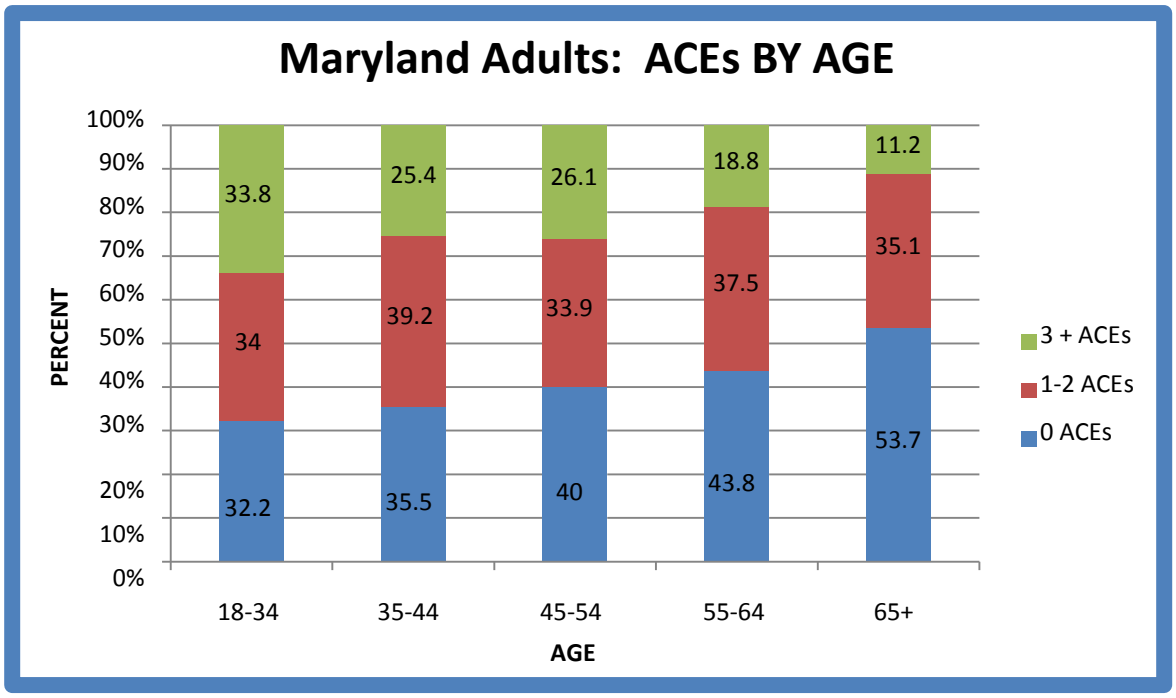
- **ACEs are RARELY FOUND IN ISOLATION/ ACEs TEND TO OCCUR IN CLUSTERS**: The cumulative impact of ACEs is captured in the "ACE Score" If an individual has experienced one ACE, they are likely to have multiple. An individual's ACE score likely captures the neuro- developmental consequences of traumatic stress.

Prevalence by Number of ACEs

As reported in the 2015 Maryland BRFSS, approximately 40% of respondents reported zero ACE exposures, approximately 36 % reported between 1 or 2 ACEs and approximately 24% reported experiencing 3 or more different types of ACEs. For simplicity, we can think of this as no ACE exposure, low ACE exposure, or high ACE exposure. It is important to remember this does not give us information on which ACEs are occurring together.



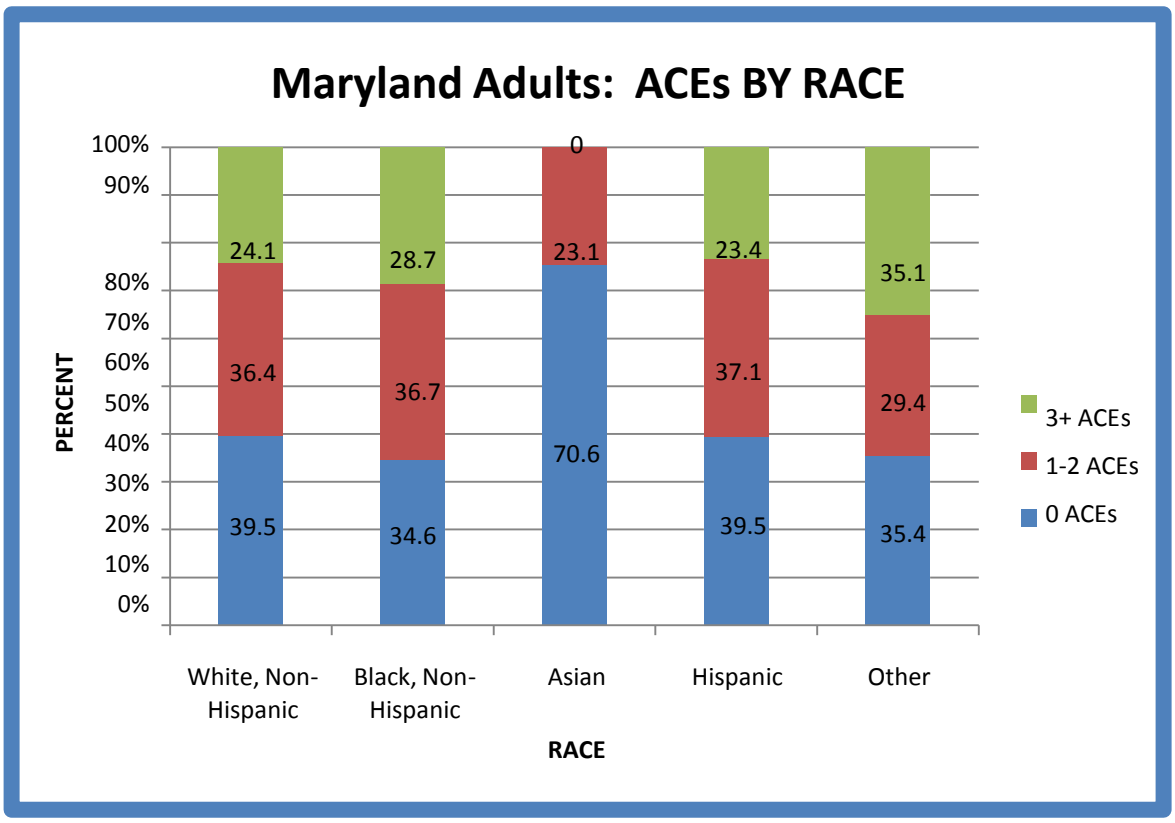
DEMOGRAPHICS:



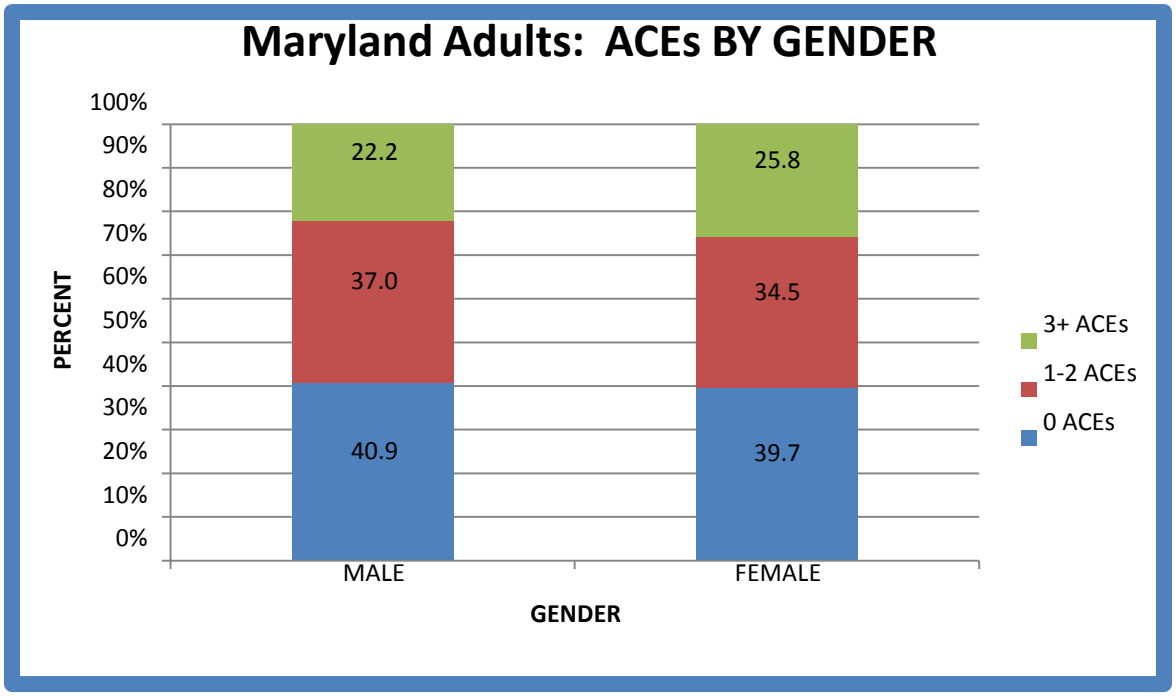
As age of the respondent increases so does the proportion of respondents who report zero ACEs (blue bars). This indicates that older respondents are reporting ACEs less frequently than younger respondents.

Implications

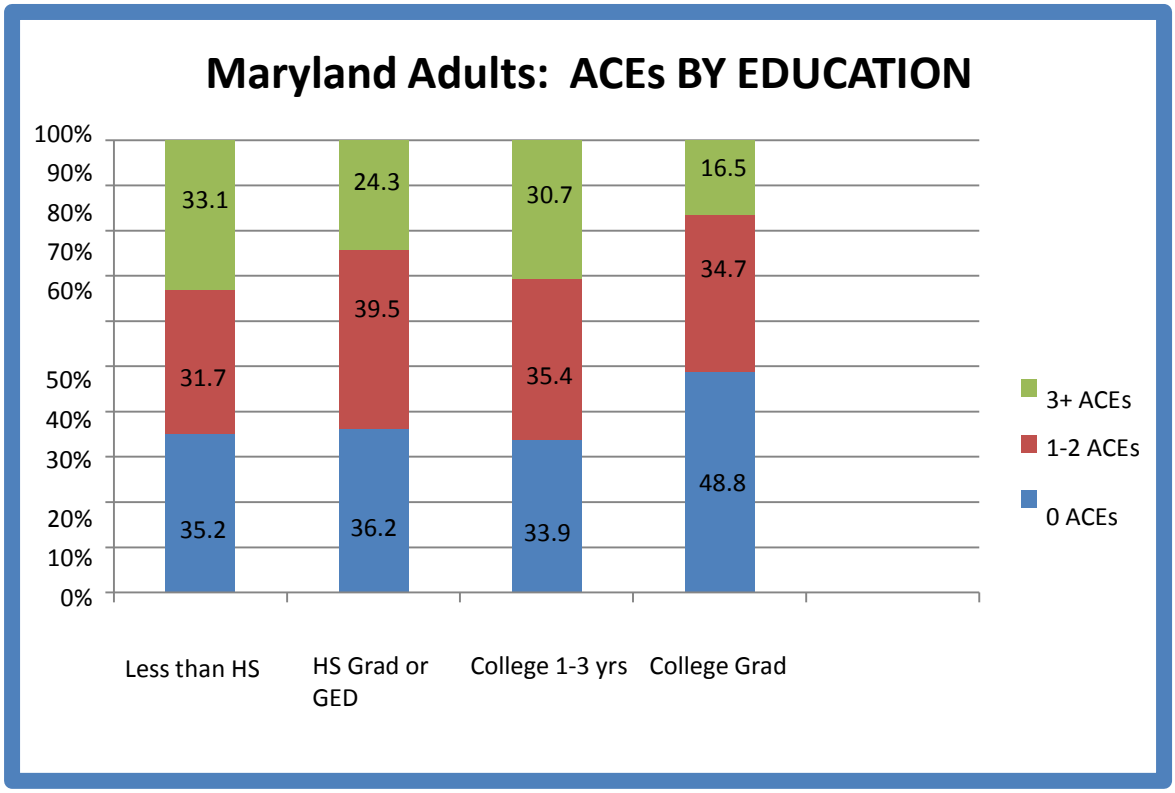
We can speculate that this could be a result of recall bias or more specifically, that as age increases our recollection decreases. Alternatively, we could hypothesize that younger generations are more aware of ACEs due to current discussions/information sharing about its importance to understanding health, and thus are more likely to report them. This data is interesting, yet we must be careful not to overstate its meaning. It is certainly a possibility that ACEs are becoming more prevalent; however, we need more data to confirm or refute this hypothesis.



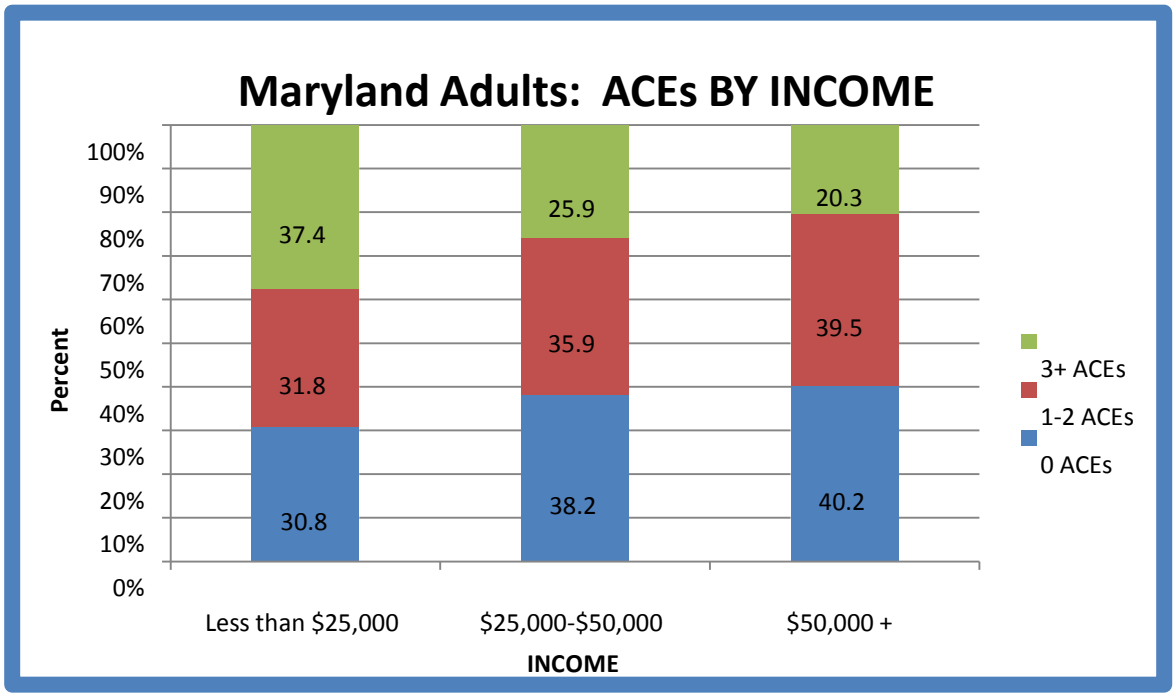
Of note, adults who identified themselves as "Asian" were more likely to report 0 ACEs, as compared to all other self-identified race categories. This difference was statistically significant.



Males and females experience a similar proportion of ACE exposures. A higher percentage of women report experiencing 3 or more ACEs, though this difference is not statistically significant.



Adults who report having a less than high school education reported a higher prevalence of 3 or more ACE exposures (33.1%), compared to adults who reported being a college graduate (16.5% reporting 3 or more ACEs). This difference is statistically significant.



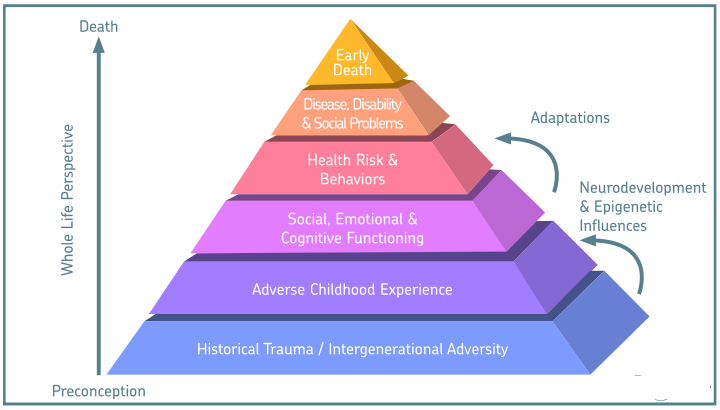
Respondents who reported having an income of $25,000 dollars or less were more likely to report high ACE exposure, as compared to those having an income of $50,000 dollars or more. This difference is statistically significant.

- **ACEs are *STRONG* DETERMINANTS OF ADULT SOCIAL WELL-BEING & HEALTH:**

  ACE-related problems have a strong, graded relationship to numerous health, learning, social and behavioral problems *throughout a person's lifespan*. As the number of ACEs increase in the life of an individual, there is an increased likelihood of the following risky behaviors and chronic physical and mental health conditions. Of note, binge drinking data were available from the Maryland BRFSS, but the increase in prevalence of binge drinking from 0 to 3+ ACEs was not statistically significant. Additionally, drug use (illicit and prescription) data was not available in the 2015 Maryland BRFSS.

BEHAVIORS	PHYSICAL & MENTAL HEALTH
SMOKING	DEPRESSION
QUALITY OF LIFE MEASURES	ANXIETY
	DISABILITY
	COGNITIVE DECLINE
	ASTHMA

ACEs and Poor Life Outcomes in Maryland:[14]



The ACE Pyramid above, is a life course model, from pre-conception to death that is designed to understand how adverse childhood experiences (ACEs) influence human development in predictable ways. ***This is important because what is predictable is preventable.*** Prior to the ACE Study, the experts primarily focused on the top three layers of the pyramid: How risk factors lead to disease and early death. Drs. Anda and Felitti, the principal investigators of the ACE study knew that something must be missing – they could see this because health risks are not random; they are concentrated in some populations, and not others. And people who have one risk tend to have others; that is, they cluster. The ACE Study tested their hypothesis that multiple forms of childhood adversity could be a major determinant of health.

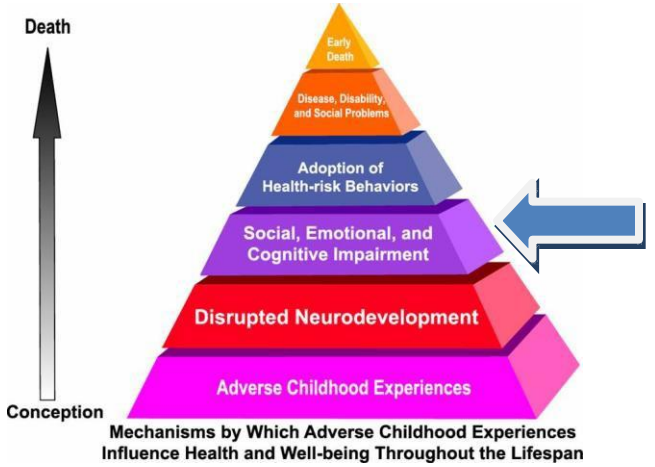
[14] Centers for Disease Control and Prevention. (2016). Adverse Childhood Experiences (ACE) Study. National Center for Chronic Disease Prevention and Health Promotion. Retrieved from https://www.cdc.gov/violenceprevention/acestudy/ACE_graphics.html.

An explanation of the ACE pyramid as a conceptual https://www.unmc.edu/bhecn/_documents/ace-handout-ne-specific.pdf

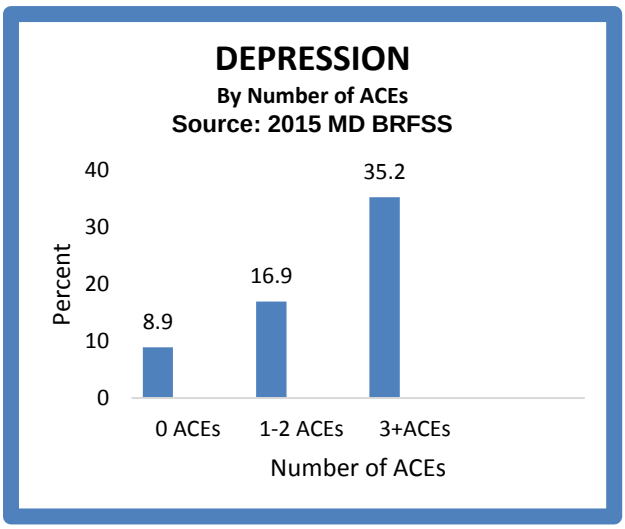
The ACE Study concept is that ACEs disrupt neurodevelopment, which in turn leads to social, emotional and cognitive adaptations that can then lead to the risk factors for major causes of disease, disability, social problems, and early death. Since the time of the ACE Study, breakthrough research in developmental neuroscience and epigenetics show us that the hypothesis of the ACE Study is biologically sound. Neuroscience and epigenetic discoveries help us to understand the progression of adversity from preconception throughout the life course. Historical trauma and generational adversity increase risk for ACEs, which, in turn, generate risk for disease, disability and social problems.

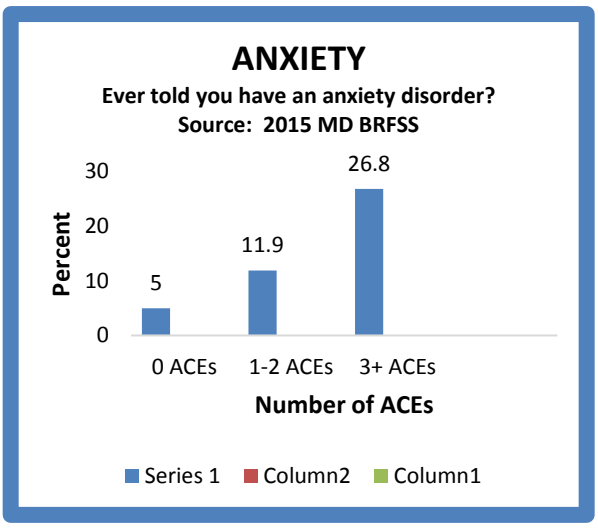
Social, Emotional, and Cognitive Impairment

Science tells us that when there are no adults to buffer a child from adverse experiences, healthy brain development is disrupted. Moving up to the third tier from the bottom of the ACEs pyramid, the result can be "social, emotional and cognitive impairment." Maryland BRFSS ACE module data has analyzed four indicators of this tier: depression, anxiety, poor mental health days and cognitive decline.



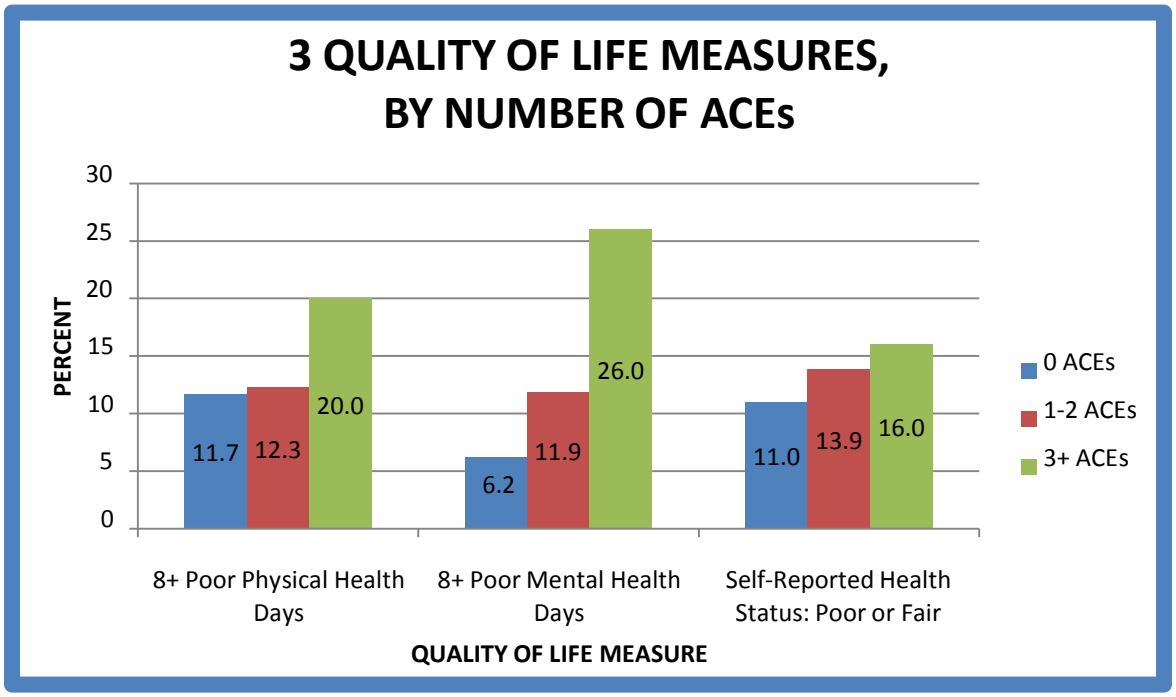
Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan





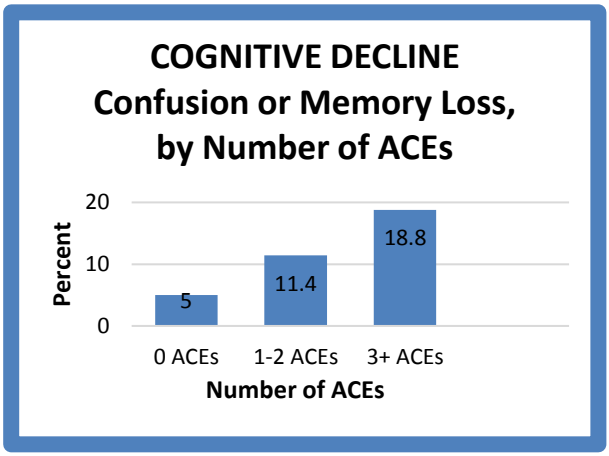
There is a strong dose-response relationship[15] when looking at both depression and anxiety in relation to ACEs. As ACE exposure increases, so does the likelihood of depression and anxiety. Adults who report 0 ACEs have the lowest prevalence of depression (8.9%) and anxiety (5%); followed by those who experience 1 to 2 ACEs (16.9 % reported depression and 11.9 % reported anxiety); and, finally 3 or more ACEs (35.2% reported depression and 26.8 reported anxiety). These differences are statistically significant.

[15] A dose response relationship is defined as a relationship in which a change in the amount, intensity, or duration of exposure is associated with a change in risk of a specified outcome

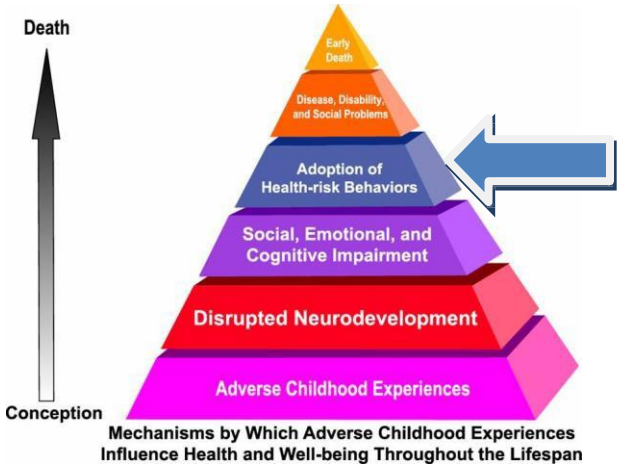


When we look at three quality of life measures, including poor physical health days, poor mental health days and self-reported health status, there is a dose response relationship between these quality of life measures and ACE exposure. As ACE exposure increases, so does the percentage of adults who report eight or more poor physical and mental health days each month, and poor or fair health status. For poor physical health days, there is a statistically significant difference between those who experience 0 ACEs and 3 +ACEs. For poor mental health days, there is a statistically significant difference between those who experience 0 ACEs, 1-2 ACEs and 3+ ACEs. There is no significant dose response relationship between ACEs and self-reported health status.

There is a strong dose response relationship when looking at ACEs and significant difference in the prevalence of cognitive decline, between those who report 0 ACEs and those who report 3 or more ACEs. There is also a statistically significant difference between those who report 0 ACEs and 1-2 ACEs. *This response was only asked of respondents aged 45 and older.



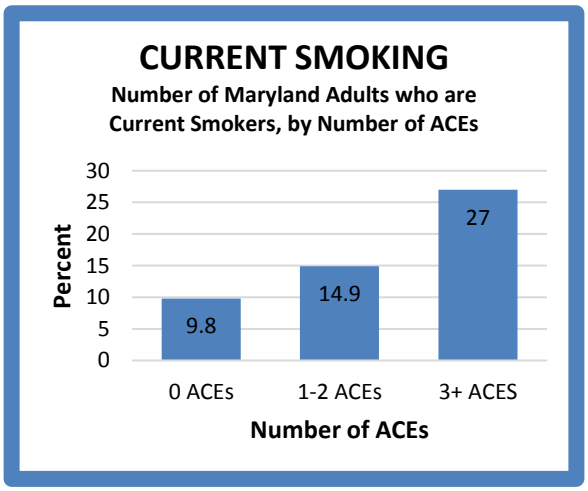
Adoption of Health-Risk Behaviors



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

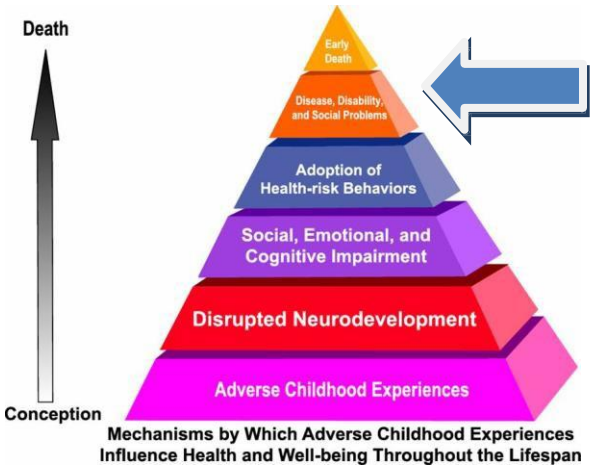
The next tier up on the ACEs Pyramid is the adoption of health-risk behaviors. As the number of ACEs goes up, there is a correlation to the adoption of unhealthy behaviors, including smoking, binge drinking and even lack of seat belt use.

There appears to be a dose response relationship between current smoking and number of ACEs. The more ACEs a respondent had, the more likely he or she was to be a current smoker. There was a significant difference in smoking behavior between those individuals with 0 ACEs, those with 1-2 ACEs, and those with 3+ ACEs.

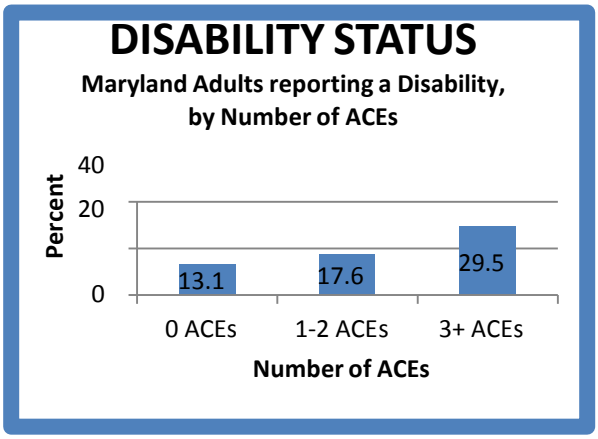


Disease, Disability, and Social Problems

The next tier on the ACEs Pyramid represents the impact of adverse childhood experiences on disease, disability and social problems of a population.

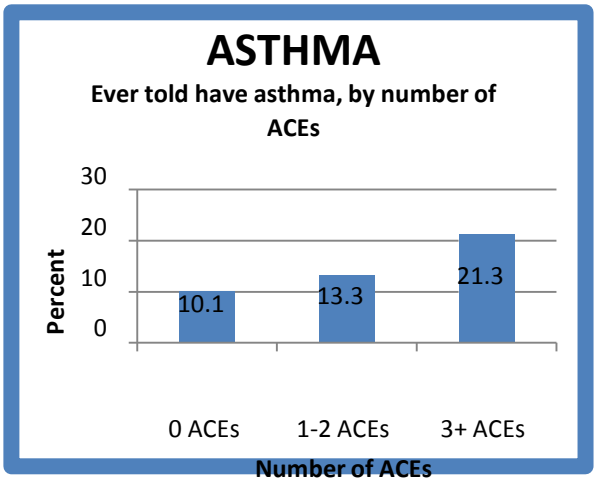


Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan



Adults who report 3 or more aces are more likely to report a disability (29.5%), compared to those who report zero ACE exposures (13.1%). This difference is statistically significant.

There is a dose response relationship between prevalence of asthma and number of ACEs. You can see that adults who report 3 or more ACEs are more likely to report asthma (21.3%), compared to those who report zero ACE exposures (10.1%)



MDH, Division of Health Promotion Administration will be collaborating with colleagues to conduct a more sophisticated analysis plan of Maryland's ACE data. This may include:

- Adjustment for age, race/ethnicity, income status
- Analysis of chronic disease prevalence by type of ACE (e.g. Household mental illness, Physical abuse)
- Summary of regional or county-level prevalence rates
- Production of a large report or series of data briefs/fact sheets

Conclusions:

What we know so far is that ACEs are common in Maryland; and, may have pervasive effects on health behaviors and outcomes. Dissemination of this data and implementation of prevention and intervention strategies based on brain science, ACEs, trauma-informed care and resilience are critical not only to current child well-being, but health and well-being throughout the lifespan. Unfortunately, childhood trauma is something that we have been reticent to discuss until now. And, as Jack Shonkoff, the Director of the Harvard Center on the Developing Child, so aptly puts it: "A defeatist attitude is completely disconnected from what 21st Century science is telling us and we should be going after that like a bear." Poor health outcomes/behaviors can be prevented – understanding the relationships between ACEs and health outcomes is one of the first steps in understanding points of intervention/prevention.

SCCAN's Actions & Accomplishments 2017

Since 2006, SCCAN has focused its' efforts and recommendations on preventing child abuse and neglect before it occurs; and researching the extent to which the seminal Adverse Childhood Experiences (ACEs) Study is known and being used to inform systemic change in Maryland. In 2012 SCCAN adopted the goals of *the* Center for Disease Control and Prevention's *state level implementation of Essentials for Childhood* as a framework for its' efforts and recommendations*;* working side-by-side its' partners to create a statewide collective impact initiative to prevent child maltreatment and other ACEs, known as Maryland Essentials for Childhood.

Maryland Essentials for Childhood Initiative:

Maryland Essentials for Childhood (EFC) is a statewide collective impact initiative to prevent child maltreatment and other adverse childhood experiences (ACEs).[16] It promotes relationships and environments that help children grow up to be healthy and productive citizens so that *they*, in turn, can build stronger and safer families and communities for *their* children (a multi-generation approach). Maryland EFC includes public and private partners from across the state and, receives technical assistance from the U.S. Centers for Disease Control. The initiative provides members the opportunity to learn from national experts and leading states. Using advances in brain science, epigenetics, ACEs and resilience and principles of collective impact, the EFC leadership and working groups are advancing the following goals:

1. *Educate* key state leaders, stakeholders, and grassroots on brain science, ACEs, and resilience; in order to, *build a commitment to put science into action* to reduce ACEs and create *safe, stable, and nurturing relationships and environments* for all Maryland children.
2. Identify and use Data to inform actions and recommendations for systems improvement.
3. Integrate the Science into and across Systems, Services & Programs
4. Integrate the Science into Policy and Financing Solutions

Key Successes of SCCAN & EFC Partners 2017:

SCCAN and Maryland Essentials for Childhood Committee Members have achieved the following goals set out at SCCAN-Maryland Essentials for Childhood Retreat in July 2017:

- Raise awareness of brain science, ACEs and resilience via:
  - ACE Interface Project: 30 Master Trainers, 45 presentations to 1352 individuals in 14 jurisdictions, Reception for 100+ policy, business, foundation and faith leaders
  - Resilience Screenings: 40 Screenings & Discussions, 1000+ participants
- Policy & Funding Priorities:
  - HB 1072 Comprehensive Child Sexual Abuse Prevention signed into law
  - HB 1582 passed mandating a Child Welfare Medical Director, an Electronic Health Passport for Foster Children and reporting on MD Think efforts signed into law
  - HB 454 passed expanding Maryland's Birth Match Law
  - HB 1- Healthy Working Families Act- Earned Sick and Safe Leave passed
  - SB 379 / HB 430 Education – Child Care Subsidies – Mandatory Funding Levels – passed mandating higher payments and therefore increased access to quality child care for low income families.
- Shared Data:
  - Collection of 2018 Behavioral Risk Factor Surveillance System ACE Module Data

[16] Channeling Change: Making Collective Impact Work, Stanford Social Innovation Review, https://ssir.org/articles/entry/channeling_change_making_collective_impact_work

Maryland Essentials for Childhood Framework & Goals Lead the Work

Maryland Essentials for Childhood Initiative uses four strategic goals statewide to create safe, stable, and nurturing relationships and environments that support the healthy development of all Maryland children. Below is an outline of the four goals and a brief description of key actions taken to achieve each goal.

Progress towards *Maryland Essentials for Childhood* Strategic Goals:

I. *Educate* key state leaders, stakeholders, and grassroots on brain science, ACEs, and resilience; in order to, *build a commitment to put science into action* to reduce ACEs and create *safe, stable, and nurturing relationships and environments* for all Maryland children.

A. **ACE Interface Project:**

In any great public health discovery, the most important actions in the first decade are:

1. To tell everyone – share the findings effectively and with fidelity, and
2. To change ourselves and promote changes within our spheres of influence.[17]

With that in mind, SCCAN played a key role in developing the ACE Interface Project, including, recruiting members of the inter-professional ACE Interface Master Trainer Cohort and inviting key policy, business, foundation and faith leaders to the ACE Interface Reception to learn about ACEs and the Maryland Essentials for Childhood Initiative.

The ACE Interface Master Trainer Program was designed by Dr. Robert Anda, the co-principal investigator of the ACE Study, and Laura Porter, to support rapid dissemination of ACE and resilience science, and promote understanding and application of the science to improve health and wellbeing across the lifespan. In less than a year, the Master Trainer Program enables delivery of ACE information to diverse communities--with fidelity to science and concepts--to tens of thousands of people. Minnesota, Wisconsin, Alaska, Oregon, Montana, South Carolina, and Washington are among the first states to adopt the ACE Interface Master Trainer Program.

Through the generous support of the Board of The Family Tree, the Maryland Essentials for Childhood ACEs Initiative hosted a two-day ACE Interface Master Trainer Session on November 16-17 2017. This training session was facilitated by Dr. Rob Anda, MD, MS, Co-Principal Investigator of the ACE Study, and Laura Porter, who has more than a decade of experience leading successful state-wide implementation of ACE Study concepts. The ACE Interface Project creates a cadre of highly skilled, well-informed trainers and presenters to disseminate the science of the developing brain, ACEs and resilience; and, to spur Maryland policy makers, providers, parents and concerned citizens to innovative action. SCCAN and MD Essentials for Childhood partners identified Master Trainers in each of the child and family serving state agencies (DHS, DJS, MDH, MSDE), as well as multiple sectors (judicial, pediatrics, parent leadership, child care, education, faith-based, law enforcement, evidence-based home visiting, domestic violence, child advocacy centers, child welfare, CASA, business, foundations, mental health, media, and higher education). Each of seven regions of the state have Master Trainers available

[17] http://www.aceinterface.com/MTE.html

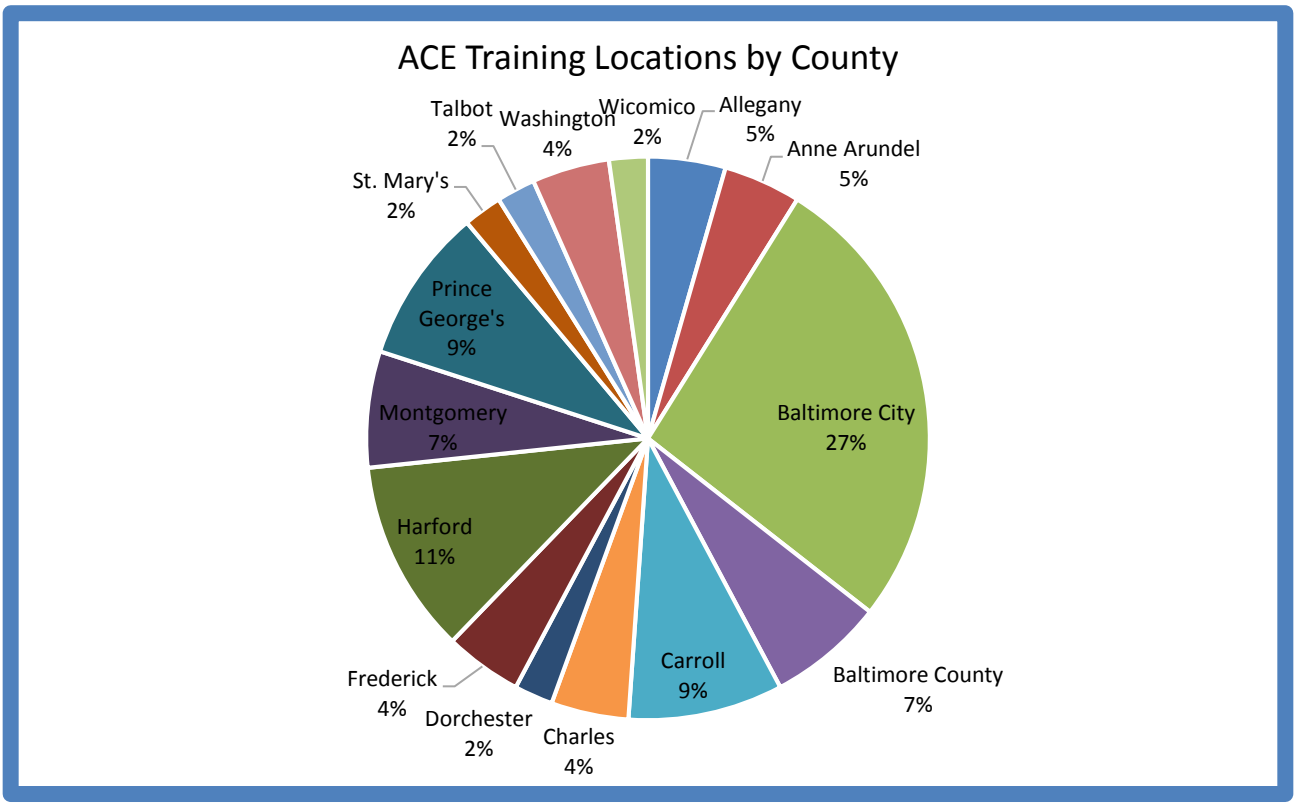
locally. Master Trainers have committed to educate their local communities and professional colleagues in brain science, ACEs, and resilience. The cohort meets quarterly to share lessons learned, improve skills and assess the progress of dissemination efforts.

ACE Interface Reception for Key Policy Makers

In addition to the two-day ACE Interface Master Trainer session, the Board of The Family Tree hosted a reception on November 15th 2017 at the Renaissance Fine Arts Gallery. Policy makers, judges, foundation, media, faith-based and business community leaders received an overview of the ACE Study by Robert Anda and Laura Porter; and, were introduced to the Maryland's ACE Interface Master Trainer Cohort.

ACE Interface Training Locations by Maryland County

Between December 2017 and May 2018, ACE Interface Master Trainers have given 45 ACE Interface presentations to 1352 attendees across fifteen Maryland jurisdictions.



B. Facilitated screenings of the newly released documentary Resilience: The Biology of Stress & The Science of Hope across the state. Since its' debut in April 2017, SCCAN and Maryland Essentials for Childhood's efforts have led to approximately 40 screenings and discussions of Resilience, reaching more than 1000 Marylanders. A sample of screenings that took place included:

- Baltimore Commons Community Gathering- 1st Friday Film- July-November 2017
- GOCCP, Child Advocacy Centers- July 2017

- Pediatric Residents- July 2017
- Enoch Pratt Branch Managers and Library Community Screenings- October 2017-present
- DHS, Executive Leadership Team- October 2017
- SSA Supervisory Meetings- Social Services Supervisory Staff- October – November 2017
- Maryland Association for the Education of Young Children- August 2017
- Maryland State Child Care Association- October 2017
- Citizens Review Board for Children Board and Volunteer In-Service Training- October 2017 and April 2018

C. Building and growing membership in the Maryland ACEs Connection Community page to connect, inform and support AEs Initiatives across Maryland:
- Recruited five Community Managers to lead the effort
- Trained five Community Managers through ACEs Connection
- Sent out Invitations to join MD ACEs Connection Community
- Launching July 2018: MDH interviews and blog posts highlighting five Maryland communities with ACEs Initiatives scheduled to launch June 2018.
- Recruitment of members of local Maryland ACE Initiatives to take part in the ACE Interface Master Trainer Cohort. Frederick County, Local Health Improvement Plan Committee
- Thriving Communities Collaborative (TCC), Baltimore City:
- Harford County ACEs Initiative
- Center for Children, Southern Maryland
- Bester Community of Hope, Washington County

D. **Development of Maryland Essentials for Childhood Resource List** to share with EFC Collective Impact Team and local communities disseminating Brain-ACEs Science.

II. Identify and use Data to inform actions and recommendations for systems improvement. The goal of the EFC Shared Data & Outcomes Workgroup is to advocate for the Improvement and enhancement of Maryland's data management systems to use common measurements to increase accountability for shared indicators and outcomes for families and children.

A. Successfully organized cross-sector partners to advocate for the inclusion of the ACE module in Maryland's Behavioral Risk Factor Surveillance Survey in 2015 and 2018. **Proposed policy:** ACE data should be collected as part of BRFSS every three years. Resilience questions similar to those being asked in Wisconsin's BRFSS should be added to Maryland BRFSS modules.

B. The ACEs module is being collected in 2 of 3 survey versions in the 2018 Maryland BRFSS. MDH anticipates that about 12,000 Maryland adults will be asked the ACE module by the end of data collection in December 2018. The 2018 ACEs data will be available late summer 2019. While no formal reports have been published by MDH on the Maryland ACEs data, there are data tables which provide prevalence of ACEs by county using the 2015 Maryland BRFSS data available at Adverse Childhood Experiences in Maryland: Data from the

2015 Maryland BRFSS.

C. Maryland Essentials for Childhood partner, Behavioral Health Systems Baltimore, is taking the lead on exploring collection of ACE and resilience data through Maryland's Youth Risk Behavior Survey (YRBS). To date, initial calls have taken place with CDC and Maryland YRBS Coordinator.
D. Participation in CDC EFC Evaluator technical assistance calls to learn from funded states.
E. SCCAN and Maryland Essentials for Childhood continue to advocate that MDH's Injury and Violence Prevention leadership fund the collection of baseline child maltreatment Awareness, Commitment and Norms Survey data.

III. Integrate the Science into and across Systems, Services & Programs

A. Recruited ACE Interface Master Trainer Cohort across professions, sectors and communities to ensure a common language for the integration of ACE science into the systems and networks that serve Maryland children and families.
B. Assisted with drafting by-laws and co-founding the Infant Mental Health Association of Maryland and D.C. together with Essentials for Childhood Collective Impact Team partners, in order to promote infant mental health.
C. Participate in meetings, activities and/or grant applications of: Resilience Wellness & Prevention Committee; Children's Mental Wellness Campaign; Project LAUNCH State Young Child Wellness Council; Early Childhood Mental Health Steering Committee; Early Childhood Comprehensive Systems; Infant Mental Health Association of Maryland & D.C.; Partnership for a Safer Maryland; Family-Informed Trauma Treatment Center Steering Committee; Maryland Commission on Caregiving; Children's Justice Act Committee; Social Services Administration (SSA) Integrated Practice Model Workgroup; SSA Alternative Response Workgroup; SSA Well-Being Workgroup; and, the Social Services Advisory Committee.

IV. Integrate the Science into Policy and Financing Solutions

A. Created ***Public and Private Sector Policy & Financing Solutions Workgroup*** to lead, identify, assess, and advocate for key policies to promote safe, stable, and nurturing relationships and environments for children and to prevent child maltreatment and other ACEs.
B. Reviewed *Exploring policies for the reduction of child physical abuse and neglect*, Joanne Klevens, Sarah Beth L. Barnetta, Curtis Florencea, and DeWayne Moore, Centers for Disease Control and Prevention, Division of Violence Prevention, Atlanta, GA, USA[18]
C. Developed and advocated for the implementation of the following key policies to promote safe, stable, and nurturing relationships and environments for children and prevent child maltreatment and other ACEs:

[18] Klevens, J., Barnett, S. B., Florence, C., & Moore, D. (2015). Exploring policies to reduce child physical abuse and neglect. *Child Abuse & Neglect, 40,* 1-11.

1. *Passage of HB 1582-Human Services Children Receiving Child Welfare Services-Centralized Comprehensive Health Care Monitoring Program to Meet the Health Needs of Children involved in the Child Welfare System:*

After reading SCCAN's 2015 Annual Report recommendations, Delegate CT Wilson sponsored HB 1582. Members of SCCAN's Medical Director Legislation Workgroup led efforts to draft, provide testimony and advocate for the bill's passage. SCCAN and Maryland Essentials for Childhood Meetings were used to solicit feedback and to improve the draft legislation. The bill passed unanimously out of both houses of the General Assembly and was signed into law by Governor Hogan on May 8, 2018. The statute creates:

- A centralized **physician medical director at DHS** to bring clinical and public health expertise to:
  - The investigation of child abuse and neglect reports
  - Ensure effective oversight, coordination, and tracking of the physical, mental, developmental, and oral health care needs of children in foster care
  - Promote early diagnosis and intervention, which can **improve health outcomes for these children, and reduce the cost of care.**
  - Ensure that children in foster care get appropriate health care coordination to improve overall health outcomes.
  - Evaluate barriers to permanency and stability for youth with disabilities in foster care, which could improve successful transition out of foster care.
- A mandate for DHS to develop and utilize an **electronic health record** for care coordination to:
  - Improve preventive health, and reduce mental health hospitalizations, psychotropic medication use, and unnecessary laboratory testing.
  - Facilitate accurate and up-to-date medical information sharing amongst the child's various care providers/caregivers to prevent fragmented care and medical errors.

2. *Passage of HB 1072- Child Sexual Abuse Prevention- Instruction & Training:*

- Adds "sexual misconduct" to the education code, which helps prevent child sexual abuse by expressly prohibiting inappropriate and dangerous sexual conduct by school employees
- Defines "sexual misconduct" as an act by an adult, including an oral, nonverbal, written, or electronic communication, or a physical activity directed toward or with a minor that is designed to promote a romantic or sexual relationship with the minor, including: sexual or romantic invitation, dating or soliciting dates, engaging in sexualized or romantic dialogue, making sexually suggestive comments, grooming behaviors, self-disclosure or physical exposure of a sexual, romantic, or erotic nature; and, a sexual, indecent, romantic, or erotic contact with the minor.
- Requires *annual* instruction and training of *all school employees* on the prevention, identification and reporting of child sexual abuse and misconduct that will provide them with the ability to:
  - Recognize sexual misconduct in adults;
  - Recognize, and appropriately respond to sexually inappropriate, coercive, or abusive behaviors among minors;
  - Recognize behaviors and verbal cues that could indicate a minor has been a victim of child sexual abuse; and,

- Respond to disclosures by minors or their parents or guardians of child sexual abuse or reports of boundary-violating behaviors of adults or minors in a supportive and appropriate manner that meets mandatory reporting requirements under state law.

- Allows for in-person or e-learning instruction and training.
- Requires the instruction and training to be periodically reviewed and updated.
- Requires each County Board to establish and implement policies that support the prevention of child sexual abuse through ongoing training of staff regarding:
  - Behavior that constitutes adult perpetration;
  - Reporting obligations and procedures; and,
  - For staff involved in the hiring process, comprehensive screening of prospective employees
- Requires each County Board to develop Employee Codes of Conduct that address appropriate contact between staff and students.
- Requires the Interagency Committee on School Construction and the State Council on Child Abuse and Neglect to jointly develop guidelines and best practices for the assessment and modification of physical facilities and spaces to reduce opportunities for child sexual abuse.
- Requires each County Board to make information about the education and training opportunities available to parents, legal guardians, and other interested persons in the community.

3. ***Drafting and Advocacy for HB 1571-Child Sexual Abuse Prevention-Employment Process:***
   HB 1571 passed the House of Delegates unanimously, but failed to make it out of Committee in the Senate. HB 1571:

- Required comprehensive screening of prospective employees and volunteers to eliminate "passing the trash" among educational institutions and/or other youth serving organizations. Passing the trash occurs when a teacher accused of sexual abuse/misconduct resigns, retires or is terminated and is allowed to quietly move to another school/school district without his or her new employer being alerted to the allegations of misconduct.
- Prohibited the practice by banning confidentiality/separation agreements in instances of sexual misconduct/violence, requiring information sharing between employers, and mandating annual training of all school community stakeholders to recognize and report sexual misconduct.

4. ***Policies to Prevent Child Abuse and Neglect Fatalities:***
   ****Key Success- Passage of SB 490- Child Abuse and Neglect- Disclosure of Identifying Information,* led by Maryland Essentials for Childhood partner Advocates for Children and Youth. Other actions included:**
   a. Reviewed the National Commission of Child Abuse & Neglect Fatalities (CECANF) report Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities and fact sheet with its findings and recommendations in April 2016.
   b. SCCAN and SCFRT members formed a joint workgroup [Maryland Child Abuse & Neglect Fatalities (MCANF)] to review child fatalities related to child maltreatment. Members of CRBC later joined the workgroup.

c. As most child abuse and neglect fatalities & near fatalities in Maryland (and throughout the country) occur to children *under* 5 years of age, the Workgroup is reviewing all "unusual and unexpected" fatalities statewide of 0-4 year olds in CY2015 to determine: 1) whether or not the death was related to abuse and neglect; and, 2) what systems improvement recommendations could prevent future deaths. The state-level review will be completed in the Spring of 2019. After completing reviews of all child fatalities in Baltimore City, MCANF has made the following preliminary observations:

   i. Child victims are primarily infants and toddlers. ***Proposed policy:*** Screen in all children under 3 as "Risk of Harm" cases and do an in-home assessment of risk.

   ii. Many of the deaths are sleep-related, with additional risk factors present.

   - Based on a review of records, the child and the child's caregivers often had multiple ACEs (involvement as a child in child welfare, juvenile justice, corrections and school dropout and failure) and were struggling with substance use, mental health disorders, intimate partner violence. ***Proposed policy:*** Integrate ACE and resilience screenings into primary care and link parents/caregivers with high ACE scores to supportive services pre and post natally. ***Achieved Policy Change:*** SB 490 amended Maryland's Birth Match law to:
     - expand the scope of the existing law so that birth match is triggered for parents who have had their parental rights terminated within the last **10** rather than 5 years;
     - include individuals who have been **convicted** of murder, attempted murder, and manslaughter of a child; and
     - require an assessment of the effectiveness of data sharing between DHS, SSA and MDH in predicting and preventing child abuse and neglect, including making recommendations on how to better target record-sharing activities.

   iii. While mothers may have had prior parenting services, i.e., infant safe sleep, home visiting, etc., the fathers and/or partners who were caregivers when the children died often had not been offered nor received these services. Science: Recent science emphasizes the need and importance of a new view of fatherhood.[19] Based on this science it is critical for the healthy development of our children that we reexamine the way our current child and family serving systems engage, respond to, and encourage participation by fathers.

   Proposed policy: Involve fathers and male caregivers in pre-natal, infant safe sleep, home visiting, WIC, child welfare services, etc. as a matter of course. Purposefully recruit fathers as home visitors

[19] Fathers' Roles in the Care and Development of Their Children: The Role of Pediatricians Michael Yogman, MD, Craig F. Garfield, MD, the COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD, FAMILY HEALTH, American Academy of Pediatrics; and, Depression among Urban Fathers with Young Children: A Research Report with Tips for Responsible Fatherhood Programs and Stakeholders, US Department of Health & Human Services, Administration for Children & Families, Office of Family Assistance; and, The Father Absence Crisis in America

and other caregiver support roles. Most of the children and families had not had prior CPS contact[20], although the parents may have been involved in child welfare as children themselves.

iv. The majority of families had been in contact with multiple systems: Temporary Cash Assistance (TCA), Medical Assistance (MA), Health Care Access Maryland (HCAM), SNAP, WIC, substance abuse and mental health treatment, within the 12 months prior to the child's death.

v. Lack of safe child care options was identified as an issue in a number of cases.

5. *Policies that Support Family Economic Stability*

a. Family-friendly work policies[21]- There are four key ways for businesses to support early childhood development:

- Increasing access to quality child care – partially achieved by increasing the child care subsidy (see below – SB 379/HB430)
- Supporting affordable child care
- Developing child-friendly policies & procedures
- Optimizing tax benefits

b. Sick Leave-Healthy Working Families Act passed

c. Paid Family Leave

6. *Policies to Provide Quality Care & Education in Early Life*

a. Adequate child care subsidies with no waiting list for access are known to decrease rates of child abuse and neglect[22]

b. SB 379 / HB 430 Education – Child Care Subsidies – Mandatory Funding Levels was signed into law. The Maryland Family Network, a Maryland Essentials for Childhood partner led the efforts on SB 379 which:

- Increases Maryland's child care subsidy rates to give parents access to quality care; and,
- establishes a new "floor" so that rates never again fall so low.

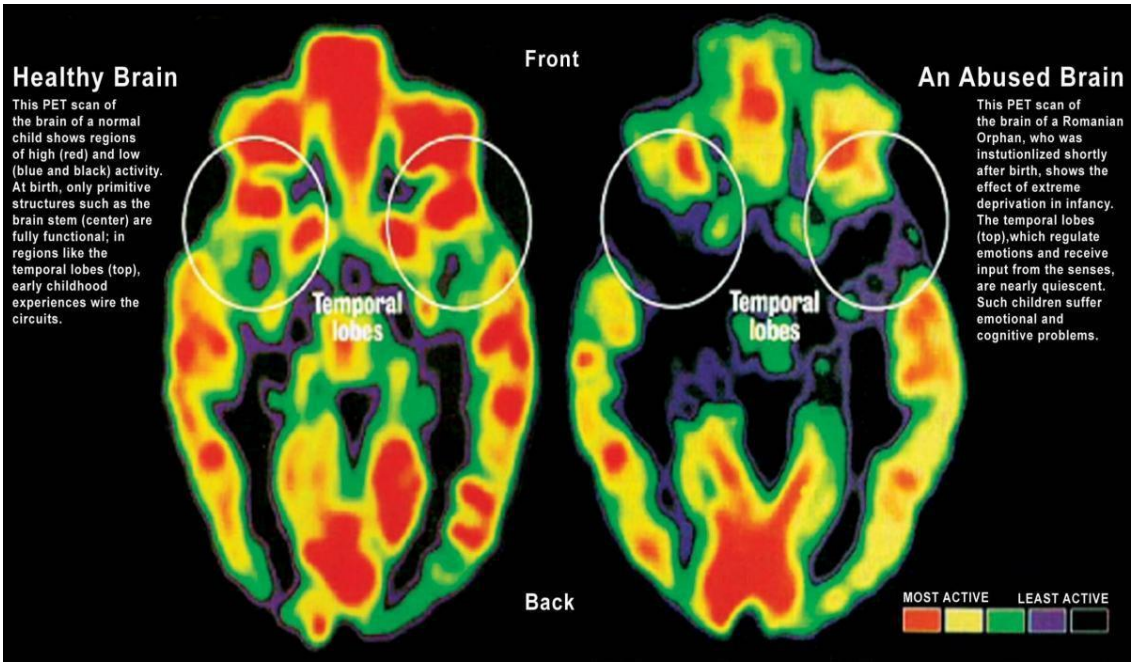
[20] Until October 1, 2016, Maryland law required all records of CPS "screened out" reports, as well as all records of investigations in which abuse and neglect was ruled out, to be expunged within 120 days.

[21] EPIC (Executives Partnering to Invest in Kids) Family-Friendly Workplace Assessment & Toolkit

[22] Klevens, J., Barnett, S. B., Florence, C., & Moore, D. (2015). Exploring policies to reduce child physical abuse and neglect. *Child Abuse & Neglect, 40,* 1-11

BRAIN SCIENCE AS A STRONG FOUNDATION FOR GOVERNOR HOGAN'S VISON OF ECONOMIC OPPORTUNITY & STRATEGIC GOALS

From the moment we take our first breath, to the moment we take our last, human connection (attachment and bonding) are central to everything in our lives, both individually and collectively. We know this intuitively, but neuroscience now clearly illustrates that our human interactions create the neural connections in our brains that form the very foundation of human development, relationships, learning, health, and economic prosperity. We can see, as in the illustration below, how the brain, especially the all-important frontal lobe, is impacted by adversity in childhood.[23]

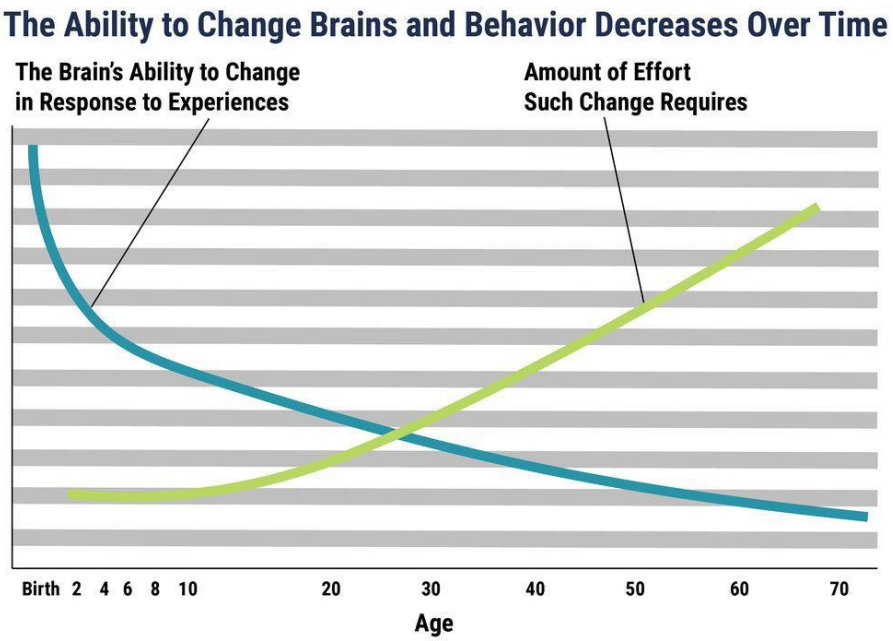


While Governor Hogan's four strategic goals identified in Maryland Children's Cabinet Three-Year Plan (Reduce the Impact of Incarceration on Children, Families, and Communities; Improve Outcomes for Disconnected/Opportunity Youth; Reduce Childhood Hunger; and, Reduce Youth Homelessness) are very important to youth well-being, they are not sufficient to realize the Governor's goal of greater economic stability and human capital formation to long-term self-sufficiency for children, youth, and families. Each of Governor Hogan's goals would be strengthened by purposeful dissemination and an understanding of the implications of the science of the developing brain, ACEs, and resilience. The Action Items laid out in the Three-Year Plan should each be grounded in this science. Policy makers should ensure that state agency policies, strategies, and technical assistance focuses on strengthening caregiver,

[23] http://wellcommons.com/groups/aces/2011/jul/22/this-is-a-brain-on-trauma-this-is-the-li/ and https://www.lcsun-news.com/story/news/local/new-mexico/2018/01/21/severe-childhood-trauma-alter-developing-brain-create-lifetime-risk/1039104001/

family and community capacity to create safe, stable and nurturing relationships and environments that most importantly promote healthy child and youth development; and, in turn, prevent a multitude of negative outcomes from substance abuse, mental illness, high school dropout, delinquency, youth suicide, bullying, youth homelessness, intimate partner violence, youth unemployment and child maltreatment. A vision based in the science of the developing brain, ACEs and resilience has helped communities around the country (especially in states where there has been coordinated efforts to disseminate the science) to coordinate their efforts at both the state and local level to move the dial on important measures such as significantly reducing high school suspension rates and increasing graduation rates.[24] The following core concepts should be infused into the Children's Cabinet Action Plan:

I. **A primary focus on Early Childhood Development is foundational to promotion and prevention efforts i.e., Brains are built from the bottom up. Skills beget skills. And, the ability to change brains and behavior decreases over time (brain plasticity).**



The Council believes that knowledge and understanding of core concepts of neuroscience, ACEs and resilience should serve as a foundation for public policies that affect the lives of children, their families and their communities. Building strong healthy families and communities requires that we make investing in early childhood a high priority to ensure social, emotional, behavioral, cognitive and physical health throughout the lifespan. It is much easier and less expensive to support caregivers, families and communities build a strong foundation in early childhood, than to wait and address weaknesses in the foundation later. See Economic Costs of Child Maltreatment in Diagram below:

[24] See, *Paper Tigers* documentary

ANNUAL 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***

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*.[25]

II. **Prevention of Childhood Adversity and Early Intervention to Mitigate Trauma is a necessary precursor to effectively preventing many youth problems, including youth homelessness and disconnection.**

A recent study looked at the link between ACEs and adult education, employment, and income. Data was analyzed from ten states and the District of Columbia that used the adverse childhood experiences (ACE) module in their 2010 Behavioral Risk Factor Surveillance System. Participants with higher ACE scores were more likely to report high school non-completion, unemployment, and living in a household below the federal poverty level, compared to those with no ACEs. This evidence suggests that preventing early adversity may impact health and life opportunities that reverberate across generations.[26]

[25] Why Early Investment Matters?, The Heckman Equation, James J. Heckman, PhD

[26] Adverse Childhood Experiences and Life Opportunities: Shifting the Narrative, Children & Youth Services Journal, Marilyn Metzler, RN, MPH; Melissa T. Merrick, PhD; Joanne Klevens, MD, PhD, MPH; Katie A. Ports, PhD; Derek C. Ford, PhD.

Another Minnesota study in 2016, found that of all students surveyed, four percent had experienced four or more adverse childhood experiences. In comparison, 16 percent of homeless children surveyed had experienced four or more adverse childhood experiences.[27] Waiting to address symptomatic behaviors (such as, youth disconnection, homelessness, school failure, substance abuse, etc.) and illness (depression, anxiety, suicide, etc.) until children enter school, their teen years or adulthood, requires expending more resources and producing less satisfactory results for both the individuals and the communities in which they live.[28]

[27] 2016 Minnesota Survey of 8th, 9th, and 11th graders regarding ACEs.

[28] Research has shown adverse childhood experiences to have multiple negative impacts throughout an individual's life. More ACEs reduce the likelihood of high school graduation and holding a skilled job (Giovanelli et al, 2016). More ACEs also increase the likelihood of teen pregnancy and fetal death in pregnancy (Hillis et al, 2004); behavioral problems (Greeson et al, 2014); juvenile arrest, and felony charges (Giovanelli et al, 2016). Moreover, ACEs can negatively impact a wide range of health and social factors including an increased risk of homelessness (Herman et
al, 1997), illicit drug use (Dube et al, 2003) and depression (Giovanelli et al, 2016; Anda et al, 2005).

Anda, R. F., V. J. Felitti, J. D. Bremner, J. D. Walker, Ch Whitfield, B. D. Perry, Sh R. Dube, and W. H. Giles. 2005. "The Enduring Effects of Abuse and Related Adverse Experiences in Childhood." *European Archives of Psychiatry and Clinical Neuroscience* 256 (3): 174–86.

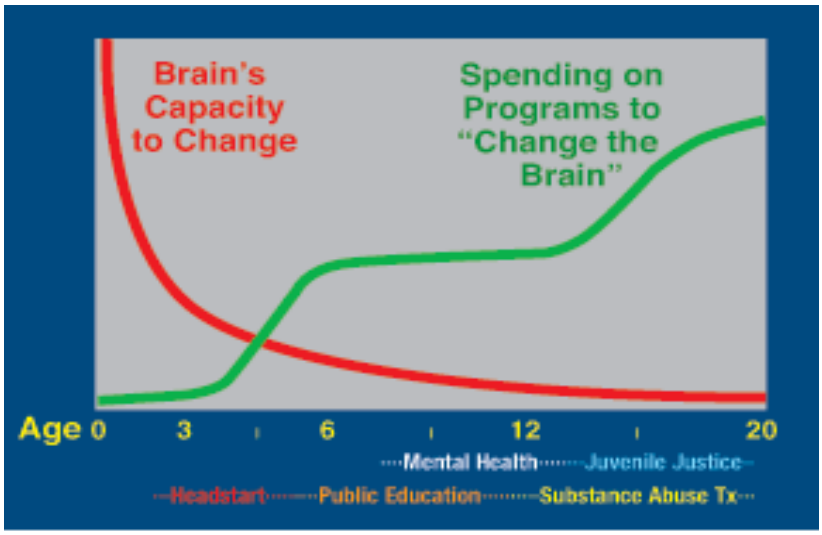
Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, and Anda RF. 2003. "Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study." *Pediatrics* 111 (3): 564–572 9p.

Giovanelli, Alison, Arthur J. Reynolds, Christina F. Mondi, and Suh-Ruu Ou. 2016. "Adverse Childhood Experiences and Adult Well-Being in a Low-Income, Urban Cohort." *Pediatrics*, April, peds.2015-4016.

Greeson, Johanna K. P., Ernestine C. Briggs, Christopher M. Layne, Harolyn M. E. Belcher, Sarah A. Ostrowski, Soeun Kim, Robert C. Lee, Rebecca L. Vivrette, Robert S. Pynoos, and John A. Fairbank. 2014. "Traumatic Childhood Experiences in the 21st Century Broadening and Building on the ACE Studies With Data From the National Child Traumatic Stress Network." *Journal of Interpersonal Violence* 29 (3): 536–56.

Herman, D B, E S Susser, E L Struening, and B L Link. 1997. "Adverse Childhood Experiences: Are They Risk Factors for Adult Homelessness?" *American Journal of Public Health* 87 (2): 249–55.

Hillis, Susan D., Robert F. Anda, Shanta R. Dube, Vincent J. Felitti, Polly A. Marchbanks, and James S. Marks. 2004. "The Association Between Adverse Childhood Experiences and Adolescent Pregnancy, Long-Term Psychosocial Consequences, and Fetal Death." *Pediatrics* 113 (2): 320–27.



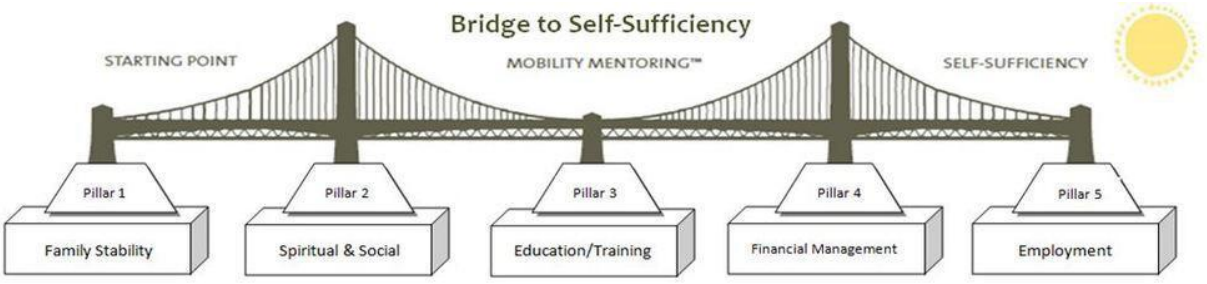
The brain has the greatest capacity for change in the earliest years. Unfortunately, we as a society tend to wait until teens begin to show symptoms of earlier childhood adversity before we allocate resources to addressing the impact of this adversity on the brain when our efforts are less likely to help and are significantly more expensive.

III. **Data systems should track the trajectory of children from one state system and/or service to the next.**

Current systems have a plethora of duplicative data; however, little sharing takes place between systems, and multiple systems working with the same families do so with little knowledge and coordination of services provided in other systems. The Maryland Child Abuse & Neglect Fatality (MCANF) Review Committee was struck by the number of systems in which caregivers had been involved, both in their childhood and early adulthood (e.g. child welfare, Medicaid, SNAP, TANF, juvenile justice, mental health and substance abuse services); with resulting poor outcomes for themselves; and, tragically, fatal outcomes for their young children. Tracking of long-term outcomes for children and families requires tracking the life course, across systems. If a child who receives services from child welfare and later ends up failing or dropping out of school, without a career, in juvenile services, homeless, pregnant as a teen, sexually trafficked, depressed, suicidal, abusing substances or experiencing a child fatality, the system cannot be said to have succeeded. Unfortunately, our current systems track only short-term system-specific outcomes.

The Council and MD EFC are encouraged by the Governor's investment in MD THINK; and, are cautiously optimistic that it will integrate access to programs across agencies, give front-line workers information to provide services in the field, link to important data from other professionals in real time, decrease duplicative data entry saving time to spend with clients, share data across agencies, and provide the ability to enter and track outcomes across agencies and the lifespan to inform decision-making regarding the programs, systems and services improvement on behalf of children and families

IV. Using Brain Science to Design Multi-Generation Paths Out of Violence, Poverty, Addiction and Mental Illness



[31]

Adverse childhood experiences, including persistent poverty, can directly derail brain development and the executive function skills (impulse control, working memory, and mental flexibility) most needed for become economically self-sufficient. Science is increasing our understanding of the challenges caused by ACEs, and with that understanding comes the ability to improve policy and program design. The sections of the brain impacted by ACEs remain plastic well into adulthood. "To attain economic independence, low-income families today must navigate a complex environment requiring strong strategic thinking skills to set a career destination and optimize their lives in the five key areas Crittenton Women's Union has identified as pillars of its Bridge to Self-Sufficiency® (Bridge) theory of change: family stability (principally housing and child stability); wellbeing (principally health/behavioral health and social supports); education; financial management; and career management."[29] Through effective coaching, executive function skills may be strengthened and improved leading to improved outcomes in relationships (people skills), parenting, money management, educational attainment and career success.[30] Coaching parents who have been impacted by ACEs, in turn helps ensure the development of those skills in their children and subsequent generations.

V. Understanding brain science, ACEs and how trauma impacts executive function skills is critical to providing the best possible Customer Service in child and family service systems.

As one of Governor Hogan's top priorities is excellent customer service to Maryland residents, it should be noted that "simply educating staff about the special executive function challenges low-income families face and the causative factors for these

[29] "Using Brain Science to Design New Pathways Out of Poverty", Elisabeth D. Babcock, MCRP, PhD, Crittendon Women's Union 2014.
[30] Ibid.

challenges can significantly improve staff interactions with clients and the quality of program delivery. Staff who formerly might have attributed willful intent to participants' seemingly counterintuitive decision making or behaviors, instead will realize that such thinking or behaviors is quite logical given the participants' history and experience. This realization alters staff behavior, increases tolerance, and generates more useful ideas and interventions that improve outcomes."[31] As level II of the Governor's G.O.L.D. Standard Customer Service Training initiative, all state agency staff working with the public, beginning with executive staff and supervisors, should be trained by ACEs Interface Master Trainers.

VI. Understanding ACEs Changes Practice: A Note on the Opioid Epidemic

Dr. Daniel Sumrok, director of the Center for Addiction Sciences at the University of Tennessee Health Science Center's College of Medicine (and one of the first 106 physicians in the U.S. to become board-certified in addiction medicine by the American Board of Medical Specialties) learned about ACEs about two years ago. It was a big turning point for his understanding of addictions. "I was working in an eating disorders clinic and someone told me '90 percent of these folks have sexual trauma'. I remember thinking: That can't be right. But that was exactly right. Since I've learned about ACEs, I talk about it every day."

Dr. Sumrok says: Addiction shouldn't be called "addiction". It should be called "ritualized compulsive comfort seeking".

He says: Ritualized compulsive comfort-seeking (what traditionalists call addiction) is a *normal* response to the adversity experienced in childhood, just like bleeding is a normal response to being stabbed.

He says: The solution to changing the illegal or unhealthy ritualized compulsive comfort-seeking behavior of opioid addiction is to address a person's adverse childhood experiences (ACEs) individually and in group therapy; treat people with respect; provide medication assistance in the form of buprenorphine, an opioid used to treat opioid addiction; and help them find a ritualized compulsive comfort-seeking behavior that won't kill them or put them in jail.[32]

Since learning of ACEs, Dr. Sumrock screens all his patients for ACEs, goes over each question with them and they get ACEs education and group therapy to help them understand their lives and addictions better.

[31] Ibid. p. 14.

[32] "Substance-abuse doc says: Stop chasing the drug! Focus on ACEs" , Jane Stevens, ACEs Connection 2017.

SCCAN Recommendations by Agent/Agency:

"If somebody would have listened, how many lives could have been saved?"

Gemma Hoskins, "The Keepers"

Break down and rebuild systems that do not work to protect children and prevent child maltreatment and other childhood adversity from happening *in the first place.* To our policy makers—we say, the science is clear; our children's pain, both current and generational unfolds daily before our eyes if we are willing to look; innovation is possible; and it requires courage to create a seismic shift in how our child and family serving agencies care for those they are meant to serve.

GOVERNOR

Strong leadership is essential to raising awareness of Adverse Childhood Experiences (ACEs) and encouraging communities to invent wise responses in support of our children and Maryland's future prosperity. The science of brain development, ACEs, and resilience must be front and center in our conversations on health, education, the economy, and community well-being and safety. To ensure public policy and practice align with the science of the developing brain, we recommend that the Governor:

1. Take meaningful action to raise awareness of brain science, adverse childhood experiences (ACEs) and resilience and build community commitment to prevent, reduce and respond to ACEs by launching an ACEs Initiative similar to Governor Bill Haslam and First Lady Chrissy Haslam's Launch Building Strong Brains Tennessee's ACEs Initiative or First Lady Tonette Walker's Fostering Futures, including Trauma-Informed State Agencies.[33]

2. Issue an executive order mandating child and family serving agencies participate in collective impact efforts to promote safe, stable & nurturing relationships and environments for children, build strong brains, prevent ACEs, and promote resilience. Building upon efforts of Maryland's Essentials for Childhood Initiative and local ACE community initiatives in Frederick, Washington, Harford Counties and Baltimore City, designate a state lead agency for the Maryland Essentials for Childhood Initiative[34]

3. Require each member of the Children's Cabinet to designate authority to two members of their staff to lead their agency's full participation in the initiative.

4. Call upon key leaders in Maryland's business and faith-based communities to join in the Initiative.[35]

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[33] Examples of other states with Brain/ACEs Initiatives: Wisconsin, South Carolina, North Carolina, Iowa, Colorado, Washington, California, Alaska, and Minnesota.

[34] Include language that the policy decisions, statements, and funding announcements of Maryland Children's Cabinet agencies will acknowledge and embed the principles of early childhood brain development and will, whenever possible, consider the concepts of toxic stress, adverse childhood experiences, and buffering relationships, and note the role of prevention, early intervention and investment in early childhood years as important strategies to achieve a lasting foundation for a more prosperous and sustainable state through investing in human capital. Use a multi-generation approach- children come with parents and grandparents; and, will become parents themselves.

[35] See, EPIC-Executives Partnering to Invest in Kids , Ready Nation, Washington County, OR, Faith-Based Organizations, and Faith Leader's Guide to Paper Tigers: Adverse Childhood Experiences

5. Support legislation and funding of a Children's ACEs Prevention Trust Fund administered by a public-private board of directors to lead innovative interventions and financing across the state.[36]

6. Establish an ongoing Child Welfare Health Coordination Expert Panel led by the Child Welfare Medical Director to ensure communication and coordination between the multiple agencies that provide health services to children with the child welfare system.

CHILDREN'S CABINET AGENCIES
GOC, GOCCP, DHS, MDH, DJS, MSDE, DOD, DPSCS, DBM, DLLR

1. Review the Tennessee and Wisconsin examples of statewide models to create a culture change in child and family serving agencies to focus on a multi- generation approach to responding to childhood adversity based on the science of the developing brain, ACEs (trauma/toxic stress) and Resilience.

2. Review Maryland's 2015 baseline ACE Module Behavioral Risk Factor Surveillance System (BRFSS) data.

3. Embed Brain Science, ACEs (trauma/toxic stress) and Resilience into the Children's Cabinet Three-Year Plan. Start by providing ACE training to all Children's Cabinet members. When creating future plans, consider how each recommendation might reduce ACEs or the effects of ACEs, and how it might improve resilience.

4. Offer free screenings and time to view the film *RESILIENCE: The Biology of Stress & The Science of Hope* to introduce staff to the Brain Science, ACEs and Resilience and trauma-informed systems and, provide opportunity for dialogue of how it might be used to provide better customer service.

5. As level II of the Governor's G.O.L.D. Standard Customer Service Training Initiative, have ACEs Interface Master Trainers train all staff, beginning with supervisors.

6. Explore ways to increase awareness of the brain science and the impact of ACEs on the people your agencies serve. Integrate the science across agencies and within individual agencies by:
    - Partnering in Maryland Essentials for Childhood to ensure cross-agency coordination.
    - Screening clients for ACEs and resilience factors
    - Providing pre-service and in-service training to all staff on brain science, ACEs and resilience
    - Identifying a standard of care that includes assessing for and responding to ACEs, to be integrated into contracts as performance measures
    - Embedding the science into strategic planning with local agencies and connect to funding
    - Ensuring organizational policies and regulations reflect the science
    - Ensuring practice models reflect the science

[36] http://www.ctfalliance.org/about.htm

- Investing resources in evidence-based trauma interventions; and, creating a trauma-informed agency
- Using effective communication strategies to connect the dots between state child and family serving programs as a response to the science. Develop an umbrella message and integrate it into messaging across agencies and programs, including websites and press releases regarding child and family serving policies and programs.

7. Require that child serving agencies and youth serving organizations receiving state funding institute the Comprehensive Child Sexual Abuse training, policies and guidelines below (under the recommendation to the General Assembly).

8. Ensure your agency has a Report Child Abuse hotlink on its homepage; and, a link to DHS page for reporting suspected abuse.

GENERAL ASSEMBLY

1. 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.[37]

2. Pass legislation establishing a robust Children's ACEs Prevention Trust Fund.[38]

3. Build upon the initial successes of HB 1072 in passing Comprehensive Child Sexual Abuse Prevention Legislation by the following:
   A. Expand HB 1072 target audience, by requiring training of volunteers; and,
   B. Expand the target audience by mandating training of adults in all youth-serving organizations receiving state funding.

   As 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 volunteers, as well as employees, and within youth-serving organizations leaves kids vulnerable both before and after abuse occurs.

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[37] Examples of 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
- 2017 Utah House Concurrent Resolution 10

[38] 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.

Comprehensive Child Sexual Abuse Prevention in youth serving agencies should include the following components:

- A clear statement delineating the need for primary prevention (before sexual abuse occurs) efforts, in addition to improving current reporting (after the fact) efforts.[39]
- Lead with a clear focus on *adult responsibility for preventing child sexual abuse*:
    - Require participation by all youth-serving organizations that are state-operated, state-licensed or state- funded;[40]
    - Educate adults first;[41]
    - Educate *all* adults whose positions bring them into nonincidental contact with children;[42]
    - Instruction should help adults:
        - recognize harmful or illegal sexual behaviors by adults against children and grooming behaviors that might indicate an adult poses a threat of harm to children;[43]
        - 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;[44]
        - Recognize behaviors that might indicate a child or youth has been a victim of sexual abuse and report concerns appropriately;[45]
        - Support the healthy development of students, children and youth by ensuring adults within the system are provided resources,[46] training,[47] and standards for promoting healthy social emotional development and relationships (e.g., sexuality education[48], focused "boundary" education to reduce child-on-child behaviors appropriately[49], knowledge of the rules (e.g., school rules) and laws (e.g., age of consent), and creating trauma-sensitive child and youth serving environments;[50]

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[39] 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

[40] Massachusetts's CSA legislation https://malegislature.gov/Bills/189/Senate/S316

[41] Prevent Child Abuse America, State and Federal Legislative Efforts to Prevent Child Sexual Abuse: A Status Report, 2015

[42] Massachusetts's CSA Prevention draft legislation https://malegislature.gov/Bills/189/Senate/S316

[43] Ibid.

[44] Ibid.

[45] Ibid.

[46] **http://www.nsvrc.org/projects/child-sexual-assault-prevention/preventing-child-sexual-abuse-resources**

[47] http://www.enoughabuse.org/training-workshops.html and http://www.d2l.org/

[48] **http://static1.squarespace.com/static/513f79f9e4b05ce7b70e9673/t/56718463a976af3e2f3ecb38/1450280035958/state-scorecard-summary-table-for-k-12-12-16-15.pdf** and **http://www.futureofsexed.org/documents/josh-fose-standards-web.pdf** , **http://www.uua.org/re/owl/**

[49] **http://www.nsvrc.org/projects/child-sexual-assault-prevention/preventing-child-sexual-abuse-resources**

[50] **http://traumasensitiveschools.org/**

- Establish and implement program and youth-serving organization policies that support the prevention of and effective response to sexual abuse through;
    - Ongoing training of staff about child sexual abuse by adults and problem sexual behavior by children;[51]
    - Comprehensive screening of prospective employees and volunteers;[52]
    - 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 grooming behaviors that don't reach the level of abuse;[53]
    - The assessment and modification of physical facilities and spaces to increase the observability and "interruptability" of adult-child and child-child interactions, to reduce opportunities for sexual abuse[54]
- Respond to all 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
- 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

▪ Provide resources for parents on how to talk with children about child sexual abuse[55]

▪ Eliminate "passing the trash" among educational institutions and/or other youth serving organizations;[56]

- 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).

▪ When child-focused prevention efforts are implemented, these should be evidence based or, at minimum, comport with recommendations for best prevention practices. Evidence-based interventions that effectively prevent practices. Evidence-based interventions that effectively prevent peer-on-peer sexual

[51] Massachusetts's CSA Prevention draft legislation

[52] Ibid.

[53] *State and Federal Legislative Efforts to Prevent Child Sexual Abuse: Status Report*, Jetta Bernier, MA CSA Prevention draft legislation, Keith Kaufman, Missouri Act

[54] Keith Kaufman, MA CSA Prevention draft legislation

[55] Vermont Act One & Oregon legislation

[56] PA, MA & MO "SESAME" acts

harassment and sexual violence perpetration and victimization include the "Shifting Boundaries middles school intervention and the "safe dates" Middle school intervention. Middle school intervention. More generally, best practices for prevention programming include the following components:

a. Multi-session dosage (i.e., a one-time training is unlikely to affect real change);
b. Skills practice with feedback (i.e., solely didactic trainings are unlikely to affect real change);
c. Parental involvement
d. Developmentally appropriate content (e.g., middle- and high-school trainings should include review of laws related to consent and sex crimes as well as focus on issues of consent and mutuality within the context of dating and friendship, whereas programs for younger children can focus more generally on positive behavior between children and inappropriate behavior by adults or other children);
e. Careful attention to language to avoid suggestion of victim-blaming and use of person-first language when talking about people who may have been victimized or people who may have engaged in harmful behavior to avoid equating youth with these experiences.

- Include CSA prevention & intervention training in educator preparatory curricula;[57]
- Provide a mechanism for evaluating the effects of policy change on institutional practices and trainings; and, the effects of policy, practice and training on the incidence of child sexual abuse;
- Provide a mechanism for quality assurance and enforcement of child sexual abuse prevention policies, practices and training at the Maryland State Department of Education;

4. Pass legislation to prevent "Passing the trash"[58] heightening the screening requirements for school employees, contractors and volunteers.
5. Pass legislation 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 health of 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

[57] North Carolina Task Force Report, MA CSA Prevention draft legislation, New Mexico Law
[58] e.g., Pennsylvania passed Act 168 in 2014 to prohibit the practice known as "pass the trash" to require extensive employment history checks be completed prior to a local education agency hiring an individual in a position that may require direct contact with children.

providing Medical Assistance to former foster care youth until age 26.

JOINT DHS & MDH

In support of effective implementation of HB 1582:
Establish an ongoing Child Welfare Health Coordination Expert Panel led by the Child Welfare Medical Director to ensure communication and coordination between the multiple agencies that provide health services to children with the child welfare system. Suggested members of this panel are included in the footnote[59].
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. Program evaluation and oversight to monitor the percentage of children who receive timely, appropriate and accurate medical evaluations.
iv. Create a mechanism for adequate reimbursement of providers that is tied to provider performance.
v. Report annually to the Governor and legislature regarding the progress of implementation.

[59] Suggested Members: *Interagency Child Welfare Health Coordination Expert Panel*
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;
- DHS Out of Home Services;
- DHS Child Protective Services and Family Preservations Services;
- DHS Resource Development, Placement, and Support Services;
- MDH, Maternal and Child Health Bureau;

MDH, Environmental Health Bureau, Center for Injury & Sexual Assault Prevention

- Medicaid;
- Behavioral Health;
- DHS and MDH representatives with expertise in their agency's child fatality review processes;
- Maryland State's Attorney's Association;
- County health department representatives;
- County DSS agency representatives;
- Maryland Legal Aid Bureau;
- Maryland CASA;
- Programs that currently contribute to medical and forensic services funding for children involved in the child welfare system
    - Maryland Medicaid,
    - MDH Center for Injury and Sexual Assault Prevention,
    - GOCCP/VOCA).

DHS

1. See Children's Cabinet agency recommendations above.

2. As plans for the new hotline for reporting child abuse are implemented:
   - Ensure that de-identified aggregate data is collected and analyzed to inform decision-making to improve the reporting and screening system.
   - Ensure that local DSS have updated phone technology, sufficient staff and standardized training to implement the statewide hotline.

3. Embed the brain, ACEs and resilience science and a multi-generational approach into policies across administrations at DHS. Implement strategies to prevent and mitigate ACEs (trauma-informed) and build resilience to create safe, stable and nurturing environments for the children of parents receiving DHS services (CSE, FIA and SSA)[60]

4. As level II of the G.O.L.D. Standard Customer Service Training, use ACEs Interface Master Trainers to train all staff who work with the public in Brain Science, ACEs and Resilience.

5. Increase fathers' and mothers' male partners' emotional support of their children and families
   - Collaborate with partners to further infuse fatherhood and male responsibility initiatives into settings with boys and men
   - Make deliberate and special efforts to include male caregivers in attachment and parenting skills programs (e.g., Circle of Security Parenting, home visiting sessions)

6. Ensure that leaders and participants in the development of MD THINK and CJAMS include experts in child welfare policy, database design and data management, and child health and health policy (the State Medical Director for Children Receiving Child Welfare Services) so that the system can effectively:
   - Integrate child-welfare, birth, and death data in order to analyze fatal maltreatment risks
   - Collect longitudinal data on foster youth and their families so that well-being and long term outcomes can be tracked. These outcomes should include frequency of placement changes, frequency of school changes, and medical and mental health services needed and received. This was a repeated recommendation included in DHR's Quality Assurance Processes in Maryland Child Welfare.[61]

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[60] "Applying the science of Child Development in Child Welfare Systems", Center on the Developing Child, Harvard University.

[61] In the 5th Annual Child Welfare Accountability Report dated December 2011, DHR makes this recommendation repeatedly and the draft of the 6th Annual Child Welfare Accountability Report, includes this robust explanation: **Recommendation: Track entry cohorts over time.** Prospective measures are preferable to measure child welfare outcomes. Following one population of children and youth through their child welfare experiences is the single best, least biased, method of measuring service receipt and outcomes (Wulczyn, 2007; Zeller & Gamble, 2007). Examining

- Determine how often children involved with child welfare end up involved with the Department of Juvenile Services, how their educational achievement and health compares to their non-system involved peers, and for older foster youth who transition out of care, whether they have stable housing as adults.
    - There has been an MOU in place between DHS and MSDE to allow for the sharing of data regarding foster youth since September 27, 2013. It is also now a federal requirement pursuant to the Every Student Succeeds Act for states to track educational outcomes for foster youth.
- Identify family service needs, determine whether those services were received, and if not received, identify the reasons why not.[62]

Social Services Administration

1. See Children's Cabinet recommendations above.

2. See Joint MDH-DHS recommendations above.

3. Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in foster care. Ensure that all adults, including foster parents, people who work or volunteer in group homes and residential treatment centers, and licensed contractors, involved with foster youth are trained and institute policies in child sexual abuse prevention.

4. Ensure that all children who are referred to the local DSS are screened for child sexual abuse and are referred and linked to service for treatment. Cases should remain open until linked to treatment services. Case records should indicate 1) child sexual abuse and 2) documentation that the child is receiving treatment.

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children's trajectory through the various levels of child welfare services is the best way to understand the effects of services on children and families. Entry cohort analyses are being successfully utilized in Maryland to examine welfare service utilization through a partnership between DHR/SSA and UM/SSW and should be expanded in the future. It is in Maryland's best interest to utilize the power available through the MD CHESSIE system to examine the trajectory of children through the child welfare system in a prospective manner. A prospective analysis will allow Maryland to follow children from report through investigation, to in-home or out-of-home child and family services, to the outcomes of safety, permanency, and well-being. (Maryland Child Welfare Performance Indicators (Draft), December 2012 p. 38)

[62] During the 2013 Legislative Session when the statute regarding substance exposed newborns (Md. Code Ann. Family Law § 5-704.2) was amended the General Assembly required the Department of Human Resources (DHR) to file an interim and final report analyzing implementation of the changes. DHR's data in those reports is telling for our purposes and underscores the importance of tracking when families receive services. The Preliminary Report from October 2014 documents 1,734 assessments of families with substance exposed newborns. According to the report, there were 400 and 89 instances of "'conditionally safe' (safe if the family accepts services)" and "unsafe" respectively. (Maryland Department of Human Resources, "Substance-Exposed Newborn Reporting in Maryland— Preliminary Report," p. 3 (October 1, 2014)) Yet, only **34% of these** individuals (168) are documented as receiving services. (Id. at p. 4. DHR's report states that MD CHESSIE might be undercounting who actually receives services.) Unfortunately, the October 2015 report documents an even smaller percentage of families receiving services. Only **26%** of families (347) identified as "conditionally safe" and "unsafe" received services. (Maryland Department of Human Resources, "Substance-Exposed Newborn Reporting in Maryland—Final Report," p. 4 (October 1, 2015)) **Given that DHR's 2015 report indicates that almost 75% of families assessed as needing services did NOT receive any, it is essential that we see why these families aren't getting the help LDSS determines that they need.**

5. Screen in all children under 3 as Risk of Harm cases and do an in-home assessment of risk. Provide services for families at risk for child fatality or near fatality.

6. Involve fathers in child welfare cases as a matter of course

MDH

1. Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in the custody of the state. Ensure that all youth serving facilities licensed or funded with state funds, are trained and institute child sexual abuse prevention policies.

2. Continue to collect ACE module data in Maryland every three years; and, collect resilience data in the BRFSS, as is being done in Wisconsin[63].

3. Collect ACE module data in Maryland's Youth Risk Behavior Survey (YRBS) in 2018.

4. Fund the baseline collection of child maltreatment Awareness, Commitment and Norms Survey initiated by the CDC's Essentials for Childhood and implemented by the five EFC funded states, as well as, several unfunded states. Collection of this data in other states cost approximately $10,000.

5. Partner with the health care community to improve integration of behavioral and primary health care and identify and promote strategies to assess for and respond to ACEs

6. Ensure that all home visiting programs (MIECHV, MOTA grants, Community Health Specialists, etc.) engage fathers, as well as mothers. Purposefully recruit fathers as home visitors.[64]

7. Maryland's Medicaid program should develop a system to generate a regularly updated list of all prenatal care providers serving Medicaid recipients and their MPRA (Maryland Prenatal Risk Assessment) completion rates for purposes of conducting ongoing provider education on MPRA procedures.[65]

8. Streamline the Postpartum Infant and Maternal Referral (PIMR) form and completion process in partnership with local health departments and birthing hospitals.[66]

9. Link completion of MPRA and PIMR and linkage to services to service provider fee payment.[67]

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[63] Maryland is collecting it's second cohort of ACE module data in 2018, but has not yet collected data on resilience. Sege, R., Bethell, C., Linkenbach, J., Jones, J., Klika, B. & Pecora, P.J. (2017). *Balancing adverse childhood experiences with HOPE: New insights into the role of positive experience on child and family development*. Boston: The Medical Foundation. Accessed at www.cssp.org

[64] See MCANF preliminary observations under "Magnitude of the Problem in Maryland" section.

[65] Ibid.

[66] Ibid. Prenatal care providers are required by Maryland Medicaid regulations to submit an MPRA for each pregnant woman at her first prenatal care visit. Women are then outreached by nurses and home visitors, to further assess needs for care and eligibility for community services, and link her to these services. Mothers and infants may also be outreached and referred following delivery; birthing hospitals are required by state regulations to submit a PIMR at postpartum discharge when Medicaid recipients have psychosocial risk factors (e.g., limited or and/or deliver infants who are born at low birth weight or have had a stay in the NICU.

[67] Ibid.

10. Medicaid should reimburse for psychosexual evaluation of youth. These should be considered medically necessary and key in the prevention of youth on younger child sexual abuse which is approximately 1/3 of all child sexual abuse perpetration.

11. Increase Infant and Early Child Mental Health workforce training in the core competencies. Integrate core competencies into evidence-based programs serving young children.

12. Amend Maryland's 1915i Waiver to eliminate the Medicaid barriers young children and their families face when trying to access behavioral health services for young children and their parents.

MSDE

1. See Children's Cabinet recommendations above

2. Implement Comprehensive Child Sexual Abuse Prevention Policy within all public schools as mandated by HB 1072 using evidence-based and promising programs, such as the Enough Abuse Campaign's ELearning for Educators.

3. Ensure that all home visiting programs (Office of Special Education-Healthy Families, etc.) engage fathers, as well as mothers. Purposefully recruit fathers as home visitors.

DJS

1. See Children's Cabinet recommendations above.

2. Implement Comprehensive Child Sexual Abuse Prevention Policy within all facilities that serve children and youth. See recommendations under General Assembly.

3. Ensure that all adults employed by or volunteering at youth serving facilities licensed and/or funded with state funds, are trained and institute comprehensive child sexual abuse prevention policy.

4. Ensure that all children are evaluated for child sexual abuse and those who may have been victimized by child sexual abuse are referred and linked to services for treatment. Cases should remain open until linked to treatment services. Case records should indicate 1) child sexual abuse and 2) documentation that the child is receiving treatment.

APPENDIX A

DHS RESPONSE TO SCCAN'S 2016 ANNUAL REPORT

The 2003 amendments to CAPTA require a written response from the state to the SCCAN Annual Report indicating *whether and how* the state will *incorporate each recommendation*: "[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."

In January 2017, SCCAN's Chair and Executive Director met with representatives from DHS to thank the Department for its response to the 2015 SCCAN Annual Report; follow up on recommendations that were not addressed; and, develop a more consistent dialogue between DHS and SCCAN. It was noted that a number of recommendations were requests to the Governor, legislature and other State Departments. In order to eliminate confusion, SCCAN agreed to categorize future recommendations by specific agent/agency and did so in the 2016 report.

The Council received a response to its' 2016 report from the Executive Director of the Social Services Agency at DHS in September 2017. The Agency responded generally to the following recommendations of the 2016 report:

- Reviewed Tennessee's Building Strong Brains Model and Maryland ACEs data. The information and lessons learned will continue to be part of SSA's strategic planning and direction discussions.
- Include screening of Resilience in five Regional Supervisory Meetings in Fall 2017.
- SSA will have a representative participating in the ACE Interface training and will work with DHS training department for additional opportunities to train SSA and DHS staff.
- SSA Family Blossoms:
    - Practice Model reflect science of trauma.
    - Update organizational policies and regulations to reflect a trauma responsive practice.
    - Increase the workforce's competence and understanding of trauma, brain science and resilience.
    - Integrate SSA communications strategies that embed trauma, brain science and resilience.
- DHS has a link on its' home page for reporting child abuse and neglect.

Significantly SSA, DHS did not respond as to whether or how the following SSA-specific recommendations would be addressed:

- Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in foster care. Ensure that all adults, including foster parents, group homes, residential treatment centers and licensed contractors, involved with foster youth are trained and institute policies in

child sexual abuse prevention.

- Develop a Centralized System for Providing Forensic and Medical Services to Children involved in the child welfare system
    - Medical Director
    - Oversight and policy development by a Child Welfare Health Coordination Expert Panel
    - A system for tracking and improving health outcomes for children in the child welfare system; including fatalities and near fatalities due to child maltreatment.
- Increase fathers' and mothers' male partners emotional support of their children and families.
    - Collaborate with partners to further infuse fatherhood and male responsibility initiatives into settings with boys and men
    - Make deliberate and special efforts to include male caregivers in attachment and parenting skills programs (e.g., Circle of Security Parenting, home visiting sessions)
- Ensure that MD THINK
    - integrates child-welfare, birth, and death data in order to analyze fatal maltreatment
    - collects longitudinal data on foster youth and their families so we can track both their long term outcomes and the quality of their well-being while they are in care. This was a repeated recommendation included in DHS's Quality Assurance Processes in Maryland Child Welfare. [66]
    - MD CHESSIE's focus on point in time data has been a significant barrier in having a true picture of how children and their families who touch our child welfare system do. We need to know how often foster youth end up involved with the Department of Juvenile Services, how their educational achievement and health compares to their non-system involved peers, and for older foster youth who transition out of care, whether, as adults, they have stable financial, employment, housing and parenting (i.e., their children do not end up in child welfare) outcomes.
    - There has been an MOU in place between DHS and MSDE to allow for the sharing of data regarding foster youth since September 27, 2013. It is also now a federal requirement pursuant to the Every Student Succeeds Act for states to track educational outcomes for foster youth.
    - We also need to know the quality of the experience for foster youth while they are in care. Currently, we don't know basic information, such as, how often they have to change placements, how often they change schools, whether they are hospitalized, whether they need in-patient psychiatric treatment.
- We also need to track when families are determined to need services, whether they receive those services, and if not, why not, and what follow up occurs
- Ensure that all children who are referred to the local DSS are screened for child sexual abuse and are referred and linked to service for treatment. Cases should remain open until linked to treatment services. Case records should indicate 1) child sexual abuse and 2) documentation that the child is receiving treatment.
- Screen in all children under 5 as Risk of Harm cases and do an in-home assessment of risk. Provide services for families at risk for child fatality or near fatality
- Involve fathers in child welfare cases as a matter of course

We respectfully request a response to each recommendation in future reports in order to address any identified barriers to implementation.

APPENDIX B

State Council on Child Abuse and Neglect (SCCAN)

SCCAN Membership

15 MEMBERS APPOINTED BY THE GOVERNOR

Name	Representing	Jurisdiction	Email	Address
Wendy Lane, MD, MPH ***(SCCAN Chair)***	Clinical Associate Professor, University of Maryland (Epidemiology & Public Health, Pediatrics)	Baltimore County	wlane@epi.umaryland.edu	660 West Redwood Street Baltimore, MD 21201
Faith Cantor	Rabbi, Beth El Congregation, Pikesville, Maryland	Baltimore County	faith@bethelbalto.com	8101 Park Heights Ave., Pikesville, MD 21208
Jena K. Cochrane	Personal experience	Anne Arundel County	jena_geb@verizon.net	1700 Basil Way, Gambrills, MD 21054
Janice Goldwater, LCSW-C	Executive Director, Adoptions Together	Montgomery County	jgoldwater@adoptionstogether.org	4061 Powder Mill Road Suite 320 Calverton, MD 20705
Darlene Hobson	Reverend Personal Experience	Baltimore City	mightywomenofgod@aol.com	Refreshing Spring Worship Center 6709 Holabird Avenue, Baltimore, MD 21222

Name	Representing	Jurisdiction	Email	Address
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	Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe Street Baltimore, MD 21205
Veto Anthony Mentzell, Jr.	Law Enforcement Officer, Harford County Sheriff's Department Program Director, Harford County Child Advocacy Center	Harford County	mentzellv@harfordsheriff.org	Harford County Sheriff's Office 45 South Main Street / P.O. Box 150
Catherine Meyers	Director, Center for Children, Inc.	Charles County	meyers@center-for-children.org	Center for Children, Inc. 6100 Radio Station Road, P.O. Box 2924, La Plata, MD 20646
Linda Ramsey	Deputy Director, Family Support/HR Officer, Maryland Family Network (Maryland's CBCAP lead agency)	Baltimore City	lramsey@marylandfamilynetwork.org	Maryland Family Network 1001 Eastern Avenue, Second Floor Baltimore, MD 21202-4325
Linda Robeson	Sr. Vice President, BB&T	Anne Arundel County	lrobeson@bbandt.com	BB&T Corporation 111 S. Calvert Street, Suite 2200, Baltimore, MD 21202

Name	Representing	Jurisdiction	Email	Address
Melissa Rock, Esq	Director, Child Welfare, Advocates for Children & Youth (ACY)	Baltimore City	mrock@acy.org	Advocates for Children & Youth, One N. Charles Street, Suite 2400, Baltimore, MD 21201
Hillary Hollander	Social Worker, Life Renewal Services	Baltimore County	hillaryshankman@gmail.com	8514 Countrybrooke Way, Lutherville, MD 21093
Danitza Simpson	Director, Adelphi/Langley Family Support Center	Prince George's County	Dsimpson@pgcrc.org	Adelphi/Langley Family Support Center 8908 Riggs Road Adelphi, Maryland 20783
Joan Stine	The Family Tree (Prevent Child Abuse, Maryland), Children's Justice Act Committee Liaison, Public health expert	Howard County	stinejg@yahoo.com	2614 Liter Court Ellicott City, MD 21042-1729
VACANT				

8 POSITIONS FILLED BY DESIGNATION OF THEIR ORGANIZATIONS

Name	Representing	Email	Address
Stephanie Cooke, LCSW-C	Supervisor, Child Protective Services and Family Preservation, Social Services Administration, Maryland Department of Human Services	Stephanie.Cooke@maryland.gov	Maryland Department of Human Resources Social Services Administration, 5th Floor 311 W. Saratoga St. Baltimore, MD
Karen Pilarski, Esq.	State's Attorney Association	kpilarski@baltimorecountymd.gov	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	Maryland House of Delegates 9 West Courtland Street P.O. Box 1204 Bel Air, MD 21014
Michael Ito, Psy D (Interim, awaiting DJS designee to SCCAN)	Director of Behavioral Health, Maryland Department of Juvenile Services	michael.ito@maryland.gov	State of Maryland Department of Juvenile Services 120 W. Fayette St. #505 One Center Plaza 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	Pupil Personnel Specialist Maryland Department of Education 200 West Baltimore St. Baltimore, MD 21201
Courtney Lewis, MPH	**Deputy Director, Prevention and Health Promotion Administration, Maryland Department of Health**	courtney.lewis@maryland.gov	Maryland Department of Health 201 W Preston Street Baltimore MD 21201
VACANT	**Maryland Senate**		

SPECIALLY DESIGNATED MEMBERS OF CJAC

Name	Relevant Background	Email	Address
Ed Kilcullen	Executive Director, Maryland Court Appointed Special Advocates, Children's Justice Act Committee	Ed@marylandcasa.org	402 W. Pennsylvania Avenue, 3rd FloorTowson, MD 21204

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 405, Baltimore, MD 21201