MARYLAND STATE COUNCIL ON CHILD ABUSE & NEGLECT ANNUAL REPORT

JANUARY 1, 2019 – DECEMBER 31, 2019

The Power of

COMMUNITY

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

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:

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- Delegates Alice Cain, Michelle Guyton, Susan McComas, Stephanie Smith, and C.T. Wilson and Senators Malcolm Augustine, Susan Lee, and Chris West for participating in the ACEs Roundtable.

- ACEs Roundtable national speakers: The First Lady of Delaware Tracey Quillen Carney, Kate Blackman and Kate Bradford (National Conference of State Legislators), Michael Castagnola (staff to the late Congressman Elijah Cummings), Joan Gillece (NASMHPD), Frank Kros (Kros Learning Group), Melissa Merrick, PhD (Prevent Child Abuse America), and Mary Rolando (Building Strong Brains Tennessee)

- ACEs Roundtable national, state, and local experts: Andrea Butler (Aetna), Cathy Costa (BCHD), Karen Kreisberg and Brooke Hisle (Krieger Fund), Anne Hoyer (MD Safe at Home Program), Stacey Jefferson (BHSB), Wendy Lane (SCCAN, MDAAP), Sarah Manekin (Abell Foundation), Lt. Veto Mentzell (Harford County ACE Initiative), Pilar Olivo (Frederick County ACEs Workgroup), Dan Press (Campaign for Trauma Informed Policy & Practice), Laurie Anne Spagnola (Board of Child Care), Terry Staudenmaier (Abell Foundation), Jimmy Venza (The Lourie Center), and Ellen Volpe (HRSA, Division of State & Community Health, Maternal and Child Health Bureau).

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- Judiciary Committee Chair Luke Clippinger and Vice Chair Vanessa Atterbeary for their leadership in Committee to pass HB 687 and HB 974 (The Hidden Predator Act of 2019 and 2020).

- Senator Clarence Lam for sponsoring SB 541 (S.E.S.A.M.E. legislation) to prevent child sexual abuse in school settings *before it occurs*.

- The Members of the Maryland General Assembly for unanimously passing the S.E.S.A.M.E. Act HB 486 (2019) and the House of Delegates for passing HB687 (2019) and HB974 (2020) legislation to prevent child sexual abuse in school settings *before it occurs*.

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- Les Nichols for dedicating countless *pro bono* hours to share his expertise as a CPTED architect and his experience as the former National Vice President, Child & Club Safety for Boys & Girls Clubs of America in assisting SCCAN in the development of the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse***.

- Charol Shakeshaft for her review of the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse*** and recommendations for collection of data points to evaluate the extent to which the design, assessment, and modification are successful in reducing child sexual abuse.

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- 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)
311 W. Saratoga Street, Room 405
Baltimore, Maryland 21201
Phone: (410) 767-7868 Mobile: (410) 336-3820
claudia.remington@maryland.gov

November 9, 2020

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

The Honorable Bill Ferguson
President of the Senate
State House
100 State Circle, Room H-107
Annapolis, Maryland 21401-1991

The Honorable Adrienne A. Jones
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 Ferguson and Speaker Jones:

I would like to begin with a heartfelt word of thanks for your continued support of State Council on Child Abuse and Neglect (SCCAN) legislative initiatives. During the 2019 Maryland General Assembly session, HB 486/SB 541 passed both Houses unanimously and was signed by the Governor. Building upon the foundation of 2018's HB 1072, which required education on preventing and identifying child sexual abuse, HB 486/SB 541 will prevent school employees with a track record of disregarding laws, policies, and codes of conduct related to sexual abuse and sexual misconduct from being passed from one school to another without consequence or question. Specific elements of this bill include:

1) Requiring anyone applying for a position in a school—public or private—involving direct contact with minors to provide a written release and a statement disclosing whether s/he has been the subject of a child sexual abuse or sexual misconduct investigation by any employer, and whether s/he has ever resigned or separated from a position amid pending allegations of child sexual abuse or misconduct.
2) Requiring the school considering the applicant to contact each of the applicant's former employers and inquire whether the applicant has been investigated for child sexual abuse or sexual misconduct, and whether the applicant resigned or separated from a position amid pending allegations of child sexual abuse or sexual misconduct.
3) Requiring all contacted former employers to furnish the requested information.
4) Banning non-disclosure agreements in cases involving child sexual abuse or child sexual misconduct;
5) Prohibiting schools from expunging data from personnel files in cases of employee sexual abuse or misconduct;
6) Providing immunity from civil and criminal liability to former and current employers for providing information or records, including personnel records, in good faith.

This bill will help ensure the health, safety, and well-being of Maryland children. Though the 2020 legislative session was cut short because of the coronavirus pandemic, we look forward to continuing our legislative partnerships to protect children.

Pursuant to the requirements of Family Law 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;" and,*
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 2019, we have chosen to continue our 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 59-69, 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 in the first place*. Specific recommendations are made to prioritize prevention of ACEs, create a Children's Trust & Prevention Fund, coordinate the work of child and family serving systems, pass additional child sexual abuse prevention legislation, prevent child abuse and neglect fatalities, and improve health care for children involved in child welfare. Each of these issues has become more urgent as a result of the coronavirus pandemic, with job losses, school closures, and isolation increasing the risk of abuse and neglect for Maryland children.

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 Acting Secretary James Rzepkowski
Governor's Office of Crime Prevention, Youth, and Victim Services, V. Glenn Fueston, Jr., Executive Director
SCCAN Members

EXECUTIVE SUMMARY

As a result of the COVID-19 pandemic, the ensuing stay-at-home orders, economic downturn, unemployment, food and housing insecurity, and other financial difficulties, day care and school closing, and the death of family members, experts are seeing a significant increase in parental stress. That stress is known to create increased risk for ACEs such as child maltreatment, and parental mental health, substance misuse, intimate partner violence, and divorce and separation to name a few, Now more than ever, it is critical that we consider instituting trauma-informed and resilience-building public and private policies and practices to create the safe, stable, and nurturing relationships and environments for children and prevent and mitigate ACEs.

SCCAN's 2019 Annual Report to the Governor and General Assembly continues to provide a framework for a seismic shift in how we as a state address child abuse and neglect, along with related adverse childhood experiences (ACEs) or childhood trauma. 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 but not limited to 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, peer violence, and bullying, and historical and intergenerational trauma. 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 N.E.A.R. (Neurobiology, Epigenetics, ACE Study, and Resilience) science to reach that vision. SCCAN's recommendations for more than ten years have 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 initiative 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 multi-generation approach). Maryland Essentials for Childhood (MD EFC) 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 about the science of the developing brain, epigenetics, the ACE Study, and theories of resilience, they begin to understand the interconnection of many of the social problems that confront our state; and, begin learning and working together to innovatively solve these problems. Over the past year, SCCAN and MD EFC have been the catalyst for the following achievements toward making Maryland a trauma-informed and resilient state:

- Raising awareness of N.E.A.R. Science and continuing to build commitment and political will to put the science into action to reduce and mitigate ACEs by:
  - Increasing the breadth and reach of the ACE Interface Project:
    - ACE Interface Master Trainers trained 97 Master Trainers representing all 24 Maryland jurisdictions; including two specialized cohorts:
      - Opioid Epidemic – MDH's Regrounding Our Response to the Opioid Crisis (31 Master Presenters statewide)
      - Education- MSDE (36 Master Presenters statewide)
    - Since its inception in December 2017 and March 2019, volunteer ACE Interface Master Trainers and Presenters have given 255 ACE Interface presentations to over 8000 attendees across all 24 jurisdictions.
  - Consulting with Congressman Elijah Cummings Office on development of the first Congressional Hearing on Childhood Trauma which took place on July 11, 2019.
  - Meeting with staffers of the Maryland Members of the House Committee on Oversight and Reform and Leader Hoyer to brief them on Maryland's efforts to reduce and mitigate childhood trauma.
  - SCCAN's E.D. serving on Congressman Cummings' fourteen member Baltimore City Childhood Trauma Roundtable to share SCCAN and MD EFC statewide efforts to prevent and mitigate childhood trauma and build resilience.
  - Consulting with Councilman Zeke Cohen on the Elijah Cummings Healing City Act (Trauma-Responsive Baltimore).
  - Holding the 1st full day ACEs Roundtable for Members of the Maryland General Assembly on December 13, 2019 sponsored by Delegate Vanessa Atterbeary and Senator Antonio Hayes, including presentations on the N.E.A.R. Science, The CDC's Best Available Evidence Research: ACE Data (MD & US) & Implications for Government Policy, the Economy, & Business, State Legislative Strategies to Prevent & Mitigate the Effects of ACEs, Translating the Science into Federal and State Policies Panel, Translating the Science Maryland's State and Local Efforts, and the "So What Now? World Café": Designing the Future MGA Working Groups with "Call an expert" lifeline. By the end of the day, the group of legislators who attended committed to developing a Maryland Legislative Caucus to Prevent and Heal Childhood Trauma, arranging for a joint ACEs hearing for the Senate Judicial Proceedings and House Judiciary Committee, working with MD EFC to develop an ACE-informed platform of bills through the newly formed caucus, and encouraging their colleagues to attend the SCCAN-MD EFC ACEs Education & Advocacy Day at the General Assembly on Thursday, February 7th.
  - Hosting SCCAN-MD EFC Education, Advocacy, and Awards Days at the General Assembly in February 2019 and 2020.
  - Continuing to develop and expand Maryland ACEs Action blog page on ACEs Connection:
    - Recruited a lead Community Manager to recruit additional members.
    - Doubled Membership, making Maryland ACEs Connection Community the 43rd largest of 285 Communities on ACEs Connection and the 6th largest statewide community after California, Washington, Arizona, Michigan, and Oklahoma.
    - Provided a statewide mapping of ACE Interface trainings on the Maryland ACEs Action Community Tracker and a link to Maryland BRFSS ACE data by county.
  - Developing a Maryland Essentials for Childhood webpage: https://mdessentialsforchildhood.org/.
- Educating and Advocating for ACE-Informed Policy & Funding Priorities by:
  - Developing and publishing ***Toward a More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient***

Communities (See Appendix B).
    - Providing the state and national expertise necessary to jointly develop the **_Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of [School] Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse with the Interagency Commission on School Construction_** (See Appendix C).
    - Sharing expertise with and participating in survivor and ally led efforts to pass the Hidden Predator Act of 2019 and 2020 (See Appendix D) and Justice4MDSurvivors.org.
- Leading efforts to create shared ACE and resilience data:
    - Successfully advocating for the inclusion of 4 ACE questions that were included in the Fall 2018 Youth Risk Behavior Study (YRBS) for Maryland high schoolers. Following upon the example of Monroe County, New York, Maryland and New Hampshire became the first two states to collect statewide ACE data through their YRBS.
    - Successfully advocating for BRFSS and YRBS/YTS ACE data to be collected in 2015, 2018, and 2020.
    - Completing MCANF Reviews of child fatalities of children under the age of 5. Analysis of data and recommendations are forthcoming, as our volunteer reviewer time permits.

SCCAN's Annual Report includes the following:

- A brief background of SCCAN's mandate, focus, and efforts.
- An overview of the key concepts of neurodevelopmental science and the impact of adversity on the developing brain.
- A discussion of Maryland data on the magnitude of the problem.
- A description of the MD EFC and 2019 SCCAN & MD EFC actions and accomplishments toward achieving our four strategic goals.
- Recommendations to the Governor, the General Assembly, and child and family serving agencies.

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

1. Take meaningful action to raise awareness of brain science, adverse childhood experiences (ACEs), resilience, and build community commitment to prevent, reduce, and respond to ACEs by launching an ACEs Initiative similar to former Governor Bill Haslam's ACEs-Building Strong Brains Tennessee, former Wisconsin First Lady Tonette Walker's Fostering Futures[2], and Governor Carey's Executive Order Making Delaware a Trauma-Informed State. Maryland's Governor and/or the General Assembly should take the following actions, similar to sister states, to create a trauma-informed and resilient state through an executive order or legislation:
    - Establish a state lead coordinating body.
    - Develop and implement a State Plan for Preventing and Mitigating ACEs to
        - Incorporate the six strategies and evidence-based programs and approaches listed in the CDC's *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence* resource tool.
        - Incorporate trauma-informed best practices across state child and family serving agencies.
        - Provide executive level awareness trainings and opportunities.
        - Enhance the State's ACEs surveillance system, data collection and analysis.

[1] A comprehensive list of SCCAN Recommendations by Agent/Agency can be found on pages 59-69.

[2] While Governors Haslam and Walker no longer hold office, their legacies live on in the communities and agencies across their states.

- Develop ACE awareness campaigns, employing science-based communication strategies.
- Make budgetary commitments to prevent and mitigate ACEs.
- Make use of the expertise and build upon the cross-sector and interdisciplinary partnerships and efforts of Maryland Essentials for Childhood.
- Recruit the support of private foundations, business, and faith-based communities in efforts to prevent and mitigate ACEs.

2. Review, analyze, publish, and effectively disseminate Maryland's 2015 and 2018 baseline state and local ACE Module Behavioral Risk Factor Surveillance System (BRFSS) data (pp. 29-43 below) and 2018 YRBS/YTS (Youth Risk Behavior Survey/Youth Tobacco Survey) (pp. 44-51 below).

3. Continue to collect BRFSS ACE data every three years.

4. Expand Maryland's YRBS/YTS ACE module to include all CDC YRBS ACE module questions and collect this data every two years.

5. Begin collecting resilience or positive childhood experiences (PCE) data in the BRFSS (as is being done in Wisconsin) and the YRBS/YTS in order to both understand the magnitude of this public health epidemic and to develop policy solutions to reduce the numbers and impact of ACEs.

6. Embed the science of the developing brain, 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 their impact, and improve child, family, organizational, and community resilience.

7. 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, including the importance of trauma-informed systems. Provide opportunity for dialogue on how it might be used to provide better customer service within child and family serving agencies.

8. Fund free screenings of the film *RESILIENCE: The Biology of Stress & The Science of Hope* through Maryland Public Television (MPT). Provide virtual townhall opportunities for dialogue with local communities on how they might employ the science within their communities to improve outcomes for kids.

9. As the next level 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.

10. Explore ways to increase awareness of the brain science and the impact of ACEs on the children and families each agency serves. Integrate the science into agency and cross agency work:

- Participate in developing a State Plan to Prevent and Mitigate ACEs
- Partner in Maryland Essentials for Childhood Initiative to ensure cross-agency coordination

- Consider the appropriateness of screening clients for ACEs and resilience factors.[3]
- Provide pre-service and in-service training to all staff on brain science, ACEs and resilience.
- Research and develop Maryland guidelines for becoming a trauma-informed agency similar to The Missouri Model: A Developmental Framework for Trauma-Informed Approaches.
- Ensure that state contracts require providers meet performance measures to become trauma-informed based on the above referenced Maryland guidelines.
- Embed- the science into agency strategic planning and technical assistance to local agencies: and, create funding opportunities to local agencies for cross-sector planning and coordination of ACE prevention and mitigation efforts.
- Ensure agency policies and regulations reflect the science.
- Ensure agency practice models reflect the science.
- Invest resources in evidence-based trauma prevention and treatment interventions and creating trauma-informed agencies.[4]
- Partner with the FrameWorks Institute (FWI) to develop an in-depth communications plan that can be implemented by state agencies and local communities across the state to use research-based values and metaphors to communicate about trauma and its effects on brain development. A similar plan in Tennessee included:
    - Three scientific symposia: Neurobiology, the Science of Programmatic Innovations, and the Science of Policy Innovations.
    - Four three-day “FrameLabs” in which individuals from all sectors and professional disciplines learned values and metaphors that help even people who have no familiarity with child development.
    - A three-day “Train the Trainer” workshop for curriculum designers and agency training leaders.
    - Ongoing technical assistance and a review of materials.
    - Advisory services for the initiative steering group.
    - In-depth editing and framing advice for communications projects (e.g. PSA scripts, social media content, press releases, agency websites, annual reports, public marketing materials, brochures, one-pagers, etc.).

11. Establish a robust Children’s/ACEs Trust and Prevention Fund.

12. Pass legislation providing for Paid Family Leave.

13. Pass legislation eliminating the civil statute of limitations for child sexual abuse, including a two-year look-back window or “window of justice” to expose hidden predators.

14. Pass legislation that requires all public and nonpublic schools and their contracting agencies to do CPS background checks on all applicants for positions involving direct contact with minors.

15. Pass legislation requiring state and local child and youth serving agencies, and child and youth serving organizations receiving state funding to institute Comprehensive Child Sexual Abuse

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[3] Bartlett, J.D., Adversity and Resilience Science, *Screening for Childhood Adversity: Contemporary Challenges and Recommendations*, 20, April 2020. Anda, R. Porter, L. Brown, D., American Journal of Preventive Medicine (2020) *Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications*; and, Finkelhor, D., Child Abuse & Neglect (2017) *Screening for adverse childhood experiences (ACEs): Cautions and suggestions*.

[4] See the National Child Traumatic Stress Network for resources on creating trauma-informed systems.

training, policies, and guidelines; similar to those required in public and nonpublic schools.

16. 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.

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 (SCCAN) as one of three citizen review panels[5] 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.[6]

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"[7] 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."[8] 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".[9]

Prevention as a priority

For over a decade, 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 citizens-- is well documented.* Historically, most

[5] The other panels are the Citizens' Review Board for Children and the State Child Fatality Review Team.

[6] See Appendix D for current members.

[7] Section 5016a (c) (4) (A)

[8] Section 5016a (c) (4) (C)

[9] Section 5-7-09A (a)

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.

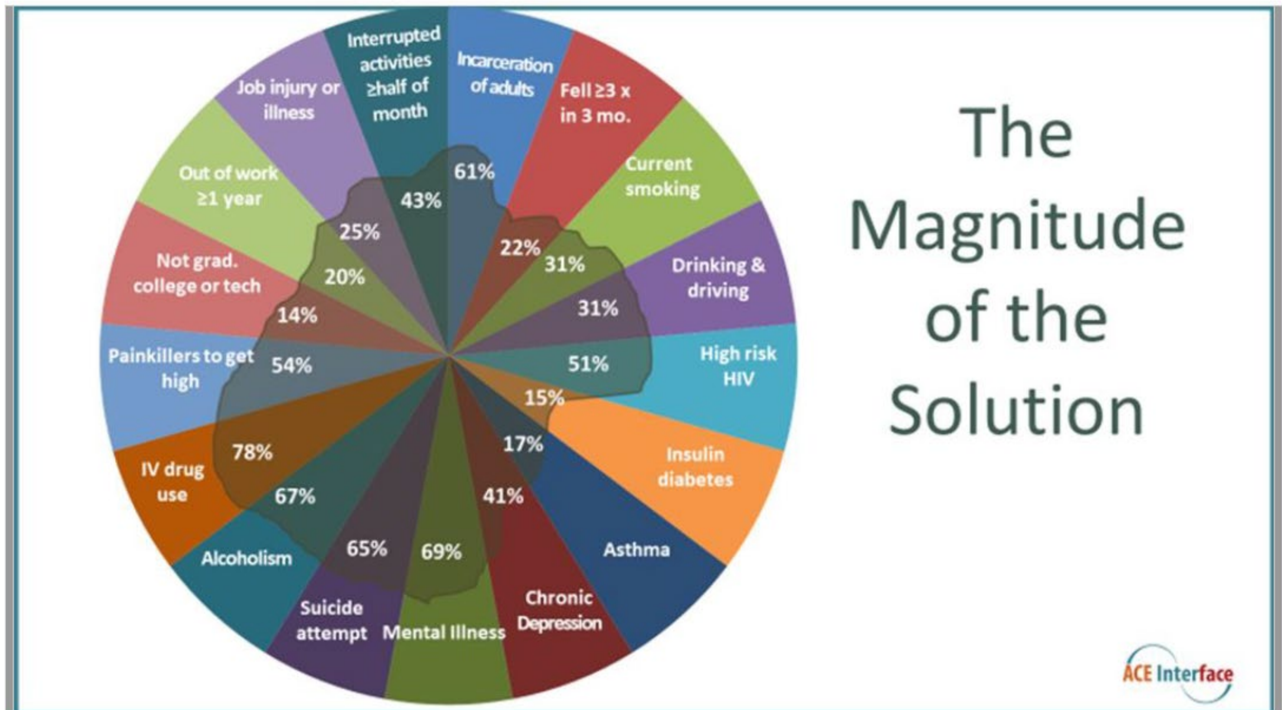
A broader public health approach is needed to prevent child maltreatment *before it occurs.* The public health approach extends our criminal justice and case-based approaches by fostering a better understanding of the complex causes of child maltreatment in order to more effectively and preemptively 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, leaving 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[10] initiative that promotes safe, stable, nurturing relationships and environments for children and prevents, mitigates ACEs, and builds resilience in children, families, and communities.

[10] 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[11]

As Marylanders understand the impact of Adverse Childhood Experiences, they 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. 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. This shift in our focus will considerably *reduce childhood adversity at a population level* and stem the tide of ever-more-costly social problems. Understanding the implications of the ACE study and the developments in fields of neuroscience, epigenetics, trauma and resilience is a powerful pathway to health, well-being, and a more prosperous Maryland. Preventing ACEs and their intergenerational transmission is the greatest opportunity of our time…perhaps of all time…for improving the well-being of human populations.

The figure below from the ACE Interface training shows the percentage of various health and social problems that epidemiologists estimate is caused by ACEs. The calculation that is commonly used to do this in public health studies is called Population Attributable Risk (PAR). The PAR calculation is displayed as an "oil spill" on this slide. The percentage of a problem coated by the oil spill represents the percentage of each problem that is potentially preventable by preventing ACEs. The percentages are quite large. In fact the high percentages portrayed in the figure below are rarely seen in public health studies.



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

The cumulative effects of ACES reflect a powerful opportunity for prevention – no matter if you are working to prevent heart disease or cancer, end homelessness or hopelessness, or improve business profitability – as we align a portion of our work around a common goal of preventing the accumulation of ACEs and moderating their effects, we will reduce all of these problems, and many others, all at once!

Preventing and mitigating ACEs will require that our vision, policies, and practices as a state are guided by the following ten principles[12] from the neurodevelopmental science:

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

2. Experiences Build Brain Architecture

3. Serve & Return Interactions Shape Brain Circuitry

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

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

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

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

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

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

10. Rethinking Our Policies

We should focus on preventing ACEs (the original 10 ACEs, urban and community ACEs), whenever possible and on providing trauma-informed services to children, families, and communities when trauma occurs. Preventing and mitigating ACEs will require strong collaboration across disciplines, departments, agencies, and communities with a focus on building state infrastructure (state agencies knowledgeable in the ACE science, data to measure the magnitude of the problem and the effectiveness of the solutions, effective funding mechanisms, and technical assistance) to support local community cross-sector action. The CDC's ***Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence*** lists 6 strategies that are effective in preventing ACEs. Maryland should develop a statewide plan

[12] For further discussion of the 10 neurodevelopmental principles see the 2018 SCCAN Report and Maryland Essentials for Childhood's ***Toward A More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities*** (Appendix B).

to prevent ACEs that include these six strategies and help build resilient communities:

- Strengthen Economic Supports for Families
- Promote Social Norms that Protect Against Violence and Adversity
- Ensure a Strong Start for Children
- Teach Skills (parenting, social emotional learning, safe dating and healthy relationships)
- Connect Youth to Caring Adults and Activities
- Intervene to Lessen Immediate and Long-term Harms

Maryland's future prosperity depends on how well we, as adults, foster the healthy development of our youngest generation. Raising happy, competent children who will lead our communities tomorrow requires smart and innovative thinking today. ACE science provides us with a blueprint for how to ensure children get what they need for healthy development. We now know that early experiences literally build the architecture of the brain, and that stable, responsive interactions with caring adults at home and in the community are the key ingredient in building a solid foundation for future growth. We also know that not all children have access to the kinds of experiences that will most benefit their development - some children are exposed to conditions or events that are so severe and persistent as to produce toxic stress responses that damage the brain's developing architecture. By passing policies that provide the kinds of experiences in early care, education and family support settings that help parents and provide sturdy foundations for children's development as outlined in the six strategies above, Maryland policy makers will promote the health and well-being of future generations and build the foundation for a more prosperous Maryland.

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 more effective service delivery systems and a healthier, socially and economically stronger Maryland.

BRAIN SCIENCE SERVES AS A STRONG FOUNDATION FOR GOVERNOR HOGAN'S VISION OF ECONOMIC OPPORTUNITY & STRATEGIC GOALS13

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 focus on strengthening caregiver, 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. 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. The ability to change brains and behavior decreases over time (brain plasticity).**
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.**
III. **Data systems should track the trajectory of children from one state system and/or service to the next.**
IV. **Brain Science should be used to Design Multi-Generation Paths Out of Violence, Poverty, Addiction and Mental Illness**
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**.
VI. **Understanding neurobiology, epigenetics, ACEs, and resilience changes practice.**

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.*[14]

[13] For further elaboration on this section, See SCCAN 2018 Annual Report.
[14] Why Early Investment Matters?, The Heckman Equation, James J. Heckman, PhD

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.[15] 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 three Maryland sources below: Maryland CPS Data (incidence), Behavioral Risk Factor Surveillance System ACE Module data (childhood prevalence among Maryland adults of all ages), and Youth Risk Behavior Survey data (prevalence to date among adolescents).

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

Figure A 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 2018, DHS SSA reports that it received 64,200 referrals of suspected child abuse or neglect, down from 67,467 referrals in 2017. Of those, 26,841 reports or 41.8% were screened in for a CPS response (either investigative or alternative response).
- During FFY 2018, 13,722 investigations were completed. Of this total, 5,922 were indicated for abuse or neglect (or 26.5%, a 15.7% decrease in indicated cases from 2017). The 5,831 indicated cases represent -9.2% of the total abuse and neglect reports. Once there is an indicated referral, children are considered victims of child abuse/neglect.[16]
- During FFY 2018, 8,253 screened-in reports (12.9% of total reports) received an alternative response (AR). Of those 8,253 cases, 465 (or 5.6% of AR cases) received services and 663 cases

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

[16] In one report of child abuse and neglect, there may be multiple case types (physical abuse, neglect, sexual abuse, mental injury), as well as multiple victims and maltreators. As a result, one report may have multiple findings for multiple victims. For instance, one report may indicate physical abuse but rule out neglect on one child and indicate physical abuse and neglect on another child. This results in multiple findings per report.

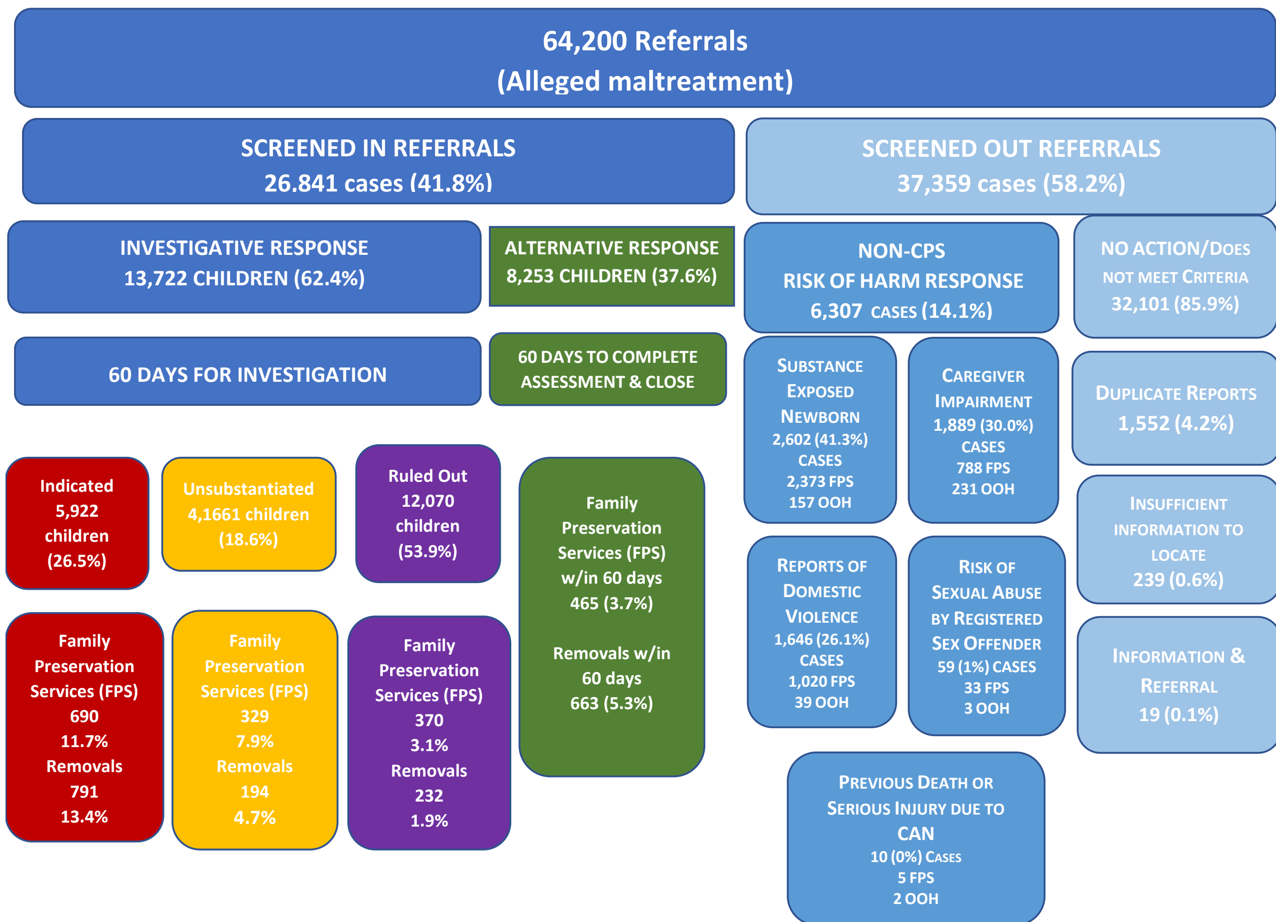
(or 8% of AR cases) ended up with a removal; and, the majority of AR cases (86.4%) received neither services nor ended up in a removal.

- Data was not readily available to indicate what, if any, services were offered to and 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. Almost 60% of cases reported to child protective services (CPS) by mandated reporters and concerned citizens go unaddressed according to the data provided by DHS, SSA (Figure A). Even cases that receive a child welfare response lack accurate tracking and reporting services and outcomes. This 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; and, being known to CPS is a risk factor for child maltreatment fatalities[17].

Data from SCCAN's 2013-2018 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, criminal and juvenile justice, education, public assistance, and 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. **A comprehensive state plan to prevent and mitigate ACEs should include gathering, sharing and analyzing data to help understand the magnitude of the problem and ensure data-driven solutions.**

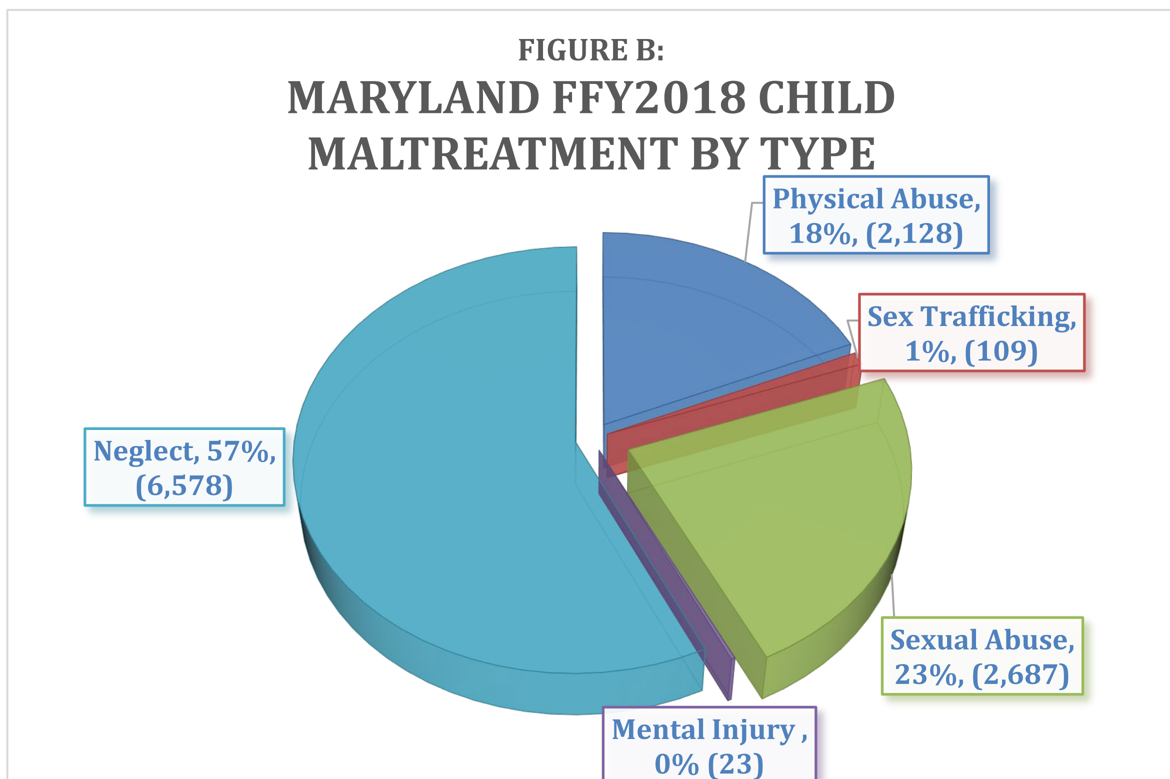
[17] Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, p. 14.

Figure A: FFY2018 Child Maltreatment Referral, Pathways, and Services



Child Maltreatment by Type:

- Neglect is the largest category of child abuse/neglect at 57% (down from 63% in 2017), followed by sexual abuse at 23% (up from 11% in 2017), physical abuse at 18% (down from 26% in 2017), sex trafficking at 1% (1st reported period) and mental injury at 0%. 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 physical or sexual 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.[18]
- Sexual abuse was up from 11% of indicated cases in 2017 to 23% of indicated cases in 2018. SCCAN asked for a deeper dive into this data to begin to understand the significance of this increase. Due to demands for data analysis concerning COVID-19 issues, the data and analysis could not be provided by SSA. Further analysis of this data would be helpful, especially if this trend continues.



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 are documented risk factors. 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

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

Children and Families *Child Maltreatment 2018* report on National Child Abuse and Neglect *Data* (NCANDS) analyzed data for two caregiver risk factors, alcohol abuse and drug abuse, defining those risk factors as:

- Alcohol abuse (caregiver): The compulsive use of alcohol that is not of a temporary nature.
- Drug abuse (caregiver): The compulsive use of drugs that is not of a temporary nature.

The Maryland Department of Human Services submitted data to NCANDS that 2.2% of child maltreatment victims (i.e. cases with an indicated finding) in Maryland had a caregiver risk factor of alcohol abuse and 5% had a caregiver risk factor of substance abuse.[19] Maryland's caregiver alcohol abuse and drug abuse risk factor numbers are significantly smaller than numbers in most other states (victims with alcohol abuse caregiver factor varies from 45.5% in Alaska to Maryland's 2%; victims with substance abuse caregiver factor varies from 66.1% in New Mexico to Maryland's 5% and Arkansas's 3.1%).

In contrast, DHS reported significantly higher parental substance abuse (both alcohol and other substances) to SCCAN (see Figure C below) than they did to NCANDS. The data reported to SCCAN indicates that parental substance abuse was a factor in the removal decision for 37.9% of all children removed from their homes in FY 2018.[20] These numbers are more in line with data collected by the National Surveys on Drug Use and Health 2009-2014 that indicates that at least 1 in 8 children nationally (not limited to child welfare involved children) lived in a household with at least 1 parent with substance abuse disorder.[21] SCCAN is concerned about the accuracy of the data for this and other key child maltreatment risk factors. For example, domestic violence over the last three years has fluctuated from 16.7 in 2016 to 38.1% in 2017 to 25.6% in 2018. As addressing caregiver risk factors are key to preventing and responding to child maltreatment, it is critical to have accurate data upon which to base policy and practice decisions.

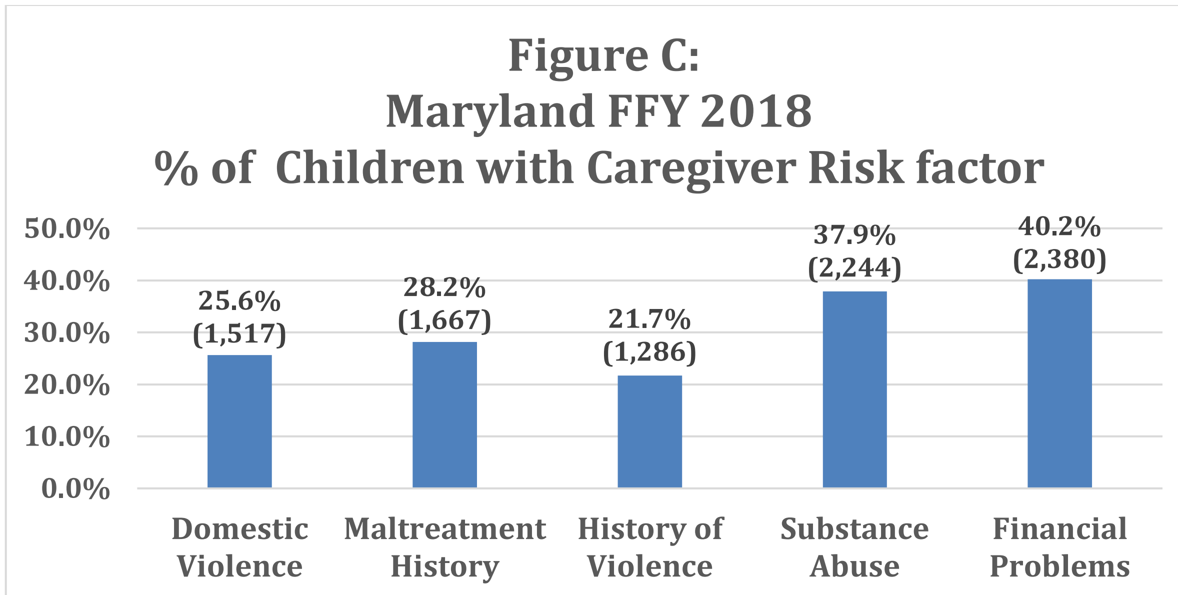
Parental **Risk Factors Among Maryland Children Who Receive an Investigative Response from DSS no matter the finding (as reported to SCCAN by DHS)**:

- 25.6% (down from a reported 38.1% in 2017) of child victims had a caregiver risk factor for domestic violence
- 37.9% (different from 2% and 5.1% with a caregiver risk factors for alcohol - and drug abuse, respectively, as reported to NCANDS) of child victims had a caregiver risk factor of substance abuse.
- 40.2% of child victims had a caregiver risk factor for financial problems
- 28.2% of child victims had a caregiver risk factor of maltreatment history.
- 21.7% of child victims had a caregiver risk factor of a history of exposure to violence.

[19] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2018), *Child Maltreatment 2017*; https://www.acf.hhs.gov/sites/default/files/cb/cm2017.pdf

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

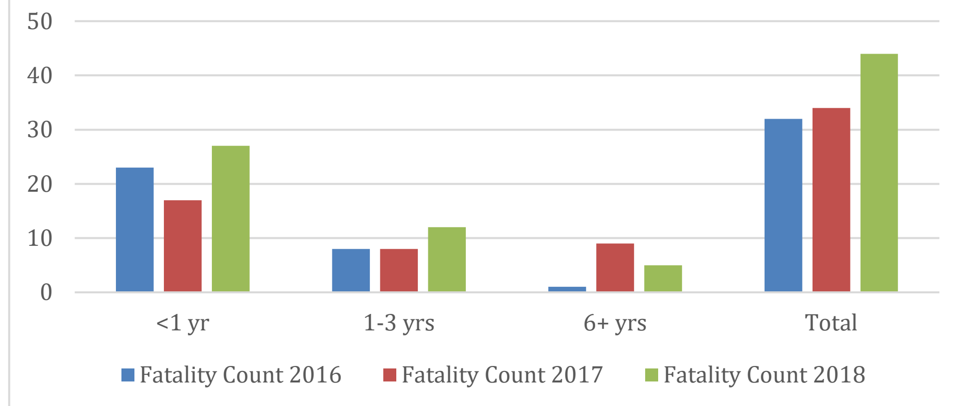
[21] https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html



Given the strong likelihood that NCANDS data – obtained from DHS child welfare data – grossly underestimates the risk of parental substance abuse, SCCAN is concerned that parental risk factors may or may not be accurately identified or documented by trained child welfare workers, go undocumented in the child welfare data systems, and are inaccurately reported to NCANDS. As this is data upon which child welfare policy is formulated, it is critical to ensure that risk factors are accurately identified and documented in the child welfare data systems; and, accurately reported to policy makers.

Child Abuse & Neglect Fatalities as Reported by DHS:

- In FFY 2018, DHS reported to NCANDs that at least 40 Maryland children had died with child maltreatment as a contributing factor. This data has increased each year over at least the last 3 years from 34 the prior year and 32 and 28 the two years before. It was reported that of those 40 children, none of the children's families had received Family Preservation Services within the previous 5 years and no child was removed from his/her family within the previous 5 years.
- SSA reported 44 child fatalities in FFY 2018 to SCCAN. Twenty-seven (61%) of child deaths were < 1 years old; 12 (27%) were 1-3 years old; and 5 (11%) were between 6-17 years old. Due to COVID-19 data requests, the SSA was unable to provide data on the race and ethnicity of the children.
- In FFY 2018, DHS reported that there were 49 serious physical injuries (SPIs) with child maltreatment as a contributing factor (up from 19 in FFY 2017). Thirty-three (or 67%) of the SPIs were of children <1-year-old; 12 (or 24%) were 1-3 years old; and 4 (or 8%) were 6-10 years old. No data was provided regarding the number of SPIs that had an active case or prior child welfare case which had been closed within the past 12 months.
- SSA was unable to provide data on the race and ethnicity of child fatalities and children with SPIs and this is of great concern to the Council. This data should be publicly available on a regular basis.



COLLECTING ACE DATA in MARYLAND:

Background: **The Adverse Childhood Experiences Study**

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 Centers for Disease Control and Prevention (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 can be found in prior SCCAN annual reports and at the CDC ACEs website.

Collecting ACE Data through the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS)

BRFSS and the ACEs Module

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 and MD EFC recommended adding the ACEs module to Maryland's BRFSS and successfully advocated in 2014 for inclusion of the module in the 2015 BRFSS. SCCAN and MD EFC recommended inclusion of the ACE

module in the BRFSS every three years and the module was repeated in 2018 and 2020. Maryland BRFSS surveyed 12,000 non-institutionalized adults aged 18+ in 2015. Six thousand of those surveyed were administered the ACE module. In the 2018 Maryland BRFSS, 12,000 participants out of 18,000 total were administered the ACE module.

The BRFSS ACE module collects data on eight of the original ten ACEs, excluding physical and emotional neglect from the questionnaire. The following questions were asked on the 2015 and 2018 BRFSS surveys:

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 try to make you touch them sexually?" or "Before the age of18, 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.

Forty-two states and D.C. have collected at least one year of ACE data. While SCCAN and MD EFC are encouraged that Maryland is collecting ACEs prevalence data, effective analysis and publication of that data at both statewide and jurisdictional levels is essential to using the data to inform state and local action. From the 2015 and 2018 Maryland ACE BRFSS data, we hope to learn about the prevalence of ACEs in Maryland adults, populations most at risk by demographic characteristics, prevalence of risky health behaviors by the number or “dose” of ACEs, as well as the prevalence of health outcomes by the number or “dose” of ACEs.

YRBSS and the ACEs Module

The CDC’s Youth Risk Behavior Surveillance System (YRBSS) monitors the prevalence of six types of health-related behaviors that contribute to the leading causes of death and disability among youth and adults:

- Behaviors that contribute to unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity

YRBSS also measures the prevalence of obesity, asthma, and other health-related behaviors as well as sexual identity and sex of sexual contacts.

The YRBSS includes both a high school and middle school-based core survey conducted by CDC and additional state and local questions selected by individual states. The CDC provides the core YRBSS survey questions and approves each state's additional questionnaire. Maryland chooses two-thirds of its' questions from the core YRBSS and one-third from Youth Tobacco Survey (YTS) and stakeholder requests. Separate instruments are used in middle school and high school. The survey is conducted via paper and pencil during one class period (45 minutes) and is confidential and anonymous. State- and Jurisdiction-level YRBSS data is available on the Maryland Department of Health website. The CDC produces data tables and figures of all survey questions.

In 2018 at the urging of SCCAN and MD EFC, Maryland became one of two states (along with New Hampshire) to begin collecting ACEs data through the YRBSS. MDH together with MSDE decided to include a limited four of ten ACE questions on the 2018 YRBSS. They decided which four questions they would ask in part based on research by Christina Bethell, et. al.[22] which found the highest prevalence ACEs were parental incarceration, parental substance abuse, parental mental illness, and witnessing intimate partner violence (IPV); followed by physical abuse, sexual abuse, and emotional abuse respectively. In the 2018 YRBSS survey of high schoolers, MDH and MSDE asked four original ACE questions: emotional abuse, household substance abuse, household mental illness, and household incarceration. According to Bethell, et.al., those who experienced these most prevalent ACEs were more likely to have experienced other ACEs. Original ACE questions not asked included four of the five questions on child abuse and neglect (physical abuse, sexual abuse, physical neglect, emotional neglect), household domestic violence, and divorce or separation.

The following questions were asked of Maryland high school students:

Emotional abuse	"Does a parent or other adult in your home regularly swear at you, insult you, or put you down? Response options: Yes, No.
Household Substance Abuse	"Have you ever lived with anyone who was an alcoholic or problem drinker, used illegal street drugs, took prescription drugs to get high, or was a problem gambler?" Response options: Yes, No.
Household Mental Illness	"Have you ever lived with anyone who was depressed, mentally ill, or suicidal?" Response options: Yes, No.

[22] Bethell, C., Carle, D., Hudziak, J., Gombojav, N., Powers, K., Wade, R., Braveman, P., *Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice,* Academic Pediatrics, Sep-Oct 2017;17(7S):S51-S69. doi: 10.1016/j.acap.2017.04.161.

Household Incarceration	"Has anyone in your household ever gone to jail or prison?" Response options: Yes, No.

Four states now collect ACE data through their YRBSS and the CDC has adopted an ACEs module with all ten questions and six positive childhood experiences (PCEs) questions for future YRBSSs. Maryland should include these sixteen questions in future YRBSS.

PREVALENCE OF ACEs IN MARYLAND ADULTS:

Maryland collected baseline ACE data in 2015 and 2018. In the collection of this data, important insights into prevalence of ACEs were 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 does not indicate the severity or frequency of each ACE, but rather whether each ACE occurred or did not occur.
- Data does not indicate the temporality of each ACE; data indicates whether an ACE happened, not when it happened. Because 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.

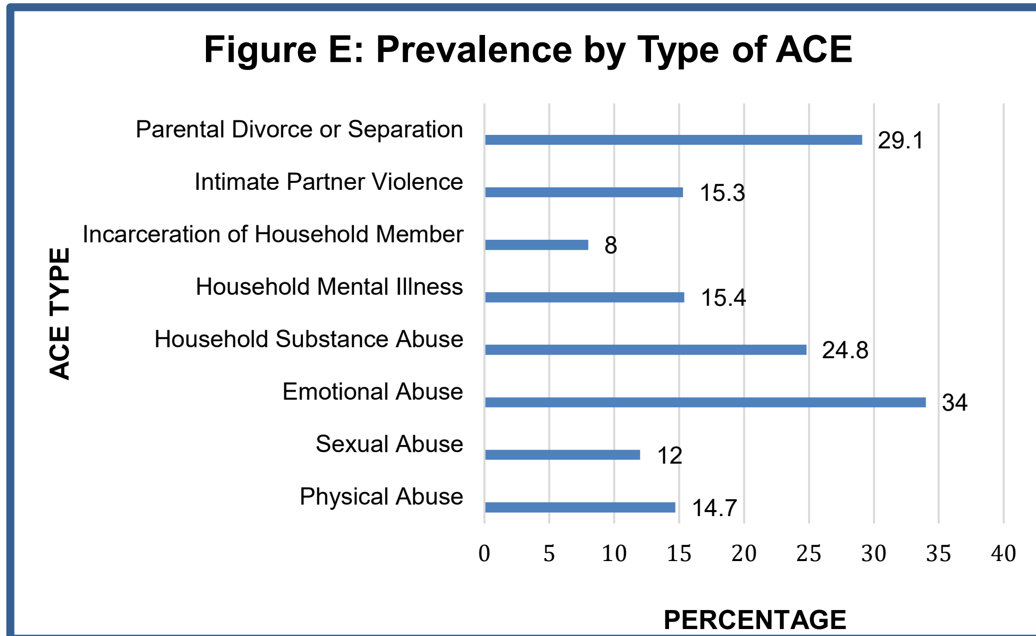
KEY FINDINGS in MARYLAND:

ACEs are COMMON:

Three fifths of the 12,000 BRFSS participants who completed the ACE module in Maryland in 2018 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

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 E below.



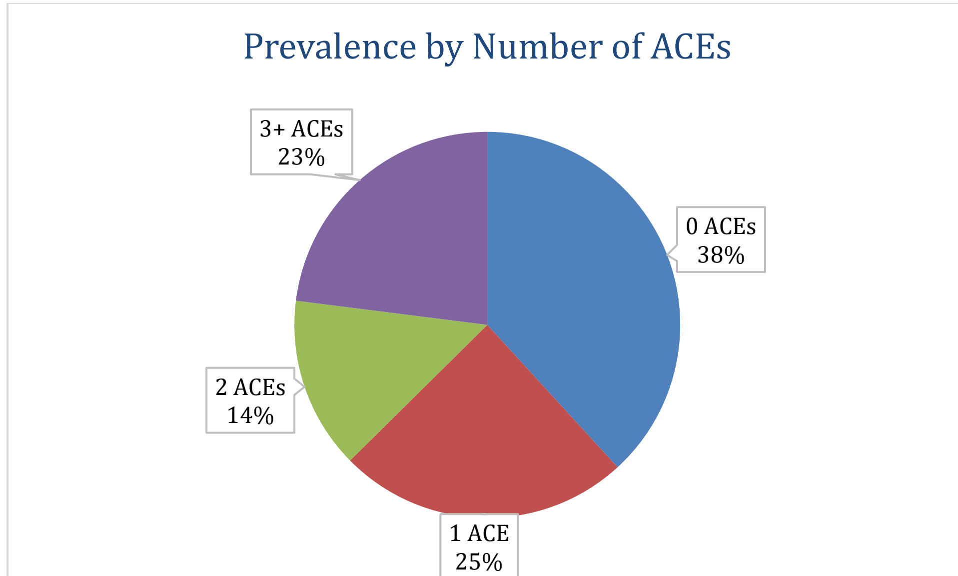
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

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; 24.4% reported one ACE compared to 37.4% reporting 2 or more ACEs. The ACE score captures the potential extent of neuro-developmental disruption as a result of traumatic stress.

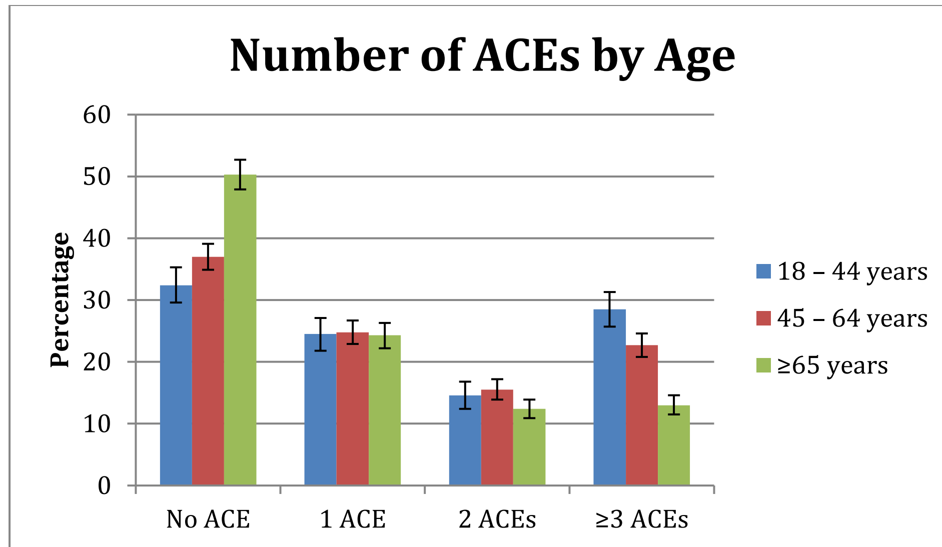
Prevalence by Number of ACEs

As reported in the 2018 Maryland BRFSS, approximately 38% of respondents reported zero ACE exposures, 25% reported 1 ACE, 14% reported2 ACEs, and 23% 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.



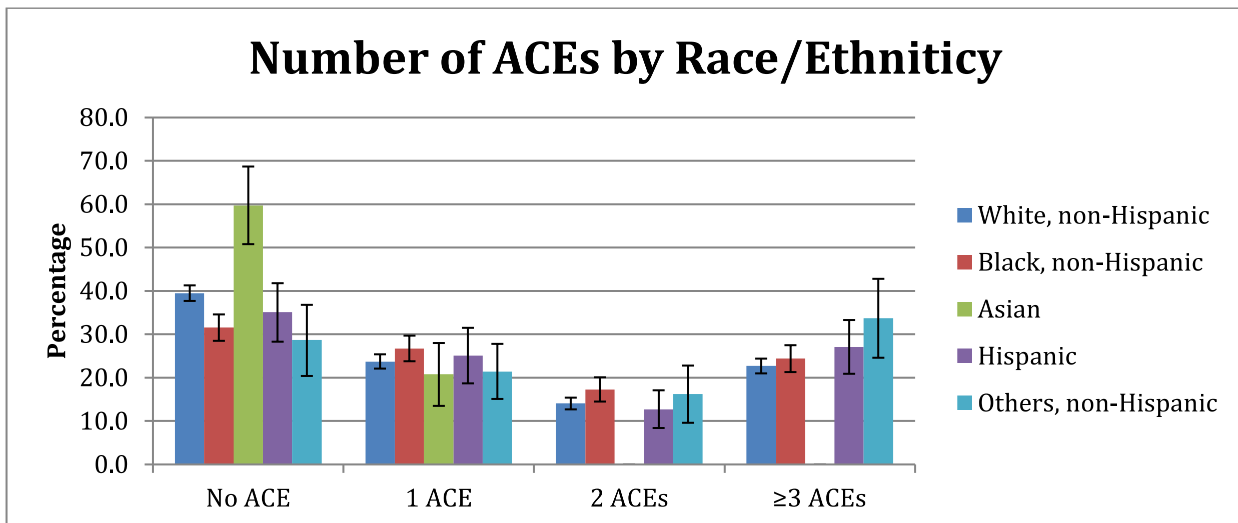
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

DEMOGRAPHICS



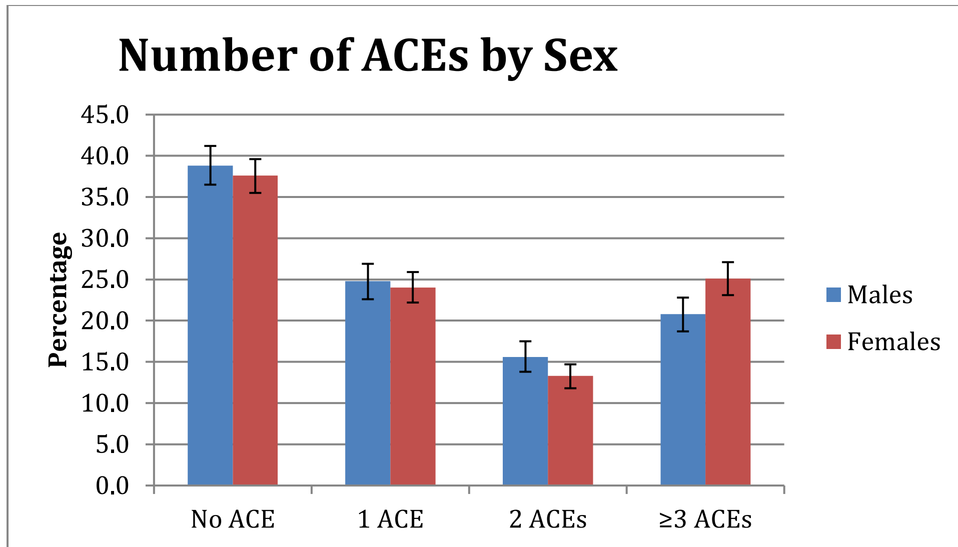
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

As respondent age increases, the frequency of reporting multiple ACEs decreases. Individuals over 65 are significantly more likely to report no ACE exposure and less likely to report greater than 3 ACEs compared to younger respondents. 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.



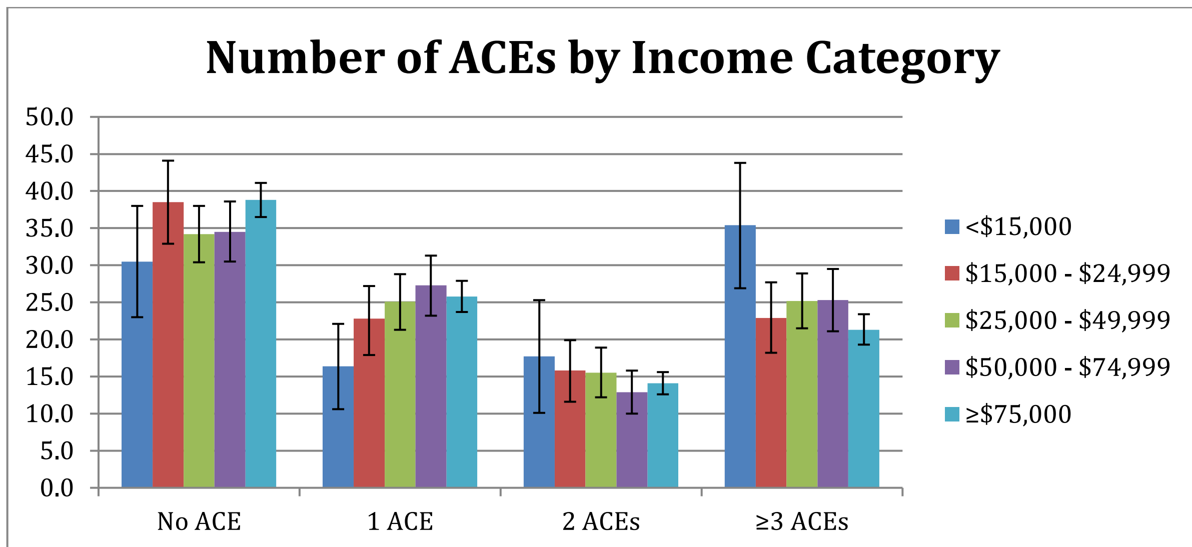
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.
Note: The sample size for Asian populations are too small to provide reliable estimates.

Adults who identified as "Asian" were significantly more likely to report no ACE exposure. No other differences were statistically significant.



Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Males and females experience a similar proportion of ACE exposures. A statistically significant higher percentage of women report experiencing 3 or more ACEs.



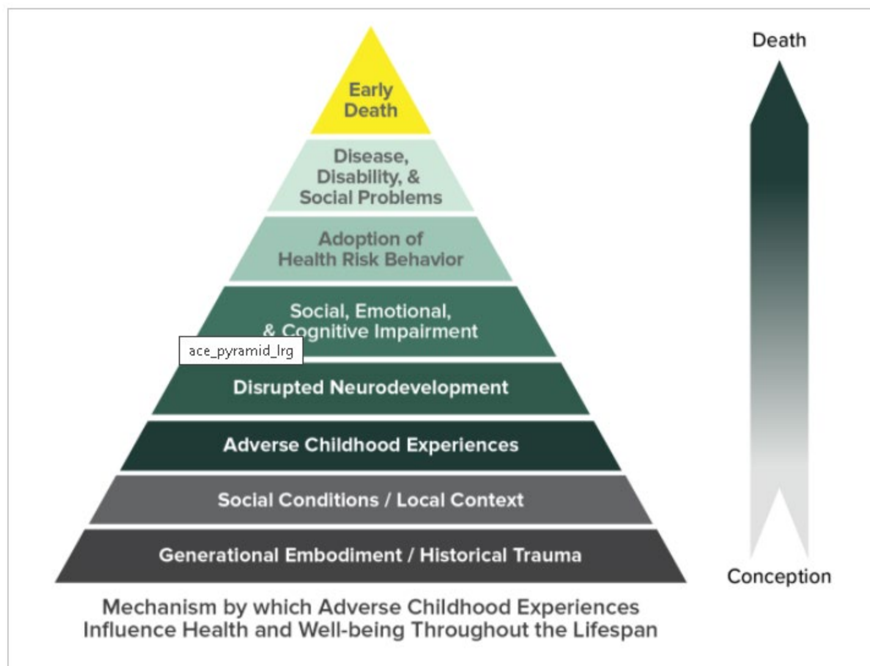
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Thirty-five percent (35%) of respondents who reported having an income of less than $15,000 dollars per year have 3 or more ACEs, while 21-25% of those with higher annual incomes have 3 or more ACEs. This difference is only significant between those reporting less than $15,000 and those reporting greater than $75,000.

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*. Many studies have shown as the number of ACEs increase in the life of an individual, there is an increased likelihood of risky behaviors and chronic physical and mental health conditions.[23]

ACEs and Poor Life Outcomes in Maryland:[24]



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. 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. 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

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[23] Childhood Adversity and Adult Chronic Disease An Update from Ten States and the District of Columbia, 2010 Leah K. Gilbert, MD, MSPH, Matthew J. Breiding, PhD, Melissa T. Merrick, PhD, William W. Thompson, PhD, Derek C. Ford, PhD, Satvinder S. Dhingra, MPH, Sharyn E. Parks, PhD; Associations Between Adverse Childhood Experiences, High-Risk Behaviors, and Morbidity in Adulthood, 2015 Jennifer A. Campbell, BS, Rebekah J. Walker, PhD, Leonard E. Egede, MD, MS; Unpacking the impact of adverse childhood experiences on adult mental health 2017 Melissa T. Merrick, Katie A. Ports, Derek C. Ford, Tracie O. Afifi, Elizabeth T. Gershoff, Andrew Grogan-Kaylor

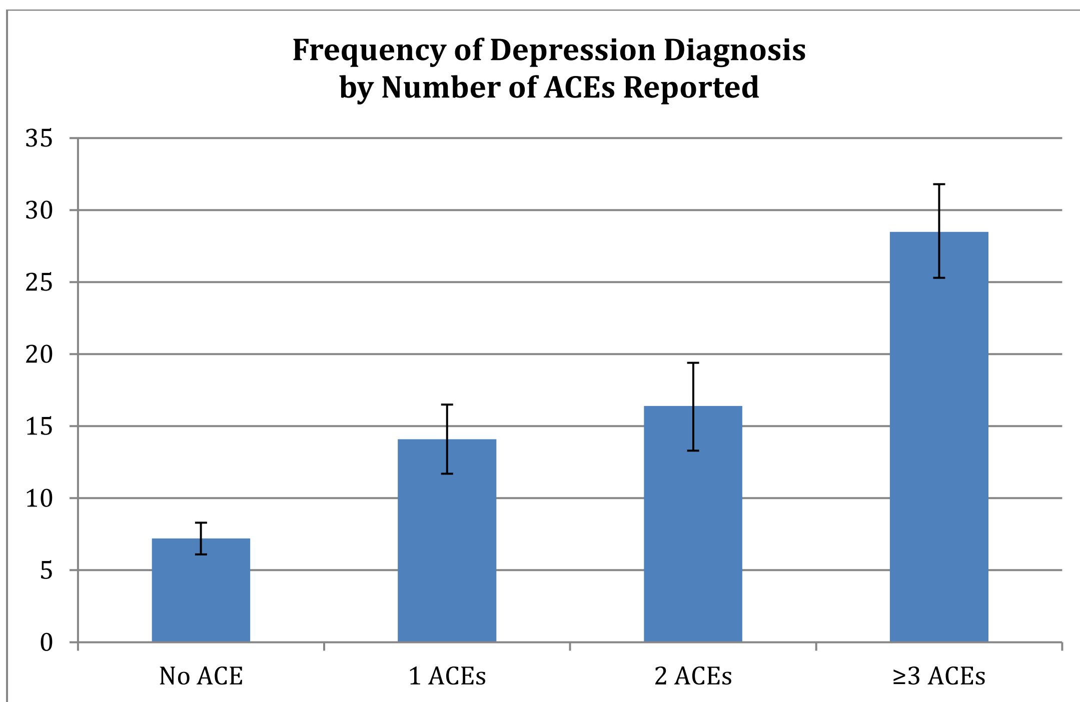
[24] Centers for Disease Control and Prevention. (2016). Adverse Childhood Experiences (ACE) Study. National Center for Chronic Disease Prevention and Health Promotion. Retrieved from https://www.cdc.gov/violenceprevention/acestudy/ACE_graphics.html.

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

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 healthy brain development is disrupted when there are no adults to buffer a child from adverse experiences. Moving up to the third tier from the bottom of the ACEs pyramid, the result of ACEs can be "social, emotional and cognitive impairment." The Maryland Department of Health (MDH) analyzed 2015 Maryland BRFSS ACE module data vis a vis four indicators within this tier: depression, anxiety, poor mental health days, and cognitive decline. All indicators showed a strong dose-response relationship[25] to increasing ACEs.[26] MDH has also analyzed the 2018 Maryland BRFSS ACE data vis a vis two indicators within this tier; depression and poor mental health days. Questions related to anxiety and cognitive decline were not asked in the 2018 questionnaire.

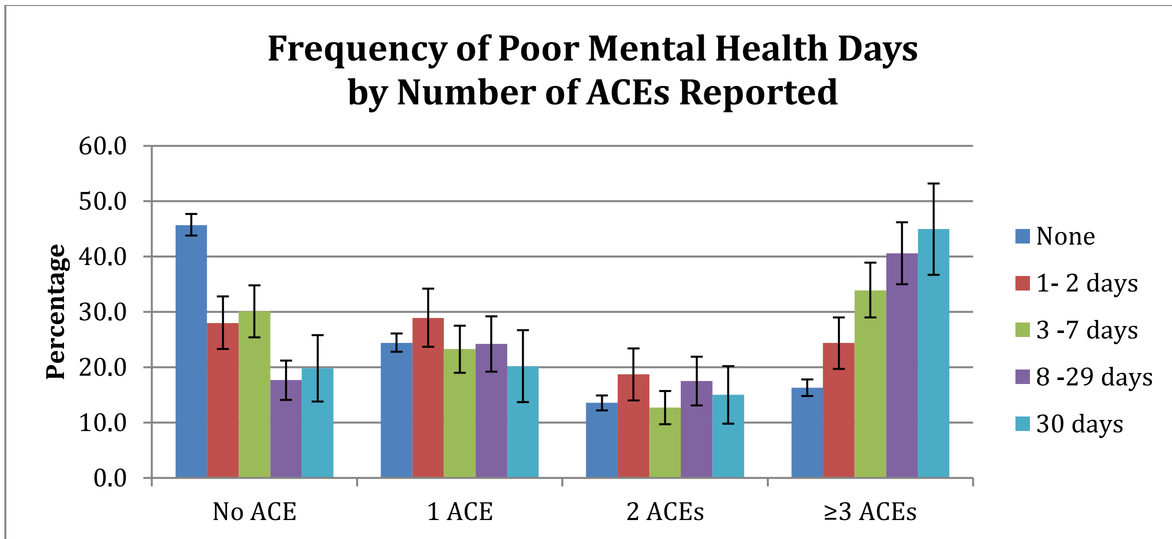


Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

There is a strong dose-response relationship when looking at depression in relation to ACEs. As ACE exposure increases, so does the likelihood of depression. Adults who report 0 ACEs have the lowest prevalence of depression (7.2 %) followed by those who experience 1 ACE (14.1 % reported depression), 2 ACEs (16.4% reported depression) and finally 3 or more ACEs (28.5% reported depression). All differences are statistically significant except between 1 ACE and 2 ACEs.

[25] 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

[26] See SCCAN's 2018 Annual Report.

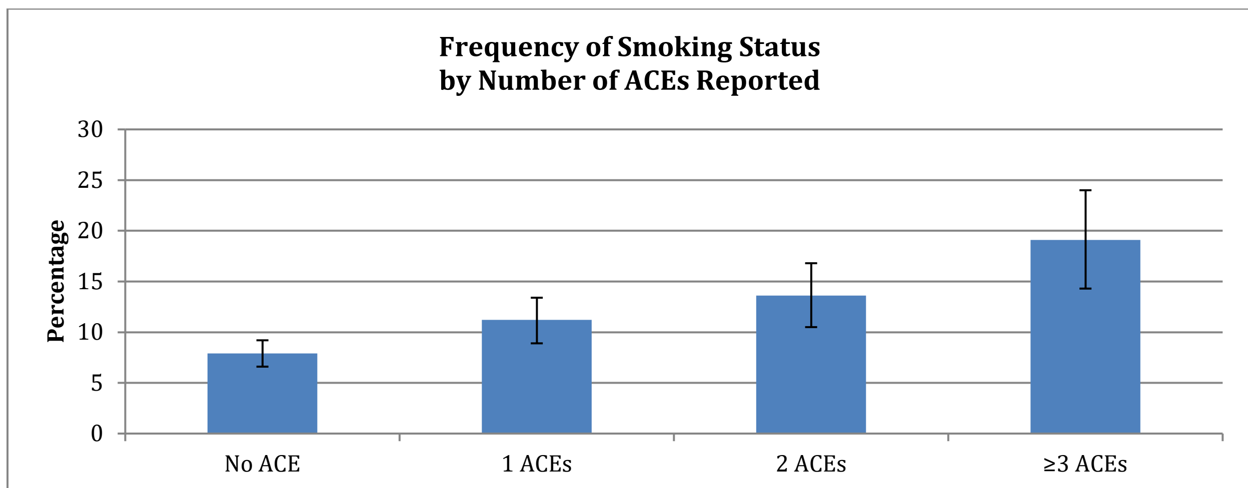


Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Individuals who reported no ACEs were significantly more likely to report no poor mental health days in the past 30 days than to report any poor mental health days (1-2, 3-7, 8-29, or 30). Additionally, those with 3 or more ACEs were less likely to report no poor mental health days than to report any poor mental health days.

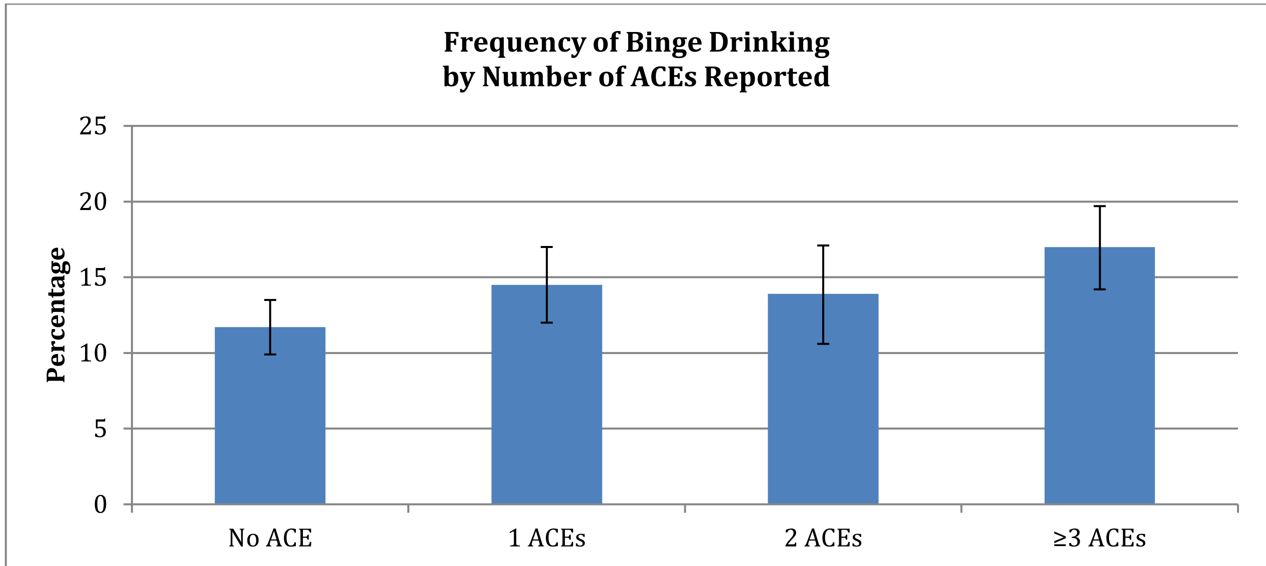
Adoption of Health-risk Behaviors

The next tier up on the ACEs Pyramid is the adoption of health-risk behaviors. Utilizing the 2018 Maryland BRFSS ACEs data, correlations with the adoption of unhealthy behaviors was analyzed. For all three unhealthy behaviors analyzed (current smoking, binge drinking, and seatbelt usage) there appears to be a dose response relationship; as the number of reported ACEs increase, the rates of unhealthy behaviors also increase.



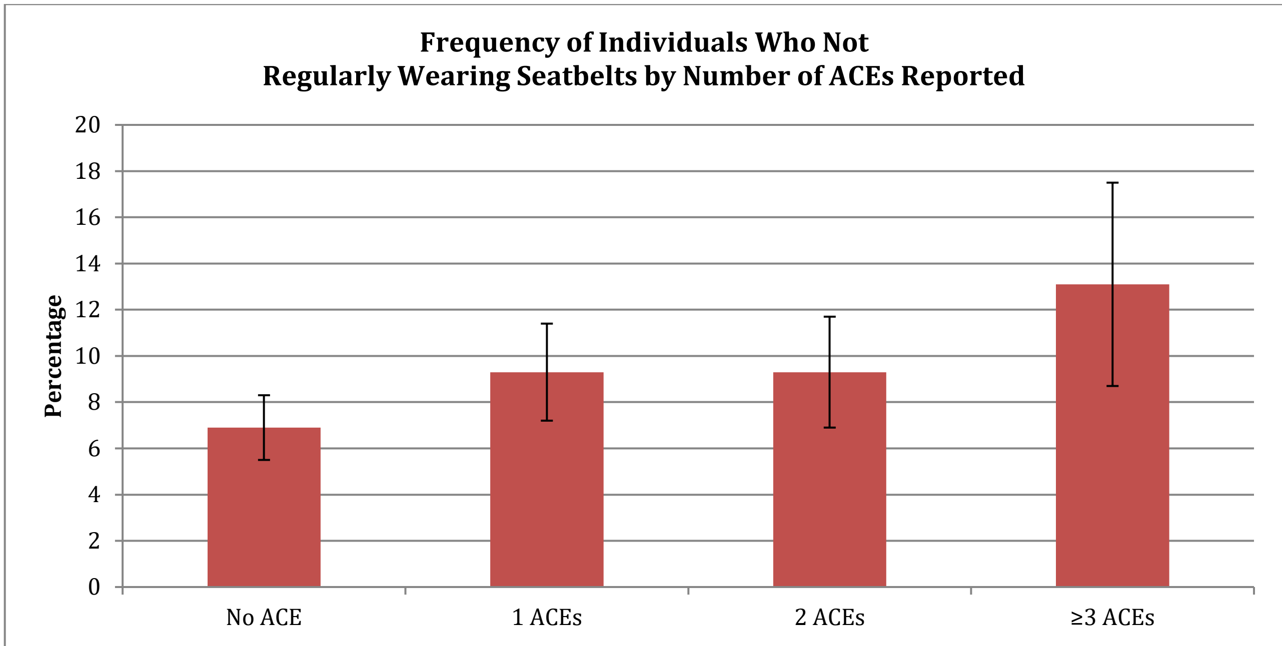
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Individuals with no ACEs were significantly less likely to smoke (~7% smoke) than those with 3 or more ACEs (~18% smoke), indicating that the prevalence of current smoking behavior increases as reported ACE exposure increases.



Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Individuals who report binge drinking were significantly less likely to report no ACE exposure. Additionally, a dose response can be seen; as individuals report more ACEs, the prevalence of binge drinking also increased.

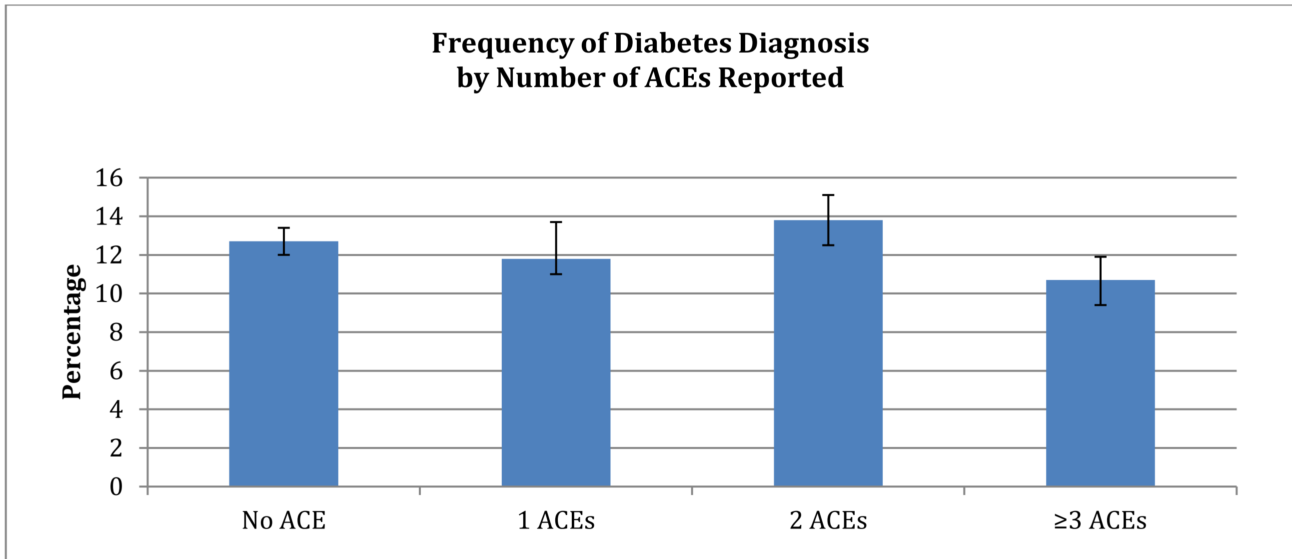


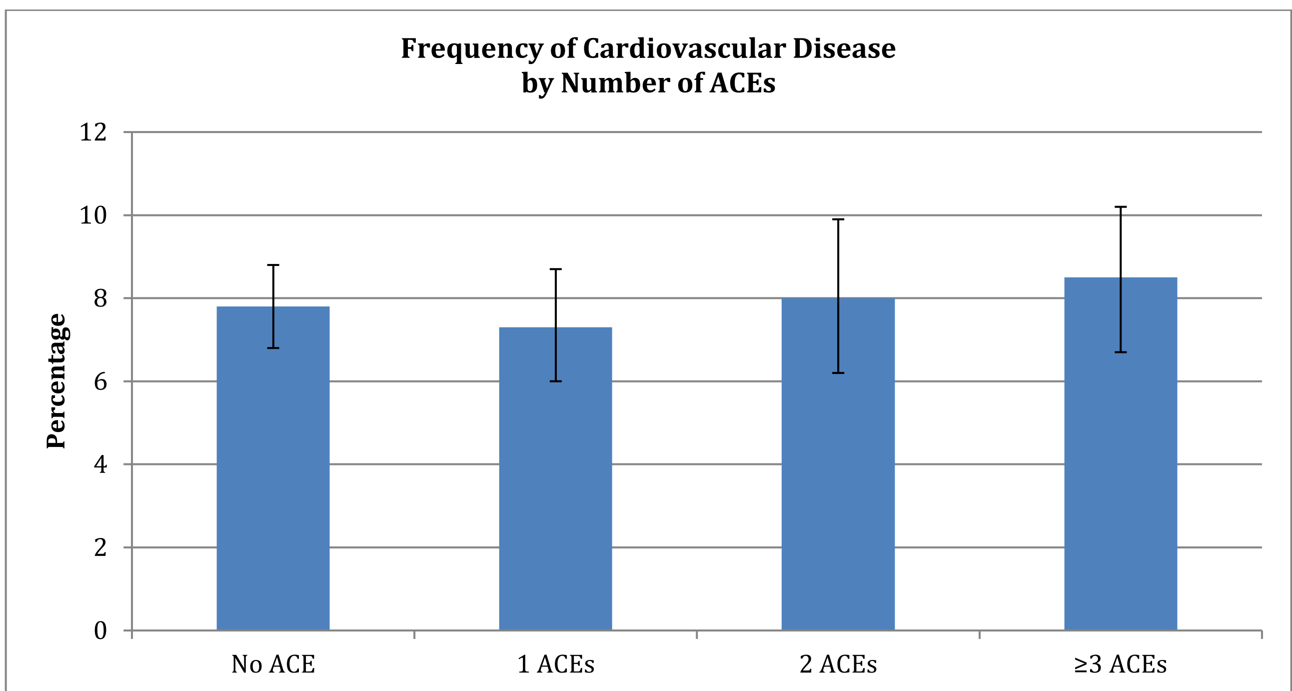
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

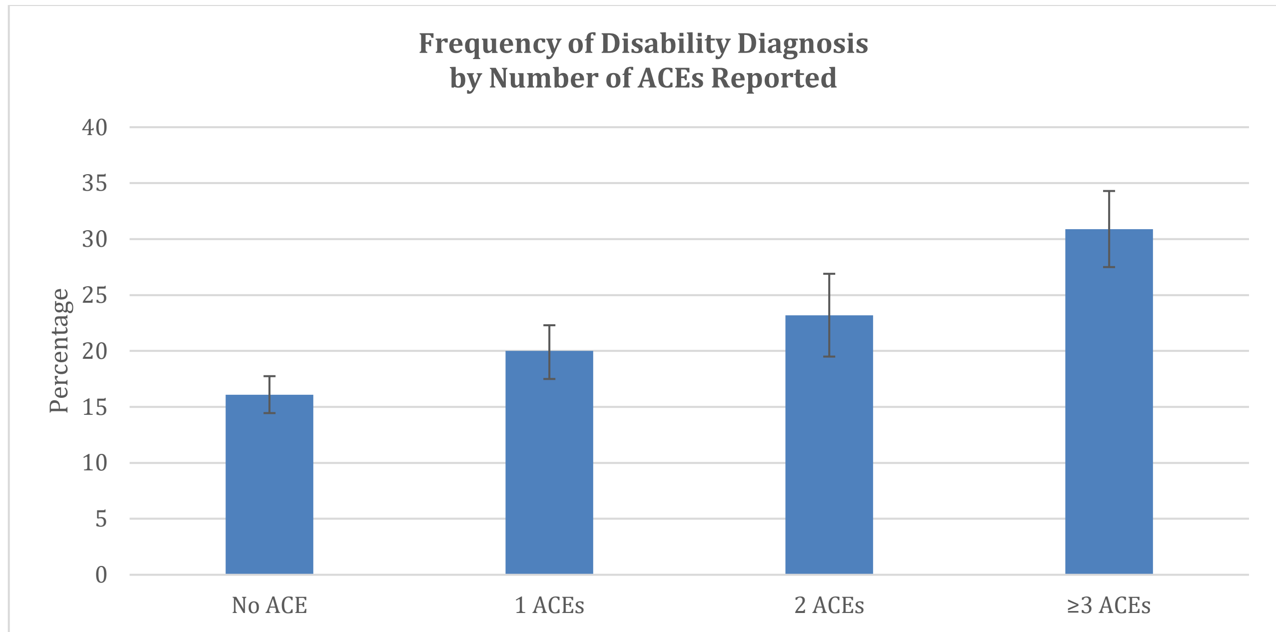
There appears to be a dose response relationship between ACE exposure and seatbelt use, although the relationship is not statistically signficiant. Individuals with 3 or more ACEs were less likely to wear seatbelts regularly than those with no ACEs.

Disease, Disability, and Social Problems

There were few statistically significant associations between ACE exposure and chronic health problems in the 2018 Maryland BRFSS data.







Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

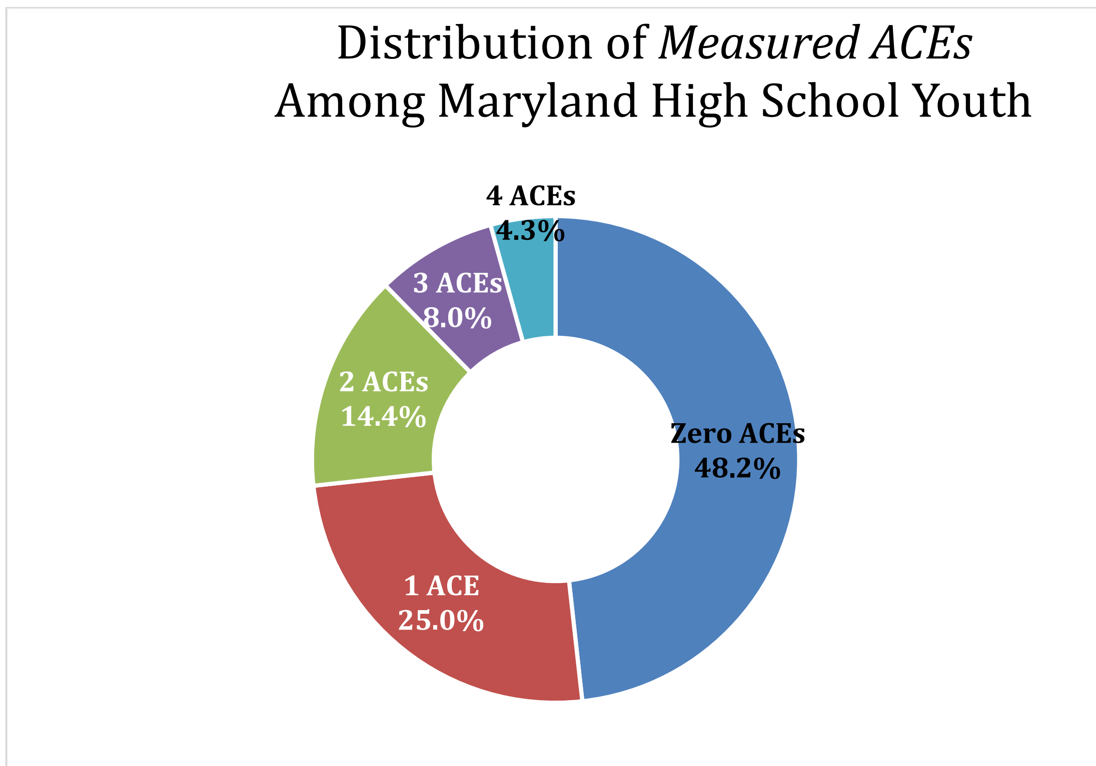
As can be seen in the previous graphs, although there are some differences in chronic disease prevalence by ACE exposure, they are not statistically significant for many chronic diseases. In the 2018 BRFSS analyses, one differing point is the rates by disability status. There appears to be a dose response relationship between number of ACEs and disability status, indicating that the prevalence of disability status increases as reported ACE exposure increases.

Considering the ACEs Pyramid and the ACE exposure, and their relationship to time, it appears that data associated with the bottom of the pyramid shows a stronger dose response relationship between ACEs and health behavior/outcome. As you move up the ACE Pyramid, the dose-response relationship becomes less strong, with fewer statistically significant associations. This is an interesting and noteworthy trend and may be related to the large number of risk factors that contribute to chronic disease.

PREVALENCE OF ACEs IN MARYLAND YOUTH:

41,891 Maryland high school students from 184 high schools participated in the 2018 Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS). There was an 80% overall high school response rate. Four ACE questions were asked in the survey: emotional abuse, household substance abuse, household mental illness, and household incarceration. Children who have experienced any of the four ACEs measured by the Maryland YRBS/YTS are more likely to have other ACEs, as well.[27] To get a clear picture of the adversity experienced by Maryland youth, it is important that the full panoply of the CDCs ACE module questionnaire be included in Maryland's YRBSS. The CDC ACE module includes 8 of the original ACE questions, 2 incidence ACE questions, 3 community ACEs, and 3 positive childhood experiences (PCE) questions. (See Appendix E)

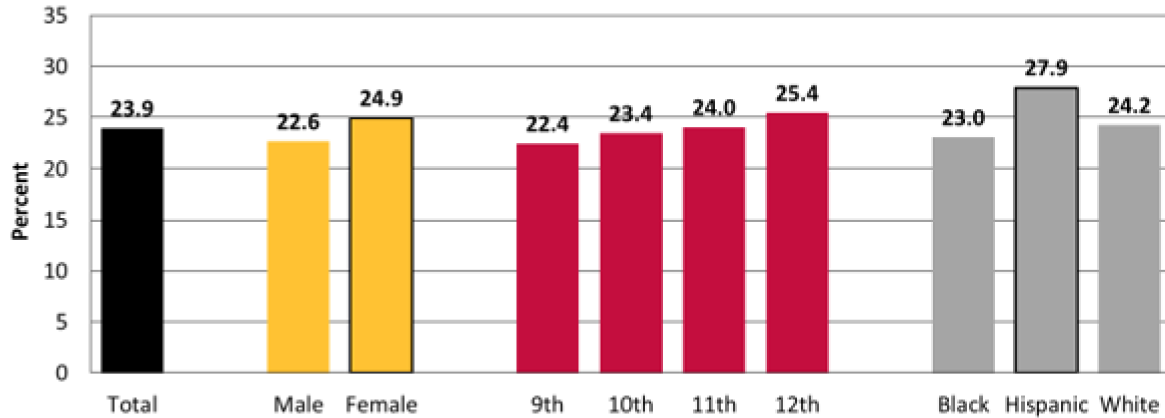
ACEs are Common:



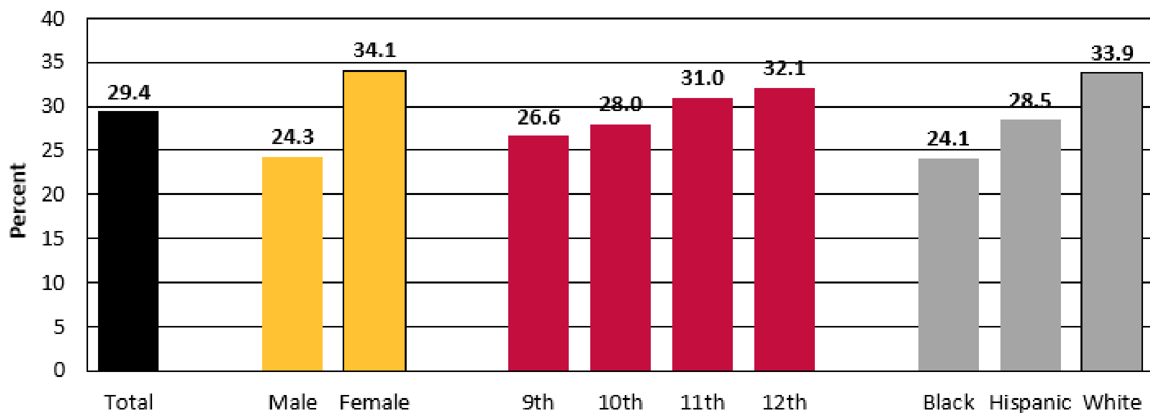
A little *more than one in two students were exposed to the measured ACEs*. 25% had one ACE, 14.4% had two ACEs, 8% had three ACEs and 4.3% had all four measured ACEs.

[27] Bethell, C., et.al., *Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice,* Academic Pediatrics Journal, (2017).

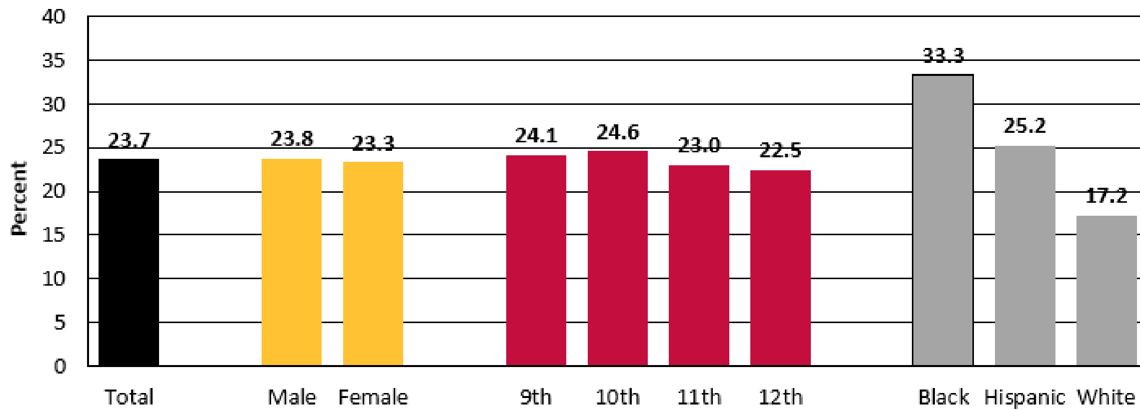
High Schoolers Exposure to the Four Measured ACEs:



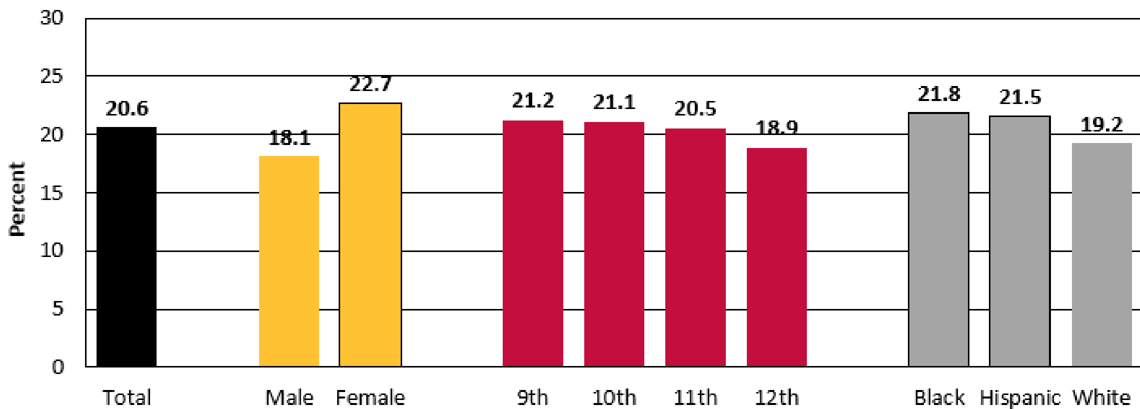
Not surprisingly, teens in higher grades were more likely to report living with someone with an addiction problem than those in early years of high school, as they had more time for potential exposure. Female teens were more likely than males to report living with someone with an addiction problem, and Hispanic teens were more likely to report living with someone with an addiction problem than Black or white teens.



Females were more likely than males to report living with someone with a mental health issue. White teens were more likely to report living with someone with a mental health issue than Black or Hispanic teens.



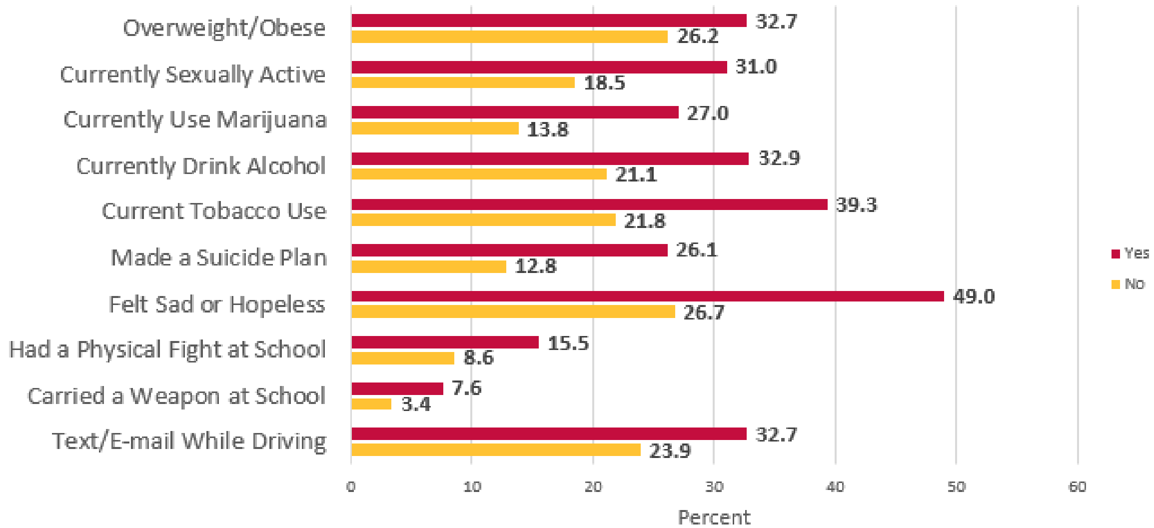
Black teens were more likely than Hispanic or white teens to report living with someone who had been incarcerated. This data is consistent with national data showing disproportionate rates of incarceration among Black adults.[28]



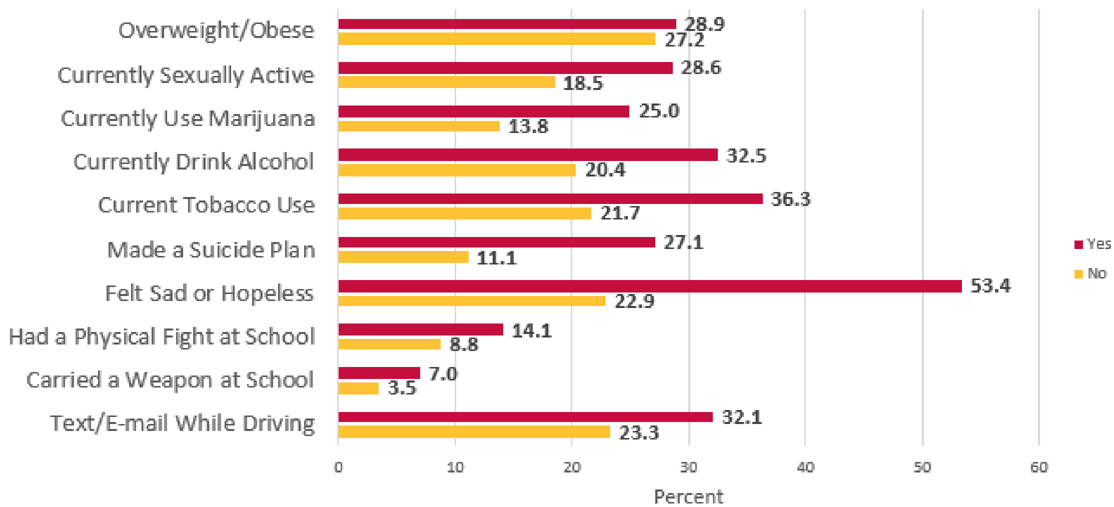
Approximately one in five Maryland teens reports regular emotional abuse by adults in their household. This is important because emotional abuse can have more deleterious effects on teen's mental health than even physical abuse.[29]

[28] https://www.pewresearch.org/fact-tank/2020/05/06/share-of-black-white-hispanic-americans-in-prison-2018-vs-2006/
[29] Miller-Perrin, et al. Child Abuse & Neglect, 2009

ACEs and Adolescent Risk Behaviors:

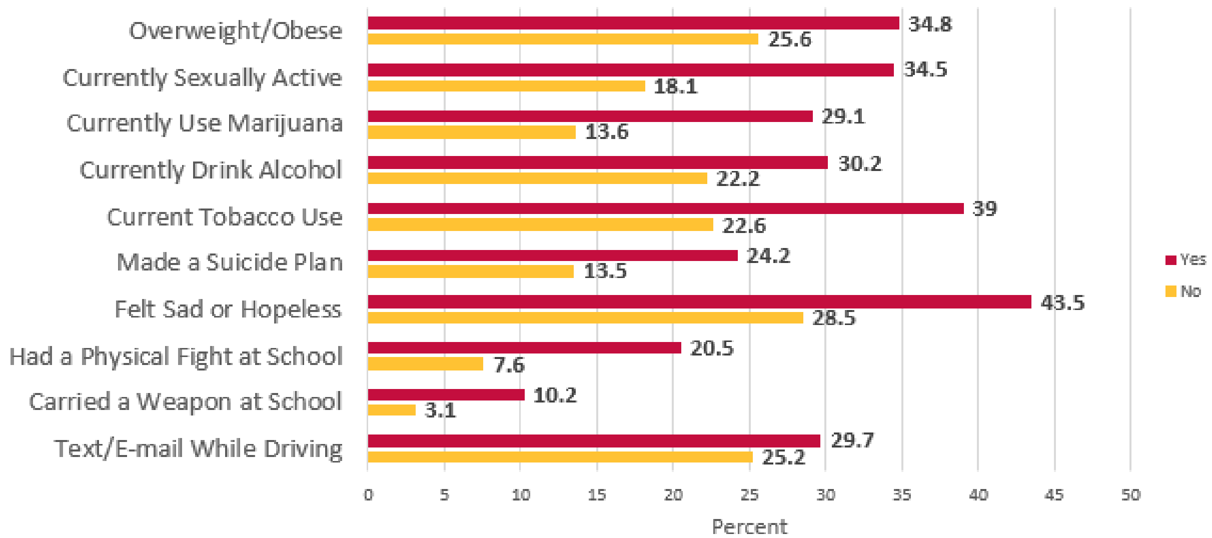


Teens exposed to household substance abuse have higher rates of obesity, risky behavior, and mental health issues compared to those not exposed to household substance abuse.



Teens exposed to household mental illness have higher rates of risky behavior than those not exposed. More than half of teens living with someone with mental illness reported symptoms of depression, and more than one quarter had made a suicide plan.

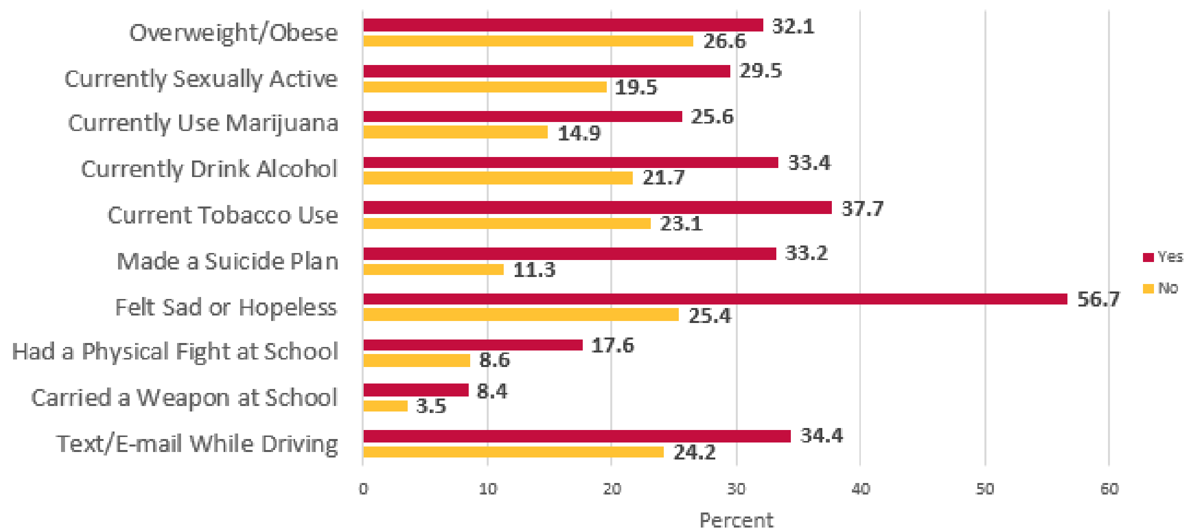
Exposed to Household Incarceration



Source: 2018-2019 Maryland HS YRBS/YTS

When compared to unexposed teens, those exposed to household incarceration had higher rates of overweight/obesity, risky behavior, and depressive symptoms. Almost half of teens exposed to household incarceration reported symptoms of depression and nearly one quarter had made a suicide plan. Nearly 40% reported smoking cigarettes, and approximately 30% reported current marijuana or alcohol use.

Exposed to Emotional Abuse

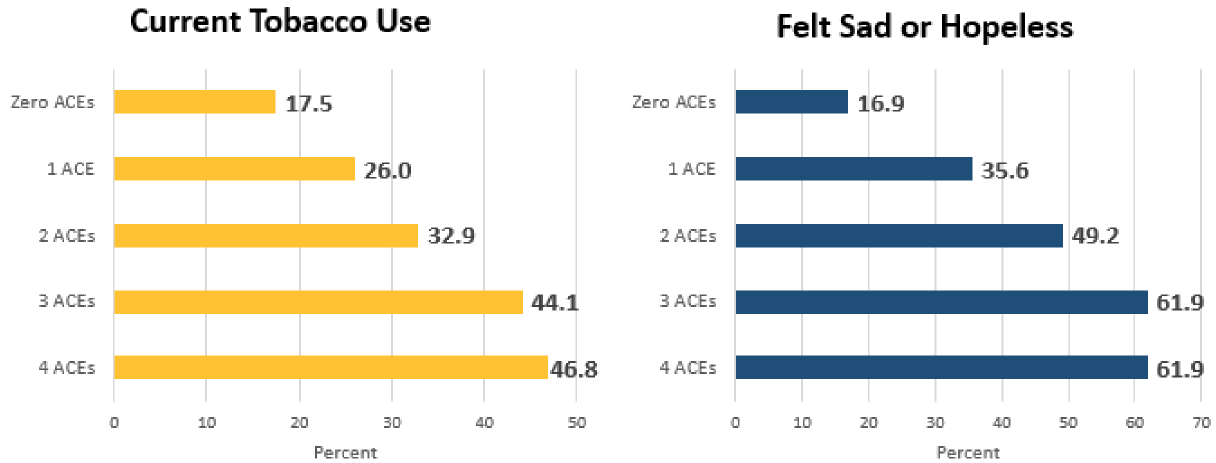


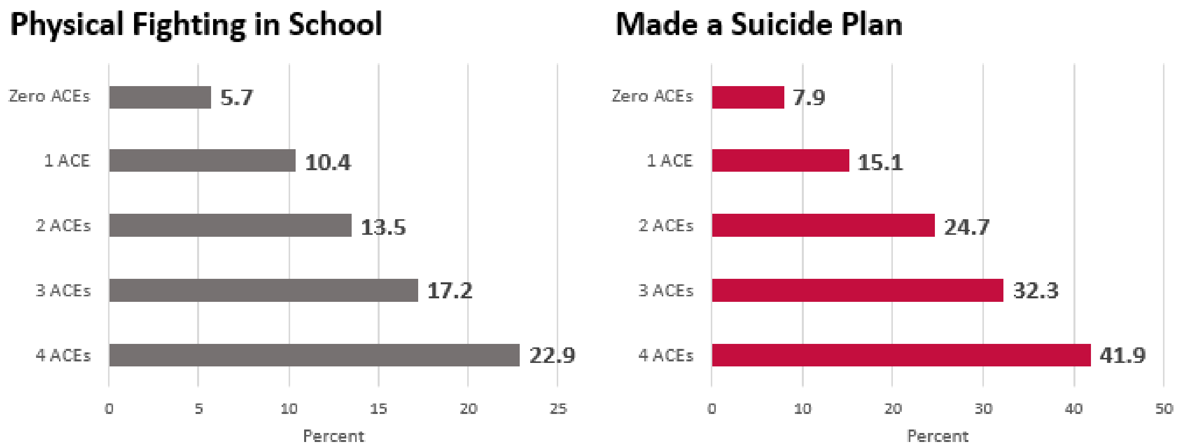
Source: 2018-2019 Maryland HS YRBS/YTS

Findings for emotional abuse are similar to those for other ACEs. However, rates of depressive symptoms (57%) and suicidal ideation (33%) among teens exposed to emotional abuse were higher than those of

teens exposed to any of the other ACEs included in the YRBS.

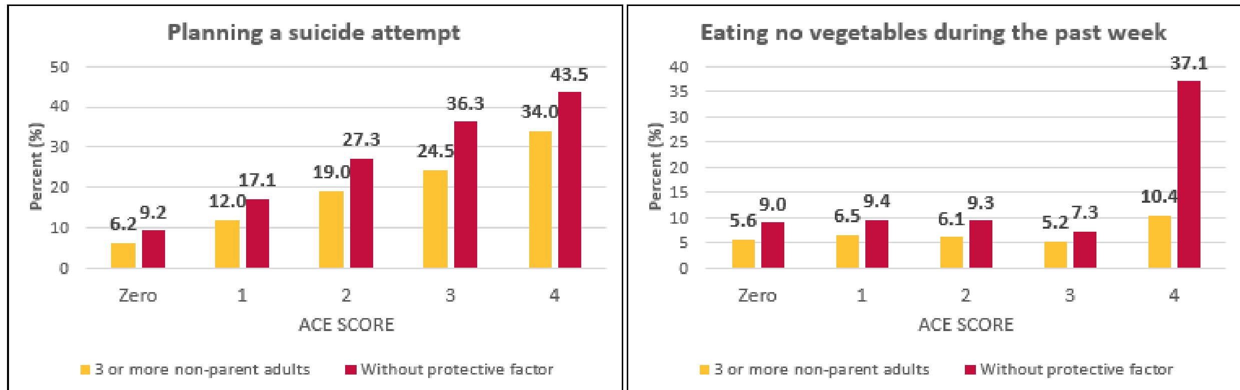
Dose Response Relationship ACEs and Risk Behaviors:





YRBS data show a dose response relationship between the number of ACEs Maryland teens experience and their likelihood of tobacco use. Likewise, as ACEs increase, the likelihood of symptoms of depression and suicidal ideation also increase. Dose response relationships can also be seen between ACE exposure and fighting at school.

Protective Factors: Support from 3 or More Non-Parent Adults



Having the support of multiple non-parental adults appears to have a buffering effect. While there is a dose response relationship between ACE score and suicidal ideation, adult support reduces that risk across every ACE level. Similarly, the presence of supportive adults appears to have a positive effect on healthy eating, most substantially among teens exposed to four or more ACEs. These findings suggest that providing additional social support to at-risk teens could reduce risky behavior and improve both their mental and physical health.

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. As Jack Shonkoff, 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.

Maryland Department of Health (MDH), Division of Health Promotion Administration should conduct a more in-depth analysis of Maryland’s ACE data. At a minimum, a complete examination of the association between ACEs and health outcomes should be undertaken. Ideally, expanded analysis of ACE data should be completed. This should 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, to the extent possible given the small sample sizes for some counties.
- Production of a large report or series of data briefs/fact sheets

- The IBIS data portal for BRFSS data should be modified so that users can examine associations between ACEs and health outcomes themselves. The current configuration of the data only allows for examination of the likelihood of having a specific number of ACEs given the presence of a health outcome, rather than the likelihood of having a health outcome given the presence of ACEs.

SCCAN'S ACTIONS & ACCOMPLISHMENTS 2019

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).[30] 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, 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

Maryland Essentials for Childhood Initiative works statewide toward achieving the four strategic goals above with the purpose of creating the safe, stable, and nurturing relationships and environments that support the healthy development of all Maryland children, i.e., becoming a trauma-informed and resilient state. Below is a brief description of key actions by SCCAN and MD EFC Partners to achieve these broad goals.

Key Successes of SCCAN & MD EFC Partners 2019-2020:

SCCAN and Maryland Essentials for Childhood Committee Members have achieved the following goals set out at SCCAN-Maryland Essentials for Childhood Retreat in July 2019:

GOAL 1: Raise awareness of N.E.A.R. Science and build commitment to put the science into action to reduce and mitigate ACEs by.

- Increased the breadth and reach of the ACE Interface Project[31] to spread the knowledge of the N.E.A.R. Science throughout Maryland public and private agencies and communities:
  - The ACE Interface Master Trainer cohort trained an additional 97 Master Presenters

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

[31] For more on the ACE Interface Project, see the 2018 and 2019 SCCAN Annual Reports.

representing all 24 Maryland jurisdictions to the original 30 Master Trainers; including two specialized cohorts:

- Opioid Epidemic – MDH's Regrounding Our Response[32] to the Opioid Crisis- a multi-disciplinary approach to understanding the overdose epidemic. (31 Master Presenters statewide)
- Education- MSDE and local education agency personnel. (36 Master Presenters statewide)

▪ Since its inception in December 2017 through March 2020, volunteer ACE Interface Master Trainers and Presenters have given 281 ACE Interface presentations (See Appendix F for list of key presentations) to over 8652 attendees across all 24 jurisdictions (See Appendix G for presentations by jurisdiction).

- Acted in a consulting capacity to Congressman Elijah Cummings Office on development of the first Congressional Hearing on Childhood Trauma which took place on July 11, 2019.
- Met with staffers of the Maryland Members of the U.S. House Committee on Oversight and Reform and Leader Hoyer to brief them on Maryland's efforts to reduce and mitigate childhood trauma.
- SCCAN's E.D. served on Congressman Cummings' fourteen member Baltimore City Childhood Trauma Roundtable to share SCCAN and MD EFC statewide efforts to prevent and mitigate childhood trauma and build resilience.
- Acted in a consulting capacity to Councilman Zeke Cohen on the Elijah Cummings Healing City Act (Trauma-Responsive Baltimore).
- Held the 1st full day ACEs Roundtable for Members of the Maryland General Assembly on December 13, 2019 sponsored by Delegate Vanessa Atterbeary and Senator Antonio Hayes, including presentations on the N.E.A.R. Science, The CDC's Best Available Evidence Research: ACE Data (MD & US) & Implications for Government Policy, the Economy, & Business, State Legislative Strategies to Prevent & Mitigate the Effects of ACEs, Translating the Science into Federal and State Policies Panel, Translating the Science Maryland's State and Local Efforts, and the "So What Now? World Café: Designing the Future" MGA Working Groups with "Call an expert" lifeline. By the end of the day, the group of legislators who attended committed to developing a Maryland Legislative Caucus to Prevent and Heal Childhood Trauma, arranging for a joint ACEs hearing for the Senate Judicial Proceedings and House Judiciary Committee, working with MD EFC to develop an ACE-informed platform of bills through the newly formed caucus, and encouraging their colleagues to attend the SCCAN-MD EFC ACEs Education & Advocacy Day at the General Assembly on Thursday, February 7th.
- Continued to develop and expand Maryland ACEs Action blog page on ACEs Connection[33]:
  - Recruited a lead Community Manager to recruit additional members
  - Doubled Membership, making Maryland ACEs Connection Community the 43rd largest of 285 Communities on ACEs Connection and the 6th largest statewide community after California, Washington, Arizona, Michigan, and Oklahoma.
  - Provided a statewide mapping of ACE Interface trainings on the Maryland ACEs

[32] For more on the Regrounding Our Response Initiative, see the 2019 SCCAN Annual Report.
[33] Developed Maryland ACEs Action blog page on ACEs Connection. ACEs Connection is "the most active, influential ACEs community in the world." Its goal is to help community members and professionals stay current with news, research, and events regarding ACEs and trauma-informed/resilience-building practices. Maryland ACEs Action blog page is for anyone who wishes to share information about and promote ACEs research awareness, trauma-informed/resilience-building practices, and to influence positive social change in Maryland. Both ACEs Connection and Maryland ACEs Action are free and open to anyone who wishes to join this virtual community.

Action Community Tracker and a link to Maryland BRFSS ACE data by county.

- Continued development of Maryland Essentials for Childhood webpage: https://mdessentialsforchildhood.org/.
- Supported development of and/or connection between local ACE Initiatives. St. Mary's and Talbot County have created ACE initiatives since the last report:
  - Frederick County, Local Health Improvement Plan Committee
  - Thriving Communities Collaborative (TCC), Baltimore City
  - Harford County ACEs Initiative
  - Center for Children, Southern Maryland
  - St. Mary's County ACEs Initiative
  - Talbot County Children's Initiative
  - Bester Community of Hope, Washington County

- GOAL 2: Identify and use data to inform actions and recommendations for systems improvement.
  - Successfully advocated for the inclusion of 4 ACE questions that were included in the Fall 2018 Youth Risk Behavior Study (YRBS) for Maryland high schoolers. Following upon the example of Monroe County, New York, Maryland and New Hampshire became the first two states to collect statewide ACE data through their YRBS.
  - Successfully advocated for BRFSS ACE data to be collected in 2015, 2018, and 2020.
  - Completed MCANF Reviews of child fatalities of children under the age of 5, An analysis of data and recommendations are forthcoming, as our volunteer reviewer time permits.

- GOAL 3: **Integrate the N.E.A.R. Science into and across Systems, Services, and Programs.**
  - Recruited ACE Interface Master Presenters across professions, sectors, and communities to ensure a common language for the integration of N.E.A.R. science into the systems and networks that serve Maryland children and families.
  - Multiple MD EFC Members and ACE Interface Trainers helped to found and now serve on the Board of Directors of the Infant Mental Health Association of Maryland and D.C., in order to promote infant mental health.[34] The ASSOCIATION promotes healthy social, emotional, cognitive and physical development of infants from pre-conception through early childhood by creating safe, supportive, stable and nurturing relationships and environments.
  - Partnered with the Maryland Department of Health on their Regrounding Our Response (ROR) Initiative to effectively respond to the opioid crisis by tackling the persistent and ubiquitous misunderstandings, myths, and prejudices that underlie harmful stigma of opioid misuse. In its conception, ROR followed the model SCCAN and MD EFC used to create the ACE Interface Project i.e., cross-sector and interdisciplinary and regional dissemination of the science. The ROR curriculum includes five topic areas: Stages of Change training (Center for Community Collaboration) on how behavior changes. Adverse Childhood Experiences (ACE Interface/Maryland Essentials for Childhood) on why people use drugs. Social Determinants of Health (Office of Minority Health) on how and why drug use inequitably impacts populations. Understanding MAT (Medication-Assisted Treatment) as being the frontline overdose prevention gold standard. Drug User Health Framework (NASTAD - National Alliance of State and Territorial AIDS Directors) on what it means to meet someone "where they are at."
  - Partnered with the Maryland State Department of Education to build capacity in local

[34] See 2018 SCCAN Annual Report for prior info

education agencies (LEAs) to provide N.E.A.R. Science informed professional development for educators. Thirty-six educators from LEAs have been trained as ACE Interface Master Presenters.

- GOAL 4: **Integrate the N.E.A.R. Science into Policy and Financing Solutions.**
  - Hosted SCCAN-MD EFC Education, Advocacy, and Awards Day at the General Assembly in February 2019 and 2020: Approximately 50 SCCAN and MD EFC Members participated on both February 7, 2019 and February 6, 2020. Participants shared the contents of ACE legislative packets with Members of the General Assembly and/or their staff, including information on multiple ACE-informed bills before the General Assembly: SESAME Act, Hidden Predator Act, Trauma-Informed Schools Bill, $15 Minimum Wage Bill, Time to Care Act, Child Advocacy Center Defining Legislation, Equitable Graduation Requirements for Foster Youth, Parental Notification of Student Problematic Sexual Behavior and TANF Cash Assistance Eligibility Requirements. Delegate Vanessa Atterbeary spoke in 2019 on the importance of the science and ensuring that this information gets to all of her colleagues. In 2020, Frank Kros presented on the ACE Science and Policy to Members in attendance. SCCAN-MD Essentials for Childhood Leadership Awards were presented to in 2019 to Delegate C.T. Wilson, Legislator of the Year; Frank J. Kros, MSW, JD, Advocate of the Year; and, The Board & Staff of The Family Tree, Community Partner of the Year; and, in 2020 posthumously to Congressman Elijah Cummings, Legislator of the Year; and to Joan L. Stine, MHS, MS, Advocate of the Year; and, The Board & Staff of No More Stolen Childhoods, Community Partner of the Year. Framed graphic recordings of the ACEs Roundtable were awarded to Members of the General Assembly who participated in the ACEs Roundtable for Members of the General Assembly in December 2019. (See Appendix H)
  - Created a legislative brief for Members of the Maryland General Assembly, ***Toward a More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities*** (See Appendix B), which outlines the N.E.A.R. science and catalogues ACE-informed policy and state legislation throughout the country.
  - Provided the state and national expertise necessary to jointly develop the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of [School] Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse with the Interagency Commission on School Construction*** (See Appendix C).
  - Developed and/or advocated for the following key legislation to promote safe, stable, and nurturing relationships and environments for children and prevent child maltreatment and other ACEs:

1. **SESAME Act- HB 486/SB 541 passed unanimously and was signed by Governor Hogan.** Helps prevent child sexual abuse & exploitation in schools by eliminating hiring of personnel with prior history of abuse or misconduct. ALL STUDENTS HAVE THE RIGHT TO BE FREE FROM TRAUMA AT SCHOOL, INCLUDING FREEDOM FROM SEXUAL ABUSE AND MISCONDUCT.
2. **Hidden Predator Act -Child Sexual Abuse Civil Statute of Limitations Reform- HB 974 (2020) passed the House 127-0 however because of the abbreviated session in response to the COVID-19 pandemic, no hearing was held In the Senate Judicial Proceedings Committee. Hidden Predator Act -Child Sexual Abuse Civil Statute of Limitations Reform- HB 687 (2019) passed the House 135-3 however received an unfavorable report 5-5 in the Senate Judicial Proceedings Committee.** The Hidden Predator Act will eliminate the civil statute of limitations for child sexual abuse. Look-back

windows in other states have been proven to provide justice to survivors, as well as identifying and prosecuting hidden predators, thus preventing future child sexual abuse by these predators. Many SCCAN and MD EFC members and member organizations participated in survivor and ally led efforts to pass the Hidden Predator Act, including efforts to galvanize survivor support and connection through the creation and promotion of the Justice4MDSurvivors.org website.

3. **Education- Guidelines on Trauma-Informed Approach HB 277/SB 367 (2020) passed both Houses unanimously.** The law requires MSDE, in consultation with MDH and DHS, to develop guidelines for schools on a trauma-informed approach. MSDE must distribute the guidelines to local school systems and publish the guidelines on its website. SCHOOL-BASED PROGRAMS THAT ADDRESS TRAUMA SYMPTOMS IMPROVE EDUCATIONAL OUTCOMES FOR CHILDREN.
4. **$15 Minimum Wage- HB 16/SB 280 (2019) passed both Houses unanimously and became law.** Increases Maryland's minimum wage to $15/hour by 2023. INITIATIVES THAT INCREASE FAMILY INCOME REDUCE RATES OF CHILD MALTREATMENT
5. **2019 Time to Care Act- HB 341/SB 500 (2019) and HB 839/SB 539 (2020) died in the respective Economic Matters and Finance Committees**. Provides up to 12-weeks of paid family leave. PAID FAMILY LEAVE IS ASSOCIATED WITH DECREASED INFANT MORTALITY, IMPROVED CHILD HEALTH, IMPROVED PARENT-CHILD BONDING, & REDUCED CHILD MALTREATMENT
6. **Education – Child Care Subsidies – Mandatory Funding Levels- SB 379/HB 430 was signed into law in 2018.** 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. Adequate child care subsidies with no waiting list for access are known to decrease rates of child abuse and neglect[35]
7. **Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations- SB 567 (2019) passed both Houses unanimously and was signed by Governor Hogan.** Establishes the Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations and requires the Workgroup to study State child custody court proceedings involving child abuse or domestic violence allegations. SCCAN's E.D., the ACE Interface Project Director, and other ACE Interface Master Presenters were represented on the Workgroup. The Workgroup's role will be to make recommendations about how State courts could incorporate the latest science regarding the safety and well-being of children and other victims of domestic violence into court proceedings. The final report will be submitted to the Governor and General Assembly in September of 2020.
8. **Child Advocacy Center Defining Legislation- HB 1007/SB 739 passed both Houses unanimously and was signed by Governor Hogan.** Makes sure that every abused or victimized child in Maryland has access to an accredited children's advocacy center. CACs are a critical first stop after an allegation of abuse is made. CACs PROVIDE EVIDENCE-BASED, TRAUMA-INFORMED SERVICES THAT HELP CHILDREN COPE WITH AND RECOVER FROM CHILDHOOD TRAUMA.
9. **Temporary Cash Assistance (TCA) Funding- HB 339/SB 456 died in Appropriations**

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[35] 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

and Budget and Taxation Committees. The bill would have raised TCA from 61 to 71% of the Maryland Minimum Living Level over 5 years. INCREASES IN FAMILY INCOME IMPROVE FAMILY STABILITY, REDUCES FAMILY STRESS, AND MAY PREVENT CHILD NEGLECT.

10. **Family Investment Program - Temporary Cash Assistance – Eligibility- HB1313/SB 787- passed the Senate unanimously and the House 111-23** This law prohibits DHS from reducing or terminating the assistance provided to Family Investment Program (FIP) recipients for noncompliance with work activity requirements if individuals have "good cause." Individuals who are noncompliant with FIP work requirements for good cause must receive a lesser sanction, particularly individuals who have children in the assistance unit. The bill modifies the conciliation processes for individuals found to be noncompliant and requires local departments of social services to assist individuals to return to compliance.

- Follow Up on Implementation of 2018 Bills Passed:

  1. 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 passed unanimously out of both houses of the General Assembly and was signed into law by Governor Hogan on May 8, 2018. The statute mandates the creation of a Child Welfare Medical Director at DHS and the creation of an electronic health passport for foster youth.

     - Dr. David Rose began his position as Child Welfare Medical Director in April, 2019. Efforts toward improving the health care of children in foster care have included the following:
       - Alignment of DHS policies regarding health care service oversight and monitoring with the American Academy of Pediatrics' 2015 policy statement on health care issues in foster care and kinship care. The modified policies will clarify the timing and content of care entry assessments and periodic preventive care. The goal is to allow for improved planning and health care encounter recording. Requests for changes to the Code of Maryland Regulations (COMAR) to implement these changes has been made.
       - Required quarterly and annual internal reporting on existing foster care entry and periodic preventive care exams began in September 2019.
       - Work with MD THINK-CJAMS on the health-related measures for case management.
       - Examination of psychotropic medication and psychotherapy use in foster care based on community indicators
       - Work on the State of Maryland Task Force on Maternal and Child Health, which is charged with developing a plan for MDH, Medicaid, and the Health Services Cost Review Commission to prevent "key adverse health outcomes."
     - SCCAN's Chair and Executive Director serve on the Health and Education Workgroup of SSA's Families Blossom Initiative and have shared critical data points that should be included in the MD THINK-CJAMS project to help ensure inclusion of data necessary to develop and utilize an **electronic health record** required by HB 1582 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. HB 1072- Child Sexual Abuse Prevention- Instruction & Training:

- SCCAN's Executive Director, Chair, and Child Sexual Abuse Prevention Workgroup Chair worked with national experts and the Commission on School Construction to develop the "GUIDELINES AND BEST PRACTICES FOR THE ASSESSMENT AND MODIFICATION OF PHYSICAL FACILITIES AND SPACES TO REDUCE OPPORTUNITIES FOR CHILD SEXUAL ABUSE" required by HB 1072. These guidelines were recently approved by both SCCAN and the Interagency Commission on School Construction.

SCCAN RECOMMENDATIONS BY AGENT/AGENCY:

"No epidemic has ever been resolved by paying attention to the treatment of the affected individual."

Dr. George Albee,

The science is clear; our children's pain, both current and generational unfolds daily before our eyes if we are willing to look; innovation and prosperity are possible; and require 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.[36] Maryland's Governor should take the following actions, similar to sister states, to create a trauma-informed and resilient state through an executive order or legislation::

- Establish a state lead coordinating body
- Develop and implement a State Plan for Preventing and Mitigating ACEs to
  - Incorporate the six strategies and evidence-based programs and approaches listed in the CDC's *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence* resource tool.
  - Incorporate trauma-informed best practices across state child and family serving agencies
  - Provide executive level awareness trainings and opportunities
  - Enhance the State's ACEs surveillance system, data collection and analysis
  - Develop ACE awareness campaigns, employing science-based communication strategies
  - Make budgetary commitments to prevent and mitigate ACEs
  - Make use of the expertise and build upon the cross-sector and interdisciplinary partnerships and efforts of Maryland Essentials for Childhood
  - Recruit the support of private foundations, business, and faith-based communities in efforts to prevent and mitigate ACEs

2. Issue an executive order similar to Governor Carey's in Delaware [37] mandating child and family serving agencies participate in collective impact efforts to promote safe, stable, and nurturing relationships and

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

[37] Delaware Governor John Carney's Executive Order on Making Delaware a Trauma Informed State.

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[38]

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.[39]

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.[40]

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. Support Governor or General Assembly led action to create a trauma-informed and resilient state through the:
    - Establishment and participation in a state lead coordinating body
    - Development and implementation of a State Plan for Preventing and Mitigating ACEs to
        - Incorporate the six strategies and evidence-based programs and approaches listed in the CDC's *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence* resource tool.
        - Incorporate trauma-informed best practices across state child and family serving agencies
        - Provide executive level awareness trainings and opportunities
        - Enhance the State's ACEs surveillance system, data collection and analysis
        - Develop ACE awareness campaigns, employing science-based communication strategies
        - Make budgetary commitments to prevent and mitigate ACEs
        - Make use of the expertise and build upon the cross-sector and interdisciplinary

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[38] 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.

[39] 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

[40] https://ctfalliance.org/

partnerships and efforts of Maryland Essentials for Childhood
- Recruit the support of private foundations, business, and faith-based communities in efforts to prevent and mitigate ACEs

2. Review, analyze, and publish state and county-level ACE Module data from the 2015 and 2018 Maryland Behavioral Risk Factor Surveillance System (BRFSS).

3. Provide an ACE Interface presentation to all Children's Cabinet members.

4. Create a statewide plan to prevent and mitigate childhood trauma and build community resilience through the Children's Cabinet Three-Year Plan.

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

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

7. Explore ways to increase awareness of the brain science and the impact of ACEs on the people your agencies serve. Integrate the science of the developing brain, ACEs, and resilience across agencies and within individual agencies by:

   - Participate in developing a State Plan to Prevent and Mitigate ACEs
   - Partner in Maryland Essentials for Childhood Initiative to ensure cross-agency coordination
   - Consider the appropriateness of screening clients for ACEs and resilience factors[41]
   - Provide pre-service and in-service training to all staff on brain science, ACEs and resilience
   - Research and develop Maryland guidelines for becoming a trauma-informed agency similar to The Missouri Model: A Developmental Framework for Trauma-Informed Approaches.
   - Ensure that state contracts require providers meet performance measures to become trauma-informed based on the above referenced Maryland guidelines.
   - Embed- the science into agency strategic planning and technical assistance to local agencies: and, create funding opportunities to local agencies for cross-sector planning and coordination of ACE prevention and mitigation efforts
   - Ensure agency policies and regulations reflect the science
   - Ensure agency practice models reflect the science
   - Invest resources in evidence-based trauma prevention and treatment interventions and creating trauma-informed agencies[42]
   - Partner with the FrameWorks Institute (FWI) to develop an in-depth communications plan that can be implemented by state agencies and local communities across the state to use research-based values and metaphors to communicate about trauma and its effects on brain development. A similar plan in Tennessee included:

[41] Bartlett, J.D., Adversity and Resilience Science, *Screening for Childhood Adversity: Contemporary Challenges and Recommendations*, 20, April 2020. Anda, R. Porter, L. Brown, D., American Journal of Preventive Medicine (2020) *Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications*; and, Finkelhor, D., Child Abuse & Neglect (2017) *Screening for adverse childhood experiences (ACEs): Cautions and suggestions*.

[42] See the National Child Traumatic Stress Network for resources on creating trauma-informed systems.

- Three scientific symposia: Neurobiology, the Science of Programmatic Innovations, and the Science of Policy Innovations
- Four three-day "FrameLabs" in which individuals from all sectors and professional disciplines learned values and metaphors that help even people who have no familiarity with child development.
- A three-day "Train the Trainer" workshop for curriculum designers and agency training leaders
- Ongoing technical assistance and a review of materials
- Advisory services for the initiative steering group
- In-depth editing and framing advice for communications projects (e.g. PSA scripts, social media content, press releases, agency websites, annual reports, public marketing materials, brochures, one-pagers, etc.).

8. 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).

9. 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. Review Maryland Essentials for Childhood's ***Toward A More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities.***[43]

2. Establish a Maryland Legislative Caucus to Prevent and Heal Childhood Trauma and develop a nonpartisan platform of legislation to prevent and mitigate ACEs.

3. 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.[44]

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[43] See Appendix B
[44] 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:
- 2017 Vermont passed legislation to establish an Adverse Childhood Experiences Working Group of key legislators to consider future legislation. Four bills were introduced as a result of the report and Act 204 passed in 2018 based on the report.
- 2015 Minnesota HF 892/ SF 1204 Resolution on childhood brain development and ACEs.
- 2016 Alaska House Resolution 21
- 2017 Utah House Concurrent Resolution 10

4. Pass legislation establishing a robust Children's/ACEs Prevention Trust Fund.[45]

   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. The National Alliance for Children's Trust & Prevention Funds is available to consult with state leadership on the most successful models across the country.

5. Pass legislation providing for Paid Family Leave. Paid Family Leave is associated with decreased infant mortality, improved child health, improved parent-child bonding, and reduced child maltreatment.

6. Pass legislation eliminating the civil statute of limitations for child sexual abuse, including a two-year look-back window or "window of justice". (See Appendix D) Nine states have no civil statute of limitations for child sexual abuse.[46] Eleven states and the District of Columbia have created look back windows.[47] The average age of disclosure for child sexual abuse in 52. Maryland's current statute allows certain cases up to age 38. Goals of look back windows, opening prior barred claims for a short period of time include:

   - Identifying hidden child predators (during California's look back window, more than 300 hidden predators were identified). Civil litigation and discovery provide a critical tool to states to expose predators who remain a risk to children.
   - Disclosing the facts of the epidemic of child sexual abuse to public
   - Arming parents with facts to protect children
   - Shifting cost of sexual abuse from the victim to those who caused it
   - Providing justice for victims ready to come forward

7. Pass legislation that requires all public and nonpublic schools and their contracting agencies to do CPS background checks on all applicants for positions involving direct contact with minors.

8. Build upon legislation passed unanimously by both Chambers (HB 1072, Education Law Article, Sec. 6-113.1) by passing similar legislation to include the following:

   - Expand child sexual abuse prevention in public and non-public schools, by requiring child sexual abuse training, policies, and codes of conduct for volunteers.
   - Mandating all state agencies serving children and youth and youth-serving organizations to provide child sexual abuse prevention training, policies, and codes of conduct for adults in direct contact with children and youth.

   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

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[45] The National Alliance for Children's Trust & Prevention Funds.
[46] Child USA, 2019 Alaska, Connecticut, Delaware, Florida, Illinois, Maine, Minnesota, Nebraska, and Utah.

[47] Ibid. California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Massachusetts, Michigan, Minnesota, New Jersey, New York, and Utah.

provide adult-focused training to volunteers, as well as employees, of all child and youth-serving organizations leaves kids vulnerable both before and after abuse occurs. Comprehensive Child Sexual Abuse Prevention in youth serving agencies should include the components enumerated in HB 1072 as passed in 2018.

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

JOINT DHS & MDH

1. In support of effective implementation of HB 1582, Human Services-Children Receiving Child Welfare Services-Centralized Comprehensive Health Care Monitoring Program, 2018:

    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[48].The Panel's responsibilities should include:

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[48] 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;

- Develop regulations and guidelines to ensure that children with suspected maltreatment receive timely, high quality, evidence-based medical assessments.
- Develop regulations and guidelines for effective management and oversight of health care services for children in foster care.
- Program evaluation and oversight to monitor the percentage of children who receive timely, appropriate, and accurate medical evaluations.
- Create a mechanism for adequate reimbursement of providers that is tied to provider performance
- Report annually to the Governor and legislature regarding the progress of implementation.

DHS

- See Children's Cabinet agency recommendations above.

- 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.

- 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)[49]

- As level II of the G.O.L.D. Standard Customer Service Training, use ACE Interface Master Trainers to train all staff who work with the public in brain science, ACEs, and resilience.

- Increase efforts that promote fathers' and mothers' male partners' emotional support, rather than solely financial 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 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:

· Maryland Legal Aid Bureau;
· Maryland CASA;
· Programs that currently contribute to medical and forensic services funding for children involved in the child welfare system
o Maryland Medicaid,
o MDH Center for Injury and Sexual Assault Prevention,
o GOCCP/VOCA).

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

- 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.[50]
- 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.
- Comply with the MOU in place between DHS and MSDE to allow for the sharing of data regarding foster youth since September 27, 2013 and the federal requirement pursuant to the Every Student Succeeds Act for states to track educational outcomes for foster youth.
- Track 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, and whether they need in-patient psychiatric treatment.
- Track when families are determined to need services, determine whether those services were received, and if not received, identify the reasons why not.[51]

Social Services Administration

1. See Children's Cabinet recommendations above.

2. See Joint MDH-DHS recommendations above.

3. Child Welfare data should be disaggregated by race, ethnicity, gender, and socio-economic status. This data should be publicly available on a regular basis.

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[50] 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 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)

[51] 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.**

4. Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in foster care. Ensure that all adults involved in the child welfare system are trained in the primary prevention of child sexual abuse, including: child welfare workers and supervisors, foster parents, people who work or volunteer in group homes and residential treatment centers, and licensed contractors involved with foster youth. Institute policies and codes of conduct for the prevention of child sexual abuse within state and local child welfare agencies.

5. 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.

6. 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.

7. 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 BRFSS every three years and YRBS/YTS ACE module data in Maryland every two years. Resilience questions[52] similar to those being asked in Wisconsin's BRFSS should be added to Maryland BRFSS modules.

3. Publish a formal report on BRFSS and YRBS/YTS ACEs data, similar to reports in other states. Proposed policy: The CDCYRBS ACE module data, including the 8 original ACE questions, 2 incidence ACE questions, 3 community ACEs, and 3 PCE questions should be collected regularly as part of YRBS/YTS[53].

4. Fund the baseline collection of child maltreatment Awareness, Commitment, and Norms Survey[54] 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.[55]

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[52] See Appendix I
[53] See Appendix E
[54] See Appendix J
[55] See MCANF preliminary observations under "Magnitude of the Problem in Maryland" section.

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.[56]

8. Streamline the Postpartum Infant and Maternal Referral (PIMR) form and completion process in partnership with local health departments and birthing hospitals.[57]

9. Link completion of MPRA and PIMR and linkage to services to service provider fee payment.[58]

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.

13. Medicaid should eliminate some of the billing barriers that behavioral health providers serving young children face including:
    - allowing behavioral health providers working with young children up to five appointments before they need to have a diagnosis since it takes longer than one visit to diagnose young children.
    - allowing behavioral health providers to use the DC:0-5 for diagnosing young children as it is better tailored for their developmental milestones.

MSDE

1. See Children's Cabinet recommendations above.

2. Support the collection of data on all ACE and resilience questions[59] recommended by the CDC through the Maryland YRBS/YTS for all middle schoolers and high schoolers.

3. 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.

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[56] Ibid.

[57] 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.

[58] Ibid.

[59] See Appendix E

4. 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.