MARYLAND DEPARTMENT OF HUMAN SERVICES

MARYLAND STATE COUNCIL ON CHILD ABUSE & NEGLECT ANNUAL REPORT

JANUARY 1, 2020 – DECEMBER 31, 2021

MARYLAND

SCCAN
Maryland's
State Council on Child Abuse and Neglect

ACKNOWLEDGMENTS

With tremendous gratitude, we acknowledge the many individuals and organizations who share their time, experience, expertise and passion for promoting child well-being and preventing child maltreatment and other adverse childhood experiences (ACEs) *before they occur*. Special thanks this year go to:

- Council Members (Appendix B) for sharing their expertise and for the many volunteer hours they have contributed to the State Council on Child Abuse and Neglect (SCCAN).

- Council Chair, Wendy Lane and Maryland Essentials for Childhood (EFC) Committee Chair, Joan Stine, for their leadership.

- Council Member agencies for dedicating staff time and expertise to the important cross agency work of the Council and Maryland Essentials for Childhood. Interagency collaboration and coordination are critical to effectively addressing childhood trauma.

- Achieving Racial Equity in Child Welfare Workgroup Co-Chairs, Rachel White and Erica LeMon for their leadership. And, Workgroup Members (See Appendix C) for developing SCCAN's Anti-Racist Statement and working to pass the Child Welfare Data bill in 2021. Special thanks go to Dr. Michael Sinclair, PhD and his graduate students at Morgan State for drafting the historical preamble to the Anti-Racist Statement, including supportive literature.

- Childhood Resilience Action Team Chair, Frank Kros and Coordinating Committee Members Quinton Askew, Dave Brown, Kay Connors, Marianne Gibson, Jessica Lertora, Vanessa Milio, Amie Myrick, Claudia Remington, Joan Stine, and D'lisa Worthy for their leadership and the Action Team (See Appendix D) for their many contributions to the work.

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- ACE Interface Project Master Trainers and Presenters (See Appendix E) for dedicating their valuable time and skills to the efforts to ensuring Maryland becomes a N.E.A.R. Science-Informed State.

- Maryland ACEs Connection Community Managers, Matila Jones, Claudia Remington, Jamie Shepard and Erik Weber.

- The Opioid Operational Command Center and the Governor's Office for Crime Prevention, Youth, and Victims Services for their advocacy of Maryland's application to the National Governors Association Center for Best Practices' (NGA Center) 2020-2021 *Addressing ACEs State Learning Collaborative* and Governor Hogan's Executive Order on ACEs.

- The NGA Center, Duke-Margolis Center for Health Policy (Duke-Margolis) and the National Academy for State Health Policy (NASHP), along with mentor and fellow collaborative states for sharing a wealth of knowledge on statewide approaches to addressing ACEs across the lifespan.

- Dr. Maria Rodowski-Stanco, Dr.James Yoe, and Sabriya Dennis at the Behavioral Health Administration for coordinating, taking the lead on, and including Maryland Essentials for Childhood in the submission of Maryland's application for the CDC's Preventing Adverse Childhood Experiences: Data to Action grant which developed into the establishment of a cross-agency ACEs Data Workgroup.

- Vanessa Milio, former Executive Director of No More Stolen Childhoods (NMSC), and the Board of NMSC for lending their expertise to efforts to pass HB 974 (2020) and SB 134/ HB 263 (Child Sexual Abuse Civil Statute of Limitations Reform) through testimony, and media, and social media advocacy.

- Delegate C.T. Wilson for sponsoring and tirelessly advocating for HB 974 (2020) and SB 134/ HB 263 ((2021) The Hidden Predator Act of 2020 and 2021 - Child Sexual Abuse Civil Statute of Limitations Reform) to prevent child sexual abuse *before it occurs*.

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

- The Members of the House of Delegates for passing HB974 (2020) legislation to prevent child sexual abuse in school settings *before it occurs*.

- Vanessa Milio and Maroon PR for the design of legislative talking points for SB 134/ HB 263, social media images, and S.E.S.A.M.E. Social Media Toolkit.

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- The following organizations for their support and advocacy on behalf of passing the Hidden Predator Act of 2020 and 2021: Advocates for Children and Youth, Baltimore County Progressive Democrats Club, Beau Biden Foundation, Boys & Girls Clubs of Cecil & Harford Counties, Call to Action Maryland, Center for Hope at Lifebridge Health Group, Children's Justice, Child USA, Child USAdvocacy, Citi Ministries, Citizens Review Board for Children, Court Appointed Special Advocates (CASA), Enough Abuse Campaign, Enradius, the Episcopal Dioceses of Maryland, Federation of Christian Ministries, First Star Institute, GBMC Healthcare, Harrity, Heartly House, Inc., Housing Authority of the City of Frederick, International Brotherhood of Teamsters, Justice 4 MD Survivors, Key School Survivors, Kros Learning Group, Maroon PR, Maryland Catholics for Action, Maryland Chapter of the Academy of Pediatrics, Maryland's Children's Alliance, Maryland Coalition Against Pornography, Maryland Coalition Against Sexual Assault, Maryland Coalition of Families, Mid-Atlantic P.A.N.D.A., Montgomery Young Democrats, MOST Network, NAACP Maryland State Conference, No More Stolen Childhoods, Parents Anonymous of Maryland, Parents' Coalition of Montgomery County, Partnership for a Safer Maryland, Prevent Child Abuse Maryland, Progressive Neighbors, ProMD Health, ProMD Helps, Renew Your Core with Trauma Healing, Sisterhood of Salaam Shalom, Survivors Network of those Abused by Priests (SNAP), The Family Tree, The Living Water, The Maryland Family Network, The Moore Center for the Prevention of Child Sexual Abuse at Johns Hopkins Bloomberg School of Public Health, and Turn Around.

- Marci Hamilton, CEO and Academic Director of Child USA, and interdisciplinary think tank to prevent child abuse and neglect at the University of Pennsylvania for sharing her time and expertise and written testimony on statute of limitations reform, as well as the resources of Child USA.

- Alix Boren, JD, Executive Director of Child USA, for her legal research on Maryland's civil statute of limitations.

- Kathryn Robb, JD, Executive Director of Child USAdvocacy, for her outstanding and considerable legal research, written testimony, advocacy, and oral testimony on behalf of HB 687 and HB 974 The Hidden Predator Acts of 2020 and 2021.

- Delegate C.T. Wilson, Jena Cochrane, Sarah Conway, Lil Hughes Knipp, Theresa Lancaster, David Lorenz, Patti Mills, Kathryn Robb, Kurt Ruprecht, David Schappelle, Carolyn Surrick, Jean Wehner for their powerful, compelling, and courageous oral and written testimony, media advocacy, and legislative advocacy to pass HB 974 and SB 134/ HB263 The Hidden Predator Acts of 2020 and 2021. Allies for their powerful and compelling testimony: Kay Connors, LCSW-C Michael Fitzpatrick, Paul Griffin, JD, Jennifer Gross, Felicia Langel, Wendy Lane, MD, MPH, Claudia Remington, JD

- Sarah Conway for her development of Justice4MDSurvivors.org in support of Maryland child sexual abuse survivor efforts for child sexual abuse statute of limitations reform.

- Elizabeth Letourneau, PhD and Rebecca Fix, PhD of the Moore Center for the Prevention of Child Sexual Abuse at the Johns Hopkins School of Public Health and Wendy Lane, MD, MPH of the University of Maryland School of Medicine for their work on the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse***.

- 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.

- Jillian Storms for sharing her architectural expertise; and, Jillian Storms, Joan Schaffer and Cassandra Viscarra for their collaboration in drafting the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse***.

- The Maryland Association of School Business Officials, R. Leslie Nichols, President, at R.L. Nichols & Associates, LLC, Ron Pierce, School Prevention & Intervention Specialist, at the Maryland Center for School Safety, Claudia Remington, Executive Director for SCCAN, Jillian Storms, AIA, School Architect, at MSDE, Merril Plait, PE, Director, office of Facilities & Improvement, at Baltimore County Public Schools, Todd Vukmanic, CPD, Senior Project Manager and Lori Walls, Director, at Crabtree, Rohrbaugh Architects for their collaboration on two presentations at the MD ASBO Virtual Conference on effective implementation 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***.

- The many partners, stakeholders, and citizens who contribute to moving SCCAN Recommendations and MD EFC efforts forward.

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December 1, 2021

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 the actions you took to implement State Council on Child Abuse and Neglect (SCCAN) key recommendations. During 2020-2021, Governor Hogan issued and Executive Order on Adverse Childhood Experiences (ACEs), designating the Governor's Office of Crime Prevention Youth and Victims Services to coordinate efforts, including monitoring data on ACEs; and, the General Assembly passed legislation creating a Trauma-Informed Care Commission and mandating collection and analysis of ACEs and positive childhood experiences (PCEs) data for middle schoolers and high schoolers in the Youth Risk Behavior Survey/Youth Tobacco Survey; among key actions laid out in the Executive Summary of the report.

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 2020-2021, we have chosen to continue our focus on the primary prevention of child maltreatment, health care for children involved in the child welfare system, racial equity for children and families involved in the child welfare system, and efforts to build resilience in children and families during the pandemic. On pages 47-61, the Council[1] 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; get a clearer picture of the racial disparities within the child welfare system, 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 Dennis Schrader
DJS Secretary Sam Abed
MSDE State Superintendent of Schools, Mohammed Choudhury
MDD Secretary Carol A. Beatty
DBM Secretary David R. Brinkley
DPSCS Secretary Robert L. Green
DLLR Secretary Tiffany Robinson
Governor's Office of Crime Prevention, Youth, and Victim Services, V. Glenn Fueston, Jr., Executive Director
SCCAN Members

[1] While state agency designees sit on the Council to provide information and perspective to inform Council recommendations, state agencies take no position either for or against the recommendations.

EXECUTIVE SUMMARY

SCCAN's 2020-2021 Annual Report to the Governor and General Assembly continues to provide a framework for a seismic culture change in how we as a state address child abuse and neglect, along with related adverse childhood experiences (ACEs) and childhood trauma. Child physical, sexual, and emotional abuse and child neglect, along with 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, bullying, historical and intergenerational trauma, as well as other adverse experiences disrupt the healthy development of children. Individually and particularly when experienced in combination, these ACEs lead to poor child health, educational, and relational outcomes. These outcomes then impact communities by reducing public safety and economic productivity at an immense cost to taxpayers. In North America, total health system costs attributed to ACEs were estimated, in a study funded by the World Health Organization, to amount to $748 billion per year.[2] Tennessee's Sycamore Institute study estimated that ACEs led to $5.2 billion in medical costs and lost productivity among Tennessee adults in 2017.[3] And, a recent study published in *JAMA Pediatrics* by researchers at Columbia and Harvard University, found that "Childhood adversity accounted for approximately 439,072 deaths annually in the U.S. through associations with leading causes of death including heart disease, cancer, and suicide, or 15 percent of the 2,854,838 total number of U.S. mortalities in 2019."[4] The significant costs of ACEs emphasize that the future prosperity of any society depends on its ability to foster the health and well-being of the next generation. As Maryland policy makers invest early and wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship.

As a result of the COVID-19 pandemic, the ensuing stay-at-home orders, economic downturn, unemployment, food and housing insecurity, day care and school closings, and the deaths of family members, communities are seeing a significant increase in parental and child stress. Parental stress creates 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.

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 and Prevention's (CDC) 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 CDC. 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

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[2] Mark A Bellis , Karen Hughes , Kat Ford , Gabriela Ramos Rodriguez , Dinesh Sethi , Jonathon Passmore Life **course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systematic review and meta-analysis, September 3, 2019.**

[3] Courtnee Melton, The Economic Costs of ACEs in Tennessee, The Sycamore Institute, February 1, 2019.

[4] *Exposure to childhood adversity is linked to early mortality and associated with nearly half a million annual U.S. deaths,* October 2021.

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.

SCCAN and MD EFC's efforts over the last decade have been a catalyst for disseminating the N.E.A.R. science (neurobiology, epigenetics, ACEs, and resilience) across Maryland's child and family serving agencies, sectors, and communities. In December of 2019 MD EFC held an ACEs Roundtable for the Maryland General Assembly, increasing interest among Members in legislative action to address ACEs. SCCAN and MD EFC ACE Interface testimony was offered in support of legislation passed to create a Trauma-Informed Care Commission. MD EFC's ACE Interface Project also teamed up with MDH's Regrounding Our Response Initiative, strategically training ACE Interface Master Presenters within the state's opioid crisis response sector, to begin to address the trauma quite often underlying substance use disorder. In January of 2020, MD EFC representatives met with Lt. Governor Rutherford and MD EFC ACE Interface Master Trainers and the Executive Director of SCCAN were asked to present to members of the Opioid Operational Command Center. These combined efforts culminated in support by the Governor's Office for Maryland's participation in the National Governor's Association's ACEs Learning Collaborative with Delaware, Pennsylvania, Virginia, and Wyoming. MD EFC and SCCAN efforts within the executive and legislative branches have helped to ensure action on key SCCAN recommendations toward making Maryland a trauma informed and resilient state:

- Governor Hogan issued an Executive Order on ACEs
- Governor Hogan dedicated $25 million in COVID relief funding to create Project Bounce Back to build post-COVID resilience among Maryland youth, families and communities. The Project created a public-private partnership which includes the Maryland State Department of Education, the Governor's Office of Crime Prevention, Youth, and Victim Services, the Boys and Girls Clubs of America, Microsoft, LinkedIn Learning, KPMG, Discourse Analytics, and eCare Vault to provide critical services to young people.
- The Maryland General Assembly (MGA) passed legislation to create a Trauma Informed Care (TIC) Commission HB548/SB299
- The Governor's Office of Crime Prevention, Youth and Victims Services was established as the state coordinating body for both the Executive Order and HB548/SB299
- The Executive Order requires that state agencies provide data and other information with the GOCPYVS to study and monitor policies and programming to prevent and mitigate ACEs
- .HB548/SB299 requires each state agency lead to appoint two staff members to lead their agency's effort to become trauma-informed
- HB548/SB299 requires the development of a statewide strategy toward an organizational culture shift into a trauma-informed state government
- HB548/SB299 requires the TIC Commission to establish metrics to evaluate and assess the progress of the statewide trauma informed care initiative
- The MGA passed legislation HB771/SB548 requiring inclusion of ACEs questions in the Youth Risk Behavior Survey/Youth Tobacco Survey for both middle schoolers and high schoolers
- Several MD EFC partners and ACE Interface Master Trainers were appointed by the Governor to serve on the TIC Commission

In addition to these major accomplishments, members of MD EFC formed a COVID-19 Childhood Resilience Action Team to prevent and mitigate childhood trauma associated with and/or exacerbated by the pandemic.

The Action Team is focused on creating a website domain containing a childhood resilience resource library and informing the public of the availability of the resources. The Behavioral Health Administration will provide grant funding to develop the childhood resilience website, ACEs training and data to support the Governor's Executive Order and Trauma-Informed Care Commissions efforts to prevent and mitigate ACEs across the state.

Similarly, members of SCCAN and MD EFC formed an Achieving Racial Equity in Child Welfare Workgroup in response to the movement for racial justice brought about by the murder of George Floyd. The Achieving Racial Equity Workgroup developed and SCCAN adopted an Anti-Racist Statement to guide the Council's efforts on racial equity; and, successfully advocated for legislation to ensure DHS and MSDE collect and disseminate critical population level data on children in the child welfare system disaggregated by gender, race, and ethnicity. That data will be essential to informed decision-making that eliminates racial disparities, dismantles systemic racism within the child welfare system, and reduces childhood adversity associated with experiencing racism and the foster care system.

SCCAN's Annual Report for 2020-2021 includes the following:

- A discussion of Maryland data on the magnitude of the problem
- A description of the 2020 and 2021 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.
- A brief background of SCCAN's, mandate, focus, and efforts is found in Appendix F
- An overview of the key concepts of neurodevelopmental science and the impact of adversity on the developing brain which are foundational to many of the SCCAN recommendations is included in Appendix G

Key Recommendations for the Governor, the General Assembly, and Agencies[5]:

To align public policy and practice with the science of childhood trauma and the developing brain:

1. Educate all Children's Cabinet and senior-level management staff in N.E.A.R. science and science-based communications strategies.
2. Develop and implement a Trauma and Resilience-Informed State Action Plan for Preventing and Mitigating Childhood Trauma/ACEs that:
    - Makes ***budgetary commitments*** to prevent and mitigate ACEs, ***including staffing an Office of Resilience*** similar to those in neighboring Pennsylvania and New Jersey to lead ACEs/trauma/resilience work
    - Establishes a ***public/private collaboration*** to serve as ***infrastructure*** to prevent and mitigate the impacts of ACEs on Marylanders and assures local solutions to address community issues. Recruit champions from all three branches of government, as well as private funders, business, faith-based, and local community leaders, and experts in trauma and resilience to participate.
    - Develops an ***ACE awareness and mobilization campaign, employing N.E.A.R. science and communication science strategies,*** to develop common unified language and messages when communicating about ACEs, trauma, and healthy social, emotional, and physical development by partnering with the Harvard Center on the Developing Child and FrameWorks Institute. (See Building Strong Brains Tennessee and Alberta Wellness Initiative)

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

- Develops a ***framework or standard for state child and family serving agencies*** to become ***designated*** a ***trauma-informed agency***. (Footnote - Trauma-Informed State Agencies, MO, DE, PA, NJ)
- ***Surveys current ACEs, trauma-informed, and resilience efforts*** in state agencies, agencies contracted by the state and local communities and ***builds upon those efforts***
- Develops and/or adopts ***cross-agency, cross-sector ACEs training*** for agencies, providers, and communities; as well as, ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation***.
- ***Enhances the State's ACEs surveillance system, data collection and analysis*** building upon the work of the ACEs Cross-Agency Data Workgroup led by the Behavioral Health Administration.
- ***Promotes the creation of local community based cross sector coalitions***
- Includes a ***strong focus on early childhood,*** ensuring safe, stable, nurturing relationships and environments from the start
- ***Incorporates 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.
- ***Aligns with the work of the Trauma-Informed Care and Health Equity Commissions*** and other trauma-informed, health equity, and racial equity efforts in the state. (See Appendix H)

4. 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.[6]

5. Collect, review, analyze, publish, and effectively disseminate Maryland's state and local ACEs and positive childhood experiences (PCE) data using the Behavioral Risk Factor Surveillance System (BRFSS data) and the Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS).

6. Continue to collect BRFSS ACE data every three years

7. Expand Maryland's YRBS/YTS ACE module to include all CDC BRFSS ACE and PCE module questions and collect this data every two years. Legislation that passed in the 2021 legislative session will require ongoing inclusion of ACE questions in the YRBS but will require only 5 questions. Legislation should be amended to ensure that ACE questions are alternated so that all 10 ACE questions are included during each 4-year interval. Data on protective factors should be examined for each Maryland jurisdiction.

8. Children's Cabinet members should integrate the science of the developing brain, ACEs, and resilience across agencies and within individual agencies by:
    - Participating in developing and implementing a State Plan to Prevent and Mitigate ACEs
    - Identifying, designating, and empowering two staff from each agency with experience, expertise, and interest in brain, ACEs, and resilience science and multi-generational approaches to collaborate with sister agencies and serve as principal advisors to each agency Secretary/Director in trauma-responsive and trauma-informed care, including aligning agency training, policies, practices, and procedures with a trauma-informed approach, as required under Md. Code Ann., Human Services § 8-1301- 8-1308 (2021)

[6] https://ctfalliance.org/

- Ensuring that your agency's communications tools and messaging embed the ACE awareness and mobilization campaign, based on N.E.A.R. science and communication science strategies
- Considering the appropriateness of screening clients for ACEs and resilience factors[7]
- Providing the ***cross-agency, cross-sector ACEs training*** developed for agencies, providers, and communities through the work of the Trauma Informed Care Commission; as well as, ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation to your all state and local agency staff***
- Ensuring that your ***local agency staff participate in local community based cross sector coalitions***
- Ensuring that state contracts require providers meet performance measures to become trauma-informed based on the Maryland developmental framework or standards for a trauma-informed approach developed by the Trauma Informed Care Commission
- Embedding the science into agency mission, vision, 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
- Ensuring agency policies and regulations reflect the science
- Ensuring agency practice models reflect the science
- Investing resources in evidence-based trauma prevention and treatment interventions and creating trauma-informed agencies[8]

9. Pass legislation to amend Md. Code Ann., Family Law § 5-1312 (2021) to include additional data to be collected by DHS and MSDE on youth in foster care

10. Pass legislation requiring all mandated reporters in Maryland to receive racial bias training focused on the role of bias and racism in child abuse and neglect reporting

11. Pass legislation requiring all DHS employees and local DSS supervisors and caseworkers in Maryland to receive racial bias training focused on the role of bias and racism in decision-making throughout the continuum of child welfare cases

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

[7] 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*.

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

16. Hold a legislative hearing regarding implementation and possible reforms to strengthen Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the issue of informed consent for psychotropic medications

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). DHS assured the Council and partners that this ground-breaking project, MD THINK, would bring needed accuracy, efficiency, data analysis capabilities, and tracking of critical outcomes for children across child and family serving agencies. Disappointingly five years later, key data points are either not regularly and systematically collected or are not readily accessible and therefore not analyzed [e.g., health care data required under Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), service provision data, disaggregated referral and pathway data for children and families involved in child welfare, and ACEs of children involved in child welfare]. In addition, despite the requirement under Md. Code Ann., Human Services § 8-1101- 8-1103 (2018) to integrate child welfare data with data from CRISP (Chesapeake Regional Information Systems for our Patients), Immunet, and Medicaid to create a centralized data portal and electronic health passport, much of this important health information remains inaccessible to DHS leadership and staff, as well as to foster youth, foster parents, biologic parents, and foster care workers. CJAMS child welfare data must be linked to other electronic health data at the patient level to accurately assess children's health care needs and treatment and services received. Many other states and jurisdictions have successfully linked Medicaid and Child Welfare data; Maryland needs to expeditiously create these linkages. Doing so *will provide critical data and 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 (health, education, courts, juvenile services, corrections, housing, etc.) 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.[9] 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).

[9] 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.

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.

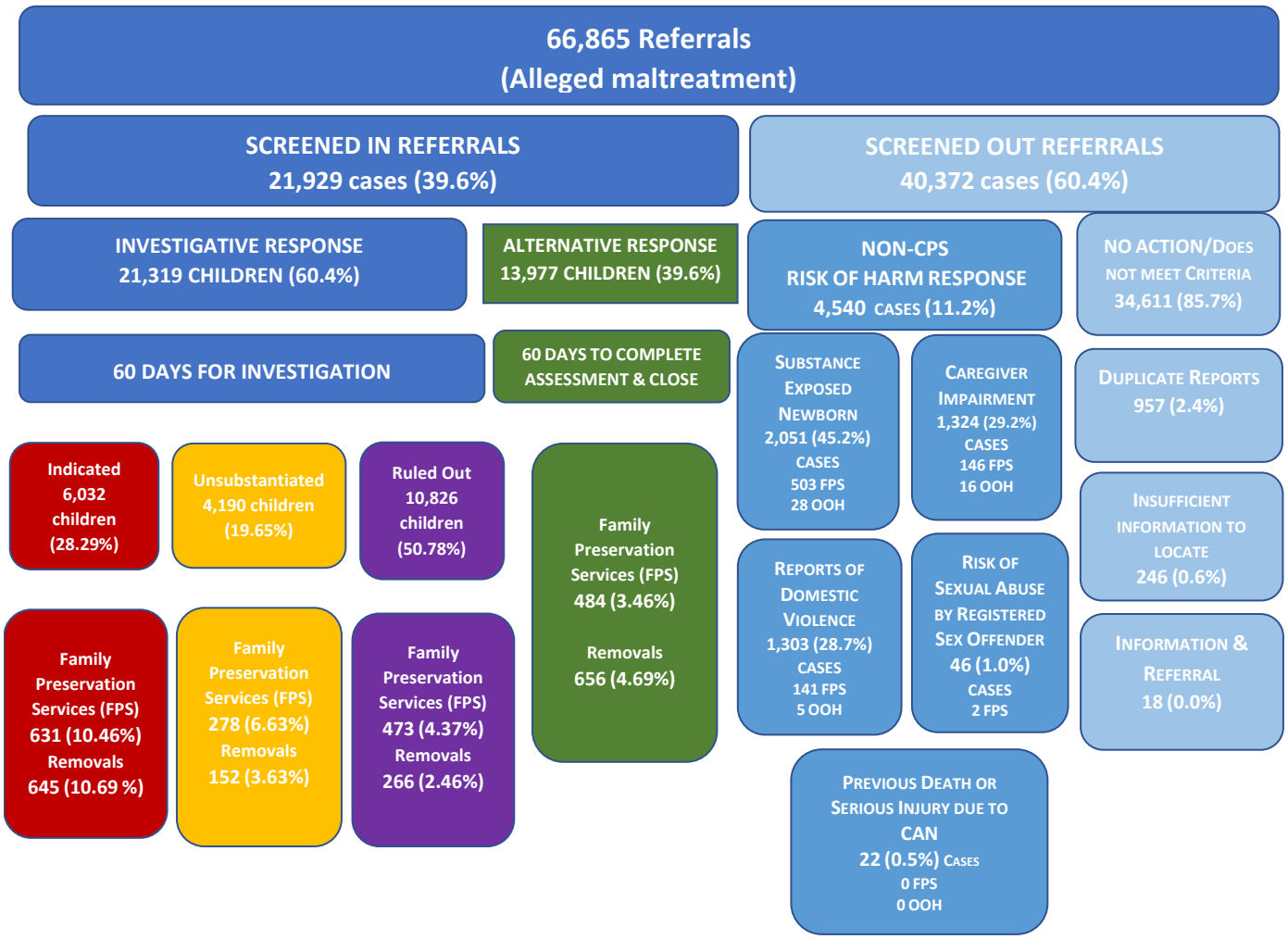
- During FFY 2019, DHS SSA reports that it received 66,865 referrals of suspected child abuse or neglect, up from 6 64,200 referrals in 2018. Of those, 21,929 reports or 39.6% were screened in for a CPS response (either investigative or alternative response).
- During FFY 2019, 21,319 investigations were completed. Of this total, 6,032 or 28,3% were indicated for abuse or neglect. The 6,032 indicated cases represent 9% of the total abuse and neglect reports. Once there is an indicated referral, children are considered victims of child abuse/neglect.[10]
- During FFY 2019, 13,977 screened-in reports (20.9% of total reports) received an alternative response (AR). Of those 13,977 cases, 484 (or 3.46% of AR cases) received services and 656 cases (or 4.69% of AR cases) ended up with a removal; and, the majority of AR cases (91.85%) 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 Citizens 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 of 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[11].

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.**

[10] 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.

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

Figure A: FFY2019 Child Maltreatment Referral, Pathways, and Services



RACE AND ETHNICITY DATA for Reports, Pathways, and Services

	Screened-In Cases		
	All CPS	AR	IR
Hispanic	2,509	903	1,606
Black (NH)	12,288	4,426	8,862
White (NH)	9,657	3,567	6,090
All Others (NH)	480	204	276
Unknown/Declined	5,706	2,456	3,250
Missing	569	203	366
Total	32,209	11,759	20,450

CPS Screened-In Cases by Race and Ethnicity Compared to the Maryland Child Population by Race and Ethnicity[12]

	Percentage of 2020 MD Child Population	Percentage of Screened-In Cases
Hispanic	16.6%	7.8%
White (NH)	40.6%	30.0%
Black (NH)	30.6%	38.2%
All others (NH)	12.2%	1.5%

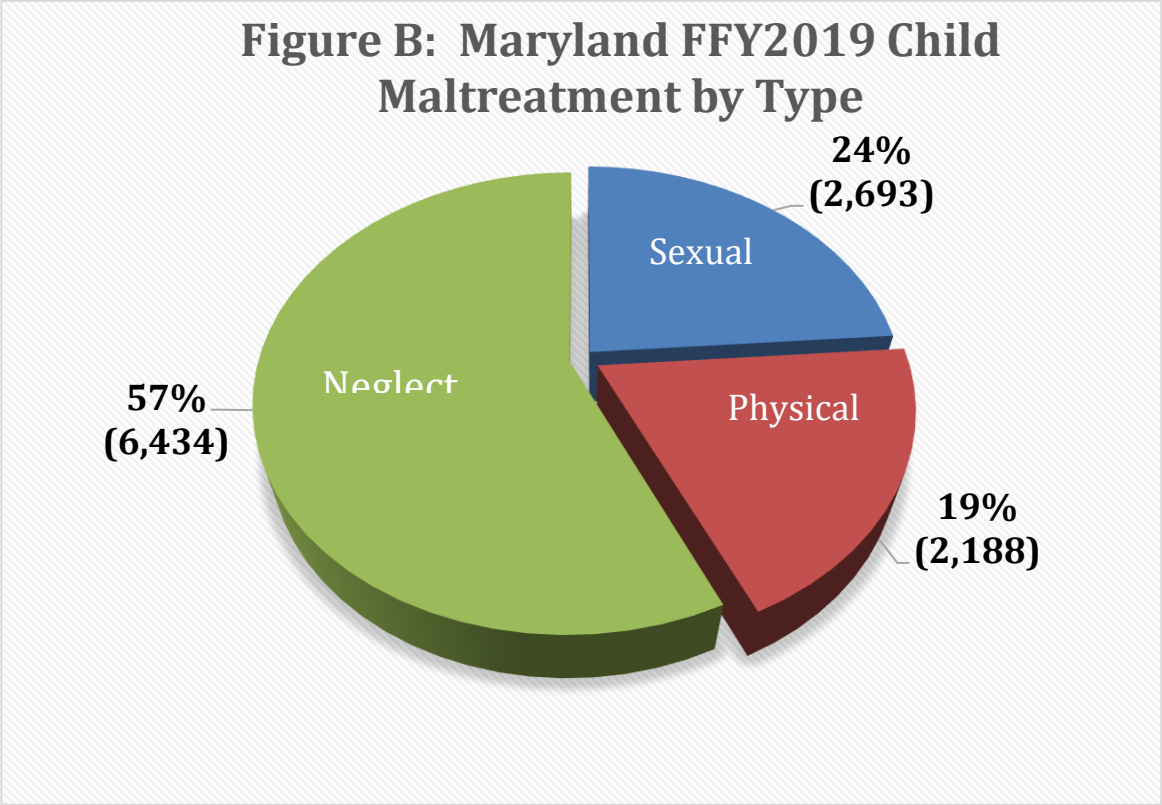
SCCAN requested that each data point in Figure A, referrals, pathways, and services be disaggregated by race, gender, age, and ethnicity. It appears that the new CJAMS system is unable to disaggregate this data at this time. A comparison of the racial and ethnic make-up of children/families investigated for maltreatment (i.e. screened-in) to the racial and ethnic make-up of all children in Maryland shows several disparities. While Black families are over-represented in child maltreatment investigations, White and Hispanic families are under-represented.

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.[13]
- 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

[12] Maryland census data from: https://planning.maryland.gov/MSDC/Pages/pop_estimate/CensPopEst.aspx
[13] *In Brief, The Science of Neglect*, Harvard Center on the Developing Child.

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 Children and Families *Child Maltreatment 2019* 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: The compulsive use of alcohol that is not of a temporary nature.
- Domestic Violence: Any abusive, violent, coercive, forceful, or threatening act or word inflicted by one member of a family or household on another. In NCANDS, the caregiver may be the perpetrator or the victim of the domestic violence.
- Drug abuse: The compulsive use of drugs that is not of a temporary nature.
- Financial Problem: A risk factor related to the family's inability to provide sufficient financial resources to meet minimum needs.
- Inadequate Housing: A risk factor related to substandard, overcrowded, or unsafe housing conditions, including homelessness.
- Public Assistance: A risk factor related to the family's participation in social services programs, including Temporary Assistance for Needy Families; General Assistance; Medicaid; Social

Security Income; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); etc.

- Any Caregiver Disability: This category counts a victim with any of the six disability caregiver risk factors—Intellectual Disability, Emotional Disturbance, Visual or Hearing Impairment, Learning Disability, Physical Disability, and Other Medical Condition.

Data submitted to NCANDS by the Maryland Department of Human Services showed that 2.3% of child maltreatment victims (i.e. cases with an indicated finding) in Maryland had a caregiver risk factor of alcohol abuse and 5.8% had a caregiver risk factor of drug abuse.[14] 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 46% in Massachusetts to Maryland's 2.3%; victims with drug abuse caregiver factor varies from 57.8% in West Virginia to Maryland's 5.8%, Florida's 2.0% and Arkansas's 2.1%).

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 35.5% of all children removed from their homes in FY 2019. 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 a substance abuse disorder.[15] 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 to 38.6% as reported to NCANDS and 24.3% reported to SCCAN in 2019. As addressing caregiver risk factors is key to preventing and responding to child maltreatment, it is critical to have accurate data upon which to base policy and practice decisions.

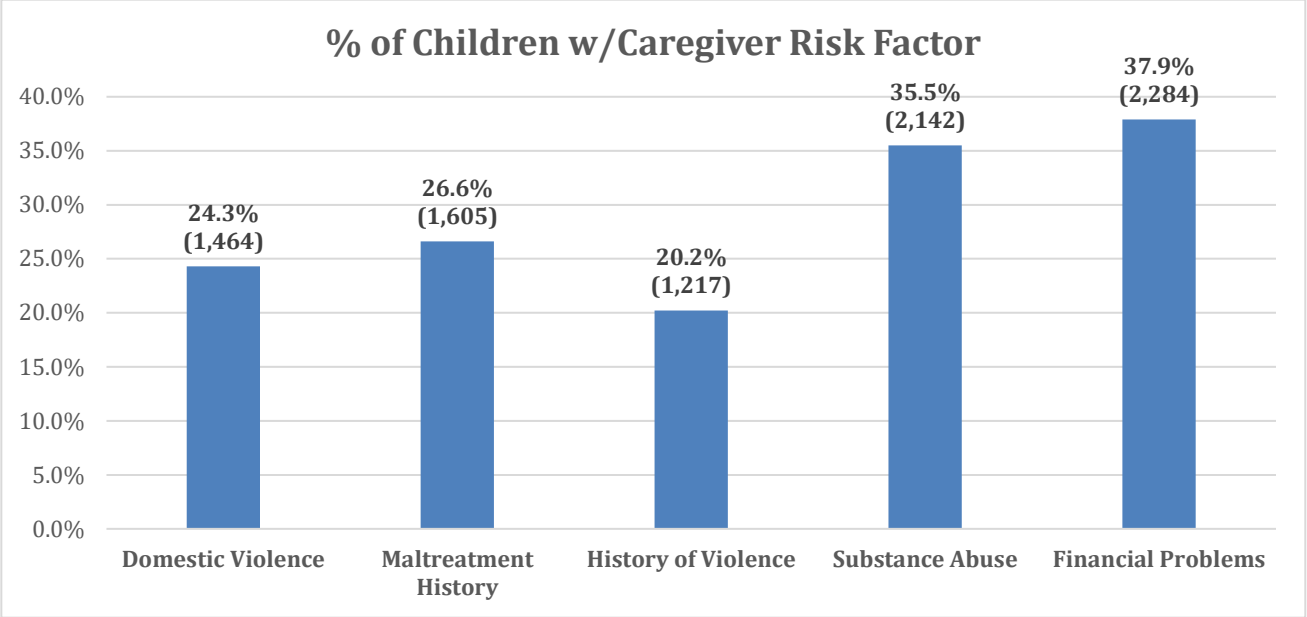
Parental **Risk Factors Among Maryland Children Who Receive an Investigative Response from DSS no matter the finding (as reported to SCCAN by DHS) See Figure C below**:

- 24.3% of child victims had a caregiver risk factor of domestic violence (down from a reported 38.1% in 2017 and 25.6% in 2018).
- 35.5% of child victims had a caregiver risk factor of substance abuse (down from a reported 37.9% in 2018; and, different from 2.3% and 5.8% with a caregiver risk factors for alcohol - and drug abuse, respectively, as reported to NCANDS).
- 37.9% of child victims had a caregiver risk factor for financial problems (down from 40.2% in 2018).
- 26.6% of child victims had a caregiver risk factor of maltreatment history (down from 28.2% in 2018).
- 20.2% of child victims had a caregiver risk factor of a history of exposure to violence (down from 22.7% in 2018).

[14] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2020), *Child Maltreatment 2019*

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

Figure C: Maryland FFY2019
Risk Factors among MD Children with an Indicated Maltreatment Finding



CAREGIVER RISK FACTOR	# of children with risk factor as reported by MD SSA to SCCAN	% of children with risk factor as reported by MD SSA to SCCAN	# of children with risk factor reported by MD SSA to NCANDS	% of children with risk factor reported by MD SSA to NCANDS
Alcohol abuse	Not reported	Not reported	173	2.3%
Drug abuse[16]	Not reported	Not reported	447	5.8%
Domestic Violence	1464	24.3%	2955	38.6%
Maltreatment History	1605	26.6%	NCANDs did not analyze this factor	NCANDs did not analyze this factor
History of Violence	1217	20.2%	NCANDs did not analyze this factor	NCANDs did not analyze this factor
Financial Problems	2284	37.9%	2637	34.4%
Inadequate Housing	Not reported	Not reported	248	3.2%
Public Assistance	Not reported	Not reported	432	5.6%
Any Reported Disability	Not reported	Not reported	401	5.2%
Substance Abuse[17]	2142	35.5%	NCANDs did not analyze this factor	NCANDs did not analyze this factor

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

[16] NCANDS collects separate data on alcohol abuse and drug abuse.
[17] DHS SSA collects data on substance abuse, combining both alcohol and drug abuse.

child welfare data systems, and thus 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 2019, DHS reported to NCANDs that 55 Maryland children had died with child maltreatment as a contributing factor. Child maltreatment fatalities have increased each year over the last 5 years 2015, 28 deaths; 2016, 32 deaths; 2017, 41 deaths; 2018, 40 deaths; 2019, 55 deaths. It was reported that of those 55 children who died in 2019, none of their families had received Family Preservation Services within the previous 5 years and only one child was removed from and reunited from his/her family within the previous 5 years.
- SSA reported 64 child fatalities in FFY 2019 to SCCAN. Thirty-seven (57.8%) of child deaths were < 1 years old; 20 (31.3%) were 1-3 years old; and 7 (11%) were between 6-17 years old.
- According to SSA, in FFY 2019, 34 (53.1%) of child fatalities were African American; 26 (40.6%) were White; 7 (10.9%) were Hispanic; 2 (3.1%) were Asian; and 2 (3.1%) were designated “other” race or ethnicity.
- SCCAN requested data on serious physical injuries, disaggregated by age and race, but did not receive this information from DHS, SSA. This is of great concern to the Council. This data should be publicly available on a regular basis.

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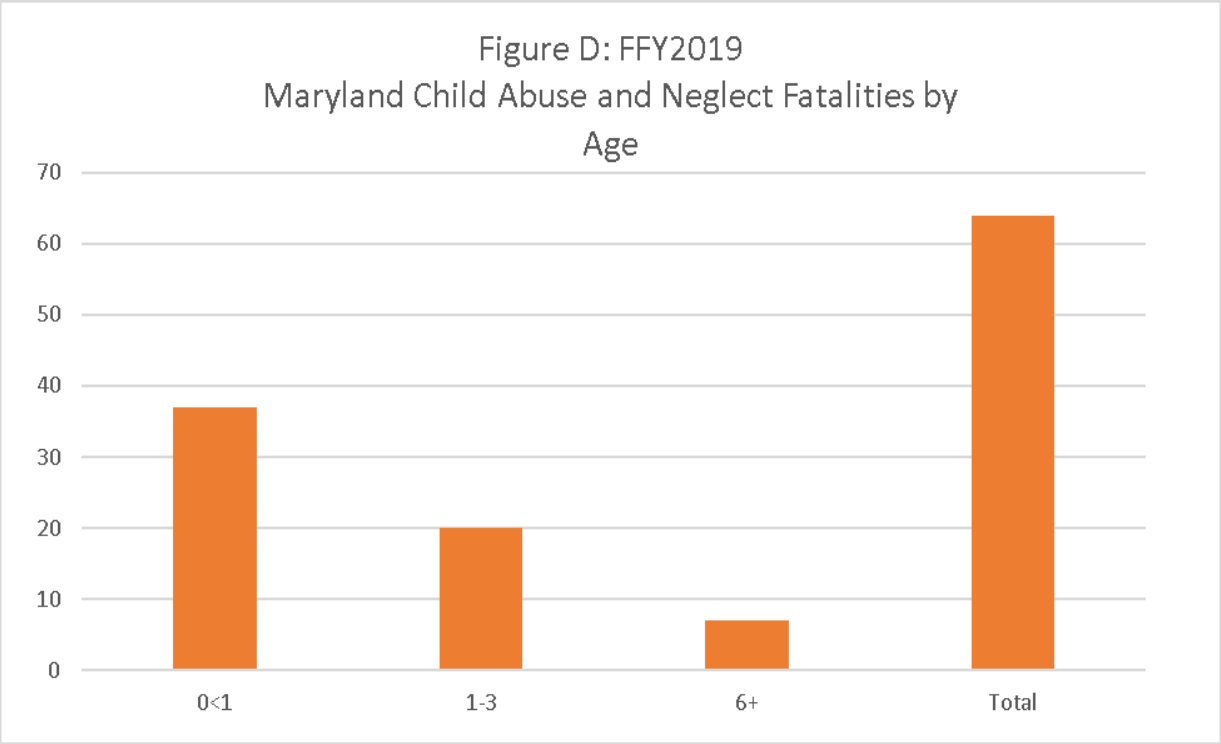


Age Group	Fatality Count	Hispanic Ethnicity	Asian	Black/African American	Other	White
0<1	37	3	1	20	1	15
1-3	20	3	1	9	0	10
6+	7	1	0	5	1	1
Total	64	7	2	34	2	26

As with maltreatment investigations, there is an over-representation of Black children in child maltreatment fatalities, and an under-representation of Hispanic children. The percentage of white child maltreatment fatalities closely reflects their percentage of Maryland children.

COLLECTING ACE DATA in MARYLAND:

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

The ACE Study examines the social, behavioral and health consequences of adverse childhood experiences throughout the lifespan. ACE Study participants (17,337) were members of Kaiser Permanente Medical Care Program in San Diego, California and reflected a cross-section of middle-class American adults. The study is an ongoing collaboration between Kaiser Permanente and the 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 (See 2019 SCCAN Annual Report for 2018 BRFSS ACE data). The BRFSS ACE module collects data on eight of the original ten ACEs, excluding physical and emotional neglect from the questionnaire.

PREVALENCE OF ACEs IN MARYLAND YOUTH:

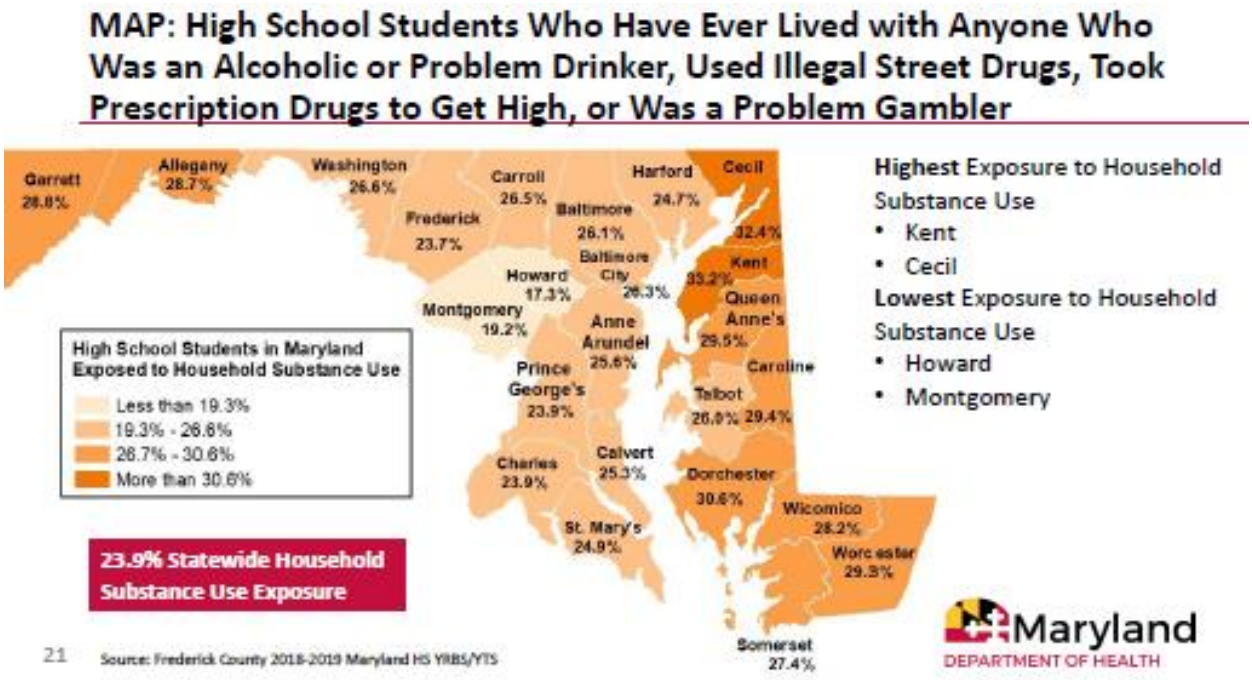
41,891 Maryland high school students from 184 high schools participated in the 2018 Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS). There was an 80% overall high school response rate. Four ACE questions were asked in the survey: emotional abuse, household substance abuse, household 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.[18] To get a clear

[18] 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).

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 I)

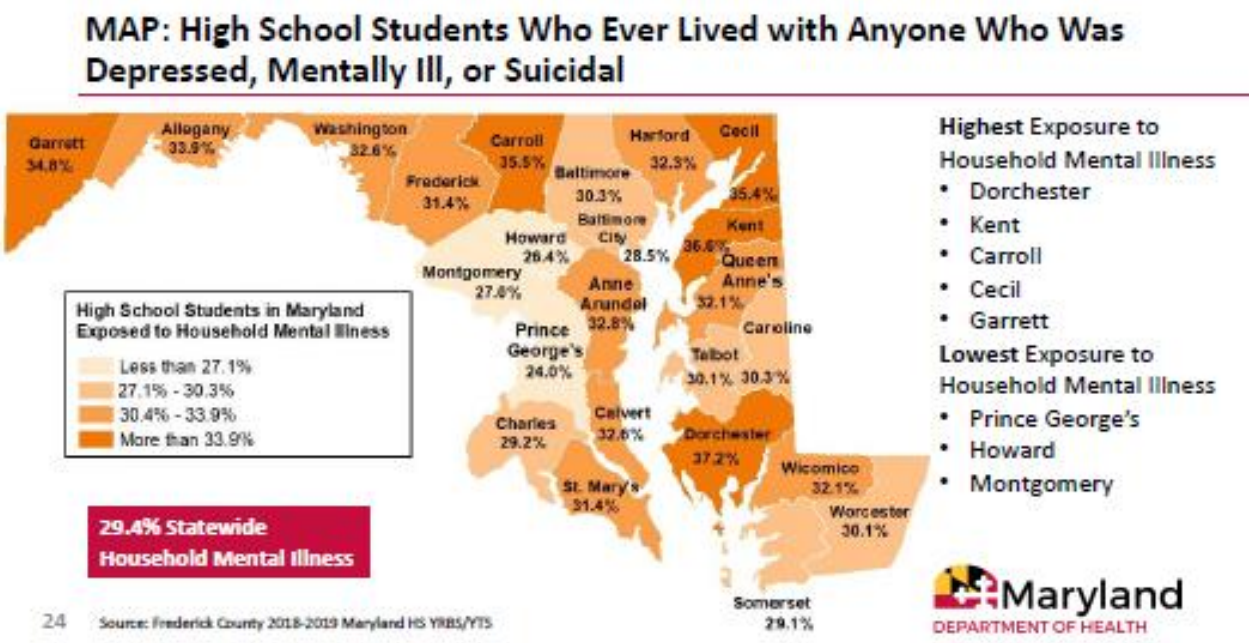
The YRBS/YTS is administered only during even years and there is no new data available at this time. However, analysis of the 2018 YRBS data has continued over the past year. In particular, jurisdiction-level data has been analyzed by Nikardi Jallah, MPH from the MDH Center for Tobacco Prevention and Control and released to stakeholders.

Household Member with Substance Use or Gambling Disorder by Jurisdiction:



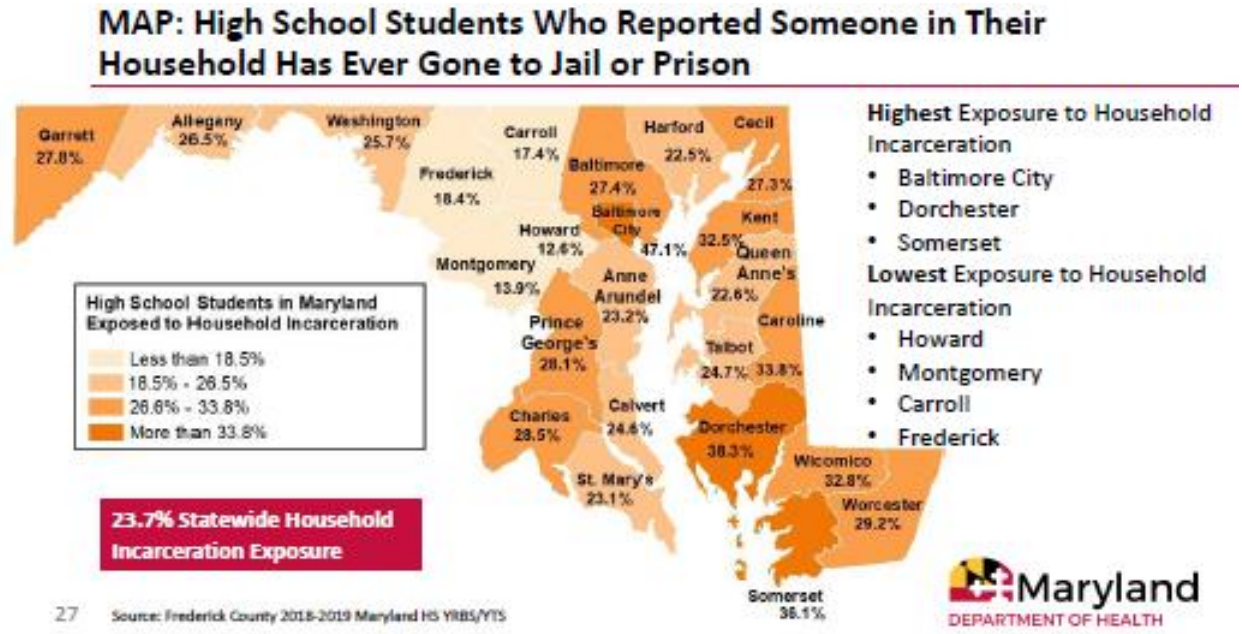
Substance use is common among caregivers in all Maryland jurisdictions, with about 24% of teens exposed to household substance use. Rates are highest in Kent and Cecil Counties, and lowest in Howard and Montgomery Counties.

Household Members with Depression, Mental Illness, or Suicidality



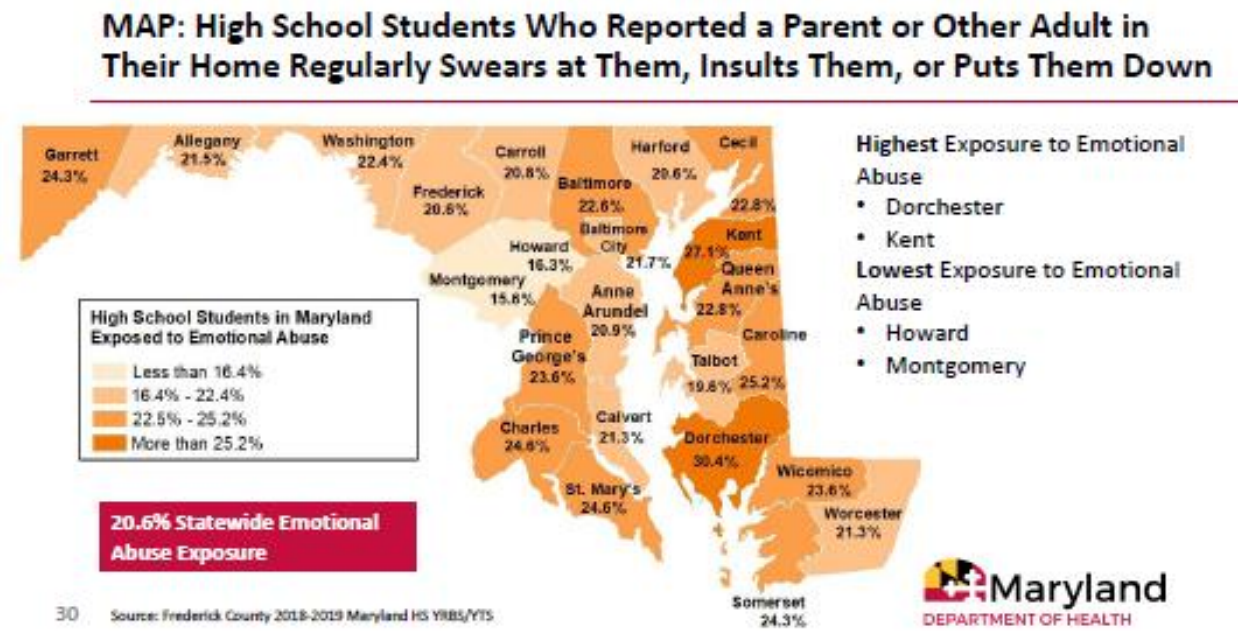
Mental illness is common among caregivers and household members in all Maryland Jurisdictions, with 29% of Maryland teens living with someone diagnosed with a mental illness. The highest rates of household mental illness were seen in Dorchester, Kent, Carroll, Cecil, and Garrett Counties. The lowest rates of household mental illness were seen in Prince George's, Howard, and Montgomery Counties.

Household Members Who Have Gone to Jail or Prison



Nearly 25% of Maryland teens have a caregiver or household member who has gone to jail or prison. Rates of household incarceration are highest in Baltimore City, Dorchester County, and Somerset County. Rates of household incarceration are lowest in Howard, Montgomery, Carroll, and Frederick counties.

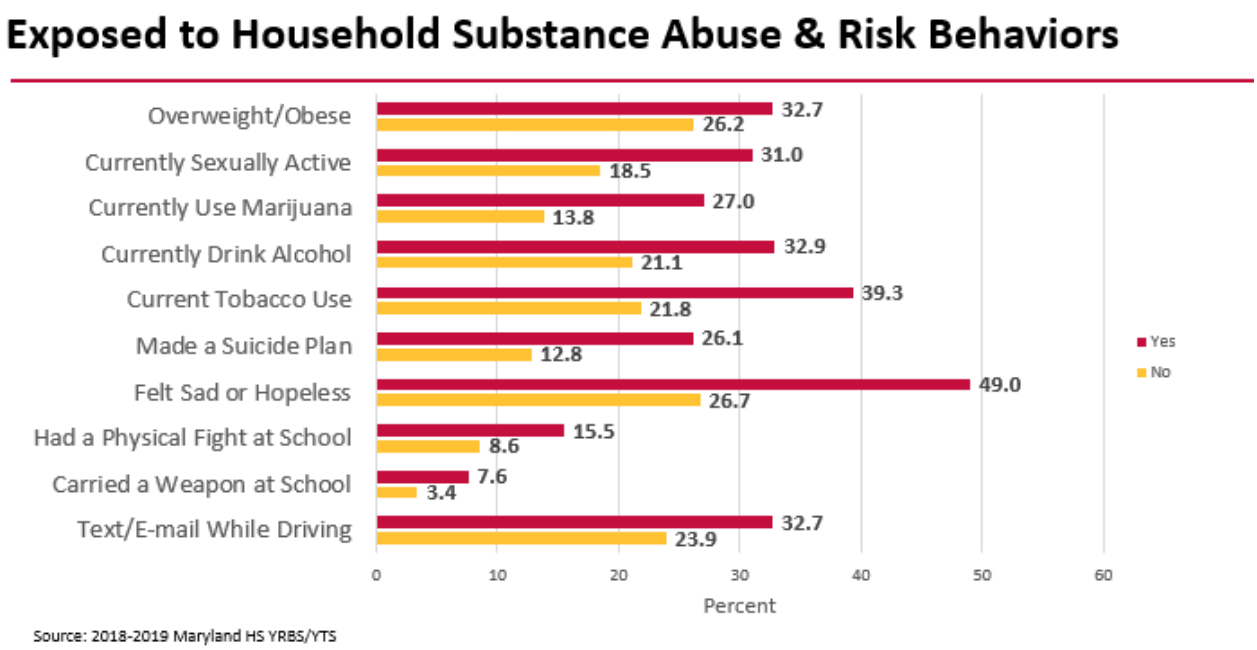
Emotional Abuse in the Home



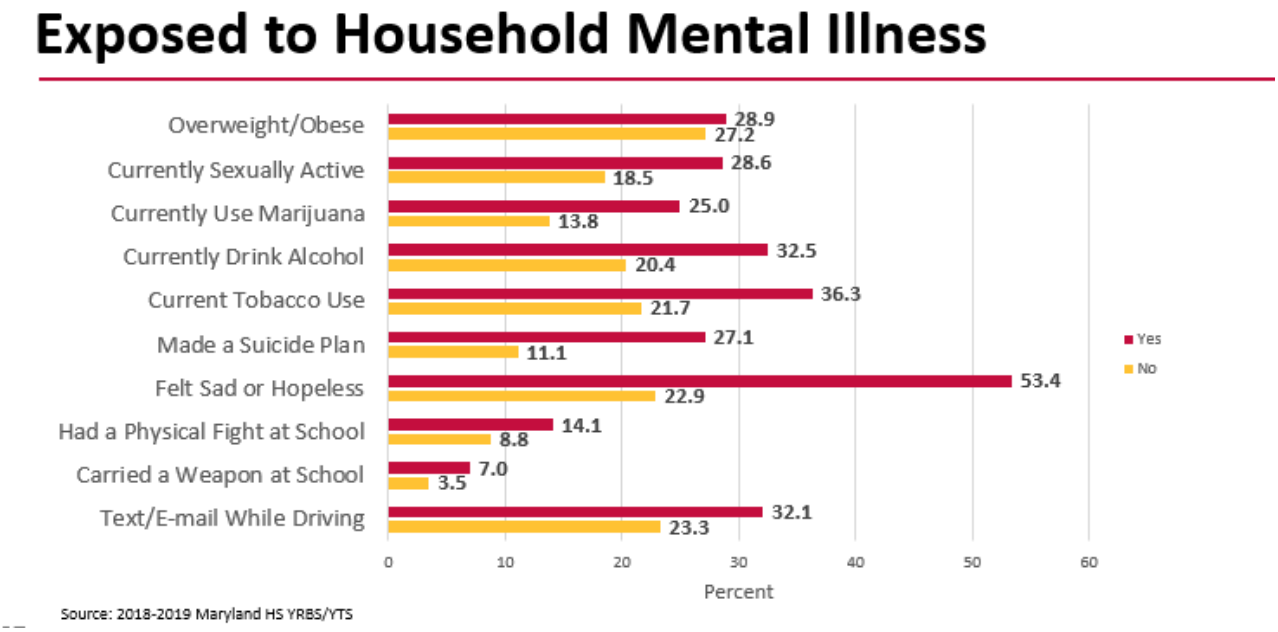
Approximately one in five Maryland teens reports regular emotional abuse by adults in their household. This is important because emotional abuse can have more deleterious effects on teen's mental health than even physical abuse.[19] The highest rates of exposure to emotional abuse were seen in Dorchester and Kent Counties. The lowest rates were seen in Howard and Montgomery Counties.

[19] Miller-Perrin, et al. Child Abuse & Neglect, 2009

ACEs and Adolescent Risk Behaviors:

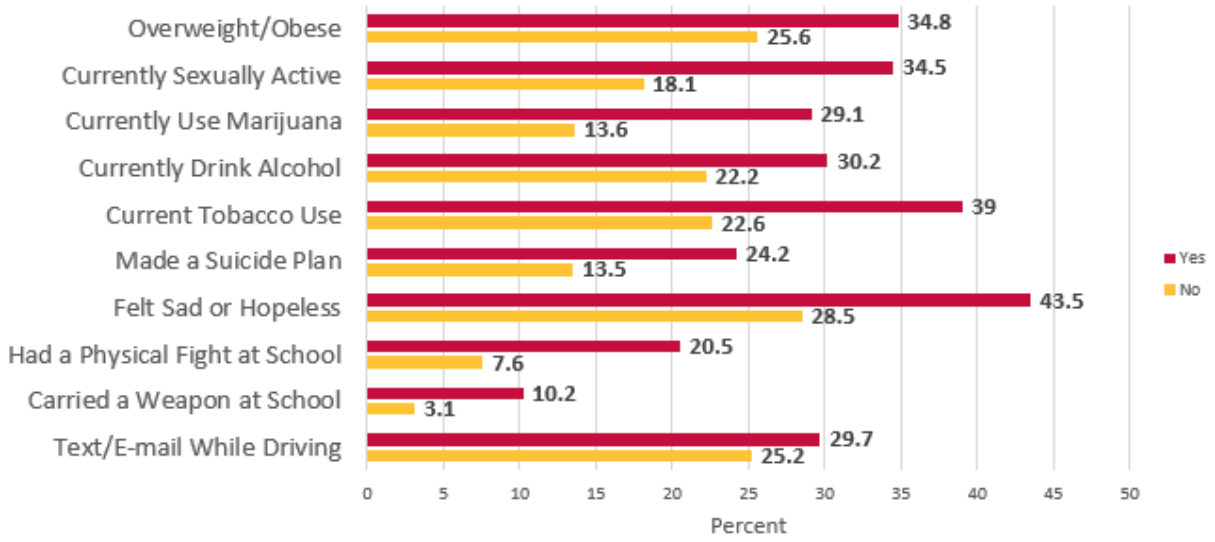


Teens exposed to household substance abuse have higher rates of obesity, risky behavior, and mental health issues compared to those not exposed to household substance abuse.



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.

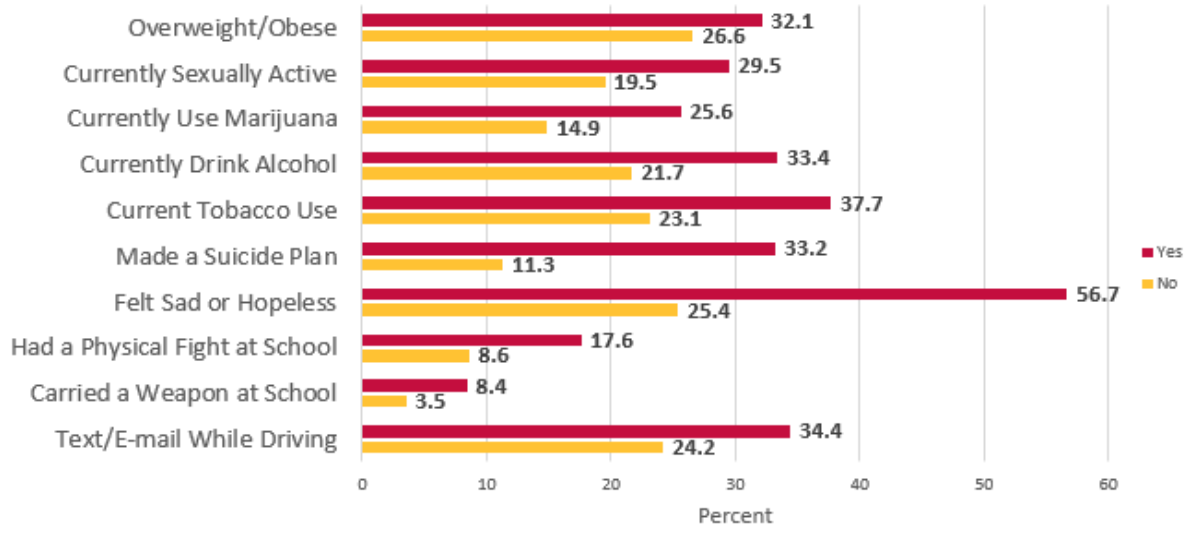
Exposed to Household Incarceration



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.

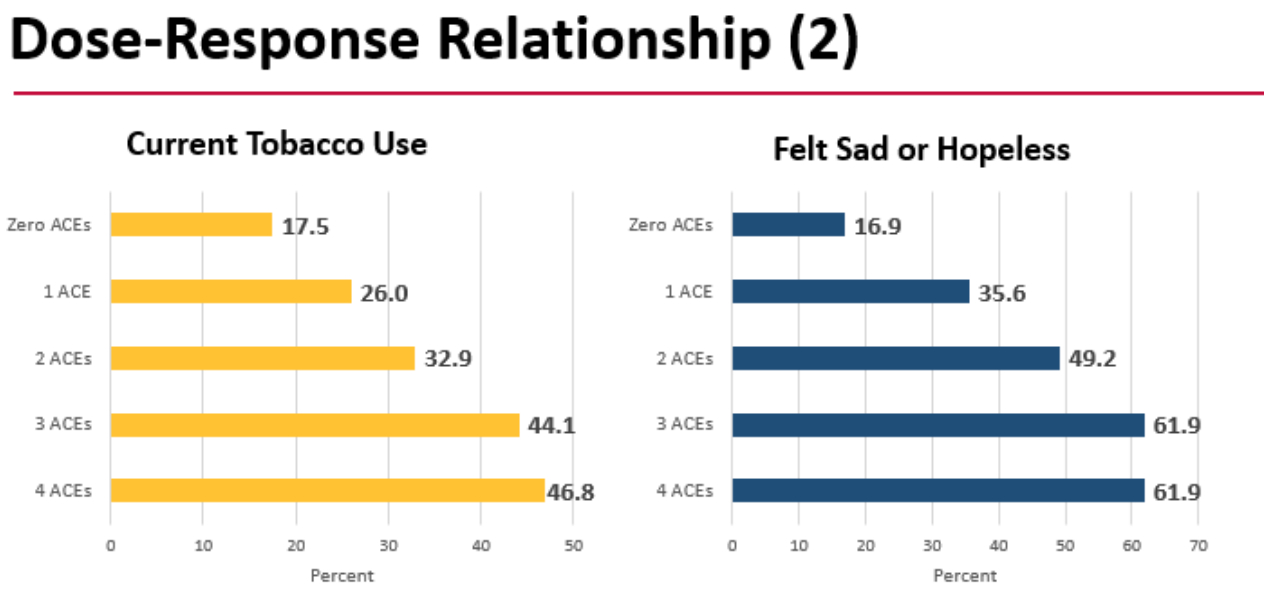
Exposed to Emotional Abuse

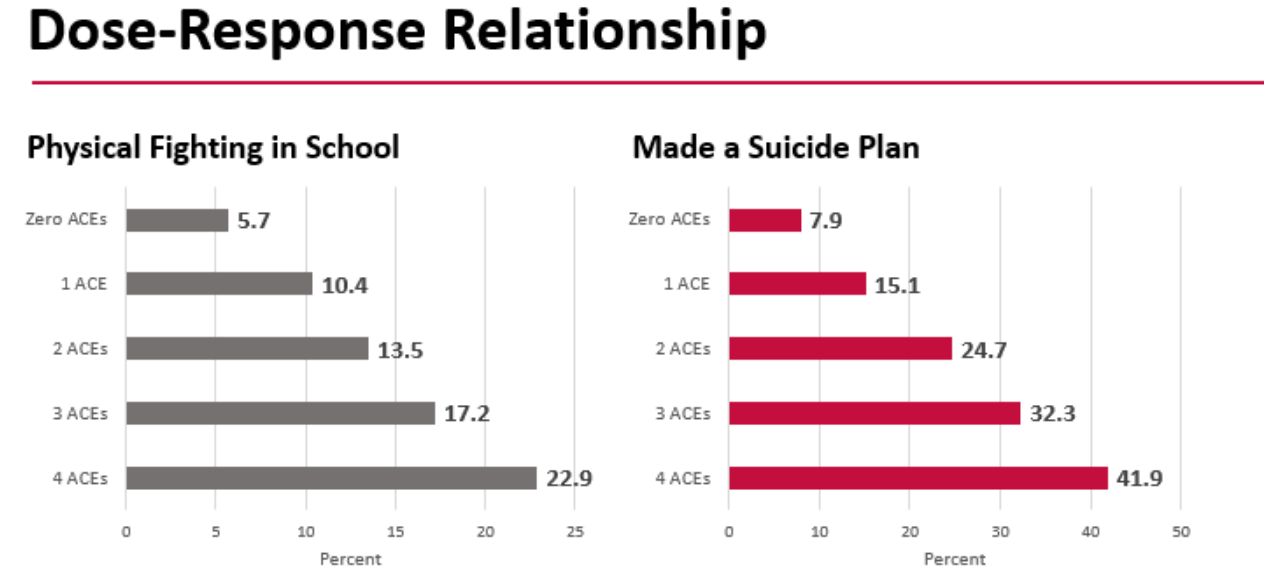


Source: 2018-2019 Maryland HS YRBS/YTS

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.

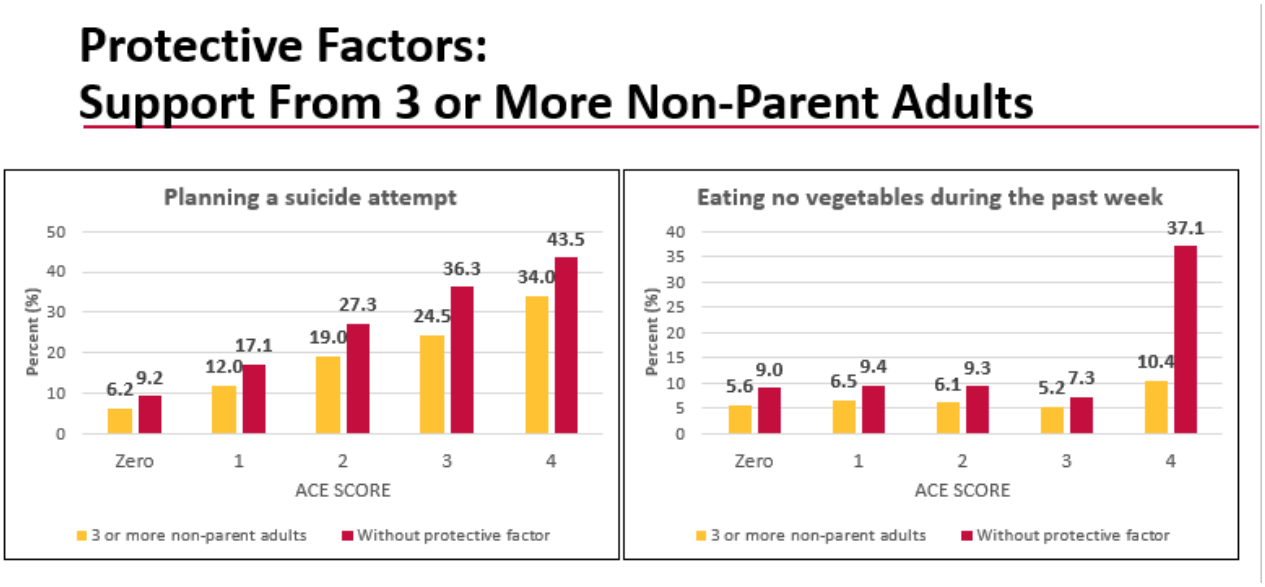
Dose Response Relationship ACEs and Risk Behaviors:





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, no jurisdiction is spared, and ACEs 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 put 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.
- The YRBS ACE questions should be expanded to include all 10 ACEs. Legislation that passed in the 2021 legislative session will require ongoing inclusion of ACE questions in the YRBS but will require only 5 questions. We recommend that ACE questions be alternated by YRBS year so that all 10 ACE questions are included during each 4-year interval. Data on protective factors should be examined for each Maryland jurisdiction.

SCCAN'S ACTIONS & ACCOMPLISHMENTS 2020-20211

Maryland Essentials for Childhood Initiative:

Since 2006, SCCAN has focused its efforts and recommendations on preventing child abuse and neglect *before it occurs* and promoting public and systems awareness of Adverse Childhood Experiences (ACEs) science to inform policy and practice changes in Maryland systems in order to improve the lives of our children. 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 with its partners, to create a statewide collective impact initiative—Maryland Essentials for Childhood (MD EFC) —with the mission of preventing and mitigating child maltreatment and other ACEs. SCCAN and MD EFC continue to choose specific priorities and develop recommendations that advance the following overarching strategic 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. Additionally, in response to pressing global events of 2020 and 2021, SCCAN and MD EFC began to examine the impact of the COVID-19 pandemic and systemic racism on Maryland's children. As the pandemic and racial inequity are significant adversities in the lives of Maryland's children, SCCAN and MD EFC members formed two working groups to develop potential solutions to mitigate short and long-term harms of the pandemic and systemic racism within the child welfare system. Below is a brief description of key actions by SCCAN and MD EFC Partners to achieve our collective goals.

Key Successes of SCCAN & MD EFC Partners2020-2021:

COVID-19 Childhood Resilience Action Team:

When the harsh realities of the global pandemic emerged in the spring of 2020, members of SCCAN and Maryland Essentials for Childhood recognized that the needs of children and families were about to change—and keep changing—in dramatic ways. Recruiting interested child and family serving professionals from across the state, SCCAN and Maryland Essentials for Childhood organized an effort, known as the COVID-19 Childhood Resilience Action Team, to research, identify, collect, and distribute emerging resources that could inform and support the resilience of children so significantly impacted by COVID-19 and beyond.

The Team's effort to locate and organize resources to benefit Maryland's children and their caregivers developed in two phases. In the first phase, more than 70 volunteers from scores of organizations (See Appendix D) formed groups that worked collaboratively to identify relevant issues, research and vet viable

solutions and supports and plan for sharing of the collected materials. These dedicated volunteers have now assembled a resource library encompassing 17 categories and hundreds of individual items to help children and families navigate both the seen and unforeseen effects of the pandemic. Resources for children, caregivers, and service providers are included and encompass health, mental health, behavioral health, education, childcare and economic supports.

The Childhood Resilience Action Team is now in Phase 2 and focused on creating a website domain containing the resource library and informing the public of the availability of the resources. The Behavioral Health Administration will provide grant funding to develop the childhood resilience website, ACEs training and data to support the Governor's Executive Order and Trauma-Informed Care Commissions efforts to prevent and mitigate ACEs across the state.

The work of these committed volunteers to contribute hundreds of hours toward creating this new statewide resource library is truly salutary. While challenged by the demands and changes in their own professional work and organizations, these forward-looking volunteers responded to the emerging needs of children and families resulting from the pandemic and created a rich and diverse collection of resources that will provide benefits for years to come.

Achieving Racial Equity within Maryland's Child Welfare System Workgroup:

The Achieving Racial Equity Workgroup began meeting in October 2020. Initially the group educated itself and fellow SCCAN and MD EFC members through expert presentations by Dr. Adrianne M. Fletcher, PhD of Case Western Reserve University and Alexandra Citrin, MSW, MPP and Maya Pendleton, MPP of the Center for the Study of Social Policy; and, creating an extensive resource list for members continued learning. They developed an Anti-Racist Statement, adopted by the Council in May 2020, and supported legislation requiring the Maryland Department of Human Services and Maryland Department of Education to provide disaggregated data by race, gender, age, and geographic region on outcomes for children and youth in Maryland's Child Welfare System.

Since the beginning of the child welfare system, disparity in treatment and services offered to African American children has existed. In fact, prior to 1865, slavery was the primary welfare institution for African Americans.[20] African Americans were not alone in tracing the history of the U.S child welfare system and the racist, discriminatory and disparate practices that have been used with children of color from the creation of the system, to current times. Native American and Indigenous people have also been victims of biased practices and discriminatory procedures within the child welfare system.[21]

After slavery was abolished, many White children were sent to orphanages, almshouses or sent west on "Orphan Trains" to live with foster families through indentured servitude. African Americans were largely excluded from that type of assistance with the exception being the Society of Friends (an abolishment group

[20] Dettlaff, A. J., Weber, K., Pendleton, M., Boyd, R., Bettencourt, B., & Burton, L. (2020). It is not a broken system, it is a system that needs to be broken: The upEND movement to abolish the child welfare system. *Journal of Public Child Welfare*, *14*(5), 500-517. Barth, R. P., Jonson-Reid, M., Greeson, J. K., Drake, B., Berrick, J. D., Garcia, A. R., ... & Gyourko, J. R. (2020). Outcomes following child welfare services: what are they and do they differ for black children?. *Journal of Public Child Welfare*, *14*(5), 477-499.

[21] Bird, S. E. (2018). Introduction: Constructing the Indian, 1830s–1990s. In *Dressing in feathers* (pp. 1-12). Routledge. Berkhofer, R. F. (1979). *The white man's Indian: Images of the American Indian, from Columbus to the present* (Vol. 794). Vintage.

in Philadelphia, PA).[22] The under-funded and short-lived Freedman Bureau provided direct relief for many African American children and their respective families. More often than not, most of the support services provided (i.e. day care, orphanages) to African American children were through self-help efforts offered through schools, churches, and other social organizations[23]. It was not until 1910, with the founding of the National Urban League, that large-scale efforts began to advocate for equitable distribution of child welfare services.

By 1935, mothers' pension laws had been adopted in 46 states. Similarly, the Social Security Act established Title IV-A, which was Aid to Dependent Children (ADC). However, many states instituted "home suitability clauses"[24], "illegitimate child clauses" and "substitute father in the house clauses". These clauses were established to weed out "immoral" homes and often excluded African American from receiving any public welfare benefits. Consequently, states like Mississippi, Florida and Louisiana were notorious for removing African American children from their families because their families were, in their opinion, too poor to take care of children.[25]

During the 1960's there was a major shift in America's conceptualization of the poor. The growing use of contraception and liberalized abortion laws increased social acceptability of many unwed, single parent households. The reduction of White children eligible for adoption led many private agencies to focus on African American children. African American children began to be over-represented in the child welfare system.[26]

Maryland only began disaggregating child welfare data by race beginning in 2015. The data shows black children and families continue to be disproportionately overrepresented year after year in Maryland. In addition to overrepresentation, Black children also experience disparate outcomes. In Maryland, Black Youth are overrepresented in out of home foster care placements and are also more likely to exit care without achieving permanency compared to their white counterparts. Of all youth emancipated (not being adopted, reunified, or placed in guardianship) Black youth comprise the overwhelming majority.

With this information, in the Fall of 2020, SCCAN dedicated time, attention and resources to address racial inequities and disparate outcomes within Maryland's child welfare system. Below are SCCAN's accomplishments and recommendations to date.

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[22] Dettlaff, A. J., & Boyd, R. (2020). Racial disproportionality and disparities in the child welfare system: Why do they exist, and what can be done to address them?. *The ANNALS of the American Academy of Political and Social Science*, *692*(1), 253-274. Cénat, J. M., Noorishad, P. G., Czechowski, K., Mukunzi, J. N., Hajizadeh, S., McIntee, S. E., & Dalexis, R. D. (2021). The Seven Reasons Why Black Children Are Overrepresented in the Child Welfare System in Ontario (Canada): A Qualitative Study from the Perspectives of Caseworkers and Community Facilitators. *Child and Adolescent Social Work Journal*, 1-16.

[23] Burslem, R. R. (2021). TRANSFORMING OUTCOMES TO INCREASE PARTICIPATION IN THE INDEPENDENT LIVING PROGRAM SPONSORED BY SUNRISE CHILDREN'S SERVICES. Bremner, R. H. (1983). Other people's children. *Journal of Social History*, *16*(3), 83-103.

[24] Fong, K. (2020). Getting eyes in the home: Child protective services investigations and state surveillance of family life. *American Sociological Review*, *85*(4), 610-638. Piven, F. F., & Cloward, R. (2012). *Regulating the poor: The functions of public welfare*. Vintage.

[25] Lawrence-Webb, C. (2018). African American children in the modern child welfare system: A legacy of the Flemming Rule. *Serving African American Children*, 9-30. Simon, R. J. (1984). Adoption of black children by white parents in the USA. *Adoption: Essays in Social Policy, Law, and Sociology. New York/London, Tavistock Publications*.

[26] Hamilton, E., Samek, D. R., Keyes, M., McGue, M. K., & Iacono, W. G. (2015). Identity development in a transracial environment: Racial/ethnic minority adoptees in Minnesota. *Adoption quarterly*, *18*(3), 217-233.

Accomplishments

To address racial disparities and disparate outcomes for youth and families involved in Maryland's Child Welfare System, SCCAN created an "Achieving Racial Equity in Child Welfare" Workgroup within SCCAN to develop recommendations to address current racial inequities and disparate outcomes for youth and families of color within the child welfare system. The Workgroup:

- Developed an Anti-Racism statement which was adopted by SCCAN. (See Appendix J)
- Prioritized 2021 Child Welfare Data Bill, HB258/SB592 which requires the Maryland Department of Human Services and Maryland Department of Education to provide disaggregated data by race, gender, age, and geographic region on outcomes for children and youth in in Maryland's Child Welfare System. The bill passed both the House and Senate unanimously.
- Began educating SCCAN and MD EFC members on historical systemic racism within the child welfare system and other child and family serving systems through presentations by expert speakers, including Dr. Adrianne M. Fletcher, PhD of Case Western Reserve University and Alexandra Citrin, MSW, MPP and Maya Pendleton, MPP of the Center for the Study of Social Policy.
- Built a list of resources to achieve racial equity, address white privilege, and reduce disparate outcomes within child and family serving systems. Resources will be added continually to the list and shared with SCCAN and MD EFC members and partners. (See Appendix K)

Recommendations

- Maryland Department of Human Services
    - Require caseworkers to input race demographic data on all cases brought to the attention of the Department of Human Services. Recent data received from the Department of Human Services indicates that of all new child abuse and neglect cases in fiscal year 2020, nearly a quarter did not include the race of the child.
    - Collect and make publicly available disaggregated data (race, gender, age, and geographic region) on the following indicators:
        - The number of referrals and the number of screened-in and screened out referrals
        - The stability of early care and education as measured by number of child care provider placements
        - The number and percentage of children 0-5 in a quality childcare program as defined by Maryland Excels
        - The number and percentage of children 0-5 in informal childcare
        - The number and percentage of children with CPS involvement referred to Infants and Toddlers
        - The number and percentage of children and youth receiving all Early Periodic Screening Diagnosis and Treatment visits recommended by Maryland Healthy Kids.
        - Data collected by child welfare medical director as defined in MD Human Services Code Section 8-1101 (2018)
    - The 2020 Department of Human Services, Child Welfare Indicators Report, indicates that 38% of children reported for suspected child abuse and neglect were Black Youth although Black Youth only make up 33% of the child population in MD. We recommend that:
        - DHS disaggregate referral (both screened in and screened out) data further by abuse type; specifically, when a youth is referred to the Department as a result of

neglect this information should be disaggregated by risk factor (food insecurity, housing status, poverty, etc.).

        - DHS collect referral source data and disaggregate referral data by the source type. (i.e. School, medical professionals, neighbors, family/friends, etc.)
    - According to DHS, 60% of referrals received are screened out. We recommend that:
        - DHS disaggregate all referrals data, screened in and screened out, by race, age, gender, and geographic region.
    - Require all DHS employees, and DSS supervisors and caseworkers receive annual racial equity training.
- Maryland Department of Education
    - Collect and make publicly available disaggregated data (race, gender, age, and geographic region) on the following indicators:
        - The number and percentage of all Maryland children with a current individualized education plan
        - The number and percentage of children in out-of-home placement with a history of individualized education plans.
        - The number and percentage of children in out-of-home placement with a current individualized education plan.
        - The number and percentage of children in out-of-home placement with an individualized family services plan.
        - Rate of college and postsecondary application, acceptance, and attendance amongst youth in out-of-home placement.
- Maryland General Assembly
    - Amend current statute to expand data currently collected by Maryland's Department of Human Services within their Child Welfare Indicators Report. Additional indicators include:
        - The number of referrals and the number of screened-in and screened out referrals
        - The number of referrals (both screened in and screened out) by referral source (i.e., school, medical professionals, neighbors, family/friends, etc.)
        - The number of referrals (both screened in and screened out) by abuse type; and, more specifically, when a child or youth is referred to the Department as a result of neglect this information should be disaggregated by risk factor (food insecurity, housing status, poverty, etc.).
        - The stability of early care and education as measured by number of child care provider placements
        - The number and percentage of children 0-5 in a quality childcare program as defined by Maryland Excels
        - The number and percentage of children 0-5 in informal childcare
        - The number and percentage of children with CPS involvement referred to Infants and Toddlers
        - The number and percentage of children and youth receiving all Early Periodic Screening Diagnosis and Treatment visits recommended by Maryland Healthy Kids.
        - Data collected by child welfare medical director as defined in MD Human Services Code Section 8-1101 (2018)
        - Disaggregate all indicators by race, age, gender, and geographic region.
    - Amend current statute to expand the data collected by the Maryland State Department of Education. Additional indicators include:

        - The number and percentage of all Maryland children with a current individualized education plan
        - The number and percentage of children in out-of-home placement with a history of individualized education plans.
        - The number and percentage of children in out-of-home placement with a current individualized education plan.
        - The number and percentage of children in out-of-home placement with an individualized family services plan.
        - Rate of college and postsecondary application, acceptance, and attendance amongst youth in out-of-home placement.
        - Disaggregate all indicators by race, age, gender, and geographic region.
    - Pass legislation to require all mandated reporters in the state of Maryland to receive racial bias training focused on the role of bias and racism in child abuse and neglect reporting.
    - Pass legislation to require all DHS employees and local DSS supervisors and caseworkers in the state of Maryland to receive racial bias training focused on the role of bias and racism in decision-making throughout the continuum of child welfare cases.

Maryland Essentials for Childhood Initiative:

GOAL 1: Raising awareness of N.E.A.R. Science and building a commitment to put the science into action to create the safe, stable, nurturing relationships and environments that reduce and mitigate ACEs and build resilience:

- With the tremendous leadership, staffing, and financial support of The Family Tree and the generous dedication of thousands of hours by our ACE Interface Master Trainers and Presenters, we have increased the breadth and reach of the ACE Interface Project[27]. Knowledge of the N.E.A.R. Science was strategically disseminated throughout Maryland public and private agencies and communities:
    - The Family Tree, supported by ACE Interface Master Trainers, trained an additional 42 Master Presenters through a specialized training to MSDE and local education agencies.
    - Through the generous support of The Family Tree, Dr. Robert Anda and Laura Porter trained an additional 30 Master Trainers in November 2021. The Project has added Master Trainers to the following sectors, agencies, and communities:
        - Psychiatric Rehabilitation
        - Supported Employment
        - Media Arts Education
        - Home Visiting
        - Frederick County Office of Children & Families
        - Springboard Community Services
        - Citizens Review Board for Children
        - St. Mary's Health Department
        - Maryland Community Action Partnership
        - University of Maryland Extension
        - Maryland CASA Association
        - Maryland Department of Human Services

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

- Thriving Communities Collaborative
- Mental Health Association of Frederick County
- Adoptions Together
- University of Maryland, Baltimore County, Choice Program
- Howard County Government
- Morgan State University
- Howard County Office of Children & Families
- Maryland Child Care Providers and Technical Assistance Communities
- Human Services Consultation
- Community Youth Organization, Racial and Social Justice
- Roberta's House
- Worcester County Board of Education
- Boys & Girls Clubs of Metro Baltimore
- Judy Centers
- Frederick County Safe Babies Court
- Zero to Three

▪ As of December 2020, the ACE Interface Project has more than 200 Master Trainers and Presenters representing all 24 Maryland jurisdictions; and include two specialized cohorts:
  - Opioid Epidemic – MDH's Regrounding Our Response[28] to the Opioid Crisis- a multi-disciplinary approach to understanding the overdose epidemic. (32 Master Presenters statewide)
  - Education- MSDE and local education agency personnel. (57 Master Presenters statewide)

▪ From January 2020 to November 2021, volunteer ACE Interface Master Trainers and Presenters gave a total of 145 ACE Interface presentations (See Appendix F for list of key presentations) to over 17,609 attendees across all 24 jurisdictions (See Appendix L for presentations by jurisdiction).

▪ Since its inception in December 2017 through November 2021, volunteer ACE Interface Master Trainers and Presenters have given 390 ACE Interface presentations (See Appendix M for list of key presentations) to over 24,883 attendees across all 24 jurisdictions.

- Continued to develop and expand Maryland ACEs Action blog page on PACEs Connection[29]:
  - Increased membership five-fold to 1104 members, making Maryland ACEs Connection Community the 9th largest of 362 Communities on ACEs Connection and the 3rd largest statewide community after California, and North Carolina.
  - 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 on PACEs Connection.

[28] For more on the Regrounding Our Response Initiative, see the 2019 SCCAN Annual Report.
[29] Developed Maryland ACEs Action blog page on PACEs 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.

- GOAL 2: Identify and use data to inform actions and recommendations for systems improvement.
    - Successfully advocated for unanimous passage of the 2021 Child Welfare Data Bill, HB258/SB592 which requires the Maryland Department of Human Services and Maryland Department of Education to provide disaggregated data by race, gender, age, and geographic region on outcomes for children and youth in in Maryland's Child Welfare System
    - Worked closely with the Behavioral Health Administration (BHA) at MDH on Maryland's application to the CDC's ACEs Prevention and Data to Action Grant (PACE-D2A). Unfortunately, Maryland was not awarded one of the six grants nationwide (CT, GA, MA, MI, MN & NJ). However, the work and partnerships created in developing the grant have served as the foundation for the cross-agency ACEs Data Workgroup being led by BHA. SCCAN and MD EFC have shared key resources from the technical assistance they received from the CDC's Essentials for Childhood Initiative which have been incorporated into work of Maryland's ACEs Data Workgroup.
    - Supported HB771/SB548 Public Schools - Centers for Disease Control and Prevention Surveys – Revisions requiring that all sixteen of the CDC's Adverse Childhood Experiences and Positive Childhood Experiences questions be included in the YRBS/YTS for high school and middle school students. Legislation was passed to require "at least five questions" from the CDC's YRBS on ACEs or positive childhood experiences (PCEs).
    - Successfully advocated for the inclusion of 4 ACE questions that were included in the Fall 2018 and 2020 (deferred until 2021 due to pandemic) 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.

- GOAL 3: **Integrate the N.E.A.R. Science into and across Systems, Services, and Programs.**
    - Successfully advocated for Maryland to join Delaware, Pennsylvania, Virginia, and Wyoming to participate in the National Governor's Association Center for Best Practices (NGA Center), Duke-Margolis Center for Health Policy, and the National Academy of State Health Policy's 2020-2021 *Addressing ACEs State Learning Collaborative*, an intensive, multi-state technical assistance project on statewide approaches to address ACEs across the lifespan. States with more advanced ACEs work (AL, CA, NJ, TN) served as models for participating states. The Behavioral Health Administration, the Governor's Office of Crime Prevention Youth and Victims Services (GOCPYVS), the Child Welfare Medical Director at DHS, SSA, the Opioid Operational Command Center at the Maryland Department of Emergency Management (MEMA), the Department of Juvenile Services (DJS) and SCCAN participated in the learning collaborative for Maryland. The work culminated in Governor Hogan's ***Executive Order on Adverse Childhood Experiences*** directing state agencies to coordinate efforts to reduce ACEs and consider how each agency's policies and programs could reduce ACEs and implement care models informed by ACEs. ***May 6th was declared ACEs Awareness Day*** to coincide with Mental Health Awareness Month.
    - Successfully advocated for the unanimous passage of HB548/SB299 – Trauma Informed Care- Commission and Training (Healing Maryland's Trauma Act) mirrored after the Elijah Cummings' Healing City Baltimore Act. The legislation creates an independent Commission that functions at DHS, is staffed by GOCPYVS, and to which MDH provides technical

advisory support. The Commission's purpose is to coordinate a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of state services that impact children, youth, families, and older adults. SCCAN's Executive Director and several MD EFC members, including multiple ACE Interface Project Master Trainers and Presenters, will serve as members of the Trauma-Informed Care Commission. The Commission is tasked to develop a statewide strategy toward an organizational culture shift into a trauma-responsive state; identify state programs and services that impact children, youth, families, and older adults; establish metrics (with MDH) to evaluate and assess progress of the initiative, develop and coordinate trauma-informed training (with MDH); disseminate information among agencies regarding best practices for preventing & mitigating the impact of trauma; study, develop, and implement a process and framework for an ACEs Aware Program in Maryland; make recommendations on improving existing laws related to children, youth, families, and older adults; and report to the Governor and General Assembly on metrics and agency progress on becoming trauma-responsive. Additionally, the legislation requires each agency head to designate two staff members to lead their trauma-responsive culture shift through training, and changes to policies, and practices.

- 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. (See Appendix E)
- 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. 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.
    - Eighty-five percent of a person's brain development happens in the first three years of life. During this time if babies or young children experience traumatic stress, it can disrupt that brain development. However, one of the best buffers to the negative impact trauma can have is a strong attachment to at least one caretaker. If a young child has this strong attachment, despite experiencing traumatic stress, that strong healthy attachment can help ensure the child's brain development is not disrupted. For this reason, among others, support for parents with young children and for young children's behavioral health is especially important.

      One especially effective way to ensure that families with young children receive the services they need is to embed a social worker in the doctor's office where families go for their well visits. There are twelve (12) well baby visits in a baby's first two years. So, there are multiple opportunities to get to know these families and build a great deal of trust. That trust makes families more comfortable accepting and following through with referrals to other services.

      Maryland's Department of Health is working on the sustainability of programs with social workers embedded in pediatricians' offices, and we applaud those efforts. One way to make this affordable for a doctor's office is to allow that doctor to bill Medicaid for certain codes that aren't currently reimbursable. Effective prevention programs would benefit from allowing reimbursement for "Z codes" (which Oregon, Ohio, Philadelphia, and San Francisco Health Plan do). (See Appendix N)

      As set forth in the Maternal and Child Health priorities of the Health Services Costs

Review Commission, we urge MDH to:

- Open the code for preventive medicine counseling (99401);
- Attach reimbursement for z-code diagnoses; and
- Allow a Per Member Per Month[30] reimbursement for children being seen by medical practices that also have social workers meeting with families.

There are several Medicaid billing barriers that make it difficult for families with young children to receive the behavioral health services they need. First, in Maryland, a behavioral health provider needs to have a diagnosis for a patient on the first visit with that patient. It can be especially difficult with young children to have that diagnosis so early. In many other states, a clinician can have up to five visits with a patient before having a diagnosis. In Colorado, for example, reimbursement is permitted via H0002- Behavioral health screening.

- MDH should allow behavioral health providers to receive reimbursement for R69, R45, and R46 for up to five visits before requiring a specific behavioral health diagnosis.

For young children, a lot of the work the counselor needs to do to support the young child's behavioral health is with that child's caregiver. However, in Maryland, clinicians cannot bill for providing individual therapy and family therapy on the same day. Another barrier in Maryland is the inability to bill for evidence-based parenting support programs, like Chicago Parent Program, Mom Power, Circle of Security and others. Maryland rules should allow "multifamily group without patient present, billing groups via tele & reimbursement for H2027".[31]

- MDH should eliminate the exclusion that prevents behavioral health providers from billing for individual therapy with a child and family therapy for that child's family on the same day.
- Optumm should allow reimbursement for H2027 even when a child is not present.

Finally, the DC:0-5 diagnostic tool is much more well suited for diagnosing behavioral health issues in young children than the DSM V. However, Maryland Medicaid only allows diagnoses via the DSM V. Other states are integrating the DC:0-5 into their state behavioral health systems.[32]

- MDH should allow usage of the DC:0-5 in addition to the DSM V because it

[30] A Per Member Per Month reimburses allows a Managed Care Organization to receive a set monthly amount from Medicaid for the services they provide to that patient.

[31] Optumm (the behavioral health carve out Administrative Service Organization) denies these claims and says the patient (child) must be present. This is not an issue in other states. In Minnesota, they allow licensed mental health professionals or clinical trainees to receive reimbursement via H2027 HQHS – psychoeducation—the patient may or may not be there ($24.12 - $24.97 per 15 minutes with a single family or ($5.96 - $8.26 per 15 minutes for multiple families). Minnesota also allows reimbursement for Clinical Care Consultation via 90899 when a mental health professional or clinical trainee speaks to a patient's other professionals (child welfare, childcare provider, school staff, etc.). This can be in person or on the phone (rates vary by time (5 minutes to 30 plus minutes) and if on the phone or in person ($14.80-$79.82). Colorado allows reimbursement for care management with collaterals via T1017. Colorado also allows reimbursement via H0023- outreach attempts to keep family engaged or to re-engage family that is disengaged.

[32] **THERESE AHLERS, JULIE COHEN, CINDY OSER, AND AMANDA SZEKELY, *Advancing Infant and Early Childhood Mental Health: The Integration of DC:0-5™ Into State Policy and Systems*, July 31, 2018.**

is better suited for diagnosing behavioral health issues in young children.

- Partnered with the Maryland State Department of Education to increase the capacity of local education agencies (LEAs) to provide N.E.A.R. Science informed professional development for educators. Fifty-seven educators from LEAs have been trained as ACE Interface Master Presenters.
- Multiple SCCAN and MD EFC partners participate in the Frederick County Safe Babies Court Team (SBCT) Active Community Team monthly meetings, Maryland's first and only SBCT at this time. The SBCT approach improves outcomes for infants and toddlers involved in the child welfare system. The approach focuses on minimizing trauma and its impact on early development by improving how the courts, child welfare agencies, and related child-serving organizations work together to support young children and their families. There are SBCTs in local communities in 27 states. SCCAN recommends that DHS, MDH/BHA, and the Administrative Office of the Courts work together to expand SBCT across the state, as evaluations have identified improved outcomes in the following areas[33]:
  - ***Improved safety*** – children served by SBCT show a child maltreatment recurrence rate of .07% compared to national average recurrence rate of 9.1%
  - ***Faster time to permanency***- children served by SBCT exit foster care faster, 92.7% achieved permanency within 12 months, compared to 40.5% national permanency rate.
  - ***Preserved family relationships*** – 87.8% of children served by SBCT were reunified with either their parents or family members, compared to the national average of 66% of children who exited foster care to their parents, guardianship, or to live with relatives.
  - ***Placement stability*** - 94.2% of children served by SBCTs were in care for less than 12 months had no more than two placements, compared to the national median of 86%
  - ***Racial equity*** – One study indicated that children of all races and ethnicities were served equally well by SBCTs with regard to both placement stability and length of stay in foster care.
  - ***Increased service delivery*** – 93.9% of children served by SBCTs received needed Child-Parent Psychotherapy, compared to the national average of 66% of all children in the child welfare system receiving needed mental health services.
  - ***Cost savings*** – One cost analysis showed that up to two-thirds of the program's average cost per child could be directly generated from savings to jurisdictions due to children's shortened stays in foster care.

- 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 2020: Approximately 50 SCCAN and MD EFC Members participated on 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: The Hidden Predator Act, Trauma-Informed Schools Bill, Time to Care Act, Equitable Graduation Requirements for Foster Youth, and TANF Cash Assistance Eligibility Requirements. Frank Kros presented on the ACE Science and Policy to General Assembly Members and staff in attendance. SCCAN-MD

[33] *How does the Safe Babies Court Team™ approach improve outcomes for infants and toddlers?* Casey Family Programs Strategy Brief, November 2019.

Essentials for 2020 Childhood Leadership Awards were presented , to Joan L. Stine, MHS, MS, Advocate of the Year; The Board & Staff of No More Stolen Childhoods, Community Partner of the Year; and, posthumously to Congressman Elijah Cummings, Legislator 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.

- 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 2019 SCCAN Report and the updated Appendix O), which outlines the N.E.A.R. science and catalogues ACE-informed policy and state legislation throughout the country.
- 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. **Hidden Predator Act -Child Sexual Abuse Civil Statute of Limitations Reform- SB134/HB263 (2021). SB134 had a hearing but was not brought to a vote by the Judicial Proceedings Committee. HB263 was withdrawn. 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.** The Hidden Predator Act will eliminate the civil statute of limitations for child sexual abuse. More than 50 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. Look-back windows in other states have been proven to provide justice to survivors, as well as identify and prosecute hidden predators. The national trend toward lookback windows has helped states expose hidden predators who were still harming children.

2. **Education- Guidelines on Trauma-Informed Approach HB 277 (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.

3. **Time to Care Act- HB375/SB211 (2021) and HB839/SB539 (2020):** The bills did not get a vote in their respective Committees**.** Would have provided up to 12-weeks of paid family leave. Paid Family Leave is associated with decreased infant mortality, improved child health, improved parent-child bonding, and reduced child maltreatment.

4. **Equitable Graduation Requirements for Foster Youth- SB564 (2020) passed both houses unanimously.** The legislation standardizes graduation requirements for foster youth throughout Maryland and increases the opportunity for youth to graduate.

5. **Child Welfare Data Bill- HB258/SB592 passed both houses unanimously.** The legislation requires the Maryland State Department of Education to provide DHS with disaggregated data by county, gender, race, and ethnicity on the educational outcomes for young people in foster care to allow for a collaborative inter-agency response.

6. HB771/SB548 **Public Schools - Centers for Disease Control and Prevention Surveys – passed both houses** requiring that at least five questions from the CDC's Adverse Childhood Experiences and Positive Childhood Experiences questions be included in Maryland's YRBS/YTS for high school and middle school students.

7. **SCCAN and MD EFC Members participated in the 2019-2020 Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations created by SB 567 (2019).** The final report was submitted to the Governor and General Assembly in September of 2020 and included recommendations on 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. Three pieces of legislation were introduced by Workgroup Members Senators Susan Lee and Mary Beth Carozza and Delegate Vanessa Atterbeary in the 2021 legislative session HB748/SB57, Family Law- Child Custody and Visitation passed each house in different forms by significant margins, but not in enough time to be reconciled and passed by both houses. Neither HB1036 nor SB675, Child Custody – Cases Involving Child Abuse or Domestic Violence – Training for Judges and Child's Counsel received a vote in their respective Committees. SB355, Family Law – Custody Evaluators – Qualifications and Training did not receive a vote in the Senate Judicial Proceedings Committee.

8. **Family Investment Program - Temporary Cash Assistance – Eligibility- HB1313 (2020)- 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. Increases in family income improve family stability, reduce family stress, and prevent adverse childhood experiences

- 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. Md. Code Ann., Human Services § 8-1101- 8-1103 (2018) mandates:
        i. the creation of a Child Welfare Medical Director at DHS to:
            1. Ensure best practice medical review and evaluation of cases of suspected abuse or neglect, and
            2. Collect data on timeliness and effectiveness of health services provision and procurement; track health outcomes; analyze the data to assess the competency of health providers and the supply and diversity of services; and identify and propose systemic solutions to problems affecting health care for children in foster care.

ii. the creation of a centralized data portal with health information integrated from CRISP (Chesapeake Regional Information System for Our Patients), Immunet, and Medicaid, and
iii. the creation of an electronic health passport for foster youth.

- DHS hired Dr. David Rose as Child Welfare Medical Director in April 2019 and he left the department in August 2021. Under Dr. Rose efforts toward improving the health care of children in foster care have included the following:
    - Drafted DHS policies regarding health care service oversight and monitoring to align 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. Requests for changes to the Code of Maryland Regulations (COMAR) to implement these changes have been made to MDH. A draft policy has been drafted by DHS SSA, and feedback has been requested.
    - Required quarterly and annual internal reporting on existing foster care entry and periodic preventive care exams began in September 2019.
    - Worked with MD THINK-CJAMS on the health-related measures for case management. This health-related measures section, like MD CHESSIE, still requires hand input by DSS foster care workers. In addition, there have been some challenges with inputting information in the correct fields, which may require additional worker training and/or improved explanation of specific data fields.
    - At the recommendation of the Maryland Chapter of the American Academy of Pediatrics, Dr. Rose reached out to Dr. Lisa Burgess at Maryland Medicaid requesting collaboration in a 1-year Centers for Medicare and Medicaid (CMS) quality improvement learning collaborative. Dr. Rose and Dr. Burgess were co-chairs until Dr. Rose left DHS. While the primary focus of CMS is on improving the quality of Comprehensive Health Assessments, Maryland's collaborative will also examine subsequent health care management. The first meeting of the Learning Collaborative was held on August 10th, 2021. However, with the resignation of Dr. Rose, there have been weekly meetings between Medicaid and DHS staff, but the full learning collaborative membership has not met again.
    - Worked with CRISP for more than a year to access CRISP for patient information. The medical director (Dr. Rose) alone was given approval to access CRISP. DHS has not yet completed the necessary steps to enable this access. Because access was granted to the medical director, since his departure, no one at DHS currently has permission to access CRISP data. Consequently, DHS has not made significant progress towards data sharing with CRISP.
- The following issues are still of major concern to the Council:
    - There has been little or no progress toward integrating information from Medicaid, Immunet, and/or CRISP with CJAMS, nor in developing an electronic health passport. Many other states and jurisdictions, including

Texas, Washington, Oregon, Illinois, Washington, D.C., Milwaukee, WI, Allegheny County, PA, San Diego County, CA, and Dade and Monroe Counties, FL have found ways to electronically link Medicaid records with child welfare records, enabling child welfare professionals to have more accurate information about health visits and medications.[34] In addition, Hamilton County, OH has implemented a program to link child welfare records with those of Cincinnati Children's Hospital. Such linkages reduce data entry errors, reduce duplication of services, and improve care coordination. Without this data, it is difficult, if not impossible to assess whether children are receiving quality care by HEDIS or other valid measures. In DHS' 2019 report to the Legislature on health care services for children in out of home placement, DHS noted that "planning is underway for memoranda of understanding with MCOs around data sharing and care coordination." While SSA has been holding monthly Health Workgroup meetings that include MCOs, representatives from county DSS agencies, and other stakeholders, there is no mention of this effort, nor their accomplishments in the 2020 report.

- There has been little or no progress toward ensuring best practice medical review and evaluation of cases of suspected abuse or neglect.
- Data from the 2020 Citizen's Review Board for Children Annual Report indicate that health care data and services remain incomplete. Of the 871 children in foster care reviewed by CRBC, only 370 (42%) had health care needs met, and 360 (41%) had completed medical records. In addition, 323 (37%) were prescribed psychotropic medications.
- The DSS foster care workers continue to have primary responsibility for health care oversight of the children in their caseload. A survey of Local DSS Assistant Directors indicated that only 4 of 20 responding counties (20%) had a formal medical director or consultant. Local agencies most often relied on primary care and mental health providers for input regarding individual cases. Some also used their Medicaid MCO or behavioral health case manager for input. Most respondents indicated that they would like additional assistance, particularly for mental and behavioral health issues, health and developmental issues, informed consent for psychotropic medication use, case management, and completion of required health visits.
- In the annual reports (MSAR #11703 – Report on the Current Status of Health Care Services for Children in Out-of-Home Placement 2019 and 2020) required by Md. Code Ann., Human Services § 8-1102(C), DHS has not responded to most issues enumerated in the legislation in SECTION 3. In particular, DHS has not provided information on MCOs provision of additional case management for children in foster care, they have not addressed benefits and challenges of implementing regional health care monitoring programs, and they have not examined linkages between DHS data and electronic health records.

[34] Beth Morrow, *Electronic Information Exchange: Elements that Matter for Children in Foster Care*, The Children's Partnership, State Policy Advocacy and Reform Center, 2013.

- Recommendations:
  - DHS, MDH: Direct Maryland Medicaid, CRISP, and the Child Welfare Medical Director to link Medicaid and CRISP data to CJAMS to meet the requirements of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the tracking of health care outcomes using HEDIS or other quality measures.
  - DHS: Create an electronic health passport to replace the current paper passport, as is required by Md. Code Ann., Human Services § 8-1101- 8-1103 (2018). This electronic passport is vital to ensure that foster youth, foster care workers, foster parents, biological parents, and health care providers have access to critical health information.
  - General Assembly: Hold a hearing regarding implementation and possible reforms to strengthen Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the issue of informed consent for psychotropic medications.
  - DHS, MDH: Direct the Child Welfare Medical Director, Medicaid, Medicaid Managed Care Organizations, and their special needs case managers to identify ways in which case managers can assist with ensuring health care needs of foster youth are met beyond the initial and comprehensive health screenings, including analyzing health care quality measures for children in care to meet the requirements of the statute.
  - DHS: Direct the Child Welfare Medical Director to work with Maryland CHAMP (Child Abuse Medical Professionals) to ensure best practice medical review and evaluation of cases of suspected abuse or neglect to meet the requirements of the statute.
  - DHS: Create at least 2 additional positions at DHS for physicians or nurse practitioners to assist the Medical Director in reviewing health care data, assessing quality of care, and providing input to local DSS agencies. One of these positions should be filled by a child psychiatrist to address the issue of psychotropic medication prescriptions for foster youth, including informed consent.

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

- SCCAN brought together 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 P). These guidelines were approved by SCCAN on May 7, 2020 and the Interagency Commission on School Construction on May 14, 2020.
- SCCAN worked with the Maryland Association of School Business Organizations (MD ASBO), MSDE, the Maryland Center for School Safety, Baltimore County Public Schools, R.L. Nichols & Associates, LLC - R. Leslie Nichols, CPP, and

Crabtree, Rohrbaugh Architects, to present two sessions, May 18th (***Legislative Mandates, Guidelines & Best Practices for Plan Development***, *PowerPoint pdf, recording*) and 19th (***Best Practices in Facility Design & Modification for Implementation***, *PowerPoint pdf, recording*) 2021, at the ASBO virtual conference in an effort to educate school business professionals on the implementation of 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***. The audiences consisted of architects, facilities planners, facilities inspectors, planning and design specialists, construction specialists, CADD technicians, safety, security, and risk managers, project managers, auditors, buyers, purchasing analysts, energy and sustainability managers, workmen's compensation analysts, human resources, staff relations managers, business services managers, information and technology specialists, monitoring, accountability, and compliance specialists, principal's and attendance secretaries, pupil transportation specialists, and government affairs for Maryland Association of Boards of Education.

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 future prosperity of any society depends on its ability to foster the health and well-being of the next generation. When Maryland invests wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship. The Council and Maryland Essentials for Childhood are grateful to the Governor and General Assembly for their progress in developing infrastructure to move strategies to prevent and mitigate ACEs and build resilient children, youth, families, and communities in our state.

GOVERNOR

Through his Executive Order on ACEs and funding of Project Bounce Back, Governor Hogan demonstrated the strong leadership necessary to raise awareness of Adverse Childhood Experiences (ACEs) and encourage state agencies and local communities to invent wise responses in support of our children and Maryland's future prosperity. As next steps in aligning public policy and practice with the science of the developing brain, we recommend that the Governor:

1. Educate all Children's Cabinet and senior-level management staff in N.E.A.R. science and science-based communications strategies.
2. Develop and implement a Trauma and Resilience-Informed State Action Plan[35] for Preventing and Mitigating Childhood Trauma/ACEs that:
    - Makes ***budgetary commitments*** to prevent and mitigate ACEs, ***including staffing an Office of Resilience*** similar to those in neighboring Pennsylvania and New Jersey to lead ACEs/trauma/resilience work
    - Establishes a ***public/private collaboration*** to serve as ***infrastructure*** to prevent and mitigate the impacts of ACEs on Marylanders and assures local solutions to address community issues. Recruit champions from all three branches of government, as well as private funders, business, faith-based, and local community leaders, and experts in trauma and resilience to participate.[36]
    - Develops an ***ACE awareness and mobilization campaign, employing N.E.A.R. science and communication science strategies,*** to develop common unified language and messages when communicating about ACEs, trauma, and healthy social, emotional, and physical development.[37] Partner with the FrameWorks Institute, an interdisciplinary team of social scientists, linguists, and communications practitioners who work with policy makers, funders, and others to frame complicated social and scientific issues in understandable, actionable terms.
        - Partner with 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

[35] Trauma-Informed PA: A Plan to Make PA a Trauma-Informed, Healing-Centered State, July 2020.; NJ ACEs Statewide Action Plan, February 2021

[36] 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)

[37] See *Building Strong Brains Tennessee*.

brain development. A similar plan in Tennessee included:

a. Three scientific symposia: Neurobiology, the Science of Programmatic Innovations, and the Science of Policy Innovations
b. Four three-day "Frame Labs" in which individuals from all sectors and professional disciplines learned values and metaphors that help even people who have no familiarity with child development.
c. A three-day "Train the Trainer" workshop for curriculum designers and agency training leaders
d. Ongoing technical assistance and a review of materials
e. Advisory services for the initiative steering group
f. 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.).

- Develops a ***framework or standard for state child and family serving agencies*** to become ***designated*** a ***trauma-informed agency***[38]
- ***Surveys current ACEs, trauma-informed, and resilience efforts*** in state agencies, agencies contracted by the state and local communities and ***builds upon those efforts***
- Develops and/or adopts ***cross-agency, cross-sector ACEs training*** for agencies, providers, and communities; as well as, ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation***.
- ***Enhances the State's ACEs surveillance system, data collection and analysis*** building upon the work of the ACEs Cross-Agency Data Workgroup led by the Behavioral Health Administration.
- ***Promotes the creation of local community based cross sector coalitions***
- Includes a ***strong focus on early childhood,*** ensuring safe, stable, nurturing relationships and environments from the start
- ***Incorporates 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
- ***Aligns with the work of the Trauma-Informed Care and Health Equity Commissions*** and other trauma-informed, health equity, and racial equity efforts in the state (See Appendix H)

3. 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[39]

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

1. Ensure that the Children's Cabinet standing agenda includes ACE-related agenda items.
2. Educate all Children's Cabinet and senior-level management staff in N.E.A.R. science and science-based communications strategies.
3. Develop and implement a Trauma and Resilience-Informed State Action Plan for Preventing and Mitigating Childhood Trauma/ACEs that:
    - Makes ***budgetary commitments*** to prevent and mitigate ACEs, ***including staffing an Office of***

[38] The Missouri Model: A Developmental Framework for Trauma-Informed Approaches; Delaware Developmental Framework for Trauma Informed Care
[39] https://ctfalliance.org/

Resilience similar to those in neighboring Pennsylvania and New Jersey to lead ACEs/trauma/resilience work

- Establishes a ***public/private collaboration*** to serve as ***infrastructure*** to prevent and mitigate the impacts of ACEs on Marylanders and assures local solutions to address community issues. Recruit champions from all three branches of government, as well as private funders, business, faith-based, and local community leaders, and experts in trauma and resilience to participate.
- Develops an ***ACE awareness and mobilization campaign, employing N.E.A.R. science and communication science strategies,*** to develop common unified messages about the importance of early childhood development, safe, stable and nurturing environments and how to build coping skills and community resilience. (Add link/footnote to BSBT) Partner with the FrameWorks Institute, an interdisciplinary team of social scientists, linguists, and communications practitioners who work with advocates, policy makers, funders, and others to frame complicated social and scientific issues in understandable, actionable terms. (See Governor's recommendation #2 for further details)
- Develops a ***framework or standard for state child and family serving agencies*** to become ***designated*** a ***trauma-informed agency***.
- ***Surveys current ACEs, trauma-informed, and resilience efforts*** in state agencies, agencies contracted by the state and local communities and ***builds upon those efforts***
- Develops and/or adopts ***cross-agency, cross-sector ACEs training*** for agencies, providers, and communities; as well as, ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation***.
- ***Enhances the State's ACEs surveillance system, data collection and analysis*** building upon the work of the ACEs Cross-Agency Data Workgroup led by the Behavioral Health Administration
- ***Promotes local community based cross sector coalitions***
- Includes a ***strong focus on early childhood,*** ensuring safe, stable, nurturing relationships and environments from the start
- ***Incorporates 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.
- ***Aligns with the work of the Trauma Informed Care and Health Equity Commissions*** and other trauma-informed and health equity efforts in the state. (See Appendix H)

4. Collect, review, analyze, and publish state and county-level ACE and positive childhood experiences (PCEs) module data from prior and ongoing Maryland Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey/Youth Tobacco Survey.

5. Integrate the science of the developing brain, ACEs, and resilience across agencies and within individual agencies by:

    - Participating in the development and implementation of a State Plan to Prevent and Mitigate ACEs
    - Identifying, designating, and empowering two staff from each agency with experience, expertise, and interest in brain, ACEs, and resilience science and multi-generational approaches to collaborate with sister agencies and serve as principal advisors to each agency Secretary/Director in trauma-responsive and trauma-informed care, including aligning agency training, policies, practices, and procedures with a trauma-informed approach, as required under Md. Code Ann., Human Services § 8-1301- 8-1308 (2021)

- ***Ensuring that your agency's communications tools and messaging embed the ACE awareness and mobilization campaign, based on N.E.A.R. science and communication science strategies***
- Considering the appropriateness of screening clients for ACEs and resilience factors[40]
- Providing the ***cross-agency, cross-sector ACEs training*** developed for agencies, providers, and communities through the work of the Trauma Informed Care Commission; as well as ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation to your all state and local agency staff***
- Ensuring that your ***local agency staff participate in local community based cross sector coalitions***
- Ensuring that state contracts require providers meet performance measures to become trauma-informed based on the above referenced Maryland developmental framework or standards for a trauma-informed approach
- Embedding the science into agency mission, vision, strategic planning, and technical assistance to local agencies: and, creating funding opportunities to local agencies for cross-sector planning and coordination of ACE prevention and mitigation efforts
- Ensuring agency policies and regulations reflect the science
- Ensuring agency practice models reflect the science
- Investing resources in evidence-based trauma prevention and treatment interventions and creating trauma-informed agencies[41]

6. 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).

7. 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.***[42]

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 that policy decisions enacted by the MGA will acknowledge and take into account the principles of early childhood brain development, consider the concepts of toxic stress, adverse childhood experiences, and buffering relationships, and, note the role of promotion of healthy development, 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

[40] 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*.
[41] See the National Child Traumatic Stress Network for resources on creating trauma-informed systems.
[42] See 2019 SCCAN Report and the updated Appendix O

in human capital.[43]

4. Pass legislation establishing a robust Children's/ACEs Prevention Trust Fund.[44]

   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. Amend HB771/SB548 (2021) which requires ongoing inclusion of ACE questions in the YRBS but will require only 5 questions. Amend the bill to mandate that the 5 ACE questions be alternated by YRBS every two years so that all 10 ACE questions are included during each 4-year interval. Data on ACEs and protective factors should be analyzed for each Maryland jurisdiction.

6. Pass legislation to amend Md. Code Ann., Family Law § 5-1312 (2021) to:
   - Expand data currently collected by Maryland's Department of Human Services within their Child Welfare Indicators Report. Additional indicators include:
     i. The number of referrals and the number of screened-in and screened out referrals
     ii. The number of referrals (both screened in and screened out) by referral source (i.e., school, medical professionals, neighbors, family/friends, etc.)
     iii. The number of referrals (both screened in and screened out) by abuse type; and, more specifically, when a youth is referred to the Department as a result of neglect this information should be disaggregated by risk factor (food insecurity, housing status, poverty, etc.).
     iv. The stability of early care and education as measured by number of child care provider placements
     v. The number and percentage of children 0-5 in a quality childcare program as defined by Maryland Excels
     vi. The number and percentage of children 0-5 in informal childcare
     vii. The number and percentage of children with CPS involvement referred to Infants and Toddlers

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[43] 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

[44] The National Alliance for Children's Trust & Prevention Funds.

viii. The number and percentage of children and youth receiving all Early Periodic Screening Diagnosis and Treatment visits recommended by Maryland Healthy Kids.
ix. Data collected by child welfare medical director as defined in MD Human Services Code Section 8-1101 (2018)
x. All indicators disaggregated by race, age, gender, and geographic region.

- Expand data collected by the Maryland State Department of Education. Additional indicators include:
    - The number and percentage of all Maryland children with a current individualized education plan
    - The number and percentage of children in out-of-home placement with a history of individualized education plans.
    - The number and percentage of children in out-of-home placement with a current individualized education plan.
    - The number and percentage of children in out-of-home placement with an individualized family services plan.
    - Rate of college and postsecondary application, acceptance, and attendance amongst youth in out-of-home placement.
    - All indicators disaggregated by race, age, gender, and geographic region.

7. Pass legislation requiring all mandated reporters in the state of Maryland to receive racial bias training focused on the role of bias and racism in child abuse and neglect reporting.

8. Pass legislation requiring all DHS employees and local DSS supervisors and caseworkers in the state of Maryland to receive racial bias training focused on the role of bias and racism in decision-making throughout the continuum of child welfare cases.

9. 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.

10. 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 Q) Nine states have no civil statute of limitations for child sexual abuse.[45] Eleven states and the District of Columbia have created look back windows.[46] 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

[45] Child USA, 2019 Alaska, Connecticut, Delaware, Florida, Illinois, Maine, Minnesota, Nebraska, and Utah.

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

- Shifting the costs for treatment and recovery after sexual abuse from the victim to those who caused the harm
- Providing justice for victims ready to come forward

11. 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.

12. 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 that all state agencies, nonprofits, community-based organizations and businesses serving children and youth 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 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.

13. Hold a hearing regarding implementation and possible reforms to strengthen Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the issue of informed consent for psychotropic medications.

14. Pass legislation requiring an ongoing training program for judges who preside over child custody cases that involve domestic violence or child abuse as laid out in Workgroup to Study Child Custody Proceedings Involving Child Abuse or Domestic Violence Allegations Final Report.

JOINT DHS & MDH

In order to meet the requirements of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018):

1. Direct Maryland Medicaid, CRISP, and the Child Welfare Medical Director to link Medicaid and CRISP data to CJAMS to meet the requirements of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the tracking of health care outcomes using HEDIS or other quality measures.

2. Direct the Child Welfare Medical Director, Medicaid, Medicaid Managed Care Organizations, and their special needs case managers to identify ways in which case managers can assist with ensuring health care needs of foster youth are met beyond the initial and comprehensive health screenings, including analyzing health care quality measures for children in care to meet the requirements of the statute.

3. 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 care services to children within the child welfare system. Suggested members of this panel are included

in the footnote[47]. The Panel's responsibilities should include:

- 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

1. See Children's Cabinet agency recommendations above.

2. Create an electronic health passport to replace the current paper passport, as is required by Md. Code Ann., Human Services § 8-1101- 8-1103 (2018). This electronic passport is vital to ensure that foster youth, foster care workers, foster parents, biological parents, and health care providers have access to critical health information.

3. Direct the Child Welfare Medical Director to work with Maryland CHAMP (Child Abuse Medical Professionals) to ensure best practice medical review and evaluation of cases of suspected abuse or neglect to meet the requirements of the statute.

4. Create at least 2 additional positions at DHS for physicians or nurse practitioners to assist the Medical Director in reviewing health care data, assessing quality of care, and providing input to local DSS agencies. One of these positions should be filled by a child psychiatrist to address the issue of psychotropic medication prescriptions for foster youth, including informed consent.

[47] 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
- MDH, Medicaid;
- MDH, Behavioral Health;
- DHS and MDH representatives with expertise in their agency's child fatality review processes;
- Maryland State's Attorney's Association;
- County health department representatives;
- County DSS agency representatives;
- Maryland Legal Aid Bureau;
- Maryland CASA;
- GOCPYVS/VOCA
- Programs that currently contribute to medical and forensic services funding for children in the child welfare system

5. .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.

6. Identify, designate, and empower two staff from DHS with experience, expertise, and interest in brain, ACEs, and resilience science and multi-generational approaches to collaborate with sister agencies and serve as principal advisors to the Secretary in trauma-responsive and trauma-informed care, including aligning agency training, policies, practices, and procedures with a trauma-informed approach, as required under Md. Code Ann., Human Services § 8-1301- 8-1308 (2021).[48]

7. Require caseworkers to input race demographic data on all cases brought to the attention of DHS/SSA/local DSS. Recent data received from DHS/SSA indicates that of all new child abuse and neglect cases in fiscal year 2020, nearly a quarter did not include the race of the child.

8. Collect and make publicly available disaggregated data (race, gender, age, and geographic region) on the following indicators:
   i. The number of referrals and the number of screened-in and screened out referrals
   ii. The stability of early care and education as measured by number of child care provider placements
   iii. The number and percentage of children 0-5 in a quality childcare program as defined by Maryland Excels
   iv. The number and percentage of children 0-5 in informal childcare
   v. The number and percentage of children with CPS involvement referred to Infants and Toddlers
   vi. The number and percentage of children and youth receiving all Early Periodic Screening Diagnosis and Treatment visits recommended by Maryland Healthy Kids.
   vii. Data collected by child welfare medical director as defined in MD Human Services Code Section 8-1101 (2018)

9. The 2020 Department of Human Services, Child Welfare Indicators Report, indicates that 38% of children reported for suspected child abuse and neglect were Black Youth although Black Youth only make up 33% of the child population in MD. We recommend that:
   - DHS disaggregate referral (both screened in and screened out) data further by abuse type; specifically, when a youth is referred to the Department as a result of neglect this information should be disaggregated by risk factor (food insecurity, housing status, poverty, etc.).
   - DHS collect referral source data and disaggregate referral data by the source type. (i.e. School, medical professionals, neighbors, family/friends, etc.)

10. According to DHS, 60% of reports received are screened out. We recommend that:
    - DHS disaggregate all referrals data, screened in and screened out, by race, age, gender, and geographic region.

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

11. Ensure that leaders and participants in the development of MD THINK and CJAMS include experts in child welfare policy, database design and data management, and child health and health policy (the State Medical Director for Children Receiving Child Welfare Services) so that the system can effectively:

    - Integrate child-welfare, birth, and death data in order to analyze fatal maltreatment risks.
    - Collect longitudinal data on foster youth and their families so that well-being and long-term outcomes can be tracked. These outcomes should include frequency of placement changes, frequency of school changes, and medical and mental health services needed and received. This was a repeated recommendation included in DHS's Quality Assurance Processes in Maryland Child Welfare.[49]
    - 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 change placements, how often they change schools, whether they are hospitalized, and whether they need in-patient psychiatric treatment.
    - Track when (from referral through risk of harm, investigative and alternative responses, foster care placement, reunification, and kinship and adoption) families are determined to need services, determine whether those services were received, and if not received, identify the reasons why not.[50]

12. Increase efforts that promote fathers' and mothers' male partners' emotional support, rather than solely financial support, of their children and families.

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[49] 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)

[50] 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.**

- 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)

Social Services Administration

1. See Children's Cabinet recommendations above.

2. See Joint MDH-DHS recommendations above.

3. See DHS recommendations above.

4. Work with the Administrative Office of the Courts and MDH/BHA to expand Safe Baby Court Teams across the state, as evaluations have identified improved outcomes for children. [51]

5. Child Welfare data, including referrals, pathways, and service provision, should be disaggregated by race, ethnicity, gender, and socio-economic status. This data should be publicly available on a regular basis.

6. 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.

7. 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.

8. 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.

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

MDH

1. See Children's Cabinet recommendations above.

[51] *How does the Safe Babies Court Team™ approach improve outcomes for infants and toddlers?* Casey Family Programs Strategy Brief, November 2019.

2. See Joint MDH-DHS recommendations above.

3. Work with DHS and the Administrative Office of the Courts to expand Safe Baby Court Teams across the state, as evaluations have identified improved outcomes for children.[52]

4. 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.

5. Continue to collect BRFSS every three years and YRBS/YTS ACE module data in Maryland every two years. Resilience questions[53] similar to those being asked in Wisconsin's BRFSS should be added to Maryland BRFSS modules. The CDC YRBS 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[54].

6. 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.
    - The YRBS ACE questions should be expanded to include all 10 ACEs. Legislation that passed in the 2021 legislative session will require ongoing inclusion of ACE questions in the YRBS but will require only 5 questions. We recommend that ACE questions be alternated by YRBS year so that all 10 ACE questions are included during each 4-year interval. Data on protective factors should be examined for each Maryland jurisdiction.

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

8. 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.

[52] Ibid.
[53] See Appendix R
[54] See Appendix I
[55] See Appendix S

9. 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.[56]

10. 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.[57]

11. Streamline the Postpartum Infant and Maternal Referral (PIMR) form and completion process in partnership with local health departments and birthing hospitals.[58]

12. Link completion of MPRA and PIMR and linkage to services to service provider fee payment.[59]

13. 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.

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

15. 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.

16. 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.

17. 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[60].

18. Fund the baseline collection of child maltreatment Awareness, Commitment, and Norms Survey[61]

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

[57] Ibid.

[58] 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.

[59] Ibid.

[60] See Appendix S

[61] See Appendix R

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.

MSDE

1. See Children's Cabinet recommendations above.

2. Support the collection of data on all ACE and resilience questions[62] recommended by the CDC through the Maryland YRBS/YTS for all middle schoolers and high schoolers.

3. Collect and make publicly available disaggregated data (race, gender, age, and geographic region) on the following indicators:
    i. The number and percentage of all Maryland children with a current individualized education plan
    ii. The number and percentage of children in out-of-home placement with a history of individualized education plans.
    iii. The number and percentage of children in out-of-home placement with a current individualized education plan.
    iv. The number and percentage of children in out-of-home placement with an individualized family services plan.
    v. Rate of college and postsecondary application, acceptance, and attendance amongst youth in out-of-home placement.

4. 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.

5. 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.

[62] See Appendices I & R

ADMINISTRATIVE OFFICE OF THE COURTS

1. Support implementation of the Workgroup to Study Child Custody Proceedings Involving Child Abuse and Domestic Violence Allegations' final report recommendations on how State courts can incorporate the latest science regarding the safety and well-being of children and other victims of domestic violence into child custody proceedings, including legislation on training judges and child's counsel similar to HB1036 nor SB675, Child Custody – Cases Involving Child Abuse or Domestic Violence – Training for Judges and Child's Counsel.

2. Work with DHS and MDH/BHA to expand Safe Baby Court Teams across the state, as evaluations have identified improved outcomes for children.[63]

[63] *How does the Safe Babies Court Team™ approach improve outcomes for infants and toddlers?* Casey Family Programs Strategy Brief, November 2019.

APPENDIX A

DHS RESPONSE TO SCCAN'S 2019 ANNUAL REPORT

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

In January 2017, SCCAN's Chair and Executive Director met with representatives from DHS to thank the Department for its response to the 2015 SCCAN Annual Report, follow up on recommendations that were not addressed, and develop a more consistent dialogue between DHS and SCCAN. It was noted that some of the recommendations to the Governor and General Assembly did not fall under the authority of DHS (the agency responsible for responding to the SCCAN recommendations) and needed to be acted on by other state agencies or a combination of state agencies. Since the 2016 report, SCCAN has categorized recommendations by the specific agent/agency that has the authority to make the recommended systems change. ***Despite agency-specific recommendations, DHS's response has failed to acknowledge and address many of those recommendations and they remain unaddressed.***

The Agency responded by enumerating current agency efforts that might collaterally address some Council recommendations in the 2019 report:

- SSA efforts on trauma, resiliency, and brain science
- SSA efforts to increase collaboration with families and systems
- SSA efforts to improve data sharing and reporting
    - In late 2019 DHS/SSA began roll out of a new electronic child and adult welfare case management system, the Child Juvenile Adult Management System (CJAMS).
    - The letter asserts that "Access to more robust data will allow DHS/SSA to have more timely and relevant data exchange in order to more effectively serve youth and families."
    - In August 2020, the child welfare module of CJAMS was implemented in all Maryland jurisdictions.

Significantly DHS SSA did not respond as to whether, how, and or when the following DHS and SSA-specific recommendations would be addressed, nor how they were coordinating with their fellow Children's Cabinet agencies on cross-agency recommendations:

- "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 and parents receiving DHS services (Child Support Administration and Family Investment Administration, as well as SSA.)" *While SSA generally discusses its efforts to become a trauma-informed system, there is no mention of efforts within the sister administrations within DHS, nor any cross-agency work with the other child and family serving agencies in the state.*
- In support of effective implementation of HB 1582, Human Services-Children Receiving Child Welfare Services-Centralized Comprehensive Health Care Monitoring Program, 2018. *No mention is made of progress toward linking Medicaid and CRISP data to CJAMs, nor an electronic health passport*:

    - 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. *While there is mention that an expert panel is being considered, no timetable is offered for when a decision will be made on this proposal.*
- Child Welfare data should be disaggregated by race, ethnicity, gender, and socio-economic status. This data should be publicly available on a regular basis. *While there is a general mention in the DHS response that "Access to more robust data will allow DHS/SSA to have more timely and relevant data exchange in order to more effectively serve youth and families," DHS has been unable to provide accurate data on several of the requested indicators disaggregated by race for the current 2020-2021 report.*
- Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in foster care. Ensure that all adults, including foster parents, group homes, residential treatment centers, and licensed contractors involved with foster youth are trained and institute policies in child sexual abuse prevention. *No mention.*
- 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. *No mention.*
- Increase efforts that promote fathers' and mothers' male partners' emotional support, rather than solely financial support, of their children and families. *DHS's response regarding "Increasing collaboration with families" notably does not address specific attention to fathers. As historically fathers' voices have been overlooked, it would be helpful to know the specifics of how DHS/SSA is remedying this critical systems issue.*
- Involve fathers in child welfare cases as a matter of course. *DHS's response regarding "Increasing collaboration with families" notably does not address specific attention to fathers. As historically fathers' voices have been overlooked, it would be helpful to know the specifics of how DHS/SSA is remedying this critical systems issue.*
    - Collaborate with partners to further infuse fatherhood and male responsibility initiatives into settings with boys and men.
    - Make deliberate and special efforts to include male caregivers in attachment and parenting skills programs (e.g., Circle of Security Parenting, home visiting sessions).
- Ensure that MD THINK makes data improvements listed below. *While DHS/SSA suggests that "Access to more robust data [through CJAMs] will allow DHS/SSA to have more timely and relevant data exchange in order to more effectively serve youth and families," there is no mention of any specifics and no response regarding the requests for improved data below:*
    - Integrate child-welfare, birth, and death data in order to analyze fatal maltreatment.
    - Collect longitudinal data on foster youth and their families so we can track both their long-term outcomes and the quality of their well-being while they are in care. This was a repeated recommendation included in DHS's Quality Assurance Processes in Maryland Child Welfare.
    - MD CHESSIE's focus on point-in-time data has been a significant barrier in having a true picture outcomes for children and their families who touch our child welfare system. We need to know how often foster youth end up involved with the Department of Juvenile Services, how their educational achievement and health compares to their non-system involved peers, and for older foster youth who transition out of care, whether, as adults, they have stable financial, employment, housing, and parenting (i.e., their children do not end up in child welfare) outcomes.
    - 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 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, whether they receive those services, and if not, why not, and what follow up occurs.
- Screen in all children under 5 as Risk of Harm cases and do an in-home assessment of risk. Provide services for families at risk for child fatality or near fatality.
- 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.

As Council Members serve as a Citizens Review Panel collectively volunteering thousands of hours each year to develop thoughtful, specific, and implementable recommendations, the Council ***respectfully requests a specific response to each recommendation (i.e., whether or not DHS/SSA and/or sister agencies are or will act on the recommendation) in future reports so that barriers to implementation can be identified.***

APPENDIX B

State Council on Child Abuse and Neglect (SCCAN)

SCCAN Membership

15 MEMBERS APPOINTED BY THE GOVERNOR

Name	Representing	Jurisdiction	Email	Address
Wendy Lane, MD, MPH ***(SCCAN Chair)***	Clinical Associate Professor, University of Maryland (Epidemiology & Public Health, Pediatrics)	Baltimore County	wlane@epi.umaryland.edu	660 West Redwood Street Baltimore, MD 21201
Jena K. Cochrane	Personal experience	Anne Arundel County	jena_geb@verizon.net	1700 Basil Way, Gambrills, MD 21054
Janice Goldwater, LCSW-C	Executive Director, Adoptions Together	Montgomery County	jgoldwater@adoptiontogether.org	4061 Powder Mill Road Suite 320 Calverton, MD 20705
Elizabeth Letourneau, PhD	Director, The Moore Center for the Prevention of Child Sexual Abuse, Johns Hopkins University, Bloomberg School of Public Health	Baltimore City	eletourn@jhsph.edu	Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe Street Baltimore, MD 21205

Name	Representing	Jurisdiction	Email	Address
Veto Anthony Mentzell, Jr.	Law Enforcement Officer, Harford County Sheriff's Department Program Director, Harford County Child Advocacy Center	Harford County	mentzellv@harfordsheriff.org	Harford County Sheriff's Office 45 South Main Street P.O. Box 150
Catherine Meyers	Director, Center for Children, Inc.	Charles County	meyers@center-for-children.org	Center for Children, Inc. 6100 Radio Station Road, P.O. Box 2924, La Plata, MD 20646
Linda Robeson	Business Community Representative	Anne Arundel County	lindasrobeson@gmail.com	306 Fairtree Drive Severna Park, MD 21146
Melissa Rock, Esq	Director, Child Welfare, Advocates for Children & Youth (ACY)	Baltimore City	mrock@ac y.org	Advocates for Children & Youth, One N. Charles Street, Suite 2400, Baltimore, MD 21201
Danitza Simpson	Director, Adelphi/Langley Family Support Center	Prince George's County	Dsimpson@pgcrc.org	Adelphi/Langley Family Support Center, 8908 Riggs Road Adelphi, Maryland 20783
Joan Stine	The Family Tree (Prevent Child Abuse, Maryland), Children's Justice Act Committee Liaison, Public health expert	Howard County	stinejg@yahoo.com	2614 Liter Court, Ellicott City, MD 21042-1729

8 POSITIONS FILLED BY DESIGNATION OF THEIR ORGANIZATIONS

Name	Representing	Email	Address
Stephanie Cooke, LCSW-C	Supervisor, Child Protective Services and Family Preservation, Social Services Administration, Maryland Department of Human Services	Stephanie.Cooke@maryland.gov	Maryland Department of Human Resources Social Services Administration, 5th Floor 311 W. Saratoga St. Baltimore, MD 21201
VACANT.	State's Attorney Association		
Delegate Susan K.C. McComas	Maryland House of Delegates	susan_mccomas@house.state.md.us	Maryland House of Delegates 9 West Courtland Street P.O. Box 1204 Bel Air, MD 21014
VACANT	Department of Juvenile Services		State of Maryland Department of Juvenile Services 120 W. Fayette St. #505 One Center Plaza Baltimore, MD 21201
The Honorable Karla Smith, Montgomery County Circuit Court	Representative of the Judicial Branch appointed by the Chief Judge of the Maryland Court of Appeals		Montgomery County Circuit Court 50 Maryland Avenue Rockville, MD 20850
John McGinnis	Pupil Personnel Specialist, Maryland Department of Education	john.mcginnis@maryland.gov	Pupil Personnel Specialist Maryland Department of Education 200 West Baltimore St. Baltimore, MD 21201
Courtney McFadden, MPH	Deputy Director, Prevention and Health Promotion Administration, Maryland Department of Health	courtney.mcfadden@maryland.gov	Maryland Department of Health 201 W Preston Street Baltimore MD 21201
VACANT	Maryland Senate		

SPECIALLY DESIGNATED MEMBERS OF CHILDREN'S JUSTICE ACT COMMITTEE

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

SCCAN EXECUTIVE DIRECTOR

Name	Relevant Background	Email	Phone	Address
Claudia Remington, Esq.	Attorney, Mediator, and CASA volunteer	Claudia.remington@maryland.gov	Office: 410-767-7868 Cell: 240-506-3050	311 W. Saratoga Street, Room 405, Baltimore, MD 21201

APPENDIX C

ACHIEVING RACIAL EQUITY IN CHILD WELFARE WORKGROUP MEMBERS

CO-CHAIRS:

Erica Lemon, Maryland Legal Aid

Rachel White, Advocates for Children and Youth

MEMBERS:

Andrew Bell, JBS International

Stacey Brown, The Family Tree

Patricia Cobb-Richardson, Behavioral Health Systems Baltimore

Stephanie Cooke, SCCAN, DHS, SSA

Eiza Cooper, Thriving Communities Collaborative

Serafinam Cooper, MDH

Patricia Cronin, The Family Tree

Noy Davis, First Star

Courtney Dowd, Child Justice, Inc.

Janice Goldwater, SCCAN, Adoptions Together

Dr. Edwin Green, Jr., Citizens Review Board for Children

William Jernigan, GOCPYVS

Eileen King, Child Justice, Inc.

Vlada Kirilenko, SCCAN Intern, Johns Hopkins University student

Sara Lewis, MDH

Carletta Lundy, City of Bladensburg Council Member

Courtney McFadden, SCCAN, MDH

Amanda Odorimah, Hearns Law Group

Meghan Resler, Maryland CASA

Davina Richardson, Citizens Review Board for Children

Linda Robeson, SCCAN

Dr. Michael Sinclair, Morgan State University

Joan Stine, SCCAN, The Family Tree

Vanita Taylor, Office of the Public Defender

Denise Wheeler, Citizens Review Board for Children

D'lisa Worthy, MDH. BHA

APPENDIX D

COVID-19 CHILDHOOD RESILIENCE ACTION TEAM MEMBERS & ORGANIZATIONS

CHAIR:

Frank Kros, Kros Learning Group

COORDINATING COMMITTEE:

Quinton Askew, 211 Maryland

Dave Brown, Echo Resource Development

Kay Connors, University of Maryland, Taghi Modarressi for Infant Study

Marianne Gibson, Opioid Operational Command Center

Jessica Lertora, Frederick County Safe Babies Court Team

Amie Myrick, Amatus Health

Claudia Remington, SCCAN

Joan Stine, SCCAN, Maryland Essentials for Childhood

D'Lisa Worthy, Maryland Department of Health, Behavioral Health Administration, Child, Adolescent and Young Adult Services Unit, Early Childhood Services

MEMBERS:

Adoptions Together – Janice Goldwater

Allegany County Library System – John Taube

Behavioral Health Systems Baltimore – Stacey Jefferson, Patricia Cobb Richardson

Bricks4Kidz – Nana Ama Adom-Boakye

Cecil County Local Management Board – Jan Brewer

Child Advocacy Center of Frederick, ACEs Workgroup, Interagency Early Childhood Committee– Pilar Olivo

Citizens Review Board for Children – Denise Wheeler

Family Informed Trauma Treatment Center – Laurel Kiser

First Star Institute – Noy Davis

Franklin Law Group – Ashley Edwards, Cherie Jones

Governor's Office of Crime Prevention, Youth, and Victims Services – William Jernigan

Greater Baltimore Medical Center Healthcare – Gregory Shaffer

Maryland Chapter of the American Academy of Pediatrics – Scott Krugman, MD

Maryland Court Appointed Special Advocates (CASA) – Ed Kilcullen, Meghan Resler

Maryland Department of Health, Center for Harm Reduction Services, Infectious Disease Prevention and Health Services Bureau, Prevention and Health Promotion Administration – Marie Stratton

Maryland State Department of Education, Division of Student Support, Academic Enrichment, and Educational Policy – John McGinnis

Maryland Department of Health, Center for Injury and Sexual Assault Prevention – Sarafina Cooper

Maryland Department of Human Services, SSA – Marcia Morris, Tawanda Epps

Maryland Emergency Management Agency – Teresa Heath

No More Stolen Childhoods – Vanessa Milio

RENEW Your C.O.R.E. – Michelle Solloway

Roberta's House – Annette March-Grier, Veronica Land-Davis

Linda Robeson

St. Mary's County Health Department, Behavioral Health Division – Stephanie Scharmen

Sustainable Life Solutions, LLC – Naketta Lowery

TCYSB – Laurel James

Thriving Communities Collaborative – Eliza Cooper

The Family Tree – Stacey Brown, Patricia Barger, Pat Cronin

The Lourie Center for Children's Social and Emotional Wellness – Jimmy Venza

The Promise Resource Center – Kelly Hutter

University of Maryland Extension Program – Alexander Chan

University of Maryland Medical Center – Deborah Badawi, MD

University of Maryland School of Medicine, Department of Psychiatry and Taghi Modaressi Center for Infant Study, Division of Child and Adolescent Psychiatry – Kay Connors

University of Maryland School of Pharmacy, Pharmaceutical Health Services Research Department, Behavioral Health Resources and Technical Assistance Program – Nicole Sealfon

Walden Pyramid Healthcare – Breana Pearsall, Roy Maddox

Sponsored By: The Family Tree

MARYLAND essentials for childhood

SCCAN Maryland's State Council on Child Abuse and Neglect

APPENDIX E

THE ACE INTERFACE PROJECT
ACE INTERFACE MASTER TRAINERS & PRESENTERS LIST

1. Rachel Abbott-Gray, Somerset County Public Schools
2. Catherine Abrams, Eastern Correctional Institution/Salisbury University
3. Dorinda Adams, Maryland Department of Human Services-Adult Protective Services
4. Nana Ama Adom-Boakye, Health and Well-Being International/Bricks 4 Kidz
5. William Allen, Caroline County Public Schools
6. Staci Aperance, Worcester County Public Schools
7. Ulysses Archie, Jr., Community Advocate, Baltimore Gift Economy
8. Joy Ashcraft, Maryland Army National Guard
9. Vanessa Atterbeary, Maryland House of Delegates
10. Carol Auerbach, Baltimore City Department of Social Services
11. Jessica Baker, Talbot County Public Schools
12. Khadim Baluch, Baltimore City Public Schools
13. Patricia Barger, The Family Tree
14. Amy Beal, Maryland State Department of Education
15. Andrew Bell, JBS International, Inc.
16. Leah Bentfield, Outward Bound
17. Christina Bethell, Johns Hopkins Bloomberg School of Public Health
18. Wendy Blackwell, Center for Urban Families
19. Tara Blades, Talbot County Public Schools
20. Keisha Blake, I Am Me Project, Inc.
21. Latisha Bordley, Caroline County Public Schools
22. Jan Brewer, Harford County Community College
23. Stacey Brown, The Family Tree
24. Kimberly Buckheit, Maryland State Department of Education
25. Andrea Butler, Aetna Better Health of Maryland
26. Cara Calloway, Caroline County Public Schools
27. Shannon Cassidy, Washington County Public Schools
28. Kip Castner, United States Department of Health and Human Services, Health Resources and Services Administration (HRSA)
29. Alexander Chan, University of Maryland Extension
30. Chanei Clemons, Roberta's House
31. Sandra Colea, Citizens Review Board for Children
32. Vonda Colson, Baltimore City Health Department
33. Kristy Conklin, Voices of Hope
34. Nicole Conner, Queen Anne's County Public Schools
35. Kay Connors, University of Maryland, National Child Traumatic Stress Network
36. Eliza Cooper, Thriving Communities Collaborative
37. Miera Corey, Behavioral Health Systems Baltimore
38. Tracey Cottman, Somerset County Public Schools
39. Stella Lee Coulbourne, Caroline County Public Schools
40. Laverne Cray, Worcester County Public Schools

41. Charlene Creese, Worcester County Public Schools
42. Patricia Cronin, The Family Tree
43. Robin Davenport, Maryland Court Appointed Special Advocates Association (CASA)
44. Shekinah Davis, Maryland Court Appointed Special Advocates Association (CASA)
45. Rebecca DeHoff, Caroline County Public Schools
46. Stacy Doak, Washington County Public Schools
47. Michael L. Dorsey Sr., Maryland Department of Human Services
48. Kim Dumas, Washington County Public Schools
49. Barbara Dziedzic, Baltimore City Public Schools
50. Brittany Echols, Baltimore City Public Schools
51. Guli Fager, Independent Practice
52. Ann Ferkler, Caroline County Public Schools
53. Jennifer Fiechtner, Center for Children, Inc.
54. Nicole Fisher, Caroline County Public Schools
55. Doria Fleisher, Charles County Government
56. Leslie Follum, Queen Anne's County Public Schools
57. Stephanie Freeman, St. Mary's Health Department
58. Melita Friend, CARE 1st Wellness & MedMark Treatment Centers
59. Laurie Galloway, On Our Own of Carroll County, Inc.
60. Charles Gammons, Charles County Public Schools
61. Sandra Gammons, Charles County Public Schools
62. Elizabeth Garcia, Children's Guild
63. Ivy Garcia, For All Seasons
64. Denise Garman, Archdiocese of Baltimore City
65. Carmen Getty, Advanced Systems
66. J David Gibbons, Caroline County Public Schools
67. Michelle Gilliam, Charles County Public Schools
68. Heather Glass, APPLES for Children, Inc.
69. Myra Sturgis Glover, Anne Arundel County Public Schools
70. Julissa Gomez, University of Maryland-Baltimore County, The Choice Program
71. Keiona Gorham, Wide Angle Youth Media
72. Latrice Gray, Salisbury University
73. Angela Gray, Office on Mental Health
74. Tonya Green-Pyles, Baltimore County Health Department
75. Raymond Greene-Joyner, The Family Tree
76. Paul Griffin, Child Justice, Inc.
77. Euphemia Griffin, Restoration Community Development Corporation
78. Amber Guthrie, Maryland Network Against Domestic Violence
79. Sara Haina, Calvert County Behavioral Health
80. Jasmin Haley, University of Maryland Dental School/Beyond the Prophy
81. Nikki Ham, Bowie State University
82. Heather Hanline, Dove Center
83. Heather Harding, Caroline County Public Schools
84. Tarik Harris, Maryland State Department of Education
85. Joyce Harrison, Johns Hopkins Bloomberg School of Public Health
86. Lori Hauser, The Family Tree, Board Member
87. Candace Hawkins, Aetna Better Health of Maryland
88. Jay Hessler, Frederick County Health Department
89. Angela Holocker, Kent County Public Schools

90. Veronica Hopkins, Baltimore City Public Schools
91. Tyvon Horsey, Caroline County Public Schools
92. Jenny Howard, Worcester County Public Schools
93. David Humphries, Frederick County Public Schools
94. Stephanie Hutter-Thomas, Maryland Rural Opioid Training Assistance (MD ROTA)
95. Kelly Hutter, The Promise Resource Center
96. Kim Jackson, The Family Tree
97. Donna Jacobs, University of Maryland Medical System
98. Tasha Jamison, Wicomico County Health Department
99. Lauren Jenkins, Department of Juvenile Services
100. William Jernigan, Governor's Office of Crime Control and Prevention
101. Debra Johnson, Maryland Department of Transportation
102. Joan Johnson, Howard County Office of Children and Families
103. Chari Jones, Somerset County Public Schools
104. Lindsay Julius, Talbot County Public Schools
105. Jahneen Keatz, Baltimore City Public Schools
106. Susan Kerin, Capital Consulting Corporation
107. Allie Ketterman, Talbot County Public Schools
108. Diane King-Shaw, Lourie Center School
109. Melissa King, Kent County Health Department
110. Frank Kros, Kros Learning Group
111. Lucane LaFortune, Maryland Network Against Domestic Violence
112. Michelle Lancaster, St. Mary's County
113. Beth Anne Langrell, For All Seasons
114. Jessica Lertora, Zero to Three
115. Sadie Liller, Garrett County Health Department
116. Naketta Lowery, Sustainable Life Solutions LLC
117. Christine Lybolt, Caroline County Public Schools
118. Sarah Manekin, The Abell Foundation
119. Angela Martin, Maryland Community Action Partnership
120. Jennifer Martinez, St. Mary’s Health Department
121. Shelley Mason, Worcester County Board of Education
122. Shantay McKinily, University of Maryland School of Social Work Positive Schools
123. Kia McKinney, Caroline County Public School
124. Dillon McManus, Maryland Department of Health
125. Sheryl Menendez, Restoration Community Development Corporation
126. Veto Mentzell, Harford County Sheriff's Office
127. Denise Messineo, Thallo Leadership Consulting/Citizens Review Board of Children
128. Cathy Meyers, Center for Children, Inc.
129. Meredith Miller, Wicomico County Public Schools
130. Crystal Miller, Wraparound Maryland, Inc.
131. Erica Moltz, Adoptions Together
132. Emily Moody, Talbot County Public Schools
133. Patty Morison, Child Care Choices
134. Tina Morris, Talbot County Public Schools
135. Pat Mosby, Montgomery County Federation of Families for Children's Mental Health
136. Amie Myrick, Licensed Clinical Professional Counselor
137. Deborah Nelson, Maryland State Department of Education
138. Jess Nesbitt, Maryland Department of Health

139. Stephanie O'Hara, Somerset County Public Schools
140. Pilar Olivo, Frederick County Office for Children and Families
141. Jessica Oterson, Anne Arundel County Public Schools
142. Pam Brown, Anne Arundel County Partnership for Children, Youth, and Families
143. Ruby Parker, The Family Tree
144. Twanda Pickett, Baltimore City Public Schools
145. Donnell Pinder, Dorchester County Public Schools
146. Megan Pinder, Queen Anne's County Public Schools
147. Alexandra Podolny, Harm Reduction Community
148. Kathy Powderly, Hagerstown Religious Council
149. Melissa Prettyman, Caroline County Public Schools
150. Cherry Melissa Price, Prince George's County Public Schools
151. Jim Raley, Archway Station
152. Jennifer Redding, Family & Children's Services/Harford Counseling
153. Amber Reed, Boys and Girls Club of Metro Baltimore
154. Kristin Reel, Howard County Government
155. Claudia Remington, Maryland State Council on Child Abuse and Neglect
156. Victoria Rentz, Maryland State Department of Education, Juvenile Services Education
157. Kimberly Repass, Calvert County Public Schools
158. Kelly Reynolds, Outward Bound
159. Jennifer Roberts, The Family Tree
160. Lindsay Robeson, St. Mary's Public Schools
161. Sean Robinson, Johns Hopkins University Workforce Development
162. Steve Rohde, Maryland Family Network
163. Eric Rollins, Western Maryland Consortium
164. Martha Ruiz, Family Partnership of Frederick County
165. Matila Sackor-Jones, The Family Tree
166. Terrell Sample, Maryland State Department of Education
167. Alisha Saulsbury, For All Seasons
168. Stephanie Scharmen, St. Mary's County Health Department
169. Rob Schmidt, Talbot County Public Schools
170. Gail Schmidt, Talbot County Public Schools
171. Beth Schmidt, Maryland Coalition of Families
172. Robin Schrader, St. Mary's Public Schools
173. Chalarra Sessoms, Behavior Health Administration
174. Amy Shaffer-Post, Washington County Public Schools
175. Diane Shannon, Catholic Charities
176. Jamie Shepard, Foster Parent Community
177. Scott Showalter, Prince Georges County Public Schools
178. Teresa Simmons, University of Salisbury
179. Ernestina Simmons, Springboard Community Services
180. Michael Sinclair, Morgan State University
181. Desiree Shantai Smith, National Coalition of STD Directors
182. Harriet Smith, Baltimore Harm Reduction Coalition
183. Michele Solloway, Trauma Therapy and Health Services Research
184. Shepard W. Stephenson, St. Mary's Public Schools
185. Joan Stine, State Council on Child Abuse and Neglect
186. Marie Stratton, Maryland Department of Health
187. Ligia Teodorovici, Washington County Department of Social Services

188. Carmen Terrazas, Caroline County Public Schools
189. Jen Thomas, University of Pittsburg Medical Center
190. Cierra Thompson, The Clubhouse/H2O
191. Lacey Tsonis, Maryland Family Network
192. William Tucker, Circuit Court for Howard County
193. Stirling Ward, Queen Anne's County Public Schools
194. Kawana Webb, Dorchester County Public Schools
195. Merrideth Wile, Washington County Public Schools
196. Jonathan Williams, Shore Community Music Center/ Chesapeake College
197. Lauren Williams, Worcester County Public Schools
198. Joseph Windsor, Calvert County Sheriff's Office
199. D'Lisa Worthy, University of Maryland, Center of Excellence in Infant and Early Childhood Mental Health
200. Harold Young, Baltimore City Department of Social Services
201. Steve Youngblood, Washington County Department of Social Services
202. Robert Zellner, Awakenings Recovery Center
203. Rose Zollinger, Worcester County Public Schools

APPENDIX F

SCCAN & MARYLAND ESSENTIALS FOR CHILDHOOD 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[1] 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.[2]

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"[3] 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."[4] 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".[5]

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-*

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

[2] See Appendix D for current members.

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

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

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

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 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[6] initiative that promotes safe, stable, nurturing relationships and environments for children and prevents, mitigates ACEs, and builds resilience in children, families, and communities.

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).[7] 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

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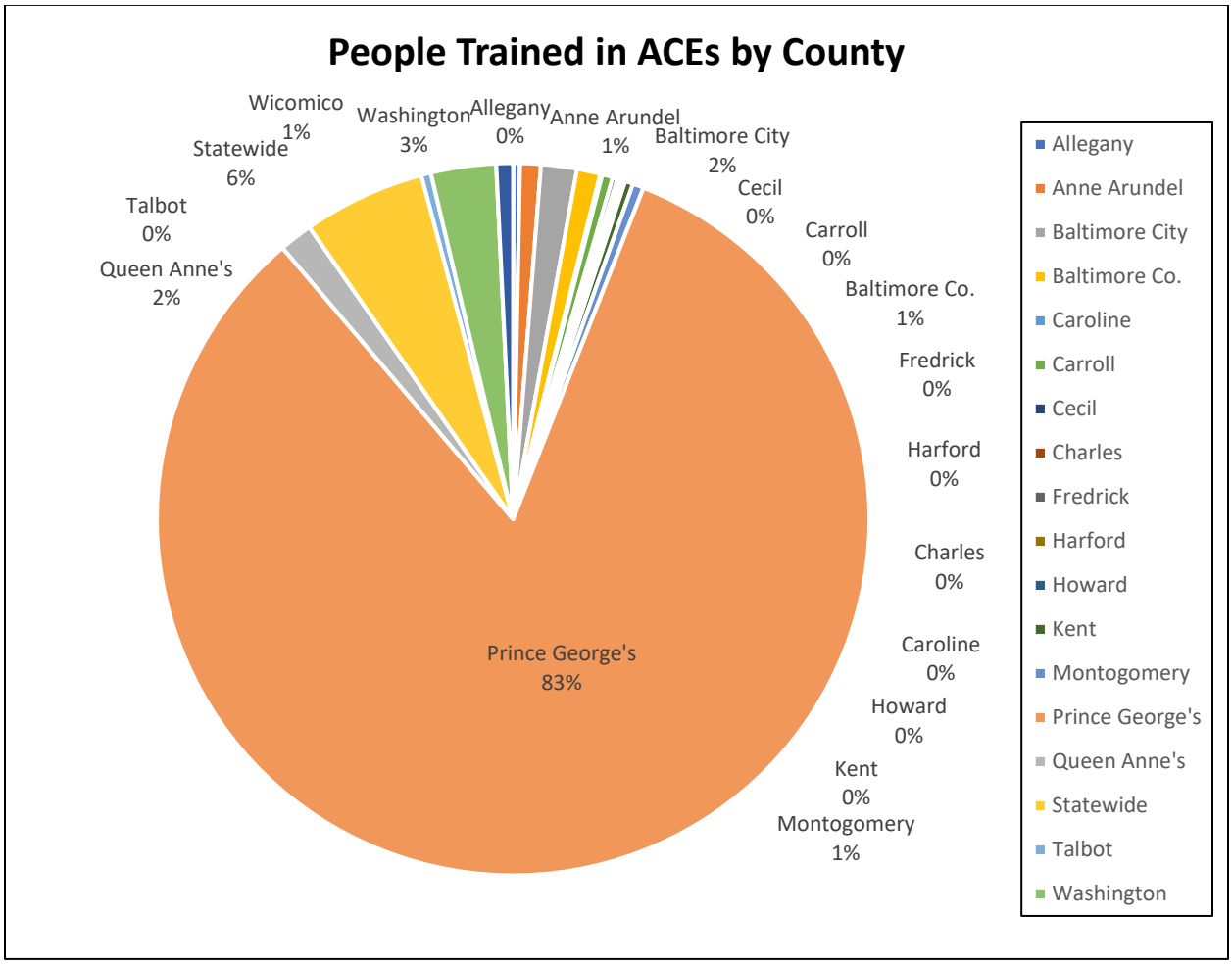
[6] Channeling Change: Making Collective Impact Work, Stanford Social Innovation Review, https://ssir.org/articles/entry/channeling_change_making_collective_impact_work

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

APPENDIX G:

ACE Interface Training Locations by Maryland County

Between March 2020 and April of 2021, ACE Interface Master Trainers have given 87 ACE Interface presentations to 15,012 attendees across all of Maryland's 24 jurisdictions. The graphs below show the percentage of trainings by number of people trained and number of trainings per jurisdiction.

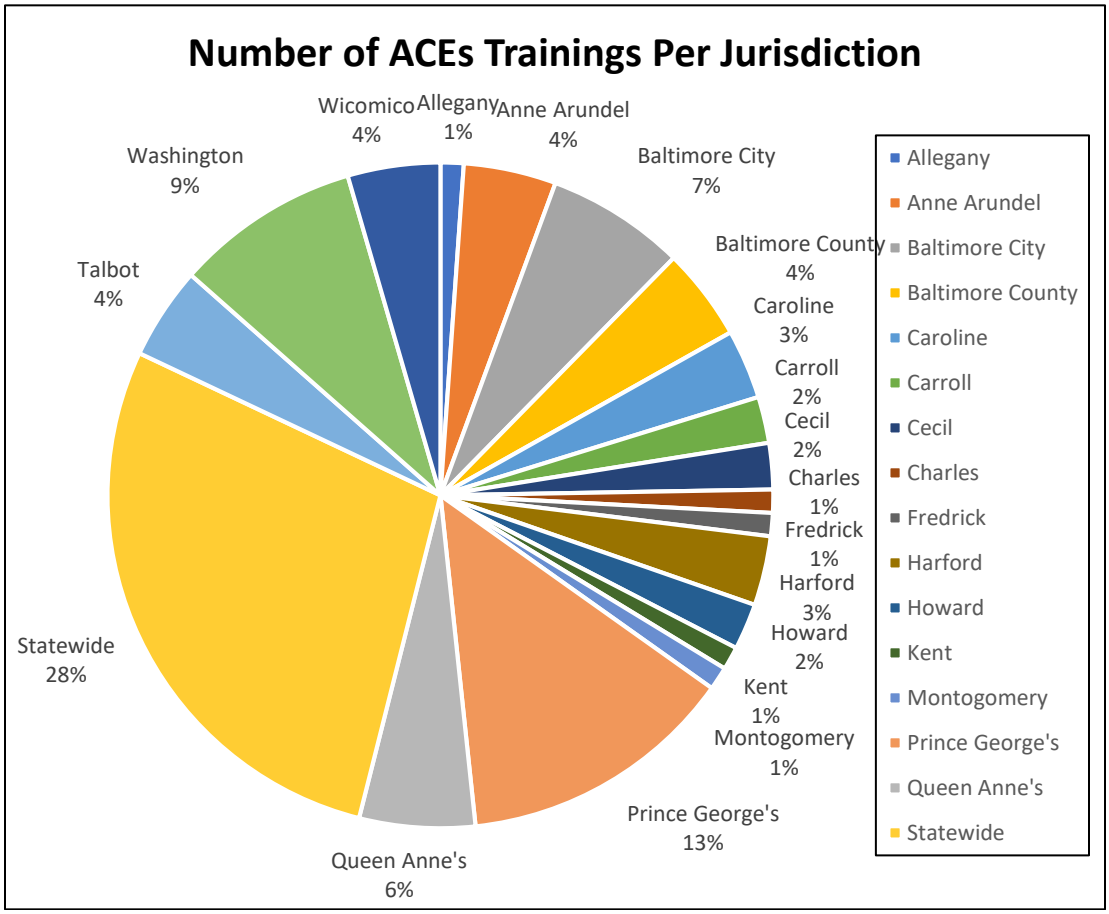


People Trained in ACEs by County (Participant Count)

Maryland County/Jurisdiction Served	Number of Participants
Allegany	46
Anne Arundel	141
Baltimore City	244
Baltimore County	159
Caroline	14

Carroll	73
Cecil	32
Charles	15
Fredrick	10
Harford	21
Howard	9
Kent	55
Montgomery	75
Prince George's	12,414
Queen Anne's	227
Statewide	830
Talbot	66
Washington	443
Wicomico	114

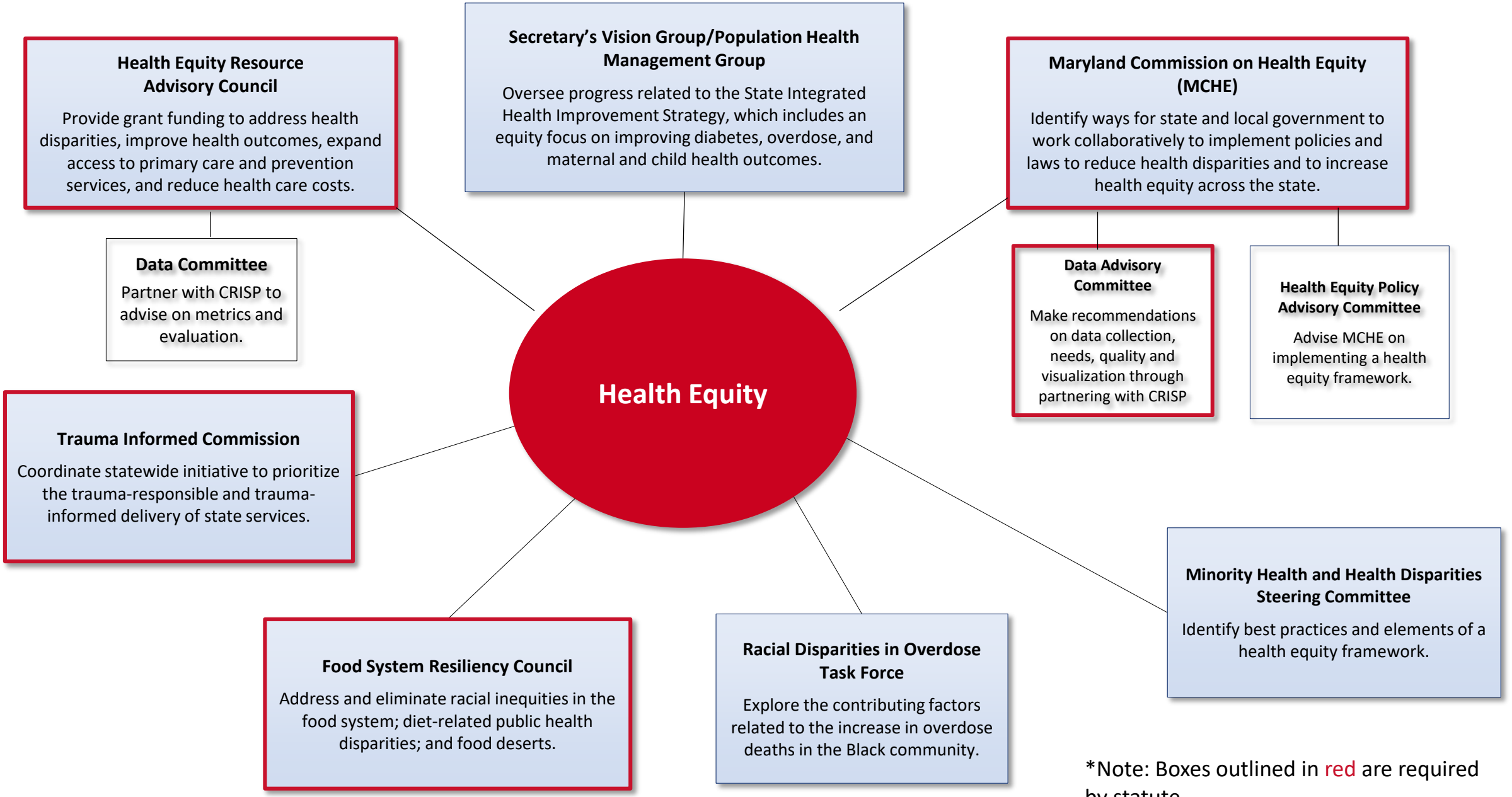
Number of ACEs Trainings Per Jurisdiction



Number of ACEs Trainings Per Jurisdiction (By Number of Occurrences)

Maryland County/Jurisdiction Served	Number of Participants
Allegany	1
Anne Arundel	4
Baltimore City	6
Baltimore County	4
Caroline	3
Carroll	2
Cecil	2
Charles	1
Fredrick	1
Harford	3
Howard	2
Kent	1
Montgomery	1
Prince George's	12
Queen Anne's	5
Statewide	25
Talbot	4
Washington	8
Wicomico	4

APPENDIX H - Health Equity Initiatives



*Note: Boxes outlined in red are required by statute.

Date: September 17, 2021

APPENDIX I

CDC ACES MODULES

Tier 1

Question	Construct	Question
1	*Lifetime prevalence of emotional abuse*	During your life, how often has a parent or other adult in your home sworn at you, insulted you, or put you down? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
2	*Lifetime prevalence of physical abuse*	During your life, how often has a parent or other adult in your home hit, beat, kicked, or physically hurt you in any way? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
3	*Lifetime prevalence of sexual abuse*	Has an adult or person at least 5 years older than you ever made you do sexual things that you did not want to do? (Count such things as kissing, touching, or being made to have sexual intercourse.) A. Yes B. No
4	*Lifetime prevalence of physical neglect*	During your life, how often has there been an adult in your household who tried hard to make sure your basic needs were met, such as looking after your safety and making sure you had clean clothes and enough to eat? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
5	*Lifetime prevalence of witnessed intimate partner violence*	During your life, how often have your parents or other adults in your home slapped, hit, kicked, punched, or beat each other up? A. Never B. Rarely C. Sometimes D. Most of the time

		E. Always
6	*Lifetime prevalence of household substance abuse*	Have you ever lived with someone who was having a problem with alcohol or drug use? A. Yes B. No
7	*Lifetime prevalence of household mental illness*	Have you ever lived with someone who was depressed, mentally ill, or suicidal? A. Yes B. No
8	*Lifetime prevalence of incarcerated relative*	Have you ever been separated from a parent or guardian because they went to jail, prison, or a detention center? A. Yes B. No

Tier 2

Question	**Construct**	**Question**
9	*Lifetime prevalence of perceived racial/ethnic injustice*	During your life, how often have you felt that you were treated badly or unfairly because of your race or ethnicity? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
10	*Lifetime prevalence of perceived sexual minority discrimination*	During your life, how often have you felt that you were treated badly or unfairly because of your sexual orientation? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
11* *Note this question will be on the standard	*Lifetime prevalence of community level violence*	Have you ever seen someone get physically attacked, beaten, stabbed, or shot in your neighborhood? A. Yes B. No

question-naire, it will not need to be added and should not be deleted if applying for Tier 2 Funds.		
12	*Past 12-month incidence of physical violence*	During the past 12 months, how many times has a parent or other adult in your home hit, beat, kicked, or physically hurt you in any way? A. 0 times B. 1 time C. 2 or 3 times D. 4 or 5 times E. 6 or more times
13	*Past 12-month incidence of emotional violence*	During the past 12 months, how many times has a parent or other adult in your home sworn at you, insulted you, or put you down? A. 0 times B. 1 time C. 2 or 3 times D. 4 or 5 times E. 6 or more times
14	*Lifetime prevalence of feeling able to talk to adults about feelings*	During your life, how often have you felt that you were able to talk to an adult in your family or another caring adult about your feelings? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
15	*Lifetime prevalence of feeling supported by friends*	During your life, how often have you felt that you were able to talk to a friend about your feelings? A. Never B. Rarely C. Sometimes D. Most of the time E. Always

16** **Note this question is the same question that is already required for DASH-funded LEAs	*Incidence of feeling a sense of belonging at school*	Do you agree or disagree that you feel close to people at your school? A. Strongly agree B. Agree C. Not sure D. Disagree E. Strongly disagree

APPENDIX J

State Council on Child Abuse and Neglect (SCCAN)
ANTIRACIST STATEMENT

Preamble

Evidently, the disparity in service offered and treatment of African Americans children has existed since the beginning of the child welfare system. In fact, prior to 1865, slavery was the primary welfare institution for African American s.[1] African Americans were not alone in tracing the history of the U.S child welfare system and the racist, discriminatory and disparate practices that have been used with children of color from the beginning of the system, to current times. Native American and Indigenous people have also been victims of biased practices and discriminatory procedures within the child welfare system. [2]

After slavery was abolished many White children were sent to orphanages, almshouses or sent west on "Orphan Trains" to live with foster families through indentured servitude. African Americans were largely excluded from that type of assistance with the exception being the Society of Friends. (an abolishment group in Philadelphia, PA). [3] The under-funded and short-lived Freedman Bureau provided direct relief for many African American children and their respective families. More often than not, most of the support services provided (i.e. day care, orphanages) to African American children were through self -help efforts offered through schools, churches, and other social organizations. [4] It was not until the National Urban League founded in 1910 began to advocate for equitable distribution of child welfare services.

By 1935, mothers' pension laws had been adopted in 46 states. Similarly, the Social Security Act established Title IV-A, known as Aid to Dependent Children (ADC). However, many states instituted "home suitability clauses" [5], "illegitimate child clauses" and "substitute father in the house clauses". These clauses were established to weed out "immoral homes" and often

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[1] Dettlaff, A. J., Weber, K., Pendleton, M., Boyd, R., Bettencourt, B., & Burton, L. (2020). It is not a broken system, it is a system that needs to be broken: The upEND movement to abolish the child welfare system. *Journal of Public Child Welfare*, *14*(5), 500-517. Barth, R. P., Jonson-Reid, M., Greeson, J. K., Drake, B., Berrick, J. D., Garcia, A. R., ... & Gyourko, J. R. (2020). Outcomes following child welfare services: what are they and do they differ for black children?. *Journal of Public Child Welfare*, *14*(5), 477-499.

[2] Bird, S. E. (2018). Introduction: Constructing the Indian, 1830s–1990s. In *Dressing in feathers* (pp. 1-12). Routledge. Berkhofer, R. F. (1979). *The white man's Indian: Images of the American Indian, from Columbus to the present* (Vol. 794). Vintage.

[3] Dettlaff, A. J., & Boyd, R. (2020). Racial disproportionality and disparities in the child welfare system: Why do they exist, and what can be done to address them?. *The ANNALS of the American Academy of Political and Social Science*, *692*(1), 253-274. Cénat, J. M., Noorishad, P. G., Czechowski, K., Mukunzi, J. N., Hajizadeh, S., McIntee, S. E., & Dalexis, R. D. (2021). The Seven Reasons Why Black Children Are Overrepresented in the Child Welfare System in Ontario (Canada): A Qualitative Study from the Perspectives of Caseworkers and Community Facilitators. *Child and Adolescent Social Work Journal*, 1-16.

[4] Burslem, R. R. (2021). TRANSFORMING OUTCOMES TO INCREASE PARTICIPATION IN THE INDEPENDENT LIVING PROGRAM SPONSORED BY SUNRISE CHILDREN'S SERVICES. Bremner, R. H. (1983). Other people's children. *Journal of Social History*, *16*(3), 83-103.

[5] Fong, K. (2020). Getting eyes in the home: Child protective services investigations and state surveillance of family life. *American Sociological Review*, *85*(4), 610-638. Piven, F. F., & Cloward, R. (2012). *Regulating the poor: The functions of public welfare*. Vintage.

excluded African Americans from receiving any public welfare benefits. Consequently, states like Mississippi, Florida and Louisiana were notorious for removing African American children from their families because their families were, in their opinion, too poor to take care of children.[6]

During the 1960's there was a major shift in America's conceptualization of the poor. The growing use of contraception and liberalized abortion laws increased social acceptability of many unwed, single parent households. The reduction of White children eligible for adoption led many private agencies to focus on African American children. African American children began to be over-represented in the child welfare system and experience disparate outcomes.[7] White culture maintaining the privilege of being the standard against which everyone else is compared perpetuates racial disparities.

Historically, Black children have experienced overrepresentation within the child welfare system throughout the U.S.. Maryland only began disaggregating child welfare data by race beginning in 2015. The data shows Black children and families continue to be disproportionately overrepresented year after year in Maryland.

In addition to overrepresentation, Black children also experience disparate outcomes. Black Youth are overrepresented in out-of-home foster care placements and are more likely to exit care without achieving permanency compared to their White counterparts. Of all youth emancipated (not being adopted, reunified, or placed in guardianship) Black youth comprise the overwhelming majority of cases.

As a society, it is our duty to ensure that every child has a bright future. Child welfare interventions require active and ongoing responsibility and accountability to minimize the potentially harmful effects of these interventions.

Achieving permanency prior to aging out of care is correlated to better outcomes in housing, education, employment, economic stability, physical and mental health, healthy relationships and connections to community. Providing research-informed guidance and support around housing, finances, relational stability, nutrition and the development of lifelong connections, builds resiliency and leads to personal well-being and healthy community members.

Additionally, experiencing racism is an Adverse Childhood Experience (ACE) that causes toxic stress and trauma.[8] We are actively building our knowledge, skills, and resources to increase equitable outcomes for all children and families. We are committed to being antiracist, to using an equity lens in our policy work, and to being intentional about addressing and eliminating racial inequities.

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[6] Lawrence-Webb, C. (2018). African American children in the modern child welfare system: A legacy of the Flemming Rule. *Serving African American Children*, 9-30. Simon, R. J. (1984). Adoption of black children by white parents in the USA. *Adoption: Essays in Social Policy, Law, and Sociology. New York/London, Tavistock Publications*.

[7] Hamilton, E., Samek, D. R., Keyes, M., McGue, M. K., & Iacono, W. G. (2015). Identity development in a transracial environment: Racial/ethnic minority adoptees in Minnesota. *Adoption quarterly*, *18*(3), 217-233.

[8] Research, Publications and Applications of the Expanded ACE Survey, The Philadelphia ACE Project; Philadelphia ACE Study; Racism and Discrimination as Risk Factors for Toxic Stress – Transcript, April 28, 2021.

SCCAN
ANTIRACIST STATEMENT

1. **Racism exists.**

Racism is prevalent in all institutions. Historic and systemic racism permeates the child welfare system and other child and family serving systems, including health, education, economic and justice systems. The State Council on Child Abuse and Neglect (SCCAN) unequivocally supports and stands in solidarity with all racially oppressed individuals and communities (African American, Black, Indigenous, and People of Color[9]) as an ally in the fight against racism, racial inequity, and racial discrimination.

In our role as a citizen review panel mandated by CAPTA, SCCAN *"evaluate[s] the extent to which State and local agencies are effectively discharging their child protection responsibilities."*[10] As an advisory body by Maryland law, we *"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."*[11] In these roles *SCCAN* is particularly allied with black children and families who are disproportionately represented in and impacted by the child welfare system.

2. **Racism is both conscious and unconscious.**

It is every individual's responsibility to learn the meaning and impact of how race influences and impacts everyone's interactions. Each of us must embrace the duty to understand our history, biases, prejudice, bigotry, and societal assumptions.

We acknowledge that racism can be unconscious or unintentional, and that identifying racism as an issue does not automatically mean that those involved in the act are racist or intend a negative outcome.

3. **Systematic racism exists, and we must distinguish intent from impact.**

We are committed to being actively antiracist. and we adopt Ibram X. Kendi's definition of racism, racial equity, racist policy, and racist ideas:

"Racism is a powerful collection of racist policies that [produce and normalize racial inequities] and are substantiated by racist ideas. **Antiracism** is a powerful collection of antiracist policies that lead to racial equity and are substantiated by antiracist ideas."[12] An antiracist idea is any idea that suggests the racial groups are equals in all their apparent differences—that there is nothing right or wrong with any racial group. Antiracist ideas argue that racist policies are the cause of racial inequities. Policies are any written and unwritten laws, practices, rules, procedures, processes, regulations, and guidelines that govern people.

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[9] We use the phrase "People of Color" to intentionally include individuals who may identify as Black, African-American, Asian, South Asian, Middle Eastern, Pacific Islander, Latinx, Chicanx, Native American, and multiracial. People of color are not a monolithic group. We specifically differentiate Black, African-American, and Indigenous people, as they have historically experienced overrepresentation in the child welfare system.

[10] 42 USC Ch. 67: CHILD ABUSE PREVENTION AND TREATMENT AND ADOPTION REFORM

[11] Family – General Article, Annotated Code of Maryland, § 5-7A-09, State Council on Child Abuse and Neglect (SCCAN)

[12] Kendi, Ibram X., How to Be an Antiracist. New York: One World, 2019.

SCCAN is committed to evaluating and reevaluating all Council recommendations regarding policies, procedures, services, and trainings to ensure that they are inclusive, equitable, accessible and antiracist.

4. **It is not the job of the oppressed to teach the oppressors about their mistakes.**

We understand it is not the job of the historically oppressed to educate the oppressors about oppression. We must teach ourselves to recognize the inappropriate assumptions that deny the humanity of the oppressed, based on our biases and accept responsibility for our role in perpetuating unfair advantages, disadvantages and racism. We pledge to be informed and promise not to be complicit or silent against racism. We are committed to identify and unlearn dominant narratives in the child welfare and other child and family serving systems.

5. **We need to validate and affirm members of our communities.**

We must do our absolute best to validate and affirm members of our community by ensuring that their voices are heard and valued. As a Council, it is our responsibility to actively elevate the voices of those unheard and marginalized by systems and structures. Silence normalizes oppression, bias, and other systemic issues, and as an entity committed to creating change in our society, we will not be silent. Until African American, Black, Indigenous, and People of Color communities are seen, heard, and valued, our work is not done.

6. **White Supremacy Exists**

White supremacy, white supremacy culture, and white privilege are prevalent today despite some advancements towards racial equity. The United States remains deeply embedded with the historical legacy of visible and invisible racist structures, policies and ideas. White people enjoy unfair advantages but are not a superior race and should not dominate society or serve as the standard of acceptability. We believe that equity is paramount.

7. **Acknowledgment**

SCCAN admits that while recommendations and advocacy efforts have been well-intended, we have not viewed our systems recommendations through an actively antiracist lens and towards antiracists solutions. We challenge and encourage our members and partners in child welfare and other child and family serving systems to address racist ideas and policies that perpetuate inequities.

8. **Reconciliation and Forward Progress**

SCCAN will hold itself accountable for promoting antiracist policies and ideas in child welfare and other child and family serving systems and commits to:

1. Recruit, interview and recommend to the Governor for appointment only individuals who have read, understood, and are committed to our antiracist statement. The interview process will consist of questions related to an understanding of the statement.
2. Ensure broader and consistent outreach to increase engagement in SCCAN's education and advocacy efforts and in order to recruit a more diverse membership.

3. Deliberately establish meaningful relationships and dialogue with impacted communities in order to inform our recommendations and advocacy efforts.
4. Actively build the knowledge, skills, and resources of Council members and partner organizations to increase equitable outcomes for all children and families.
5. Draft and review all recommendations to the Governor and General Assembly to ensure the recommended policy improvements address racial inequities.
6. All legislative proposals submitted for consideration of support by the Council must include information about racial impact and be reviewed by the Council using a racial equity lens.
7. Engage with our members and partners to exercise our collective influence with decision makers to promote antiracist ideas and policies, racial equity and develop antiracist solutions.

SCCAN's Antiracist Statement is a living document. We are committed to regular reviews and consistent accountability.

APPENDIX K

SCCAN ACHIEVING RACIAL EQUITY WORKGROUP

RESOURCES ON RACISM, RACIAL EQUITY AND CHILD WELFARE*

ORGANIZATIONS

- childwelfare.gov
- State Automated Child Welfare Information Systems (SACWIS)
- The Casey-CSSP Alliance for Racial Equity
- ABA https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january---december-2019/race-and-poverty-bias-in-the-child-welfare-system---strategies-f/
- Implicit Association Test American Bar Association: https://www.americanbar.org/groups/litigation/initiatives/task-force-implicit-bias/implicit-bias-test/

RESOURCES ON RACIAL EQUITY

- Racial Equity Discussion Guide
- 3 Tools for Getting Started with the Race Matters Toolkit
- Continuum on Becoming an Anti-Racist Multicultural Organization
- [Infographic] Promoting Racial Equity Through Workforce & Organizational Actions
- NCWWI Innovations Exchange 2: Inclusivity, Racial Equity, and Community Engagement
- Racial Disproportionality and Disparity in Child Welfare
- [1-Pager] Microaggressions in the Child Welfare Workplace
- [1-Pager] Addressing Racial Disparity in Foster Care Placement
- Staff Core Competencies for Working to Achieve Racial Equity
- Implicit Bias in the Child Welfare, Education and Mental Health Systems
- Race Equity and Inclusion Action Guide
- Five guiding principles for integrating racial and ethnic equity in research
- AWAKE to WOKE to Work: Building a Race Equity Culture
- Tribal sovereign status: Conceptualizing its integration into the social work curriculum
- Communities Creating Racial Equity: Ripple Effects of Dialogues to Change

HUBS

National Association of Counsel for Children, Race Equity Hub

TOOLKITS

CASA Anti Racism Toolkit: https://marylandcasa.org/antiracism-toolkit/?emci=70d65f12-660d-eb11-96f5-00155d03affc&emdi=89a70bc9-140e-eb11-96f5-00155d03affc&ceid=3284581

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WEBINARS

ABA WEBINAR 9-16-20

https://imprintnews.org/opinion/sad-omission-child-welfare-mainstream-discussion-race/46315

https://youthtoday.org/2020/02/mandatory-child-abuse-reporting-belongs-in-dustbin-new-research-makes-clear/

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2924920

https://drive.google.com/file/d/0B291mw_hLAJsUlRxVnB0SDlOUnM/view

https://www.nccprblog.org/2020/06/child-welfare-responds-to-racism-in.html

https://eastbayfamilydefenders.org/ebfd-founding-defense-parent-advocate-honored-with-2020-casey-excellence-for-children-award/

http://harvardlawreview.org/wp-content/uploads/2019/04/1695-1728_Online.pdf

American Bar Association- A Conversation about the Manifestation of White Supremacy in the Institution of Child Welfare Level 2
https://americanbar.zoom.us/webinar/register/WN_2jzyQQOFS4SnDnd1Ez_-3Q

VIDEOS & DOCUMENTARIES

Race: The Power of an Illusion Documentary This three-part documentary by California Newsreel is important for understanding the history of racialization in America and how racial categories came about that we often innacurately equate with biology. InterVarsity has purchased the rights to stream this documentary online for three years.

https://socialimpactexchange.org/initiative/2020-exchange-conference/#blackwell

To transform child welfare, take race out of the equation (Jessica Pryce | TED Residency)

https://www.ted.com/talks/jessica_pryce_to_transform_child_welfare_take_race_out_of_the_equation?utm_source=tedcomshare&utm_medium=email&utm_campaign=tedspread

Redlining Video from Dr. Fletcher's presentation:
https://www.youtube.com/watch?v=ETR9qrVS17g&feature=emb_logo

ARTICLES AND CITATIONS

Strategies to Reduce Racially Disparate Outcomes in Child Welfare
https://files.eric.ed.gov/fulltext/ED561817.pdf

Racial Disproportionality and Disparity in Child Welfare
https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf

Strategies for Reducing Inequity
https://www.childwelfare.gov/topics/systemwide/cultural/disproportionality/reducing/

Achieving Racial Equity

https://cssp.org/wp-content/uploads/2018/08/achieving-racial-equity-child-welfare-policy-strategies-improve-outcomes-children-color.pdf

White Privilege and Racism in Child Welfare

http://cascw.umn.edu/wp-content/uploads/2013/12/WhitePrivilegeSubSum.pdf

Race and Poverty Bias in the Child Welfare System: Strategies for Child Welfare Practitioners

https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january---december-2019/race-and-poverty-bias-in-the-child-welfare-system---strategies-f/

Institutional racism in child welfare
https://www.sciencedirect.com/science/article/abs/pii/S1090952404000403

Minority Children and the Child Welfare System: An Historical Perspective

https://academic.oup.com/sw/article-abstract/33/6/493/1941010

Systematic Inequality and Economic Opportunity
https://www.americanprogress.org/issues/race/reports/2019/08/07/472910/systematic-inequality-economic-opportunity/

Systemic Inequality: Displacement, Exclusion, and Segregation
https://www.americanprogress.org/issues/race/reports/2019/08/07/472617/systemic-inequality-displacement-exclusion-segregation/

A new take on the 19th-century skull collection of Samuel Morton
https://www.sciencedaily.com/releases/2018/10/181004143943.htm

Race and Class in the Child Welfare System
https://www.pbs.org/wgbh/pages/frontline/shows/fostercare/caseworker/roberts.html

Poverty, Homelessness, and Family Break-Up

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5760188/

Implicit Bias in the Child Welfare, Education and Mental Health Systems
https://youthlaw.org/publication/implicit-bias-in-the-child-welfare-education-and-mental-health-systems/

"This link has very helpful video resources and other advocacy tools for racial justice work: And this webpage has many resources

https://www.futureswithoutviolence.org/health/racism/

The link to Cracking the Codes of Racial Inequity is the one I referenced with a discussion guide."

BOOKS

Race Matters in Child Welfare: The Overrepresentation of African American Children in the System - by Dennette M. Derezotes (Editor), John Poertner (Editor), Mark F. Testa (Editor)

Shattered Bonds: The Color Of Child Welfare Paperback – by Dorothy Roberts

Stamped: Racism, Antiracism, and You, A Remix of the National Book Award-Winning Stamped from the Beginning, by: Jason Reynolds, Ibram X. Kendi

Post Traumatic Slave Syndrome https://www.joydegruy.com/post-traumatic-slave-syndrome

22 books on race and white privilege that will show you what's really happening in America right now

https://www.businessinsider.com/books-white-privilege-novels-racism-antiracism-black-scholars-2020-6#white-fragility-why-its-so-hard-for-white-people-to-talk-about-racism-by-robin-diangelo-3

Racial Equity and Housing Justice During and After COVID-19

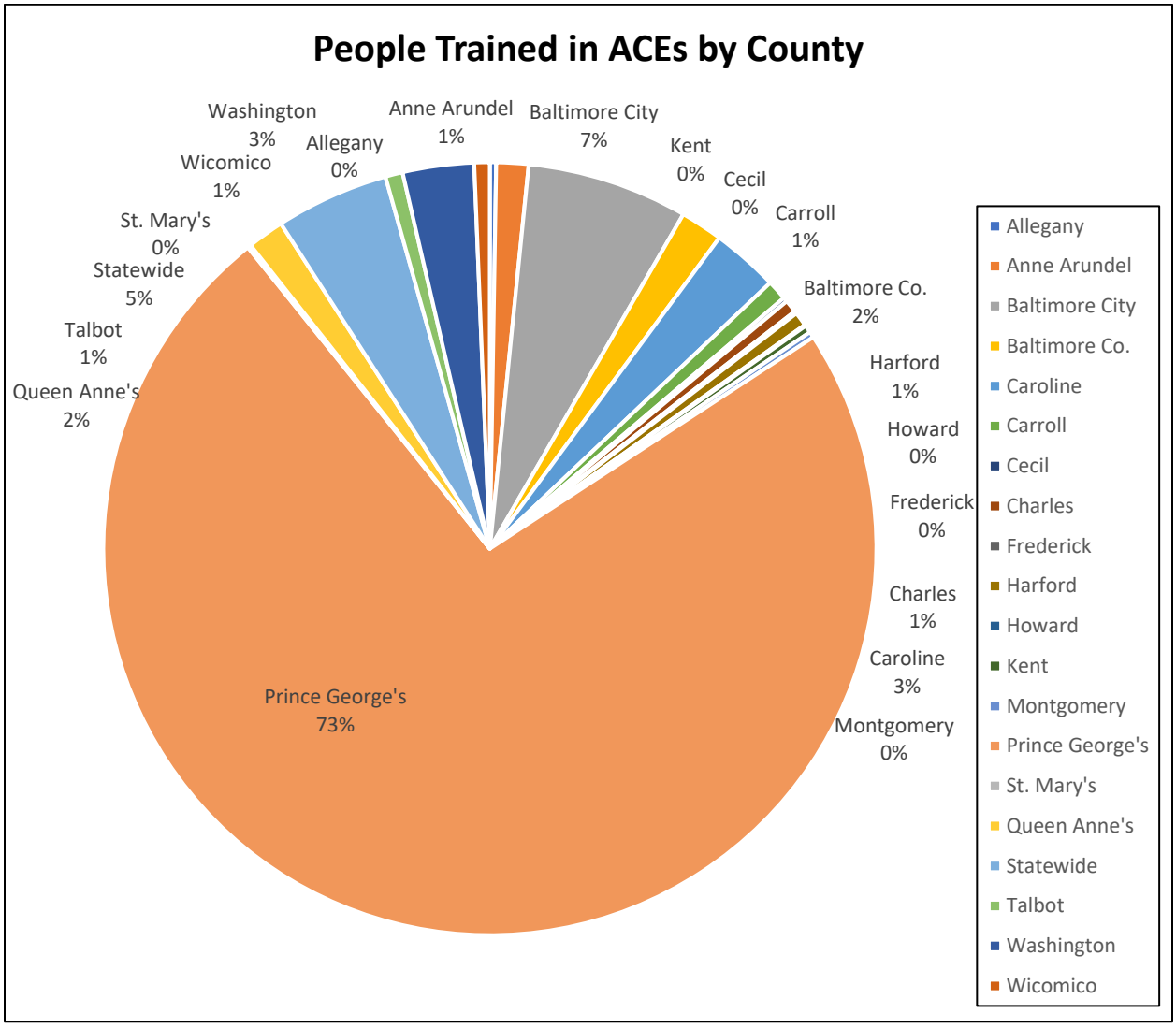
Ta-Nehisi Coates is a distinguished writer in residence at NYU's Arthur L. Carter Journalism Institute. He is the author of the bestselling books *The Beautiful Struggle*, *We Were Eight Years in Power*, and *Between The World And Me*, which won the National Book Award in 2015. Ta-Nehisi is a recipient of a MacArthur Fellowship. He is also the current author of the Marvel comics *The Black Panther* and *Captain America*.
As an author and thought leader, Ta-Nehisi has been a vital voice in shaping the discourse on race in the United States and globally. His seminal article in *The Atlantic*, "The Case for Reparations," discusses thirty-five years of racist housing policy that led to the inequities still plaguing housing in the U.S. Please join us for this conversation with Ta-Nehisi Coates on "Racial Equity and Housing Justice During and After COVID-19" on October 6 at 1 pm ET. Register at: https://bit.ly/32yRqi6

**This list contains a few resources. The resources are as expansive and complex as the subject matter.*

APPENDIX L

ACE Interface Training Locations by Maryland County

Between December 2017 and November 2021 ACE Interface Master Trainers have given 390 ACE Interface presentations to more than 24,883 attendees across all of Maryland's 24 jurisdictions. The graphs below show the percentage of trainings by number of people trained and number of trainings per jurisdiction.



Sponsored By: The Family Tree

MARYLAND essentials for childhood

SCCAN Maryland's State Council on Child Abuse & Neglect

APPENDIX M

Select strategic ACE Interface Presentations

January 2020-November 2021 included:

2020 Tuerk Conference on Mental Health and Addiction Treatment

2021 Healing City Baltimore Summit

2021 Healthy St. Mary's Partnership Annual Meeting

2021 Maryland CASA's 14th Annual Conference on Child Well-Being-Roads to Resilience

2021 Maryland Office of the Public Defender (MOPD) Conference

2021 Maryland Violence and Injury Prevention Conference

Aetna Better Health of Maryland

Amerigroup Maryland Incorporated

Anne Arundel County Maryland WIC Program

Baltimore County Public Schools

Boys and Girls Clubs of Maryland

Citizens Review Board for Children

Enoch Pratt Library

Fallston Volunteer Fire and Ambulance

Frederick Police Department

Harford County Council

Harford County Sheriff's Office

Leadership Southern Maryland

Maryland Coalition of Families

Maryland Department of Health LEAD Partners

Maryland Department of Rehabilitation Services (DORS)

Maryland Office of Administrative Hearings

Maryland Rural Opioid Training Assistance (MD ROTA)

Maryland State Department of Education

McDaniel College

Office of the State's Attorney for Anne Arundel County

Prince George's County Public Schools

Talbot County Department of Social Services

United States Department of Health and Human Services (HRSA), Federal Office of Rural Health Policy

Washington County Anti-Human Trafficking Collaborative

Weave: The Social Fabric Project- The Aspen Institute

Wicomico County Department of Social Services

Wicomico County Health Department

Wicomico Partnership for Families and Children

Youth Empowerment Source

Potential HealthySteps Financing Opportunities

HealthySteps National Office Policy and Finance Team

To ensure positive health and development of young children, the child-caregiver relationship and the caregiver's well-being must be foci of primary care interventions during early childhood. Evidence-based dyadic models, such as HealthySteps, have shown effectiveness in employing this two-generation lens to mitigate the effects of trauma and adverse childhood experiences, address social determinants of health, and support behavioral health prevention and connection to needed treatment through team-based integrated pediatric primary care.

State Medicaid agencies are finding innovative ways to support dyadic integrated pediatric primary care models by utilizing new billing codes, allowing flexibilities in how codes are used, and exploring the use of alternative payment models to support team-based care. Below are recommendations and examples of how states reimburse and provide funding for HealthySteps services under Medicaid. There are variations between state Medicaid agencies and benefits that would impact how these approaches could be implemented by state Medicaid agencies, possibly in partnership with Medicaid managed care organizations (MCOs) and other types of payers.

Billing and Coding Approaches

HealthySteps has eight core components as highlighted below.

In order to support ongoing sustainability of the model, states have used fee-for-service reimbursement opportunities to cover some of the model's core components and related services – a HealthySteps Specialist's salary and benefits are the main ongoing costs of implementing the model. Below are examples of ways states have provided payment for HealthySteps services by increasing billing opportunities.

Reimbursement for Ongoing Preventive Team-Based Well-Child Visits

HealthySteps Specialists are pediatric behavioral health professionals, available to address developmental and behavioral health concerns as soon as they are identified, bypassing the many obstacles families face when referred to external behavioral health services. HealthySteps Specialists provide services and supports for children in the context of the family so that caregivers' behavioral health and social needs are also addressed in the universally accessed pediatric primary care setting.

State Medicaid agencies could establish a diagnosis and procedure code that would capture and allow payment for a pediatric primary care preventive dyadic behavioral health visit.

Examples:

- San Francisco Health Plan (California) is now allowing credentialed behavioral health providers (including HealthySteps Specialists) to submit a Z-code (including Z00.11, Z00.12) as the primary ICD-10 code attached to any allowable CPT code, for a preventive behavioral health well-child visit. This is critically important, providing a mechanism for payment for prevention. The encounter can be paired with a physical health well-child visit occurring at the same time (e.g., a HealthySteps Tier 3 visit).
- California Medicaid (Medi-Cal) is exploring the potential to open HCPCS code H0025 (behavioral health prevention education service) for the reporting of preventive behavioral health well-child visits. This would establish a new statewide Medicaid benefit, circumventing the need for individual Medicaid MCOs to create their own billing pathways.
- A Colorado Medicaid payment pilot focuses on the use of H0025 for preventive psychosocial education services provided during well-child visits. Several HealthySteps sites are participating (including an FQHC) and using the enhanced payment to fund up to the full costs associated with HealthySteps Specialists' salaries.
- Ohio Medicaid is allowing reimbursement under a pilot program for preventive medicine counseling codes 99402-99404, with ICD-10 code Z71.89 (persons encountering health services for other counseling and medical advice, not elsewhere classified), when billed by a psychologist in 15-minute increments as part of a HealthySteps encounter. This is important because it creates a new payment pathway that recognizes the value HealthySteps Specialists can provide to families during brief interventions. With the addition of these codes, overall billing reimbursement is sufficient to cover the costs associated with HealthySteps Specialists' salaries.

Reimbursement for Child Development and Behavior Consults

Fortunately, the vast majority of young children do not qualify for a diagnosable behavioral health disorder. However, as a result, most dyadic health care services delivered by a behavioral health clinician in the pediatric setting are not reimbursable in the traditional health care delivery system.

Medicaid agencies could allow reimbursement for family therapy visits (90846, 90847, 90849) without a diagnosis or with a diagnosis of "at-risk" using social determinants of health Z-codes to support dyadic behavioral health interventions that take place within the pediatric primary care setting.

Examples:

- Medi-Cal recently expanded its family therapy benefit:
  - Recipients under age 21 who have risk factors for mental health disorders are eligible for family therapy (with no session limits).
    - Child risk factors include: separation from a parent/guardian due to incarceration or immigration, death of a parent/guardian, foster home placement, food insecurity, housing instability, exposure to domestic violence or other traumatic event, maltreatment, severe and persistent bullying, experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability.
    - Parent risk factors include: a serious illness or disability, a history of incarceration, depression or other mood disorder, PTSD or other anxiety disorder, psychotic disorder under treatment, substance use disorder, a history of intimate partner violence or interpersonal violence, or a teen parent.
- In July 2018, Colorado Medicaid created a new billing pathway for primary care based behavioral health services – a behavioral health diagnosis is not required, however, providers must use the most appropriate diagnosis supporting medical necessity. Behavioral health providers can bill Medicaid for short-term therapeutic services delivered in the primary care setting (up to six visits per year using a set of specific codes).
- In Philadelphia, behavioral health consultants working in FQHCs are reimbursed through the behavioral health MCO with the use of a non-specific diagnosis code as primary (R69-Illness, unspecified) and the following SDOH Z-codes as secondary:

Z55.9	Academic or education problem
Z60.3	Acculturation difficulty
Z60.4	Social exclusion or rejection
Z60.5	Target of (perceived) adverse discrimination or persecution
Z62.29	Upbringing away from parents
Z62.820	Parent-child relational problem
Z62.891	Sibling relational problem
Z62.898	Child affected by parental relationship distress
Z63.4	Uncomplicated bereavement
Z63.5	Disruption of family by separation or divorce
Z63.8	High expressed emotional level within family
Z64.0	Problems related to unwanted pregnancy
Z69.010	Encounter for mental health services for victim of child abuse by parent
Z69.010	Encounter for mental health services for victim of child neglect by parent
Z69.010	Encounter for mental health services for victim of child psychological abuse by parent
Z69.010	Encounter for mental health services for victim of child sexual abuse by parent
Z69.020	Encounter for mental health services for victim of non-parental child abuse
Z69.020	Encounter for mental health services for victim of non-parental child neglect
Z69.020	Encounter for mental health services for victim of non-parental child psychological abuse
Z69.020	Encounter for mental health services for victim of non-parental child sexual abuse

Z70.9	Sex counseling
Z71.9	Other counseling or consultation
Z72.810	Child or adolescent antisocial behavior

Reimbursement for Child and Family Needs Screenings

In order to support increased compliance with the American Academy of Pediatrics Bright Futures screening schedule, state Medicaid agencies could allow separate reimbursement for developmental screenings (96110), patient/caregiver focused health risk assessments (96160/96161), and maternal depression screenings (G8510, G8431, 96127) above the rate for a well-child visit.

Examples:

- The following 23 states reimburse for the CPT code 96110 for developmental screenings, separate from the well-child visit rate: Alaska, Delaware, Idaho, Iowa, Kansas, Kentucky, Massachusetts, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming.
- Colorado allows CPT code 96127 (Social-Emotional Screening) to be used for the billing of Autism screenings when the CPT code 96110 (Developmental Delay Screening) is reported on the same day of service, for a different screening (e.g., the ASQ). This allows the state to capture and reimburse for all screenings rendered on the same date of service.
- New York reimburses for 96160 and 96161 (health risk assessments) to reimburse providers for patient- and caregiver-focused ACEs screenings.
- California reimburses providers for completing ACEs screenings with children and adults through G9919 (positive screen with patient score of 4 or greater) and G9920 (negative screen with patient score of 0 to 3).
- Many states require or recommend screening and separate reimbursement for maternal depression screenings, utilizing CPT codes 96160 (Nevada) and 96161 (Michigan, Mississippi, South Carolina, Vermont, Washington, etc.).
- New York, California, and Colorado also allow billing for separate reimbursement for maternal depression screening, utilizing CPT codes G8510 (negative depression screening) and G8431 (positive depression screening). Colorado reimburses more for a positive screen because it requires additional follow-up.
- Minnesota allows reimbursement for up to six maternal depression screenings for each child who is less than 13 months old. The screens are also valid for paternal depression screening.

Reimbursement for Care Coordination and Systems Navigation

Care coordination and systems navigation are key components of integrated primary care. Reimbursing for the time spent by the HealthySteps Specialist helping connect families to needed services and supports that can address social determinants of health and behavioral health needs is a critical component of addressing overall health and well-being for the child and caregiver. Reimbursing for case management code 99484 for use in primary care is an opportunity to advance the goal of integrated physical and behavioral health.

Example:

- New York will reimburse for general behavioral health integration, including non-physicians, for services rendered within a month using 99484 (care management for a behavioral health condition for at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month). It allows for the work of clinical staff time, supervised by either a physician, psychologist or licensed clinical social worker, to be integrated into the time and care that is incorporated into this reimbursable code.
- California Medicaid is considering the use of case management code T1016 to provide reimbursement for the HealthySteps Specialist's time providing care coordination and systems navigation. The Medicaid definition of covered case management services for this code includes services to help beneficiaries gain access to needed medical, social, educational, and other services.

An Alternative Payment Model Approach

The HealthySteps National Office recently developed a framework to support states, MCOs, health systems, and providers in developing an alternative payment model (APM) that supports a payment and measurement structure based on the dyadic HealthySteps model. Three elements of HealthySteps make it well-positioned for an APM: 1) a clear set of eight core components organized into three service delivery tiers, 2) a robust evidence-base with demonstrated dyadic outcomes, and 3) quantifiable, annualized cost savings to state Medicaid agencies. Additionally, National Office fidelity monitoring ensures that all eight core components of the model are delivered as intended within three years of initial implementation. An APM could provide a flexible payment to providers that can support all HealthySteps core components (including those core components for which a fee-for-service reimbursement is not currently available such as the child development support line, positive parenting guidance and information, and early learning resources).

Payment

While there are many different approaches states and payers can consider when developing an APM for a pediatric primary care prevention program like HealthySteps, the framework recommends a specific payment structure which can be customized to align with site/state specific initiatives. The National Office recommends a phased approach that initially utilizes fee-for-service payments to allow time for data collection and infrastructure-building to help inform the structure of a longer-term APM payment.

Phase I:

The payment structure proposed for Phase I includes support for initial costs incurred by a participating HealthySteps site, and fee-for-service payments to support key program elements that are not traditionally reimbursable through state Medicaid programs:

Initial payment: A one-time payment to HealthySteps sites to support infrastructure costs such as enhanced electronic health record capacity to track universal screenings and referral follow up, provide additional data

supports, and bolster practice transformation efforts – all necessary components to operationalize a new model of care.[1]

Reimbursement for universal screenings: Separate payments to providers for each administered child, caregiver, and family-focused (health related social needs and SDOH) universal screening, all recommended by the AAP Bright Futures Guidelines. Reimbursement for each screening is critical to ensure screenings are completed, child/family needs are addressed, and utilization data is collected to help inform a future capitated payment.

Separate reimbursement for dyadic prevention, short-term behavioral health interventions, and care coordination services using expanded billing/coding opportunities: Many of these services are not currently reimbursed by state Medicaid agencies and MCOs without a patient diagnosis. Using innovative fee-for-service-based payment approaches to support the delivery of these services in pediatric primary care provides an opportunity to gather cost and utilization data to inform a more comprehensive payment in Phase II to more broadly encompass the dyad.

Examples of how payers can separately reimburse for dyadic prevention, short-term behavioral health interventions, and care coordination services include:

- Reimbursement for H0025 (preventative psychosocial intervention) to enable delivery and payment of behavioral health prevention education services. H0025 would allow behavioral health clinicians to provide behavioral health well-child visits aligned with medical well-child visits and would achieve parity for preventive/surveillance behavioral health services. H0025 could be used with a Z03.89 diagnosis deferred or alternatively a well-child visit code or behavioral health modifier to indicate a team-based well-child visit was conducted.

- Allow codes and established at-risk conditions to be used as the primary diagnosis for short-term behavioral health prevention services (e.g., family therapy CPT codes 90846 and 90847) targeting dyadic behavioral health services (including caregiver(s) and overall family well-being).

- Reimburse for 99484 when billed by a behavioral health provider for care coordination services using Z-codes as the primary diagnosis.

Phase II:

Fee-for-service-based payments made in Phase I would be used to inform a Phase II payment. Phase I payments would end once sufficient data is collected. Utilization data gathered on services provided and reimbursed in Phase I should be used to build a capitated payment. The *per member per month (PMPM)* payment should be *comprehensive, age-based, and risk-stratified (based on the HealthySteps model service tiers),* covering the provision of universal screenings by the practice and Tier 2 and Tier 3 services provided by the HealthySteps Specialist, including health promotion, interdisciplinary team-based well-child visits, care coordination, and preventive behavioral health services based on family needs.

Other potential payment options that could be implemented in Phase II include:

[1] This payment does not cover the cost of the one-time HealthySteps Institute for new sites and associated salary and fringe benefit costs of the HealthySteps Specialist(s).

- *Performance incentive payments:* Incentives and rewards for high-performance on quality metrics as determined by the state and/or payer (recommended quality measures are outlined below).

- *Shared savings:* Practices can share in demonstrated cost-savings calculated using the Manatt Health short-term cost-savings model, matched against Medicaid claims data.

Who Would the APM Serve?

The framework is designed to apply to all children ages birth to three in a primary care practice and their caregivers. Within the HealthySteps model, children/families are risk-stratified based on their needs. Children with significant medical complexity and/or special health care needs are not included in the proposed APM framework; however, it could be customized to develop an APM for a specific population such as children with special health care needs. The framework is also designed to be implemented in practices that employ a licensed behavioral health clinician as the HealthySteps Specialist (e.g., licensed clinical social worker, child psychologist, etc.), allowing for the delivery of short-term behavioral health interventions to children and caregivers in the primary care setting as needs are identified.

What Needs Are Addressed By the APM?

Child well-being:

- Preventive health care
- Development
- Social-emotional and behavioral health
- Early learning
- Positive parenting
- Oral health
- Early nutrition

Caregiver well-being:

- Breastfeeding
- Maternal mental health
- Access to preventive health care
- Healthy birth spacing
- Tobacco use

Family well-being:

- Health related social needs influenced by social determinants of health (SDOH) (e.g., intimate partner violence, food insecurity, housing stability, transportation needs, and substance use)

What Outcome Areas Will the APM Aim to Affect?

Improved health of the population:

- Well-child visit frequency
- Childhood immunization

- Developmental screening
- Social-emotional/behavioral screening
- Screening for social needs related to SDOH
- Closed-loop referrals
- Pediatric oral health
- Postpartum care
- Postpartum maternal depression

Improved patient experience of care:

- Patient satisfaction

Improved clinical experience:

- Provider satisfaction

Decreased total cost of care related to:

- Well-child visit and immunization rates
- Pediatric oral health
- Appropriate use of outpatient and emergency services
- Breastfeeding
- Postpartum maternal depression
- Intimate partner violence
- Healthy birth spacing
- Smoking cessation

Why Design an APM for HealthySteps?

Now, more than ever, with the impacts of the COVID-19 pandemic and subsequent economic downturn, states and health plans have an opportunity to achieve the quadruple aim of improving outcomes for young children, caregivers, and their families, saving money, and increasing patient and provider satisfaction by creating a true population health focused APM for young children. By explicitly focusing on prevention, screening and follow-up, and trusted relationships, the HealthySteps model can help create the foundation for creating an innovative, dyadic and early childhood pediatric primary care APM.

APPENDIX O

APPENDIX TO

Toward a More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities, 2019

STATE LEGISLATIVE STRATEGIES TO PREVENT & MITIGATE ACES*

This document is a 2020-2021 update of the appendix to the legislative brief "Toward a More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Community Resilience", 2019. The legislation below has been compiled to demonstrate the range of approaches being utilized across the nation to prevent and mitigate ACEs, and to serve as food-for-thought for how legislators can move forward in addressing ACEs strategically. As such, individual pieces of legislation presented here are not necessarily endorsed by the authors of this document.

Section A of this document shows Maryland's and other states' developments across six different legislative mechanisms used to advance the science of ACEs and resilience within policy-making. These six mechanisms are:

1. Joint Resolutions and Executive Orders establishing statewide policy on ACEs
2. Funding for primary prevention of ACEs
3. ACE- or trauma-informed caucuses
4. ACE task forces/workgroups
5. Creation or use of an existing coordinating body for cross-sector collaboration
6. Collection and analysis of ACE related data

Section B of this document presents Maryland's and other states' policy developments across the CDC's "Six Research-Informed Policy Strategies to Prevent and Mitigate ACEs." These six policy strategies are:

1. Strengthen economic supports for families
2. Promote social norms that protect against violence and adversity
3. Ensure a strong start for children
4. Teach skills to caregivers, children, and youth
5. Connect children and youth to caring adults and activities
6. Intervene to lessen immediate and long-term harms of ACEs.

SECTION A: CREATING INFRASTRUCTURE TO TACKLE ACEs - FIVE LEGISLATIVE MECHANISMS

I. JOINT RESOLUTIONS & EXECUTIVE ORDERS ESTABLISHING STATEWIDE POLICY ON ACES

MGA COMMITTEE: Joint Committee on Children Youth & Families | All Standing Committees

Rationale: While resolutions may not require specific action, recognition by federal, state, and local legislative bodies increases awareness of ACEs in households, communities, and the government alike. This is a crucial step in getting the science into the hands of the general public, in developing innovative legislative strategies to prevent and mitigate ACEs, and in creating a system of public services that is ACE-Trauma-& Resilience- Informed.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
JOINT RESOLUTIONS ESTABLISHING STATEWIDE POLICY ON ACES	Governor's Executive Order 01.01.2021.06	*Passed:* Alaska: HCR 21 (2016). Urges Governor Bill Walker to join with the Alaska State Legislature to respond to the public and behavioral health epidemic of adverse childhood experiences by establishing a statewide policy and providing programs to address this epidemic. S105 (2018). Revises licensure of marital and family therapists and creates a state policy directive that "policymakers, administrators, and those working within state programs and grants make decisions based on the principles of early childhood and youth brain development and, whenever possible, consider the concepts of early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, supports, self-regulation, and services." California: CA ACR 140 and CA ACR 145 (2020) Designates the month of January 2020 as Positive Parenting Awareness Month In California, and proclaims January 23, 2020 as Maternal Health Awareness Day, to recognize that positive parenting can prevent or mitigate the effects of adverse childhood experiences and to draw attention to the efforts that have improved maternal health in the state. ACR155 (2014) Recognizes ACEs and urges Governor to identify evidence-based solutions to reduce exposure to ACEs, address the impacts of ACEs, and invest in prevention of ACEs. And, ACR 235 designates a specified date as Trauma Informed Awareness Day, in conjunction with National Trauma Informed Awareness Day, to highlight the impact of trauma and the importance of prevention and community resilience through trauma informed care. Minnesota: HF892/SF1204 (2015) "Resolution on Childhood Brain Development and ACEs". Calls on the Governor to create a cross-sector task force and to support a voluntary tax checkoff on the income tax return form, other dedicated appropriations, or other state

		resources designated for child abuse prevention services with a percentage set aside for program evaluation. New Jersey: SCR100, (2019). Urges Governor to develop strategies to reduce children's exposure to ACEs. Utah: Concurrent Resolution 10 (2017), "Identification and Support of Traumatic Childhood Experiences Survivors". Encourages state officers, agencies, and employees to become informed regarding well-documented detrimental short-term and long-term impacts to children and adults from serious traumatic childhood experiences; and to implement evidence-based interventions and practices that are proven to be successful in developing resiliency in children and adults currently suffering from trauma-related disorders. Wisconsin: SJR59 (2013) Recognizes the effects of ACEs and resolves that the legislature will consider principles of early childhood brain development, toxic stress, adversity, buffering relationships, and the importance of early intervention when creating policy. SJR59 (2013) Recognizes the effects of ACEs and resolves that the legislature will consider principles of early childhood brain development, toxic stress, adversity, buffering relationships, and the importance of early intervention when creating policy. SJR59 (2013) Recognizes the effects of ACEs and resolves that the legislature will consider principles of early childhood brain development, toxic stress, adversity, buffering relationships, and the importance of early intervention when creating policy. *Executive Orders:* Delaware: Executive Order 24 (2018), "Making Delaware a Trauma-Informed State." Declares Delaware a trauma informed state and recognizes the significance of early intervention for children and caregivers exposed to ACEs. *Proposed Policies*: Michigan: MI HCR 2 (2020) Would declare Adverse Childhood Experiences a critical health issue, commits the Legislature to action and encourages the governor to direct agencies to assess and report progress on reducing ACEs.

II. FUNDING FOR PRIMARY PREVENTION OF ACES

MGA COMMITTEE: Appropriations | Budget & Taxation | Finance

Rationale: Most states across the country have developed robust prevention trust funds with combined annual revenues in excess of $100 million dedicated to prevention. Robust Funds generate $1-18 million annually from the corpus of their Funds. Children's Trust Fund Boards actively raise funds to support statewide prevention efforts. This is a gap in Maryland's infrastructure to support prevention.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
CHILDREN'S PREVENTION TRUST FUNDS	Maryland Code, Health General, Sec. 13-2207, (2010) Established Maryland's Children's Trust Fund.	Hawaii: HI Rev Stat § 350B-4 (2016). Kansas: Children's Trust Fund Statute. Massachusetts: S2130, General Laws Sec. 202 (1987) and Sec. 50. Oklahoma: Act No. 231 (2018). Creates the Children's Endowment Fund to stimulate new programs, activities, research or evaluation that will improve the well-being and reduce the ACEs of Oklahoma's children. South Carolina: SC Code § 63-11-910 (2012) through SC Code § 63-11-960. *Proposed Amendments to current Trust Funds:* Colorado: H1044 (2018). Would amend current statutory language in the ""Colorado Children's Trust Fund Act"" to place a greater priority on preventing child maltreatment fatalities and continuing to prevent child maltreatment. This includes reducing the occurrence of prenatal drug exposure and drug endangerment and reducing the occurrence of other adverse childhood experiences.
APPROPRIATE FUNDING FOR STATE & LOCAL ACE INITIATIVES ***"Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings"***[1]		*Passed:* Washington RCW 70.190.010 (1994.) Establishes the Washington Family Policy Council to facilitate services at the local level. Despite significant improved outcomes for children and families, this program was eliminated during the Great Recession.
APPROPRIATE FUNDING FOR ACE EVIDENCE BASED PROGRAMS (EBPs) AND INNOVATION		*Passed:* California S1004 (2018). Provides that the Mental Health Services Oversight and Accountability Commission, on or before January 1, 2020, will establish priorities for the use of

		prevention and early intervention funds. These priorities will include childhood trauma prevention and early intervention to address the early origins of mental health needs. A1812 (2018). Establishes the Youth Reinvestment Grant Program. Provides funds to local jurisdictions and Indian tribes for the implementation of trauma-informed diversion programs for minors. Indiana H 766 (2019) Appropriates $40,000 to support the Iowa effort to address the needs of children who experience adverse childhood experiences. Pennsylvania: S1142 (2018). Establishes the School Safety and Security Grant Program and related Fund. Funds can be used for the administration of evidence-based screenings for adverse childhood experiences and to provide trauma-informed counseling services as necessary to students based upon screening results. Washington S 6259 (2020) Improves the Indian behavioral health system, revises provisions relating to the Indian Health Improvement Reinvestment Account, requires funds in the Account to be expended on programs that address the ongoing suicide and addiction crisis among American Indians and Alaska Natives. *Proposed Policies:* Colorado: S10 (2019). Would allow grant funds to be used for behavioral health care services, including services to support social-emotional health, at recipient schools or through service contracts with community providers.

III. ACE or TRAUMA-INFORMED CAUCUS

MGA COMMITTEE: Joint Committee on Children Youth & Families | All Standing Committees

Rationale: ACEs, Trauma-Informed, or Children's Caucuses have been developed to cultivate a legislature dedicated to advancing NEAR Science promising and evidence-informed public policy that improves the life of every child, from the prenatal stages through young adulthood.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE

ACE OR TRAUMA-INFORMED CAUCUS		Hawaii: Keiki (Children) Caucus, 2019. The Legislative Keiki Caucus is sponsoring 24 senate and house bills focusing on the education, health and well-being of children in Hawai'i. Wisconsin: https://legis.wisconsin.gov/topics/childrenscaucus/. The caucus was founded in 2015 in a joint effort to create a sustainable forum to educate legislators and build bi-partisan support for promising, evidence-informed investments in children and families.

IV. ACE TASK FORCES/WORKGROUPS

MGA COMMITTEE: Joint Committee on Children Youth & Families | All Standing Committees

Rationale: Policy-related Task Forces and Workgroups operate to review and analyze the research, both scientific and policy, to develop coordinated and strategic policy recommendations to address ACEs as a public health epidemic.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
ACE/ TRAUMA- INFORMED TASK FORCES ***"Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings"***[2]	State Council on Child Abuse and Neglect (SCCAN) focuses its' efforts and recommendations on ACEs. *Passed:* SB 567 (2019). Establishes a Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations. Requires the Workgroup to study available science and best practices pertaining to children in traumatic situations, including trauma-informed decision making. and make	*Passed:* Illinois H2649 (2019.) Amends the Code of Criminal Procedure, creates the Task Force on Children of Incarcerated Parents, provides that the Task Force shall review available research, best practices, and effective interventions to formulate recommendations. Maine Act 63 (2019). Convenes a task force to develop guidance for kindergarten-12th grade educators and administrators on appropriate training for and responses to addressing childhood trauma, including ACEs training, trauma informed care, health screenings, and a social-emotional curriculum from K-8th grade. H 851 (2019.) Directs the Commissioner of Education to convene a task force, inviting the participation of experts and interested parties, to develop guidance for kindergarten to grade twelve administrators on appropriate training and responses to childhood trauma. ME H 851 (2019) Directs the Commissioner of Education to convene a task force, inviting the participation of experts and interested parties, to develop guidance for kindergarten to grade twelve administrators on appropriate training and responses to childhood trauma.

	recommendations about how State courts could incorporate the science into child custody proceedings. HB 548 (2021). Establishes the Commission on Trauma Informed Care Task Force to coordinate a statewide initiative to prioritize trauma-response informed delivery of State services that affect children, youth, families, and older adults. Requires the Commission to study developing a process and framing for implementing an Adverse Childhood Experiences (ACEs) Aware Program in the State.	New Hampshire H 111 (2019) Establishes a committee to study the effect of the opioid crisis, substance misuse, adverse childhood experiences, and domestic violence as a cause of post-traumatic stress disorder syndrome, and other mental health and behavioral problems in children and students. Oklahoma Act 112 (2018). Establishes the Task Force on Trauma-Informed Care to identify, evaluate, recommend, maintain, and update a set of best practices for youth who have experienced/ are at risk of experiencing trauma (ACEs). Vermont No.42 (2017). "An Act Relating to Building Resilience for Individuals Experiencing Adverse Childhood Experiences". Establishes 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. Washington H1482 (2018). Establishes the Work First Poverty Reduction Oversight Task Force, which will collaborate with an advisory committee to develop and monitor strategies to prevent and address adverse childhood experiences and reduce intergenerational poverty. Wisconsin S5903 (2019). Creates the Children's Mental Health Workgroup to identify barriers to accessing mental health services, monitor the implementation of legislation and policies relating to children's mental health and consider strategies to improve coordination between education and health systems. H 2116 (2020) Establishes a task force on improving institutional education programs and outcomes, the task force shall examine several issues, including goals and strategies for addressing adverse childhood experiences of students in institutional education and providing trauma-informed care. West Virginia H 4773 (2020) Creates a workgroup to investigate and recommend screening protocols for adverse childhood trauma in this state. *Proposed Policies:* Georgia HR421 (2019). Would create the Committee on Infant and Toddler Social and Emotional Health. Massachusetts HP 122 (2019) Would relate to establishing a working group on adverse childhood experiences and childhood trauma.

		New York A2451(2019). Would establish a task force to identify evidence based and evidence informed solutions to reduce children's exposure to adverse childhood experiences.

V. CREATION OR USE OF AN EXISTING COORDINATING BODY FOR CROSS-SECTOR COLLABORATION

MGA COMMITTEE: Health and Government Operations | Finance | Budget & Taxation

Rationale: Achieving improved outcomes for children requires coordination across public and private systems that serve children and families and must include a multi-generational approach and strengthening adult core capabilities. Coordination must take place at both the state and local levels.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
ESTABLISHED COORDINATING BODY FOR ACE SCIENCE WORK **"Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings"[3]**	Governor's Executive Order 01.01.2021.06	*Passed:* California: Executive Order N-02 (2019). Solidifies the state's promise to address ACEs by creating the position of the Surgeon General, which allows for the creation of health-informed legislation. A887, (2019). Requires the Office of Health Equity to advise and assist other state departments in their mission to increase the general well-being of all state residents and to work toward eliminating adverse childhood experiences. Prescribes the qualifications of the Surgeon General. Eliminates the position of Deputy Director of the Office of Health Equity. Colorado: S195 (2019). Creates the Office of Children and Youth Behavioral Health Policy Coordination in the office of the Governor, creates the Children and Youth Behavioral Health Policy Coordination Commission and the Children and Youth Behavioral Health Advisory Council in the office, provides for the duties, powers, and composition of the commission and the council, makes an appropriation. DC R 865 (2020.) Declares the existence of an emergency with respect to the need to amend the Data Sharing and Information Coordination Amendment Act to allow the disclosure of health and human services information to aid in the development of the report on the root causes of youth crime and the prevalence of adverse childhood experiences among justice involved youth. B 810 - DC B 811 (2020) Amends, on an emergency basis, the Data Sharing and Information Coordination Amendment Act to allow the disclosure of health and human services information to aid in the development of the report on the root causes of youth crime and the prevalence of adverse childhood experiences among justice involved youth.

		B 927 (2020) Allows the disclosure of health and human services information to aid in the development of the report on the root causes of youth crime and the prevalence of adverse childhood experiences among justice-involved youth, allows the disclosure of mental health information when necessary. R 958 (2020) Declares the existence of an emergency, due to congressional review, with respect to the need to amend certain Acts to allow the disclosure of health and human services information to aid in the development of the report on the root causes of youth crime and the prevalence of adverse childhood experiences among justice-involved youth. Vermont: Act 204 (2018). Creates the permanent position of Director of Trauma Prevention and Resilience Development within the Office of the Secretary in the Agency of Human Services. The role of the Director is to direct public health approaches to address ACES, toxic stress, and resilience. HB1965 (2011) "An Act Relating to Public and Private Partnership in Addressing Adverse Childhood Experiences". Creates the Washington State ACEs Public Private Initiative
		Passed: Oklahoma S 446 (2019) Relates to schools, directs the State Department of Education and the Department of Mental Health and Substance Abuse Services, in certain consultation, to develop and make available to school districts certain information, training and resources regarding the mental health needs of students. *Proposed Policies:* Indiana S 273 (2020) Would establish the Indiana behavioral health commission and directs it to conduct a series of reports that assess behavioral health in Indiana. Michigan H 5396 (2020) Would provide omnibus budget appropriations, including for the development and operation of a resiliency center for families and children to address the multifaceted needs of those experiencing trauma, toxic stress, chronic disability, neurodevelopmental disorders, or addictions. Washington RCW 70.190.010 (1994.) Would establish the Washington Family Policy Council to facilitate services at the local level. Despite significant improved outcomes for children and families, this program was eliminated during the Great Recession.

VI. COLLECTION AND ANALYSYS OF ACE RELATED DATA

MGA COMMITTEE: Education, Health and Environmental Affairs

Rationale: The original ACE study and decades of research since have linked ACEs to an increased risk of developing chronic diseases and behavioral challenges. The greater the number of ACEs, the greater the risk for negative outcome. Analyzing ACE data, we can work together to help create neighborhoods, communities, and a world in which every child can thrive.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
	Passed: HB 258 / SB 592 (2021) Alters the information the Department of the Human Service (DHS) must report to the General Assembly and publish on the DHS website regarding children and foster youth in the State child welfare system. HB 771 / SB 548 (2021) Requires the Maryland State Department of Education (MSDE), in coordination with the Maryland Department of Health (MDH), to include at least five questions from the Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS) on adverse childhood experiences (ACEs) or positive childhood experiences in the Youth Risk Behavior Surveillance System survey. People with ACE exposure may show signs of behavioral and mental health challenges. They may be irritable, depressed, display acting-out behaviors, and show other traumatic stress symptoms. Continued exposure to violence and other adversity increases the risk that these patterns will continue affecting their own future and their children's future. Timely access to	*Passed:* Washington State S 6191 (2020) Assesses the prevalence of adverse childhood experiences in middle and high school students to inform decision making and improve services, provides for the Healthy Youth Survey.

	assessment, intervention, and effective care, support, and treatment for children and families in which ACEs have already occurred can help mitigate the health and behavioral consequences of ACEs, strengthen children's resilience, and break the cycle of adversity. *Proposed Policies:* HB666 (2020) Establishes a Workgroup on Screening Related to Adverse Childhood Experiences; requiring the Workgroup to update, improve, and develop certain screening tools, submit screening tools to the Maryland Department of Health, and study and make recommendations on the actions primary care providers should take after screening a minor for mental health disorders that may be caused by or related to ACEs.	

SECTION B: THE CDC'S SIX RESEARCH INFORMED POLICY STRATEGIES TO PREVENT OR MITIGATE ACEs[4]

I. STRENGTHEN ECONOMIC SUPPORTS FOR FAMILIES

MGA COMMITTEE: Economic Matters | Finance

Rationale: Policies that strengthen economic supports to families (increasing the minimum wage, paid family leave, paid sick and safe leave, earned income tax credits, child care subsidies, affordable housing, temporary cash assistance, flexible and consistent work schedules, and other family-friendly work policies) have been shown to increase economic stability and family income, increase maternal employment, increase parental ability to meet children's basic needs, and reduce parental stress, including financial stress, maternal

depression, and conflict in family relationships[5] [6] [7] [8]. Parental stress compromises effective parenting and increases the risk of family violence and other ACEs. Furthermore, 4 in 10 children live in low-income households[9],1 in 10 live in deep poverty[10], and research consistently links low incomes to ACE exposure and poor long-term health, educational, and social outcomes[11] [12].

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
LIVING WAGE **Research has shown that increased wages can lead to lower instances of child abuse and neglect, as releasing families of financial burden can reduce parental stress and allow parents to provide for their children.[13]**	Increased Minimum Wage *Passed:* HB166 / SB 280 "Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)" in 2019, Raises the minimum wage to $15/ hour by 2024.	*Passed:* Illinois SB81 (2018). Increases minimum wage to $15/hour by 2025. Massachusetts: H4640 (2018) Increases minimum wage to $15/ hour over five years. *Proposed:* New Jersey: A15 (2019.) The bill would raise minimum wage to $15/ hour by 2024, with tipped workers earning a minimum of $9.87 by 2024.
PAID FAMILY LEAVE **The time after the birth or adoption of a baby is an essential time of development for babies and families. Because early relationships nurture early brain connections that form the foundation for all learning and relationships that follow, parents and caregivers are on the front line of preparing our future workers, innovators, and citizens.** **Paid Family Leave supports babies' health & development. Newborns reap the benefits of paid family leave, including:** **better bonding with parents,[14]** **increased breastfeeding and health benefits for mother and child,[15]** **vaccination completion,[16] decreased**	*Passed:* SB 859 / HB 775 "State Employees – Parental Leave" in 2018. Provides up to 12 weeks of paid leave for State employees following the birth or adoption of a child.[20] *Proposed Policies:* HB 34 (2021) Would establish the Family and Medical Leave Insurance (FAMLI) program and FAMLI Fund to provide up to 12 weeks of benefits to a covered individual taking leave from employment due to specified personal and family circumstances. Research shows that parents facing financial hardships are more likely to experience stress, depression, and conflict in their relationships and family, all of which increase the risk for violence and other	*Passed:* Massachusetts: H4640 (2018). Provides family leave to individuals to bond with their newborn, foster or adoptive child for up to twelve weeks; to provide care in the case of a family member's deployment; or to care for a family member who is a covered service member. The bill also provides medical leave to anyone with a serious health condition for up to 20 weeks. New Jersey: A3975 (2019). Paid family leave was established in 2014 and expanded in 2019. Provides paid family leave in order to "to maintain consumer purchasing power, relieve the serious menace to health, morals and welfare of the people caused by insecurity and the loss of earnings, to reduce the necessity for public relief of needy persons, to increase workplace productivity and alleviate the enormous and growing stress on working families of balancing the demands of work and family needs, and in the interest of the health, welfare and security of the people" New York: Chapter 54 (2016). Provides paid family leave, allotting 10 weeks for paid family leave at 55% average earnings, and 12 weeks at 67% average earnings beginning in 2021. Washington: SP.L.5975 (2017). Provides paid leave finding if it is associated with health benefits, including reduced infant mortality and increased well-baby visits,

infant mortality,[17] increased placement in high quality stable childcare,[18] and a reduction in child abuse.[19]	ACEs. Parents facing financial hardship are also have fewer resources to invest in their children and face difficult choices when trying to balance work and family responsibilities. About 4 in 10 children under the age of 18 in the United States live in a low-income household including more than half African American and Hispanic children. Addressing social and economic underpinnings of ACEs is critical to achieve lasting and sustainable effects. Policies that strengthen household financial security and family-friendly work policies can prevent ACEs by increasing economic stability and family income, increasing maternal employment, and improving parents' ability to meet children's basic needs and obtain high-quality childcare.	increased child development and reduced child health problems, as well as increased paternal engagement with children. Provides a paid family and medical leave insurance program for placement of a child/ birth of a child, care of a family member with a serious health condition, and for one's own serious health condition. Maximum leave is 12 times the typical amount of workweek hours per 52 weeks. *Proposed:* California: Act 686 (2017). Establishes aid family leave and disability insurance across the state.
PAID SICK & SAFE LEAVE	*Passed:* HB1 (2018) "Maryland Health Working Families Act." Employers with fewer than 15 employees must provide unpaid sick and safe leave.	None known or reported by NCSL that reference N.E.A.R. Science.
INCREASED EARNED INCOME TAX CREDITS (EITC) **Research has shown that tax credits, such as EITCs increase income for working families, lift millions of families above the poverty line, offsets the costs of child care, decreases infant mortality, maternal stress and mental health problems, and child behavioral problems (e.g., aggression, anxiety, and hyperactivity that impact later perpetration of violence) ;and,**	*Passed:* HB 810 / SB 870 "Income Tax – Child and Dependent Care Tax Credit - Alteration" in 2019. Expands Maryland's Child and Dependent Care Tax Credit for the first time in nearly two decades—increasing the income threshold from $50,000 to $143,000 for married couples (and to $92,000 for individuals), indexing these limits annually for inflation, and making the credit refundable for low-income filers.[22]	*Passed:* Colorado: HB17-1002 (2017). Grants an earned income tax credit expansion for childcare expenses for families who earn an adjusted gross income of $25,000 or less. The tax credit is equal to 25% of childcare expenses during the tax year up to $500 for one child and $1,000 for two or more children. South Carolina: Act 40 (2018). Establishes an earned income tax credit, which is shown by research to encourage workforce participation and increase earnings. Virginia: Chapter 29 (2016). Provides annual notice to recipients of state benefits of the availability of federal and state earned income tax credit to increase outreach and claiming of the tax credit.

increases health insurance coverage, school performance, and parents' ability to provide for their children physically and emotionally.[21]		
AFFORDABLE EARLY CHILD CARE *Increased Child Care Subsidies* **Childcare subsidies tend to promote parents accessing higher quality childcare. This increases the likelihood that children will experience safe, stable, nurturing relationships & environments.** **Access to affordable childcare reduces parental stress and maternal depression, key risk factors for child abuse and neglect and other risk behaviors associated with ACEs.[23]**	*Passed:* SB 379 / HB 430 (2018) Increases childcare subsidy rates, establishing mandatory funding levels so that rates never again fall so low. HB 248 / SB 181 (2019). Accelerates the mandated increase of childcare subsidy rates. Beginning July 2020, subsidy rates must equal or exceed and remain at 60 percent of market rates.	*Passed:* California A-108 (2018). Creates county-based child care subsidy plan to decrease the cost of child care for low income families. District of Columbia: A22-0453 (2018). Expands the income eligibility for subsidized child care to increase access to child care and develops a competitive compensations scale for educators in child development centers to increase quality of care. Louisiana: Act 354 (2015). Establishes an Early Childhood Education Fund to provide funding for early childhood care placements for low-income families through childcare assistance programs.
FLEXIBLE AND CONSISTENT WORK SCHEDULES **Provide parents with a predictable pattern of work, making it easier to access quality childcare. Children whose parents work unpredictable schedules have more cognitive deficits. Parents with irregular shift times are also more prone to work-family conflict and stress, which are risk factors for multiple forms of violence.**		None known or reported by NCSL that reference N.E.A.R. Science.
AFFORDABLE HOUSING **A major component of creating family stability is ensuring that each family and child has a safe, stable place to live. Affordable housing policies, such as rent controls and inclusionary zoning. which requires a specified percentage of new housing construction to be affordable to people**		*Passed:* Louisiana: RS33 (2006). Permits municipalities to use inclusionary zoning to promote development of affordable housing for low-income families, given the lack of affordable housing and the health and wellbeing concerns that come with it.

with low or moderate incomes, help ensure that each child has a safe place to live.[24]		
MULTI- GENERATIONAL APPROACH TO HUMAN SERVICES BENEFITS		*Passed:* Hawaii: SB1227 (2019). Recognizes the connection of intergenerational poverty and ACEs and requires the Human Services agency implement an integrated and multigenerational approach designed to improve the social well-being, economic security, and productivity of the people of the State, and to reduce the incidence of intergenerational poverty and dependence upon public benefits. (pending) Massachusetts H 4808 (2020) Makes appropriations for the current fiscal year to authorize certain coronavirus spending in anticipation of federal reimbursement.

II. PROMOTE SOCIAL NORMS THAT PROTECT AGAINST VIOLENCE & ADVERSITY

MGA COMMITTEE: Joint Committee on Children Youth & Families |Ways & Means | Appropriations | Finance | Budget & Taxation | Health & Government Operations

Rationale: "Norms are group-level beliefs and expectations about how members of the group should behave. Changing social norms that accept or allow indifference to violence and adversity is important in the prevention of ACEs.[25] [26] [27] [28] [29]" Pieces of legislation that promote community norms around a shared responsibility for the health and well-being of all children[30]; support parents and positive parenting, including norms around safe and effective discipline[31]; foster healthy and positive norms around gender, masculinity, and violence to protect against violence towards intimate partners, children, and peers[32] [33] [34]; reduce stigma around help-seeking[35]; and enhance connectedness to build resiliency in the face of adversity[36] [37], help families and communities prevent ACEs and other forms of childhood trauma.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
PUBLIC EDUCATION CAMPAIGNS have been shown to help parents understand the cycle of abuse; Campaigns targeting child physical abuse positively impact parenting practices,		*Passed:* California ACR 140 (2020) Designates the month of January 2020 as Positive Parenting Awareness Month In California, partially in recognition

reduce children's exposure to parental anger and conflict and reduce child behavior problems.[38]		that positive parenting can prevent or mitigate the effects of adverse childhood experiences.
LEGISLATIVE APPROACHES TO REDUCE CORPORAL PUNISHMENT are associated with decreases in the use of harsh physical punishment to discipline children and help to establish social norms around safer, more effective discipline strategies.[39] [40] **Experiencing harsh physical punishment as a child increases mental health problems, weakens school performance, lowers self-esteem and increases risk for involvement in crime and violence in adolescence and later perpetration of violence toward a partner and one's own children.**[41]		None known or reported by NCSL that reference N.E.A.R. Science.
BYSTANDER APPROACHES & EFFORTS TO MOBILIZE MEN & BOYS AS ALLIES "Bystander approaches and efforts to mobilize men and boys as allies in prevention change the social context for violent and abusive behavior. Programs such as Green Dot and Coaching Boys into Men®, for instance, have been shown to reduce violence against dating partners, negative bystander behaviors (such as laughing at sexist jokes or encouraging abusive behaviors), as well as sexual violence perpetration and victimization."[42]		None known or reported by NCSL that reference N.E.A.R. Science.

III. ENSURE A STRONG START FOR CHILDREN

MGA COMMITTEE: Ways & Means | Appropriations | Finance | Budget & Taxation | Health & Government Operations

Rationale: The knowledge and understanding of core concepts of neuroscience, ACEs, and resilience should serve as a foundation for public policies that affect the lives of children, their families, and their communities. Building strong healthy families and communities requires that we make investing in early childhood a high priority to ensure social, emotional, behavioral, cognitive, and physical health throughout the lifespan. It is much easier and less expensive to support caregivers, families and communities to build a strong foundation in early childhood than to wait and address weaknesses in the foundation later. Waiting to address symptomatic behaviors (e.g., youth disconnection, homelessness,

school failure, substance abuse, etc.) and illness (e.g., depression, anxiety, suicide, etc.) until children enter school, their teen years, or adulthood requires expending more resources and producing less satisfactory results for both the individuals and the communities in which they live.[43]

High quality early investments (e.g., evidence-based home visiting, early child care and education, pre-K, and infant mental health programs, all with an effective family engagement component) in children prenatal to 5, i.e.," going upstream," is essential to healthy brain development and preventing the intergenerational transmission of the impact of childhood trauma. Evidence-based (EBP) and promising home visitation program models. Effective programs include services such as parent-child therapy to build the parent-child relationship, which has been shown to be a key factor in decreasing early stress and adversity, developing supportive parental practices, which are associated with positive child behavior and development. Because no child or family is immune to ACE exposure, extensive, universal home visitation programs which allow service providers to identify the needs of families and refer them to the proper resources, as well as provide education and support to families, can drastically decrease instances of childhood trauma, particularly exposure to a parent with mental health disorders, substance abuse disorder, or domestic violence in the home.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
EVIDENCE- BASED & PROMISING HOME VISITING PROGRAM MODELS **Not only have home visitation programs been shown to be effective in reducing ACEs, but they have also been shown to offer a high rate of return on investment, offsetting the costs of implementing the programs themselves.[44]** **Studies show that, when provided with home visitation services, families with children between three and six years of age who had been exposed to multiple ACEs were two times less likely to have referrals to child protective services, four times more likely to develop at an age appropriate pace, and five times less likely to show signs of aggression compared to families that did not participate in any home visitation programs. [45]**	*Passed:* HB 699 / SB 566-The Home Visiting Accountability Act of 2012., Requires - the state fund only evidence-based and promising home visiting models; and, that 75% of funding go to evidence-based models. SB 373 / HB 547 "Education – Head Start Program – Annual Funding (The Ulysses Currie Act)" in 2018. Restores a $1.2 million budget cut imposed in 2009, potentially increasing services for more than 2,100 Head Start children. SB 912 / HB 1685 "Maryland Prenatal and Infant Care Coordination Services Grant Program Fund (Thrive by Three Fund)" in 2018. Creates a grant program to expand the coordination of direct services for jurisdictions with a high percentage of births to Medicaid-eligible mothers.	*Passed:* Arkansas: Act 528 (2013). Establishes a statewide voluntary home visiting service to promote prenatal care and healthy births, requires that state agencies develop protocols for collecting and sharing program data with providers to include in child welfare and health data systems. California S 98 Extends the date for completion of a standardized English language teacher observation protocol by the State Department of Education. Requires the Superintendent of Public Instruction to administer childcare and development programs that offer a full range of services and to reimburse contracting agencies for certain state subsidized childcare programs due to the ongoing impacts of closures and low attendance due to the coronavirus pandemic. Kentucky: Chapter 118 (2013). Provides voluntary home visit for at-risk parents during the prenatal period-3rd birthday, establishes goals for statewide home visiting system, and requires programs to adhere to research based or promising models. Maine: Chapter 683 (2011). Requires that the Department of Health and Human Services offers voluntary universal home visiting for new families regardless of family income. Texas: Chapter 421 (2013). Establishes the voluntary Texas home visiting program for pregnant women and families with children under the age of 6, requiring that home visit programs be evaluated and submit reports biannually.

		Proposed Policies: Hawaii SR 16 (2020) Would urge the Department of Health to expand and improve Hawaii's home visiting program. Vermont: H500 (2019). Would establish a universal home visiting program and parenting classes for families caring for a newborn infant and calls for the evaluation of current home visiting services in each district to determine where there are unmet needs and which evidence-based and home visiting models are appropriate. The bill also provides $100,000 in grants to three parent child centers for the creation of pilot programs offering parenting classes, with the hope of preventing multigenerational childhood trauma.
ACCESSIBLE HIGH QUALITY CHILD CARE *Invest in early childhood development: Reduce deficits, strengthen the economy.*, Heckman, J. J. (2013). **High quality childcare programs with family engagement help children build a strong foundation for future learning and help build physical, social, emotional, and cognitive skills. They buffer young children from ACEs by creating safe, stable, nurturing, and supportive environments for the child and parent or caregiver.**[46]	*Passed:* SB 379 / HB 430 (2018) Increases childcare subsidy rates, establishing mandatory funding levels so that rates never again fall so low. HB 248 / SB 181 (2019). Accelerates the mandated increase of childcare subsidy rates. Beginning July 2020, subsidy rates must equal or exceed and remain at 60 percent of market rates.	*Passed:* Colorado H 1053 (2020) Concerns measures to support the early childhood educator workforce, directs the department to develop a statewide professional development plan to support mental health consultants, requires the plan to include training related to trauma and trauma-informed practices and interventions, adverse childhood experiences, and the science of resilience, among others. New York (2019) S 4990 (2019) Amends the Social Services Law, requires training with respect to adverse childhood experiences, focused on understanding trauma and on nurturing resiliency, for day care providers.
HIGH QUALITY AFFORDABLE PRE-K **High quality affordable Pre-K help children build a strong foundation for future learning and help build physical, social, emotional, and cognitive skills. They buffer young children from ACEs by creating safe, stable, nurturing, and supportive environments for the child and parent or caregiver.**[47]	*Passed:* SB 1030 (2019). As part of "The Blueprint for Maryland's Future," requires a 3 year "down payment" on the implementation Kirwan Commission recommendations totaling approximately $1 billion of State funding for pre-kindergarten will expand by $31.7 million in FY 2020 and an estimated $53.6 million in FY 2021. [48]	*Passed:* Maine S 287 Requires the Commissioner of Education to implement a statewide voluntary early childhood consultation program to provide support, guidance, and training to families, early care and education teachers, and providers working in public elementary schools, child care facilities, family child care settings, and Head Start programs serving infants and young children who are experiencing challenging behaviors that put them at risk of learning difficulties and removal from early learning.

	HB 1415 (2018). Preserves $22.3 million in pre-K expansion dollars that might otherwise have been lost when a federal grant expired.	

IV. TEACH SKILLS TO PARENTS, CAREGIVERS, CHILDREN, & YOUTH

MGA COMMITTEE: Ways & Means | Finance | Health & Government Operations | Judiciary | Judicial Proceedings

Rationale: Policies that promote healthy parenting, keep children, parents, and families connected rather than separated, and provide evidence-based skill building for parents, family members, and community caregivers (home visitors, medical providers, childcare workers, educators, after-school child and youth serving providers and mentors) have been proven to improve developmental outcomes in children and decrease instances of abuse and neglect. It is also crucial that lawmakers focus on policies which recognize the importance of building awareness in families and communities about NEAR Science and the need to prevent ACEs and mitigate their effects by addressing trauma and its impacts.

Opportunities in all child and family serving systems that help adults to develop and practice executive function skills, including impulse control, emotional control (self-regulation), flexible thinking, working memory, self-monitoring, planning and prioritizing, task initiation, and organization help to provide the experiences that strengthens parts of the brain that tend to be less developed in adults who have experienced childhood trauma. Through effective training and coaching, executive function skills may be strengthened and lead to improved outcomes in relationships (people skills), parenting, money management, educational attainment and career success.[49] Coaching parents who have been impacted by ACEs, in turn helps ensure the development of those skills in their children and subsequent generations.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
EVIDENCE-BASED (EBP) & PROMISING HOME VISITATION PROGRAMs **Studies show that, when provided with home visitation services, families with children between three and six years of age who had been exposed to multiple ACEs were two times less likely to have referrals to child protective services, four times more likely to develop at an age appropriate pace, and five times less likely to show signs of aggression compared to families that did not participate in any home visitation programs.** [50]	*Passed:* HB699/SB566-The Home Visiting Accountability Act of 2012. Requires the state fund only evidence-based and promising home visiting models; and, that 75% of funding go to evidence-based models. [51]	*Passed:* Arkansas: Act 528 (2013). Establishes a statewide voluntary home visiting service to promote prenatal care and healthy births, requires that state agencies develop protocols for collecting and sharing program data with providers to include in child welfare and health data systems. Colorado CO S 10 (2019) Allows grant funds to be used for behavioral health care services, including services to support social-emotional health at recipient schools or through service contracts with community providers. CO H 1053 (2020) Concerns measures to support the early childhood educator workforce, directs the department to develop a statewide professional development plan to support mental health consultants, requires the plan to include training related to trauma and trauma-informed practices and interventions, adverse childhood experiences, and the science of resilience, among others.

		IN H 1283 (2020) Relates to trauma response instruction for teachers, requires a teacher preparation program to include training on trauma response instruction and recognition of social, emotional, and behavioral reactions to trauma that may interfere with students' academic functioning. Kentucky: Chapter 118 (2013). Provides voluntary home visit for at-risk parents during the prenatal period-3rd birthday, establishes goals for statewide home visiting system, and requires programs to adhere to research based or promising models. (I did not find this bill) Maine: Chapter 683 (2011). Requires that the Department of Health and Human Services offers voluntary universal home visiting for new families regardless of family income. New York S 4990 (2019) Amends the Social Services Law, requires training with respect to adverse childhood experiences, focused on understanding trauma and on nurturing resiliency, for day care providers. Texas: Chapter 421 (2013). Establishes the voluntary Texas home visiting program for pregnant women and families with children under the age of 6, requiring that home visit programs be evaluated and submit reports biannually. *Proposed Policies* Vermont: H500 (2019). Would establish a universal home visiting program and parenting classes for families caring for a newborn infant and calls for the evaluation of current home visiting services in each district to determine where there are unmet needs and which evidence-based and home visiting models are appropriate. The bill also provides $100,000 in grants to three parent child centers for the creation of pilot programs offering parenting classes, with the hope of preventing multigenerational childhood trauma.
EB & PROMISING PARENTING AND FAMILY SKILL BUILDING PROGRAMS **Shown to decrease early stress and adversity and develop supportive**		*Passed:* Vermont: H500 (2019). Provides $100,000 in grants to three parent child centers for the creation of pilot programs offering parenting classes, with the hope of preventing multigenerational childhood trauma.[53]

parental practices, which are associated with positive child behavior and development.[52]		
EB & PROMISING PROGRAMS FOR PARENTS WITH A HISTORY OF SUBSTANCE USE DISORDER **Providing comprehensive care to parents who struggle with substance use disorder has been shown to increase parent and child welfare.**[54]		None known or reported by NCSL that reference N.E.A.R. Science.
EB & PROMISING PROGRAMS & VISITATION PROGRAMS FOR INCARCERATED PARENTS AND THEIR CHILDREN **Research has shown strong links between parent-child relationships and childhood development, meaning that it is crucial to enact programs that allow for visitation between children and their incarcerated parents when possible.**[55]		*Passed:* Hawaii: SCR7 (2019). Establishes that human services and public safety work to develop a plan for the establishment of visitation centers at all state correctional facilities and jails for children to visit their incarcerated parent. The resolution recognizes that the incarceration of a parent is seen as an ACE and can lead to adverse outcomes for children and that parental bonding is essential for children's development. Illinois: H2444 (2019). Amends code of corrections to expand consideration of factors such as whether the defendant is the parent of a child or if the defendant serves as a caregiver to someone who is ill, disabled, or elderly in sentencing, recognizing the parental incarceration is an ACE and can have adverse effects on the child. Missouri: Chapter 217 (2018). Creates a women offender program to ensure that female offenders are provided with trauma-informed and gender responsive supervision strategies, including physical and mental health care, child visitation, and more.

Teach skills to caregivers, children, and youth		Oregon: SB241 (2017). Establishes a bill of rights for children with incarcerated parents, including the right to be protected from additional trauma at the time of parental arrest, the right to remain informed about their parent's arrest in an age-appropriate manner, the right to see, speak with and touch their incarcerated parent, and more. Texas: S1356 (2013). Requires all juvenile probation and supervision officers receive training on trauma informed care administered by the Department of Human Resources. In H650 (2019). Requires correctional officers to be trained on issues relating to the physical and mental health of pregnant inmates, including appropriate care, the impact of incarceration on a pregnant inmate and the unborn child, the use of restraints, the placement of administrative segregation, and invasive searches. The Act also includes provisions for reviewing visitation policies and evidence-based visitation practices that enhance paternal bonding and engagement and allow for age-appropriate visiting activities for children who visits their parents in correctional facilities. *Proposed Policies:* New York NY A 4268 (2020) Would provide for mandating training of direct care workers in adverse childhood experiences. Oregon: SB241 (2017). Would establish a bill of rights for children with incarcerated parents, including the right to be protected from additional trauma at the time of parental arrest, the right to remain informed about their parent's arrest in an age-appropriate manner, the right to see, speak with and touch their incarcerated parent, and more. Tennessee TN H 2588 (2020) Would require that a video on adverse childhood experiences be shown to parents attending a parent educational seminar. Texas: H2168 (2019). Would require screening of each inmate during the diagnostic process to determine whether the inmate has experienced ACEs or other significant trauma and refer the appropriate care when needed. The bill also requires screening and care for defendants. Washington: S5876 (2019). Would create a women's division of correctional system to develop a system of gender responsive, trauma informed practices

		within the department of corrections, informed by individuals with training in ACEs and trauma informed practices.

V. CONNECT CHILDREN & YOUTH TO CARING ADULTS & ACTIVITIES

MGA COMMITTEE: Ways & Means | Education, Health, & Environmental Affairs | Finance | Appropriations | Health & Government Operations | Judiciary | Judicial Proceedings

Rationale: Research suggests that mentoring and after school programs improve outcomes across behavioral, social, emotional and academic domains[56]. Opportunities to develop and practice executive function skills, including impulse control, emotional control (self-regulation), flexible thinking, working memory, self-monitoring, planning and prioritizing, task initiation, and organization help to provide the experiences that strengthens parts of the brain that tend to be less developed in children who experience chronic adversity. Experiences that improve executive function, improve the leadership, decision-making, self-management, and social problem-solving skills of children and youth and are important components of mentoring and after-school programs with documented success; and, help kids to be attain success in relationships, in school, and in their careers.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
MENTORING PROGRAMS		None known or reported by NCSL that reference N.E.A.R. Science.
AFTER SCHOOL PROGRAMS CONNECT CHILDREN AND YOUTH TO CARING ADULTS AND COMMUNITIES	Project Bounce Back An initiative of the Governor, Project Bounce Back creates a public-private partnership to help Maryland youth to recover from the devastating impacts of the Covid – 19 pandemic. It will provide strategic mental health services, expand the footprint of youth development programs and develop new solutions to build post Covid resilience among Maryland's youth.	None known or reported by NCSL that reference N.E.A.R. Science.

VI. INTERVENE TO LESSEN IMMEDIATE & LONG-TERM HARMS OF CHILDHOOD TRAUMA & ADVERSITY

MGA COMMITTEE: All Standing Committees

Rationale: Recognizing and effectively responding to lessen the immediate and long-term harms of childhood trauma and adversity is the responsibility of all adults in the community, as well as state and local child and family serving agencies. Primary care, mental and behavioral health, Medicaid and private insurance, public health, schools and other youth serving organizations, higher education, child welfare, juvenile and criminal and civil justice systems, along with neighborhood and businesses and faith-based communities, should align their policies and practices with NEAR Science. Children and youth with ACE exposure are at risk for school failure, behavior problems, suspension and expulsion, teen pregnancy, depression, anxiety, suicide, youth violence, as well as physical health problems. Early family centered interventions with evidence-based and promising treatments for children and parents, trauma-informed policies and practices within child and family serving systems, as well as connection to at least one safe, stable, and nurturing adult has been proved to reduce ACEs and their impacts in communities across the country.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
ENHANCED PRIMARY CARE CREATION OF STATE SURGEON GENERAL		*Passed:* California: Executive Order N-02 (2019). Solidifies the state's promise to address ACEs by creating the position of the Surgeon General, which allows for the creation of health-informed legislation. A887 (2019). Requires the Office of Health Equity to advise and assist other state departments in their mission to increase the general well-being of all state residents and to work toward eliminating adverse childhood experiences. Prescribes the qualifications of the Surgeon General.
ENHANCED PRIMARY CARE TRAINING FOR MEDICAL PROFESSIONALS	*Passed:* HB 78- SB 52 (2021) – Maryland Commission on Health Equity - Creates an advisory committee, requires state agencies to maintain and provide data sets on race. Race is a social construct with no biological basis that artificially divides people into distinct groups based on characteristics such as physical appearance, ancestral heritage, cultural affiliation, and the social, economic, and	*Passed:* CA: AB 1340 (2017). Requires Medical Board to consider including a course for primary care providers on integrated mental and physical health care, expressly to identify and treat mental health issues in children and young adults. Medi-Cal (Medicaid) Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). *Proposed Policies:* New York: A2754 (2019). Would require doctors to complete education regarding screening for ACEs in children before they can re-register to practice medicine. This bill is still pending in the legislature.

	political needs of a society at a given period. Racism has been declared as a public health crisis. There are several strategies that can prevent ACEs from happening. ACE task forces and workgroups is one of the strategies that can be implemented to fight racism. Organizing group meetings and discussing the impact of racism on accessibility of public health is the small step that could help to fight systematic racism. . *Proposed Policies:* HB1036-SB 675 (2021). The bill would require the Judiciary, in consultation with domestic violence and child abuse organizations, to develop a training program for judges presiding over child custody cases involving child abuse or domestic violence. The training must include numerous specific topics that prevent adverse childhood experience. The judges will learn about typical brain development of infants and children, the dynamics and effects of child sexual abuse, physical and emotional child abuse, and domestic violence as well as the impact of exposure to domestic violence on children and the importance of considering this impact when making child custody and visitation decisions.	
ENHANCED PRIMARY CARE EARLY SCREENING & DETECTION OF ACES **may be used to identify and address ACE exposures with brief screening assessments and referral to intervention services and supports.[57] [58] [59] For children, assessments are completed with parents/caregivers to identify risks such as parental substance**	*Passed:* HB 771 / SB 548 (2021) Requires the Maryland State Department of Education (MSDE), in coordination with the Maryland Department of Health (MDH), to include at least five questions from the Centers for Disease Control and	*Passed:* California: AB340 (2017). Establishes a working group to address the provision of trauma screening under Medi-Cal. Chapter 843 (2018). Requires the Mental Health Services Oversight Commission to create a plan to implement and monitor mental health and trauma screening and detection services. Since then, the state has approved

use, intimate partner violence, depression, stress and the use of harsh punishment. [60] Screening and assessing adults would identify a history of ACE exposures and help mitigate risk and improve treatment outcomes.[61] [62] Strong policies would ensure that intervention services are tailored to assessment findings and coordinated with and between community agencies.[63]	Prevention (CDC) Youth Risk Behavior Survey (YRBS) on adverse childhood experiences (ACEs) or positive childhood experiences in the Youth Risk Behavior Surveillance System survey. People with ACE exposure may show signs of behavioral and mental health challenges. They may be irritable, depressed, display acting-out behaviors, and show other traumatic stress symptoms. Continued exposure to violence and other adversity increases the risk that these patterns will continue affecting their own future and their children's future. Timely access to assessment, intervention, and effective care, support, and treatment for children and families in which ACEs have already occurred can help mitigate the health and behavioral consequences of ACEs, strengthen children's resilience, and break the cycle of adversity.	an allocation of $45 million for the 2019-2020 fiscal year to reimburse pediatricians for participating in ACE screening of their patients, and another $50 million to train pediatricians in conducting the screenings. In this way, doctors are encouraged to screen their patients for ACEs and other traumatic events, which will allow them to refer patients to the proper behavioral and mental health services if necessary to prevent the onset of long-term negative health outcomes as a result of high trauma exposure. District of Columbia: Act 179 (2018). Requires that the Mayor for Health and Human Services expand and coordinate health care for infants and toddlers under three years of age, including early screening for ACEs and related health outcomes. A22-0453 (2018). Requires the Department of Health to implement Healthy Steps, a primary care program which promotes healthy development and provides parenting support, medical care, and resources for mental health, domestic violence, food and shelter, and more to ensure that the needs of children ages 0-3 are met. Hawaii: HB908 (2013). Establishes a statewide hospital-based home visiting program to identify families of newborns at risk for poor health outcomes and to promote healthy child development through universal screening of newborns and referral of high-risk families to evidence-based home visit services. Maine: Act 63 (2019). Convenes a task force to develop guidance for kindergarten-12th grade educators and administrators on appropriate training for and responses to addressing childhood trauma, including ACEs training, trauma informed care, health screenings, and a social-emotional curriculum from K-8th grade.
EXPANSION OF INSURANCE COVERAGE TO MENTAL, BEHAVIORAL, & SOCIAL-EMOTIONAL HEALTH CARE TREATMENTS, INCLUDING MULTI-GENERATIONAL PROVISION OF SERVICES (INFANT MENTAL HEALTH) **Various forms of counseling, including Trauma Informed Cognitive Behavioral Therapy, have proven to be successful in**		*Passed:* California: Chapter 855 (2018). Modifies the definition of "medically necessary services" to include early screening, diagnosis and treatment programs such as screening for mental health disorders, behavioral health disorders, and trauma. Connecticut: S1085 (2015). Requires health insurance policies to cover mental and nervous conditions, maternal, infant and early childhood home visitation services, and other home-based interventions for children.

mitigating the harmful impacts of ACE exposure, both in children and adults. However, often services are not covered by insurance plans, including Medicaid. By expanding Medicaid and Insurance program coverage to support behavioral and mental health services, more people will be able to access needed services. Behavioral and mental health services designed to address trauma exposure show considerable long term saving on many public service programs, as they work to prevent chronic health conditions, response to domestic abuse and substance abuse, and more.		North Carolina: Act 57 (2019). Provides Medicaid and NC Health Choice coverage for home visits to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development. Washington WA S 6259 (2020) Improves the Indian behavioral health system, revises provisions relating to the Indian Health Improvement Reinvestment Account, requires funds in the Account to be expended on programs that address the ongoing suicide and addiction crisis among American Indians and Alaska Natives. *Proposed Policies:* New Jersey: A3035 (2017). The Mental Health Access Act of 2017 would increase Medicaid reimbursement rates for evidence-based behavioral health services.
FUNDING EVIDENCE – BASED PROGRAMS IN PRIMARY CARE – SEEK (Safe Environment for Every Kid) MODEL **"Randomized trials of the *Safe Environment for Every Kid (SEEK)* model (which screens for ACE exposures in the family environment), have demonstrated a number of positive effects including fewer reports to child protective services, fewer reported occurrences of harsh physical punishment by parents, better adherence to medical care, and more timely childhood immunizations.[64] *SEEK* is also associated with less maternal psychological aggression,[65] fewer minor maternal physical assaults,[66] and improvements among providers in addressing depression, substance misuse, intimate partner violence, and serious parental stress.[67]"[68]** PREVENTING & MITIGATING THE HARMS OF CHILD SEXUAL ABUSE	SEEK is a model created and tested in Maryland by Dr. Howard Dubowitz, MD and his team at the University of Maryland, School of Medicine. No Criminal SOL	None known or reported by NCSL that reference N.E.A.R. Science. In 2019 alone, nineteen states have passed statute of limitations reforms to better reflect the average age of disclosure.

STATUTE OF LIMITATIONS REFORM **Eliminating the Statute of Limitations for Child Sexual Abuse, including a "look back window"** **promotes community norms against violence toward children, provides justice and healing for victims of child sexual abuse, and exposes hidden predators still living in communities.**[69] **Child sexual abuse affects one in four girls and one in six boys across the United State-s. In 2019 alone, 21 states have passed statute of limitations reforms to better reflect the average age of disclosure. Seventeen states (nine this year) have passed civil SOL "windows of justice "to allow civil claims previously barred to proceed for a set period of time. Civil SOL Windows also present an opportunity to prevent incidents of child sexual abuse by exposing hidden predators**	Civil SOL: *Proposed Policies:* SB 134 /HB 263 (2021), HB 974 (2020), HB 687, (2019). Hidden Predator Act. Passed the House unanimously and failed in the Senate Judicial Proceedings Committee. It would eliminate the civil statute of limitations for child sexual abuse and provide a two-year lookback window for survivors.	*Passed:* Arizona (2021) HB 2116 Adds a civil cause of action with no SOL for sex trafficking of minors and adults with liability for perpetrators, other individuals and entities that benefited from participating in a trafficking venture. Arkansas SB 676 (2021) Extends the civil SOL for sexual abuse of minors from age 21 to age 55 and opens a 2-year revival window for expired claims. The SOL extension and window is also applicable to victims who were disabled adults at the time of the sexual abuse. California: AB218 2019. 3-year window: 3-year window will open on January 1,2020 for expired claims against perpetrators, private organizations and government. Colorado SB 73 (2021) Eliminates the civil SOL for sexual assault of minors and adults. Adds a new civil cause of action for sexual misconduct against a minor with no SOL, allowing claims to be brought at any time. The cause of action also applies retroactively and opens a 3-year window for any sexual misconduct against minors occurring from 1960 to 2021. Claims against public entities/perpetrators are limited by a damages cap of $350,000. Claims against non-public entities/perpetrators are limited by a damages cap of $500,000, with exceptions for negligence or excessive injury which raise the cap to $1,000,000. (SB 88) Connecticut: SB3 (2019). Extends the civil statute of limitations for sexual abuse victims to thirty years after age twenty-one. The law also extends the criminal statute of limitations for offenses involving sexual abuse, sexual exploitation, and sexual assault of a victim under sixteen years of age and extends the criminal statute of limitations for victims ages eighteen-twenty to fifty-one years old. Louisiana HB 492 (2021) Eliminates the civil SOL for child sex abuse claims and opens a 3-year revival window for all previously expired claims. Maine LD 589 (2021) Opens a permanent revival window for all expired claims of child sexual abuse.

		Nevada SB 203 (2021) Eliminates the civil SOL for claims against a perpetrator or someone criminally liable for sexual abuse or exploitation of a minor (including trafficking, prostitution, and pornography) and a promoter, possessor, or viewer of CSAM (child sexual abuse material) and opens a permanent revival window for expired claims. New York S 672 (2021) Extends the civil SOL for sex trafficking and compelling prostitution of minors from 10 years to 15 years after the victim is freed, 15 years after discovery of the cause of action, or age 33 (age of majority, 18, plus 15 years). Pennsylvania HB 14 (2021) A resolution proposing an amendment to the Pennsylvania Constitution to add a 2-year revival window for victims of child sex abuse and explicitly lift sovereign immunity for actions against the government. Rhode Island: H5171 (2019) Extends the statute of limitations from seven to thirty-five years in cases of child sexual abuse, including a seven-year discovery window to allow victims more time to commence action against their abuser.

TRAUMA-INFORMED CARE FOR VICTIMS **CHILD ADVOCACY CENTERS** **Child Advocacy Centers are a crucial component of trauma-informed care for children who have experienced abuse. CACs bring together a myriad of services, including child protective services, law enforcement, medical and mental health professionals, and prosecutors in a child-friendly, trauma-informed environment to allow for an inter-agency investigation and response to instances of child and family abuse.**	*Passed:* Sb739 ((2019). Child Advocacy Centers (CACs)Expansion bill defined and strengthened CACs across the state to ensure trauma-informed services to child victims of child sexual and physical abuse.	*Passed:* Florida: Act 151 (2017). Provides for trauma informed care for children who have been sexually exploited. Establishes an accountability system for residential group care providers based on quality standards, including promotion of high-quality services and accommodations, considerations of the level of availability of trauma informed care and mental and physical health services, the level of provider's engagement with school and extra circular activities, and a following report on the findings and how they will be used to improve residential group care. Currently, over 34 states, including Maryland, have some form of legislation surrounding CACs. Legislation on CACs that is supported by the National Children's alliance includes legislation which defines child advocacy centers and their role in the investigation process, the expansion of services and resources for CAC, and state funding for CACs through government funds. *Proposed Policies:* New Jersey: A3558 (2019). Children Animal Assisted Therapy Pilot Program which would establish a pilot program in Department of Children and Families providing animal-assisted therapy to victims of childhood violence, trauma, or children with behavioral health care needs, appropriates funds.
INCREASE MENTAL & BEHAVIORAL HEALTH SERVICES IN SCHOOLS: **Children with an ACE score of four or more are:** • **4 times more likely to develop depression** • **12 times more likely to attempt suicide** • **32 times more likely to experience behavioral problems in the classroom than children who have an ACE score of zero.[70] Providing mental and behavioral health services in schools allows access to resources to address the impact of ACEs in a familiar, easily accessible environment that is comfortable and easily accessible.[71]**		*Passed:* Colorado: H1017 (2019). Requires the department of education to select a school district to partake in a pilot program that provides a social worker dedicated to each grade from kindergarten to 5th grade to prevent, reduce, and resolve ACE exposure and ACE- related stress. Illinois: SB565 (2017). Requires health examinations for school entrance to include age appropriate social, emotional, and developmental screenings; performed by the child's primary care provider; proof of examination must be provided to the child's school annually. The examination form is not required to disclose the results but may include suggested services based on the results of the evaluation that may be provided by the school with parent's consent.

Studies show that the implementation of mental health services in schools has: • **increased academic success and graduation rates** • **decreased rates of truancy and discipline** • **improved overall school climate and community.**[72]		Iowa: Chapter 225.54 (2015). Provides state block grants for school- based mental health projects and crisis intervention services in schools offered through partnerships with community mental health organizations. Utah: H264/ Act 412 (2018). Provides grants for school-based counselors and social workers to provide school-based mental health supports in elementary schools, including for trauma-informed care. Washington: S5903/ Act 360 (2019). Creates a Children's Mental Health Workgroup to identify barriers to accessing mental health services, monitor the implementation of legislation and policies relating to children's mental health and consider strategies to improve coordination between education and health systems. The Act also mandates that educators have additional professional days to cover trauma-informed care, social-emotional learning, and ACEs training.
TRAUMA INFORMED SCHOOLS: TRAINING, PRACTICES, CURRICULUM, POLICIES, AND DISCIPLINE **When children have experienced trauma, they are more likely to act impulsively, have problems focusing, and regulating their emotions, leading to serious behavioral problems or lack of engagement. Creating trauma -informed schools has been shown to result in positive outcomes for students and teachers, including fewer disciplinary incidents and office referrals. Oftentimes, toxic stress and anxiety which results from ACE exposure causes adverse physical and emotional responses, such as violent behavior or aggressive outbursts by children in the classroom. This response, in turn, leads to punishment and disciplinary action, which only adds to the stress experienced by the child. Multiple studies of trauma-informed programs in schools have found that these programs reduce aggressive behavior, crime, and conduct problems,**	*Passed:* HB277 (2020) State Department of Education – Guidelines on Trauma-Informed Approach The bill establishes a pilot project to create trauma-informed schools and requires MSDE, DHS, and MDH to establish and publish guidelines for a trauma-informed approach.	*Passed:* District of Columbia: Act 22-398 (2018). Requires the Department of Education to implement measures to reduce out of school suspension and expulsion and foster trauma informed, positive school environments. Indiana IN H 1283 (2020) Relates to trauma response instruction for teachers, requires a teacher preparation program to include training on trauma response instruction and recognition of social, emotional, and behavioral reactions to trauma that may interfere with students' academic functioning. HB1421 (2018). Requires schools to reduce out of school suspension and expulsion and requires a legislative committee to be assigned the task of studying the use of positive discipline and restorative justice in schools and determine the extent to which these forms for discipline are utilized in schools currently. Iowa: S2133/ Act 1051 (2018). Requires school districts to implement employee training and establish rules and best practices on suicide prevention, the identification of ACEs, and strategies to reduce toxic stress. Tennessee: S1386 (2018). Requires the Department of Education to develop an evidence-based training program on ACEs for school teachers and leadership.

results which also produce large returns on the investments made in the programs themselves.		Resolution 166, (2019) was enacted to urge local education agencies to provide the training developed by the Department of Education to all teachers. Tennessee: S64 (2019). Requires local boards of education to adopt a policy requiring all K-12th grade teachers, principals, and assistant principals to be part of an ACEs training on an annual basis. Massachusetts: HB4376 (2014). Within the context of reducing gun violence, establishes a framework for safe and supportive schools, which considers the findings of the ACEs study and utilizes trauma informed practices. The framework aims to create schools that foster healthy relationships between children and the peers and teachers, provide mental, physical and behavioral health services, and integrate practices and services that promote social and emotional learning and reduce instances of truancy, suspension and expulsion, and dropout. Pennsylvania: S1142 (2018). Establishes School Safety and Security Grant Program and Fund, to be used for the administration of ACEs screening and trauma-informed counseling services for students based on screening results. HB1415 (2019). Defines trauma-informed approaches, requires development training for school administrators and staff on trauma informed approaches, and amends the requirements for post-baccalaureate certification to teach primary and secondary education to include coursework on trauma informed approaches. Tennessee: Act No 421 (2019). Requires local Boards of Education to adopt a policy requiring schools to perform an ACEs screening before taking disciplinary actions against a child, including suspension, in-school suspension, expulsion, or transfer to an alternative school. Washington: Act 231 (2018). Directs the Department of Children, Youth and Families to develop a 5-year strategy on expanding training in trauma informed child care for early learning providers and reducing expulsion from early learning environments. Act 386 (2019). Creates the Social-Emotional Learning Committee to promote social emotional learning that will help students build awareness and skills in managing emotions, setting goals, establishing relationships, and supporting student success. The legislation also notably includes benchmarks which

		educators must meet regarding training for trauma informed practices and consideration of ACEs. S5903/ Act 360 (2019). Creates the Children's Mental Health Workgroup and mandates that educators have additional professional days to cover trauma-informed care, social-emotional learning, and ACEs training. Wisconsin: A843/ Act 143 (2018). Creates Office of School Safety and requires the office to train school staff on school safety, trauma-informed care and how adverse childhood experiences have an impact on children and increase the need for support. Maine H 851 (2019) Directs the Commissioner of Education to convene a task force, inviting the participation of experts and interested parties, to develop guidance for kindergarten to grade twelve administrators on appropriate training and responses to childhood trauma. Maine ME H 851 (2019) Directs the Commissioner of Education to convene a task force, inviting the participation of experts and interested parties, to develop guidance for kindergarten to grade twelve administrators on appropriate training and responses to childhood trauma. *Proposed Policies:* New York: A11081 (2019). Requires ACEs training for licensed day care providers.
		Passed: Arkansas: Act 1064 (2019). Recognizes Arkansas has the highest percentage of ACEs in its students and requires that the University of Arkansas for Medical Sciences establish a pilot program that creates a school safety and crisis line that can be accessed by phone, text, application, or program participation, providing students with the ability to report anonymously unsafe activity, abuse, bullying, thoughts of suicide, drug issues, and other threatening behaviors in order to address the problems associated with high ACE scores. Also, provides

		for crisis intervention services, such as counseling. Texas: Act 464 (2019). Requires all schools to develop a plan of improvement, which includes assessment of need for various groups of students, district performance objectives for programs including suicide prevention, violence prevention, conflict resolution, and training on how trauma can affect student behavior and trauma-informed strategies to support affected students. The Act also includes provisions for teaching students about mental health and providing mental health services in schools. Utah: Act 446 (2019). Authorizes the State Board of Education to distribute money to local education agencies for personnel who provide school-based mental health support. The Act also establishes the Safe UT Crisis line to provide means for anonymous reporting of unsafe, violet, or criminal actives, bullying, physical or sexual abuse by a school employee/volunteer, and crisis intervention.
FAMILY-CENTERED SUBSTANCE USE TREATMENT FOR PARENTS **Growing up in a home where a parent experiences a substance abuse disorder was one of the ten ACEs in the original ACE study, as it often leads to dysfunction and instability within the family.[73] States have created family-centered programs that offer assistance to parents with substance use disorder to help them recover, provide EBP parenting support and provide programming for the children to buffer them from the negative consequences of parental substance use.**		*Passed:* Florida: Act 151 (2017). Creates a pilot program for shared family care residential services to families that have a member experiencing substance use disorder. Establishes an accountability system for residential group care providers based on quality standards, including promotion of high-quality services and accommodations, considerations of the level of availability of trauma informed care and mental and physical health services, the level of provider's engagement with school and extra circular activities, and a following report on the findings and how they will be used to improve residential group care. Indiana: SB446 (2017). Creates an opioid addiction recovery pilot program to assist pregnant women and new mothers that have a substance abuse disorder by providing residential facility treatment and home visitation services. *Proposed Policies:* Massachusetts: H4742, (2018). Would establish the Community Behavioral Health Promotion and Prevention Trust Fund to issue grants to community organizations establishing or supporting evidence-based programs relating to substance abuse disorder for children and adults. Programs will be selected for

		funding based on the program's use of the science of prevention, ACEs, and trauma informed care.
STATE POLICY DIRECTIVE TO ADDRESS CHILDHOOD TRAUMA **All State Child & Family Serving Systems to Address Childhood Trauma**		*Passed:* Alaska: S105 (2018). Revises provisions on licensure of martial and family therapists. Additionally, it establishes a state policy directive to policymakers, administrators, and those working within state programs and grants to make decisions that "take into account the principles of early childhood and youth brain development and, whenever possible, consider the concepts of early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, supports, self-regulation, and services."
BILL OF RIGHTS OF CHILDREN OF INCARCERATED PARENTS **Preventing and mitigating ACEs caused because of system involvement by parents. Parental incarceration is one of the ten ACEs initially identified in the original ACEs study, as separation from the parent for prolonged periods of time disrupts the relationship between the child and the parents, hindering the child's development and often causing toxic stress for the child. Ensuring support for children when a parent is incarcerated, including arrest, sentencing, visitation and parent-child contact policies, and mentoring programs, help to buffer children from the negative consequences of parental incarceration.**		*Passed:* Hawaii HI HCR 205 (2019) Requests the Department of Human Services, in consultation with the Department of Public Safety, to work with the family reunification working group and other community stakeholders to develop a plan to establish visitation centers at all state correctional facilities and jails. Illinois: H2444 (2019). Expands consideration of factors such as whether the defendant is the parent of a child or if the defendant serves as a caregiver to someone who is ill, disabled, or elderly in sentencing, recognizing that parental incarceration is an ACE for the child and can have negative impacts on the child. H2649 (2019). Amends the Code of Criminal Procedure, creates the Task Force on Children of Incarcerated Parents, provides that the Task Force shall review available research, best practices, and effective interventions to formulate recommendations. SCR7 (2019). A resolution requesting that human services and public safety work to develop a plan for the establishment of visitation centers at all state correctional facilities and jails for children to visit their incarcerated parent. It recognizes that the incarceration of a parent is an ACE and can lead to adverse outcomes for children and that parental bonding is essential for children's development. Oregon: SB241 (2017). Establishes a bill of rights for children of incarcerated parents, including the right to be protected from additional trauma at the time of parental arrest, the right to remain informed about their parent's arrest in an

		age-appropriate manner, the right to see, speak with and touch their incarcerated parent, and more. Missouri: Chapter 217 (2018). Creates a women offender program to ensure that female offenders are provided with trauma-informed and gender responsive supervision strategies, including physical and mental health care, child visitation, and more. Texas: S1356 (2013). Requires all juvenile probation and supervision officers receive training on trauma informed care administered by the Department of Human Resources. H650, (2019). Requires correctional officers to be trained on issues relating to the physical and mental health of pregnant inmates, including appropriate care, the impact of incarceration on a pregnant inmate and the unborn child, the use of restraints, the placement of administrative segregation, and invasive searches. It also includes provisions for reviewing visitation policies and evidence-based visitation practices that enhance paternal bonding and engagement and allow for age-appropriate visiting activities for children who visits their parents in correctional facilities. *Proposed:* Texas H2168 (2019). Would require screening of each inmate during the diagnostic process to determine whether the inmate has experienced ACEs or other significant trauma and refer the appropriate care when needed. The bill also requires screening and care for defendants. Washington S5876 (2019). Would create a women's division of correctional system to develop a system of gender responsive, trauma informed practices within the department of corrections, informed by individuals with training in ACEs and trauma informed practices.
POLICIES & PROGRAMS FOR CHILDREN WHO WITNESS DOMESTIC VIOLENCE		*Passed:* Illinois HR751 (2018). Declares domestic violence a public health priority given the trauma caused both to victims and their children and urging the state to provide all the necessary resources to prevent and address domestic violence.

POLICIES & PRACTICES TO ENSURE TRAUMA-INFORMED RESPONSE IN CHILD CUSTODY COURT PROCEEDINGS **Recognizing that divorce and separation, all forms of child abuse and neglect, and witnessing domestic violence are ACEs for the child, the court, in order to meet "the best interest of the child" standard," must ensure that custody and visitation proceedings and decisions are informed by ACE science and do not exacerbate harm to the child.**	*Passed:* SB 567, (2019). Establishes a Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations. Requires the Workgroup to study available science and best practices pertaining to children in traumatic situations, including trauma-informed decision making. and make recommendations about how State courts could incorporate the science into child custody proceedings. ***September 2020 Workgroup's Final Recommendations*** http://dls.maryland.gov/pubs/prod/NoPblTabMtg/CmsnChdAbuseDomViol/FinalReport_Workgroup_to_Study_Child_Custody_Court_Proceedings_Involving_Child_Abuse_or_Domestic_Violence.pdf HB 78 / SB 52 (2021) Establishes the Maryland Commission on Health Equity to employ a "health equity framework" in specified examinations; provide advice on issues of racial, ethnic, cultural, or socioeconomic health disparities; facilitate coordination of expertise and experience in developing a comprehensive health equity plan addressing the social determinants of health; and set goals for health equity and prepare a plan for the State to achieve health equity in alignment with other statewide planning activities. The commission must establish an advisory committee on data collection.	*Passed:* Florida FL H 1105 (2020) Relates to child welfare, requires the Court Educational Council to establish certain standards for instruction of circuit court judges for dependency cases, including regarding the benefits of a secure attachment with a primary caregiver, the importance of stable placement, and the impact of trauma on child development. Virginia VA H 744 (2020) Relates to sentencing of a juvenile tried as adult, in which case the court shall consider the juvenile's exposure to adverse childhood experiences, early childhood trauma or any child welfare agency.

	Proposed: HB 748 / SB 57 (2021) Would alter statutory provisions that require a court to deny custody or visitation rights to a party in specified circumstances involving the abuse or neglect of a child. Would require a supervised visitation arrangement that assures the safety and physiological, psychological, and emotional well-being of the child. These requirements would intervene to lessen immediate and long-term harm of ACE's. HB 1036 / SB 675 (2021) Would require the Judiciary, in consultation with domestic violence and child abuse organizations, to develop a training program for judges presiding over child custody cases involving child abuse or domestic violence. The training would include numerous specific topics that prevent adverse childhood experiences. Judges would be educated about typical brain development of infants and children, the dynamics and effects of child sexual abuse, physical and emotional child abuse, and domestic violence as well as the impact of exposure to domestic violence on children and the importance of considering this impact when making child custody and visitation decisions. SB355 (2020) Would establish specified requirements regarding the education, licensure, experience, and training of "custody evaluators." The evaluator must have experience in the impact of interpersonal loss and chronic stress on an individual and family system as well as	

	experience in mental health diagnoses, including current substance abuse issues relevant to the capacity of an individual to provide health, protective, or restorative parenting, etc. Skill-based learning is an important part of a comprehensive approach to prevent ACEs. Learning how to handle stress, resolve conflicts, and manage emotions and behaviors can prevent violence victimization and perpetration, as well as substance misuse.	
POLICIES & PRACTICES TO ENSURE NEXT GENERATION PREVENTION & TRAUMA-INFORMED RESPONSE IN CHILD WELFARE	*Passed:* HB 548 / SB 299 (2021) Establishes the Commission on Trauma-Informed Care as an independent commission in the Department of Human Services (DHS) to coordinate a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults. ACEs are potentially traumatic events that occurs in early childhood. ACEs can include violence, abuse, and growing up in a family with mental health or substance use problems. 1 in 6 adults experience four or more types of ACEs. 75.6 % of the chronically depressed patients reported clinically significant histories of childhood trauma. Preventing	*Passed:* Arizona: 8-471(2014). Requires that child welfare workers and child safety workers receive training on the impact of ACEs and interventions to prevent negative outcomes associated with ACE exposure. California CA A 2944 (2020) Expands the locations where a child or nonminor dependent may be placed, on and after a specified date, to be eligible for AFDCFC to include a residential family based treatment facility for substance abuse that meets specified requirements in which an eligible child is placed with a parent in treatment. Provides a one-year extension for the payments of specified established interim rates. California: S1460 (2014). Requires that recruitment include efforts to find adoption and foster care individuals who reflect the ethnic, racial and cultural diversity of foster children and adoptive children. A819 (2019). Amends child welfare code to require that core services be trauma informed and include specialty mental, physical, behavioral, transitional, and educational services be provided to children as needed. Replaces previous

ACEs could reduce the number of adults with depression by as much as 44%.
Passed:

HB 78 / SB 52 (2021) Public Health – Maryland Commission on Health Equity – (The Shirley Nathan-Pulliam Health Equity Act of 2021). Requires the creation of the Maryland Commission on Health Equity to address health equity and systemic racism. Race is a social construct with no biological basis that artificially divides people into distinct groups based on characteristics such as physical appearance, ancestral heritage, cultural affiliation, and the social, economic, and political needs of a society at a given period. Racism has been declared as a public health crisis. Exposure to racism and discrimination act as risk factors for the development of the toxic stress response. Racism and the resulting systemic inequities create conditions that lead to ACEs, such as disproportionate incarceration rates among people of color. Exposure to racism can act as a direct and chronic stressor and can lead to a prolonged activation of the body's biological stress response and disrupt the normal functioning of neuro-endocrine, immune, metabolic and genetic regulatory system systems.

licensing process for foster families with unified resource family approval process and requires that resource family applicants are trained in trauma informed practices to support children impacted by ACEs.

Oklahoma: S141 (2019).Establishes the Successful Adulthood Act, which is meant to ensure that all eligible individuals who have been or are in the foster care program due to abuse or neglect receive the protection and support necessary to allow those individuals to become self-reliant and productive citizens and break the cycle of abuse and neglect through services such as transitional planning, education, housing, medical care, and tuition waivers.

Washington WA H 2525 (2020) Establishes the family connections program to facilitate interaction between a parent of a child found to be dependent and in out-of-home-care and the individual with whom the child is placed. The program is intended to put the child first, prevent future child trauma, reduce family trauma and support the child by helping adults learn.

Proposed Policies:

New Jersey NJ A 3558 (2019) Would establish a pilot program in Department of Children and Families providing animal-assisted therapy to victims of childhood violence, trauma, or children with behavioral health care needs, appropriates funds.

ENDNOTES

*This list is an example of legislation being introduced and/or passed by states to prevent and mitigate ACEs and promote resilient communities. It is not intended to be a comprehensive list of legislation and will be updated periodically as more is learned about ACE-informed policy initiatives in Maryland and sister states.

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APPENDIX P

MARYLAND GUIDELINES AND BEST PRACTICES FOR THE DESIGN, ASSESSMENT AND MODIFICATION OF PHYSICAL FACILITIES AND SPACES TO REDUCE OPPORTUNITIES FOR CHILD SEXUAL ABUSE

Developed Jointly by
The Interagency Commission on School Construction and
The Maryland State Council on Child Abuse and Neglect
pursuant to MD Code Ann., Education, § 6-113.1(e)

May 2020

Interagency Commission on School Construction (IAC)

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EXECUTIVE SUMMARY

In 2018 the Maryland General Assembly passed HB 1072 (MD Code Ann., Education, § 6-113.1) in order to prevent child sexual abuse and sexual misconduct by school employees *before it occurs.*

§ 6-113.1 defines sexual misconduct and child sexual abuse and requires schools to train all employees in the primary prevention of child sexual abuse, as well as develop policies and codes of conduct to prevent child sexual abuse and misconduct by employees. Additionally, it requires that:

- COUNTY SCHOOL BOARDS DEVELOP POLICIES AND PROCEDURES ON THE USE AND MODIFICATION OF PHYSICAL FACILITIES AND SPACES TO REDUCE OPPORTUNITIES FOR CHILD SEXUAL ABUSE.
- THE INTERAGENCY COMMITTEE ON SCHOOL CONSTRUCTION and THE STATE COUNCIL ON CHILD ABUSE AND NEGLECT JOINTLY DEVELOP GUIDELINES AND BEST PRACTICES FOR THE ASSESSMENT AND MODIFICATION OF PHYSICAL FACILITIES AND SPACES TO REDUCE OPPORTUNITIES FOR CHILD SEXUAL ABUSE;

After several meetings between the staff from IAC, MSDE- School Facilities Branch, staff and members of SCCAN, study of the literature, and consultation with experts in the field of child sexual abuse prevention and Crime Prevention Through Environmental Design (CPTED), the enclosed guidelines and best practices were identified.

It should be noted that each of the provisions of § 6-113.1 work together and not in isolation to create schools safe from child sexual abuse and misconduct, e.g., modifying physical facilities to provide windows in classroom doors must be supported by creating and enforcing policies and codes of conduct that prohibit covering up those windows and training that supports understanding and adherence to the policies and codes of conduct for the modifications to be effective.

INTRODUCTION

Creating safe and supportive school environments is necessary not only to help all students to learn and grow but to prevent child sexual abuse and the multiple forms of violence that disrupt learning and lead to social, emotional, physical, relational, academic, health, economic issues across the lifespan.[i] Investing in safe and supportive school environments also provides a safe, healthy, less stressful and more rewarding work environment and reduces teacher turnover rates.[ii] Additionally, since an incident of child sexual abuse associated with a school, or any organization, typically attracts media attention and a lawsuit, adherence to these guidelines and best practices, the other provisions of § 6-113.1, and careful employee screening processes ensures that schools are able to demonstrate that they have taken every step to protect the

children in their care.

The Magnitude of Child Sexual Abuse & Sexual Misconduct in Schools

- *Child sexual abuse is a preventable public health problem*. Unfortunately the exact magnitude of the problem is unclear, as most school systems, including Maryland's, are not required to collect data on the incidence of child sexual abuse and misconduct by school employees. One review of existing studies found that rates of children experiencing misconduct ranged from 3.7% to 50.3%.[iii] The most comprehensive study, with national data, found that[iv]: 9.6 percent of students in grades 8 to 11 experienced contact and/or noncontact educator sexual misconduct during some point in their school career;
- 8.7 percent report only noncontact sexual misconduct and 6.7 percent experienced only contact misconduct. (These total to more than 9.6 percent because some students reported both types of misconduct.)

As child sexual abuse is correlated with higher levels of depression, guilt, shame, self-blame, eating disorders, somatic concerns, anxiety, dissociative patterns, repression, denial, sexual problems, relationship problems, physical health problems,[v] and poorer academic achievement,[vi] it is imperative that schools and other youth-serving organizations have policies and procedures in place to *prevent child sexual abuse before it occurs*. In addition to the human suffering of child sexual abuse, the economic cost is estimated to be more than $280,000 per victim.[vii] The estimated economic impact of child sexual abuse in the U.S. is $9.8 billion.[viii]

Student-on-student sexual abuse and assault is also a significant problem in schools, with roughly 17,000 official reports of sex assaults by students in the United States between 2011 and 2015.[ix] While Title IX requires colleges and universities to report sexual violence annually, elementary and secondary schools are not required by national or state law to track and disclose such incidents. Unfortunately, due to this lack of tracking and disclosure of school employee and student-on-student sexual abuse and assault, the true extent of the problem is unclear.

This document will introduce several research-based guidelines and best practices: The Situational Prevention Approach (SPA)[x], Crime Prevention Through Environmental Design (CPTED)[xi], and Centers for Disease Control and Prevention Guidelines (CDC)[xii]. Correctly applying such easily demonstrated strategies will enable schools to better protect their students.[xiii, xii]

Resources on Best Practices and Guidelines for the Design and Modification of Physical Facilities to Prevent Child Sexual Abuse

The following are best practices and guidelines for the design and modification of physical facilities to prevent child sexual abuse in schools:

1. **Centers for Disease Control and Prevention's (CDC) Recommended Policies and Procedures for *Preventing Child Sexual Abuse Within Youth-Serving Organizations*[xiv]** This document provides best practices, developed by a panel of experts and relevant literature, to help prevent child sexual abuse in youth-serving organizations, including schools. Key elements include:
   - *VISIBILITY – building or choosing spaces that are open and visible to multiple people to create an environment where individuals at risk for sexually abusive behaviors do not feel comfortable abusing*
   - *PRIVACY - when toileting, showering, changing clothes*
   - *ACCESS CONTROL – monitoring who is present at all times*

2. **Situational Prevention Approach** – *For environmental design assessment.* A number of Situational Approach Recommendations are considered best practices.[xv] Those not specifically related to design and construction are included in Appendix A. For environmental design/school construction, the Four Step Safety Assessment Process is recommended, and discussed in detail in the recommendations. This process allows schools to identify and address risks for child sexual abuse, sexual assault, and sexual misconduct, as well as other risks to student safety that are inherent in the school environment.

3. **Crime Prevention Through Environmental Design (CPTED)[xvi]** – *For designing, assessing, and modifying environmental facilities.* CPTED is a well-established and well-researched field of crime prevention used throughout the world. It employs proven methods that increase the responsible, positive use of property while decreasing the likelihood of criminal behavior. CPTED principles incorporate strategies that take into consideration physical features, social activities, and people in order to encourage positive and discourage negative human behavior as people interact with their environment. Additionally, the Centers for Disease Control and Prevention (CDC) has recognized that communities applying CPTED principles report decreases in gun violence, youth homicide, disorderly conduct, and other violent crime, as well as positive impacts on residents' stress, community pride, and physical health.[xvii]

   The overarching goals for implementing CPTED principles is to design, retro-fit, and maintain the physical space in a way that:
   - Empowers people to notice and intercept problems at an early stage; and,
   - Discourages offenders from acting because they are more likely to be noticed and apprehended.

   CPTED's four guiding principles of design are:
   - *NATURAL SURVEILLANCE - maximizes observations and visibility of unacceptable behavior by the design and placement of physical features and persons. The goal is to both eliminate hiding or hard-to-see places and increase the ability of authorized adults to monitor and respond.*
   - *ACCESS CONTROL - uses real or perceived barriers and other features to orient and guide people and vehicles along appropriate paths and to restrict inappropriate access. The*

objectives are to increase comfort and decrease prohibited behaviors by providing safe routes and restricting unauthorized access.

- *TERRITORIALITY –uses physical features to define space and to demonstrate a sense of ownership and pride. The goal is to convey that an area is not only owned and cared for, but that prohibited behavior will not be tolerated.*
- *MAINTENANCE (both physical and order) - supports the first three design principles by ensuring the repair, replacement and general upkeep of the physical space and attention and response to minor inappropriate behaviors.*[xix]

Balancing School Design Efforts to Prevent Multiple Safety Threats

Given the increase in number of school shootings over the past several decades, there have been recent discussions about how to configure schools to maximize safety in the event of an active shooter situation. It is important to note that while school shootings generate significant media attention, active shooter events within school settings thankfully remain uncommon. The probability of being sexually abused is much higher.

It should also be noted that strategies and tactics intended to prevent school shootings and those intended to prevent child sexual abuse in schools should be complimentary. For instance, during lockdown procedures designed to be carried out swiftly, the school's interior windows, installed to enhance natural surveillance and discourage child sexual abuse, can be readily covered by blinds or shades, reducing visible targets for the active shooter. The use of electronic locks with card readers not only controls an unauthorized person's access to isolated areas, it also creates an audit trail to discourage staff from being isolated with a child. Surveillance cameras, primarily used to identify trespassers, vandals and intruders, can be equally effective at discouraging student-on-student sexual abuse by recording who enters and exits group restrooms and at what time.

The following operational strategies are useful for both preventing child sexual abuse and preventing or mitigating active shooter incidents and other emergencies when visual refuge is of higher importance.

- Documenting who comes and goes on facility property;
- Having a single point of entry for the public and controlling the use of all exits and secondary entries;
- Applying a visitor management system to identify registered sexual offenders attempting to enter;
- Ensuring all locations are monitored by staff, especially group restrooms;
- Clearly mark off-limits areas;
- Posting safety rules and regulations.
- Use of cameras and surveillance to deter or monitor youth-on-youth and youth-staff/volunteer interactions and to be able to track location of an armed intruder;

- All doors that remain locked should have a vision panel or sidelight to permit natural surveillance into the room. These panels or sidelights should only be covered during a Hide-in-Place emergency.

    - Keep unused areas/rooms secured and locked;
    - Keep all areas well lit.

Additionally, minimum standards for encouraging a safe physical environment in schools can be overridden with technology or simpler design innovations during an emergency situation:

- Having windows or sidelights at doors to allow monitoring of youth-on-youth and youth-staff/volunteer interactions;
- Ensuring that meetings between staff and children are in unlocked rooms where they are visible to others via windows or sidelights at doors, but have a means to protect students and staff in case of an armed intruder entering the school (window coverings, locking system for emergency response, and policies and enforcement practices that prohibit the use of window coverings and locking systems except in emergency situations).

GUIDELINES FOR IMPLEMENTING BEST PRACTICES

Below are design review best practices that can be converted into a checklist for Capital Improvement Projects and a survey assessment for existing schools. Note that these best practices for the design of the school environment must be supported by the school policies and its employees' adherence to them. This is particularly important when school policies, on one hand, require that interior glass areas be covered during a Hide-in-Place emergency but, on the other hand, policies require that the same glass areas remain visible during normal times. For that reason, it is useful to publish and enforce clear protocols that deter a person from having unchallenged access, privacy and control over a child. For example:

- If any doors are to remain locked at all times, then vision panels or sidelights should be part of new building or renovation designs.
- Vision panel and sidelight should *not* be permanently covered with posters or decorations that make it difficult to observe activity in the room.
- Interior blinds should *not* be drawn except the brief period of a Hide-in-Place emergency.
- Supervisors should have a key or keycard to open and inspect any locked room that cannot be readily surveilled.

School systems should also collect comparable incident data (see Appendix B). on where and when abuse occurs and between what type parties (male/female, staff/student, visitor/student, etc.). Data collection is critical to the understanding of what is most important to address.

GENERAL STANDARDS

1. The organization acknowledges child sexual abuse (adult-child and child-child) as an inherent threat.

2. The organization adopts recognized prevention strategies to address each type of threat.
3. The organization demonstrates its commitment to each prevention strategy.
4. The organization regularly evaluates the effectiveness of each prevention strategy.

I. DEVELOP A CLEAR DESIGN PROCESS

Use the best practice Situational Prevention Approach **Four Step Safety Self-Assessment Process** to identify and respond to safety risks in the physical environment:

- **STEP 1 - Brainstorming Safety Risks for specific Locations.**
  Staff, older students, and parents should be engaged in this process, and it should be specific for each location. Risks are brainstormed in seven key areas: high risk locations; characteristics of high-risk youth; facilitators; organization and community policies; lifestyle and routine activities; the larger community environment; and health, safety, and accident prevention (See Appendix B).
- **STEP 2 – Developing Solutions for Each Identified Safety Risk**.
  For each identified risk, practical strategies should be implemented to eliminate or reduce the risk. Examples include limiting access to the front door that takes visitors past the receptionist and prevents entry by unknown visitors or requiring all visitors to sign in and wear a visitor badge.
- **STEP 3- Prioritization of Safety Risks to Address & Logistical Considerations**.
  This step is typically completed by the school leadership with consultation from higher level administrators since resources may be needed to implement particular safety solutions. Considerations for prioritization include how concerned the leadership is about the risk as well as costs and staffing issues associated with solutions.
- **STEP 4 – Developing Solution Implementation Plans & Taking Action**.
  Schools are asked to work on resolving **five** risks at a time (i.e., three from their "Less Challenging" to solve list and two from the "More Challenging" list). A simple implementation plan is developed for each of the top five risks and the school administration guides the process of taking action to resolve each of these risks.

In the context of implementing these Guidelines on physical facilities and spaces it is especially important to consider ***High Risk Locations***[xx] which refer to specific rooms, hallways or spaces within or around the school setting. These locations may increase the chances of a safety incident due to a variety of reasons including a place's isolated nature (e.g., a remote baseball diamond), difficulty providing adequate supervision for this location (e.g., bathrooms, stairs, locker rooms) or even a place where the large number of other people present make supervision very difficult. High Risk Locations include any part of the school building or grounds as well as any setting that

participants travel to as part of their school involvement (e.g., field trips).

Additional best practices in the design process, include:

- Review the educational specifications and design documents with school resource officers and local police officials throughout the entire planning, design, and construction process to incorporate best practices for safety and security.
- Request that the design team include a specialist with CPTED training.
- Survey staff, students, and parents. This is an important part of this assessment, as students especially know the places they feel less safe.
- Follow the four design principles of Crime Prevention through Environmental Design (CPTED):
- Ensure the design process is connected to your training, policies, practices, and codes of conduct.

II. ASSESS CURRENT FACILITIES, SITES & CAPITAL PROJECT DESIGN USING CPTED PRINCIPLES TO FOCUS ON SUCH AREAS AS:*

SITE:

- **Signs clearly establish the limitations on the use of building and grounds.**
  Examples:
  - Posting trespassing warnings at regular intervals along a fence line
  - Signs limiting the use of parking areas and playgrounds during off-hours
  - Signs directing all visitors to enter buildings through a designated entry
- **Outdoor concealment areas are minimized.**
  Examples:
  - Plantings and hedges are trimmed low and trees are trimmed high
  - Dumpster enclosures are locked when not in use
  - Door alcoves are fully lit
- **Sidewalks and parking areas are made safe for pedestrians.**
  Examples:
  - Shadows are eliminated for pedestrians
  - Persons can be seen from 100 feet away at night
  - Timers or photoelectric cells adjust outdoor lights to seasonal fluctuations
- **Exterior gathering and play areas are made safe for children.**
  Examples:
  - Gathering and play areas are clearly designated by fencing, signs, lines or lines
  - Visual obstructions to monitoring are removed or mitigated
  - Monitoring vantage points are identified for staff and volunteers
- Provide clear views around the exterior of the school, including parking lots, play and sports areas to facilitate supervision after hours and at night.

- Eliminate potential hiding places created by landscaping and site walls near to the building. Solid walls should not be of a height that affords easy concealment. Consider using open fencing instead that allows supervision from either direction.
- Avoid deep recesses in the building form or open courtyards with limited views from the street.
- Provide a clear view of all parking lots and sports areas from one location to facilitate supervision.
- Provide a clear view of all play areas from one location to facilitate supervision during recess.
- Provide a separate enclosed outdoor play area for prekindergarten and kindergarten children.

EXTERIOR BUILDING SKIN:

- **Roof access is controlled.**

  Examples:

  - Exterior downspouts, columns and building features are modified to prevent climbing
  - Large items adjacent to buildings, such as dumpsters or storage buildings are relocated
  - Ladders and hatches leading to the room remain locked when not in use.
- Consider replacing or modifying existing doors and windows to withstanding an attempted forced entry. This might include strengthening the door or window, the frame, the locking mechanism and adding intrusion resistant security film to glass areas that could serve as entry points.
- Ensure that door hinges or hinge pins cannot be removed from the outside.
- Locate windows in exterior walls to increase natural surveillance in remote areas beside and behind the building.
- Consider tinting the glazing or installing exterior sunshade devices for windows that are critical for oversight of the exterior in order to reduce the need for blinds to block glare.
- Consider using interior solar shades that permit viewing the exterior but block views into the interior. On areas of the building that are less easily seen from the road, utilize exterior lighting on motion sensor so unauthorized activity in the area is more noticeable.
- Ensure all recessed secondary entry and exit doors are lighted to eliminate hiding areas.

BUILDING ENTRANCE:

- **Exterior building entries and exits are control at all times.**

  Examples:

  - There is a primary entry into a building for the general public
  - Visitors, vendors and contractors are identified and approved before entering a building
  - Building exits and secondary entries are controlled at all times by locks, alarms or direct supervision

- Provide a single point of entry to the school that is clearly identified to persons approaching the building. Incorporate a controlled access system that routes all visitors for clearance from administrative reception area.
- Provide clearly seen signage to direct visitors to the school entry.
- Provide visual supervision of the main entrance from the main administrative office as well as the main lobby.
- Provide the school receptionist with the ability to remotely lock the main entry and to institute a lockdown with the touch of a button.
- Monitor the entry and exit points at all times if possible. If not possible, have clear policies and procedures for how to control who has access.
- Provide an area to post safety rules and regulations for all occupants and visitors to follow.
- Consider providing natural surveillance of secondary entry points to the school or grounds by locating a staff office or work space adjacent, to that entry area with visual oversight.

THROUGHOUT BUILDING:

- **Interior building rooms remain locked when not in use.**
  Examples:
    - Program areas, such as classrooms, media centers and gymnasia
    - Service areas such as kitchens, mechanical rooms and janitor closets
- **Interior building blind spots and hiding areas are eliminated or mitigated.**
  Examples:
    - Objects blocking supervision sightlines are removed or relocated
    - Monitoring vantage points are identified for staff and volunteers
    - Rooms for instruction or activities can be monitored from outside the room
    - Restrooms and dressing rooms are designed or modified to facilitate frequent monitoring by staff
    - Room lighting is controlled to prevent hiding in unoccupied rooms
    - Surveillance cameras, sensors and other security technology support the supervision of remote areas, such as stairwells and corridors
- Provide the ability to close off sections of the building to control access after school hours.
- Design circulation and congregation spaces so that they are open and visible to multiple people. Maintain clear lines of sight as much as possible, e.g. minimize “blind corners” and “blind spots” where behaviors cannot be observed.
- All areas of a classroom or teaching space should be easily visible to staff from any point in the room. Avoid designing classrooms with nooks, alcoves or long entry halls that are hard to monitor and supervise from other parts of the room, especially for the younger grades. Use convex safety mirrors if needed to ensure visibility.
- Provide vision panels or sidelights, positioned and sized to permit a complete view into offices, classrooms, meeting rooms, and other rooms that may be occupied by more than one person.
- Consider providing vision panels on all cross-corridor and stair doors to ease monitoring the facility after hours.
- Install lockable partitions or cages to prevent top and bottom stair landings from becoming hiding

areas.

- Provide motion-activated, day/night cameras in stairwells to cover the entire length of the path, with no dead spots.
- Provide signage to clearly identify areas that are off-limits or can only be used with adult/staff supervision.
- Utilize strict key or keycard control to limit access to the most remote locations, such as roofs, attics and mechanical rooms or consider installing a motion-activated camera to document the use of the door.

TOILET ROOMS:

- Establish separate bathrooms for adults and children/youth. Prohibit adults from using a bathroom at the same time as children/youth, and clearly post rules.
- To prevent adults from sharing the group toilet rooms with students, consider providing a toilet room for staff or visitors in the main lobby near the major public spaces that can also be accessed during after-hours school use.
- Address potential contact between young children and older youth who are using bathroom facilities at the same time, paying special attention to circumstances where they may be a significant age differential between them.
- Entrances to boys' and girls' toilet rooms should be designed in such a way as to allow visual supervision by staff from the corridor.
- Screen the urinal area in the boys' toilet room from direct views from the corridor.
- Post rules inside the restrooms to reinforce acceptable, unacceptable and prohibited behaviors.
- Secure windows to prevent unauthorized entry from the outside.
- Consider zoning access within large group restrooms to promote rapid turnover and reduce loitering
- If multiple restrooms are on the same floor, consider temporarily locking access to those restrooms that are the most isolated and least frequented areas.
- Install a motion-activated, security camera to monitor the entry into group restrooms.

LOCKER ROOMS:

- Make Locker Rooms easy to find and identify with colors, signs and displays
- Clearly distinguish male, female and gender-neutral entries
- Distinguish between common areas and off-limit areas with signs and colors.
- Post rules to reinforce appropriate, inappropriate and prohibited behavior.
- Organize the locker room for easy surveillance, particularly gathering areas and possible areas of isolation. Avoid dead-end spaces that can be used for entrapment. Consider limiting the lockers in the middle of the space to only 4' tall.
- The PE instructor's office should be located near the main entry and exit of the locker room and provided with glazing to monitor the locker area.
- Block access to areas that are difficult to supervise.
- Use tamper-resistant locks to prevent easy access to off-limit areas
- Install a motion-activated security camera to monitor the entry into locker rooms.

HEALTH SUITE:

- For better supervision of the health suite, provide glazing in the walls and door of the health professional's office to allow full views of the waiting, treatment and rest areas, including when the door is closed for acoustical privacy.
- Separate rest areas for male and female students are recommended at the secondary school level. Consider providing a wall between the rest areas for male and female students.
- The rest area should not be completely enclosed and self-contained as it cannot be easily monitored, both visually and acoustically. Consider the use of privacy curtains and partial walls that do not block views from the nurse's workstation.

***NOTE THAT ITEMS IN BOLD ARE CONSIDERED MINIMUM STANDARDS**[xxi]

III. MONITOR, EVALUATE, & REVISE THE PLAN

Monitoring and evaluation are critical components of the public health approach to prevention of child sexual abuse and misconduct. Schools must collect timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Planning, implementation, and assessment to prevent sexual abuse and misconduct in schools all rely on accurate measurement of the problem.[xxii]

In order to measure whether implementation of best practices in designing and retro-fitting the physical environment result in desired outcomes (i.e., reducing incidents of child sexual abuse and misconduct), it is critical that schools collect and report standard de-identified incidence data. Collection of incidence data on other negative behaviors like sexual assault, bullying, vandalism, and gang violence may reveal additional gains from implementation of improved design of physical spaces. Evaluating data, produced through program implementation and monitoring, is essential to providing information on risk and protective factors and what does and does not work to reduce child sexual abuse, sexual assault and sexual misconduct rates.
Collecting de-identified data is critical to understanding and prioritizing which problems are most important to address.

A checklist for tracking specific incidents is included in Appendix B. On an annual basis, schools should analyze the data and make called for adjustments to physical space, policies and practices.

APPENDIX A: SITUATIONAL PREVENTION APPROACH

The following Situational Approach Recommendations are considered best practices:

- School develops a clear statement about the need to set and maintain professional relationships with children;
- School personnel delineates the line between ethical or appropriate behavior from unethical/inappropriate behavior across specific situations;
- School specifically prohibits certain behaviors that constitute child sexual abuse/misconduct;
- ***School identifies and addresses higher risk situations/locations for child sexual abuse/misconduct;***
- The school's code of conduct and trainings regarding child sexual abuse/misconduct prevention apply to everyone in the organization, including administrative leadership, teachers, staff, and volunteers.
- Skills for prevention of child sexual abuse/misconduct are developed through trainings for all school staff and volunteers prior to the beginning of the school year, and trainings address the following:
    1. Knowledge about how to prevent and respond to child sexual abuse;
    2. Self-awareness that child sexual abuse can result from escalating boundary violations;
    3. Skills to keep children safe;
    4. Education to prevent, recognize, and report child sexual abuse;

Four Step Safety Self-Assessment Process[xxiii]

Applying the Situational Prevention Approach's (SPA) Four Step Safety Self-Assessment Process to school settings provides a process by which schools can ***identify and address risks for child sexual abuse, sexual assault, sexual misconduct, as well as other risks to student safety that are inherent in the school environment.*** According to Dr. Keith Kauffmann, PhD, a leading expert in preventing child sexual abuse in youth-serving organizations, the SPA process allows for brainstorming of safety risks, creating a prevention or a risk-reduction solution for each identified risk, prioritizing the order of risks to be addressed, and creating a brief implementation plan to guide taking effective action to resolve identified risks. The Four Step Safety Self-Assessment Process, fleshed out in the specific guidelines below, include:

- **STEP 1 - Brainstorming Safety Risks for specific Locations.**
- **STEP 2 – Developing Solutions for Each Identified Safety Risk**.
- **STEP 3 - Prioritization of Safety Risks to Address & Logistical Considerations**.
- **STEP 4 – Developing Solution Implementation Plans & Taking Action**.

APPENDIX B: CHECKLIST FOR TRACKING SPECIFIC INCIDENTS

Based on variables collected by the National Child Abuse and Neglect Data System (NCANDS)[xxiv], evidence-based child sexual abuse prevention programs[xxv], and the Responsible Behavior with Younger Children Survey[xxvi]; variables identified in *A Standard of Care for the Prevention of Sexual Misconduct by School Employees*[xxvii]; and variables identified through consultation with researchers and practitioners in the field[xxviii], the Maryland State Council on Child Abuse and Neglect (SCCAN) recommends that instances of child sexual abuse and sexual misconduct, as well as student-on-student sexual abuse or assault be tracked and recorded within the following data elements:

- Did the alleged incident include:
  - sexual comments, jokes, gestures, or looks?
  - showed, gave or left sexual pictures, photographs, messages or notes to victim?
  - sexual messages or graffiti about victim on bathroom walls, in locker rooms, or other places?
  - Spread sexual rumors?
  - Unwanted touching?
  - Kissing?
  - Touching the victim's private parts?
  - Having the victim touch the perpetrators private parts?
  - Oral sex?
  - Intercourse?
  - Sodomy?
- Date of Incident
- Date Incident reported to School Authorities
- Who reported/disclosed to school administration?
  - Student,
  - Teacher,
  - Administrator,
  - Other staff,
  - Parent,
  - Volunteer
- Who reported to CPS and/or Law Enforcement?
- Age of Victim
- Gender of Victim
- Race of Victim
- Ethnicity of Victim
- Victim disability
- Age of Perpetrator
- Gender of Perpetrator
- Race of Perpetrator
- Ethnicity of Perpetrator
- Role of Perpetrator within School (administrator, teacher, cafeteria worker, bus driver, parent, volunteer, student etc.)
- Was there a witness/es?
- Age of Witness/es
- Gender of Witness/es
- Race of Witness/es

- Ethnicity of Witness/es
- Role of Witness/es within the School
- Time Period:
    - Before school
    - After school
    - Planning period
    - Lunch
    - Field trip
    - Overnight trip
    - Other
- Location:
    - On or off school property?
    - Main building
    - Portable building
    - Playground
    - Sporting facility
    - Classroom
    - Office,
    - Closet,
    - Hallway,
    - Stairwell,
    - Restroom,
    - Playground,
    - Gym,
    - Locker room,
    - Cafeteria,
    - Auditorium,
    - Theater dressing rooms,
    - Backstage,
    - Outside space
    - Bus
    - Private vehicle
    - Other
- Method/s of obscuring sight lines:
    - Door closed
    - Door locked
    - Window/s obscured
    - Furniture (desks, bookcases, etc.) used to obstruct view
- Date Incident was Addressed:
- Manner of Handling Incident:
- Disciplinary Action for Incident:
- Which policies violated?
- Which tenet of the Code of Conduct was violated?
- Were drugs or alcohol involved in the incident?

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[xiii] Key information interview, R. Leslie Nichols, MSSA, CPP,October 16, 2018.
[xiv] Saul J, et,al.,2007.
[xv] Kaufman K, 2015.
[xvi] Lawrence Fennelly, Timothy Crowe, M.S., Crime Prevention Through Environmental Design, 3rd Edition, July 2013, p. 3.
[xvii] Centers for Disease Control and Prevention. Crime Prevention Through Environmental Design (CPTED) School Assessment (CSA). Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, and Carter & Carter Associates, 2017.
[xviii] Using Environmental Design to Prevent School Violence, https://www.cdc.gov/violenceprevention/youthviolence/cpted.html
[xix] Centers for Disease Control and Prevention. Crime Prevention Through Environmental Design (CPTED) School Assessment (CSA). Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, and Carter & Carter Associates, 2017.
[xx] High Risk Locations include, among others, stairwells, bathrooms, storage rooms, gym (when empty),sports equipment rooms, baseball dugouts, back seats of vehicles, woods around the building, unused, unlocked rooms, area behind vending machines,, unlit areas, unlit facility exterior areas.
[xxi] Key information interview, R. Leslie Nichols, MSSA, CPP,October 16, 2018 and October 8, 2019.
[xxii] Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., Raiford, J.L. (2016). STOP SV: A Technical Package to Prevent Sexual Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
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APPENDIX Q

HIDDEN PREDATOR ACT (SB134 & HB263)

Will Maryland protect its children or protect its predators?

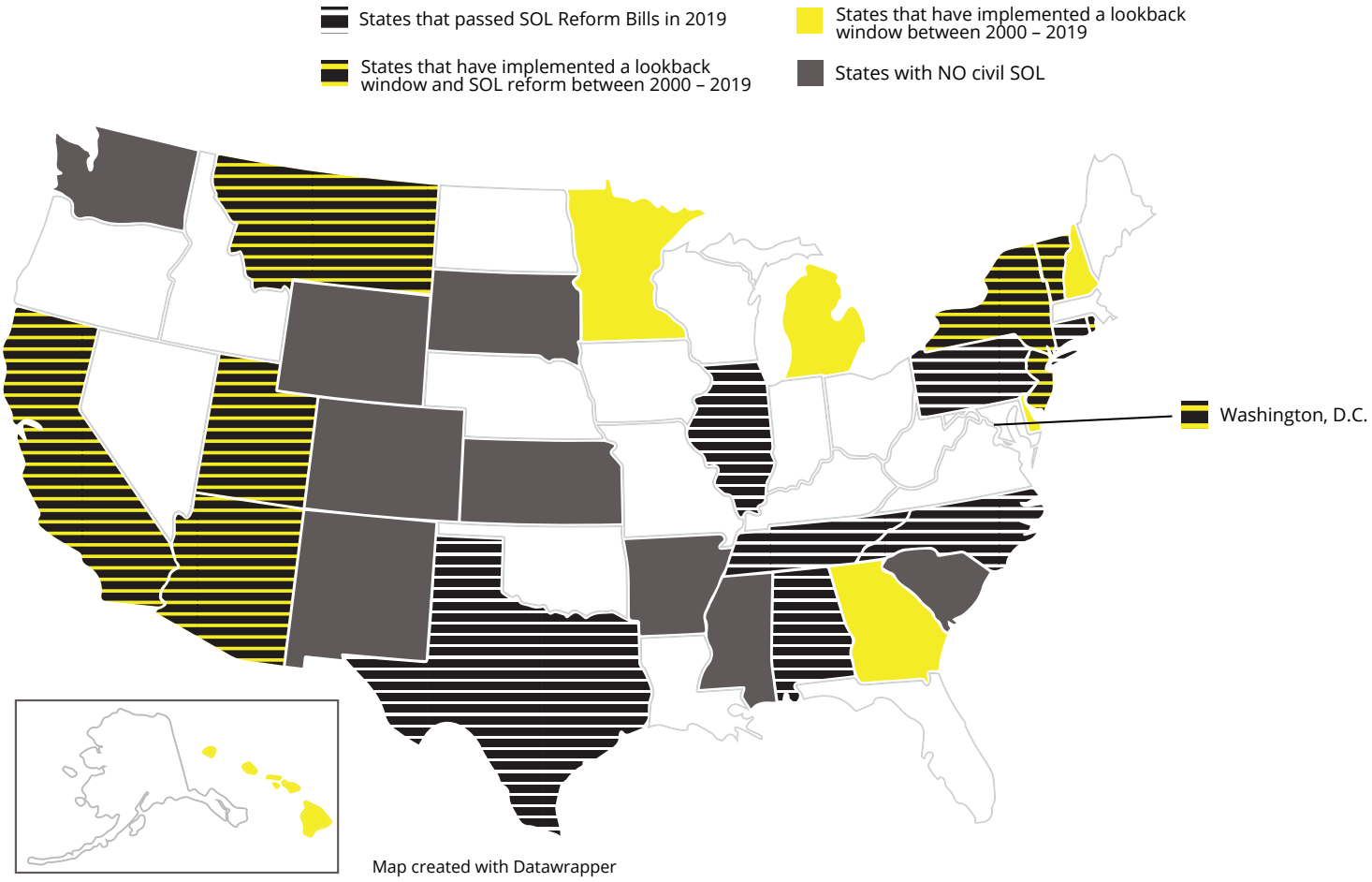
GOALS OF HIDDEN PREDATOR ACT (SB134 & HB263)

- Identify Hidden Predators
- Disclose Facts of Sex Abuse Epidemic to Public
- Arm Trusted Adults to Protect Children
- Shift Cost of Abuse from Victim to Those Who Caused It
- Justice for Victims Ready to Come Forward

WHAT WILL THE HIDDEN PREDATOR ACT (SB134 & HB263) DO?

- Eliminate the civil statute of limitations going forward.
- Create a lookback window for those victims who have been previously barred by the statute of limitations, allowing them to file suit for a period of two years.
- Removes the "statute of repose" making it clear to the courts, the public and survivors that the Maryland General Assembly did not intend to vest constitutionally protected property rights in child sexual predators nor the individuals and organizations that hid predators from discovery and prosecution.

Since 2018, 1/3 of states have passed laws extending the civil statute of limitations (SOL) and establishing a lookback window for child sexual abuse claims, enabling survivors the opportunity to have their claim considered in a court of law. This bill would apply to all individuals and organizations, **no one would be exempt from civil litigation.**



HIDDEN PREDATOR ACT (SB134 & HB263)

FACT: There is a national shift towards exposing Hidden Predators through civil SOL lookback windows.

In 2019, Washington D.C.:

- Extended the civil SOL where victim was under 35-40 with a 5 year discovery rule
- Opened 2 year revival window for victims abused as minors and adults
- **16** states + D.C. have passed "lookback windows" or revival laws and **9** states, including MD, have introduced these laws in 2020

In 2019, New Jersey:

- Extended the civil SOL for child sex abuse to age 55 or 7 years from discovery for claims against individuals, public and private institutions
- Removed claim presentment requirement for claims against public entities
- Opened 2 year revival window for victims abused as minors or adults against perpetrators and institutions

FACT: In other states lookback windows have exposed hidden predators.

In Delaware:

- During 2 year lookback window ('07-'09), **175** survivors filed claims
- Under follow-up window for healthcare providers, **1,000** claims made solely against Pediatrician Dr. Earl V. Bradley, the most active previously undisclosed predator to date

In Minnesota:

- **125+** predators identified, including the predator in the high-profile cold case of Jacob Wetterling
- During the 3 year lookback window ('13-'16), **1,006** claims were filed

In California:

- **300+** predators were identified
- During the 1 year look back window in '03, **1,150** survivors filed claims

Q: Is there a need for further Civil SOL reform?

A: Criminal and civil proceedings provide different solutions and both are needed for justice to be served. Criminal prosecutions are at the discretion of prosecutors and law enforcement with limited resources and are often not pursued. If pursued, the remedy is a criminal sentence for perpetrators. Civil suits empower victims to initiate a court case to shift the cost from the victim to those who caused the harm.

Q: How will the lookback window impact institutions that provide education and social services to low-income individuals and communities?

A: Many institutions receive a large percentage of their funding from government agencies as payment for services provided. This bill would have no effect on that funding or the ability to provide those social services. For example, nearly 77% of Catholic Charities revenue comes from governmental agencies. In rare circumstances, an organization may choose to seek legal relief under the bankruptcy code to reorganize their debt. This legal relief does not cause operations to close.

Q: In 2017, did the Maryland General Assembly intend to include a "statute of repose" in the legislation?

A: A "statute of repose" gives constitutionality protected property rights to a defendant. It is intended to be used in product liability cases to limit the length of time that the builder or inventor may be held responsible for problems or defects. It was never intended to protect wrongdoing by sexual predators and those that protect them from prosecution or discovery.

In 2017 There was no discussion or debate of the constitutional implications of the "statute of repose" in committee or on the floor of either chamber. Neither the Fiscal and Policy Note, nor the Revised Fiscal and Policy Note, make any notice of the pivotal constitutional implications to this law. Neither the constitutionality of a lookback window nor a "statute of repose" in child sexual abuse cases has been decided by the Maryland courts. Constitutionality should be determined by the courts.

The Hidden Predator Act (SB134 & HB263) removes the "statute of repose" language making it clear to the courts, the public, and survivors that the Maryland General Assembly did not intend to vest constitutionally protected property rights in child sexual predators nor the individuals and organizations that hid predators from discovery and prosecution.

Q: How will this bill help Maryland prosper?

A: The average age for adults to disclose childhood sexual abuse is 52. Research shows that children who experience an Adverse Childhood Experience (ACEs) can have poor long-term mental and physical health, educational, and employment outcomes at enormous cost to individuals and the state. The trauma from childhood sexual abuse may lead to PTSD, alcohol and opioid abuse, depression, suicide, and poor educational and employment outcomes. The lookback window provides survivors a window of time to access justice and shifts the costs of healing to those who caused the harm. It also provides protection for our children who may still be at risk from formerly unknown abusers and leads to improved institutional practices that keep children safe from sexual predators.

For additional information, please contact the State Council for Childhood Abuse and Neglect (SCCAN):
Claudia Remington, Executive Director | Claudia.Remington@maryland.gov

APPENDIX R

Questions in the 12-item Resilience Research Centre Adult Resilience Measure (RRC-ARM)

To what extent do the statements below describe you?

Response options: Not at all, a little, somewhat, quite a bit, a lot

1. I have people I can respect in my life
2. Getting and improving qualifications or skills is important to me
3. My family know a lot about me
4. I try to finish what I start
5. I can solve problems without harming myself or others (e.g. without using drugs or being violent)
6. I know where to get help in my community
7. I feel I belong in my community
8. My family stand by me during difficult times
9. My friends stand by me during difficult times
10. I am treated fairly in my community
11. I have opportunities to apply my abilities in life (like skills, a job, caring for others)
12. I enjoy my community's cultures and traditions

Questions included in the 12-item Child and Youth Resilience Measure (CYRM)

When you were growing up, during the first 18 years of life, to what extent would the following sentences have described you?

Response options: Not at all, a little, somewhat, quite a bit, a lot

1. I had people I looked up to
2. Getting an education was important to me
3. My parents/caregivers knew a lot about me
4. I tried to finish activities that I started
5. I was able to solve problems without harming myself or others (e.g. without using drugs or being violent)
6. I knew where to go in my community to get help
7. I felt I belonged in my school
8. My family would stand by me during difficult times
9. My friends would stand by me during difficult times
10. I was treated fairly in my community
11. I had opportunities to develop skills to help me succeed in life (like job skills and skills to care for others)
12. I enjoyed my community's cultures and traditions

APPENDIX S

Essentials for Childhood Survey on Awareness, Commitment, Norms

We would like to include you as a participant in the quarterly YouGov study on health and culture across the nation. If you agree to be in this study, we will ask you about your views and experiences with regard to quality of life issues. Participation is voluntary, and you may decline to answer any questions that you do not want to answer. The survey will take about 15 minutes to finish.

Below are some reasons people give to explain why some children struggle (i.e., disrupt the classroom, do poorly in school, become teen parents, get into drugs or involved in crime). For each one, please indicate how important do you think the reason is for why some children might struggle in the United States.

1. Children growing up living in poverty
2. Parents not working hard enough.
3. Families living in neighborhoods with a lot of other families that can't make ends meet
4. People not willing to support solutions that benefit all children, not just their own
5. Parents not thinking about the future of their children
6. Children born with bad personality traits that are passed from one generation to the next
7. Lack of public investment (e.g., in early care and education, schools, job opportunities) in low income neighborhoods and communities of color
8. Families living in unsafe neighborhoods (i.e., with easy access to drugs, guns, or gangs)
9. Children living in families with challenges like substance abuse, violence, mental health problems
10. Employers not adopting family-friendly practices (e.g., paying family and sick leave, flexible schedules to accommodate children's needs)
11. Parents being stressed about money
12. Children not working hard enough in school
13. Families living in neighborhoods with few resources or public services like community centers, libraries, or transportation
14. Children not having high quality (i.e., nurturing, stimulating, safe, and stable) early child care
15. Parents not knowing how to parent correctly
16. Children with learning challenges not getting the support they need
17. Limited political support for helping poor families get out of poverty
18. Children treated unfairly because of their color (e.g., in schools, by police, or the justice system)
19. Parents not having enough time for their children
20. Employers not paying parents enough to support a family
21. Children not thinking things carefully enough and end up making poor choices
22. Parents using harsh or aggressive discipline
23. Parents not supporting their children's learning through educational activities like reading to them or playing with them
24. Children going to poor quality schools
25. Parents not thinking things carefully enough and end up making poor choices.

RESPONSE OPTIONS:

extremely important
somewhat important
neither important or unimportant
somewhat unimportant
not at all important

Below are some things people have suggested communities could do to increase the opportunity for **all children** to succeed.

Please indicate how strongly you support or oppose the idea that communities should provide that all families….

26. Have easy access to affordable parenting classes
27. Have paid parental leave to care for a new child
28. Be able to buy enough nutritious food
29. Be able to live in safe and stable housing
30. Be able to leave their children in child care that is good for the child's development
31. Be able to send their children to high quality preschool
32. Be able to send their children to high quality schools in their neighborhood
33. Be able to get support to address their child's special learning challenges
34. Be able to send their children to schools that don't punish children by suspending or expelling them
35. Have easy access to after-school and summer care that provide meaningful opportunities for children
36. Have at least one adult (other than a parent or caregiver) who would provide a safe, stable, nurturing relationship for their children (e.g., a mentor, coach, or teacher)
37. Be able to live in a safe neighborhood where children aren't exposed to violence or illegal drugs
38. Be able to live in a neighborhood where few or no families have a hard time making ends meet
39. Be able to live in a city or county where their children are treated fairly in school, by police, or the justice system regardless of the color of their skin
40. Have a full-time job that provides sufficient income to cover basic needs for the employee and his/her child
41. Have a job that is "family-friendly" (e.g., provides flexible schedules, has on-site child care or provides subsides for child care, provides paid days to care for sick family members, paid leave to attend school events)
42. Have access to health care
43. Have access to mental health care or substance abuse treatment, if needed
44. Receive income support (cash, vouchers, or tax refund) to cover basic needs (e.g., housing, food, child care) if a bread winner loses his/her job or household income is below the income needed to cover basic needs

RESPONSE OPTIONS
- Strongly support
- Support
- Neither support or oppose
- Oppose
- Strongly oppose

45. Thinking about the ideas you **strongly** supported to increase the opportunity for **all children** to succeed, what action(s) have you personally taken in the past 12 months. (Check all that apply)

- I shared information about their importance with others
- I signed a petition or e-mailed a prewritten letter to decision-makers
- I asked friends or family to sign a petition or write to decision-makers
- I donated money to an organization supporting these ideas
- I made phone calls or went door to door to gather support for them
- I attended a meeting with business or community groups to urge they support them
- I attended a town hall meeting or public rally to support them

I met with an elected official or his/her staff to talk about them
I did none of the above

46. Sometimes we can feel passionate about issues in our community but not have enough time to take action. Again, thinking about the ideas you **strongly** supported to increase the opportunity for **all children** to succeed, how likely are you in the next 12 months to do the following ? (Check all that apply)
    I would share information about their importance with others
    I would sign a petition or e-mail a prewritten letter to decision-makers
    I would ask friends or family to sign a petition or write to decision-makers
    I would donate money to an organization supporting these ideas
    I would be willing to pay more taxes or higher prices at the register to support them
    I would make phone calls or go door to door to gather support for them
    I would attend a meeting with business or community groups to urge they support them
    I would attend a town hall meeting or public rally to support them
    I would meet with an elected official or his/her staff to talk about them
    I would do none of the above

In the next section, we would like to know about behaviors often used in caring for young children.

47. How many children live in your household? ____
48. This past year, was there a child under the age of 5 in your home or do you care for children under age 5 at least once a week?
    ☐ YES ☐ NO (If NO, skip to Q54).

In the past year, how often have you:

49. Let your child (or the child you cared for) know when you liked what he/she was doing?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

50. Responded to your crying infant (or infant you cared for) by trying to comfort them?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

    ☐ Not applicable because I did not care for an infant this past year

51. Played with or read a story to your child (or child you cared for) under the age of five?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

52. Spanked your child (or child you cared for) on the bottom?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

53. Yelled at or fought with another adult in front of your child (or child you cared for) or where the child could hear
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

54. Asked or searched for help with parenting or caring for children when needed?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

55. Helped your child (or child you cared for) express themselves with words when they were angry or frustrated

☐ every time ☐ almost every time ☐ sometimes ☐ seldom ☐ never

56. Been a mentor (like a Big Brother or Big Sister) to an unrelated child?
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

II. In this next section, we are interested in your perceptions of how the majority of parents behave with their children. Even if you are not sure, please give us your best guess.

Thinking about the **majority** of parents in [pipe inputstate]: how often do you think they…

57. Let their children know when they liked what they are doing
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

54. Respond to their crying infant by trying to comfort them

☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

58. Play with or read a story to their child under the age of five
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

59. Yell at or fight with another adult in front of their child or where their child could hear
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

60. Spank their child on the bottom with their hand
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

61. Help their child express themselves with words when they are angry or frustrated
☐ every time ☐ almost every time ☐ sometimes ☐ seldom ☐ never

62. Asked or searched for help with parenting when they needed it
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

63. How often do adults in your state mentor an unrelated child (like being a Big Brother or Big Sister)
☐ Every time it's needed ☐ Most of the times it's needed ☐ sometimes ☐ Rarely

III. In this final section we are interested in the opinions of those important to you. Thinking about those who you look up to and whose opinion you value, please indicate what you think they believe. Even if you are not sure about their opinion, please give us your best guess.

Thinking about those people whose opinions you trust and respect, how strongly do you believe they would agree or disagree with the following statements:

64. Letting children know when you like what they are doing is a good way to teach a child how to behave
☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

65. Always trying to comfort a crying infant will spoil the baby
☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

66. Playing with or reading a story to young children every day will help the child's brain develop
☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

67. Yelling at or fighting with another adult in front of your child or where the child could hear is bad for the child's health
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

68. Spanking your child on the bottom is a necessary part of parenting
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

69. Helping children express themselves with words when they are angry or frustrated is better than getting mad at them
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

70. Asking or searching for help with parenting means there's something wrong with you because you should know how to parent your child
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

71. Being a mentor (like a Big Brother or Big Sister) to an unrelated child is a good use of your time
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree