MARYLAND DEPARTMENT OF HUMAN SERVICES

MARYLAND STATE COUNCIL ON CHILD ABUSE & NEGLECT ANNUAL REPORT

January 1, 2022- December 31, 2023

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 promotion of child-well being and preventing child maltreatment and other adverse childhood experiences (ACEs) *before they occur.* Special thanks this year go to:

- Former Council Members, those that stayed on beyond their terms and those that engaged and participated without a formal appointment - 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, MD, MPH and Maryland Essentials for Childhood (EFC) Chair, Joan Stine, for their leadership.
- Incoming Council members for their commitment to serving Maryland children and families. Taniesha Woods, PhD for taking on the role of SCCAN Chair. Ted Gallo, our new Executive Director
- Council Members' agencies for dedicating staff time and expertise to the important cross agency work of the Council and Maryland Essentials for Childhood. Interagency collaboration is critical to effectively address childhood trauma.
- Achieving Racial Equity in Child Welfare Workgroup Co-Chairs, Erica LeMon, Esq. and Dr. Michael Sinclair for their leadership in developing SCCAN's Anti-Racist Statement and Visioning Session. Also, Workgroup Members (See Appendix C) and Dr. Sinclair's graduate students at Morgan State for their many hours of work to make December's Visioning Session possible.
- Achieving Racial Equity Visioning Session speakers: Dr. Anna McPhatter, Dean, School of Social Work, Morgan State University; Joyce James, Keynote Speaker; Corey Best, Lead Facilitator; Nilesh Kalyanaraman, MD, MDH Deputy Secretary for Public Health Services; and Hilary Laskey, Maryland DHS.
- Achieving Racial Equity in Child Welfare lead organizations: Morgan State University and Maryland Department of Health. Visioning Session donors: Maryland Judiciary, Donald A. Strauss Foundation, Child Justice, The Zanvyl and Isabelle Krieger Fund, and Maryland Legal Aid. Visioning Session Partners: Paths for Families, Maryland Essentials for Childhood, Child Justice, Child Welfare League of America, Maryland Legal Aid, The Family Tree, Maryland Judiciary, Maryland Office of the Public Defender, Echo Resource Development, Maryland Department of Human Services, and 725 Strategies, LLC.
- Pat Cronin, the former Executive Director of The Family Tree, for her countless years of invaluable work helping Maryland families and Stacey Brown, newly appointed Executive Director of The Family Tree for continuing Pat's work and staying deeply

engaged in the work of SCCAN. The Board and staff of The Family Tree for their co-backbone support of Maryland Essential for Childhood Initiative. The Family Tree Board for supporting the ACE Interface Project.

- Ace Interface Project Master Trainers and Presenters for dedicating their valuable time and skills to the efforts to ensuring Maryland become a N.E.A.R. Science Informed State.
- Maryland ACE's Connection Community Managers, Matila Jones, Claudia Remington, Jamie Sheppard and Erik Weber.
- Vanessa Milio, Nonprofit Consultant and Coach, and former Executive Director of No More Stolen Childhoods (NMSC) for lending her expertise to efforts to pass The Child's Victims Act (HB1/SB686 2023).
- Delegate C.T. Wilson for sponsoring and tirelessly advocating for the eventual passage of the Child Victims Act to give voice to adults who were victimized as children and to prevent future abuse.
- Judicial Proceedings Committee Chair Will Smith, and Vice Chair Jeff Waldstreicher, Judiciary Committee Chair Luke Clippinger for their leadership in Committee to pass the Child Victims Act. Senator Shelly Hettleman for her prior sponsorship and continuing support of the bill.
- Judicial Proceedings Committee and Chair Will Smith for supporting the Child Victims Act Legislative Briefing. Kathi Hoke, Kathryn Robb, Claudia Remington, and Wendy Lane for their testimony at the briefing.
- The Maryland State Legislature for passing the Child Victims Act.
- The Legal Resource Center for Public Health Policy at the University of Maryland Francis King Cary School of Law, Professor and Director, Kathleen Hoke, and law students, for their legal expertise, testimony, and support of efforts to pass the Child Victims Act.
- The following organizations for their support and advocacy on behalf of passing the Child Victims Act: Ashlar Public Relations, Baltimore County Progressive Democrats, Beau Biden Foundation, Boys & Girls Clubs of Harford & Cecil Counties, Center for Children, Center for Hope at Lifebridge Health Group, Child Justice, Child USA, Child USAdvocacy, Circle of Parents, Citi Ministries, Citizens Review Board for Children, Delaware Maryland Synod, 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, Justice 4 MD Survivors, Key School Survivors, Kros Learning Group, Maroon PR, Maryland Catholics for Action, Maryland Chapter of the American Academy of Pediatrics, Maryland's Children's Alliance, Maryland Coalition Against Pornography, Maryland Coalition Against Sexual Assault, Maryland Coalition of Families, Maryland Court Appointed Special Advocates (CASA), Maryland Episcopal Public Policy

Network, Maryland Family Network, Mid Atlantic P.A.N.D.A., Montgomery County Young Democrats, MOST Network, NAACP Maryland State Conference, Needworking, No More Stolen Childhoods, 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, Survivors Network of those Abused by Priests (SNAP), The Family Tree, and The Moore Center for the Prevention of Child Sexual Abuse at Johns Hopkins Bloomberg School of Public Health.

- Marci Hamilton, CEO and Academic Director of Child USA, an interdisciplinary think tank to prevent child abuse and neglect at the University of Pennsylvania for sharing her time and expertise as well as providing 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, as well as HB1/SB686, The Child Victims Act of 2023
- Linda K. Boyd, Jena Cochrane, Sarah Conway, Kay Connors, Mary Corzine, Nancy Fenton, Rebecca Fix, Paul Griffin, Jennifer Gross, Kathleen Hoke, Gemma Hoskins, Lisae Jordan, Susan Kerin, Frank Kros, Teresa Lancaster, Wendy Lane, MD, Elizabeth Letourneau, Rev. Kobi Little, David Lorenz, Judith Lorenz, Vanessa Milio, Mary Mueller, Davion Percy, Former DE Senator Karen Peterson, Claudia Remington, Kathryn Robb, Daniel Robson, Emily Rose, Kurt Rupprecht, David Schappelle, Abbie Schaub, Francis Schindler, Senator Will Smith, Carolyn Surrick, Megan Venton, Donna VonDenBosch, Jean Wehner, Matthew Wolf for their testimony, both oral and written, on behalf of HB01/SB0686, The Child Victims Act.
- Sarah Conway for her development of Justice4MDSurvivors.org in support of Maryland child sexual abuse efforts for child sexual abuse statute of limitations reform.
- Dr. Richard Lichenstein, Medical Director for Child Welfare, for engaging with SCCAN and pediatricians from the Maryland Chapter of the American Academy of Pediatrics to seek input and advice on improving health care services for youth in foster care.
- Drs. Rebecca Seltzer and Rachel Dodge, pediatricians who met twice monthly with Dr. Lichenstein and his team over the past 1 ½ years to provide input and advice on improving health care services for youth in foster care.
- Hilary Laskey, Melissa Rock, and Joan Stine for participating in two rounds of interviews to select a new SCCAN Executive Director.
- SCCAN meeting speakers: Katie Pederson, Maryland DHS, Kay Connors, Department of Psychiatry, University of Maryland School of Medicine, Dr. Margo Candelaria,

formerly of the Institute for Innovation and Implementation, University of Maryland School of Social Work, Kristen Parquette and Rovan Willis-Gorman from C4 Innovations, Tiffany Beason and Joanna Prout, from the Department of Psychiatry, University of Maryland School of Medicine, Rebecca Allyn, from the Governor's Office of Crime Prevention, Youth and Victim Services, Janice Goldwater, Commissioner on the Maryland Trauma Informed Care Commission, Dr. Richard Lichenstein, Medical Director for Child Welfare, Maryland DHS Susan Dos Reis, University of Maryland School of Pharmacy, Hilary Lasky, Maryland DHS and Erica LeMon, Esq., Maryland Legal Aid

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State Council on Child Abuse and Neglect (SCCAN)
311 W. Saratoga Street, Room 405
Baltimore, Maryland 21201
Phone: (667) 203-0898
edward.gallo2@maryland.gov

April 8, 2024

The Honorable Wes Moore
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 2022-23

Dear Governor Moore, 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 2022-2023, you supported the Child Victims Act, spearheading the legislation through the House of Delegates and Senate, then signing the bill into law. You continued your support of the Trauma-Informed Care Commission, whose members are working hard to implement the legislative mandates. Most recently, Governor Moore signed an Executive Order reinstating the Governor's Office for Children and the Children's Cabinet, and amending the Governor's Office of Crime Prevention, Youth, and Victim's Services to become the Governor's Office of Crime Prevention and Policy. Children need and deserve their own office, separate from the focus on crime prevention.

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:

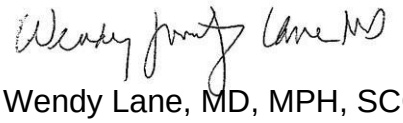
1) *to "evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities;"*
2) *to "report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of 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 2022-2023, we have chosen to continue our focus on the primary prevention of child maltreatment, including passage of the Child Victims Act, health care for children involved in the child welfare system, and racial equity for children and families involved in the child welfare system. The Council recommends several actionable steps to improve Maryland's child and family serving systems in order to protect children and to prevent child maltreatment and other Adverse Childhood Experiences (ACEs) *from occurring in the first place*. Specific recommendations are made to prioritize prevention of ACEs, create a Children's Trust & Prevention Fund, coordinate the work of child and family serving systems, ensure full implementation of past bills to prevent child sexual abuse, 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 became more urgent as a result of the coronavirus pandemic; even with the end of the national emergency, poor mental health, substance abuse disorders, isolation, loneliness and racism have persisted, 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. As I complete my term as SCCAN Chair, I am grateful for your support as well as the support of the many Maryland citizens who have given so much of their time and expertise to the

Council. And I extend a hearty welcome to our new SCCAN Executive Director, Edward (Ted) Gallo, and new SCCAN Chair, Taniesha Woods.

Sincerely,



Wendy Lane, MD, MPH, SCCAN Chair

cc: DHS Secretary Rafael J. Lopez
MDH Secretary Laura Herrera Scott
DJS Secretary Vincent Schiraldi
MSDE Interim State Superintendent of Schools, Carey M. White
MDD Secretary Carol A. Beatty
DBM Secretary Helene T. Grady
DPSCS Secretary Carolyn J. Scruggs
DLLR Secretary Portia Y. Wu
Governor's Office of Crime Prevention, Youth, and Victim Services, Dorothy J. Lennig, Executive Director
SCCAN Members[1]

[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 2022-2023 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 "Because childhood adversity increases the risk for heart disease, cancer and suicide, it contributes to approximately 400,000 excess U.S. deaths per year, or 15% of all U.S. mortality."[4] The costs of ACEs emphasize that the future prosperity of any society depends on its ability to foster health, well-being and resilience 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.

Conversely data shows a correlation between mental health outcomes and Positive Childhood Experiences (PCEs) with lower rates of mental health concerns among children with more PCEs. PCEs include protective adult relationships, school connectedness and peer connections that can build a child's resilience to life challenges. Additionally, promoting household financial security, supporting positive parenting, encouraging school safety and a sense of belonging, and providing access to programs that improve conflict resolution and stress-handling skills contribute to fostering PCEs. Research indicates that the negative effects of multiple ACEs can be mitigated by exposure to multiple PCEs, reinforcing the importance of cultivating positive environments and relationships during childhood to enhance overall well-being and resilience. This underscores the potential role of PCEs in promoting better mental health outcomes and

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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.

highlights the potential for prevention strategies focusing on fostering positive experiences during childhood.

While the COVID-19 pandemic has waned, it has left behind a mental health crisis and an epidemic of loneliness. The outcries against racism have led to increased awareness and some change, but also increasing pushback against change. Now more than ever, it is critical that we consider instituting trauma-informed and resilience-building public and private policies and practices to create 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 and strengthen relationships and environments that help children grow up to be healthy and productive citizens so that they, in turn, build more supportive 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 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. While the Essentials for Childhood initiative meetings have been on pause during the selection and onboarding of our new Executive Director, the work has continued, and we hope to see it flourish in the coming year.

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:

- In 2021, The Maryland General Assembly (MGA) passed legislation, HB548/SB299, create a Commission on Trauma Informed Care (TIC). The Commission continues to meet regularly and is creating methods and measurements to ensure that State agencies are properly trauma informed. The TIC is also looking at ways to integrate screening for ACEs and their effects into pediatric primary care and to address mental and behavioral health issues that may be the result of ACE exposure.
- In 2021, The MGA passed legislation, HB771/SB548 requiring inclusion of ACEs questions in the Youth Risk Behavior Survey/Youth Tobacco Survey for both middle and high school children. The first data collected since the passage of this legislation from the 2021-2022 school year is presented in this report.
- In 2023, after many years of SCCAN and MD EFC advocacy and support, the MGA passed HB1/SB686, The Child Victims Act. This legislation eliminated the civil statute of limitations for child sexual abuse, allowed a permanent lookback window to enable

victims previously barred by the statute of limitations to file suit, allowed both public and private entities to be sued, and eliminated the notice of claims deadlines for public entities in child sex abuse cases.

- 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. In addition, the Workgroup hosted a listening session in December 2023 to allow individuals with lived experience and professionals to engage in conversations about how to eliminate inequities in the child welfare system.
- SCCAN's Health Care for Children in Child Welfare Workgroup has worked closely with Dr. Rich Lichenstein, the Medical Director for Child Welfare, to improve the receipt and tracking of health care services for children in out-of-home placement. The Medical Director position was created by 2018's HB 1082, sponsored by Del. C.T. Wilson, which SCCAN was deeply engaged in passing.
- From March 2022 to January 2024, SCCAN held 8 membership meetings, with speakers from many organizations and agencies that serve Maryland Children. A listing of all meetings is included in Appendix K.

SCCAN's Annual Report for 2022 includes the following:

- A description of Maryland data on the magnitude of the problem.
- A description of the recent 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 in Appendix D.
- 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 and is included in Appendix F.
- Recommendations by agency in Appendix M.

Key Recommendations for the Governor, the General Assembly, and Agencies:

Overarching Recommendations:

(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,

promote positive childhood experiences, 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.

(5) Develop and implement a **Trauma and Resilience-Informed State Action Plan for Preventing and Mitigating Childhood Trauma/ACEs** that aligns with the work of the Trauma Informed Care and Health Equity Commissions. The plan should include budgetary commitments, public/private collaboration to develop infrastructure, promotion and creation of local community-based cross-sector coalitions, and incorporation of the 6 strategies and evidence-based programs and approaches listed in the CDC's *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence* resource tool.[5]

(6) Support legislation and funding of a Children's Trust Fund administered by a public-private board of directors to lead innovation and financing across the state.

Surveillance Recommendations:

(1) **MDH –** Continue collecting data on ACEs and Positive Childhood Experiences through statewide surveys including BRFSS and YRBS/YTS.

(2) **DHS, MDH, GOCPP, Maryland Children's Cabinet –** Use data from CJAMS, YRBS/YTS, BRFSS, and other sources to determine where and who should be prioritized for services.

(3) **DHS, MDH, MDTHINK –** Provide personnel and financial resources immediately to address operability issues with CJAMS.

(4) **DHS, MSDE –** Work collaboratively to gather data on educational services received by children in out-of-home care and track educational outcomes for foster youth.

(5) **Maryland General Assembly --** 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.

(6) **DHS, MSDE, Maryland General Assembly –** Also see Racial Equity recommendations (1) – (4) that address surveillance.

Achieving Racial Equity within Maryland's Child Welfare System Workgroup Recommendations (to be updated in report from Visioning Session):

(1) **DHS:** Require caseworkers to input race demographic data on all cases brought to the attention of the Department of Human Services, in order to examine disparities. Data should be gathered for all families referred to CPS, screened out, received Investigative Response, received Alternative Response or Non-CPS Risk of Harm Response, as well as those referred to and receiving services.

[5] Centers for Disease Control and Prevention. Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Online at: https://www.cdc.gov/violenceprevention/pdf/CAN-Prevention-Resource_508.pdf

(2) **DHS:** Make publicly available child welfare and health-related data that is disaggregated by race, ethnicity, gender, age, and geographic region. Child welfare data should also be disaggregated for each system level (i.e., referrals, pathways, and services). Neglect referrals should be disaggregated by risk factor (food insecurity, housing status, etc.)

(3) **DHS, MSDE:** Work collaboratively to gather data on educational services received by children in out-of-home care. 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.

(4) **Maryland General Assembly:** Amend current statute to expand data currently collected by Maryland's Department of Human Services and published in their Child Welfare Indicators Report. Recommended data are included in Appendix L.

(5) **Maryland General Assembly:** 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.

(6) **Maryland General Assembly:** 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.

Child Sexual Abuse Prevention Recommendations:

(1) **Maryland General Assembly** – Amend HB 1072 and HB 486 to require oversight of implementation by Maryland State Department of Education. Each jurisdiction should be required to annually submit to MSDE their training program, Code of Conduct, and policies for screening new staff. MSDE should be required to share information about implementation annually with the Maryland General Assembly.

(2) **Maryland General Assembly/MSDE** – require that all jurisdictions complete CPS background checks prior to hiring of new employees. This will identify individuals determined to be responsible for the maltreatment of a child who are not identified through a criminal background check.

(3) **Maryland General Assembly** – expand requirements of HB 1072 and HB 486 to other child serving organizations to help prevent the hiring of child predators.

Healthcare Committee Recommendations:

(1) **DHS, MDTHINK:** The issues with CJAMS operability, including problems with data entry and creation of reports must be fixed as soon as possible; data system linkages and an electronic health passport cannot be created without a fully functional CJAMS/MDTHINK system. Personnel and financial resources must be dedicated to this effort.

(2) **DHS, MDTHINK:** 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, biologic parents, and health care providers have access to critical health and mental health information.

(3) **DHS, MDH, MDTHINK:** 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.

(4) **Maryland General Assembly:** Mandate access to foster youth health care information by necessary personnel at Medicaid, CRISP, and DHS in order to carry out the purposes of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018). Require CRISP to notify primary care providers (PCPs) of changes in placement so that the PCP can more effectively serve as a medical home for children in foster care.

(5) **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 and mental 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.

(6) **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.

(7) **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 psychotropic medication prescribing, including informed consent.

(8) **MDH, DHS, GOCPP, Children's Cabinet** - Convene Key Stakeholders listed above as an "Expert Panel" to review system gaps and develop solutions. MDH (Secretary Herrera) could serve as convener to bring other stakeholders to the table, potentially through the Children's Cabinet, or could propose amendments to the CHAMP legislation that would reconstitute and re-purpose the "Expert Panel" created by the legislation to serve this purpose. Children's Cabinet members would need to determine specific next steps such as meeting frequency, structure, and invitees.

(9) **MDH** – Consider legislation passed in other states (e.g., Florida, New Jersey, Kansas) as a model to centralize and coordinate funding for hospital and CAC-based medical services provided by physicians, advanced practice nurses, and forensic nurse examiners. Include mandated expert consultation as a condition of funding, as this is required for CAC accreditation by the National Children's Alliance.

MAGNITUDE OF THE PROBLEM IN MARYLAND

Important to addressing any problem is understanding of its scope. Mitigation and prevention of ACEs requires an understanding of the incidence of child maltreatment in the state, along with information about what is being done by Maryland DHS and other agencies and organizations to address maltreatment, enhance caregivers' abilities to provide safe, stable, and nurturing environments, and prevent further maltreatment. Mitigation and prevention also requires an understanding of the prevalence of ACEs among Maryland adults and children, so that resources to address ACE sequelae may be equitably distributed based on need.

Several data systems [Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Survey (YRBS)] can capture estimates of ACE prevalence among adults and adolescents in Maryland. Child maltreatment-related fatalities are captured through the Office of the Chief Medical Examiner and the Maryland Vital Statistics Administration. However, other data, such as reports to Child Protective Services (CPS) by race and services received by families are more difficult, if not impossible to obtain at the current time.

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 creation of MD THINK shared services platform into which all the human service agencies could integrate their data systems. The proposal 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) into a single system, CJAMS, which would later be integrated with other MD THINK data systems. DHS assured the Council and partners that this ground-breaking project would bring needed accuracy, efficiency, data analysis capabilities, and tracking of critical outcomes for children across child and family serving agencies.

More than two years after the implementation of CJAMS, the system still does not work effectively. Key data points are either not regularly and systematically collected or are not readily accessible and therefore not analyzed. Integration of CJAMS with other state data systems (e.g. Medicaid) has not happened. This is 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. Data system integration has the potential to: (1) reduce hand entry of medical information by DSS foster care workers; (2) enable DSS staff to better track health care needs and receipt of services; and (3) provide a mechanism for health information sharing with other stakeholders (e.g., birth parents, foster parents, health care providers, and foster youth) through an electronic health passport. Much of this important health and mental 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, behavioral 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. It is important to look at multiple sources of data to understand the true scope of children's experiences with maltreatment. To give the reader some perspective on the problem in Maryland, the Council considers data from three Maryland sources below: Maryland CPS Data (incidence), Behavioral Risk Factor Surveillance System ACE Module data (childhood prevalence among Maryland adults of all ages), and Youth Risk Behavior Survey data (prevalence to date among adolescents).

Child Welfare Data, Child Abuse and Neglect Reports, Pathways and Services Provision

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

- During FFY 2021 DHS SSA reports that it received 71,077 referrals of suspected child abuse or neglect, up from 66,865 referrals in 2019. Of those, 35,298 reports or 49.7% were screened in for a CPS response (either investigative or alternative response).
- During FFY 2021, 20,547 investigations were completed. Of this total, 6,573 caregivers were indicated for abuse or neglect. The 6,573 indicated cases represent 32% of the total abuse and neglect investigations and 18.6% of all screened-in referrals. Once there is an indicated referral, children are considered victims of child abuse/neglect.
- During FFY 2021, 14,746 screened-in reports (20.8% of total referrals; 41.7% of total screened-in referrals) received an alternative response (AR). Of those 14,746 cases, 711 (or 4.8% of AR cases) received services and 136 cases (or 0.9% of AR cases) ended up with a removal. The majority of AR cases (94.3%) received neither services nor ended up in a removal.
- Data was not readily available to indicate what, if any, specific services were offered to and accepted by children and their families. This is unfortunate as many of the children referred to child welfare experience 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.***

Data from SCCAN's Annual Reports since 2013 have 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.**

Figure A: FFY2021 Child Maltreatment Referral, Pathways, and Services

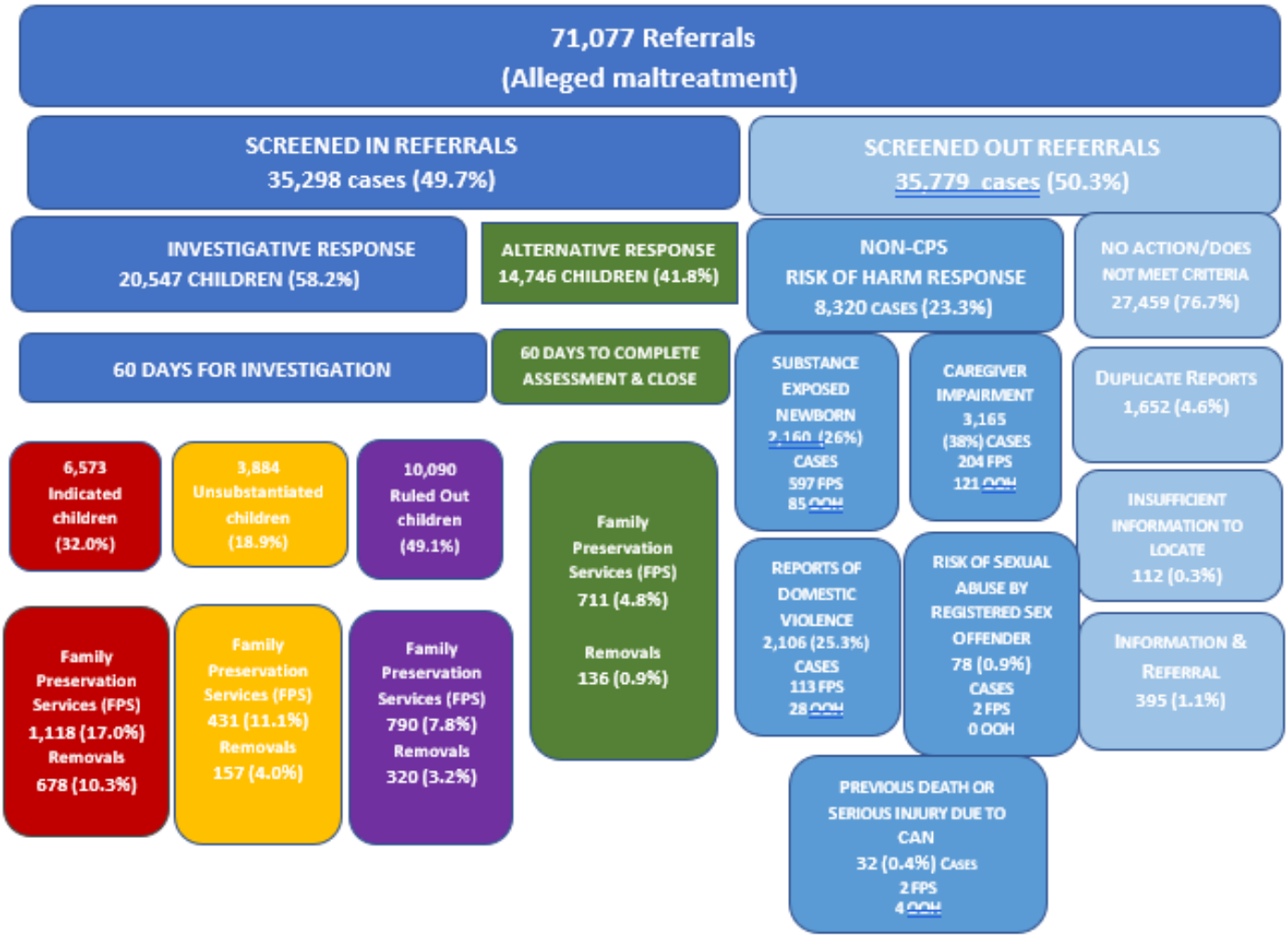


Table 1: CPS Cases in FFY2021 by Race/Ethnicity

	Screened-In Cases			Maltreatment Findings - indicated only		
	All CPS	AR*	IR**	Sexual Abuse	Physical Abuse	Neglect
Hispanic	3,076	1,215	1,861	419	58	247
Black (NH)	13,697	5,259	8,438	519	460	1,714
White (NH)	9,545	3,905	5,640	483	188	1,376
All Others (NH)	281	145	136	24	1	24
Declined	41	27	14	295	424	1,068
Missing/Unknown	8,653	4,195	4,458	508	125	427
Total	35,293	14,746	20,547	1953	832	3,788

*AR=Alternative Response **IR=Investigative Response ¥Non-Hispanic

Table 2: CPS Screened-In Cases by Race and Ethnicity Compared to the Maryland Child Population by Race and Ethnicity

	Percentage of 2020 MD Child Population	Percentage of Screened-In Cases
Hispanic	16.6%	8.72%
White (NH)	40.6%	27.0%
Black (NH)	30.6%	38.8%
All others (NH)	12.2%	25.48%

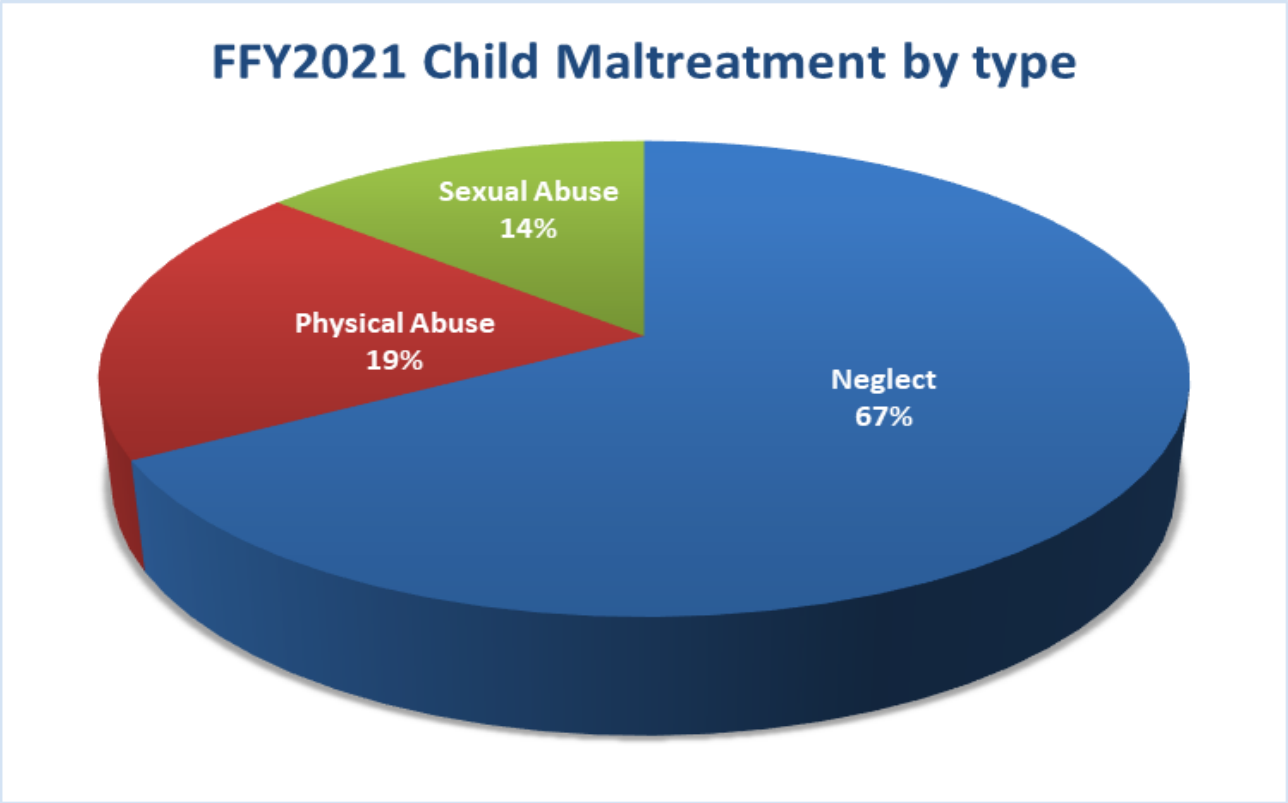
SCCAN requested that each data point in Figure A, referrals, pathways, and services be disaggregated by race, gender, age, and ethnicity. DHS provided disaggregated data by race for children/families receiving an investigative response and an alternative response. They also provided disaggregated data by race for children/families with indicated maltreatment findings (Table 1). DHS did not provide disaggregated data by race on all families/children with CPS referrals, nor on services offered or received by families/children in any pathway (IR, AR, or Non-CPS). It is therefore not possible to assess whether there are racial/ethnic disparities in the decision to screen-in a referral, nor in the decision to assign a referral to alternative response. Likewise, it is not possible to determine whether there are disparities in the offer or acceptance of services.

Data from DHS does enable us to compare the racial and ethnic make-up of children/families investigated for maltreatment (i.e., screened-in) to the 2020 racial and ethnic make-up of all children in Maryland (Table 2). This data shows that Black families are over-represented and white and Hispanic children are under-represented among screened-in referrals, when compared to all Maryland children.

Child Maltreatment by Type

- Neglect is the largest category of child maltreatment at 67% (up from 57% in 2020), followed by physical abuse at 19% (up from 18% in 2020) and sexual abuse at 14% (down from 23% in 2020) (Figure B). Sex trafficking was at 0% (down from 1% in 2020) and mental injury remained at 0%. The 2021 Maryland percentages of maltreatment by type are similar to those for the U.S. as a whole (76% neglect, 16% physical abuse, 10% sexual abuse and 0.2% sex trafficking).[6]
- 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.[7]

Figure B: FFY 2021 Child Maltreatment by Type



[6] https://www.acf.hhs.gov/cb/report/child-maltreatment-2021
[7] *In Brief, The Science of Neglect*, Harvard Center on the Developing Child.

Caregiver Risk Factors in Child Maltreatment

Caregiver risk factors are characteristics that may increase the likelihood that their children will be victims of abuse and neglect. 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 2021* report on National Child Abuse and Neglect *Data* (NCANDS) analyzed data for seven caregiver risk factors, those factors are, and are defined 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.

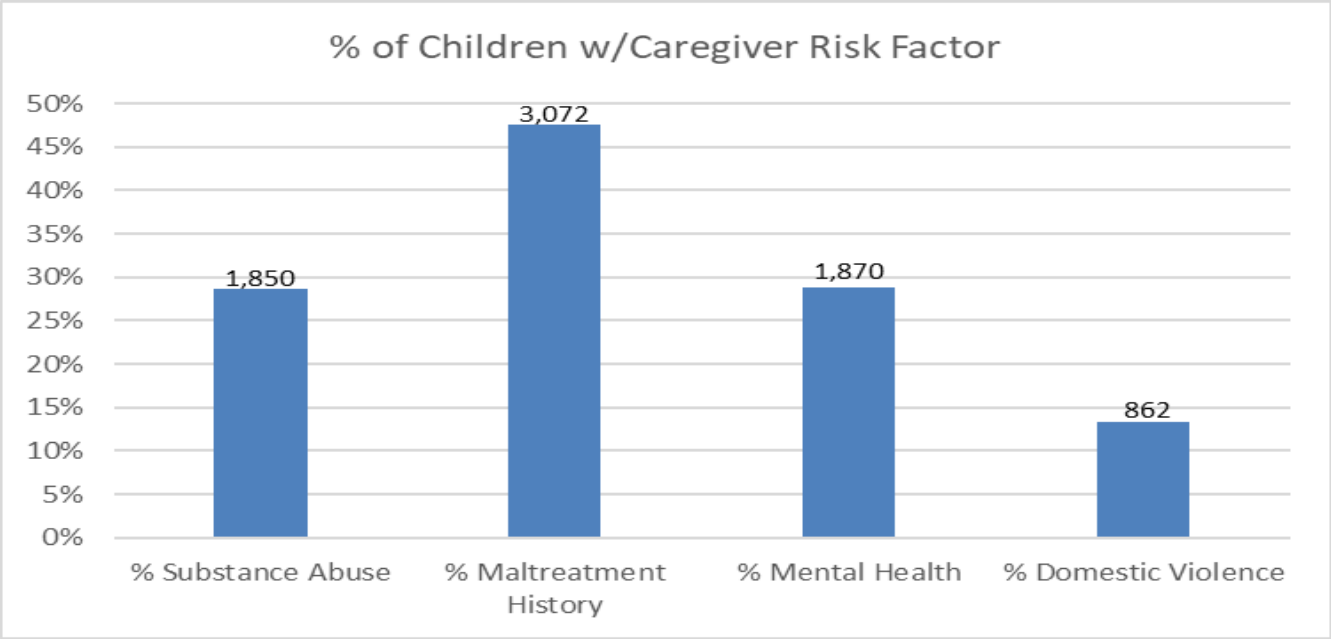
Data submitted to NCANDS by the Maryland Department of Human Services showed that in 2021, 3.6% of child maltreatment victims (i.e. cases with an indicated finding) in Maryland had a caregiver risk factor of alcohol abuse and 9.7% had a caregiver risk factor of drug abuse.[8] Maryland's caregiver alcohol abuse and drug abuse risk factor numbers are smaller than numbers in most other states (victims with alcohol abuse as a caregiver risk factor varies from 49% in Massachusetts to Maryland's 3.6% and Wisconsin's 2.5%; victims with drug abuse as a caregiver risk factor varies from 54% in Alabama to Maryland's 9.7%, Florida's 2.3% and Pennsylvania's 2.2%).

In contrast, DHS reported to SCCAN significantly higher rates of parental substance abuse (28.6% for combined alcohol and other substances - Figure C & Tables 3 & 4) than they did to NCANDS (maximum of 13.3% if no families experienced both alcohol and drug abuse). SCCAN is also concerned about the accuracy of data for other key child maltreatment risk factors. For example, DHS reported very different rates of victim exposure to domestic violence to NCANDS

[8] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2022), Child Maltreatment 2021

and SCCAN in 2021; the rate was 6.3% reported to NCANDS and 24.3% reported to SCCAN (Table 4). 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.

Figure C: Maryland FFY2021 Risk Factors among MD Children with Indicated Maltreatment Finding*



*DHS data reported to SCCAN for Federal Fiscal Year 2021

Table 3: Maryland FFY2021 Risk Factors among MD Children with Indicated Maltreatment Finding*

	% of children w/risk factor	# of children w/risk factor
Substance Abuse	28.6%	1,850
Maltreatment History	47.5%	3,072
Mental Health	28.9%	1,870
Domestic Violence	24.3%	862

*DHS data reported to SCCAN for Federal Fiscal Year 2021

Table 4: Comparison of Number and Percent of Maryland Child Victims with Specific Risk Factors Reported by Maryland DHS, Social Services Administration (SSA) to SCCAN vs. to NCANDS – FFY2021

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	230	3.6%
Drug abuse[9]	Not Reported	Not Reported	612	9.7%
Substance Abuse	1850	28.6%	NCANDS did not report this factor	NCANDS did not report this factor
Maltreatment History	3072	47.5%	2100	33.3%
History of Violence	Not Available	Not Available	NCANDs did not analyze this factor	NCANDs did not analyze this factor
Financial Problems	Not Available	Not Available	Not Reported	Not Reported
Inadequate Housing	Not Reported	Not Reported	137	2.2%
Public Assistance	Not Reported	Not Reported	Not Reported	Not Reported
Any Disability	Not Reported	Not Reported	Not Reported	Not Reported
Domestic Violence	862	24.3%	395	6.3%

Given the differences in data reported by DHS SSA to NCANDS compared to that reported to SCCAN, we are concerned about the accuracy of this data. 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

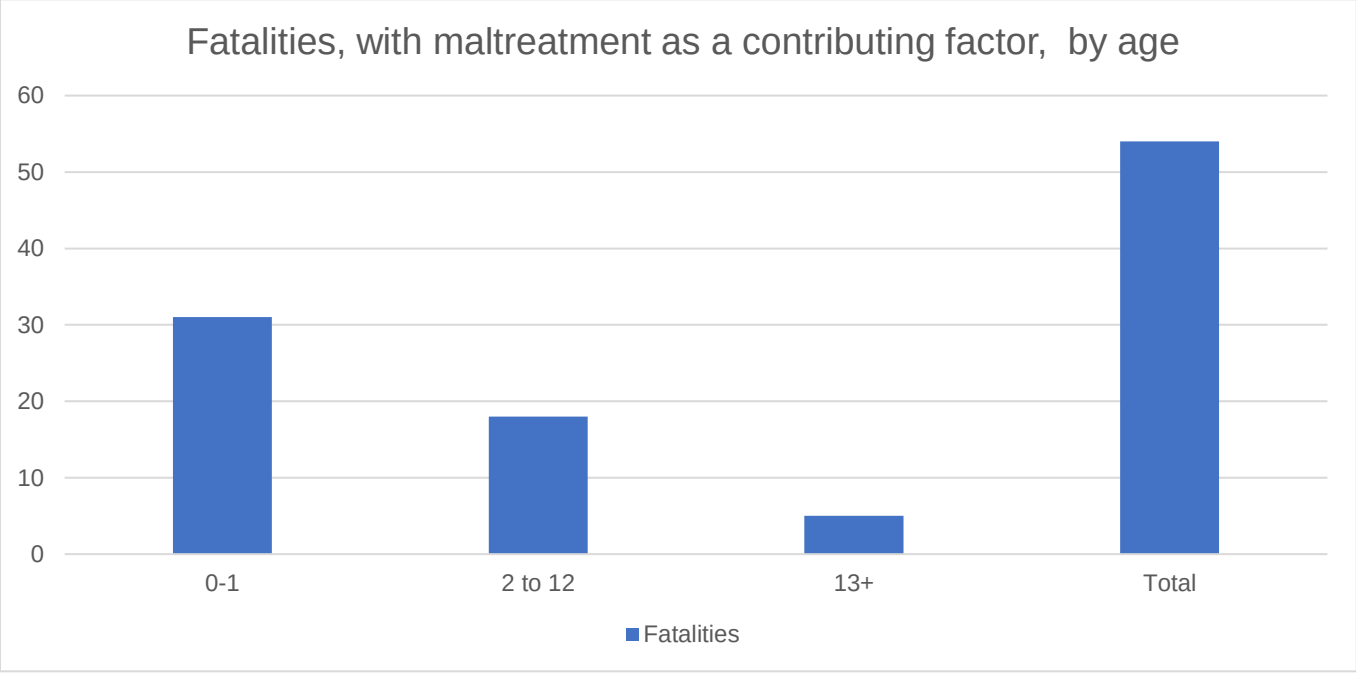
- In FFY 2021, DHS reported to NCANDS 84 fatalities with child maltreatment as a contributing factor. Child maltreatment fatalities have increased each year over the last 7 years, from 28 deaths in 2015; 32 deaths in 2016; 41 deaths in 2018;

[9] NCANDS collects separate data on alcohol abuse and drug abuse.

55 deaths in 2019; and 53 deaths in 2020. Of the 84 children who died in 2021, 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.

- DHS SSA data provided to SCCAN showed 54 child deaths in calendar year (CY) 2021. Additional demographic data for these 54 children are as follows:
    - Fatalities by Age: 31 (57%) were 0-1 years old; 18 (33%) were 2-12 years; 5 (9%) were 13-17 years.
    - Fatalities by Race: 34 (63%) were Non-Hispanic African American; 18 (33%) were White; 1 (2%) were Asian; and 1 (2%) were another race. There were no reported Hispanic fatalities.
    - As with maltreatment investigations, there is an over representation of Black children and an under-representation of Hispanic children. The percentage of white child maltreatment related fatalities closely reflects their percentage of Maryland children.
- It is important to note that the data DHS provided to NCANDS was for FFY 2021 and the data provided to SCCAN is for Calendar Year 2021. The different time frames may explain the difference in number of fatalities.
- 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.

Figure D: Fatalities with Maltreatment as a Contributing Factor by Age (Calendar Year 2021)



Collecting ACEs Data in Maryland

Background: **The Adverse Childhood Experiences Study**

The ACE Study examines the social, behavioral and health consequences of adverse childhood experiences throughout the lifespan. ACE Study participants (17,337) were members of Kaiser Permanente Medical Care Program in San Diego, California and reflected a cross-section of middle-class American adults. The study is an ongoing collaboration between Kaiser Permanente and the Centers for Disease Control and Prevention (CDC) that began with two-waves of participants beginning in 1995 and 1997. Participants were asked questions regarding ten adverse childhood experiences which included all forms of child maltreatment and five indicators of family dysfunction: substance abuse, parental separation/divorce, mental illness, domestic violence, and/or criminal behavior within the household. Key findings of the ACEs Study can be found in prior SCCAN annual reports and at the CDC ACEs website. A key takeaway from the ACE Study is that exposure to ACEs increases the risk for developing physical and mental health conditions in adulthood, and that the risk often increases in a dose-response manner based on the number of ACE exposures. That is, as the number of ACEs increases, the occurrence of poorer physical and mental health outcomes also increases. Findings from the ACE Study have been replicated in other populations and with additional ACEs.

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

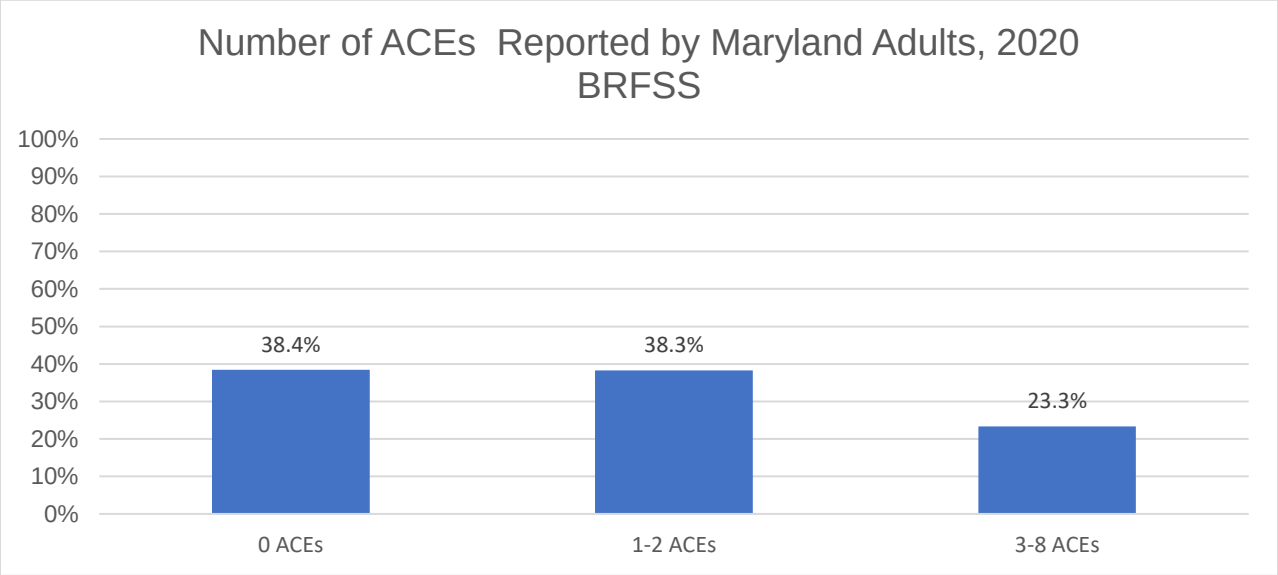
BRFSS and the ACEs Module

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 preventive services.

Several states began collecting ACEs data through their state BRFSS survey in 2009. 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. The ACEs module was included in the 2018 and 2020 Maryland BRFSS. SCCAN and MD EFC recommend inclusion of the ACE module in the BRFSS every three years. The BRFSS Module collects data on eight of the original ten ACEs. These included physical abuse, emotional abuse, sexual abuse, household incarceration and witnessing domestic violence. It does not include the original ACE questions on physical neglect and emotional neglect.

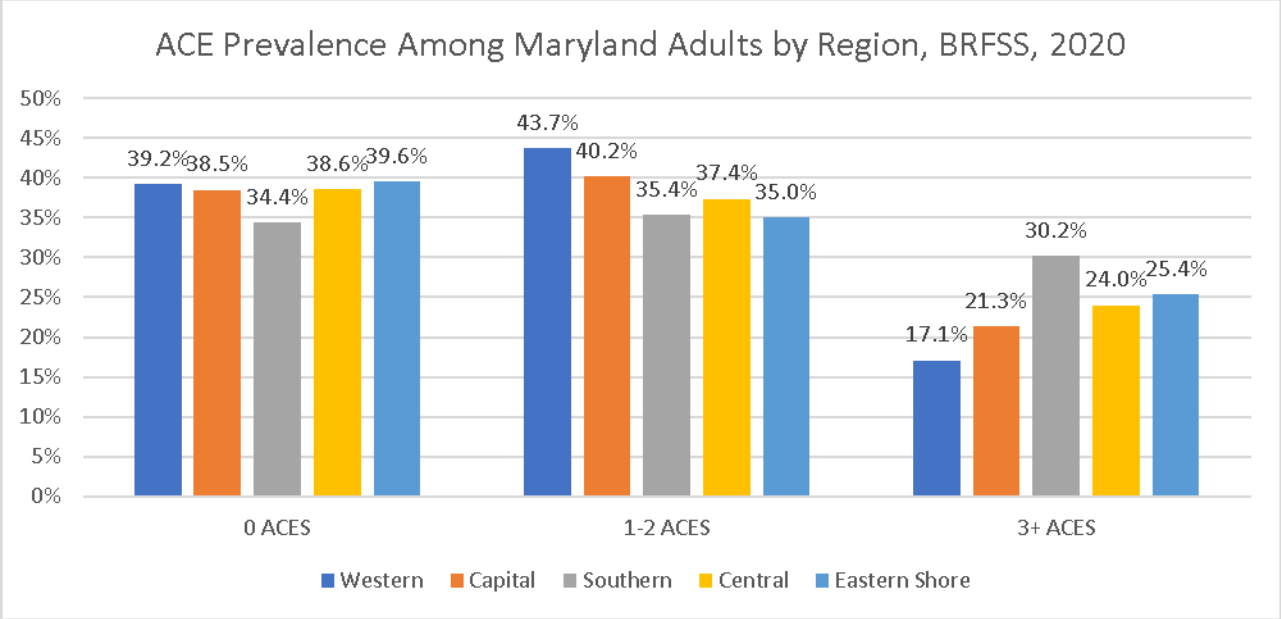
Key findings from the 2020 BRFSS ACE questions are described below.

Figure E:



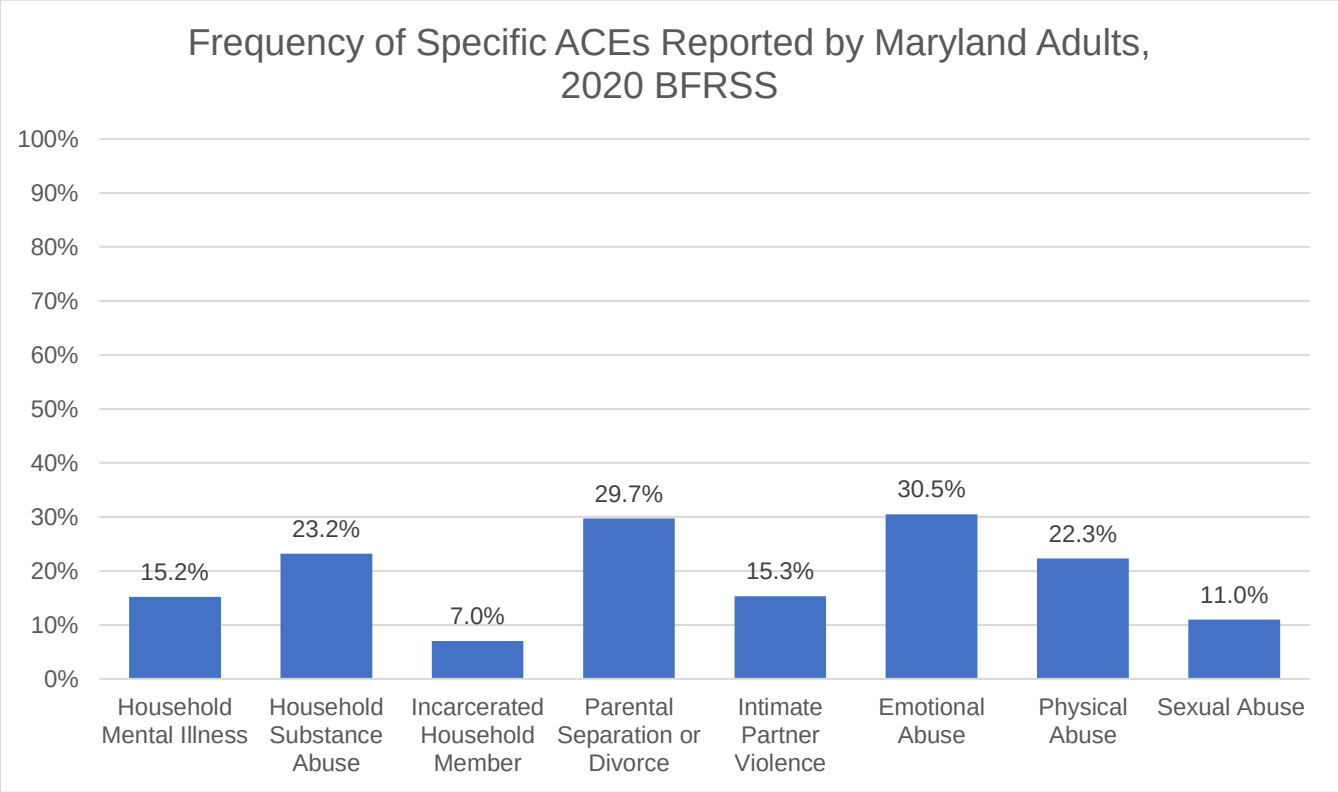
According to the 2020 BRFSS data, overall 38.4% of Maryland adults reported being exposed to 0 ACEs. 38.3% reported exposure to 1-2 ACEs and 23.3% reported 3-8 ACE exposures.

Figure F:



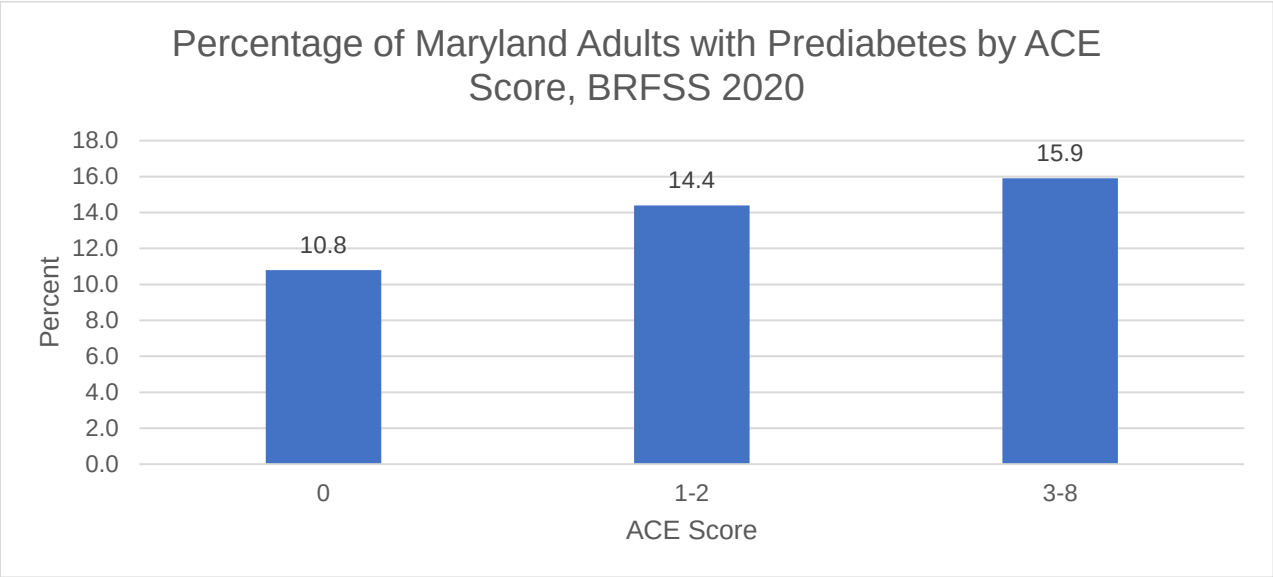
Regional differences in the prevalence of ACEs among Maryland residents highlight distinctive patterns across the state. In Western Maryland, 39.2% of individuals report having no ACEs, 43.7% report 1-2 ACEs, and 17.1% report 3 or more ACEs. The Capital region shows a similar distribution with 38.5% reporting 0 ACEs, 40.2% reporting 1-2 ACEs, and 21.3% reporting 3 or more. Southern Maryland exhibits variation, with 34.4% reporting no ACE exposures, 35.4% reporting 1-2 ACE exposures, and 30.2% reporting 3 or more. In Central Maryland, 38.6% report 0 ACE exposures, 37.4% report 1-2 ACE exposures, and 24% report 3 or more. On the Eastern Shore, 39.6% report no ACE exposures, 35% report 1-2 ACEs, and 25.4% report 3 or more exposures. These regional differences underscore the need for tailored interventions and support systems that consider the unique challenges and experiences faced by individuals in different areas of the state.

Figure G:



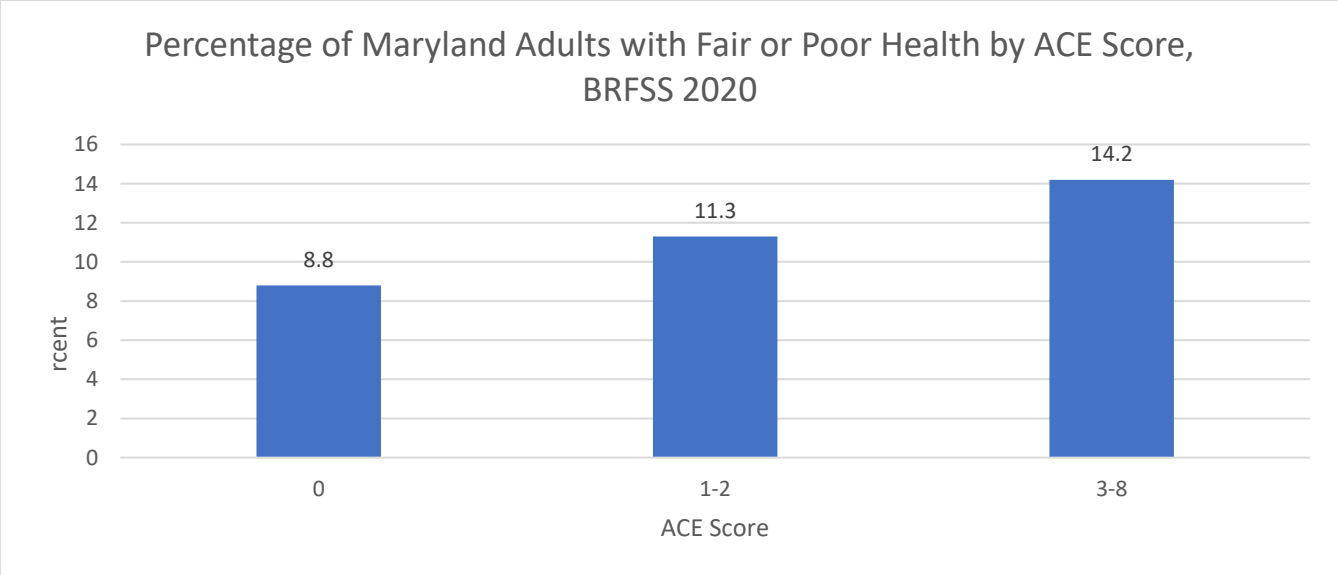
Specific ACEs show varying prevalence rates, with notable percentages reporting mental illness in the household (15.2%), household substance abuse (23.2%), an incarcerated household member (7.0%), parental separation or divorce (29.7%), intimate partner violence (15.3%), emotional abuse (30.5%), physical abuse (22.3%), and sexual abuse (11.0%).

Figure H:



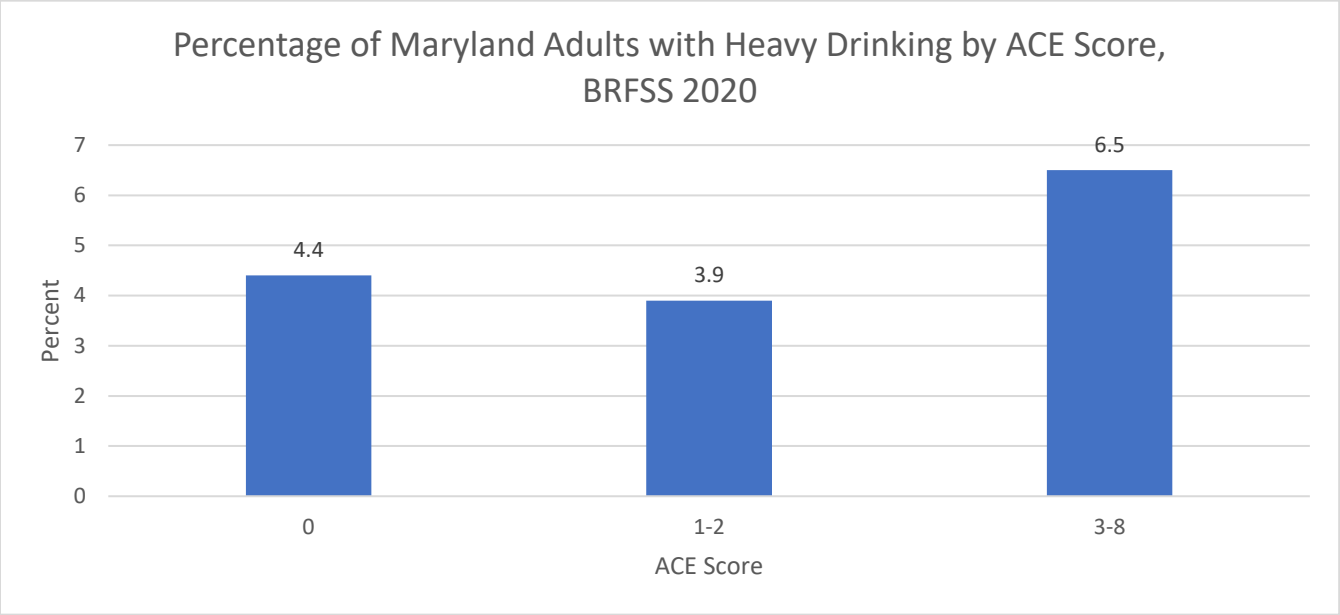
Examining the health indicators among adults in Maryland in relation to ACEs can provide valuable insights. Overall, 14% of adults in Maryland have prediabetes, however this will vary based on the number of ACEs reported. 10.8% of those exposed to 0 ACEs reported being diagnosed with Prediabetes, with 14.4% for those with 1-2 ACEs reported and 15.9% for those with 3-8 ACEs.

Figure I:



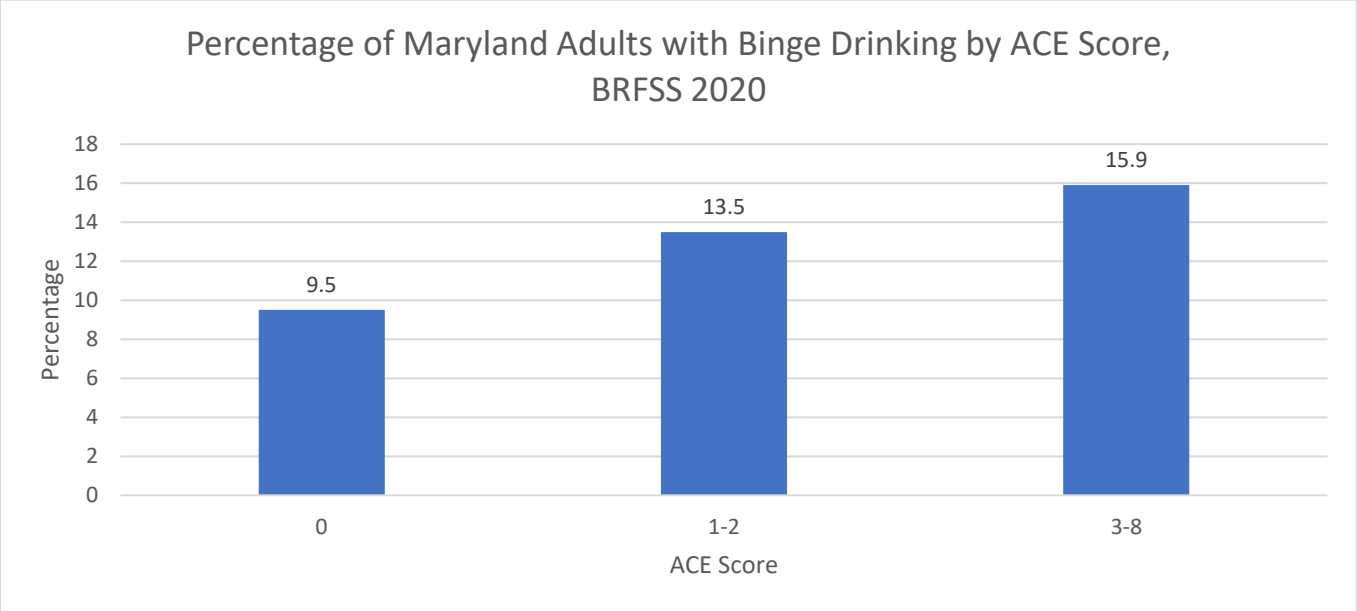
Self-reported fair or poor health is observed in 11.3% of the overall population, with disparities across ACE categories: 8.8% for 0 ACEs, 11.3% for 1-2 ACEs, and 14.2% for 3-8 ACEs.

Figure J:



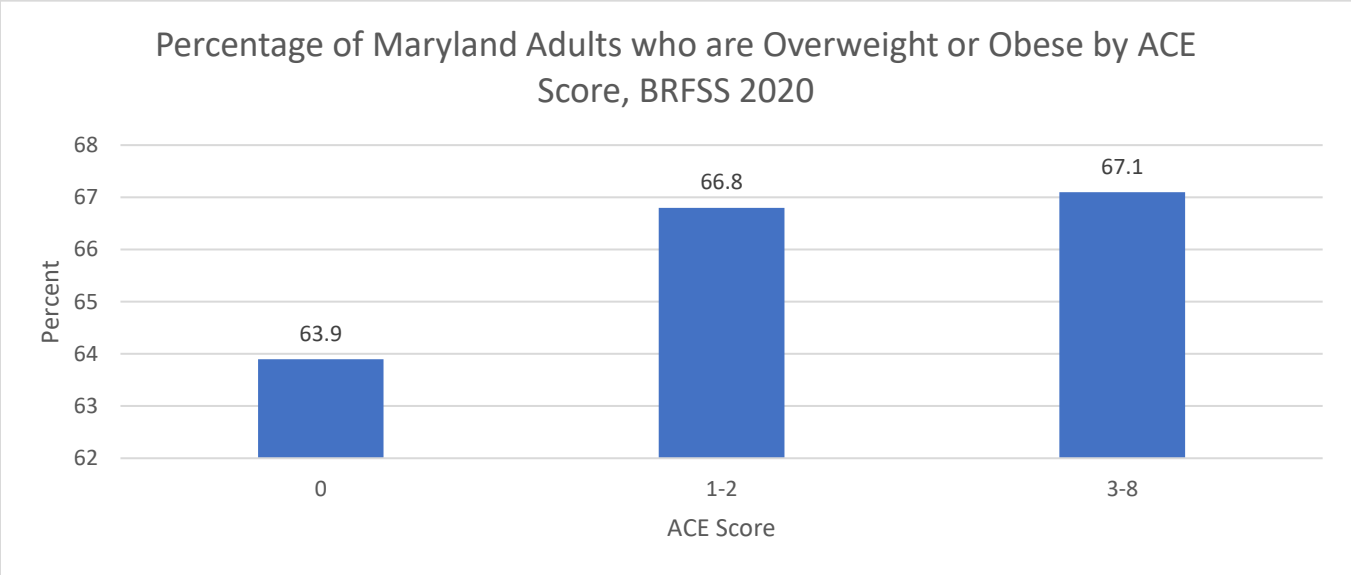
Regarding alcohol consumption, 5.2% engage in heavy drinking overall, while the breakdown by ACE categories reveals 4.4% for 0 ACEs, 3.9% for 1-2 ACEs, and 6.5% for 3-8 ACEs.

Figure K:



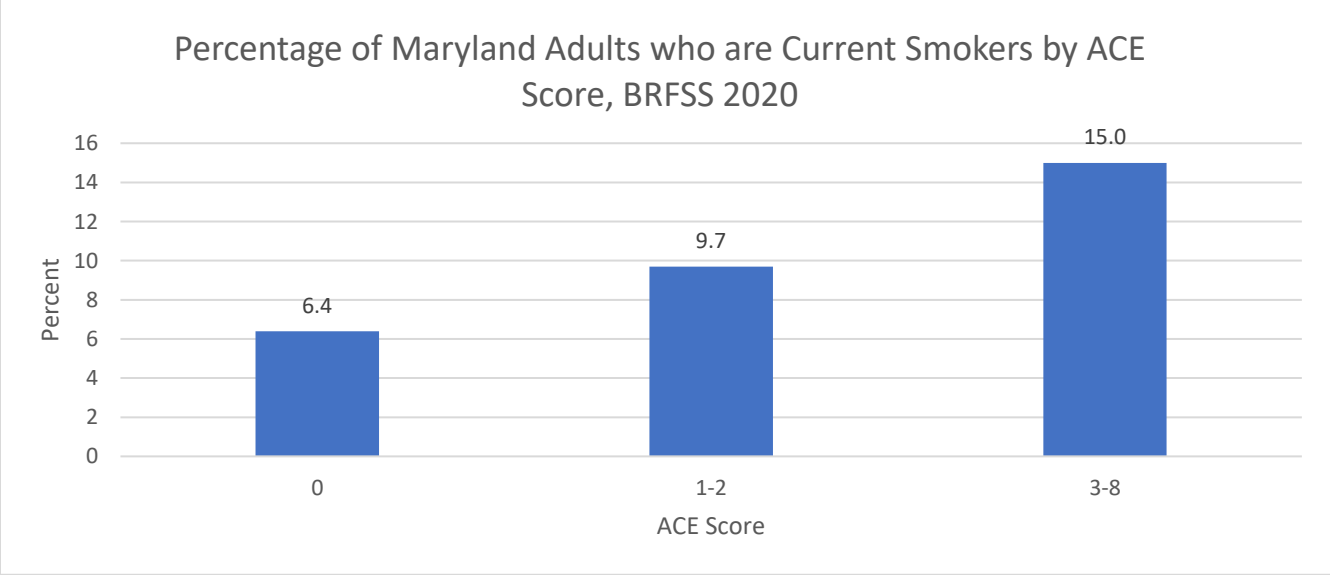
Similarly, binge drinking is reported by 12.3% overall, with distinctions based on ACEs: 9.5% for 0 ACEs, 13.5% for 1-2 ACEs, and 15.9% for 3-8 ACEs.

Figure L:



When considering weight status, 66.5% of Maryland adults are overweight or obese, with marginal variations across ACE categories: 63.9% for 0 ACEs, 66.8% for 1-2 ACEs, and 67.1% for 3-8 ACEs.

Figure M:



Examining smoking behaviors, 10.9% are current smokers, and 22.1% are former smokers overall. When combining current and former smokers, the percentages are 29.0% for 0 ACEs, 32.8% for 1-2 ACEs, and 41.0% for 3-8 ACEs.

YRBS and ACEs

The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) is an onsite survey of students at select Maryland public middle and high schools. Questions assess behaviors that contribute to leading causes of death and disability among teenagers, including alcohol and other drug use, tobacco use, sexual activity/behavior, unintentional injury, violence, physical activity, and dietary behavior. The TYBS/YTS combines the CDS's Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey (YTS). It is administered every other year to examine and monitor youth risk behavior. Results guide the Maryland Department of Health (MDH) State Health Improvement Plan (SHIP) and community health improvement plans developed by each Maryland jurisdiction. The data is also used by the Maryland State Department of Education (MSDE) and many community organizations to inform, assess, and improve programs that address child and teen health and wellbeing.

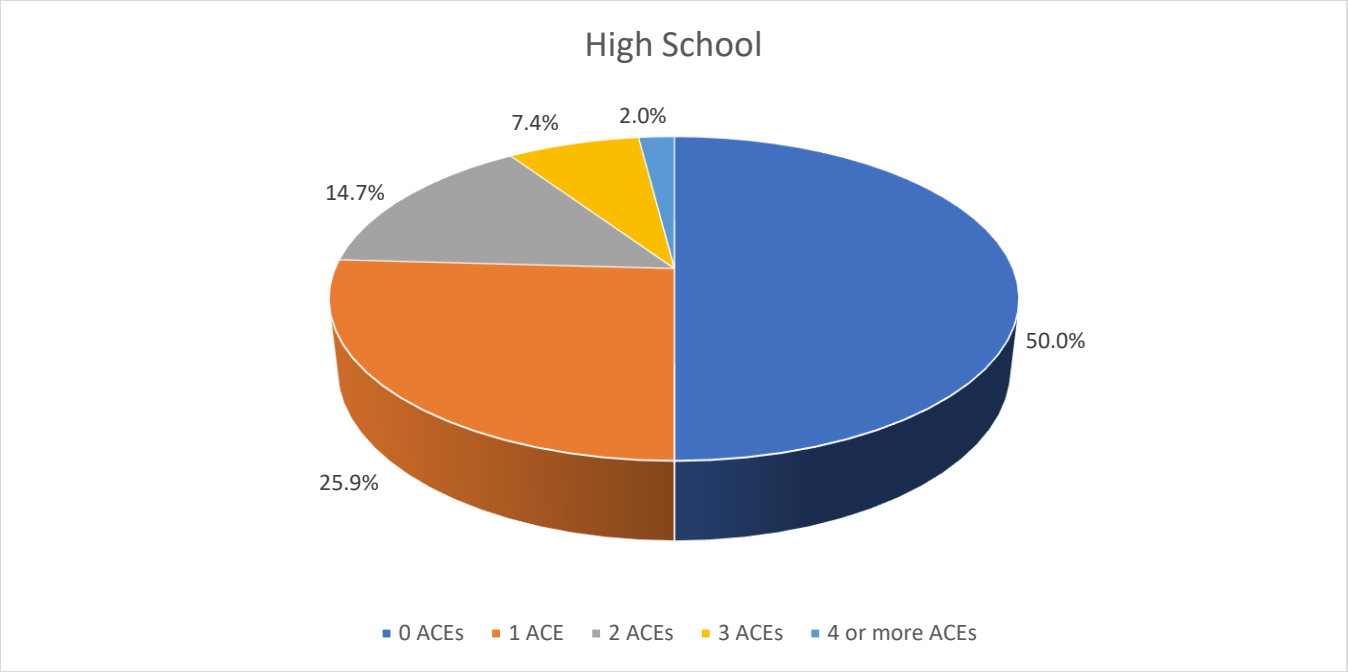
PREVALENCE OF ACEs IN MARYLAND YOUTH:

35,605 Maryland high school students from 183 Maryland public, charter and vocation high schools completed the survey during the 2021-22 school year.

Five categories of ACEs were measured on the high school survey during the 2021-22 Maryland YRBS/YTS administration: emotional abuse; living with a household member who abused substances, was mentally ill, or was ever incarcerated; and witnessing intimate partner violence. Children who have experienced any of the five ACEs measured by the Maryland YRBS/YTS are more likely to have other ACEs, as well.[10] To get a clear picture of the adversity experienced by Maryland youth, it is important that the full panoply of the CDCs ACE module questionnaire be included in Maryland's YRBSS. The CDC ACE module includes 8 of the original ACE questions, 2 incidence ACE questions, 3 community ACEs, and 3 positive childhood experiences (PCE) questions.

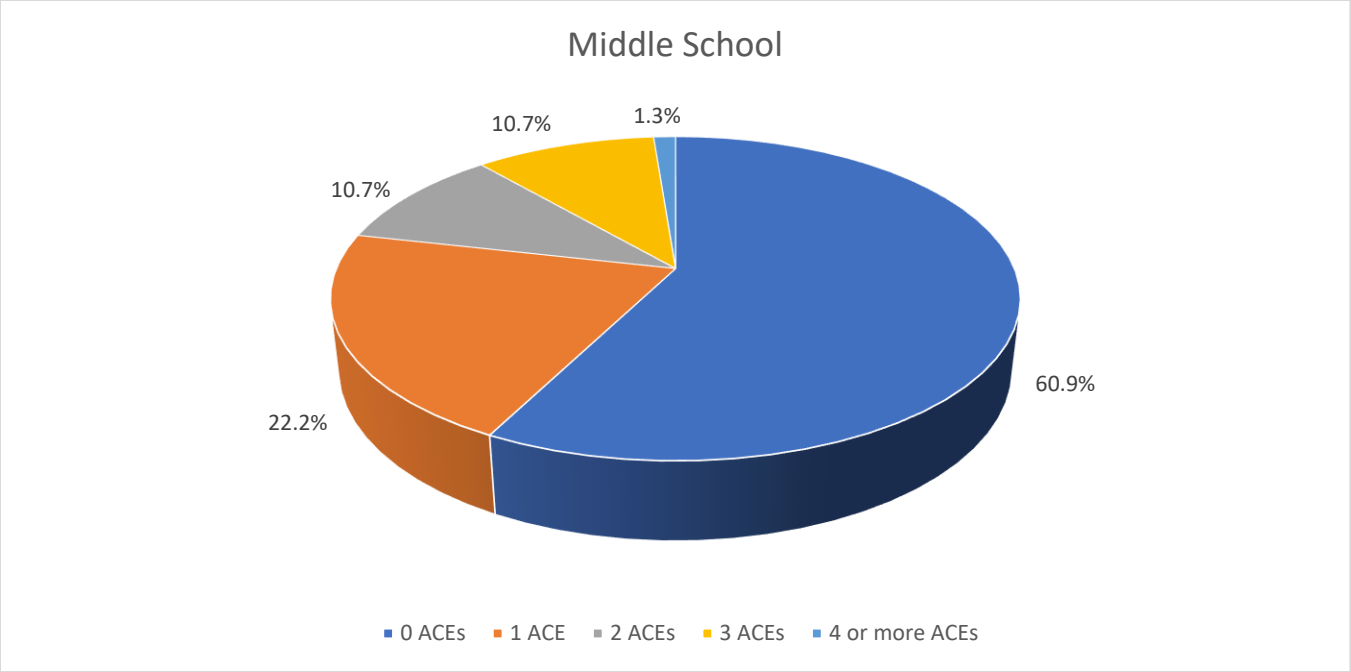
[10] Bethell, C., et.al., *Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice,* Academic Pediatrics Journal, (2017).

Figure N: Maryland Public High School Children with ACEs by Number of ACEs (YRBS 21-22)



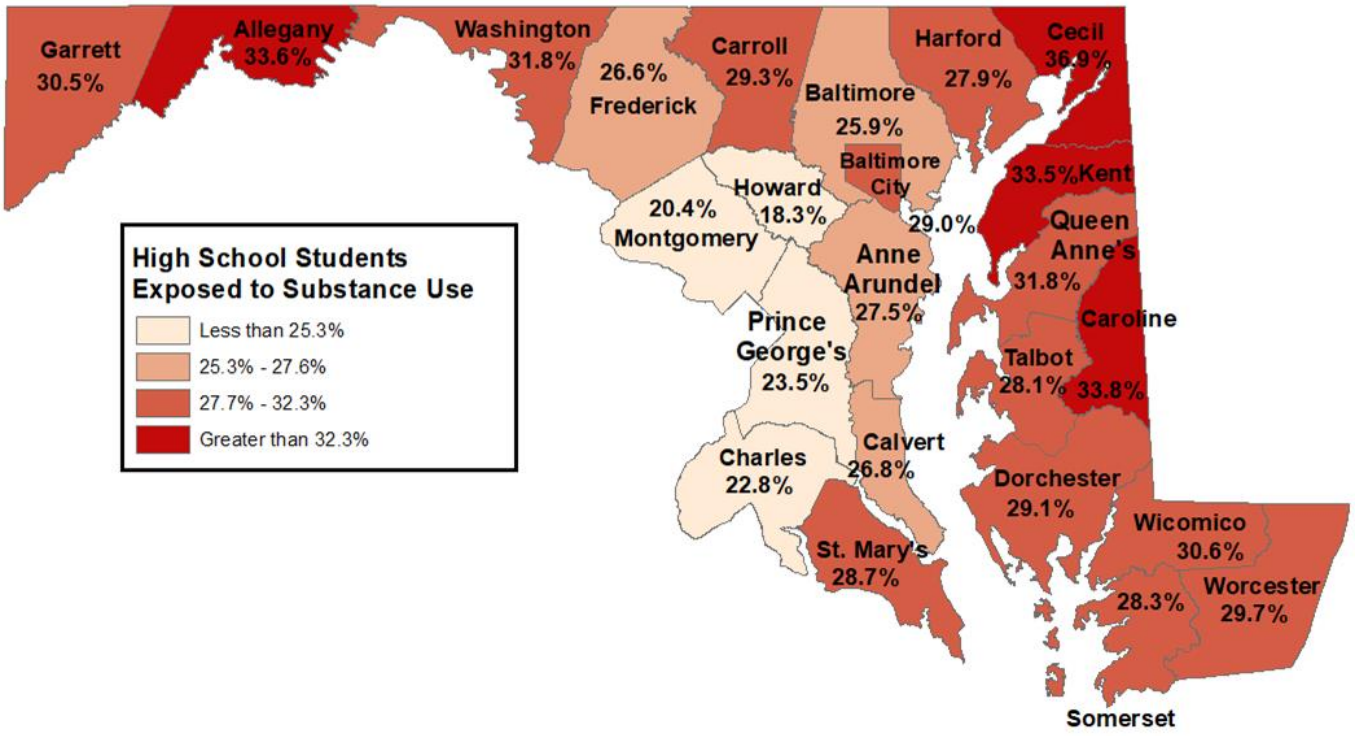
Approximately half of Maryland public high school students report that they have not been exposed to any ACEs, while 26% of these students report exposure to 1 ACE and 14.7% have been exposed to 2 ACEs. 7.4% report exposure to 3 ACEs and 2% report exposure to 4 or more ACEs (Figure N).

Figure O: Maryland Public Middle School Children with ACEs by Number of ACEs (YRBS 2021-22)



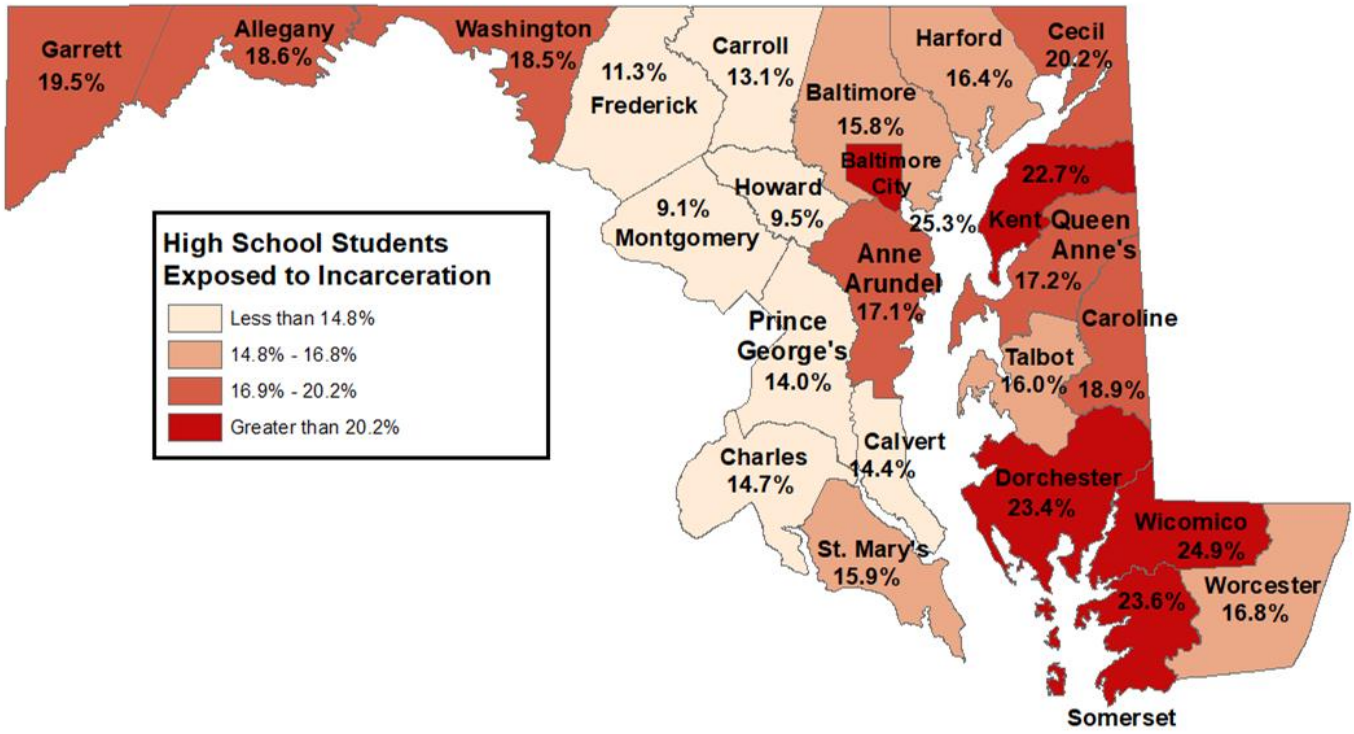
Most public middle school students report no exposure to ACEs (60.9%). 22.2% report exposure to one ACE and 10.7% report exposure to both two and three ACEs. While 1.3% report 4 or more ACEs (Figure O).

Figure P: Percentage of Maryland High School Students with Household Member with Substance Use by Jurisdiction, YRBS



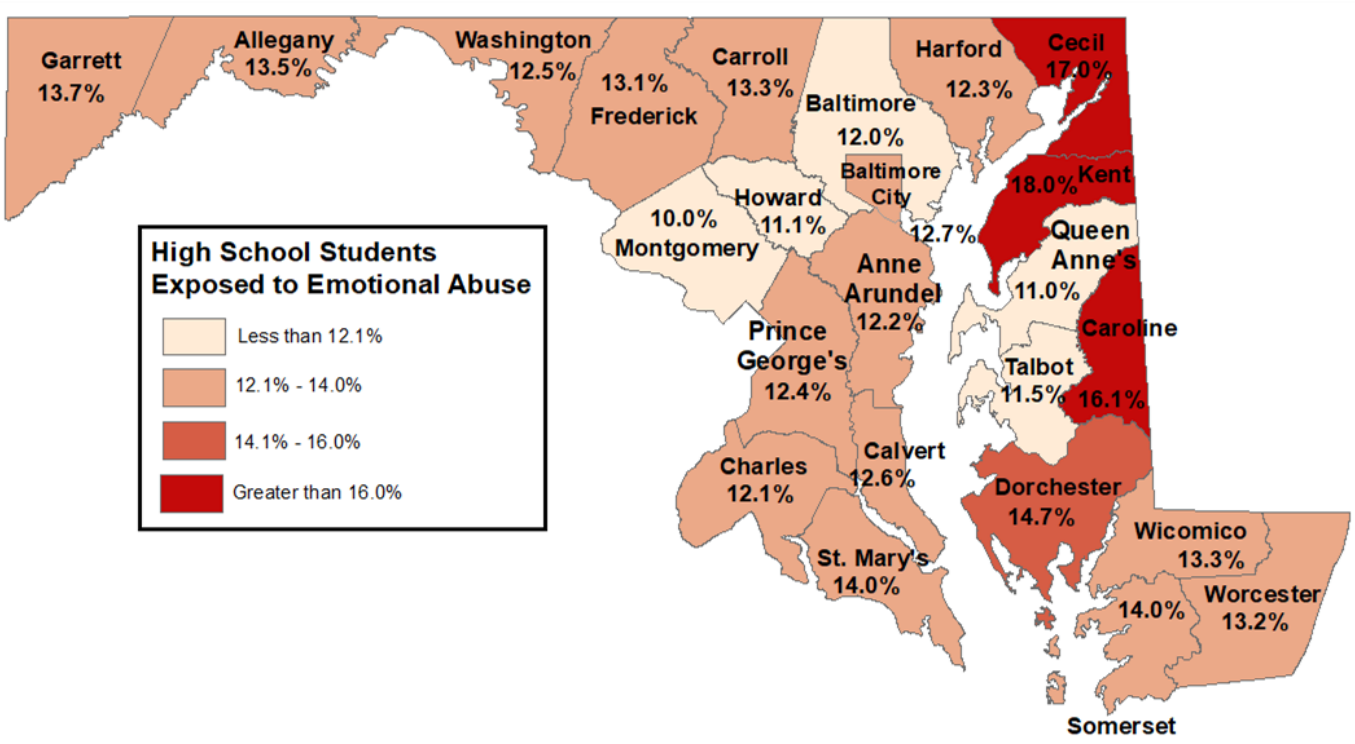
Substance use is common among caregivers in all Maryland jurisdictions, with about 25.3% of high schoolers (Figure P), up from 24% in 2021, and 18.3% of middle schoolers exposed to household substance use. Rates are highest for high schoolers in Cecil and Alleghany Counties and lowest for Montgomery and Howard Counties. For middle schoolers rates continue to be the highest in Kent and Cecil Counties and the lowest in Howard and Montgomery Counties (Middle School data not shown).

Figure Q: Percentage of Maryland High School Students with Incarcerated Household Member by Jurisdiction, YRBS



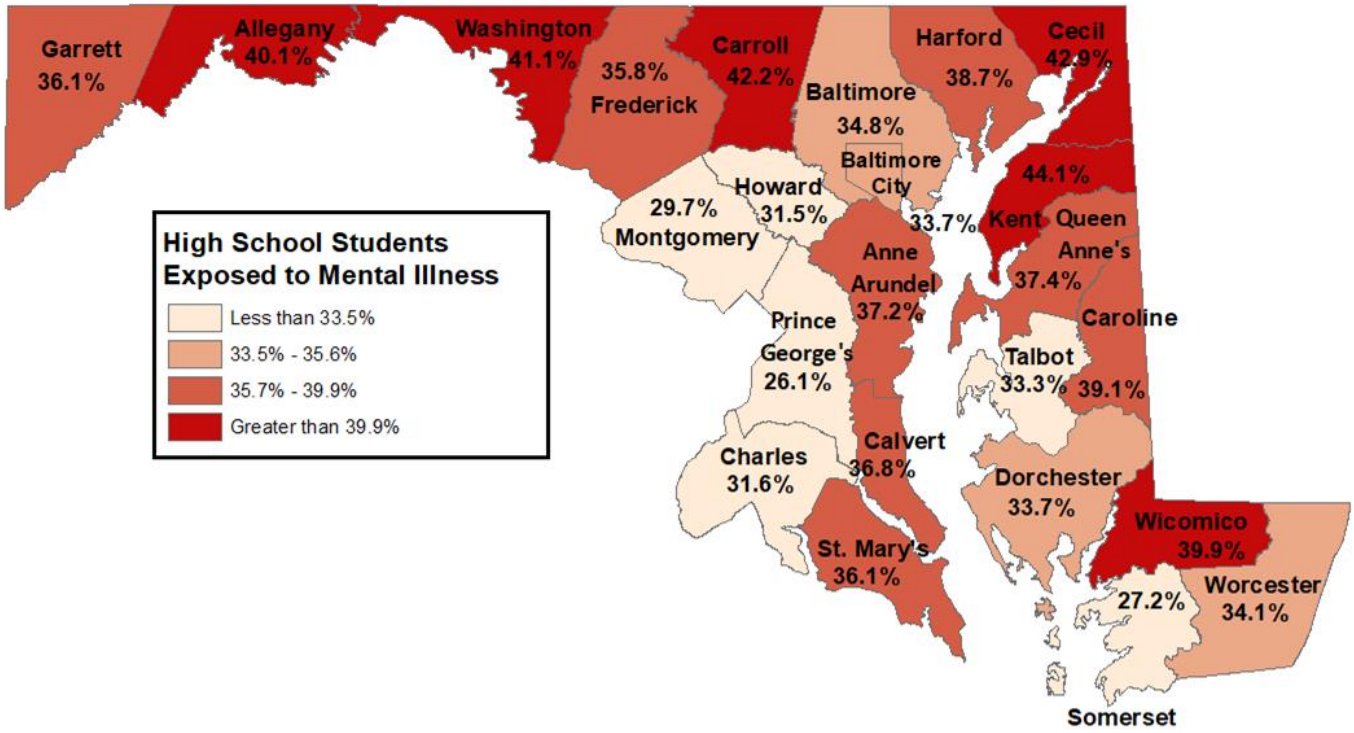
14.8 % of Maryland high schoolers and 11.4 % of middle schoolers have a caregiver or household member who has gone to jail or prison. Rates of household incarceration are highest in Baltimore City, Wicomico and Dorchester Counties for high schoolers (Figure Q), and highest in Somerset and Baltimore City for middle schoolers. Rates of household incarceration are lowest in Howard and Montgomery counties for both middle and high school students (Middle School data not shown).

Figure R: Percentage of Maryland High School Students Exposed to Emotional Abuse, by Jurisdiction, YRBS



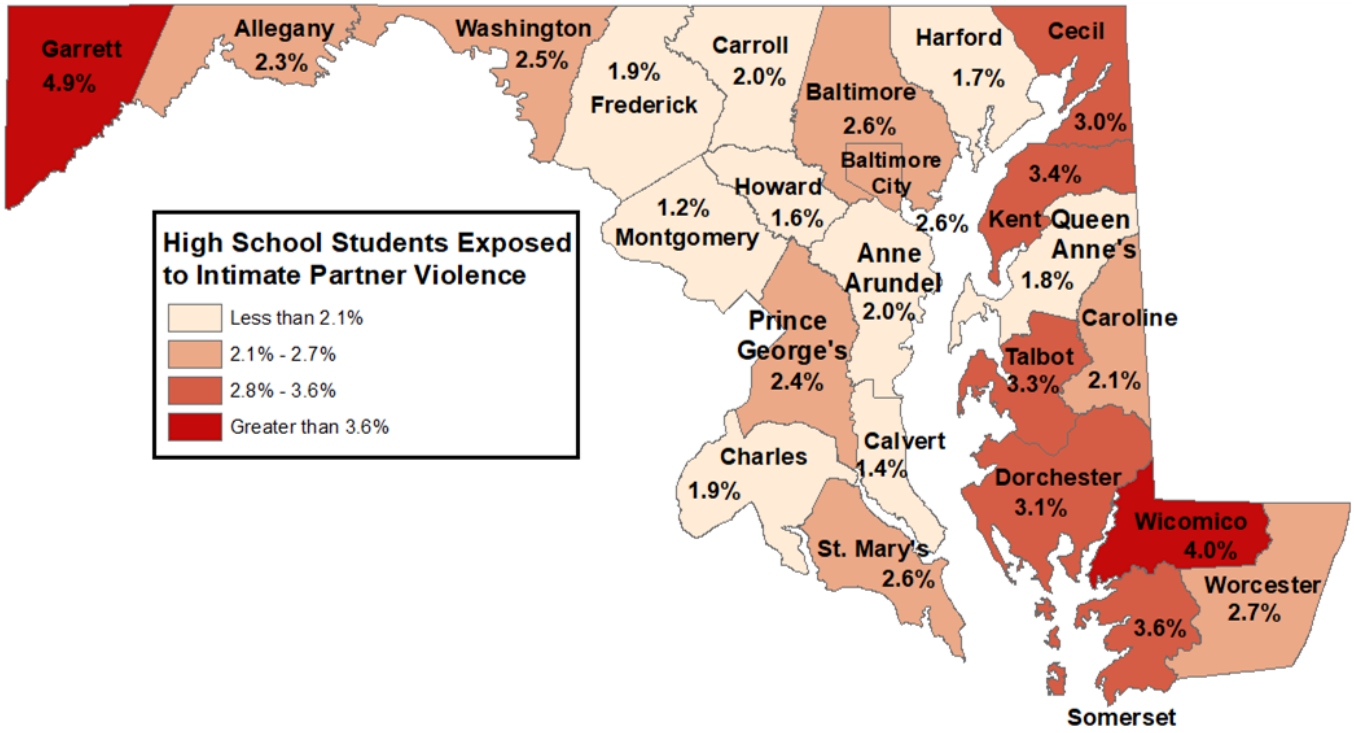
In both middle and high school 12.1% of students report emotional abuse taking place in the home. The question asked to measure emotional abuse was, “A parent or other adult in the home, sworn at you, insulted you, or put you down.” This was measured in either the lifetime, or within the past year. If the response was anything other than, “Never,” in either the lifetime, or during the past year, the question was counted as exposure to the ACE. Rates are highest in Kent and Cecil Counties for high school (Figure R). Rates are highest in Kent and Prince George’s for middle school children, and lowest in Montgomery and Queen Anne’s County for high school students and lowest in Harford and Howard Counties for middle school (Middle School data not shown).

Figure S: Percentage of Maryland High School Students Exposed to Mental Illness in the Home by Jurisdiction, YRBS



Household mental illness is common among caregivers and household members in all Maryland Jurisdictions. The highest rates of household mental illness for high schoolers were seen in Kent and Cecil Counties (Figure S). For middle school children raters were highest in Cecil and Washington Counties. The lowest rates of household mental illness were seen in Somerset and Prince George's Counties for High schoolers and Montgomery and Howard Counties of middle schoolers (Middle School data not shown).

Figure T: Percentage of Maryland High School Students Witnessing Intimate Partner Violence, by Jurisdiction, YRBS

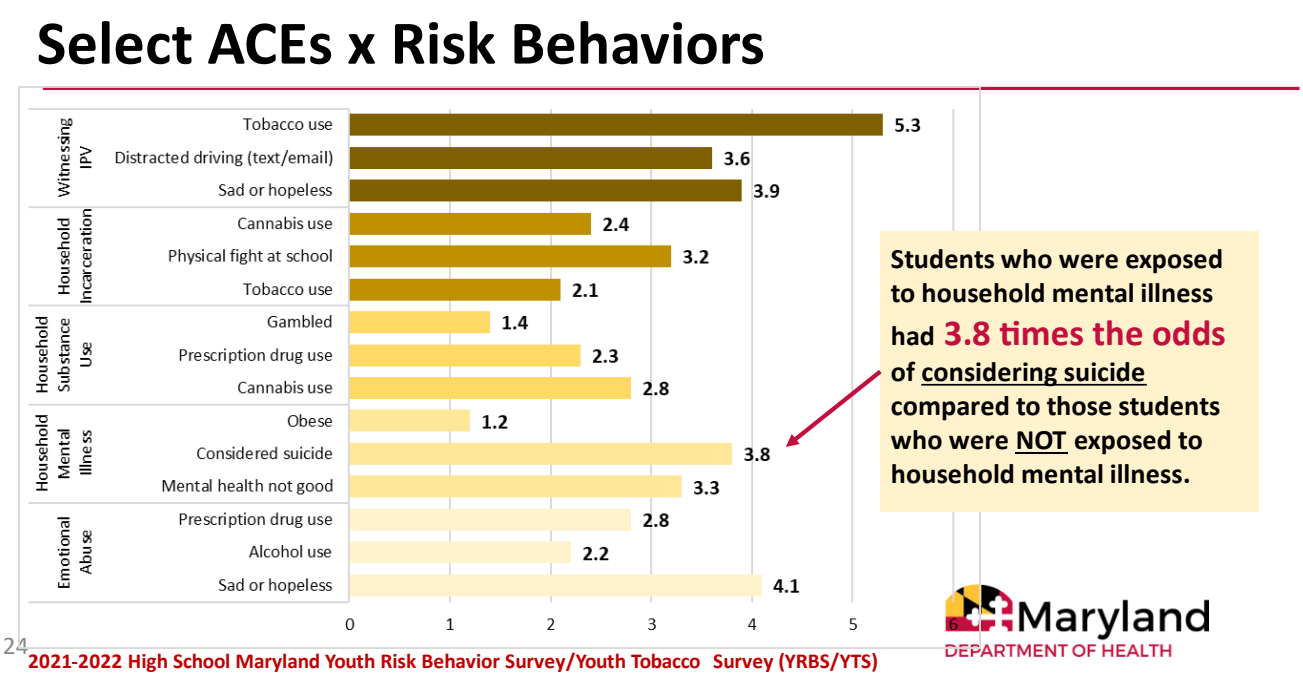


Witnessing intimate partner violence is defined as knowing that parents of other adults in you home slapped, hit, kicked punched or beat each other up. Exposure to the ACE was defined as answering, sometimes, most of the time, or always. Across the state, 2.1% of Maryland children reported witnessing physical domestic violence in their homes. Among high schoolers, rates were highest in Garrett and Wicomico Counties and lowest in Montgomery and Howard Counties (Figure T).

Dose Response Relationship ACEs and Selected Risk Behaviors

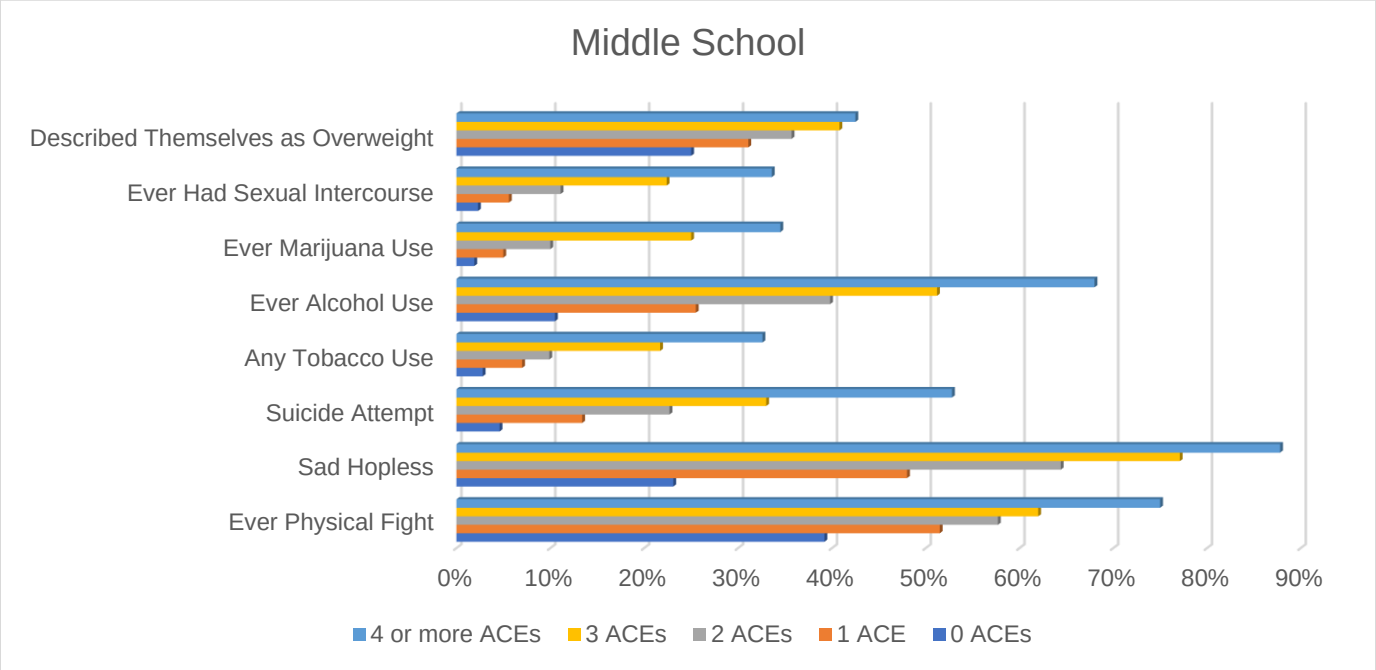
Similar to BRFSS data, YRBS data can also be examined for relationships between ACE exposure and mental health issues and between ACE exposure and risky health behavior. Figure U shows the likelihood of mental health issues and the likelihood of risky health behaviors for students exposed to specific ACEs compared to students who were not exposed to that ACE. For example, teens who witnessed IPV were 5.3 times more likely to use tobacco and were 3.9 times more likely to feel sad or hopeless than teens who did not witness IPV. Teens who experienced emotional abuse were 2.8 times more likely to acknowledge prescription drug use, 2.2 times more likely to acknowledge alcohol use, and 4.1 times more likely to feel sad or hopeless compared to teens who did not experience emotional abuse.

Figure U: Percentage of Maryland Public School Students with Risky Behavior or Mental Health Issues by Exposure to Specific ACEs (YRBS 2021-22)



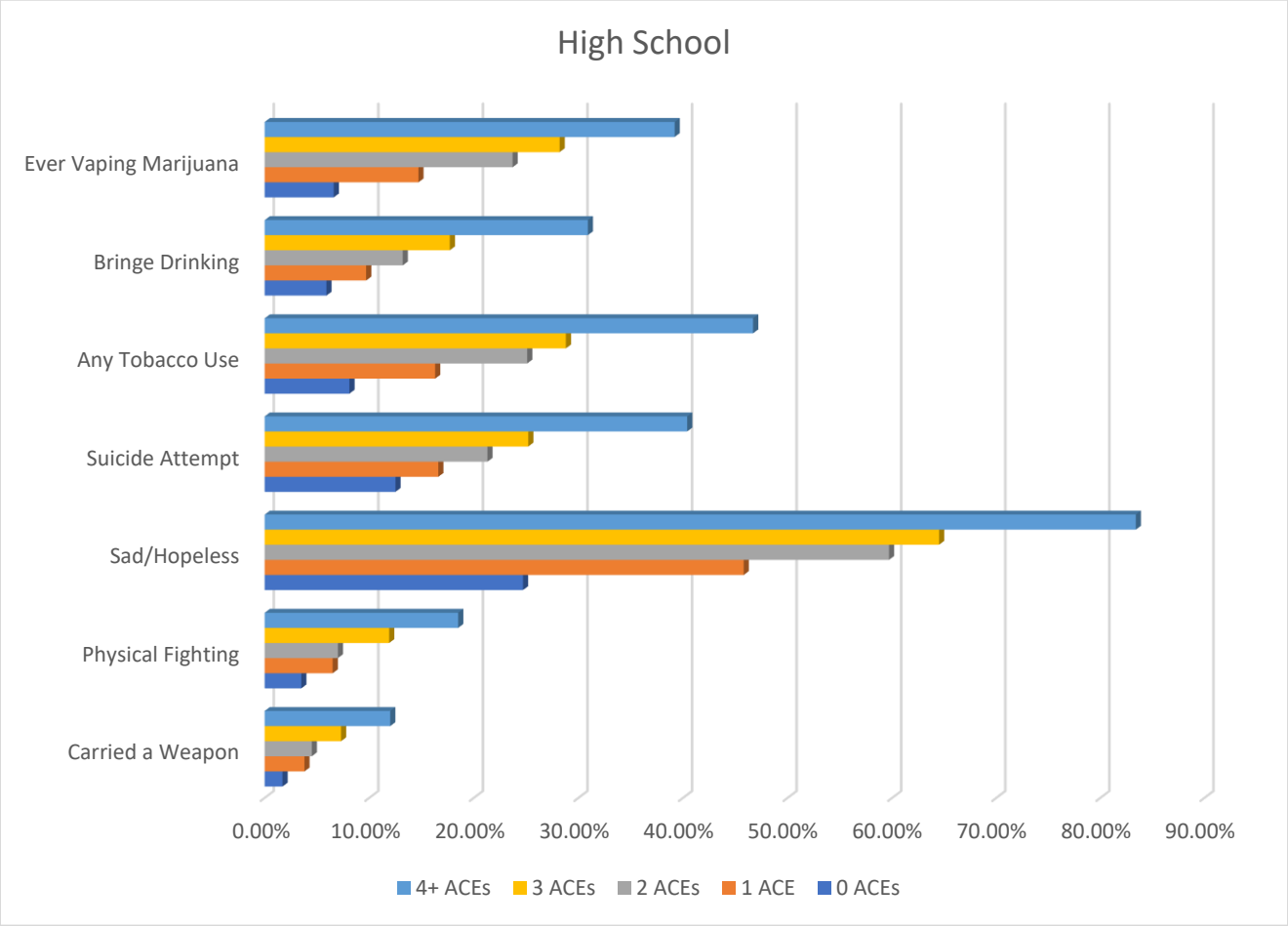
Maryland YRBS data also demonstrate dose-response relationships between ACE exposure and mental health issues and between ACE exposure and risky health behaviors (Figure U).

Figure V: Percentage of Maryland Public Middle School Students' Engaged in Risky Behavior by Number of ACEs (YRBS 2021-2)



For example, among middle school students, about 23% teens with 0 ACEs reported feelings of sadness or hopelessness, compared to 88% of teens with 4 or more ACEs. Only 5% of teens with 0 ACEs have attempted suicide, compared to 53% of teens with 4 or more ACEs. Rates of tobacco and marijuana use are also low for teens with no ACEs (3% and 2%, respectively), but much higher for teens with 4 or more ACEs (33% and 35%, respectively). Teens with more ACEs are also more likely to have gotten into a physical fight, ever used alcohol, and ever had sex, Teens with more ACEs were more likely to perceive themselves as overweight (Figure V).

Figure W: Percentage of Maryland Public High School Students' Engaged in Risky Behavior by Number of ACEs (YRBS 2021-22)

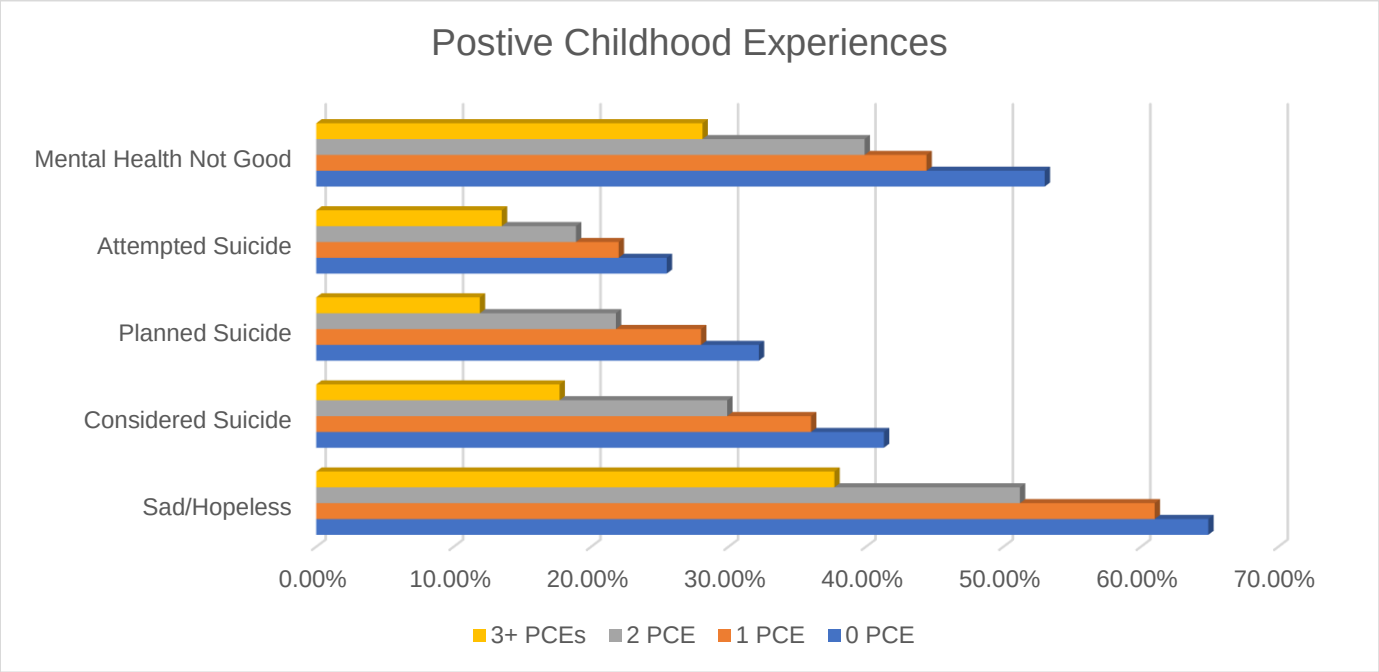


For high school students, there is also a dose-response relationship between ACE exposure and the likelihood of risky behaviors and adverse mental health outcomes (Figure W). The prevalence of violent behaviors, such as carrying a weapon and engaging in physical fights increases as the number of ACE exposures rises, peaking at 14.0% and 18.5% respectively, for those with four or more ACEs. This also shows the importance and potential benefits of early interventions among children exposed to ACEs to prevent violent behaviors in high school students. Adverse mental health indicators, including feelings of sadness or hopelessness and attempted suicide, surge with an increase in ACEs, reaching 83.4% reporting sadness or hopelessness for those with four or more ACEs. Substance use also rises with a higher number of ACEs.

Positive Childhood Experiences

ACEs can clearly adversely impact youth futures, positive childhood experiences (PCEs) can mitigate the long-term impact of ACEs. PCEs include protective adult relationships, school connectedness, and peer connections that can build student resilience to life challenges. Other PCEs include improving household financial security, supporting positive parents, encouraging school safety and belonging, and providing access to programs that improve conflict resolution and stress-handling skills. Research shows that the negative effects of multiple ACEs can be mitigated by exposure to multiple PCEs. PCEs provide students with a protective barrier against the negative outcomes that arise from ACEs by allowing them access to resources (supportive adults, peers, or teachers) to overcome difficult situations. Even students who have experienced multiple adversities can benefit from having PCEs.

Figure X: Mental Health Outcomes for Maryland Public School Children by Number of Positive Childhood Experiences (YRBS 2021-22)



YRBS data also showed a correlation between mental health outcomes and Positive Childhood Experiences (PCEs), with lower rates of mental health concerns among children with more PCEs (Figure X). Students with 3 or more PCEs have fewer mental health concerns, including feeling sad or hopeless and attempting suicide than students with fewer PCEs. Students reporting zero PCEs have the highest rates of mental health indicators such as feeling sad or hopeless, considering suicide, planning suicide, attempting suicide and poor mental health. This underscores the potential role of PCEs in promoting better mental health outcomes and highlights the potential for preventing strategies focusing on fostering positive experiences during childhood.

Surveillance Recommendations

(1) DHS: Require caseworkers to input race demographic data on all cases brought to the attention of the Department of Human Services. In order to effectively understand and interpret information about children and families served by DHS, demographic data, including race must be consistently collected. Disparities in child welfare cannot be identified and addressed without accurate data.

(2) **DHS, MDH, MDTHINK: FIX CJAMS** -In order to effectively understand and interpret information about children and families served by DHS, information must be entered into the CJAMS data management system, and DHS leadership and policymakers must be able to easily access aggregated data from the system. ***Issues with CJAMS operability, including problems with data entry and creation of reports must be fixed as soon as possible***. ***Personnel and financial resources must be dedicated to this effort.*** Doing so is necessary to understand disparities at all levels of child welfare services, the extent to which children and families are referred to and are receiving services, and the key risk factors that families face and need to be addressed. Doing so is also necessary to ensure accuracy and consistency of the data used by DHS and reported to the Federal Government.

(3) **DHS:** Make publicly available child welfare and health-related data that is disaggregated by race, ethnicity, gender, age, and geographic region. Child welfare data should also be disaggregated for each system level (i.e., referrals, pathways, and services). Neglect referrals should be disaggregated by risk factor (food insecurity, housing status, etc.)

(4) **MDH:** Continue inclusion of ACE and Positive Childhood Experiences questions in biannual YRBS/YTS surveys. Include all 10 ACEs in future surveys. Publish and widely disseminate ACE and Positive Childhood Experiences data so that it is available to all stakeholders.

(5) **MDH:** Continue collection of ACE data in Maryland BRFSS every 3 years. Publish and widely disseminate ACE data so that it is available to all stakeholders.

(6) **DHS, MDH, GOCPYVS:** Use data from CJAMS, YRBS/YTS, BRFSS and other sources to determine where and who should be prioritized for interventions. This data should also be used to identify and enhance protective factors/Positive Childhood Experiences.

(7) **DHS, MSDE:** Work collaboratively to gather data on educational services received by children in out-of-home care. 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.

(8) **Maryland General Assembly:** Amend current statute to expand data currently collected by Maryland's Department of Human Services and published in their Child Welfare Indicators Report. Recommended data are included in Appendix M.

SCCAN's Accomplishments in 2022-2023

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 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). The mission of MD EFC is to prevent and mitigate child maltreatment and other ACEs. The overarching strategic goals of MD EFC are as follows:

1) Educate key state leaders, stakeholders, and grassroots organizations 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.

The Maryland Essentials for Childhood Initiative (MD EFC) has worked 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. While MD EFC meetings have been on hold until the Governor's Appointment's Office completed appointment of new SCCAN members, work has continued on priorities initiated in response to the pressing global events of 2020 and 2021, including 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. These include the Achieving Racial Equity within Maryland's Child Welfare System Workgroup and the Childhood Resiliency Workgroup. Below is a brief description of key actions by SCCAN and MD EFC Partners to achieve our collective goals.

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

Background: A full review of the history of racism in the U.S. child welfare system can be found in the preamble of SCCAN's antiracism statement in Appendix I.

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, beginning 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.

Accomplishments prior to 2022: 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 I).
- 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.
- Began work on a visioning session to seek input on how the Maryland child welfare system can become anti-racist.

2022-2023 Accomplishments: The Achieving Racial Equity in Child Welfare committee has continued its work on the visioning session, which took place on December 11, 2023, at Morgan State University. The goal of the Visioning Session was to develop recommendations to address racial inequities at all levels of child welfare. The committee sought input from individuals with lived experience as well as professionals who work in or collaborate with child welfare agencies. The goal was to have equal representation from individuals with lived experience and professionals so that the voices of both groups were heard and incorporated into recommendations. Invited speakers include Mr. Rafael Lopez, Secretary of the Maryland Department of Human Resources and Maryland State Delegate C.T. Wilson. Much of the day was devoted to breakout discussions where key questions about improving child welfare were discussed and debated.

Next steps will include sharing a summary of recommendations from the event and developing a plan for collaborative implementation of recommendations. The recommendations and plan will be included in the 2024 SCCAN Annual Report.

Interim Workgroup Recommendations (to be updated in report from Visioning Session)

(1) **DHS:** Require caseworkers to input race demographic data on all cases brought to the attention of the Department of Human Services.
(2) **DHS:** Make publicly available child welfare and health-related data that is disaggregated by race, gender, age, and geographic region. Child welfare data should also be disaggregated for each system level (i.e., referrals, pathways, and services). Neglect referrals should be disaggregated by risk factor (food insecurity, housing status, etc.)
(3) **DHS, MSDE:** Work collaboratively to gather data on educational services received by children in out-of-home care. 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.
(4) **Maryland General Assembly:** Amend current statute to expand data currently collected by Maryland's Department of Human Services and published in their Child Welfare Indicators Report. Recommended data are included in Appendix M.
(5) **Maryland General Assembly:** 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.
(6) **Maryland General Assembly:** 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.

COVID-19 Childhood Resilience Action Team:

The Childhood Resilience Action Team began during the COVID-19 pandemic in the spring of 2020 to identify and share resources that could inform and support the resilience of children during the pandemic and beyond. More than 70 volunteers from many organizations worked collaboratively and assembled a resource library for caregivers, children, and service providers. Topics included physical, mental, and behavioral health, education, childcare, and economic supports.

The team planned to share the resources through a dedicated childhood resilience website. Through 2022, the team worked to identify funding for the website domain and additional content development. Ultimately, the effort was integrated into broader efforts of the MDH Behavioral Health Administration Adverse Childhood Experiences Initiative to allow for a unified and comprehensive approach.

With funding from the 2021 federal American Rescue Plan Act (ARPA), the Behavioral Health Administration partnered with the University of Maryland School of Medicine Department of Psychiatry and the Systems Evaluation Center at Bowie State University to "design and implement a collaborative initiative to provide ACE data surveillance, training, technical assistance and continuous quality improvement to support the adoption of trauma-informed policies and practices within the Maryland Public Behavioral Health System."[11] This initiative was later broadened to meet the mandates of Maryland SB299/HB548 – Trauma Informed Care – Commission and Training, passed in 2021. The effort was renamed the BHA TIROE (Trauma-Informed Resilience Oriented Equitable Care and Culture) Mobilization Grant. BHA is using the grant funding to provide a resource for the trauma-informed work of state agencies, and to prevent siloing of that work. Partners include Maryland 211 call and resource center, Maryland Essentials for Childhood, and the Maryland Trauma-Informed Care Commission. The resources identified by the Childhood Resilience Action Team will soon be organized and posted on a resource website.

Sexual Abuse Prevention

Statute of Limitations Legislation - After many years of advocacy, Maryland HB001/SB686, the Child Victims Act passed in 2023. Key elements of the bill include: (1) Elimination of the statute of limitations for child sexual abuse civil lawsuits; (2) Repeal of the so-called "statute of repose"; (3) Creation of a permanent lookback window for claims that would otherwise be blocked by the prior statute of limitations; (4) Allowance for suits against both public and private entities; (5) Elimination of the notice of claims deadlines for public entities in child sexual abuse cases. Effective October 1, 2023, the Child Victims Act represents a significant step forward in acknowledging and addressing the issues of child abuse and its long-lasting impact on survivors. Lawsuits are currently being filed which will set the stage for the subsequent steps in implementing this law. Ultimately, the Maryland Supreme Court will likely be asked to weigh in on the constitutionality of the legislation. The Archdiocese of Baltimore, anticipating multiple lawsuits, filed for Chapter 11 bankruptcy two days before the law went into effect. The filing put a stop to all civil claims while the Archdiocese reorganizes, and shifts the claims to bankruptcy court, a less transparent process. As the legal processes unfold, SCCAN remains committed to advocating for a system that ensure that victim's voices are heard, their experiences validated and their path to healing as survivors is facilitated.

Sexual Abuse Prevention in Schools

Over the past several years, SCCAN has been actively engaged in policy efforts to prevent child sexual abuse in schools. We have worked closely with Delegate C.T. Wilson to pass several bills requiring policies to reduce the possibility of sexual victimization in schools. These bills include:

- **2018's HB 1072 – Child Sexual Abuse Prevention – Instruction and Training**

[11] Tiffany Beason and Joanna Prout. Behavioral Health Adverse Childhood Experiences (ACEs) Initiative. Presentation to the Maryland State Council on Child Abuse and Neglect (SCCAN). January 5, 2023.

- Requires each county board of education or non-public school that receives state funds to require annual instruction of all school employees on the prevention, identification, and reporting of sexual abuse and misconduct. The training must include:
  - Recognition of sexual misconduct in adults;
  - Recognition, and appropriate response to sexually inappropriate, coercive, or abusive behaviors among minors;
  - Recognition of behaviors and verbal cues that could indicate a minor has been a victim of child sexual abuse;
  - Responding to disclosures by minors or their parents or guardians of child sexual abuse or reports of boundary-violating behaviors of adults or minors in a supportive and appropriate manner that meets mandatory reporting requirements under state law.
- Requires each county board to establish and implement policies that support the prevention of child sexual abuse through ongoing training of staff on behavior that constitutes adult perpetration; reporting obligations and procedures; and for staff involved in hiring: comprehensive screening of prospective employees.
- Requires each county board to develop an Employee Code of Conduct that addresses appropriate contact between staff and students.
- Beginning in the 2019-2020 school year, each county board shall develop policies and procedures on the use and modification of physical facilities and spaces to reduce opportunity for child sexual abuse. SCCAN worked with the Interagency Commission on School Construction to draft the "Guidelines and Best Practices for the Assessment and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse" which were approved by both groups.

- **2019 HB 486: Education – Personnel Matters – Child Sexual Abuse and Sexual Misconduct Prevention** For new employees who will have direct contact with minors: requires schools to gather information about applicant's prior employment and consent to contact prior employers. Requires schools to request of prior employer(s)' about past sexual misconduct or abuse investigation.

In 2023, SCCAN completed a search of board of education websites for all 23 Maryland jurisdictions and then attempted to contact local board of education staff in every jurisdiction to determine what had been done to comply with HB 1072 and HB 486. In addition, while not part of HB 1072 or HB 486, SCCAN asked whether boards of education routinely completed CPS background checks when hiring new employees. In conduction this work, SCCAN found that it was sometimes challenging to identify the appropriate point of contact, particularly in larger jurisdictions. For jurisdictions where contact was made, many reported using a training developed by Vector Corporation,[12] which has been recommended by the Maryland State Education Association. SCCAN is currently in the process of obtaining information from Maryland private schools through the Association of Independent Maryland Schools (AIMS).

[12] https://www.vectorsolutions.com/course-search/training/child-sexual-abuse-prevention-for-staff/

Table 5: Local Jurisdiction Implementation of Mandates from 2018 Maryland HB 1072 and 2019 HB 486 and Requirement for Child Protective Services (CPS) Background Checks for New Employees

	Employee Code of Conduct Y/N	Staff-Student Relationships Y/N	Training Vector (V) or Other (O)	Background Check per HB 486 Y/N	CPS Background Check Y/N
Allegany	Y	N	V	Y	Y
Anne Arundel	Y	Y	V	Y	Y
Baltimore City	Y	Y	O	Y	N
Baltimore County	Y	Y	Y	Y	Y
Calvert	Y	N	V, O	Y	N
Caroline	Y	Y	V	Y	N
Carroll	Y	N	V	Y	N
Cecil	Y	Y	V, O	Y	N
Charles	Y	Y	V, O	Y	Y
Dorchester	Y	Y	V	Y	Y
Frederick	Y	Y	O	Y	N
Garrett	Y	Y	V	Y	No Response
Harford	Y	Y	V, O	Y	Y
Howard	Y	Y	V	Y	N
Kent	Y	Y	V	Y	Y
Montgomery	Y	Y	O	Y	Y
Prince George's	Y	Y	V	Y	Y
Queen Anne's	Y	Y	V	Y	N
Somerset	Y	N	V	Y	Y
St. Mary's	No Response	No Response	Y	Y	N
Talbot	Y	N	V	Y	Y
Washington	Y	Y	V	Y	N

Wicomico	Y	N	V	Y	N
Worcester	Y	N	V	Y	Y

Notes:
Code of Conduct: A copy of the Code of Conduct has been obtained by SCCAN.
Staff-Student Relationships: Sexual relationships between staff and students are specifically mentioned in the Code of Conduct.
Training: The jurisdiction uses Vector Solutions (V) for their annual online training, or have they created their own (O). Note: Several jurisdictions have incorporated their own model into the Vector training.
Background Check per HB486: A background check per HB 486 requirements is done prior to employment.
CPS Background Check: The local DSS is contacted for a CPS Background check prior to employment (note: this is not a legal requirement in Maryland).

In SCCAN's efforts to obtain this information, it became clear that the legislation as written was missing a requirement for monitoring of implementation and compliance. SCCAN also found that many jurisdictions did not require CPS background checks for new employees, though this was not a requirement of either bill. Additionally, while these bills apply to schools, they do not apply to other child serving organizations such as after school programs or childcare sites.

Healthcare for Children Involved in Child Welfare Workgroup

The SCCAN medical subcommittee has focused their work on improving health care services for children in out-of-home care and children undergoing evaluation/investigation following a report of suspected child abuse or neglect.

Improving Health Care Services for Children in Out-of-Home Care

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 for children in the custody of a local department;
   (3) track health outcomes for children in out-of-home placement using the most recent health care effectiveness data and information set (HEDIS);
   (4) assess the competency, including cultural competency/humility, of health care providers who evaluate and treat abused and neglected children in the custody of

a local department;

(5) periodically assess the supply and diversity of health care services that evaluate and treat children in out-of-home placement, identify shortfalls, if any, and report them to the relevant local department, DHS, and the Maryland Department of Health; services; and work to expand the availability of health care services;

(6) work with state and local health and child welfare officials, provider agencies, and advocates to identify systemic problems affecting health care for children in out-of-home placement and develop solutions;

(7) in consultation with the local departments, develop a centralized comprehensive health care monitoring program for children in out-of-home placement that will ensure the replication of centralized health care coordination and monitoring of services across the state.

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.

Workgroup Activities: SCCAN medical workgroup members participated in an 18 month-long **Affinity Group** program sponsored by Centers for Medicare & Medicaid Innovations. Participating pediatricians included Drs. Wendy Lane, Rebecca Seltzer, and Rachel Dodge, all with expertise in medical care for children in foster care. Affinity group regular members included the Medical Director for Child Welfare, Dr. Rich Lichenstein and his team, and representatives from Maryland Medicaid. Dr. Lichenstein's team and Medicaid representatives participated in trainings provided by CMS, bimonthly technical assistance meetings, and monthly coaching sessions with a Quality Improvement advisor, data sharing advisor, and child welfare and Medicaid policy subject matter experts.

The goals of the Affinity Group were as follows – **addressing HB 1582 requirements 2, 5, and 6 above**:

- Increase the percentage of **timely completion of comprehensive health assessments** among Maryland children placed in foster or kinship care from 77% to 90%. These comprehensive assessments are required to be completed within 60 days of entry for all children entering care.
- Increase the percentage of **timely completion of initial health assessments** (within 5 business days of placement) from 65% to 90%
- Increase the percentage of **completion of at least one dental assessment annually** from 47% to 75%, with a longer-term goal of 90%

Overall, Maryland met its goals for timely initial and comprehensive health visits. Between July 1, 2022 and June 30, 2023; 92% of children had timely initial visits and 90% of children had timely comprehensive visits. Dental visits remain a challenge; only 58% of children

received at least one dental assessment during the year. The counties with the largest numbers of children in foster care, Baltimore County (34% of 527 children), and Baltimore City (34% of 1361 children), had the most difficulty meeting this goal.

The Affinity Group did not focus on increasing the percentage of timely annual visit completion. Only 75% of Maryland children in foster care received timely annual visits.

The Affinity Group examined several other issues. While not specifically named as Affinity Group goals, they addressed requirements of HB 1586. For example, the group discussed ways **to streamline completion of healthcare provider documentation**, document sharing with DSS, and data entry into CJAMS (**HB 1582 requirements 6 & 7 above**). The group worked on developing a **common medical form and dental form** to be used by all jurisdictions that would include prompts for key information while limiting the total amount of information required (**HB 1582 requirements 6 & 7 above**). Currently, most Maryland jurisdictions ask providers to complete documentation using the 631-E form, which contains very few prompts about what information should be included. Baltimore City and County use a modified and more structured 631-E form that specifically requests diagnoses, new and existing medications, testing completed, and recommendations. Fillable on-line forms that could be compatible with many electronic medical record systems as well as CJAMS were recommended to reduce the burden of paperwork and data entry for medical practices and DSS staff.

The group also discussed whether combining the initial and comprehensive medical exams could improve adherence to visits. There were concerns over getting this done quickly enough by the appropriate provider (such as a child's primary care provider) within the needed time frame. The group also discussed whether it might be possible to change the billing codes for initial visits. Currently, health care providers can bill Medicaid for initial foster care exams by adding a special modifier to a code for a periodic health exam (i.e., a well child checkup). Creating a new allowed billing code for an initial foster care health screen may enable more providers to see children during brief sick visit slots. Providers may still be reluctant to schedule initial foster care exams in these slots because of the lack of medical history and the potential need to address many health issues in a short time. We are also exploring with Medicaid the requirement for the initial screening exam to be performed by an EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) certified provider; i.e., a primary care provider who is certified by and follows preventive care standards established by the State Medicaid Program. Some jurisdictions have limited EPSDT certified providers to perform these time-sensitive exams. Another initiative has been to review all COMAR health-related legislation and make edits to ensure that the legislation best meets the health needs of children in care.

Additional Efforts by the Medical Director for Child Welfare: Dr. Lichenstein has also been working on other projects outside of the Affinity Group. For example, his team has finalized a **Data Use Agreement to access information from CRISP**, the state designated Health Information Exchange for Maryland. He can now submit lists of children in foster care to CRISP and receive notifications about visits and hospitalizations. The team is also working with Harford County to determine whether **Special Needs Coordinators from Medicaid Managed Care**

Organizations can help improve access to comprehensive exams. Within DHS, the Audit Compliance and Quality Improvement (ACQI) unit was established to monitor compliance with standards. Information is gathered from CJAMS and through one-on-one meetings with local department leadership. Guidance on improving oversight is provided to LDSS agencies by the team when needed.

Ongoing Barriers: Some of the issues with timely receipt of care may be due to documentation, as when local department staff wait until the medical report is received before documenting that the visit was kept. Even if the visit is done on time, it may not be recorded as such if the visit is not recorded in CJAMS on time. Many barriers to receipt of timely care have been reported by local departments. For example, older youth may refuse the visit, be AWOL, or may be incarcerated. Provider availability may be limited; an especially challenging problem for children who are medically fragile or who have developmental disabilities and require specialized dental care. Local DSS agencies may be understaffed, dealing with multiple crises, or may have difficulty with tracking and monitoring. Placement site and Medicaid Managed Care Organization changes may also create challenges. Finally, maintaining continuity of care can be difficult when children are placed outside of their home jurisdiction.

DHS and the office of the Child Welfare Medical Director have made many improvements to health care services for children in out-of-home placement. However, there is still much work to be done. The following issues are still of **major concern to the council**:

(1) Despite implementation more than two years ago, the **CJAMS system for child welfare information tracking continues to have defects that limit accurate data input and reporting**.[13] The L.J. vs. Massinga consent decree Independent Verification Agent (IVA) report has noted that the CJAMS application needs multiple corrections and enhancements to ensure appropriate data entry and accurate and reliable data reports. Implementation of changes has been slow, and the IVA notes that "At this rate it is not an exaggeration to say that without substantially more resources dedicated to this work, the needed application changes will not be completed until well into 2024, if not 2025."

(2) There has been **little or no progress toward integrating information from Medicaid, Immunet, and/or CRISP with CJAMS** (**HB 1582 requirement ii above**). 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 easy access to information about health visits and medications.[14] **Without this data, it is difficult, if not impossible to**

[13]L.J. vs. Massinga consent decree Independent Verification Agent (IVA) Certification Report for Defendants' 68th Compliance Report January 1, 2022 to June 30, 2022. Filed May 9, 2023. Online at: https://dhs.maryland.gov/documents/Local%20Offices/Baltimore%20City/Consent%20Decree/68th%20Compliance%20Report/IVA%20Report/Text%20of%20IVA%20Report.pdf

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

assess whether children are receiving quality care by HEDIS or other valid measures.

(3) There has been **little or no progress toward the development of an electronic health passport** (**HB 1582 requirement iii above**). The plastic health passport folder used for the past 30+ years remains the mechanism for sharing of health information between and among LDSS agencies, providers, birth parents, foster and kinship caregivers, and youth in out-of-home care. This is an antiquated system that needs to be updated. Information technology resources need to be committed to addressing this issue, while adhering to HIPAA and privacy concerns given the relationship of the child to the birth parent, resource parent, and state. There is no process for informing primary care providers when a child enters or exits foster care or has a change in placement. This makes it impossible for the PCP to know whether no-shows or lack of follow-up are due to changes in placement or an oversight by the family or DHS. PCPs are also left with no contact information to re-engage the child into health care services.

(4) **DSS foster care workers continue to have primary responsibility for health care oversight of the children in their caseload**. A survey of LDSS Assistant Directors completed in October 2021 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. The pilot program in Harford County using Medicaid Case Managers, if successful, could serve as a model for other jurisdictions.

Improving the Medical Evaluation of Children with Suspected Child Abuse and Neglect

Although ensuring best practice medical review and evaluation of cases of suspected child abuse and neglect (**HB 1582 requirement 1 above**) has not been a major focus of the Medical Director for Child Welfare, efforts are underway by Maryland Child Abuse Medical Professionals (CHAMP) to work with the Maryland Department of Health on these issues. Maryland CHAMP was created in 2005 by House bill 1341, Md. Code, Health – General § 13-2201-2205, and amended in 2008. CHAMP faculty are tasked with:

- assisting jurisdictions in development of standards and protocols for child abuse medical providers;
- providing training and consultation to local child abuse medical providers in the diagnosis and treatment of child abuse and neglect;
- providing financial support to part-time local and regional expert staff for the diagnosis and treatment of child abuse and neglect;
- collaborating with local or regional child advocacy centers and forensic nurse examiner programs

. Since its inception, CHAMP has accomplished the following:

- Offered 3x yearly trainings to Maryland physicians and nurses practicing in the field. Our most recent training in October 2023 had nearly 60 attendees.

- Established a web-based, secure, and HIPAA compliant peer review system for medical professionals to submit cases for review.
- Developed a website with practice templates (consent forms, exam documentation forms, etc.), practice guidelines, and links to local, regional, and national resources.
- Collaborated with Maryland Children's Alliance (MCA) to train Child Advocacy Center (CAC) leaders on medical standards.
- Provided technical assistance to local CACs, Departments of Social Services, and law enforcement agencies about the medical evaluation of child maltreatment.
- Trained 14 physicians and more than 30 nurses to conduct medical evaluations for children with suspected maltreatment.

Unfortunately, the **current structure of CHAMP limits our reach** and allows us to touch only a small proportion of these vulnerable children. Current systems are fragmented, without a centralized or mandatory framework to provide access to medical expertise. Access to medical expertise varies by jurisdiction, and sometimes by the practice of the referring agency within that jurisdiction. This **fragmentation and lack of medical expertise may lead to**:

- **Misinterpretation of exam findings**, and **failure to provide definitive assessments** regarding the likelihood of abuse.
- **Unnecessary investigation and family removal of children with accidental injuries or ongoing maltreatment of children when abuse is missed.**
- **Over and under-reporting,** which is costly to children's wellbeing and to child welfare systems. It also becomes a social justice issue if implicit bias substitutes for clinical knowledge.

High-quality, effective systems for providing health care to children with suspected abuse and neglect require expert oversight, continuous quality improvement, continuing education for providers, and stable funding. Multiple agencies, organizations, and experts have established these criteria as best practices for the evaluation of children with suspected child abuse and neglect.[15]

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[15] Adams JA, et al. Updated Guidelines for the Medical Assessment and Care of Children who may have been sexually abused. J Pediatr Adolesc Gynecol. 2016;29:81-87.
Christian CW and Committee on Child Abuse and Neglect. The evaluation of suspected child physical abuse. Pediatrics. 2015;135(5):e20150356. Reaffirmed 2021. Online at: http://publications.aap.org/pediatrics/article-pdf/135/5/e20150356/1344221/peds_20150356.pdf

Jenny C, Crawford-Jakubiak JE, and Committee on Child Abuse and Neglect. The evaluation of children in the primary care setting when sexual abuse is suspected. Pediatrics. 2013;132:e558.
National Children's Alliance. National Standards of Accreditation for Children's Advocacy Centers 2023 Edition. Online at: https://www.nationalchildrensalliance.org/wp-content/uploads/2021/10/2023-RedBook-v5B-t-Final-Web.pdf;
National Optional Standards of Accreditation for Children's Advocacy Centers 2023 Edition. Online at: https://www.nationalchildrensalliance.org/wp-content/uploads/2022/03/2023-Optional-Standards-Book.pdf.
U.S. Department of Justice Office on Violence Against Women. A National Protocol for Sexual Assualt Medical Forensic Examinations Adults/Adolescents, 2nd Ed. Washington: D.C.: U.S. Department of Justice, April 2013. Online at: https://www.ojp.gov/pdffiles1/owv/228119.pdf

While CHAMP provides training and CQI to providers and Children's Advocacy Centers around the state, the following *structural issues inhibit optimal care*:

(1) *Lack of coordinated system for payment of providers*. Financial support for programs is currently pieced together from multiple revenue streams, which may vary from year-to-year, and may not cover services such as multidisciplinary team participation and court testimony (Appendix). Unstable funding makes it challenging to recruit and retain experts.

(2) *Lack of mandated expert review*. Without a clear mechanism or mandate for expert medical review, local DSS and law enforcement agencies may rely on the opinions of inexperienced emergency department, inpatient, or primary care providers, who may miss abuse diagnoses, or diagnose accidental injuries as abusive.

(3) *Lack of medical professional oversight.* Despite standards that mandate medical professional participation in peer review, continuous quality improvement, and ongoing training, there is no mechanism to ensure that this occurs for providers not working at CACs.

(4) *Lack of consistent process for multidisciplinary maltreatment investigations*. CACs were initially established for the multidisciplinary investigation and management of child sexual abuse; Maryland jurisdictions routinely use CACs for this purpose. The National Children's Alliance has developed optional standards for physical abuse; these are likely to become required standards in the next decade. However, not all Maryland jurisdictions use their local CAC for physical abuse investigations, making it less likely that medical experts will be engaged.

(5) *Mismatch in availability of experts across the state.* Most physician child abuse experts are based in large metropolitan areas. It is difficult to recruit and retain providers in smaller jurisdictions without stable funding and support.

Key Stakeholders:

Many Maryland agencies and organizations play a role in meeting the needs of children with suspected maltreatment and their families. Therefore, solutions will require a collaborative process.

Stakeholders and their potential roles include:

- *Maryland Children's Alliance (MCA)* – Can assist CACs in meeting NCA medical standards for physical and sexual abuse investigations. MCA can continue to partner with CHAMP to educate about NCA medical standards and can develop templates for medical linkage agreements which require participation in training and peer review.
- *Maryland Department of Human Services* – Can mandate that local DSS agencies use child abuse experts to perform medical exams or review exams done by non-experts.

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

DHS can also require that multidisciplinary investigations of physical and sexual abuse include medical input.

- *Maryland Department of Health –* Can convene other stakeholders for system improvement, guide Maryland Board of Nursing to enforce standards for training/peer review of providers and can support the CHAMP program through collaborative partnership.
- *Maryland Medicaid* – Can create billing code modifiers that enable payment for services regardless of Medicaid Managed Care Organization.
- *Governor's Office of Crime Prevention, Youth and Victim Services (GOCPYVS)* – Can work with other agencies to streamline medical services and funding for child maltreatment. The Maryland Children's Cabinet, responsible for coordinating the state agencies that serve Maryland children, is chaired by the GOCPYV Executive Director, and includes Secretaries from the Departments of Health, Human Services, Juvenile Services, Budget and Finance, as well as the State Superintendent of Schools.
- *State's and County Attorneys* – Can pay for expert testimony for child abuse cases in Family Child in Need of Assistance (CINA) hearings and criminal courts or contribute dollars to a single funding stream.
- *Maryland Chapter of American Academy of Pediatrics (MDAAP):* Can educate pediatricians about the health needs of children being evaluated for suspected abuse or neglect and those in foster care and can provide feedback to DHS and MDH on the implementation of new protocols or policies. The MDAAP can also advocate for legislative changes that can address system issues.
- *Maryland Hospital Association and Maryland Coalition Against Sexual Assault (MCASA):* Convenes and supports hospital-based Sexual Assault Forensic Examiner programs, disseminates information about best practices for sexual assault examinations, and advocates for policies and funding to improve the availability and effectiveness of hospital-based programs.

Maryland CHAMP is currently working to financially support more CACs and to work more collaboratively with hospital-based FNE programs. CHAMP is also working with MDH to address **structural issues (1) – (4) listed above**.

Membership Committee

The 2015 Maryland legislation establishing SCCAN requires the appointment of 23 members. Representatives from the Maryland Senate and House of Representatives, and state agencies, including DHS, MDH, MSDE, DJS, Maryland Judiciary, and Maryland State's Attorney's Association are appointed by their organizational leadership. The other 15 members are appointed by the Governor via his Appointments Office, with input from SCCAN. Required representation includes a pediatrician with expertise in child abuse and neglect, recommended by the Maryland Chapter of the American Academy of Pediatrics and at least two individuals with personal experience with the child welfare system. The remaining members may come from

professional and advocacy groups, private social service agencies, and medical, law enforcement and religious communities.

With a pause in appointments under the prior administration, the terms of all appointed members had expired by 2022, and SCCAN members included only those individuals representing state agencies. Nevertheless, Wendy Lane, the SCCAN Chair, and many individuals whose terms had expired or who were recommended by SCCAN to serve but never received official appointments, have remained committed to SCCAN and have actively participated in SCCAN workgroups.

Dr. Lane and Edward Gallo, the new SCCAN Executive Director, have been working with Governor Moore's Appointment's Office to re-nominate individuals whose prior recommendation for appointment had stalled and to recommend additional individuals who are committed to SCCAN's work. By the end of 2023, a full complement of new members has been appointed to SCCAN, and a new SCCAN Chair, Taniesha Woods has been appointed.

For a current list of SCCAN members see Appendix B.

Appendix A

DHS Response to Annual Report

Appendix B

State Council on Child Abuse and Neglect (SCCAN)

SCCAN Membership

15 MEMBERS APPOINTED BY THE GOVERNOR

Name	Representing	Jurisdiction	Email	Address	Term Expires
Wendy Lane, MD, MPH ***(Outgoing 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	1st-partial 2017
Paul Marziale	Harford County Sherriff, Harford County Child Advocacy Center	Harford County			1st-10/2026
Jamie Sheppard	Individuals with Lived Experience	Baltimore County			1st-10/2026
VACANT					
Crystal Ricks	Calvert County Public Schools	Calvert County	ricksc@calvertnet.k12.md.us		1st-7/2021
Stacey Brown	The Family Tree	Baltimore City	sbrown@familytreemd.org		1st-7/2022
Rowan Willis-Gorman	Individuals with lived experience	Baltimore City	rowan.willis.powell@gmail.com		1st-7/2022
Marjorie Merida		Montgomery County	marjoriec90@gmail.com		1st- 7/2023
Lisa Weah		Baltimore County	drweah@gmail.com		1st-7/2022

Kelly Jaskiewicz	Maryland State Police		kelly.jaskiewicz@maryland.gov		1st-3/2021
Jody Burghardt		Montgomery County	jburghardt@jssa.org		1st-7/2023
Ademola Oduyebo		Prince George's County	odubeyond@gmail.com		1st-7/2023
Taniesha Woods	Maryland Family Network		twoods@marylandfamilynetwork.org		1st-7/2022
VACANT					
VACANT					

8 POSITIONS FILLED BY DESIGNATION OF THEIR ORGANIZATIONS

Name	Representing	Email	Address
Hilary Laskey	Maryland Department of Human Services	hilary.laskey@maryland.gov	Maryland Department of Human Resources Social Services Administration, 5th Floor 311 W. Saratoga St. Baltimore, MD 21201
Lindsay Carpenter	State's Attorney Association	TLeache@statesattorney.us	100 West Patrick Street Frederick, Maryland 21701
Delegate Susan 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	Maryland Department of Juvenile Services		State of Maryland Department of Juvenile Services

Karla Smith	Representative of the Judicial Branch appointed by the Chief Judge of the Maryland Court of Appeals	karla.smith@mdcourts.gov	
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.lewis@maryland.gov	Maryland Department of Health 201 W Preston Street Baltimore MD 21201
Anthony Muse	Maryland Senate	Anthony.Muse@senate.state.md.us	James Senate Office Building, Room 220 11 Bladen St., Annapolis, MD 21401

SPECIALLY DESIGNATED MEMBERS OF CJAC

Name	Relevant Background	Email	Address
Jennifer Krabil	Director, Children and Youth Division, Governor's Office of Crime Prevention, Youth and Victim Services	jennifer.krabill@maryland.gov	100 Community Place, Crownsville, MD 21032

SCCAN EXECUTIVE DIRECTOR

Name	Relevant Background	Email	Phone	Address
Ted Gallo	Child Protective Services Investigations	edward.gallo2@maryland.gov	Office: Cell:	311 W. Saratoga Street, Room 405, Baltimore, MD 21201

Appendix C

Achieving Racial Equity Workgroup

Co-Chairs:

Erica Lemon, Maryland Legal Aid

Dr. Michael Sinclair, Morgan State University

Members:

Andrew Bell, JBS International

Stacey Brown, The Family Tree

Patricia Cobb-Richardson, Behavioral Health Systems Baltimore

Stephanie Cooke, Baltimore City DSS, Former DHS, SSA Representative to SCCAN

Eiza Cooper, Thriving Communities Collaborative

Serafinam Cooper, MDH

Patricia Cronin, The Family Tree

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.

Sara Lewis, MDH

Carletta Lundy, City of Bladensburg Council Member

Courtney McFadden, SCCAN, MDH

Amanda Odorimah, Hearns Law Group

Laura Edwards, Maryland CASA

Davina Richardson, Citizens Review Board for Children

Dr. Michael Sinclair, Morgan State University

Joan Stine, The Family Tree

Vanita Taylor, Office of the Public Defender

Denise Wheeler, Citizens Review Board for Children

D'lisa Worthy, MDH. BHA

Appendix D

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 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.

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" 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." 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".

Prevention as a priority

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

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 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:

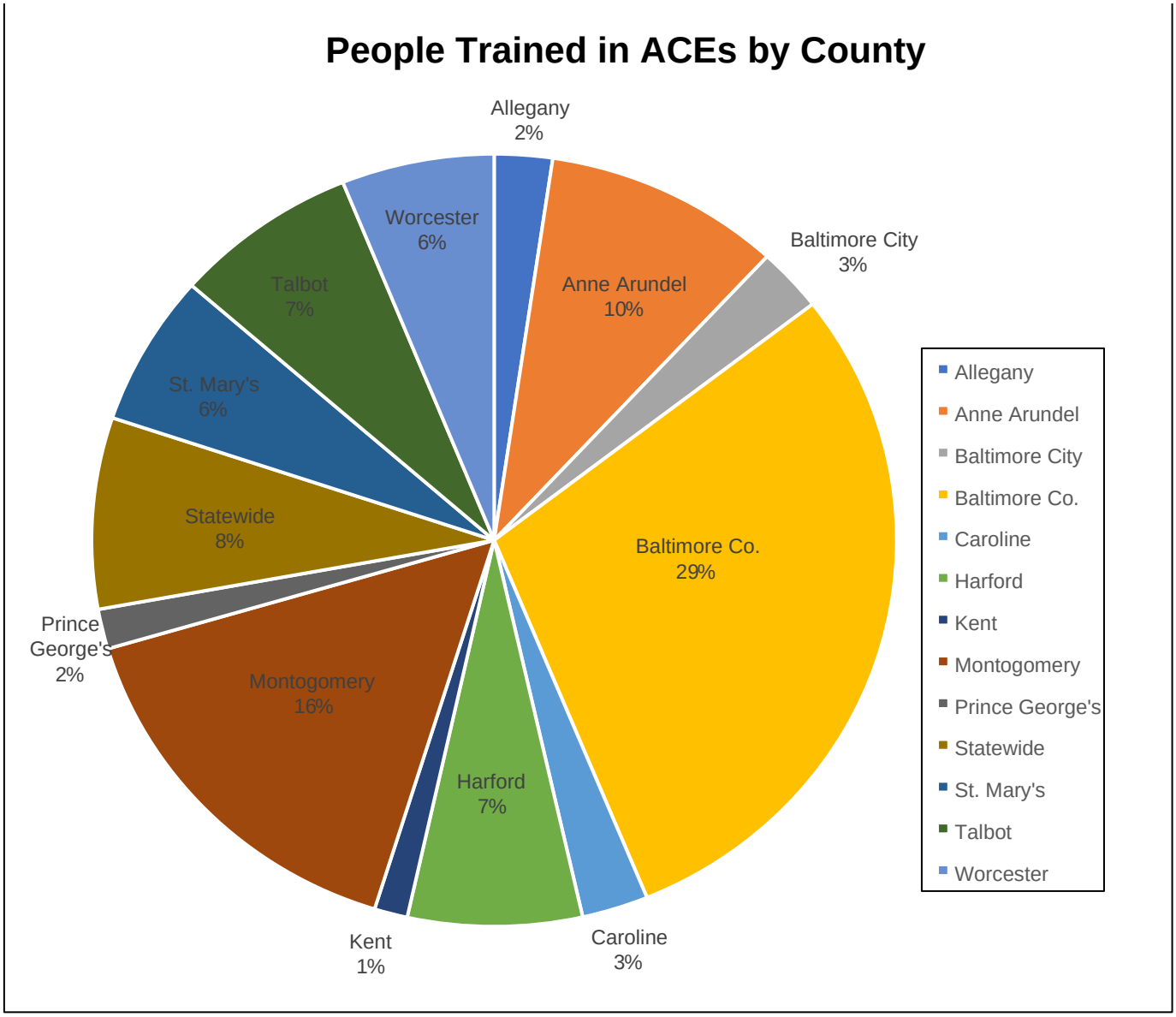
Maryland Essentials for Childhood (EFC) is a statewide collective impact initiative to prevent child maltreatment and other adverse childhood experiences (ACEs). It promotes relationships and environments that help children grow up to be healthy and productive citizens so that *they*, in turn, can build 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

Appendix E

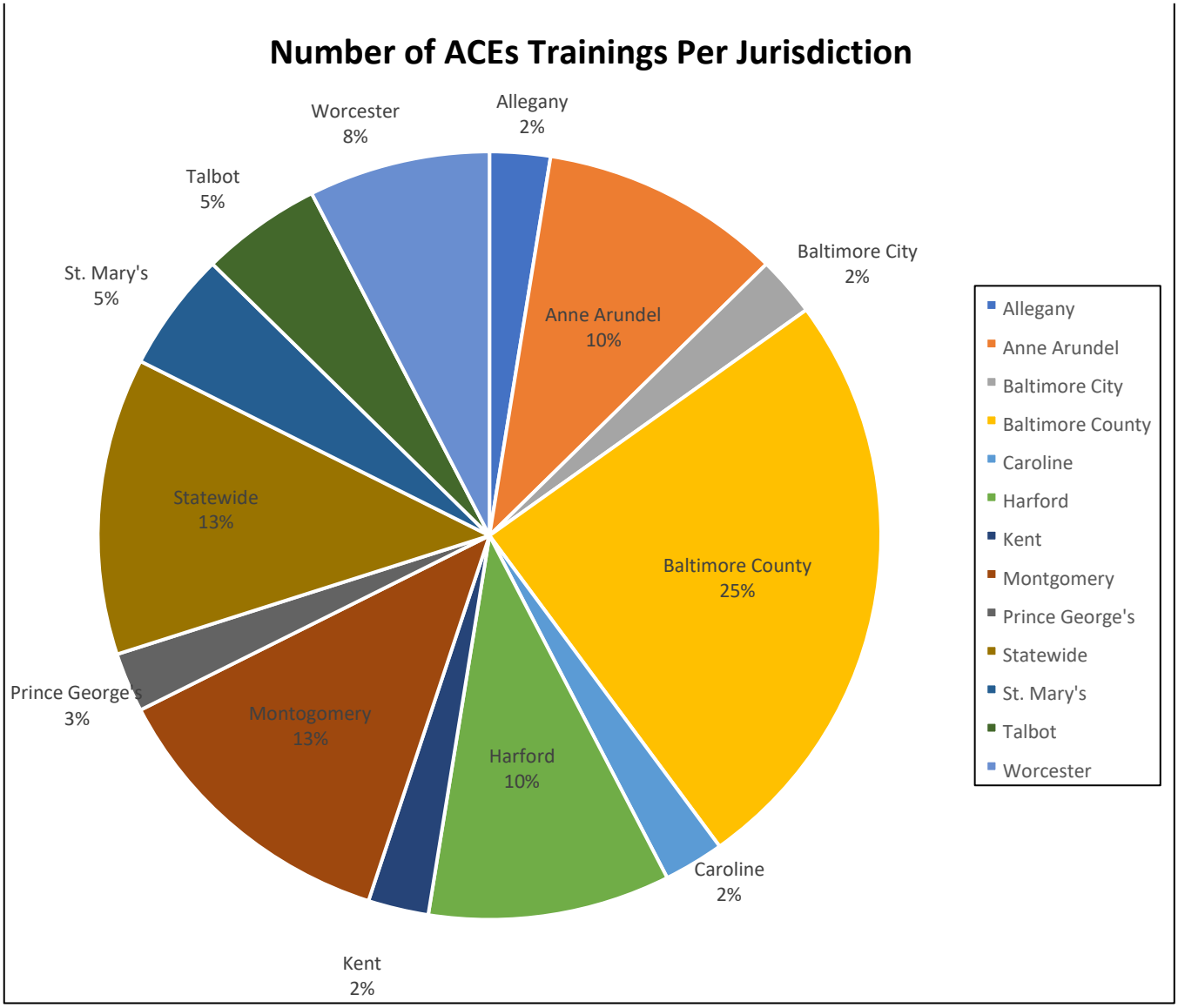
ACEs Interface Training Locations by Maryland County

Between June 2022 and June 2023, ACE Interface Master Trainers gave 40 ACE Interface presentations hosting 1,500 attendees across 12 Maryland jurisdictions. The graphs below show the percentage of people trained by Maryland County and the number of training sessions conducted per jurisdiction.



People Trained in ACEs by County (Participant Count)

Maryland County/Jurisdiction Served	Number of Participants
Allegany	35
Anne Arundel	143
Baltimore City	40
Baltimore County	439
Caroline	40
Harford	105
Kent	20
Montgomery	235
Prince George's	25
Statewide	120
St. Mary's	95
Talbot	111
Worcester County	92


Number of ACEs Trainings Per Jurisdiction
Allegany 2%
Anne Arundel 10%
Baltimore City 2%
Baltimore County 25%
Caroline 2%
Harford 10%
Kent 2%
Montgomery 13%
Prince George's 3%
Statewide 13%
St. Mary's 5%
Talbot 5%
Worcester 8%
Allegany
Anne Arundel
Baltimore City
Baltimore County
Caroline
Harford
Kent
Montgomery
Prince George's
Statewide
St. Mary's
Talbot
Worcester

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

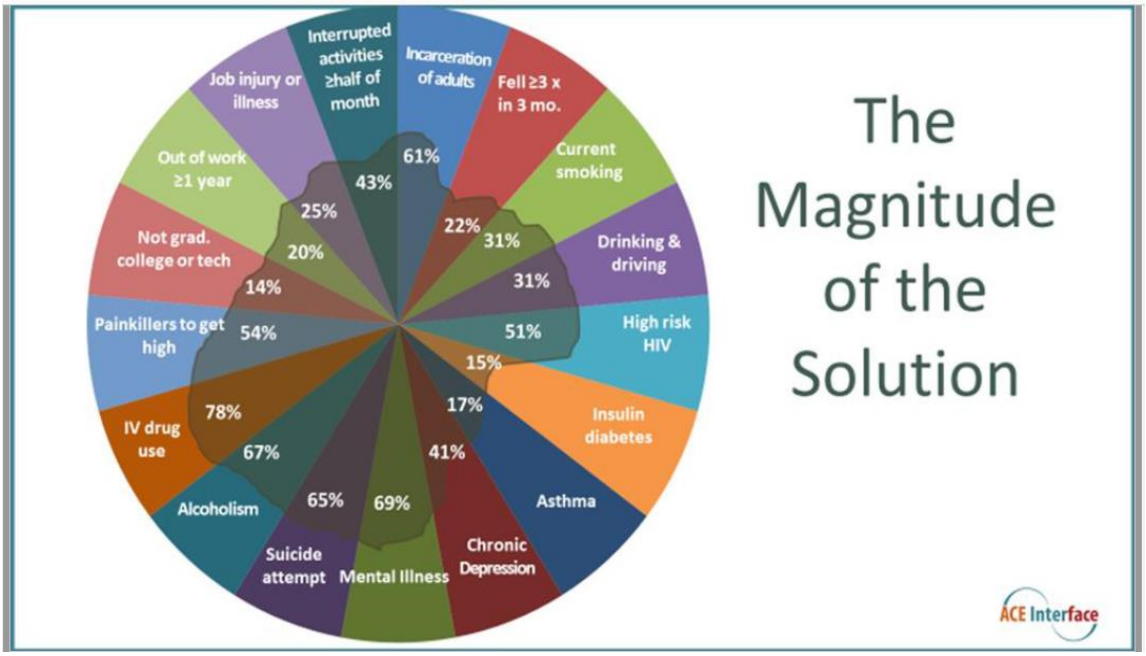
Maryland County/Jurisdiction Served	Number of Participants
Allegany	1
Anne Arundel	4
Baltimore City	1
Baltimore County	10
Caroline	1
Harford	4
Kent	1
Montgomery	5
Prince George's	1
Statewide	5
St. Mary's	2
Talbot	2
Worcester	3

APPENDIX F

THE SCIENCE OF THE DEVELOPING BRAIN, ACES & RESILIENCE: A STRONG CASE FOR A PROSPEROUS MARYLAND[1]

As Marylanders understand the impact of Adverse Childhood Experiences, they realize that the future economic development and prosperity of the state depends on rethinking our policies in health, education, public safety, justice, public assistance, child welfare, and juvenile justice. Focusing on building healthy brain architecture for every child and coordinating our efforts across all our child and family serving systems will prove to be key. This shift in our focus will considerably *reduce childhood adversity at a population level* and stem the tide of ever-more-costly social problems. Understanding the implications of the ACE study and the developments in fields of neuroscience, epigenetics, trauma and resilience is a powerful pathway to health, well-being, and a more prosperous Maryland. Preventing ACEs and their intergenerational transmission is the greatest opportunity of our time…perhaps of all time…for improving the well-being of human populations.

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



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

Appendix G

CDC ACEs Module

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 abuse? 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

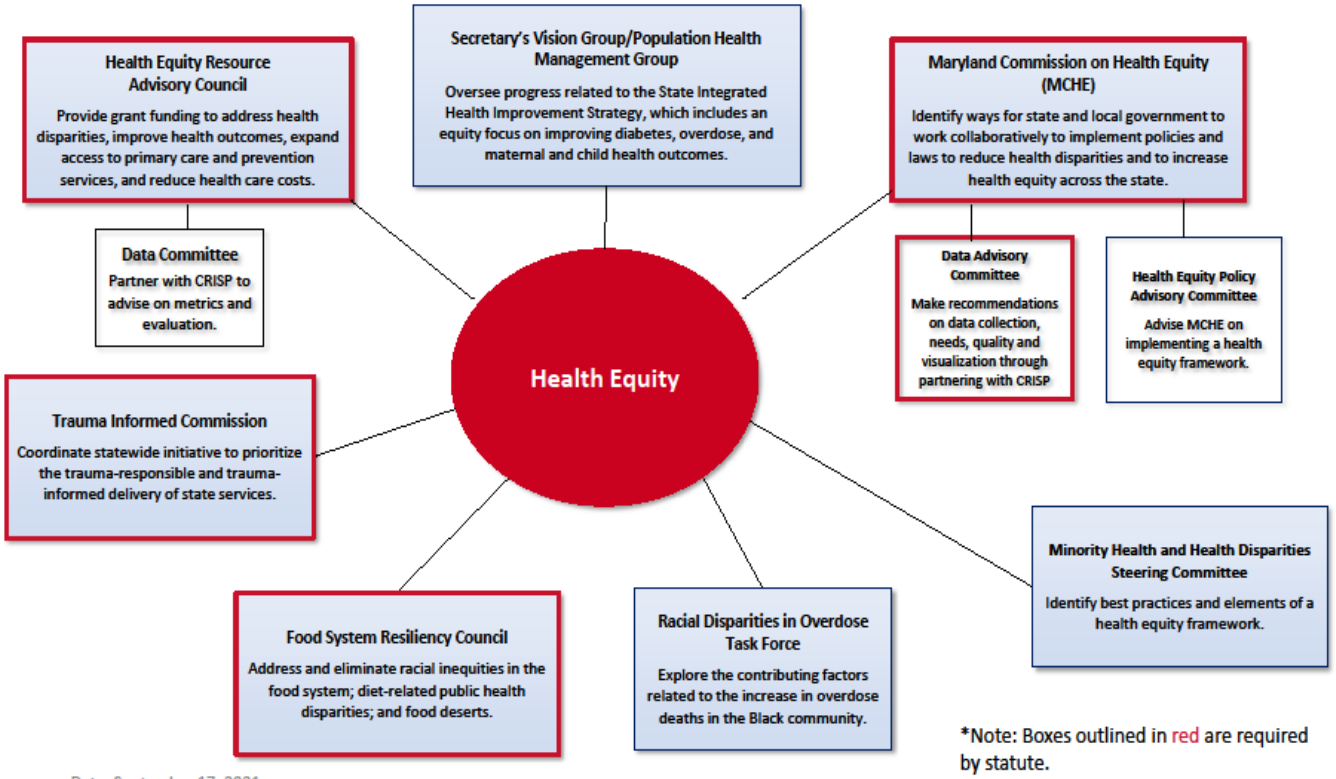
Tier 2

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 questionnaire,	*Lifetime prevalence of community level of violence*	Have you ever seen someone get physically attacked, beaten, stabbed, or shot in your neighborhood? A. Yes B. No

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. 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. 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 feeling*	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	*Incidence of feeling a sense of belonging at*	Do you agree or disagree that you feel close to people at your school? A. Strongly Agree B. Agree

the same question that is already required for DASH-funded LEAs	*school*	C. Not sure D. Disagree E. Strongly disagree

APPENDIX H - Health Equity Initiatives



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

Date: September 17, 2021

Appendix I

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.[16] 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.[17]

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).[18] 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.[19] 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

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[16] 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.

[17] 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.

[18] 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.

[19] 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.

"home suitability clauses"[20], "illegitimate child clauses" and "substitute father in the house clauses". These clauses were established to weed out "immoral homes" and often 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.[21]

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.[22] 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.[23] We are actively building our knowledge, skills, and resources to increase equitable outcomes for

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[20] 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.

[21] 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*.

[22] 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.

[23] 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.

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.

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[24]) 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."*[25] 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."*[26] 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."[27] 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

[24] 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.
[25] 42 USC Ch. 67: CHILD ABUSE PREVENTION AND TREATMENT AND ADOPTION REFORM
[26] Family – General Article, Annotated Code of Maryland, § 5-7A-09, State Council on Child Abuse and Neglect (SCCAN)
[27] Kendi, Ibram X., How to Be an Antiracist. New York: One World, 2019.

and unwritten laws, practices, rules, procedures, processes, regulations, and guidelines that govern people.

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 J

SCCAN ACHIEVING RACIAL EQUITY WORKGROUP

RESOURCES ON RACISM, RACIAL EQUITY AND CHILD WELFARE*

ORGANIZATIONS

- childwelfare.gov
- State Automated Child Welfare Information Systems (SACWIS)
- The Center for the Study of Social Policy-Alliance for Racial Equity
- American Bar Association:
  - 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/
  - Implicit Bias Test: 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 of Harford County Anti Racism Toolkit: https://www.casaofharfordcounty.org/anti-racism-toolkit

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

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

WEBINARS

ABA WEBINAR 9-16-20

American Bar Association- A Conversation about the Manifestation of White Supremacy in the Institution of Child Welfare Level 2: https://www.youtube.com/watch?v=QoggJj60VoY

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 inaccurately 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/resources/child-welfare-practice-address-racial-disproportionality-and-disparity/

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/

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

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

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

Appendix K

SCCAN Meetings 2022 and 2023 – Speakers and Topics

Meeting Date	Meeting Speaker	Speaker Topic
March 3, 2022	Katie Pederson, Maryland DHS	Maryland Child Fatalities – Risk Factors and Fatality Review
October 6, 2022	Kay Connors, MSW Instructor, Department of Psychiatry, University of Maryland School of Medicine, Executive Director, Taghi Modaressi Center for Infant Study	Healthy Steps Program – Program based in pediatric primary care to promote positive parenting and healthy development
	Margo Candelaria, PhD Co-Director, Parent, Infant, Early Childhood (PIEC) Program The Institute for Innovation and Implementation University of Maryland School of Social Work	Grow Your Tree Program – Engagement of pediatric providers to promote positive early childhood experiences in children < 2 years old living in poverty
December 1, 2022	Kristen Parquestte, MPH CEO, President C4 Innovations Rowan Willis-Gorman Behavioral Health Advocate & Researcher C4 Innovations	Project Amp – Peer support program to address youth substance use, stress management, healthy coping & self-efficacy
January 5, 2023	Tiffany Beason, PhD Joanna Prout PhD Department of Psychiatry, University of Maryland School of Medicine	ACEs and Trauma Informed Care Data-to-Action Initiative
	Carrie Freshour, LCSW-C Commissioner, Maryland Trauma Informed Care Commission	TICC Screening Committee Update
May 4, 2023	Rebecca Allyn Victim Services Program Manager Governor's Office of Crime Prevention, Youth, and Victim Services	Victim Services Programs at GOCPYV
	Janice Goldwater, LCSW-C Commissioner, Maryland Trauma Informed Care Commission	TICC Training Committee Update
September 14, 2023	Richard Lichenstein, MD Medical Director for Child Welfare Maryland DHS	Medical Director, Child Welfare Review

November 2, 2023	Susan Dos Reis, BSPharm, PhD Professor of Practice, Sciences, and Health Outcomes Research University of Maryland School of Pharmacy	Psychotropic medication prescriptions among Maryland Children Insured by Medicaid and those in Out-of-Home Care
January 4, 2024	Hilary Laskey Deputy Executive Director of Programs Maryland DHS For: Stephen Liggett-Creel	Child Welfare Planning and Key Initiative Updates
	Erica LeMon, Esq. Maryland Legal Aid	Review of December 11th Child Welfare Visioning Session

Appendix L

Recommended Child Welfare Data to be Made Publicly Available by DHS

The number of referrals and the number of screened out referrals.

The number of referrals (both screen in and screened out) by referral source (it., 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 providers placements.

The number and percentages 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 the 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.