

The Power of Community



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

**MARYLAND STATE COUNCIL
ON CHILD ABUSE & NEGLECT
ANNUAL REPORT**

JANUARY 1, 2016 – DECEMBER 31, 2016

ACKNOWLEDGMENTS

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

- ❖ Council Members for sharing their expertise and for the many volunteer hours they have contributed to SCCAN.
- ❖ Council Chairs, Pat Cronin and Wendy Lane; Maryland Essentials for Childhood (EFC) Committee Chair, Joan Stine and EFC Workgroup Chairs, Patricia Cronin, Kay Connors, D’Lisa Worthy, Joan Stine, Diane Banchiere, Cathy Costa and Wendy Lane; and, Governance & Nominations Chair, Ralph Jones for the many additional hours they contributed to the Council this year.
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- ❖ Pat Cronin, Executive Director, her staff and the Board of Directors at The Family Tree for its’ co-backbone role in Maryland Essentials for Childhood Initiative
- ❖ The Board of The Family Tree for funding the ACEs Interface Master Training Initiative to ensure that Maryland becomes and Brain Science-Informed State.
- ❖ The many other partners, stakeholders and citizens who contribute to moving child maltreatment prevention forward in the state of Maryland.

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June 14, 2017

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

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

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

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

Dear Governor Hogan, President Miller and Speaker Busch:

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

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

On pages 52-63, the Council recommends several actionable steps to improve Maryland's child and family serving systems in order to protect children and to prevent child maltreatment and other ACEs *from occurring in the first place*. Specific recommendations are made on prioritizing prevention of ACEs, coordinating the work of child and family serving systems, passing comprehensive child sexual abuse prevention legislation, preventing child abuse and neglect fatalities, improving health care for children involved in child welfare, and improving the state's mandatory

reporting system. As you read through the Council's report and recommendations, I hope you will see our deep commitment to the healthy development of every child within our state and the primary prevention of child maltreatment and other ACEs. That dedication extends to the relationships and environments of the child--their parents, their families, their communities and their state.

Sincerely,

A handwritten signature in black ink that reads "Wendy Lane MD". The signature is written in a cursive style.

Wendy Lane, MD, MPH,
SCCAN Chair

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

Executive Summary

SCCAN's 2016 Annual Report to the Governor and General Assembly lays out an overall framework for a seismic shift in how we as a state address child abuse and neglect, along with other Adverse childhood experiences (ACEs) (family dysfunction-parental mental illness, parental substance abuse, domestic violence, parental incarceration, divorce) (urban ACEs- experiencing racism, witnessing violence, living in an unsafe neighborhood, living in foster care, experiencing bullying) that lead to poor outcomes in health, education, public safety, and economic productivity at an immense cost to children and taxpayers. We support Governor Hogan's vision of economic opportunity for all of Maryland's children, youth, and families and urge him and the General Assembly to learn about and employ the exciting advances in the science of the developing brain, ACEs, and Resilience to reach that vision. The recommendations set out specific policies, strategies, and training that build the individual and collective knowledge and skills of Marylanders in our child and family serving agencies and communities to provide the safe, stable and nurturing relationships and environments that children need to grow into healthy and productive citizens. In responding to feedback on prior SCCAN reports, some recommendations are addressed specifically to the Governor, the General Assembly or one or multiple child and family serving agencies. At the same time, implementation of many of the recommendations will require leadership support and the hard work of collaboration and coordination across child and adult serving agencies that for too long have seen themselves and their missions as separate and apart.

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 Framework Statewide Implementation technical assistance. SCCAN joined with its partners in forming Maryland Essentials for Childhood (EFC); a statewide collaborative 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 two 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, learning from national experts and leading states. When people learn the brain science and ACEs, they understand the interconnection of many of the social problems that confront our state; and, begin learning and working together to innovatively solve them.

SCCAN's Annual Report includes the following:

- A brief background of SCCAN's mandate, focus, and efforts
- An overview of the Science of the Developing Brain, ACEs, and Resilience
- A discussion of Maryland Data on the Magnitude of the Problem
- An overview of the Maryland Essentials for Childhood Initiative Framework (EFC), including partnerships and a discussion of the four strategic goals of EFC
- A description of how brain science can serve as a strong foundation for Governor Hogan's vision of economic opportunity, human capital development, and self-sufficiency, as well as a streamlined and efficient state government that supports the frontline work in local communities and ensures excellent customer service.
- Recommendations to the Governor, General Assembly and Agencies
- A review of 2016 SCCAN & EFC Activities and Accomplishments toward our goals

Key Recommendations for the Governor, General Assembly, and Agencies¹:

1. Take meaningful action to raise awareness of brain science, adverse childhood experiences (ACEs) and resilience and build community commitment to prevent, reduce and respond to ACEs by launching an ACEs Initiative similar to Governor Bill Haslam's [Building Strong Brains Tennessee's ACEs Initiative](#).
2. Review Maryland's 2015 baseline ACE Module Behavioral Risk Factor Surveillance System (BRFSS) data; continue to collect BRFSS ACE data every three years; and, collect resilience data, as is being done in Wisconsin, beginning in 2018.
3. Embed Brain Science, ACEs, and Resilience into the Children's Cabinet Three-Year Plan.
4. Offer free screenings and time to view the film [RESILIENCE: The Biology of Stress & The Science of Hope](#) to introduce staff to the Brain Science, ACEs and Resilience and trauma-informed systems; and, provide opportunity for dialogue on how it might be used to provide better customer service within child and family serving agencies.
5. Participate in ACEs Interface Master Training and Learning Cohort to build awareness and commitment to act within your organization.
6. As level II of the Governor's G.O.L.D. Standard Customer Service Training Initiative, have ACEs Interface Master Trainers train all staff, beginning with supervisors.
7. Explore ways to increase awareness of the brain science and the impact of ACEs on the people your agencies serve. Integrate the science into agency and cross agency work by:
 - Partnering in Maryland Essentials for Childhood to ensure cross-agency coordination.
 - Screening clients for ACEs and resilience factors
 - Providing pre-service and in-service training to all staff on brain science, ACEs and resilience
 - Identifying a standard of care that includes assessing for and responding to ACEs, to be integrated into contracts as performance measures
 - Embedding the science into strategic planning with local agencies and connect to funding
 - Ensuring organizational policies and regulations reflect the science
 - Ensuring practice models reflect the science
 - Investing resources in evidence-based trauma interventions; and, creating a trauma-informed agency
 - Using Communication efforts to connect the dots between state child and family serving programs as a response to the science. Developing an umbrella message and integrating it into messaging across agencies and programs, including websites and press releases regarding child and family serving policies and programs.
8. Require child serving agencies and youth serving organizations receiving state funding to institute Comprehensive Child Sexual Abuse training, policies and guidelines.
9. Develop a Centralized System for Providing Forensic and Medical Services to Children Involved in the Child Welfare System. Fund each component of the Centralized System as a line item in the Governor's Budget. Components should include:
 - Management by a physician Health Director at DHR, SSA
 - Oversight and policy development via an Interagency Child Welfare Health Coordination Expert Panel
 - A system for tracking and improving health outcomes; including fatalities and near fatalities due to child maltreatment.

¹ A full list of SCCAN Recommendations by Agent/Agency begins at page 51-63.

Background

SCCAN has its historical origins in the 1983 Governor’s Task Force on Child Abuse and Neglect, appointed at the request of the General Assembly. The Task Force “found that child abuse, especially sexual abuse was far more widespread than originally estimated; [and,] the problems of child abuse and neglect require long term efforts for the implementation and monitoring of programs for the prevention, detection, and treatment of victims and offenders.” In light of the task force findings, on April 29, 1986, the task force became the Governor’s Council on Child Abuse and Neglect created by Executive Order. In 1999, the Maryland General Assembly established The State Council on Child Abuse and Neglect as one of three citizen review panels² 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 Resources, Department of Health and Mental Hygiene, Department of Education, Department of Juvenile Services, Judicial Branch, and the State’s Attorneys’ Association.³

SCCAN’s mandate is defined in Federal and State law. CAPTA charges SCCAN and all citizen review panels “to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities”⁴ and to “provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations.”⁵ The Maryland Family Law Article reiterates the CAPTA requirements and specifically charges SCCAN to “report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs”.⁶

Prevention as a priority

For several years now, the Council has focused its research, advocacy and collective energies on activities to raise awareness of the science of the developing brain and adverse childhood experiences (ACEs) and build cross-sector collaboration to advocate for systems reform to promote child well-being and prevent child maltreatment and other adverse childhood experiences (ACEs) *before they occur*. The profound impact that child maltreatment and other adverse childhood

² The other panels are the Citizens’ Review Board for Children and the State Child Fatality Review Team.

³ See Appendix D for current members.

⁴ Section 5016a (c) (4) (A)

⁵ Section 5016a (c) (4) (C)

⁶ Section 5-7-09A (a)

experiences (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. In describing our current "casework approach" and "criminal justice approach" to solving the problem of child maltreatment and other ACEs (parental: substance abuse, mental illness, domestic violence, separation/divorce, and incarceration), one of the principal investigators of the Adverse Childhood Experiences Study (ACEs), Robert Anda, MD aptly noted that:

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

A broader public health approach to the prevention of child maltreatment focuses on understanding the complex causes of child maltreatment in order to intervene at all levels of the socio-ecological model (individual, family, community and societal) to prevent it *before it occurs*. Currently, prevention programs, policies and practices in Maryland, as in many other states, 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 formal cross-sector statewide strategy for promoting child well-being and preventing child maltreatment and other ACEs *before they occur*. 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 and mitigates ACEs. Together we are raising awareness of the science of the developing brain, ACEs and resilience and a commitment to act to change programs, policies and social norms to align with the science.

THE SCIENCE OF THE DEVELOPING BRAIN, ACEs & RESILIENCE: A Strong Case for a Prosperous Maryland⁷

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

Preparing Maryland for a prosperous future begins with recognizing that our youngest residents must get what they need today to become the adults who will strengthen our communities and build our economy. When Maryland invests wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship.

2. Experiences Build Brain Architecture

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

3. Serve & Return Interactions Shapes Brain Circuitry

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

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

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

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

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

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

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

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

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

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

The factors children are exposed to affect how well they progress, and communities play a big role. A child's wellbeing is like a scale with two sides; one end can get loaded with positive things, while the other end can get loaded with negative things. Supportive relationships with adults, sound nutrition and quality early learning are all stacked on the positive side. Stressors such as witnessing violence, neglect or other forms of toxic stress are stacked on the other. This dynamic system shows us two ways we can achieve positive child outcomes: to tip to the positive side, we can pile on the positive experiences, or we can offload weights from the negative side. Children who have experienced several ACEs are carrying a heavy negative load, and to tip these children toward the positive, innovative states and communities have been able to design high-quality programs for children to prevent Adverse Childhood Experiences whenever possible, and respond to them with strong, nurturing supports to ameliorate their impact when they can't be prevented. These programs have solved problems in early childhood development and shown significant long-term improvement for children.

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

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

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

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

10. Rethinking Our Policies

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

All children need someone in their corner. The shift from “What is wrong with you, or why are you a problem?” to “What has happened to you, and how we can we support you and help you heal from these experiences?” will result in a more effective, more empathetic service delivery system and a stronger Maryland.

Magnitude of the Problem in Maryland

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

CPS reports are known to underestimate the true occurrence of maltreatment. Non-CPS studies estimate that 1 in 7 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 the problem. To give the reader some perspective on the problem in Maryland, the Council considers data from two Maryland sources below: Maryland CPS Data (incidence) and Behavioral Risk Factor Surveillance System ACE Module data (retrospective prevalence).

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

Diagram A below illustrates the number of reports, their dispositions, pathways and service provision.

During FFY 2015, DHR, SSA received 51,349 reports of suspected child abuse or neglect. Of those, 20,623 reports, including 30,972 children were referred for a CPS response.

- During the year, 13,637 investigations were completed. Of this total, 3,811 (27.94%) were indicated for abuse or neglect. The 3,811 indicated referrals represent 7.42% of the total abuse and neglect reports. Once there is an indicated referral, children are considered victims of child abuse/neglect.
- 18,740 reports (36.5% of total reports) received an alternative response.
- Data was not readily available to indicate what, if any, services were provided children and their families. This is unfortunate as many of the children referred to child welfare experience significant risk factors (multiple types of maltreatment, parental mental

illness, substance abuse, incarceration, domestic violence) that result in poor short and long-term outcomes. ***It is unclear from available data the extent to which children and families are not only referred for services, but linked and provided those services.***

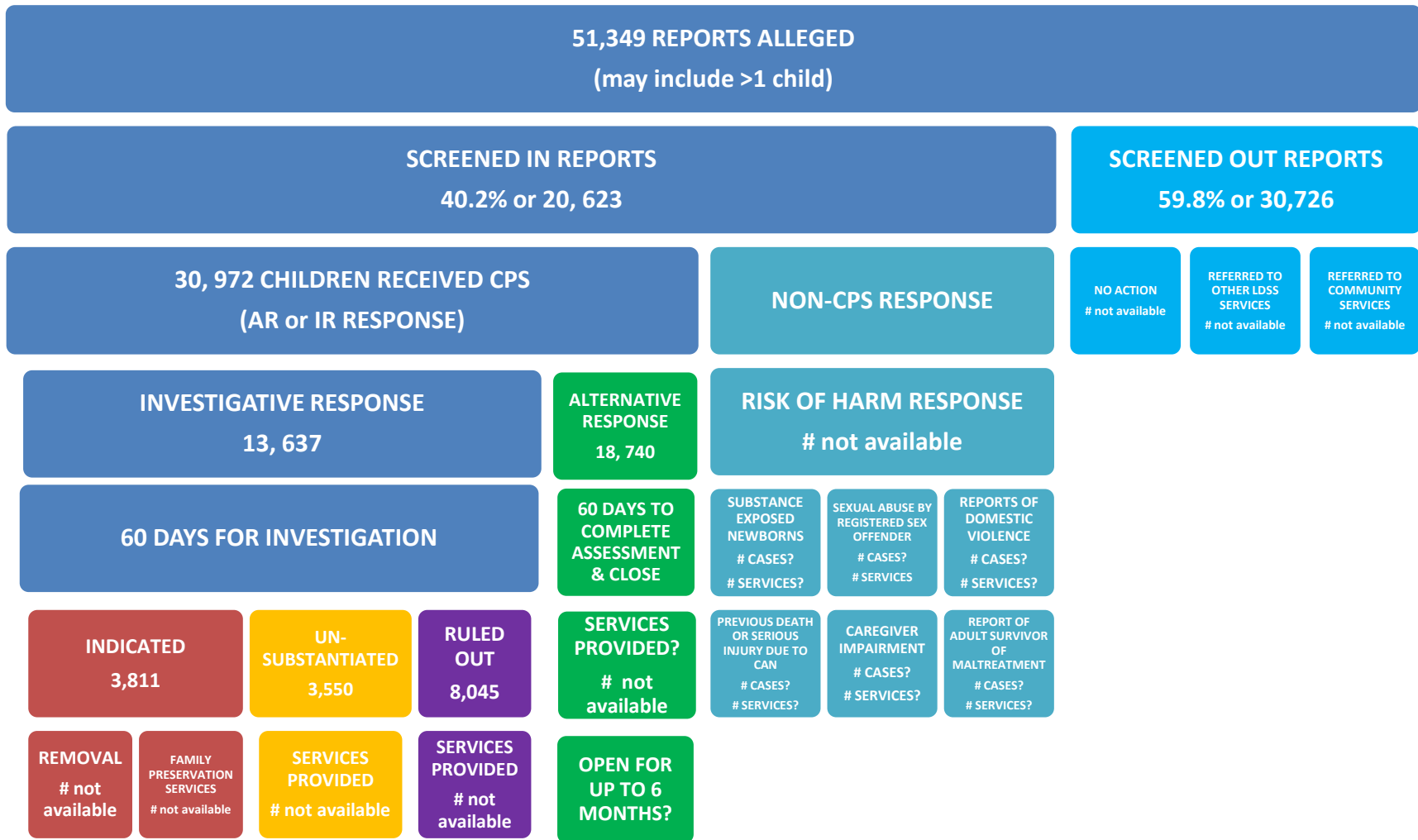
- Of particular concern to both SCCAN and the Citizen’s Review Board for Children is the absence of data to verify the extent to which children are receiving necessary health and mental health services and care coordination. Lack of accurate tracking and reporting of these services and their outcomes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

Children who experience abuse or neglect have abnormally high levels of cortisol, a hormone associated with the stress response, even after they are removed from maltreating caregivers and placed in safe circumstances. Such continuously high cortisol levels adversely affect stress responsiveness, emotion, and memory (National Scientific Council on the Developing Child, 2005). Studies have also shown that heightened stress impairs the development of the prefrontal cortex, the brain region that is critical for the emergence of abilities that are essential to “autonomous functioning and engagement in relationships” (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p.11). These “executive functions” include planning, focusing, self-regulation, and decision-making. Executive functions are necessary to successfully managing school, work, and healthy relationships.⁸

Data from SCCAN’s 2013-2015 Annual Reports emphasized the importance of tracking health services and outcomes for children involved with child welfare and should be a high priority for our state’s care of these our *most* vulnerable children. Because children and families involved in child welfare are often involved in multiple public systems--public health, behavioral health, primary care, Medicaid, child welfare, juvenile and criminal justice, education, public assistance, child support enforcement—it is essential that these systems work collectively to meet their 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.

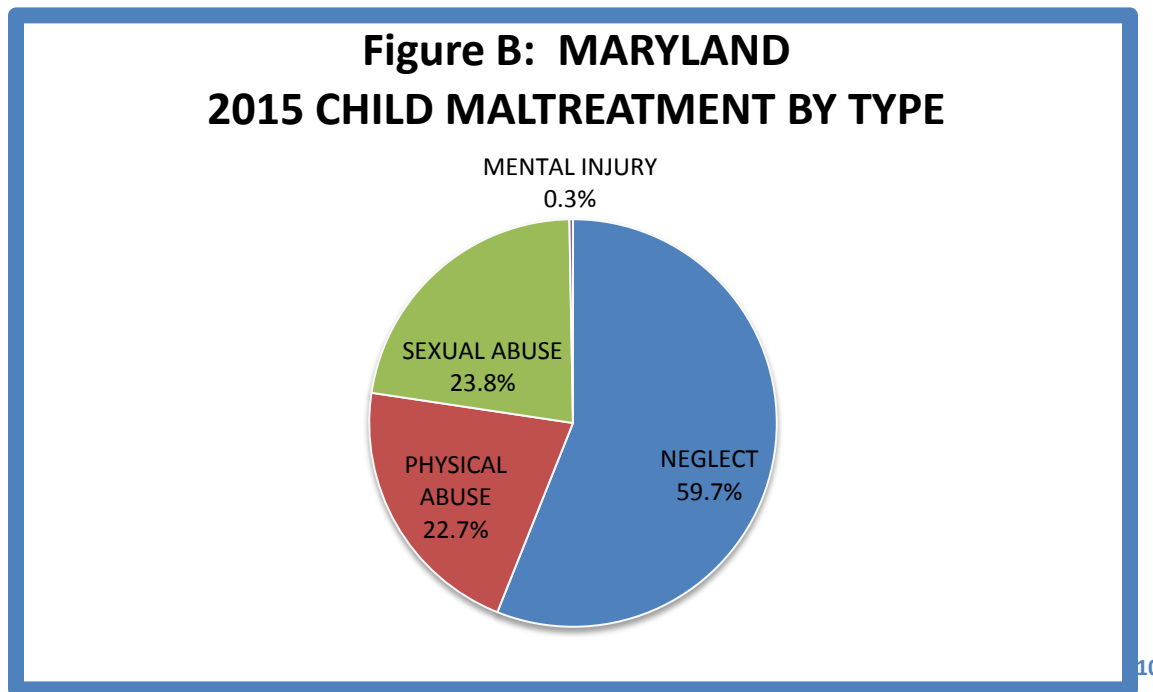
⁸ U.S. Department of Health and Human Services, Administration for Children and Families, Information Memorandum, ACYC-CB-IM-12-04. April 17, 2012, p. 4.

Figure A: 2015 CHILD MALTREATMENT *REPORTS, PATHWAYS, & SERVICES*



Child Maltreatment by Type:

- Neglect is the largest category of child abuse/neglect at 59.7 percent, followed by sexual abuse at 23.8%, physical abuse at 22.7% and mental injury at 0.3%. (The total is greater than 100% due to poly-victimization, i.e., a child may have suffered more than one type of maltreatment). See Diagram B below.
- Chronic neglect is given less attention in policy and practice, however can be associated with a wider range of damage than active abuse. Science tells us that young children are especially vulnerable to poor physical and mental health outcomes of neglect. A broad range of developmental impairments can occur, including cognitive delays, stunting of physical growth, impairments in executive function and self-regulation skills, and disruptions of the body's stress response.⁹



Caregiver Risk Factors for Child Maltreatment:

Risk factors are characteristics of a caregiver that may increase the likelihood of abuse and neglect. Maryland data reported in the federal report *Child Maltreatment 2015* on the percentage of caregivers with a risk factor of alcohol and drug abuse seems extremely low

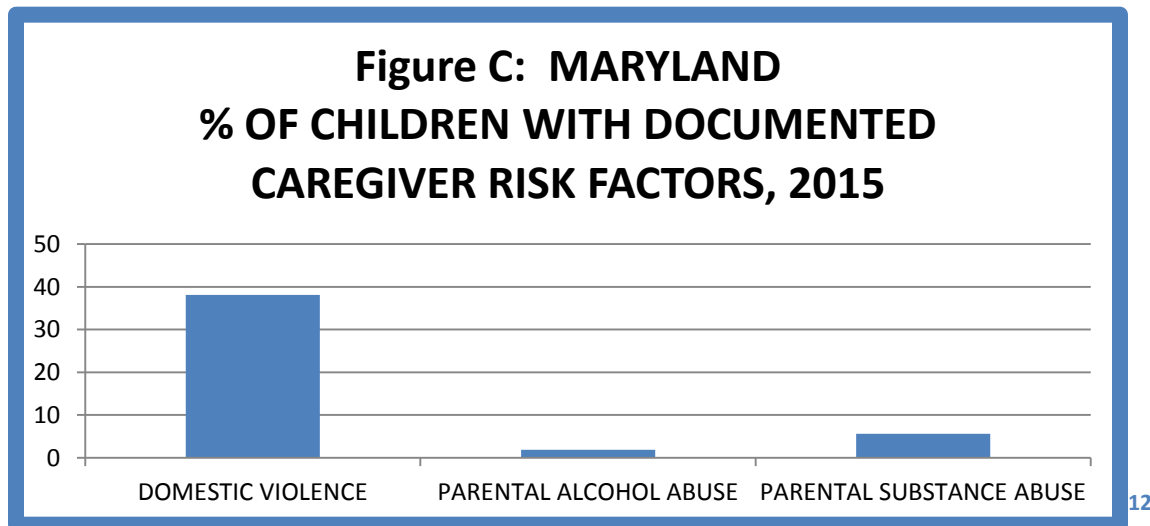
⁹ [In Brief, The Science of Neglect](#), Harvard Center on the Developing Child.

¹⁰ U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2017), *Child Maltreatment 2015*. Available at <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

based on: the data DHR collected for Maryland’s IV-E Waiver, which indicates that parental substance abuse was a factor for 29% of all children removed from their homes in FY 2012-2014¹¹; Council member experience and expertise; and based on ACE prevalence data that follows. The percentage of caregivers with a domestic violence risk factor seems more in line with anecdotal experience; and, with the adverse childhood experience prevalence data that follows.

- 38.1% of child victims had a caregiver risk factor for domestic violence
- 1.9% of child victims had a caregiver risk factor for alcohol abuse
- 5.6% of child victims had a caregiver risk factor for drug abuse

Risk factors such as alcohol abuse, drug abuse and mental illness of a parent are not necessarily accurately assessed and measured by child welfare workers, and therefore can go undocumented in child welfare data systems. For example, some risk factors must be clinically diagnosed by trained physical, mental and behavioral health specialists. Under current practices this most likely does not occur during an investigation or alternative response. If there is no diagnosis prior to the CPS case being closed, the child welfare agency may not be notified and the information is not documented in CHESSE.



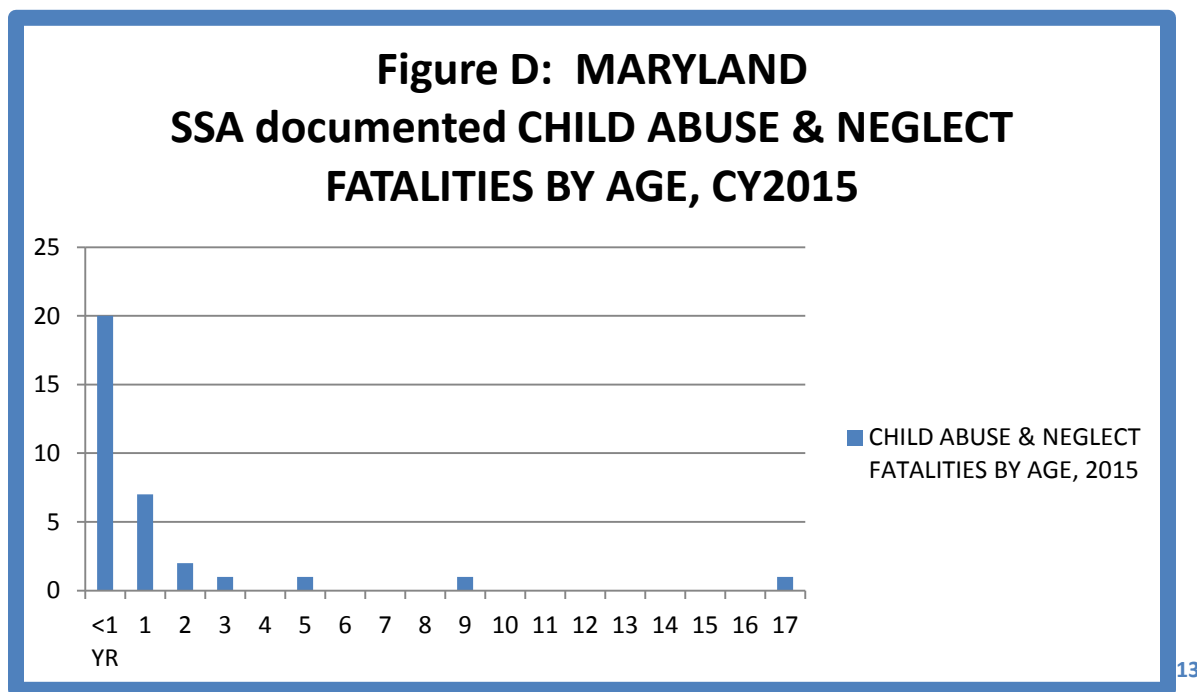
¹¹ <http://www.dhr.state.md.us/blog/wp-content/uploads/2015/01/MARYLAND-data-packet-3-6-15.pdf>, p. 10.

¹² Ibid.

Child Abuse & Neglect Fatalities:

DHR Reported:

- In CY2015, DHR reported that at least 33 Maryland children were reported by CPS as having died with child maltreatment as a contributing factor. This was an increase from 26 the prior year. At the time of death, 8 (24.2%) of the 33 fatalities had active cases or prior child welfare cases had been closed within the past 12 months.
- 20 (60.6%) of child deaths were < 1 year old; 7 (21.2%) were 1yr old; 2 (6%) were 2 yr olds; and 1 (3%) were each 3,5,9, and 7 yrs old.
- 20 children (60.6%) of children were African American; 1 child (3%) was Asian; 2 children (6%) were bi-racial; 9 children (27%) were Caucasian; and, 1 child (3%) was of unknown race.
- In CY2015, DHR reported that there were 11 serious physical injuries (SPIs) with child maltreatment as a contributing factor. 9 (82%) of the SPIs were of children <1 year old; 2 were 6 yrs old. One (1) of the 11 SPIs had an active case or prior child welfare case which had been closed within the past 12 months.
- Of the SPI cases, 4 were African American; 0 were bi-racial; 5 were Caucasian; 0 were Hispanic; and, 2 were of unknown race.



¹³ Ibid.

Maryland Child Abuse & Neglect Fatality (MCANF) Review:

In July 2015, SCCAN began exploring the work being done at the national level to prevent child fatalities related to child abuse and neglect. Below are both a brief history of the work and the goals of coordinated efforts between SCCAN, the State Child Fatality Review Team (SCFRT) and the Citizens' Review Board for Children (CRBC). SCCAN, SCFRT and CRBC serve as Maryland's three federally required Child Abuse Prevention & Treatment Act (CAPTA) citizen review panels. The SCFRT Coordinator is also DHMH's designee to SCCAN.

Following on the heels of a BBC news report on relatively high rates of child abuse fatalities in the U.S. and a call from child advocates, Congress passed the Protect Our Kids Act of 2012 establishing the National Commission to Eliminate Child Abuse & Neglect Fatalities (CECANF). The Commission held public hearings across the country from 2014-2015 to inform the development of a national strategy and recommendations for reducing fatalities resulting from child abuse and neglect.

In September of 2015, SCCAN invited Commissioner Teri Covington (Executive Director, National Center for the Review & Prevention of Child Deaths) and staff of CECANF to speak to the Council and its' partners regarding upcoming findings and recommendations regarding best practices throughout the states. DHR-SSA, DHMH-MCH, CISAP and SCFRT members were invited to the meeting. CECANF released its report [Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities](#) and [fact sheet](#) with its findings and recommendations in March 2016.

In April & June 2016 SCCAN's Essentials for Childhood (Prevention) Committee reviewed the CECANF Report findings and outlined work recommended steps for states' action. Cathy Costa from the Baltimore City Health Department CFRT presented the work being done in Baltimore to accurately identify child fatalities related to child abuse and neglect and to analyze the data for possible preventative interventions along the timeline of the children and families interactions with state and community services. SCCAN and SCFRT members agreed to form a joint workgroup (Maryland Child Abuse & Neglect Fatalities (MCANF) Workgroup) to review child fatalities related to child maltreatment. Members of CRBC later joined the workgroup. The purpose of the workgroup is to make systems recommendations to prevent future child abuse and neglect fatalities and near fatalities. Specific goals include the following:

- Review child death cases in order to develop accurate, cross-system, aggregate data to understand the root causes (risk factors- substance abuse, domestic violence, mental illness, etc.) of child abuse and neglect fatalities.
- Develop recommendations to improve policies, programs, practices and training within *all* child and family serving agencies (health care providers, hospitals, WIC, Early Care and Learning, parental mental health and substance abuse services, law enforcement, CPS, schools, etc.) to prevent child abuse and neglect and the related fatalities and near fatalities.

- A major focus of this work is on increasing family stability and child safety by strengthening the integration of mental health and addiction, domestic violence, housing, transportation and employment services and other systems.

In July 2016, Maryland began participation in the Three Branches Institute on Improving Child Safety and Preventing Child Fatalities. SCCAN and SCFRT are participants in that work, sharing information about fatality review processes in Maryland and the current reviews of the MCANF Workgroup.

As most child abuse and neglect fatalities (CANF) & near fatalities (NF) in Maryland (and throughout the country) occur to children *under* 5 yrs of age, the Workgroup is focusing on reviewing all “unusual and unexpected” fatalities statewide of 0-4 year olds in CY2015 to determine: 1) whether or not the death was related to abuse and neglect; and, 2) what systems improvement recommendations could prevent future deaths. The state-level review will take approximately one year. MCANF has just completed reviewing all child fatalities in Baltimore City and has made the following preliminary observations:

- Child victims are primarily infants and toddlers.
- Many of the deaths are sleep-related
- Based on the records, the child and the child’s caregivers had significantly high ACE scores (involvement as a child in child welfare, juvenile justice, corrections and school dropout and failure) and were struggling with substance use, mental health disorders, and intimate partner violence.
- When the biological father or mother’s boyfriend was acting as the caregiver at the time of the death, it was noted that while the mother may have had prior parenting services, i.e., infant safe sleep, home visiting, etc., the fathers had not been offered nor received these services.
- Most of the children and families had not had prior CPS contact¹⁴, although the parents may have been involved in child welfare as children themselves.
- The majority of families had been in contact with multiple systems: Temporary Cash Assistance (TCA), Medical Assistance (MA), Health Care Access Maryland (HCAM), SNAP, WIC, substance abuse and mental health treatment, within the 12 months prior to the child’s death.
- Lack of safe child care options was identified as an issue in a number of cases.

¹⁴ Until October 1, 2016, Maryland law required all records of CPS “screened out” reports, as well as all records of investigations in which abuse and neglect was ruled out, to be expunged within 120 days.

COLLECTING ACE DATA in MARYLAND:

Adverse Childhood Experiences Study or “the largest most important public health study you never heard of”

The ACE Study examines the social, behavioral and health consequences of adverse childhood experiences throughout the lifespan. ACE Study participants (17,337) were members of Kaiser Permanente Medical Care Program in San Diego, California and reflected a cross-section of middle-class American adults. The study is an ongoing collaboration between Kaiser Permanente and the CDC that began with two-waves of participants beginning in 1995 and 1997. Participants were asked questions regarding ten adverse childhood experiences which included all forms of child maltreatment and five indicators of family dysfunction: substance abuse, parental separation/divorce, mental illness, domestic violence, and/or criminal behavior within the household.

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

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

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

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

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

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

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

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

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

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

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

Maryland ACE Questions:

The Maryland BRFSS ACEs module asked the following questions:

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

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

PREVALENCE OF ACEs IN MARYLAND ADULTS:

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

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

Limitations to the Data

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

KEY FINDINGS in MARYLAND:

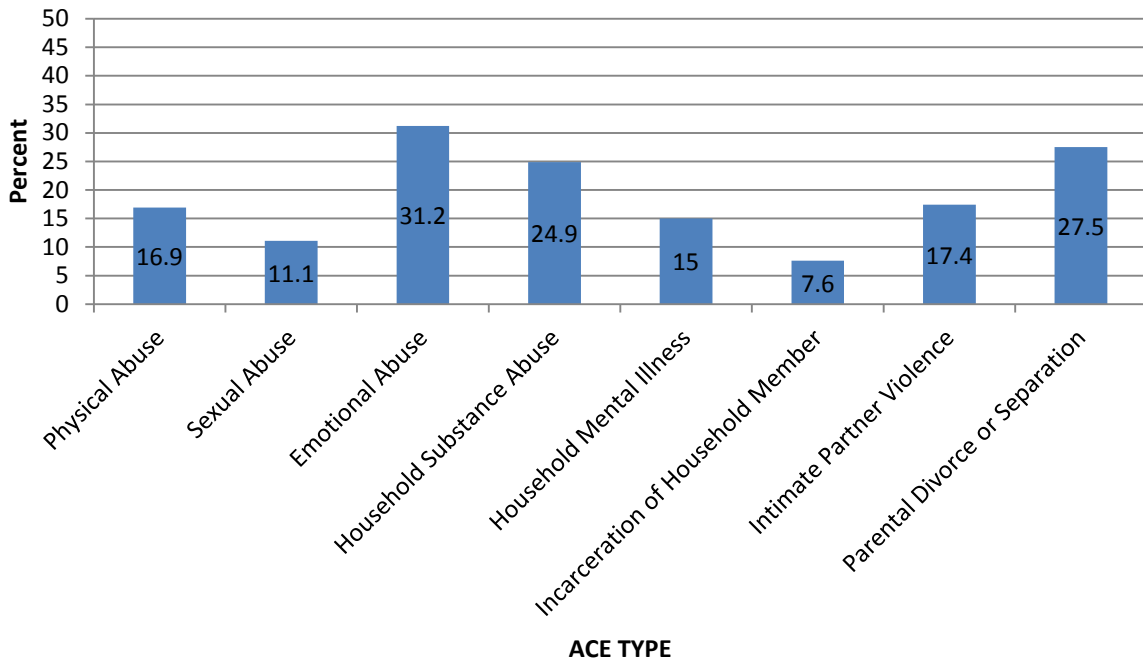
- **ACEs are COMMON:** Three fifths of BRFSS participants reported having at least one ACE. Approximately 24%, almost a quarter, reported three or more ACEs.

Prevalence by Type of ACE

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

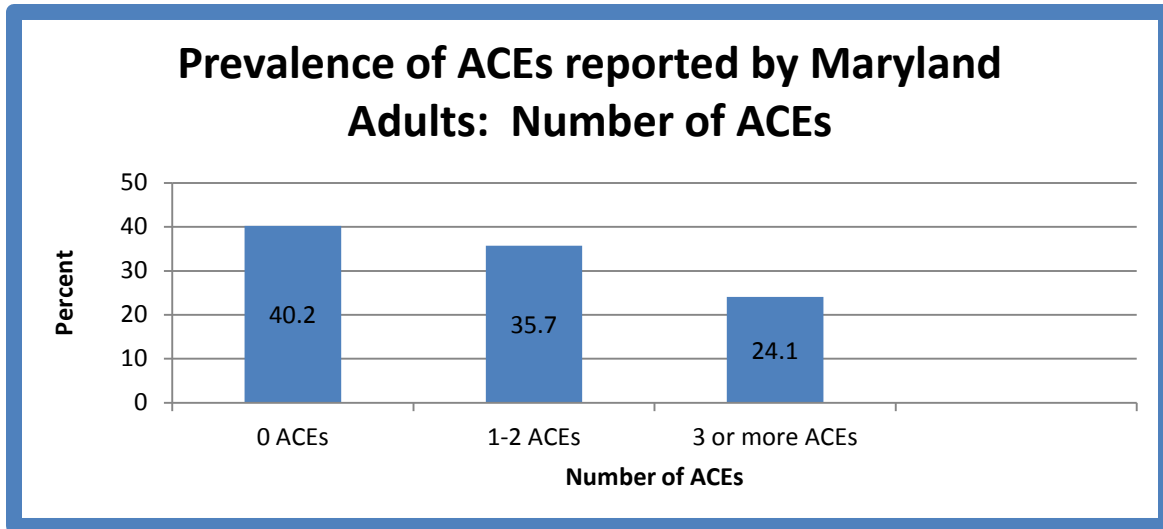
The percentage of respondents who reported experiencing each of these types of ACEs at least once are indicated in the table above. The types of ACEs with the highest prevalence include “parents who were separated or divorced” and “emotional abuse.” See Figure F below

Figure F: Prevalence by Type of ACE
Source: 2015 Maryland BRFSS

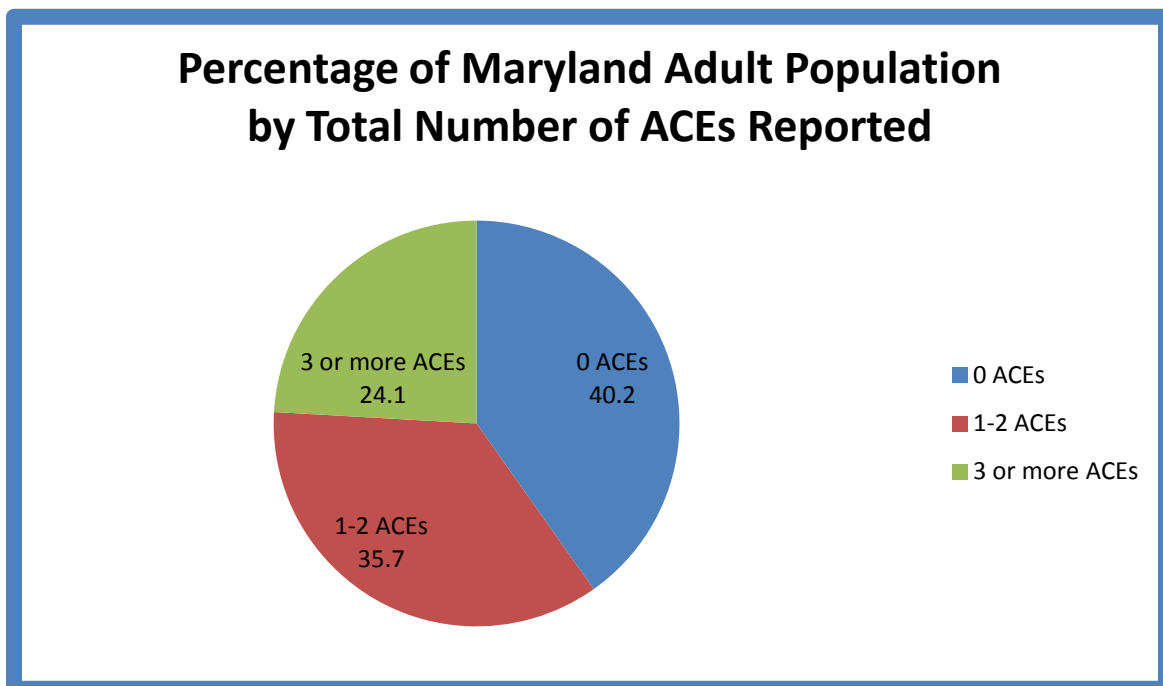


- **ACEs are RARELY FOUND IN ISOLATION/ ACEs TEND TO OCCUR IN CLUSTERS:** The cumulative impact of ACEs is captured in the “ACE Score” If an individual has experienced one ACE, they are likely to have multiple. An individual’s ACE score likely captures the neuro-developmental consequences of traumatic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

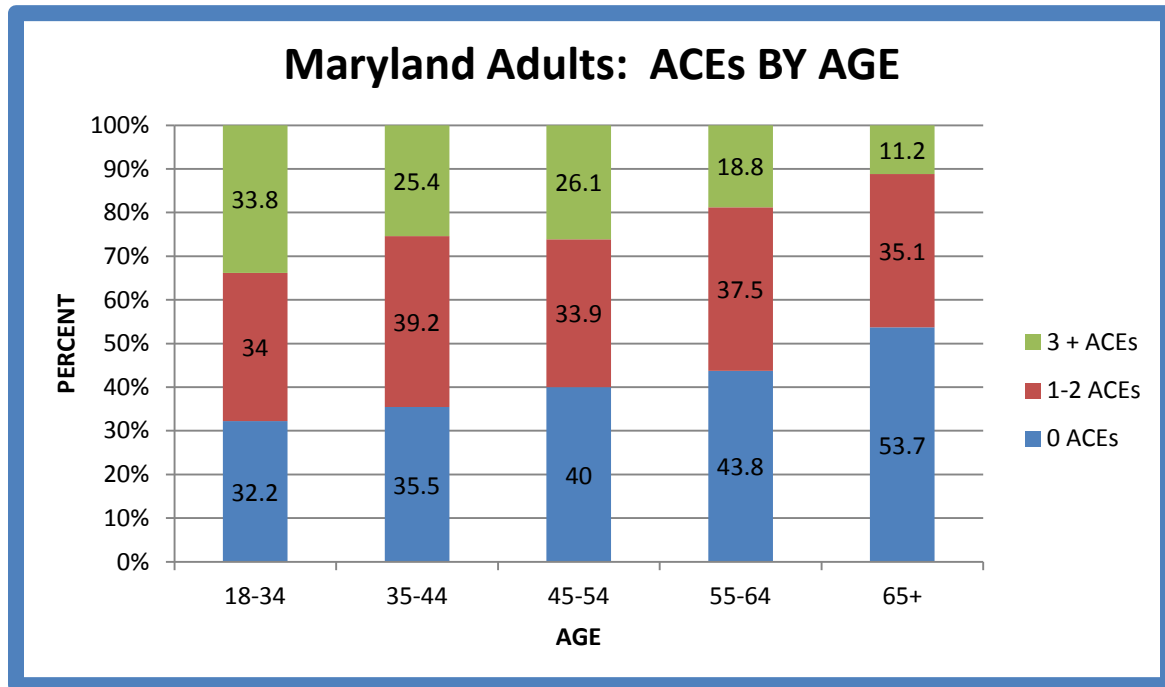
Prevalence by Number of ACEs



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



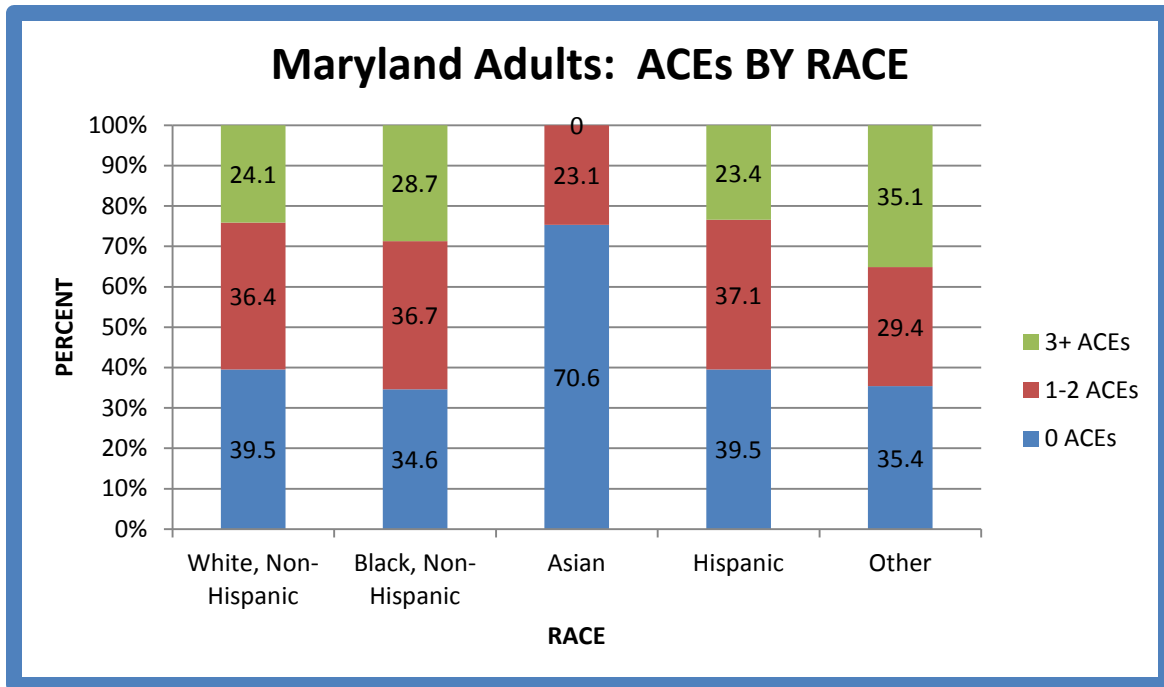
DEMOGRAPHICS:



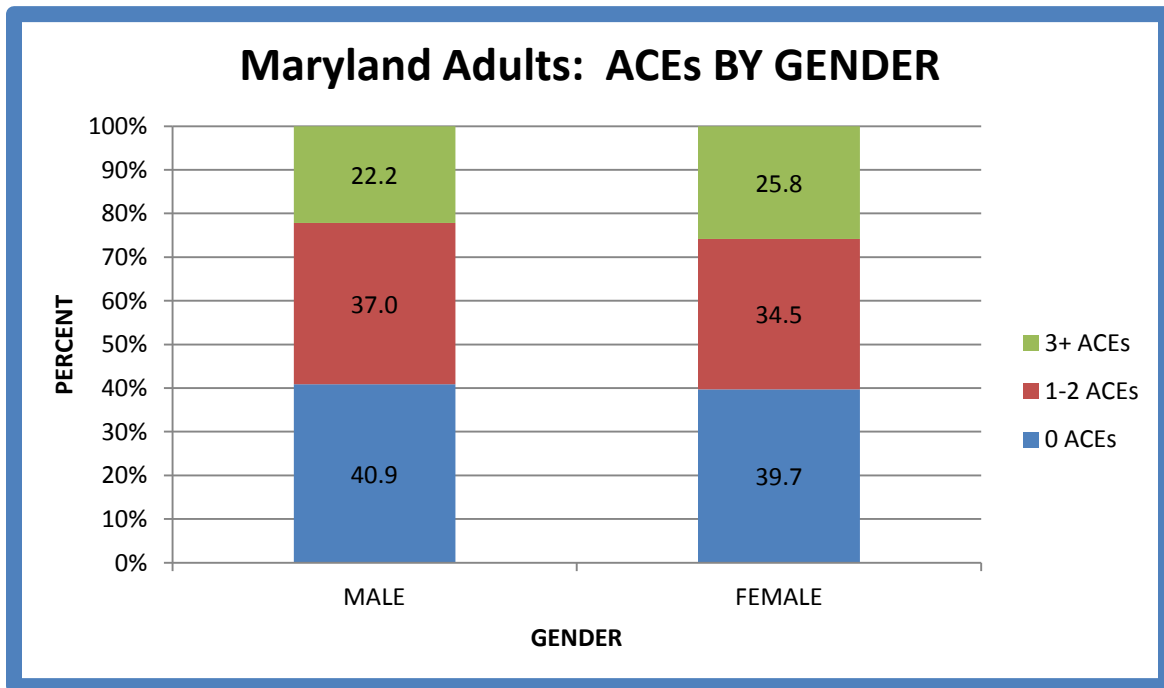
As age of the respondent increases so does the proportion of respondents who report zero ACEs (blue bars). This indicates that older respondents are reporting ACEs less frequently than younger respondents.

Implications

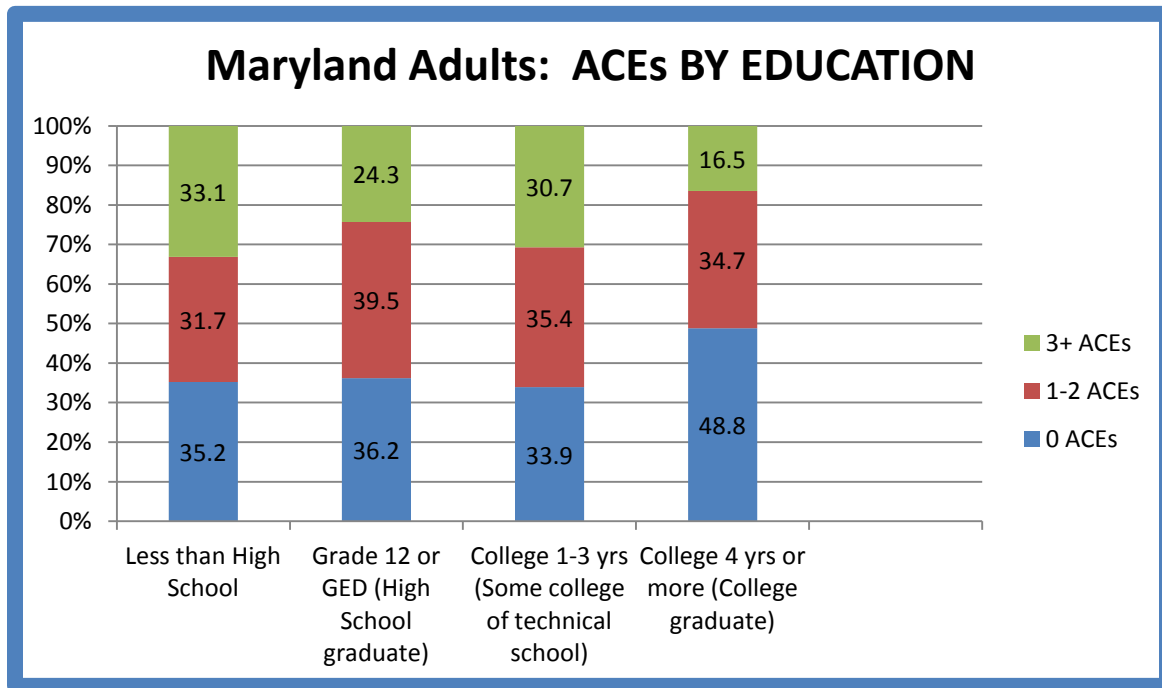
We can speculate that this could be a result of recall bias or more specifically, that as age increases our recollection decreases. Alternatively, we could hypothesize that younger generations are more aware of ACEs due to current discussions/information sharing about its importance to understanding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



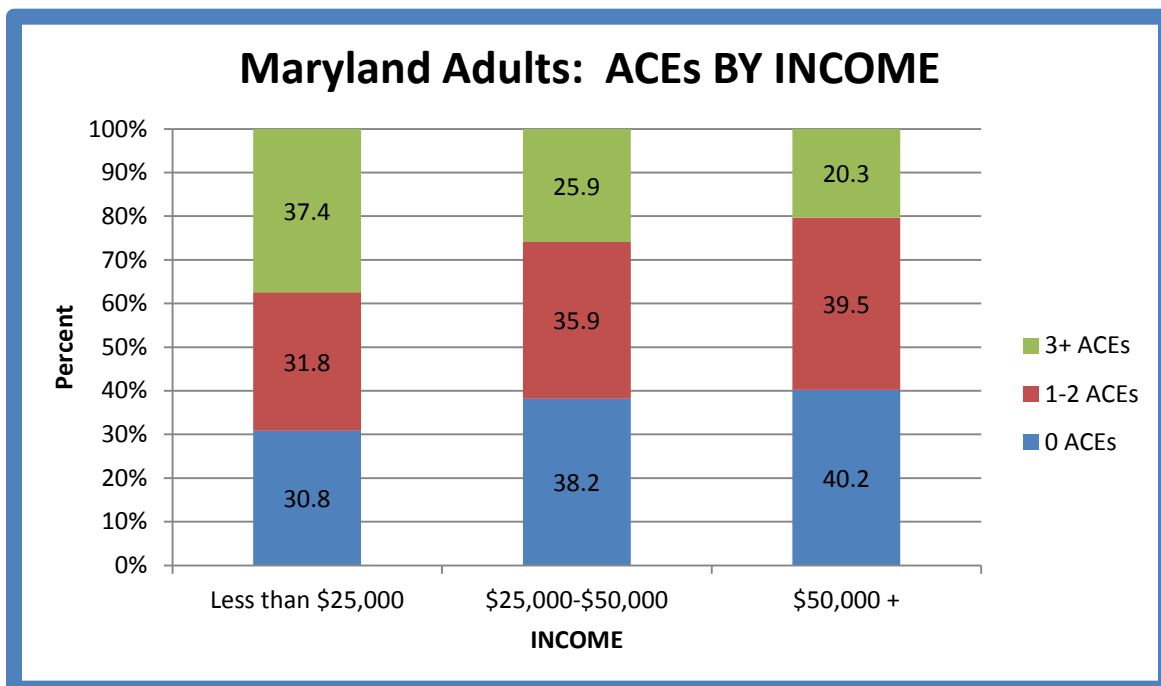
Of note, adults who identified themselves as “Asian” were more likely to report 0 ACEs, as compared to all other self-identified race categories. This difference was statistically significant.



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



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



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

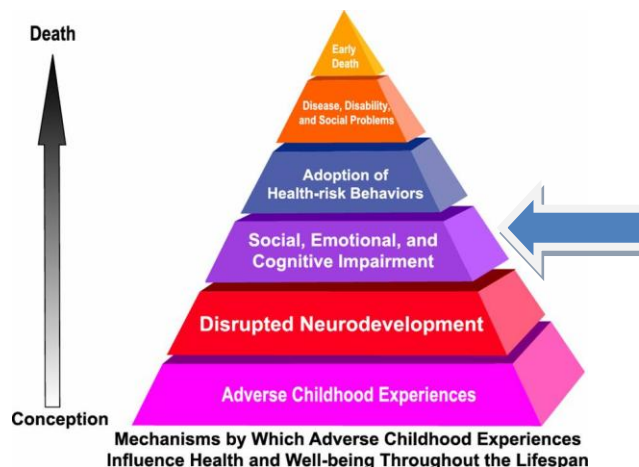
- ACEs are STRONG DETERMINANTS OF ADULT SOCIAL WELL-BEING & HEALTH:**
 ACE-related problems have a strong, graded relationship to numerous health, learning, social and behavioral problems *throughout a person's lifespan*. As the number of ACEs increase in the life of an individual, there is an increased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

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

PREVALENCE OF OUTCOMES:

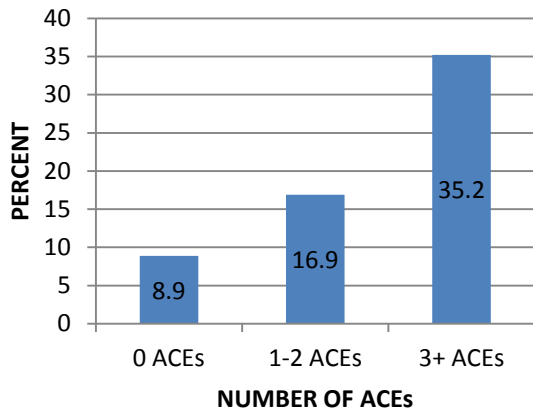
Social, Emotional, and Cognitive Impairment

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



DEPRESSION, BY NUMBER OF ACEs

Source: 2015 MD BRFS

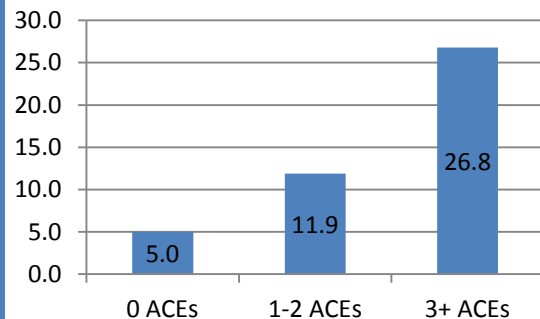


There is a strong dose response relationship¹⁵ when looking at depression and ACEs. As ACE exposure increases, so does the prevalence of depression. Adults who report 0 ACEs have the lowest prevalence of depression (8.9%), followed by those who experience 1 to 2 ACEs (16.9%), and finally 3 or more ACEs (35.2%). These differences are statistically significant.

There is a strong dose response relationship when looking at anxiety and ACEs. As ACE exposure increases, so does the prevalence of anxiety. Adults who report 0 ACEs have the lowest prevalence of anxiety (5.0%), followed by those who experience 1 to 2 ACEs (11.9%), and finally 3 or more ACEs (26.8%). These differences are statistically significant.

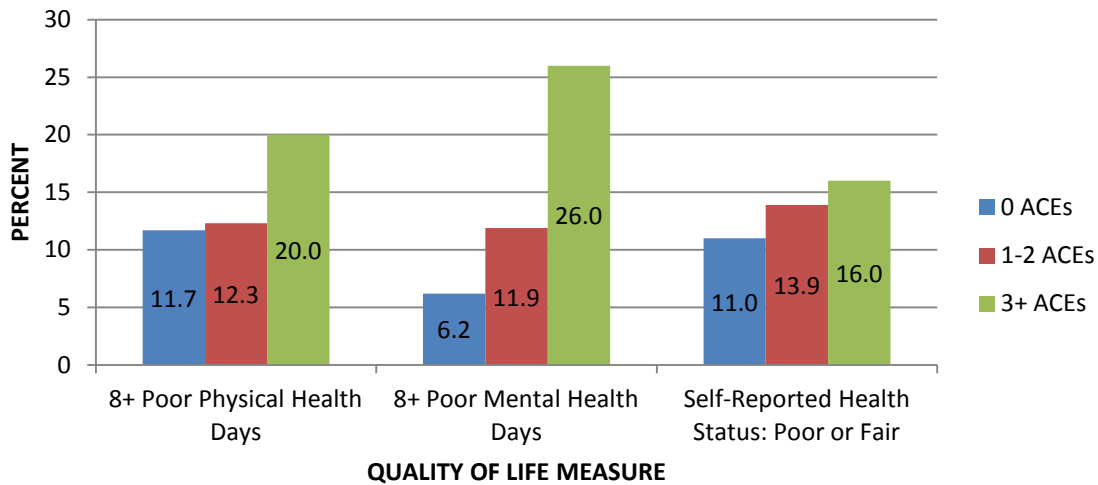
ANXIETY Ever told you have and anxiety disorder?

Source: MD BRFS 2015



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

3 QUALITY OF LIFE MEASURES, BY NUMBER OF ACEs

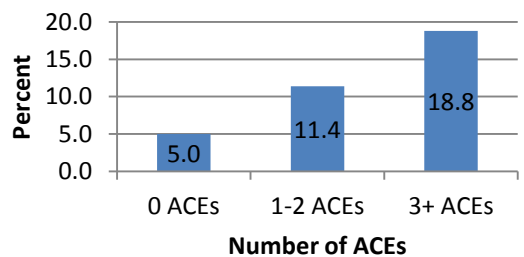


When we look at three quality of life measures, including poor physical health days, poor mental health days and self reported health status, there is a dose response relationship between these quality of life measures and ACE exposure. As ACE exposure increases, so does the percentage of adults who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

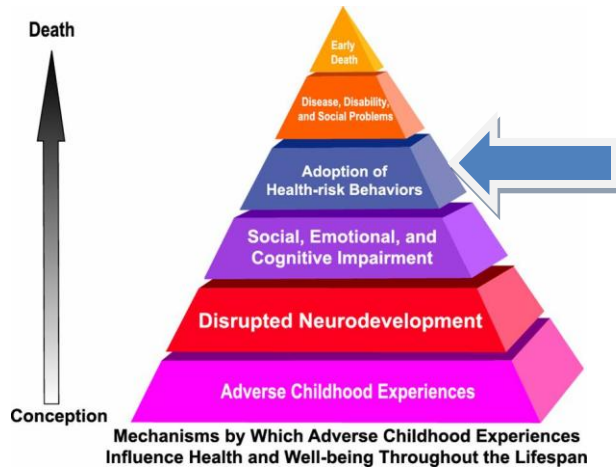
There is a strong dose response relationship when looking at ACEs and cognitive decline. There is a statistically significant difference in the prevalence of cognitive decline, between those who report 0 ACEs and those who report 3 or more ACEs. There is also a statistically significant difference between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

COGNITIVE DECLINE

Confusion or Memory Loss*,
by Number of ACEs



Adoption of Health-Risk Behaviors

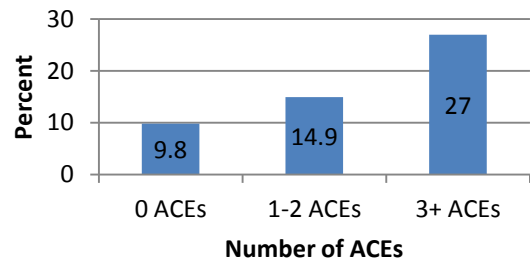


The next tier up on the ACEs Pyramid is the adoption of health-risk behaviors. As the number of ACEs goes up, there is a correlation to the adoption of unhealthy behaviors, including smoking, binge drinking and even lack of seat belt use.

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

CURRENT SMOKING

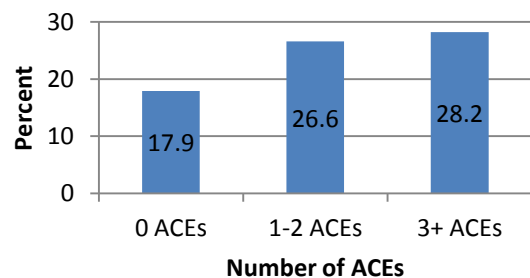
Number of Maryland Adults who are Current Smokers, by Number of ACEs



There appears to be a dose response relationship between prevalence of binge drinking and number of ACEs; however, these differences are not statistically significant.

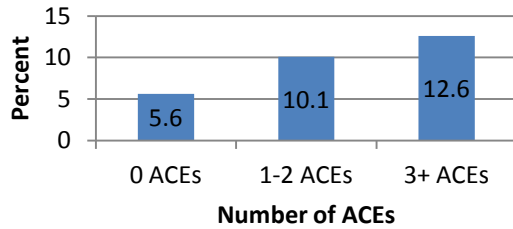
BINGE DRINKING

Number of Adults who binge drink, by number of ACEs



SEAT BELT USE

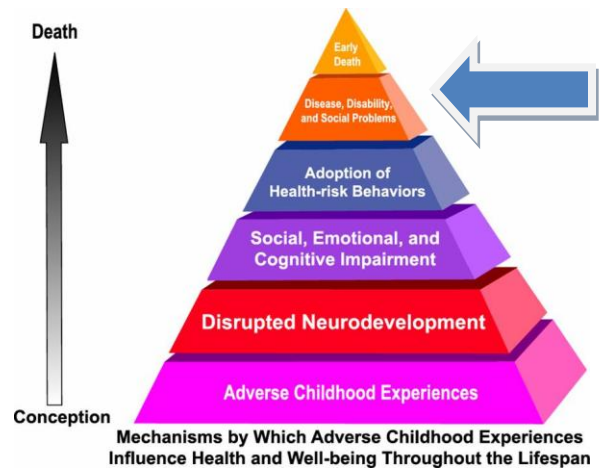
Percent of Maryland Adults who do not always use their seat belt while driving or riding in a vehicle, by Number of ACEs

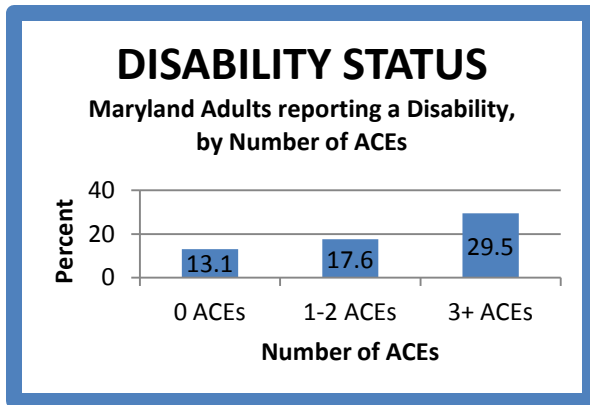


Again, there appears to be a dose response relationship between the number of ACEs and lack of seatbelt use. However, these differences are not statistically significant.

Disease, Disability, and Social Problems

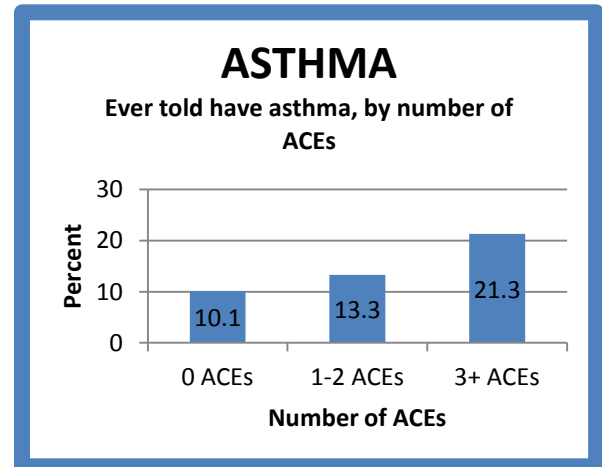
The next tier on the ACEs Pyramid represents the impact of adverse childhood experiences on disease, disability and social problems of a population.





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

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



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

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

Conclusions:

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

Overview of Maryland Essentials for Childhood Initiative Framework

As a response to the emerging science of the developing brain, the impact of adverse childhood experiences on the healthy brain development, and a need to connect and strengthen prevention and promotion efforts statewide, SCCAN and its partners joined together to participate in the CDC's Essentials for Childhood Framework State Level Implementation. The CDC's Division of Violence Prevention is funding five state health departments in California, Colorado, Massachusetts, North Carolina, and Washington to implement the four strategies in the *Essentials for Childhood* Framework using a collective impact process. CDC also offers technical assistance and training to many other states that do not receive CDC funding but are engaged at varying levels in implementing the *Essentials for Childhood* Framework.

SCCAN facilitated Maryland's participation in the CDC's technical assistance and joined with its partners in forming *Maryland Essentials for Childhood* (EFC); a statewide collaborative 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, learns from national experts and leading states taking part in technical assistance provided by the CDC. Currently, SCCAN, The Family Tree (Prevent Child Abuse, Maryland Chapter), the Maryland Family Network (Maryland's Community Based Child Abuse Prevention (CBCAP) grantee), and DHMH's Bureau of Maternal & Child Health and Prevention & Health Promotion Administration, Bureau of Environmental Health are providing backbone support through in-kind services. Using advances in brain science, ACEs and resilience and principles of collective impact, the *Maryland EFC* leadership and working groups are advancing the following [key goals](#):

- Educate key state leaders, stakeholders and grassroots on brain science, Adverse Childhood Experiences (ACEs), and resilience
- Improve data sharing and common measures across child and family serving systems to inform decision-making
- Advocate for the transformation of child and family serving systems and services to prevent and mitigate the impact of ACEs, including building trauma-informed systems
- Align systems to ensure services are provided using a multi-generation, family-centered approach i.e., identify customers as parents and serve the needs of both parent and child, including the needs of the child/youth as a future parent
- Support community ownership, impact and action
- Spark innovation in programs, policies and financing solutions

Maryland EFC Framework

Maryland Essentials for Childhood Initiative uses four strategic goals statewide to create the safe, stable, and nurturing relationships and environments that support the healthy development of all of Maryland's children.

Maryland EFC Strategic Goals:

- I. **Raise Awareness of the science of the developing brain, ACEs and Resilience, including its impact and implications; and, Raise Commitment to act to create safe, stable, nurturing relationships and environments for all Maryland children**
 - A. Funded through the generous support of the Board of The Family Tree, *Maryland EFC* will bring [ACES Interface Master Trainer Education](#) & Learning Collaborative Fall 2017 to Maryland to train a cohort of 25 master trainers with representatives from each region and multiple professions and sectors (business, judicial, faith-based, mental health, pediatrics, public health, child care, community leaders, etc). Trainers commit to educate their local communities and professional colleagues in brain science, ACEs, and resilience. The cohort will meet quarterly to share lessons learned, improve skills and assess the progress of dissemination efforts.
 - B. Facilitated screenings of the newly released documentary [Resilience: The Biology of Stress & The Science of Hope](#) across the state.
 - C. Began developing relationships with and connecting with local communities in their efforts to raise awareness about ACEs:
 - i. Frederick County, Local Health Improvement Plan Committee
 - ii. Thriving Communities Collaborative (TCC), Baltimore City:
 1. SCCAN is member of TCC Steering Committee
 - iii. Harford County ACEs Initiative
 1. Lead is SCCAN member
 2. Participated in *Resilience* screening, April 2017 and follow up planning discussions, May 2017
 - D. Presentations on MD EFC:
 - i. Maryland Children's Alliance Conference, November 2016
 - ii. Maryland Early Childhood Mental Health Steering Committee, April 2017
 - iii. Partnership for a Safer Maryland Webinar, May 2017
 - E. **Developed Maryland Essentials for Childhood Resource List** to share with EFC Collective Impact Team and local communities disseminating Brain-ACEs Science.

II. Identify and use Data to inform actions and recommendations for systems improvement.

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

- A. Successfully organized cross-sector partners to advocate for the inclusion of the ACE module in Maryland's Behavioral Risk Factor Survey. Maryland specific ACE data was collected in 2015, as a baseline indicator of ACE prevalence in Maryland. It is currently being analyzed by DHMH. Other states have been collecting ACE data every 2-5 years. **Proposed policy:** ACE data should be collected again in Maryland in 2018, and every three years thereafter.
- B. DHMH (BRFSS and Injury Prevention) has agreed to develop county specific and/or regional fact sheets to be used by local community ACE initiatives and in conjunction with ACE Interface trainings. Frederick County ACEs Initiative recently shared their Frederick specific data through an article in the [Frederick News Post](#).
- C. DHMH's Maternal and Child Health Bureau has agreed to lead efforts to compile a list of "Common indicators by Sector and Life Course" across Maryland systems of health, mental health and substance abuse, child development, education, social services, child welfare, juvenile justice, public safety & criminal justice, neighborhoods and communities, workforce development, economic/business, and social determinants; based on California's EFC Matrix of Data Indicators.
- D. Participation in CDC EFC Evaluator technical assistance calls to learn from funded states.

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

- A. Recruited Co-Chairs to lead the Systems, Services & Programs Integration Workgroup from Maryland Project LAUNCH to integrate and sustain those efforts as that federal grant ends.
- B. Co-founded the Infant Mental Health Association of Maryland and D.C. together with EFC Collective Impact Team Members, in order to promote the importance of infant mental health.
- C. Promoted Implementation of evidence-based and promising programs for parents and caregivers:
 - **Evidence-based Home Visiting:** Support evidence-based home visiting programs. Participate in the Maryland Home Visiting Alliance.
 - **Circle of Security-Parenting:**
 - Support training and statewide implementation of Circle of Security-Parenting (COS-P)
 - Support research of COS-P DVD model in Baltimore City
 - Obtained approval from COS-P developers to train SCCAN Prevention Co-Chair to provide overviews of COS-P to interested public and private agencies within Maryland.
 - Advocated for research & trainings in COS-P
 - **Enough Abuse Campaign (EAC) to Prevent Child Sexual Abuse:**

- Integrated and highlighted MPPCSA and EAC efforts within Maryland’s broader EFC Collective Impact efforts.
 - Equipping Maryland adults with valuable skills and resources to prevent CSA before it occurs:
 - Of nine hundred and thirty two (932) adults trained, about 60 completed post assessments revealing that participants improved their knowledge, attitudes and behavior – scoring on average 4.6 on a 5 pt scale.
 - Continue to disseminate [Straight Talk About Child Sexual Abuse](#), a prevention guide for parents, which was widely received in our communities.
 - Advocate for comprehensive CSA prevention policies (See below under IV. Public Policy)
- D. Participate in meetings, activities and/or grant applications of: Resilience Wellness & Prevention Committee; Children’s Mental Wellness Campaign; Project LAUNCH State Young Child Wellness Council; Early Childhood Mental Health Steering Committee; Early Childhood Comprehensive Systems; Infant Mental Health Association of Maryland & D.C., Maryland Caregivers’ Council; Children’s Justice Act Committee (CJAC); and, the Social Services Advisory Committee.

IV. Integrate the Science Into Policy and Financing Solutions

- A. Created ***Public and Private Sector Policy & Financing Solutions Workgroup*** to lead, identify, assess, and advocate for key policies to promote safe, stable, and nurturing relationships and environments for children and to prevent child maltreatment and other ACEs
- B. Reviewed *Exploring policies for the reduction of child physical abuse and neglect*, Joanne Klevens, Sarah Beth L. Barnetta, Curtis Florencea, and DeWayne Moore, Centers for Disease Control and Prevention, Division of Violence Prevention, Atlanta, GA, USA¹⁶
- C. Developed and advocated for the implementation of the following key policies to promote safe, stable, and nurturing relationships and environments for children and prevent child maltreatment and other ACEs:

1. Policies that Prioritize Meeting the Health Needs of Children involved in the Child Welfare System¹⁷:

There can be enormous long-term health consequences from child maltreatment. Long-term physical health consequences include an increased risk for cardiovascular disease, high blood pressure, asthma, obesity, diabetes, lung disease, and liver disease¹⁸. Long-term mental health is also affected, with increased risk for depression, anxiety, and substance abuse. For the U.S. as a

¹⁶ Klevens, J., Barnett, S. B., Florence, C., & Moore, D. (2015). Exploring policies to reduce child physical abuse and neglect. *Child Abuse & Neglect*, 40, 1-11.

¹⁷ See SCCAN Annual Report 2012-2015 for detailed analysis.

¹⁸ Child Welfare Information Gateway (2013). Long-term consequences of child abuse and neglect. Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau. Online at: www.childwelfare.gov/pubs/factsheets/long_term_consequences.cfm

whole, health care costs are estimated at \$552 billion during childhood and an additional \$223 billion during adulthood¹⁹. Women with a history of maltreatment have higher annual physical and mental health care costs than those without maltreatment (36% higher for those women with both physical and sexual abuse; 22% higher for women with physical abuse only; 16% higher for women with sexual abuse only)²⁰. Early attention to physical and mental health needs of children who have been abused and/or neglected has the potential to ameliorate some of these long-term effects.

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

Failure to provide appropriate forensic medical assessments jeopardizes the health and well-being of some of our most vulnerable citizens. For children being investigated by CPS for suspected maltreatment, a failure to diagnose existing maltreatment allows maltreatment to continue, and increases the short and long-term costs for physical and mental health care, education, and juvenile justice. In addition, the misdiagnosis of accidental injuries as abusive can have unwarranted and profound repercussions for children who may be faced with removal from their homes or loss of caregiver emotional and financial support.

The provision of expert medical evaluations for suspected maltreatment is also a social justice issue. Multiple studies have found that poor and minority children are more likely to have accidental injuries misidentified as abuse, while non-poor and white children are more likely to have abusive injuries misidentified as accidental. This problem may be exacerbated when either health care professionals without child maltreatment expertise or child welfare workers without health care expertise are determining whether a child has been abused or neglected.

¹⁹ Suffer the Little Children: An Assessment of the Economic Cost of Child Maltreatment (November 2014). Waco, TX: The Perryman Group. Online at: file:///H:/Child%20Maltreatment%20Literature/Costs%20of%20child%20abuse%20articles/Perryman_Child_Maltreatment_Report%202014.pdf

²⁰ Suffer the Little Children: An Assessment of the Economic Cost of Child Maltreatment (November 2014). Waco, TX: The Perryman Group. Online at: file:///H:/Child%20Maltreatment%20Literature/Costs%20of%20child%20abuse%20articles/Perryman_Child_Maltreatment_Report%202014.pdf

Council members urge the Governor to allocate funding and Members of the General Assembly to legislate reforms to ensure that children involved in the child welfare system get appropriate health care coordination to improve their overall health outcomes. The MATCH (Making All the Children Healthy) program instituted in Baltimore City, at least in part due to the L.J. vs. Massinga Consent Decree, has significantly improved health care coordination for children in the care of the Baltimore City Department of Social Services. Children in other jurisdictions around the state who are involved in local DSS deserve similar efforts to ensure good health care and coordination.

SCCAN's Annual Reports 2013-2015 laid out the argument for the need for reform of health care provision to children involved in child welfare. While the recommendations to date have gone unaddressed, the Council continues to advocate for a centralized system to provide expert forensic and health care coordination to children involved in child welfare , to include:

- a physician medical director at DHR to bring needed expertise to both the investigation of child abuse and neglect reports and health care service provision to children receiving child welfare services
- Oversight and policy development via an Interagency Child Welfare Health Coordination Expert Panel
- A system for tracking and improving health outcomes for children in the child welfare system; including fatalities and near fatalities due to child maltreatment.

2. *Comprehensive Child Sexual Abuse Policies:*

The target of prevention is adult-focused knowledge and responsibility for prevention of child sexual abuse.

- a. Developed Comprehensive Sexual Abuse Prevention Legislation for Maryland after reviewing policy research by Prevent Child Abuse America and the Enough Abuse Campaign and in consultation with The Moore Center for the Prevention of Child Sexual Abuse at Johns Hopkins Bloomberg School of Public Health
- b. Developed Comprehensive Child Sexual Abuse Prevention Legislation and organizational policies²¹ recommendation to General Assembly, MSDE, DHR, and DJS.
- c. Advocated for Comprehensive Child Sexual Abuse Prevention Legislation in meetings with:
 - i. Delegate Eric Luedtke
 - ii. Christopher B. Shank, Deputy Chief of Staff, Maryland Office of the Governor
 - iii. Arlene Lee, Governor's Office for Children
 - iv. Governor's Office for Crime Control and Prevention

²¹ See Comprehensive Child Sexual Abuse Prevention Legislation under SCCAN Recommendations by Agent/Agency on pp. 54-57.

- v. Dr. Karen Salmon, Superintendent of Schools
 - vi. Elizabeth Ysla Leight, President, Maryland PTA
 - vii. Dr. Lawson, Deputy State Superintendent for School Effectiveness
- d. EFC, MPPCSA partners were asked to provide education and input into policy reform in Prince George’s County Public Schools after the sexual abuse of eighteen students by a teacher’s aide in 2016.
 - e. Developed and led the *Maryland Partnership to Prevent Child Sexual Abuse’s* Enough Abuse Campaign in cooperation with Prevent Child Abuse America (PCA).
 - f. Trained key agencies and communities in Worcester and Talbot Counties and Baltimore City.
 - g. Developed policy and training recommendations for Youth Serving Organizations to institute to prevent of child sexual abuse *before it occurs* in conjunction with Prevent Child Abuse America and the Moore Center for the Prevention of Child Sexual Abuse at Johns Hopkins Bloomberg School of Public Health.

3. Policies to Prevent Child Abuse and Neglect Fatalities:

- a. Reviewed the National Commission of Child Abuse & Neglect Fatalities (CECANF) report [Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities](#) and [fact sheet](#) with its findings and recommendations in April 2016.
- b. SCCAN and SCFRT members agreed to form a joint workgroup (Maryland Child Abuse & Neglect Fatalities (MCANF) Workgroup) to review child fatalities related to child maltreatment. Members of CRBC later joined the workgroup.
- c. As most child abuse and neglect fatalities (CANF) & near fatalities (NF) in Maryland (and throughout the country) occur to children *under 5 yrs* of age, the Workgroup is focusing on reviewing all “unusual and unexpected” fatalities statewide of 0-4 year olds in CY2015 to determine: 1) whether or not the death was related to abuse and neglect; and, 2) what systems improvement recommendations could prevent future deaths. The state-level review will take approximately one year. MCANF has just completed reviewing all child fatalities in Baltimore City and has made the following preliminary observations:
 - Child victims are primarily infants and toddlers. **Proposed policy:** Screen in all children under 5 as “Risk of Harm” cases and do an in-home assessment of risk.
 - Many of the deaths are sleep-related
 - Based on the records, the child and the child’s caregivers had significantly high ACE scores (involvement as a child in child welfare, juvenile justice, corrections and school dropout and failure) and were struggling with substance

use, mental health disorders, intimate partner violence.

Proposed policy: Integrate ACE and resilience screenings in primary care and link parents/caregivers with high ACEs to supportive services pre and post natally. Expand Safe Haven and Birth Match laws.

- When the biological father or mother’s boyfriend was acting as the caregiver at the time of the death, it was noted that while the mother may have had prior parenting services, i.e., infant safe sleep, home visiting, etc., the fathers had not been offered these services. Science: Recent science emphasizes the need and importance of a new view of fatherhood.²² Based on this science it is critical for the healthy development of our children that we reexamine the way our current child and family serving systems engage, respond to, and encourage participation by fathers.

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

- Most of the children and families had not had prior CPS contact²³, although the parents may have been involved in child welfare as children themselves.
- The majority of families had been in contact with multiple systems: Temporary Cash Assistance (TCA), Medical Assistance (MA), Health Care Access Maryland (HCAN), SNAP, WIC, substance abuse and mental health treatment, within the 12 months prior to the child’s death.
- Lack of safe child care options was identified as an issue in a number of cases.

4. Policies that Support Family Economic Stability

- a. Family-friendly work policies²⁴- There are four key ways for businesses to support early childhood development:
 - Increasing access to quality child care
 - i. Supporting affordable child care
 - ii. Developing child-friendly policies and procedures

²² [Fathers’ Roles in the Care and Development of Their Children: The Role of Pediatricians](#) Michael Yogman, MD, Craig F. Garfield, MD, the COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD, FAMILY HEALTH, American Academy of Pediatrics; and, [Depression among Urban Fathers with Young Children: A Research Report with Tips for Responsible Fatherhood Programs and Stakeholders](#), US Department of Health & Human Services, Administration for Children & Families, Office of Family Assistance; and, [The Father Absence Crisis in America](#)

²³ Until October 1, 2016, Maryland law required all records of CPS “screened out” reports, as well as all records of investigations in which abuse and neglect was ruled out, to be expunged within 120 days.

²⁴ [EPIC \(Executives Partnering to Invest in Kids\) Family-Friendly Workplace Assessment & Toolkit](#)

- iii. Optimizing tax benefits
- b. Earned Sick and Safe Leave
- c. Paid Family Leave

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

- a. Adequate child care subsidies with no waiting list for access are known to decrease rates of child abuse and neglect²⁵

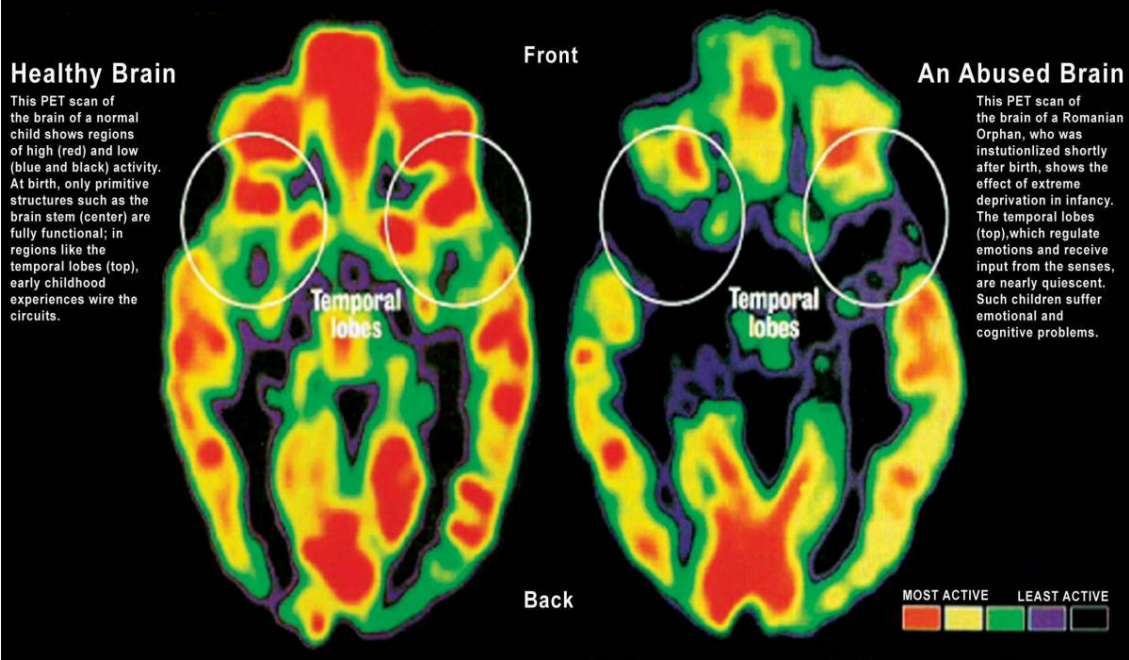
6. *Policies that Promote Social Norms Change*

- a. Public engagement and education campaigns regarding brain science, ACEs, and resilience
- b. Legislative approaches to reduce corporal punishment
- c. Public engagement campaigns that share the message “Everyone plays a role in the healthy development of children”; including, encouraging community members offering a hand to parents; improved referral and linkage to services; and, child welfare reporting systems reform, including a statewide reporting hotline.

²⁵ Klevens, J., Barnett, S. B., Florence, C., & Moore, D. (2015). Exploring policies to reduce child physical abuse and neglect. *Child Abuse & Neglect*, 40, 1-11.

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

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

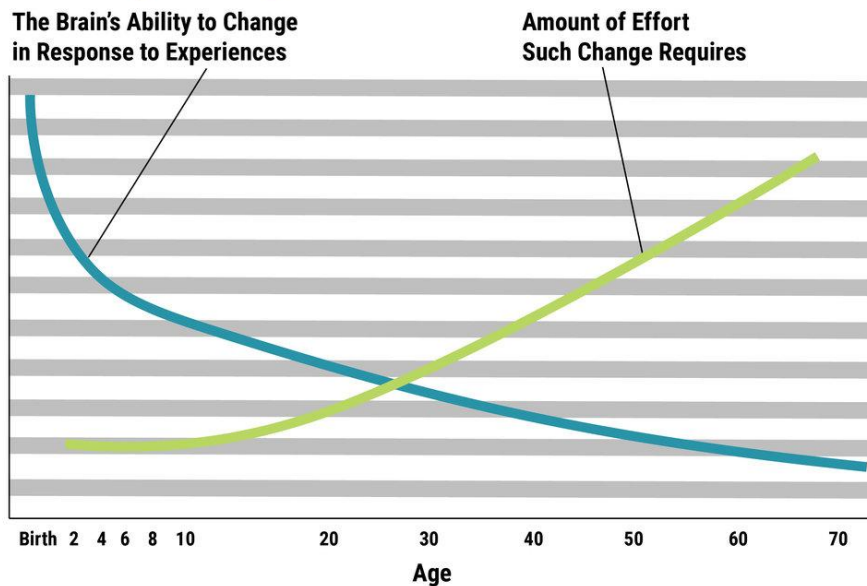


While Governor Hogan’s four strategic goals identified in Maryland Children’s Cabinet Three-Year Plan (Reduce the Impact of Incarceration on Children, Families, and Communities; Improve Outcomes for Disconnected/Opportunity Youth; Reduce Childhood Hunger; and, Reduce Youth Homelessness) are important to youth well-being, they are not sufficient to realize the Governor’s goal of greater economic stability and human capital formation to long-term self-sufficiency for children, youth, and families. Each of Governor Hogan’s goals would be strengthened by purposeful dissemination and an understanding of the implications of the science of the developing brain, ACEs, and resilience. The Action Items laid out in the Three Year Plan should each be grounded in this science. Policy makers should ensure that state agency policies, strategies, and technical assistance focuses on strengthening caregiver, family and community capacity to create safe, stable and nurturing relationships and environments that most importantly promote healthy child and youth development; and, in turn, prevent a multitude of negative outcomes from substance abuse, mental illness, high school dropout, delinquency, youth suicide, bullying, youth homelessness, intimate partner violence, youth unemployment and child maltreatment. A vision based in the science of the developing brain, ACEs and resilience has helped communities around the country (especially in states where there has been

coordinated efforts to disseminate the science) to coordinate their efforts at both the state and local level to move the dial on important measures such as significantly reducing high school suspension rates and increasing graduation rates.²⁶ The following core concepts should be infused into the Children’s Cabinet Action Plan:

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

The Ability to Change Brains and Behavior Decreases Over Time



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

²⁶ See, [Paper Tigers](#) documentary.

**ANNUAL ECONOMIC COSTS OF CHILD
MALTREATMENT IN MARYLAND**

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

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

Our failure to prevent children’s maltreatment (CM) *before it occurs* is conservatively estimated to cost Maryland’s economy, businesses and taxpayers over \$1.5 billion each year. Investing in child well-being and preventing CM is not only *humane and just*, but *makes good economic sense*.²⁷

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

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

²⁷ [Why Early Investment Matters?](#), The Heckman Equation, James J. Heckman, PhD

early adversity may impact health and life opportunities that reverberate across generations.²⁸

Another Minnesota study in 2016, found that of all students surveyed, four percent had experienced four or more adverse childhood experiences. In comparison, 16 percent of homeless children surveyed had experienced four or more adverse childhood experiences.²⁹ Waiting to address symptomatic behaviors (such as, youth disconnection, homelessness, school failure, substance abuse, etc.) and illness (depression, anxiety, suicide, etc.) until children enter school, their teen years or adulthood, requires expending more resources and producing less satisfactory results for both the individuals and the communities in which they live.³⁰

²⁸ Adverse Childhood Experiences and Life Opportunities: Shifting the Narrative, *Children & Youth Services Journal*, Marilyn Metzler, RN, MPH; Melissa T. Merrick, PhD; Joanne Klevens, MD, PhD, MPH; Katie A. Ports, PhD; Derek C. Ford, PhD.

²⁹ [2016 Minnesota Survey of 8th, 9th, and 11th graders regarding ACEs.](#)

³⁰ Research has shown adverse childhood experiences to have multiple negative impacts throughout an individual's life. More ACEs reduce the likelihood of high school graduation and holding a skilled job (Giovannelli et al, 2016). More ACEs also increase the likelihood of teen pregnancy and fetal death in pregnancy (Hillis et al, 2004); behavioral problems (Greeson et al, 2014); juvenile arrest, and felony charges (Giovannelli et al, 2016). Moreover, ACEs can negatively impact a wide range of health and social factors including an increased risk of homelessness (Herman et al, 1997), illicit drug use (Dube et al, 2003), and depression (Giovannelli et al, 2016; Anda et al, 2005).

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

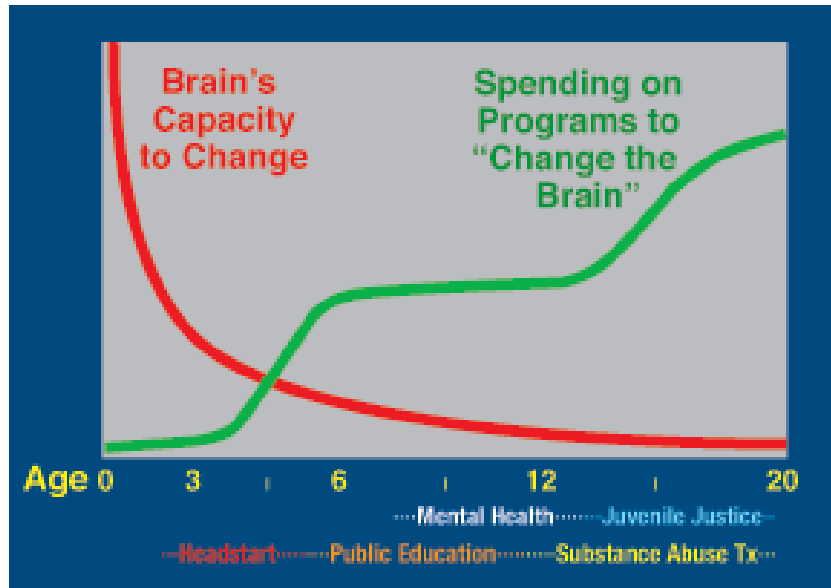
Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, and Anda RF. 2003. "Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study." *Pediatrics* 111 (3): 564–572 9p.

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

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

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

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



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

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

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

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

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



31

Adverse childhood experiences, including persistent poverty, can directly derail brain development and the executive function skills (impulse control, working memory, and mental flexibility) most needed for become economically self-sufficient. Science is increasing our understanding of the challenges caused by ACEs, and with that understanding comes the ability to improve policy and program design. The sections of the brain impacted by ACEs remain plastic well into adulthood. “To attain economic independence, low-income families today must navigate a complex environment requiring strong strategic thinking skills to set a career destination and optimize their lives in the five key areas Crittenton Women’s Union has identified as pillars of its Bridge to Self-Sufficiency® (Bridge) theory of change: family stability (principally housing and child stability); wellbeing (principally health/behavioral health and social supports); education; financial management; and career management.”³² Through effective coaching, executive function skills may be strengthened and improved leading to improved outcomes in relationships (people skills), parenting, money management, educational attainment and career success.³³ Coaching parents who have been impacted by ACEs, in turn helps ensure the development of those skills in their children and subsequent generations.

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

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

³¹ “Using Brain Science to Design New Pathways Out of Poverty”, Elisabeth D. Babcock, MCRP, PhD, Crittenton Women’s Union 2014.

³² Ibid. p.4.

³³ Ibid.

challenges can significantly improve staff interactions with clients and the quality of program delivery. Staff who formerly might have attributed willful intent to participants' seemingly counterintuitive decision making or behaviors, instead will realize that such thinking or behaviors is quite logical given the participants' history and experience. This realization alters staff behavior, increases tolerance, and generates more useful ideas and interventions that improve outcomes."³⁴ As level II of the Governor's G.O.L.D. Standard Customer Service Training initiative, all staff, beginning with executive staff and supervisors should be trained by ACEs Interface Master Trainers.

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

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

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

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

He says: The solution to changing the illegal or unhealthy ritualized compulsive comfort-seeking behavior of opioid addiction is to address a person's adverse childhood experiences (ACEs) individually and in group therapy; treat people with respect; provide medication assistance in the form of buprenorphine, an opioid used to treat opioid addiction; and help them find a ritualized compulsive comfort-seeking behavior that won't kill them or put them in jail."³⁵

Since learning of ACEs, Dr. Sumrock screens all his patients for ACEs, goes over each question with them and they get ACEs education and group therapy to help them understand their lives and addictions better. He sees improvement in outcomes for his patients, but knows he needs data to prove it.

³⁴ Ibid. p. 14.

³⁵ ["Substance-abuse doc says: Stop chasing the drug! Focus on ACEs"](#), Jane Stevens, ACEs Connection 2017.

SCCAN Recommendations by Agent/Agency:

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

Gemma Hoskins, “The Keepers”

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

GOVERNOR

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

1. Take meaningful action to raise awareness of brain science, adverse childhood experiences (ACEs) and resilience and build community commitment to prevent, reduce and respond to ACEs by launching an ACEs Initiative similar to Governor Bill Haslam and First Lady Chrissy Haslam’s Launch [Building Strong Brains Tennessee’s ACEs Initiative](#).³⁶
2. Issue an executive order mandating child and family serving agencies participate in collective impact efforts to promote safe, stable & nurturing relationships and environments for children, build strong brains, prevent ACEs, and promote resilience. Building upon efforts of Maryland’s Essentials for Childhood Initiative and local ACE community initiatives in Frederick, Washington, Harford Counties and Baltimore City, designate a state lead agency for the MD EFC initiative³⁷
3. Require each member of the Children’s Cabinet to designate authority to two members of their staff to lead their agency’s participation in the initiative.
4. Call upon key leaders in Maryland’s business and faith-based communities to join in the Initiative.³⁸

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

³⁷ Include language that the policy decisions, statements, and funding announcements of Maryland Children’s Cabinet agencies will acknowledge and embed the principles of early childhood brain development and will, whenever possible, consider the concepts of toxic stress, adverse childhood experiences, and buffering relationships, and note the role of prevention, early intervention and investment in early childhood years as important strategies to achieve a lasting foundation for a more prosperous and sustainable state through investing in human capital. Use a multi-generation approach- children come with parents and grandparents; and, will become parents themselves.

³⁸ See, EPIC-[Executives Partnering to Invest in Kids](#) , [Ready Nation](#), [Washington County, OR, Faith-Based Organizations](#), and [Faith Leader’s Guide to Paper Tigers: Adverse Childhood Experiences](#)

5. Support legislation and funding of a Children's ACEs Prevention Trust Fund administered by a public-private board of directors to lead innovative interventions and financing across the state.
6. Require DHR and DHMH to Develop a Centralized System for Providing Forensic and Medical Services to Children Involved in the Child Welfare System. Fund each component of the Centralized System as a line item in the Governor's Budget.

CHILDREN'S CABINET AGENCIES

GOC, GOCCP, DHR, DHMH, DOJ, MSDE, DOD, DPSCS, DBM, DLLR

1. Review Tennessee's example of a statewide model to create a culture change in child and family serving agencies to focus on a multi-generation approach to responding to childhood adversity based on the science of the developing brain, ACEs (trauma/toxic stress) and Resilience.
2. Review Maryland's 2015 baseline ACE Module Behavioral Risk Factor Surveillance System (BRFSS) data.
3. Embed Brain Science, ACEs (trauma/toxic stress) and Resilience into the Children's Cabinet Three-Year Plan.
4. Offer free screenings and time to view the film [*RESILIENCE: The Biology of Stress & The Science of Hope*](#) to introduce staff to the Brain Science, ACEs and Resilience and trauma-informed systems; and, provide opportunity for dialogue of how it might be used to provide better customer service.
5. Participate in ACEs Interface Master Training and Learning Cohort to build awareness and commitment to act within your organization.
6. As level II of the Governor's G.O.L.D. Standard Customer Service Training Initiative, have ACEs Interface Master Trainers train all staff, beginning with supervisors.
7. Explore ways to increase awareness of the brain science and the impact of ACEs on the people your agencies serve. Integrate the science across agencies and within individual agencies by:
 - Partnering in Maryland Essentials for Childhood to ensure cross-agency coordination.
 - Screening clients for ACEs and resilience factors
 - Providing pre-service and in-service training to all staff on brain science, ACEs and resilience
 - Identifying a standard of care that includes assessing for and responding to ACEs, to be integrated into contracts as performance measures
 - Embedding the science into strategic planning with local agencies and connect to funding
 - Ensuring organizational policies and regulations reflect the science
 - Ensuring practice models reflect the science

- Investing resources in evidence-based trauma interventions; and, creating a trauma-informed agency
 - Communications efforts should connect the dots between state child and family serving programs as a response to the science. Develop an umbrella message and integrate it into messaging across agencies and programs, including websites and press releases regarding child and family serving policies and programs.
8. Require that child serving agencies and youth serving organizations receiving state funding institute the Comprehensive Child Sexual Abuse training, policies and guidelines below (under the recommendation to the General Assembly).
 9. Ensure your agency has a Report Child Abuse hotlink on its homepage.

GENERAL ASSEMBLY

1. Pass a joint resolution mandating child and family serving agencies participation in collective impact efforts to promote safe, stable & nurturing relationships and environments for children (Essentials for Childhood (EFC)) & preventing ACEs.³⁹
2. Pass Legislation establishing a robust Children’s ACEs Prevention Trust Fund.⁴⁰
3. Pass Comprehensive Child Sexual Abuse Prevention Legislation
Child sexual abuse is a complex problem requiring a comprehensive approach. All adults in child and youth serving organizations play a role in preventing child sexual

³⁹ Examples of State Legislation:

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

⁴⁰ The National Alliance for Children’s Trust & Prevention Funds is available to consult with state leadership on the most successful models across the country. Maryland’s current Children’s Trust Fund was established by Sec. 13-2207 of the Maryland Health General Article. While funds initially supported small prevention grants, an ongoing source of income for the Trust Fund was never established. At the same time, many states across the country have developed robust prevention trust funds with combined annual revenues in excess of \$100 million dedicated to prevention. Children’s Trust Fund Boards actively raise funds to support statewide prevention efforts. This is a gap in Maryland’s infrastructure to support prevention.

abuse *before it occurs*. Failing to provide adult-focused training to schools and youth-serving organizations leaves kids vulnerable both before and/or after abuse occurs.

Comprehensive Child Sexual Abuse Prevention should include the following components:

- A clear statement delineating the need for primary prevention (before sexual abuse occurs) efforts, in addition to improving current reporting (after the fact) efforts.⁴¹
- Lead with a clear focus on *adult responsibility for preventing child sexual abuse*:
 - Require participation by all schools (public and private) and youth-serving organizations that are state-operated, state-licensed or state-funded;⁴²
 - Educate adults first;⁴³
 - Educate *all* adults not just teachers but all employees as well as volunteers;⁴⁴
 - Instruction should help adults:
 - recognize sexually offending behaviors in adults, and signs in adults that might indicate they pose a sexual risk to children;⁴⁵
 - Recognize the difference between normative and non-normative child-on-child sexual behavior; and, appropriately respond to, and prevent sexually inappropriate, coercive, or abusive behaviors among children and youth served by schools, programs and youth-serving organizations;⁴⁶
 - Recognize behaviors that might indicate a child or youth has been a victim of sexual abuse;⁴⁷
 - Support the healthy development of students, children and youth by building the protective factors to mitigate against their sexual victimization by adults or by other children or youth (ensuring adults within the system are provided resources⁴⁸ training⁴⁹ and standards for promoting healthy social emotional development and relationships (e.g., , sexuality education⁵⁰ , focused “boundary” education to reduce child-on-child behaviors appropriately⁵¹, knowledge of the rules (e.g., school

⁴¹ Vermont Act One <http://www.leg.state.vt.us/docs/2010/Acts/Act001.pdf> and Michigan’s Task Force Report, Goal # 1, p. 18 https://www.michigan.gov/documents/dhs/ReportRecommendations_491970_7.pdf

⁴² Massachusetts’s CSA legislation <https://malegislature.gov/Bills/189/Senate/S316>

⁴³ Prevent Child Abuse America, State and Federal Legislative Efforts to Prevent Child Sexual Abuse: A Status Report, 2015

⁴⁴ Massachusetts’s CSA Prevention draft legislation <https://malegislature.gov/Bills/189/Senate/S316>

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ <http://www.nsvrc.org/projects/child-sexual-assault-prevention/preventing-child-sexual-abuse-resources>

⁴⁹ <http://www.enoughabuse.org/training-workshops.html> and <http://www.d2l.org/>

⁵⁰

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

⁵¹ <http://www.nsvrc.org/projects/child-sexual-assault-prevention/preventing-child-sexual-abuse-resources>

- rules) and laws (e.g., age of consent), and creating trauma-sensitive child and youth serving environments⁵²;
- Establish and implement school, program and youth-serving organization policies that support the prevention of and response to sexual abuse through;
 - Ongoing training of staff about adult and child-on-child sexual abuse;⁵³
 - Comprehensive screening of prospective employees and volunteers;⁵⁴
 - The development of codes of conduct to identify inappropriate or boundary-violating behaviors that if left unchecked could escalate to reportable sexual offenses, including methods to interrupt behaviors by school/other personnel that don't reach level of abuse;⁵⁵
 - The assessment and modification of physical facilities and spaces to reduce opportunities for sexual abuse⁵⁶
 - Respond to disclosures of sexual abuse or reports of boundary-violating behaviors of adults or children in a supportive, trauma-sensitive and appropriate manner and which meets mandated reporting requirements under MD Family Law Code Ann., Sec. 5-704
 - Learn about community resources available to assist schools, programs, and youth-serving organizations in the prevention, identification, reporting and referral to treatment of cases involving the sexual abuse or exploitation of children and youth
 - Provide resources for parents on how to talk with children about CSA⁵⁷
 - Eliminate “passing the trash” among educational institutions and/or other youth serving organizations;⁵⁸
 - Provide developmentally appropriate and trauma-sensitive instruction for children and youth K-12 on healthy social emotional development, healthy relationships, sexuality education, focused “boundary” education to reduce child-on-child behaviors appropriately, knowledge of the rules (e.g., school rules) and laws (e.g., age of consent).
 - When child-focused prevention efforts are implemented, these should be evidence based or, at minimum, comport with recommendations for best prevention practices. Evidence-based interventions that effectively prevent peer-on-peer sexual harassment and sexual violence perpetration and victimization include the “Shifting Boundaries” middle school intervention and the “Safe Dates” middle

⁵² <http://traumasensitiveschools.org/>

⁵³ Massachusetts's CSA Prevention draft legislation

⁵⁴ Ibid.

⁵⁵ *State and Federal Legislative Efforts to Prevent Child Sexual Abuse: Status Report*, Jetta Bernier, MA CSA Prevention draft legislation, Keith Kaufman, Missouri Act

⁵⁶ Keith Kaufman, MA CSA Prevention draft legislation

⁵⁷ Vermont Act One & Oregon legislation

⁵⁸ PA, MA & MO “SESAME” acts

school intervention. More generally, best practices for prevention programming include the following components:

- a. Multi-session dosage (i.e., a one-time training is unlikely to effect real change);
 - b. Skills practice with feedback (i.e., solely didactic trainings are unlikely to effect real change);
 - c. Parental involvement
 - d. Developmentally appropriate content (e.g., middle- and high-school trainings should include review of laws related to consent and sex crimes as well as focus on issues of consent and respect within the context of dating and friendship, whereas programs for younger children can focus more generally on positive behavior between children and inappropriate behavior by adults or older children);
 - e. Careful attention to language to avoid suggestion of victim-blaming and use of person-first language when talking about people who may have been victimized or people who may have engaged in harmful behavior to avoid equating these youth with these experiences.
- Provide Evidence-Based Treatment for youth with child sexual behavior problems⁵⁹
 - Include CSA prevention & intervention training in educator preparatory curricula,⁶⁰
 - Provide a mechanism for evaluation of the implementation of policy change on institutional practices and trainings; and, the implementation of policy, practice and training change on the incidence of CSA;
 - Provide a mechanism for quality assurance and enforcement of CSA prevention policies, practices and training at the Maryland State Department of Education;
4. Pass legislation to prevent “Passing the Trash”⁶¹ heightening the screening requirements for school employees, contractors and volunteers.
 5. Pass legislation to change the Medicaid eligibility categories to make identification of children in foster care more transparent.
 - Currently, the state uses eligibility categories that include subsidized adoption and subsidized guardianship cases to identify the foster care population. In addition, kinship care cases that are receiving TCA are excluded. Medicaid data that the state uses in reports and that could potentially be used to monitor the health of the foster care population is not an accurate reflection of the youth in foster care. Improving or redefining eligibility codes would allow the state to more accurately monitor health care utilization (including psychotropic medication) use for children in foster care. In addition, more transparent eligibility codes will allow programs that use these codes the ability to easily

⁵⁹ North Carolina Task Force Report, MA CSA Prevention draft legislation

⁶⁰ New Mexico Law

⁶¹ e.g., Pennsylvania passed Act 168 in 2014 to prohibit the practice known as “pass the trash” to require extensive employment history checks be completed prior to a local education agency hiring an individual in a position that may require direct contact with children.

identify youth in foster care. Identification will result in improving coordination with the child welfare agency and will assist the state in providing Medical Assistance to former foster care youth until age 26.

6. Pass legislation amending Maryland's Safe Haven law⁶²
 - Extend the maximum age at which an infant can be voluntarily relinquished from 10 days to at least 1 year and potentially to age 2 or 3 years.⁶³
 - Mandate community promotion of law, including signage in all safe haven sites and on all child and family serving state agency websites; include 211 number on signage as referral source to service alternatives to relinquishment.
 - Include a listing and contact information for state and local services available as alternatives to relinquishment.
7. Pass legislation amending Birth Match Law to improve identification of newborns at high risk of fatality.
 - Match parents who have not contested the child welfare system's decision to seek termination of their parental rights (excluding parents who are the initiators of voluntary adoption processes for their children)
 - Match parents who have a previous criminal conviction for abuse and neglect and/or homicide
 - Extend the matching timeframe from the previous 5 years to the previous 20 years
8. Pass legislation creating a statewide, toll-free, 24 hour, 7 day-a-week Report Child Abuse Hotline, 1-800-MD-CHILD (1-800-632-2443) that will connect reporters to a centralized screening unit or to the appropriate local office or law enforcement to report suspected child abuse or neglect.
 - Ensure that de-identified aggregate data is collected and analyzed to inform decision-making to improve the reporting and screening system.
 - Ensure that local DSS have updated phone technology, sufficient staff and standardized training to implement the statewide hotline.

JOINT DHR & DHMH

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

The following components should be included:

⁶² *Infant Safe Haven Laws*, US Department of Health & Human Services, ACF, ACYF, Children's Bureau, Child Welfare Information Gateway, <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/safehaven/> .

⁶³ Barth, R. P., Putnam-Hornstein, E., Shaw, T. V., & Dickinson, N. S. (2015). *Safe children: Reducing severe and fatal maltreatment* (Grand Challenges for Social Work Initiative Working Paper No. 17). Cleveland, OH: American Academy of Social Work and Social Welfare. Retrieved from <http://aaswsw.org/wp-content/uploads/2015/12/WP17-with-cover.pdf>

- A. Management by a physician Health Director at DHR, SSA (either as a DHR employee or contractual position) to provide the medical expertise necessary to ensure effective oversight and coordination of the physical, mental, developmental and oral health care needs of children who come in contact with the child welfare system. The physician Health Director's responsibilities should include:
- i. Lead ongoing efforts to ensure best practice medical review and evaluations in cases of suspected child maltreatment.
 - ii. Lead ongoing efforts to ensure that children in foster care receive effective care coordination for their physical and mental health needs, developmental needs and dental needs. Align these efforts with recommendations from the American Academy of Pediatrics, the Child Welfare League of America, and the Federal Fostering Connections Act.
 - iii. Lead coordination and collaboration efforts between Maryland DHR, DHMH (Medicaid, DHMH Child and Adolescent Health, Behavioral Health, Child Fatality Review), and other health care and child welfare experts
 - iv. Assist with case decision-making when health care issues are involved.
- B. *Oversight and policy development via an Interagency Child Welfare Health Coordination Expert Panel: An ongoing Child Welfare Health Coordination Expert Panel should be established and led by the physician Health Director. Suggested members of this panel are included in the footnote⁶⁴. The Panel's responsibilities should include:*

⁶⁴ Suggested Members: *Interagency Child Welfare Health Coordination Expert Panel*

The Panel should include representatives from the following agencies and organizations:

- Maryland Children's Cabinet;
- Maryland Children's Alliance;
- Maryland Chapter of the American Academy of Pediatrics;
- Maryland CHAMP program (CHAMP physician and nurse affiliates);
- Maryland Forensic Nurses;
- DHR Out of Home Services;
- DHR Child Protective Services and Family Preservations Services;
- DHR Resource Development, Placement, and Support Services;
- DHMH, Maternal and Child Health Bureau, Child and Adolescent Health;
- Medicaid;
- Behavioral Health;
- DHR and DHMH representatives with expertise in their agency's child fatality review processes;
- Maryland State's Attorney's Association;
- County health department representatives;
- County DSS agency representatives;
- Maryland Legal Aid Bureau;
- Maryland CASA;
- Programs that currently contribute to medical and forensic services funding for children involved in the child welfare system
 - Maryland Medicaid,
 - DHMH Center for Injury and Sexual Assault Prevention,
 - GOCCP/VOCA).

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

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

DHR

1. See Children’s Cabinet agency recommendations above.
2. Embed the brain, ACEs and resilience science and a multi-generational approach into policies across administrations at DHR. Implement strategies to prevent and mitigate ACEs (trauma-informed) and build resilience to create safe, stable and nurturing environments for the children of parents receiving DHR services (CSE, FIA and SSA)⁶⁵
3. As level II of the G.O.L.D. Standard Customer Service Training, use ACEs Interface Master Trainers to train all staff in Brain Science, ACEs and Resilience.
4. Increase fathers and mothers’ male partners’ emotional support of their children and families
 - Collaborate with partners to further infuse fatherhood and male responsibility initiatives into settings with boys and men
 - Make deliberate and special efforts to include male caregivers in attachment and parenting skills programs (e.g., Circle of Security Parenting, home visiting sessions)
5. Ensure that MD THINK
 - integrates child-welfare, birth, and death data in order to analyze fatal maltreatment risks
 - collects longitudinal data on foster youth and their families so we can track both their long term outcomes and the quality of their well-being while they are in care. This was a repeated recommendation included in DHR’s Quality Assurance Processes in Maryland Child Welfare.⁶⁶

⁶⁵ “Applying the Science of Child Development in Child Welfare Systems”, Center on the Developing Child, Harvard University.

⁶⁶ In the 5th Annual Child Welfare Accountability Report dated December 2011, DHR makes this recommendation repeatedly and the draft of the 6th Annual Child Welfare Accountability Report, includes this robust explanation:

- MD CHESSIE’s focus on point in time data has been a significant barrier in having a true picture of how children and their families who touch our child welfare system do. We need to know how often these youth end up involved with the Department of Juvenile Services, how their educational achievement and health compares to their non-system involved peers, and for older foster youth who transition out of care, whether they have stable housing as adults.
 - There has been an MOU in place between DHR and MSDE to allow for the sharing of data regarding foster youth since September 27, 2013. It is also now a federal requirement pursuant to the Every Student Succeeds Act for states to track educational outcomes for foster youth.
- We also need to know the quality of the experience for foster youth while they are in care. Currently, we don’t know basic information, such as, how often they have to change placements, how often they change schools, whether they are hospitalized, whether they need in-patient psychiatric treatment.
- We also need to track when families are determined to need services, whether they receive those services, and if not, why not, and what follow up occurs.⁶⁷

Social Services Administration

1. See Children’s Cabinet recommendations above.

Recommendation: Track entry cohorts over time. Prospective measures are preferable to measure child welfare outcomes. Following one population of children and youth through their child welfare experiences is the single best, least biased, method of measuring service receipt and outcomes (Wulczyn, 2007; Zeller & Gamble, 2007). Examining children’s trajectory through the various levels of child welfare services is the best way to understand the effects of services on children and families. Entry cohort analyses are being successfully utilized in Maryland to examine welfare service utilization through a partnership between DHR/SSA and UM/SSW and should be expanded in the future. It is in Maryland’s best interest to utilize the power available through the MD CHESSIE system to examine the trajectory of children through the child welfare system in a prospective manner. A prospective analysis will allow Maryland to follow children from report through investigation, to in-home or out-of-home child and family services, to the outcomes of safety, permanency, and well-being. (Maryland Child Welfare Performance Indicators (Draft), December 2012 p. 38)

⁶⁷ During the 2013 Legislative Session when the statute regarding substance exposed newborns (Md. Code Ann. Family Law § 5-704.2) was amended the General Assembly required the Department of Human Resources (DHR) to file an interim and final report analyzing implementation of the changes. DHR’s data in those reports is telling for our purposes and underscores the importance of tracking when families receive services. The Preliminary Report from October 2014 documents 1,734 assessments of families with substance exposed newborns. According to the report, there were 400 and 89 instances of “‘conditionally safe’ (safe if the family accepts services)” and “unsafe” respectively. (Maryland Department of Human Resources, “Substance-Exposed Newborn Reporting in Maryland—Preliminary Report,” p. 3 (October 1, 2014)) Yet, only **34% of these** individuals (168) are documented as receiving services. (Id. at p. 4. DHR’s report states that MD CHESSIE might be undercounting who actually receives services.) Unfortunately, the October 2015 report documents an even smaller percentage of families receiving services. Only **26%** of families (347) identified as “conditionally safe” and “unsafe” received services. (Maryland Department of Human Resources, “Substance-Exposed Newborn Reporting in Maryland—Final Report,” p. 4 (October 1, 2015)) **Given that DHR’s 2015 report indicates that almost 75% of families assessed as needing services did NOT receive any, it is essential that we see why these families aren’t getting the help LDSS determines that they need.**

2. See Joint DHMH-DHR recommendations above.
3. Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in foster care. Ensure that all adults, including foster parents, group homes, residential treatment centers and licensed contractors, involved with foster youth are trained and institute policies in child sexual abuse prevention.
4. Ensure that all children experiencing child sexual abuse are referred and linked to service for treatment. Cases should remain open until linked to treatment services. Case records should indicate 1) child sexual abuse and 2) documentation that the child is receiving treatment.
5. Screen in all children under 5 as Risk of Harm cases and do an in-home assessment of risk. Provide services for families at risk for child fatality or near fatality.
6. Involve fathers in child welfare cases as a matter of course

DHMH:

1. Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in the custody of the state. Ensure that all youth serving facilities licensed and/or funded with state funds, are trained and institute comprehensive child sexual abuse prevention policy.
2. Collect ACE module data in the 2018 BRFSS; continue to collect BRFSS ACE data every three years thereafter; and, collect resilience data in the BRFSS, as is being done in Wisconsin, beginning in 2018⁶⁸.
3. Collect ACE module data in Maryland's next Youth Risk Behavior Survey (YRBS).
4. Partner with the health care community to improve integration of behavioral and primary health care and identify and promote strategies to assess for and respond to ACEs
5. Ensure that all home visiting programs (MIECHV, MOTA grants, Community Health Specialists, etc.) engage fathers, as well as mothers. Purposefully recruit fathers as home visitors.⁶⁹

⁶⁸ Sege, R., Bethell, C., Linkenbach, J., Jones, J., Klika, B. & Pecora, P.J. (2017). *Balancing adverse childhood experiences with HOPE: New insights into the role of positive experience on child and family development*. Boston: The Medical Foundation. Accessed at www.cssp.org

⁶⁹ See MCANF preliminary observations under "Magnitude of the Problem in Maryland" section.

6. Maryland's Medicaid program should develop a system to generate a regularly updated list of all prenatal care providers serving Medicaid recipients and their MPRA (Maryland Prenatal Risk Assessment) completion rates for purposes of conducting ongoing provider education on MPRA procedures.⁷⁰
7. Streamline the Postpartum Infant and Maternal Referral (PIMR) form and completion process in partnership with local health departments and birthing hospitals.⁷¹
8. Link completion of MPRA and PIMR and linkage to services to service provider fee payment.⁷²
9. Medicaid should reimburse for psychosexual evaluation of youth. These should be considered medically necessary and key in the prevention of youth on younger child sexual abuse which is approximately 1/3 of all child sexual abuse perpetrations.

MSDE:

1. Implement Comprehensive Child Sexual Abuse Prevention Policy within all public schools and licensed child care facilities. See recommendations under General Assembly.
2. Ensure that all home visiting programs (Office of Special Education-Healthy Families, etc.) engage fathers, as well as mothers. Purposefully recruit fathers as home visitors.

DJS:

1. Implement Comprehensive Child Sexual Abuse Prevention Policy within all public schools and licensed child care facilities. See recommendations under General Assembly.
2. Ensure that all youth serving facilities licensed and/or funded with state funds, are trained and institute comprehensive child sexual abuse prevention policy.
3. Ensure that all children experiencing child sexual abuse are referred and linked to services for treatment. Cases should remain open until linked to treatment services. Case records should indicate 1) child sexual abuse and 2) documentation that the child is receiving treatment.

⁷⁰ Ibid.

⁷¹ Ibid. Prenatal care providers are required by Maryland Medicaid regulations to submit an MPRA for each pregnant woman at her first prenatal care visit. Women are then outreached by nurses and home visitors, to further assess needs for care and eligibility for community services, and link her to these services. Mothers and infants may also be outreached and referred following delivery; birthing hospitals are required by state regulations to submit a PIMR at postpartum discharge when Medicaid recipients have psychosocial risk factors (e.g., limited or and/or deliver infants who are born at low birth weight or have had a stay in the NICU).

⁷² Ibid.

APPENDIX A

DHR RESPONSE TO SCCAN'S 2015 ANNUAL REPORT

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

recommendation: “[n]ot later than 6 months after the date on which a report is submitted by the panel to the State, the appropriate State agency shall submit a written response to State and local child protection systems and the citizen review panel that describes whether or how the State will incorporate the recommendations of such panel (where appropriate) to make measurable progress in improving the State and local child protection system.”

The Council received a response to its' 2015 from the Secretary of the Department of Human Resources in September 2016. In January 2017, SCCAN's Chair and Executive Director met with representatives from DHR to thank the Department for its response, follow up on recommendations that were not addressed and develop a more consistent dialogue between DHR and SCCAN. It was noted that a number of recommendations were requests to the Governor, legislature and other State Departments and agreed that SCCAN would categorize future recommendations by the specific agent or agency needing to act. We have done so in this report. We hope it will eliminate any confusion as to which agency should act and/or respond to specific recommendations.

APPENDIX B

SCCAN & EFC ADDITIONAL ACTIVITIES

SCCAN and its EFC partners continued to develop a shared understanding of the problem of child maltreatment and ACEs, the science and the multiple solutions through SCCAN and the MD EFC Committee and Workgroup Meetings and presentations to potential partners. SCCAN facilitated the following knowledge-building activities in 2016:

- **“Policies to Prevent Child Maltreatment and other ACEs”**

Speaker:

- “Peace Code in the Human Brain” an 18 minute TEDMed Talk with Robin Grille, psychologist, parent and educator at <https://www.youtube.com/watch?v=EHlvAm4huQs>
- Melissa Broome, Deputy Director of the Job Opportunities Task Force, “Working Matters Coalition: The Urgent Need for Earned Sick Leave”

Materials: “Exploring policies for the reduction of child physical abuse and neglect” Joanne Klevens, Child Abuse and Neglect Journal; Healthy Working Families Fact Sheet; “White Paper on Paid Leave and Health” Minnesota Department of Health

- **“Overview of ‘Within Our Reach: Commission to Eliminate Child Abuse and Neglect Fatalities Report’ and Dissenting Report”**

Speakers: Cathy Costa, Baltimore, Infant Mortality and Child Fatality Review Director, Maternal and Child Health, Baltimore City Health Department

Materials: [Within Our Reach: Commission to Eliminate Child Abuse and Neglect Fatalities Report](#) and [Dissenting Report by Judge Patricia M. Martin](#)

- **“Review and Discussion of SCCAN Draft Recommendations”**

Speakers: Elizabeth Letourneau, Ph.D. Johns Hopkins Bloomberg School of Public Health, The Moore Center for the Prevention of Child Sexual Abuse

Materials: Comprehensive Child Sexual Abuse Prevention Legislation

- **“Maryland Child Welfare Screening and Risk & Safety Assessment Process”**

Speakers: Diane Banchiere, Policy Analyst, In-Home Service; Stephanie Cooke, Analyst, In-Home Services

Materials: SSA 04-03 MFRA Policy Directive, SSA 14-19 Child Protective Services Screening (1), Structured Decision Making Tool, SSA 10-05 Child Fatality Serious Physical Injury Critical Incident Protocol Policy, SSA 12-27 SAFE-C OHP Policy, SSA 14-15 Human Sex Trafficking Victims, CECANF Within Our Reach Report.

- **SCCAN Retreat: “Creating a Learning Organization, “Science of the Positive”, “The Science of Mindfulness”, “N.E.A.R. Science”, “SCCAN Mandate-Systems Change, Role, Member Roles, Committee Overview, SCCAN Etiquette”**
 Speakers: Erica Moltz, MA NCC, Frank Kros, MSW, JD, President, The Upside Down Organization
 Materials: “Applying the Science of the Positive to Health and Safety”, Jeffrey W. Linkenbach, PhD

- **“DHR Data on Child Abuse & Neglect Related Fatalities and Near Fatalities to guide review and prevention efforts” and “DHMH Data on Child Abuse & Neglect Related Fatalities and Near Fatalities to guide review and prevention efforts”**
 Speakers: David Ayer, Deputy Director of Operations at DHR, SSA Dr. Lawrence Reid, PhD, Director of Maternal & Child Health Epidemiology, DHMH
 Materials: PowerPoints available upon request.

- **“Trauma Informed Systems”**
 Speakers: Kay Connors, University of Maryland School of Medicine, Taghi Modaresi Center for Infant Study, Family Informed Trauma Treatment (F.I.T.T.) Center
 Materials: The Facilitator’s Guide to *Resilience: The Biology of Stress & The Science of Hope*, “Is-Your-Organization-Trauma-Informed?”, “Discussion Prompts Applying TI Principles”, Power Point available upon request.

- **“Differing and Supportive Roles & Purposes of Child Fatality Investigation & Child Fatality Review” Law Enforcement & State’s Attorney’s Panel**
 Speakers: Moe Greenberg, Baltimore County Police Department
 Lisa Marts, Harford County State’s Attorneys Office
 Ernest Reitz, Baltimore City State’s Attorneys Office
 Veto Mentzell, Harford County Sheriff’s Office and Harford County Child Advocacy Center (CAC)
 Karen Pilarski, State’s Attorney’s Association
 Wendy Lane, Howard County CFRT
 Materials: Agency Roles for Investigating Suspicious Child Deaths and Serious Injury

- **“Discussion of EFC Legislative Proposal Process”**
 Materials: SCCAN-EFC Legislative Proposal Form; “Using a Brain-Infused Lens for Policy Development” Alliance for Stronger Families and Communities; “Exploring policies for the reduction of child physical abuse and neglect” Joanne Klevens, Child Abuse and Neglect Journal

- **“Performance by The Performing & Visual Arts High School Magnet Program on the Impact of Child Abuse & Neglect” & Legislative Proposals for SCCAN Consideration**
 - Speakers: Ms. Peragallo and Scholars of the Performing & Visual Arts High School Magnet Program
 - Materials: SCCAN-EFC Legislative Proposal Form; “Using a Brain-Infused Lens for Policy Development” Alliance for Stronger Families and Communities; “Exploring policies for the reduction of child physical abuse and neglect” Joanne Klevens, Child Abuse and Neglect Journal

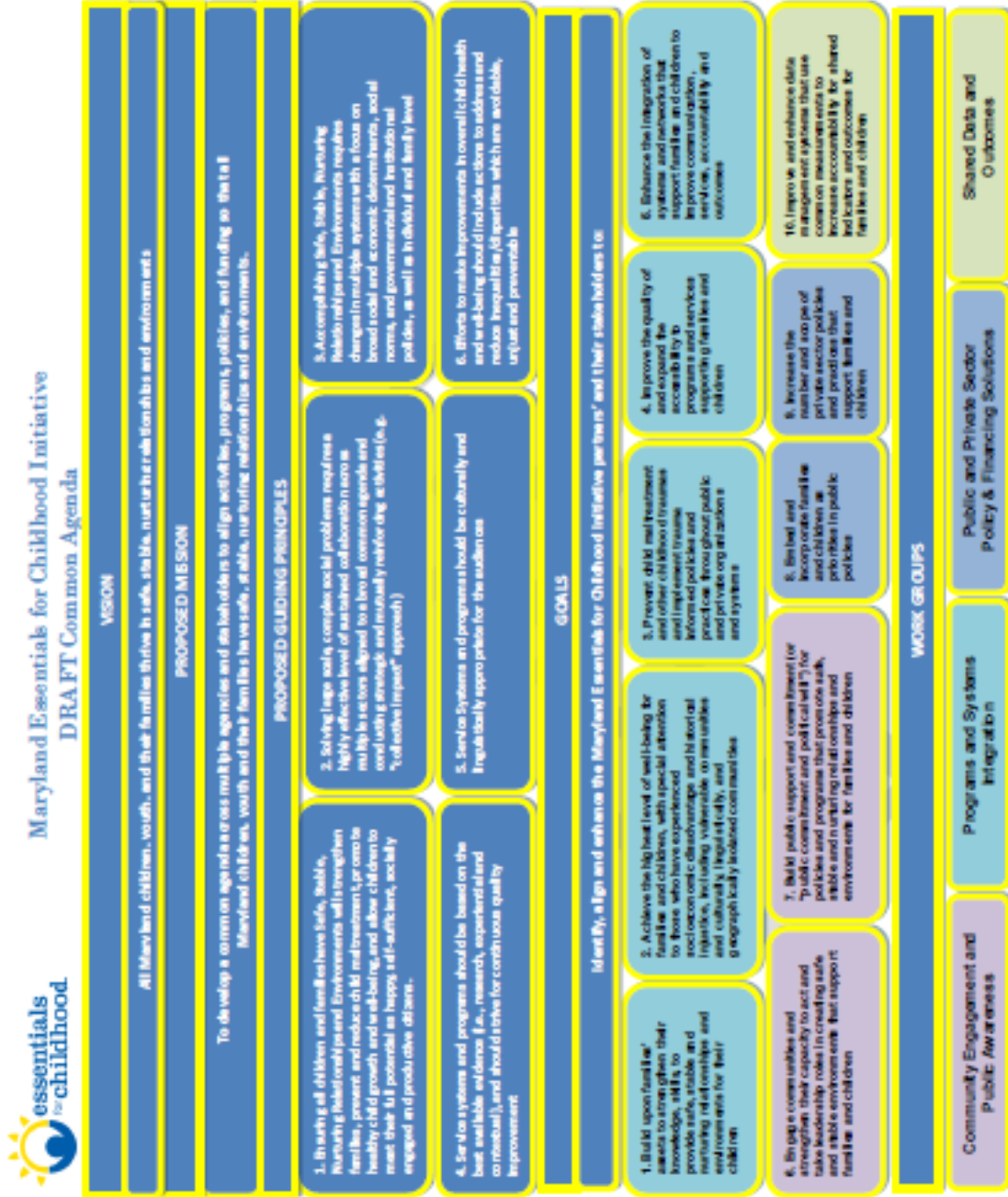
- **“Maryland’s Behavioral Risk Factor Surveillance System ACEs Module Data”**
 - Speakers: Georgette Lavetsky, MPH DHMH BRFSS Coordinator
Alicia Vooris, MSPH, Program Evaluator
 - Materials: Power Point available upon request.

- **“Eliminating Child Abuse & Neglect Fatalities in Baltimore City”**
 - Speaker: Cathy Costa, MSW, MPH, Baltimore City Health Department, Infant Mortality and Child Fatality Review Director
 - Materials: [Eliminating Child Abuse & Neglect Fatalities in Baltimore City Report](#), Power Point available upon request.

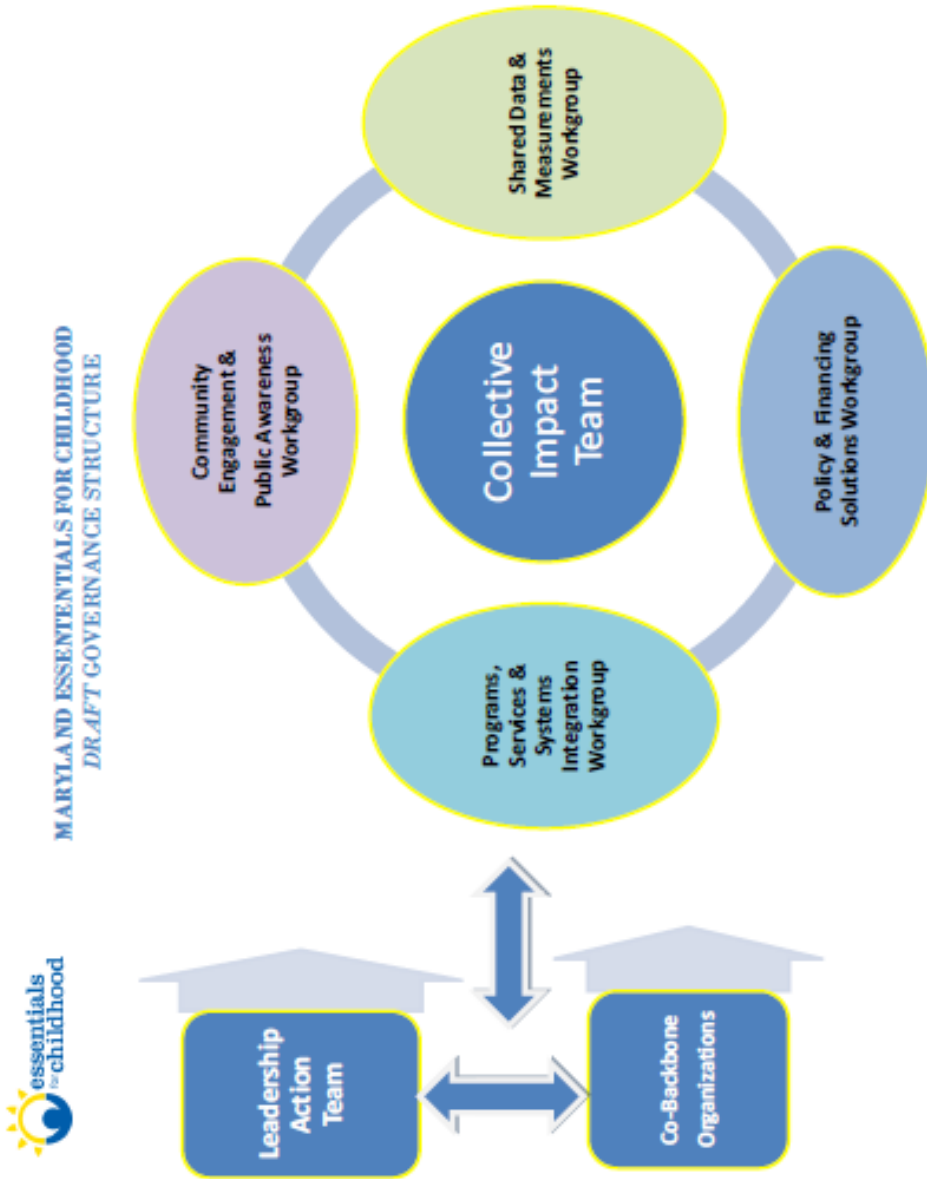
- **Presentations to Stakeholders on MD EFC:**
 - Maryland Children’s Alliance Conference, November 2016
 - Maryland Early Childhood Mental Health Steering Committee, April 2017
 - Partnership for a Safer Maryland Webinar, May 2017

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

APPENDIX C



APPENDIX D



APPENDIX E



State Council on Child Abuse and Neglect (SCCAN)

SCCAN Membership

15 MEMBERS APPOINTED BY THE GOVERNOR

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

Name	Representing	Jurisdiction	Email	Address
Elizabeth Letourneau, PhD	Director, The Moore Center for the Prevention of Child Sexual Abuse, Johns Hopkins University, Bloomberg School of Public Health	Baltimore City	eletourn@jhsp.h.edu	Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe Street Baltimore, MD 21205
Veto Anthony Mentzell, Jr.	Law Enforcement Officer, Harford County Sheriff's Department Program Director, Harford County Child Advocacy Center	Harford County	mentzelly@harfordsheriff.org	Harford County Sheriff's Office 45 South Main Street / P.O. Box 150
Catherine Meyers	Director, Center for Children, Inc.	Charles County	meyers@center-for-children.org	Center for Children, Inc. 6100 Radio Station Road, P.O. Box 2924, La Plata, MD 20646
Linda Ramsey	Deputy Director, Family Support/HR Officer, Maryland Family Network (Maryland's CBCAP lead agency)	Baltimore City	iramsey@marylandfamilynetwork.org	Maryland Family Network 1001 Eastern Avenue, 2 nd Floor Baltimore, MD 21202-4325
Linda Robeson	Sr. Vice President, BB&T	Anne Arundel County	lrobeson@bbandt.com	BB&T Corporation 111 S. Calvert Street, Suite 2200, Baltimore, MD 21202

Name	Representing	Jurisdiction	Email	Address
Melissa Rock, Esq	Director, Child Welfare, Advocates for Children & Youth (ACY)	Baltimore City	mrock@acy.org	Advocates for Children & Youth 8 Market Place, Suite 500 Baltimore, Md 21202
Hillary Hollander Shankman	Social Worker	Baltimore County	hillaryshankman@gmail.com	8514 Countrybrooke Way, Lutherville, MD 21093
Danitza Simpson	Director, Adelphi/Langley Family Support Center	Prince George's County	Dsimpson@pgcrc.org	Adelphi/Langley Family Support Center 8908 Riggs Road Adelphi, Maryland 20783
Joan Stine	The Family Tree (PCA Maryland), CJAC Liaison Former Director, Center for Health Promotion Maryland Department of Health and Mental Hygiene	Howard County	stinejg@yahoo.com	2614 Liter Court Ellicott City, MD 21042-1729
VACANT				

8 POSITIONS FILLED BY DESIGNATION OF THEIR ORGANIZATIONS

Name	Representing	Email	Address
Steven K. Berry	Manager, In-Home Services, Social Services Administration Maryland Department of Human Resources	Sberry@maryland.gov	Maryland Department of Human Resources Social Services Administration, 5 th Floor 311 W. Saratoga St. Baltimore, MD 21201
Karen Pilarski, Esq.	State's Attorney Association	kpilarski@baltimorecountymd.gov	Baltimore County State's Attorneys Office 401 Bosley Avenue Towson, MD 21204-4420
Delegate Susan K.C. McComas	Maryland House of Delegates	susan_mccomas@house.state.md.us	Maryland House of Delegates 9 West Courtland Street P.O. Box 1204 Bel Air, MD 21014
Ralph Jones	Director, Child Advocacy Unit, Maryland Department of Juvenile Services	Ralph.jones@maryland.gov	Director - Hickey, Maryland Department of Juvenile Services Child Advocacy Unit One Center Plaza 120 W. Fayette St. Baltimore, MD 21201
VACANT	Representative of the Judicial Branch appointed by the Chief Judge of the Maryland Court of Appeals		
John McGinnis	Pupil Personnel Specialist, Maryland Department of Education	john.mcginnis@maryland.gov	Pupil Personnel Specialist Maryland Department of Education 200 West Baltimore St. Baltimore, MD 21201
Stacey Little and Richa	Department of Health and Mental Hygiene	Richa.ranade@maryland.gov	Child Health Program Manager, SCFRT, CHAMP, etc. Maryland

Name	Representing	Email	Address
Ranade			Department of Health & Mental Hygiene, Center for Maternal & Child Health 201 W Preston Street Baltimore MD 21201
VACANT	Maryland Senate		

SPECIALLY DESIGNATED MEMBERS OF CJAC

SCCAN EXECUTIVE DIRECTOR

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

SCCAN EXECUTIVE DIRECTOR

Name	Relevant Background	Email	Phone	Address
Claudia Remington, Esq.	Attorney, Mediator, and CASA volunteer	Claudia.remington @maryland.gov	Office: 410-767-7868 Cell: 410-336-3820	311 W. Saratoga Street, Room 405, Baltimore, MD 21201