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SCCAN is an advisory body required by Maryland Family Law Article (Section 5-7A) "to make recommendations annually to the Governor and General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs."

TESTIMONY IN SUPPORT OF SB 548:

CENTERS FOR DISEASE CONTROL AND PREVENTION SURVEYS - REVISIONS
****SUPPORT****

TO: Hon. Paul G. Pinsky, Chair, and members of the Senate Education, Health, and Environmental Affairs Committee

FROM: Wendy Lane, MD, MPH, Chair, State Council on Child Abuse & Neglect (SCCAN)
Claudia Remington, Executive Director, State Council on Child Abuse & Neglect (SCCAN)

DATE: February 25, 2021

SCCAN strongly supports SB 548, Public Schools – Centers for Disease Control and Prevention Surveys – Revisions. The Maryland State Department of Education (MSDE) currently establishes procedures for the annual administration of the Center for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey (YRBS) to public middle school and high school students. This bill would require that the version of the survey administered to Maryland students include all CDC questions from the Adverse Childhood Experiences (ACE) and Positive Childhood Experiences module. It would also require that the Maryland Department of Health (MDH) publish a state and county-level data summary and trends report, disaggregated by gender, race, and ethnicity, within 6 months after receiving the data. Finally, it would remove language that permits MSDE to omit up to one-third of YRBS questions that they believe are "inappropriate."

There is no doubt that adverse childhood experiences (ACEs) have short and long-term physical and mental health consequences, as evidenced by the Centers for Disease Control's Adverse Childhood Experiences (ACEs) study, as well as a number of confirmatory studies.[1] Maternal depression increases the risk that their children will exhibit aggressive behavior, peer conflict, hyperactivity and inattention,

[1] https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html. Merrick M, et al. Unpacking the impact of adverse childhood experiences on adult mental health. Child Abuse Negl. 2017;69:10-19. Kerker BD, et al. Adverse Childhood Experiences and mental health, chronic medical conditions, and development in young children. Academic Pediatrics. 2015;15:510-517.

and be diagnosed with depression, anxiety, and conduct disorder.[2] Adolescents of parents who use substances show high rates of psychopathology such as depression, anxiety and substance use. A recent study found that parental substance use was associated with children's hospitalization for both somatic and psychiatric conditions.[3] There is substantial evidence linking children's exposure to IPV with a wide range of serious consequences, including emotional, behavioral, physical, social, and academic problems.[4] During childhood and adolescence, victims of child sexual abuse may exhibit anxiety, social withdrawal, school failure, depression, self-injury, suicide attempts, eating disorders, risky sexual behavior, and teen pregnancy.[5,6]

The Maryland Department of Health (MDH) has previously collected data on ACEs in 2015 and 2018 through the Behavioral Risk Factor Surveillance Survey (BRFSS), which surveys a sample of Maryland adults about a wide range of health behaviors and physical and mental health conditions. This data is useful in showing how common it is for Maryland adults to have experienced ACEs. For example, results of the survey administered in 2018 indicated that 34% of Maryland adults had been emotionally abused as children, 14.7% had been physically abused, and 12% had been sexually abused. In addition, 24.8% of adults grew up with a substance abusing caregiver, 15.4% grew up with a caregiver with mental illness, and 15.3% grew up with a caregiver who was a victim of intimate partner violence. The data is also useful in examining the association between ACEs and health outcomes in Maryland Adults. For example, while only 7.2% of adults with no ACEs have been diagnosed with depression, 14.1% of those with 1 ACE have been diagnosed with depression, and 28.5% of those with 3 or more ACEs have been diagnosed with depression.

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[2]Glasheen C, et al. Exposure to maternal pre-and postnatal depression and anxiety symptoms: risk for major depression, anxiety disorders, and conduct disorder in adolescent offspring. Dev Psychopathol. 2013;25:1045-1063.

Lieb R, et al. Parental major depression and the risk of depression and other mental disorders in offspring: a prospective-longitudinal community study. Arch Gen Psychiatry. 2002;59:365-374.

Fletcher RJ, et al. The effects of early paternal depression on children's development. Med J Aust. 2011;195:685-689.

[3] Raitasalo K. Parental substance abuse and risks to children's safety, health and psychological development. Drugs Educ Prev Policy. 2017;24:17-22.

[4] Widom CS, et al. Child abuse and neglect and intimate partner violence victimization and perpetration: a prospective investigation. Child Abuse Negl. 2014;38:650-663.

[5] Trickett PK, Noll JG, Putnam FW. The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. Development & Psychopathology. 2011;23:453-476.

[6] Homma Y, Wang N Saewyc E, Kishor N. The relationship between sexual abuse & risky sexual behavior among adolescent boys: A meta-analysis. Journal of Adolescent Health. 2012;51:18-24.

Sanci L, Coffey C, Olsson C, Reid S, Carlin JB, Patton G. Child sexual abuse & eating disorders in females. Arch Pediatr Adolesc Med. 2008;162:261-267.

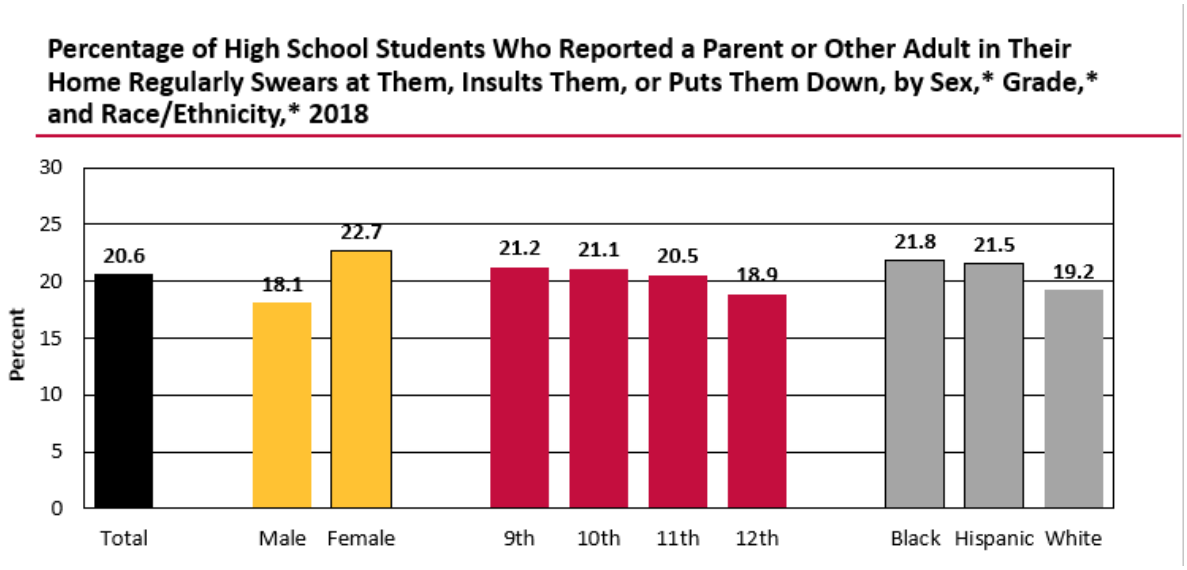
Pallitto CC, Murillo V. Abuse as a risk factor for adolescent pregnancy in El Salvador. J Adolescent Health. 2008;42:580-586.

Mills R, Alati R, O'Callaghan M. Child maltreatment and adolescent mental health problems in a large birth cohort. Child Abuse & Neglect. 2013;37:292-302.

As noted above, the BRFSS data is useful in establishing the extent of ACE exposure among Maryland adults, and the extent to which ACE exposure can lead to negative health outcomes. However, it is not very useful for the purpose of prevention or amelioration given that many of these ACEs occurred decades ago.

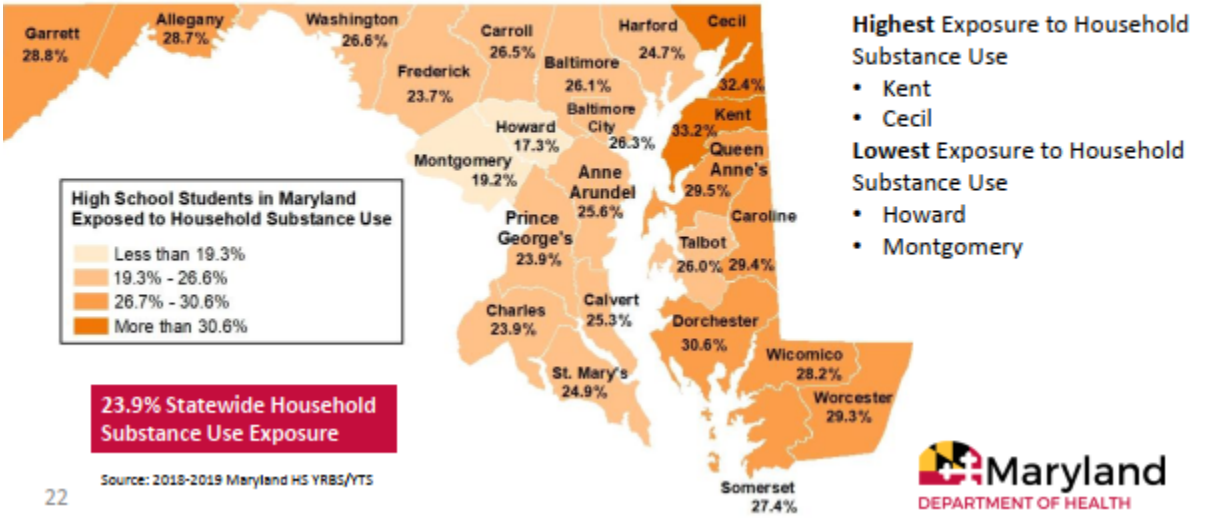
The YRBS, in contrast, gathers data during childhood – in much closer proximity to when the adverse experiences may have occurred. This timely data serves multiple purposes. First, it provides **information about the extent of our youth's exposure to ACEs**. Second, data collected over multiple years can be used to **assess whether prevention efforts are reducing ACEs**. Third, ACE data can provide **information about communities where ACEs are most prevalent, enabling effective distribution of resources** and services to communities at greatest need. Fourth, data can be used to show **associations between ACEs and risky behavior and adverse health outcomes**. This data is valuable in demonstrating the importance of preventing ACEs. Finally, inclusion of questions on positive childhood experiences enables us to examine the **potential ameliorative effects of positive experiences** such as having supportive adults available outside the home.

In 2018, Maryland was one of two states to pilot the inclusion of ACE questions in the YRBS, enabling a successful test run of inclusion of ACE questions. Only four ACEs were included in the pilot – emotional abuse, household substance abuse, household mental illness, and household incarceration. Yet these four questions provided valuable information to policymakers. For example, the data below show how common emotional abuse is among Maryland teenagers.



The data in the following maps, created by MDH, show not only how common these ACEs are, but also that no jurisdiction is immune. Cecil and Kent counites have the highest rates of caregivers with substance abuse or gambling addiction.

MAP: High School Students Who Have Ever Lived with Anyone Who Was an Alcoholic or Problem Drinker, Used Illegal Street Drugs, Took Prescription Drugs to Get High, or Was a Problem Gambler



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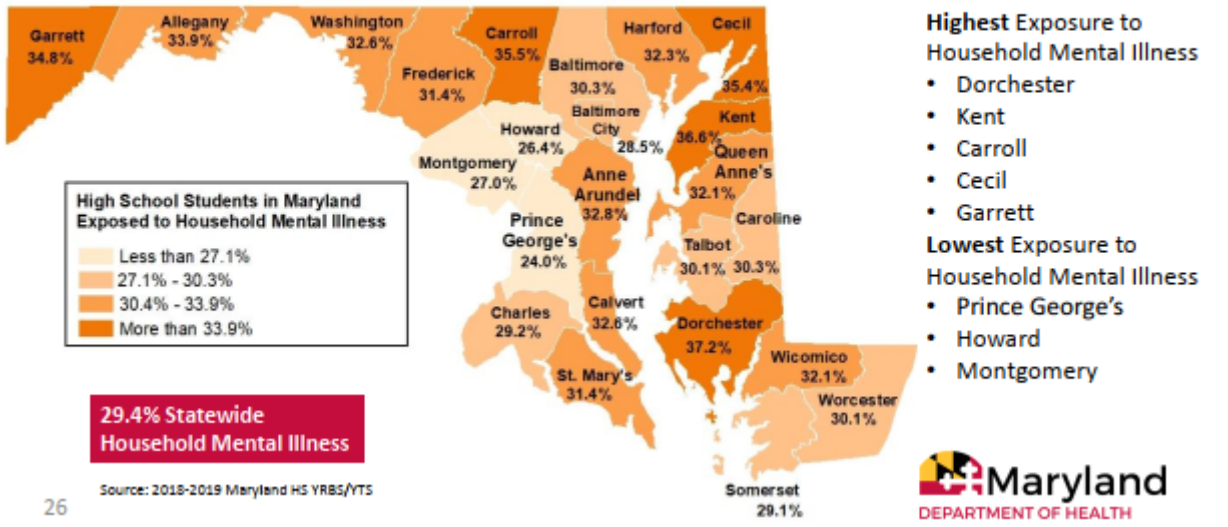
Dorchester, Kent, Carroll, Cecil, and Garrett counites have the highest rates of caregivers with mental illness.

MAP: High School Students Who Ever Lived with Anyone Who Was Depressed, Mentally Ill, or Suicidal



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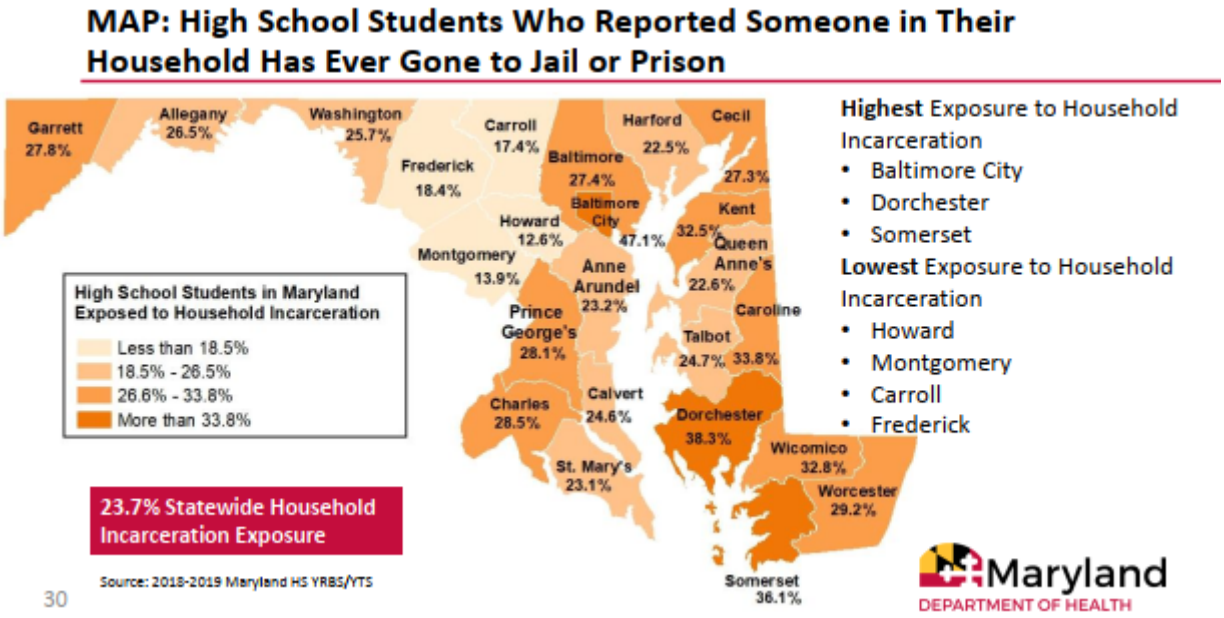
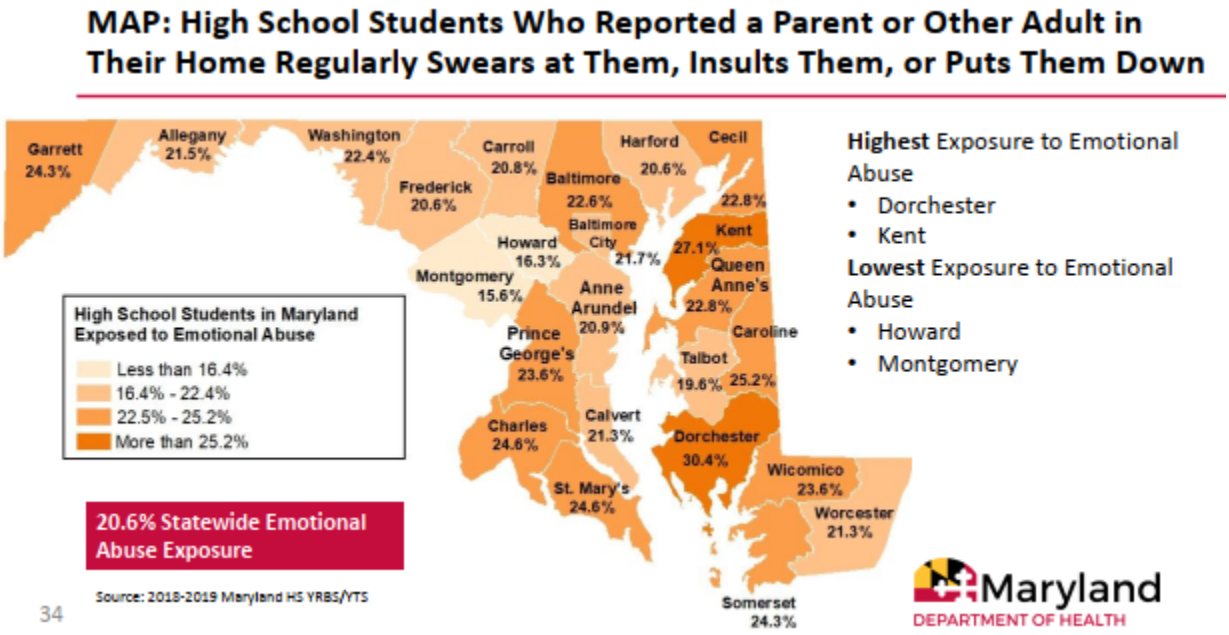
Baltimore City, Dorchester, and Somerset counties have the highest rates of caregivers who have been incarcerated.

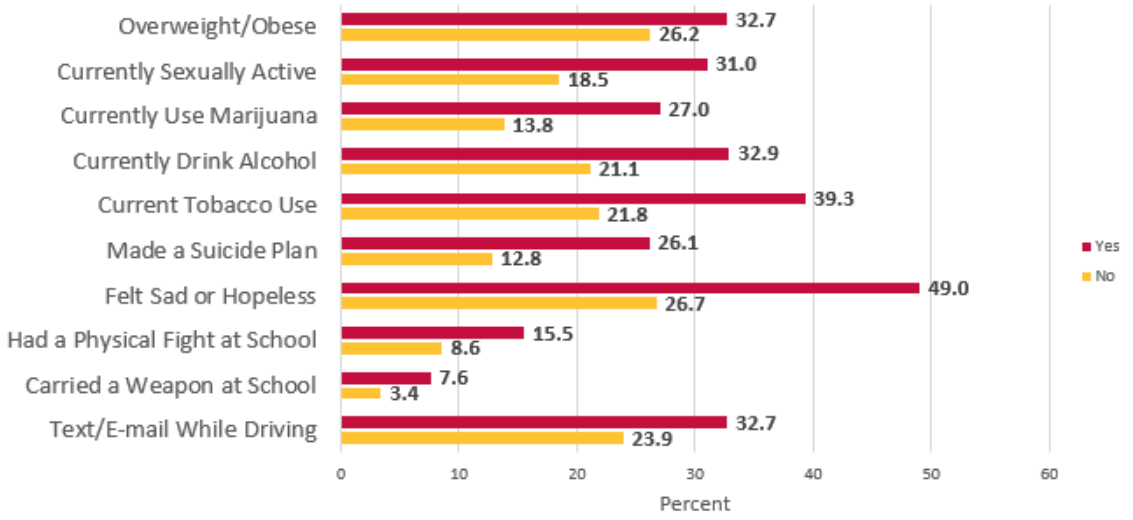


Dorchester and Kent counties have the highest rates of teens exposed to emotional abuse.



A comparison of teens exposed to household substance abuse compared to unexposed teens showed higher rates of obesity, alcohol, tobacco, and marijuana use, depressive symptoms, and risky behavior among those teens exposed to substance abuse.

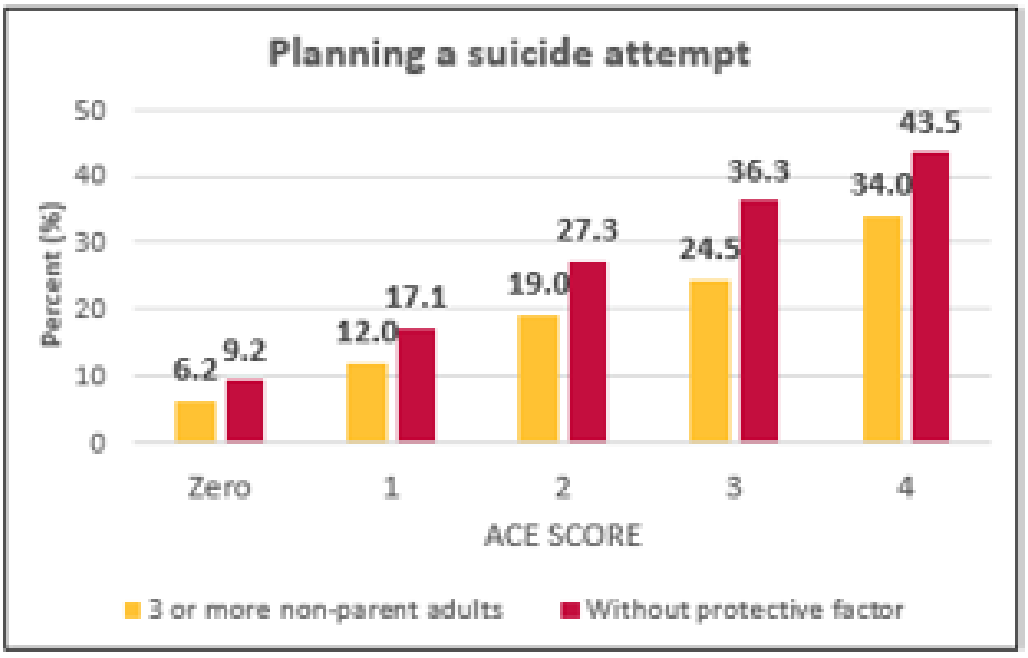
Exposed to Household Substance Abuse & Risk Behaviors



Source: 2018-2019 Maryland HS YRBS/YTS

Such data point to the importance of identifying caregivers with substance abuse, engaging caregivers in treatment, and having adequate treatment resources available in all communities.

The data below show the importance of having support from 3 or more non-parent adults in protection from suicidal ideation. For all levels of ACEs, teens with this protective factor were less likely to exhibit suicidal ideation than those without the protective factor.



Additional YRBS ACE data can be found in the 2019 SCCAN Annual report attached to this testimony.

Inclusion of the full complement of ACE questions and questions on positive childhood experiences would provide additional valuable data to Maryland citizens and policymakers. The required reports will enable the data to be used to target prevention and treatment services and to track the success of interventions.

For these reasons, we strongly support Senate Bill 548 and urge a favorable committee report.

MARYLAND DEPARTMENT OF HUMAN SERVICES

MARYLAND STATE COUNCIL ON CHILD ABUSE & NEGLECT ANNUAL REPORT

JANUARY 1, 2019 – DECEMBER 31, 2019

MARYLAND

SCCAN
Maryland's
State Council on Child Abuse and Neglect

ACKNOWLEDGMENTS

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

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

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

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

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

- Pat Cronin, Executive Director of The Family Tree, her Board, and staff. Presidents, Charles Roebuck and Sally Bauer, and the Board for funding the ACE Interface Project, supporting ACEs Education & Advocacy Day in Annapolis for policy makers and the ACEs Roundtable for Members of the General Assembly to ensure that Maryland becomes a N.E.A.R. Science-Informed State; and, for testifying on behalf of HB 486, S.E.S.A.M.E. (Stop Educator Sexual Abuse Misconduct & Exploitation) legislation. Pat Cronin and the staff of The Family Tree for their co-backbone support of Maryland Essentials for Childhood Initiative, particularly Ruby Parker, Naketta Lowery, and Jennifer Roberts for their leadership and support of the ACE Interface Project.

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

- ACE Interface Master Presenters for joining the ACE Interface Project and dedicating their valuable time and skills to the efforts to ensuring Maryland becomes a N.E.A.R. Science-Informed State: Alexandra Podolny, Alisha Saulsbury, Amie Myrick, Andrea Butler, Andrew Bell, Angela Gray, Angela Holocker, Beth Anne Langrell, Beth Schmidtt, Candace Hawkins, Cara Calloway, Carmen Getty, Carol Auerbach, Catherine Abrams, Chari Jones, Charlene Creese, Charles Gammons, Denise Garman, Denise Messineo, Desiree Shantai Smith, Dillon McManus, Donna Jacobs, Doria Fleisher, Elizabeth Garcia, Emily Moody, Eric Rollins, Guli Fager, Harold Young, Harriet Smith, Heather Hanline, Jamie Shepard, Jan Brewer, Jay Hessler, Jen Thomas, Jennifer Redding, Jennifer Roberts, Jenny Howard, Jessica Oterson, Jim Raley, Jonathan Williams, Joseph Windsor, Joy Ashcraft, Kawana Webb, Kelly Hutter, Kelly Reynolds, Kim Dumas, Kimberly Buckheit, Kimberly Repass, Kip Castner, Kristy Conklin, Lacey Tsonis, Latrice Gray, Lauren Williams, Laurie Galloway,

Laverne Cray, Leah Bentfield, Leslie Follum, Ligia Teodorovici, Lori Hauser, Lucane LaFortune, Marie Statton, Martha Ruiz, Matila Jones, Megan Pinder, Melissa King, Melita Friend, Meredith Miller, Michelle Gilliam, Michelle Lancaster, Miera Corey, Myra Sturgis Glover, Nana Ama Adom-Boakye Kanyi, Nicole Conner, Nicole Fisher, Pat Mosby, Patricia Barger, Paul Griffin, Robert Zellner, Rose Zollinger, Sadie Liller, Sandra Gammons, Sara Haina, Scott Showalter, Sean Robinson, Shannon Cassidy, Shantay McKinily, Staci Aperance, Stephanie Scharmen, Stirling Ward, Tarik Harris, Tasha Jamison, Terrell Sample, Tonya Green- Pyles, Tracey Cottman, Victoria Rentz, Vonda Colson, and William Jernigan.

- Maryland ACEs Connection Community Managers, Jamie Shepard, Ruby Parker, Claudia Remington and Erik Weber.

- Vanessa Milio, Executive Director of No More Stolen Childhoods (NMSC), and the Board of NMSC for lending their expertise to efforts to pass S.E.S.A.M.E. legislation and HB 687 and HB 974 (Child Sexual Abuse Civil Statute of Limitations Reform) through testimony, and media, and social media advocacy. Special thanks go to Founder, Wayne Coffey; Board Presidents, Michael Fitz-Patrick and Pamela Piro; and Secretary, Brooks Patternotte for their bill testimony and/or support of the ACEs Roundtable for Members of the General Assembly; and, Vice President, Christian Mester, for sharing his legal expertise. Additionally, thanks go to Sondheim Nonprofit Leadership Fellow, Olivia Morse (with the support of NMSC E.D. and Board) for her assistance in the researching and drafting of Maryland Essentials for Childhood's ***Toward A More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities.***

- Delegate Vanessa Atterbeary and Senator Antonio Hayes for sponsoring the ACEs Roundtable for Members of the Maryland General Assembly (MGA).

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

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

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

- Maryland Essentials for Childhood partners for their volunteerism and support of the Roundtable: Ulysses Archie for providing photography services, Pat Cronin, Stacey Jefferson, Eileen King, Wendy Lane, Brittany Lore, Denise Messineo, Olivia Morse, Ruby Parker, Pam Piro, Claudia Remington, Melissa Rock, Jamie Shepard, and Joan Stine.

- Sarah Manekin and The Abell Foundation for their generous support of facilitation services and graphic recording of the ACEs Roundtable for Members of the MGA.

- Sue Borchardt for her assistance in planning and facilitating the ACEs Roundtable; and, Lucinda Levine of Inkquiry Visuals for her graphic recordings of the ACEs Roundtable.

- Delegate C.T. Wilson for sponsoring and tirelessly advocating for HB 486 (S.E.S.A.M.E. legislation) and HB 687 (2019) HB 974 (2020) (The Hidden Predator Act of 2019 and 2020 - Child Sexual Abuse Civil Statute of Limitations Reform) to prevent child sexual abuse *before it occurs*.

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

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

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

- Vanessa Milio and Becca Lestner for the design of legislative talking points for HB 486/SB 541, social media images, and S.E.S.A.M.E. Social Media Toolkit.

- Nicole Atkinson, Owner of Push to Start, for her pro bono publications and communications services on behalf of Maryland's S.E.S.A.M.E bill.

- Shannon Sollenberger, Legislative Counsel to the Senate of the Commonwealth of Pennsylvania for sharing her expertise and experience and important lessons learned in passing S.E.S.A.M.E. legislation in Pennsylvania.

- S.E.S.A.M.E. President, Teri Miller for sharing her time, expertise and national S.E.S.A.M.E. organization resources in support of passage of Maryland's HB 486/SB 541.

- Dr. Chester Kent for sharing his time and expertise to inform Maryland's S.E.S.A.M.E. legislation and for traveling to Maryland to testify on behalf of the bill.

- Jetta Bernier, Executive Director of Mass Kids, and Rush Russell, Executive Director of Prevent Child Abuse New Jersey, for sharing their time, expertise, and lessons learned from efforts in their states to pass S.E.S.A.M.E. legislation.

- The Legal Resource Center for Public Health Policy at the University of Maryland Francis King Carey School of Law, Professor and Director, Kathleen Hoke, and law students Kevin Redden, Lauren Fash, Ariel Neumann, Felicia Langel and Brooke Kasoff for their legal expertise, testimony, and support of efforts to pass S.E.S.A.M.E. legislation and the Hidden Predator Act of 2020.

- The following organizations for their support and advocacy on behalf of passing S.E.S.A.M.E: Maryland Association of Boards of Education (MABE); No More Stolen Childhoods; The Moore Center for the Prevention of Child Sexual Abuse; Maryland PTA; American Academy of Pediatrics, Maryland Chapter; Prevent Child Abuse, Maryland, The Family Tree; Advocates for Children and Youth (ACY); Parents' Coalition of Montgomery County; Child Justice; Maryland Children's Alliance; Baltimore Child Abuse Center; Citizens' Review Board for Children; Maryland Family Network; Maryland Catholic Conference; CASA; Parents' Anonymous of Maryland; Center for Children; Council for American Private Education (CAPE); and National Association of Social Workers, Maryland Chapter (NASW);

- The Maryland State Education Association, particularly Sean Johnson, and the Maryland Association of Nonpublic Special Education Facilities, particularly Dorie Flynn, for their good faith negotiations on HB 486/ SB 541 in order to find solutions to their concerns about the bill, while ensuring the protection of the students in their care.

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

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

- Kathryn Robb, JD, Executive Director of Child USAdvocacy, for her outstanding and considerable legal research, written testimony, advocacy, and oral testimony on behalf of HB 687 and HB 974 The Hidden Predator Acts of 2019 and 2020.

- Delegate C.T. Wilson, Jena Cochrane, Sarah Conway, Lil Hughes Knipp, Theresa Lancaster, David Lorenz, Patti Mills, Kathryn Robb, Kurt Ruprecht, David Schappelle, Carolyn Surrick, Jean Wehner for their powerful, compelling, and courageous oral and written testimony, media advocacy, and legislative advocacy to pass HB 687 and HB 974 The Hidden Predator Acts of 2019 and 2020. Allies for their powerful and compelling testimony: Kay Connors, LCSW-C Michael Fitzpatrick, Paul Griffin, JD, Jennifer Gross, Felicia Langel, Wendy Lane, MD, MPH, Claudia Remington, JD

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

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

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

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

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

- Maryland Child Abuse & Neglect Fatality (MCANF) Workgroup: Rich Lichenstein, Wendy Lane, Cathy Costa, Joan Stine, Melissa Rock, Rachel White, Denise Wheeler, Pam Dorsey, Linda Ramsey, Erica LeMon, Corine Mullings, Cathy Meyers, Veto Mentzell, Sheree Keitt, Maura Dwyer, and Claudia Remington.

- Nicholle Cross, Capstone Project master's in public health candidate at University of Maryland, for her analysis and drafting of the initial MCANF Workgroup Report.

- Sara Manetta, Medical and master's in public health student at the University of Maryland, for her assistance with developing the SCCAN-MD EFC Education, Advocacy, and Awards Day at the General Assembly.

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

TABLE OF CONTENTS

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November 9, 2020

The Honorable Larry Hogan
Governor of Maryland
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The Honorable Bill Ferguson
President of the Senate
State House
100 State Circle, Room H-107
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The Honorable Adrienne A. Jones
Speaker of the House
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Re: Family – General Article, Annotated Code of Maryland, § 5-7A-09, State Council on Child Abuse and Neglect (SCCAN) Final Report for 2017

Dear Governor Hogan, President Ferguson and Speaker Jones:

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

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

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

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

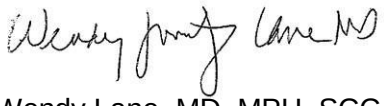
1) *to "evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities;"*
2) *to "report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of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

As the SCCAN mandates are quite broad, the Council must choose priorities on which to focus each year. For 2019, we have chosen to continue our focus on the primary prevention of child maltreatment, health care for children involved in the child welfare system, and child abuse and neglect fatalities. On pages 59-69, the Council recommends several actionable steps to improve

Maryland's child and family serving systems in order to protect children and to prevent child maltreatment and other Adverse Childhood Experiences (ACEs) *from occurring in the first place*. Specific recommendations are made to prioritize prevention of ACEs, create a Children's Trust & Prevention Fund, coordinate the work of child and family serving systems, pass additional child sexual abuse prevention legislation, prevent child abuse and neglect fatalities, and improve health care for children involved in child welfare. Each of these issues has become more urgent as a result of the coronavirus pandemic, with job losses, school closures, and isolation increasing the risk of abuse and neglect for Maryland children.

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

Sincerely,



Wendy Lane, MD, MPH, SCCAN Chair

cc: DHS Secretary Lourdes R. Padilla
MDH Secretary Robert R. Neall
DJS Secretary Sam Abed
MSDE State Superintendent of Schools, Dr. Karen B. Salmon, PhD
MDD Secretary Carol A. Beatty
DBM Secretary David R. Brinkley
DPSCS Secretary Stephen T. Moyer
DLLR Acting Secretary James Rzepkowski
Governor's Office of Crime Prevention, Youth, and Victim Services, V. Glenn Fueston, Jr., Executive Director
SCCAN Members

EXECUTIVE SUMMARY

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

SCCAN's 2019 Annual Report to the Governor and General Assembly continues to provide a framework for a seismic shift in how we as a state address child abuse and neglect, along with related adverse childhood experiences (ACEs) or childhood trauma. Child physical, sexual, and emotional abuse and child neglect are traditional foci; to these more obvious forms of abuse, we now add other adverse events shown to disrupt the healthy development of children, including but not limited to parental mental illness, parental substance abuse, domestic violence, parental incarceration, divorce and separation, experiencing racism, witnessing violence, living in an unsafe neighborhood, living in foster care, peer violence, and bullying, and historical and intergenerational trauma. Individually and particularly when experienced in combination, these ACEs lead to poor child health and educational outcomes and also reduce public safety and economic productivity at an immense cost to children and taxpayers. We support Governor Hogan's vision of economic opportunity for all of Maryland's children, youth, and families and urge him and the General Assembly to develop and refine policy in ways that leverage the exciting advances in the N.E.A.R. (Neurobiology, Epigenetics, ACE Study, and Resilience) science to reach that vision. SCCAN's recommendations for more than ten years have set out specific policies, strategies, and training that build the individual and collective knowledge and skills of Marylanders in our child and family serving agencies and communities to provide the safe, stable and nurturing relationships and environments that children need to grow into healthy and productive citizens. In responding to feedback on prior SCCAN reports, some recommendations are addressed specifically to the Governor, the General Assembly, or one or multiple child and family serving agencies. At the same time, implementation of many of these recommendations will require leadership support and the hard but attainable work of collaboration and coordination across child and adult serving agencies that strive now more than ever to integrate themselves and their missions toward this shared vision.

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

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

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

SCCAN's Annual Report includes the following:

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

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

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

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

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

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

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

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

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

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

6. Embed the science of the developing brain, ACEs, and resilience into the Children's Cabinet Three-Year Plan. Start by providing ACE training to all Children's Cabinet members. When creating future plans, consider how each recommendation might reduce ACEs or their impact, and improve child, family, organizational, and community resilience.

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

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

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

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

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

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

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

12. Pass legislation providing for Paid Family Leave.

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

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

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

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

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

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

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

BACKGROUND

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

SCCAN consists of up to twenty-three members, most of whom are private citizens appointed by the Governor of Maryland, including representatives from the Maryland Chapter of the American Academy of Pediatrics, professional and advocacy groups, private social service agencies, and the medical, law enforcement, education, and religious communities. At least two members must have personal experience with child abuse and neglect within their own families or have been clients of the child protective services system. Eight members of SCCAN are designated representatives of their respective organizations including: the Maryland Senate, Maryland House of Delegates, Department of Human Services, Department of Health, Department of Education, Department of Juvenile Services, Judicial Branch, and the State's Attorneys' Association.[6]

SCCAN's mandate is defined in Federal and State law. CAPTA charges SCCAN and all citizen review panels "to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities"[7] and to "provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations."[8] The Maryland Family Law Article reiterates the CAPTA requirements and specifically charges SCCAN to "report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs".[9]

Prevention as a priority

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

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

[6] See Appendix D for current members.

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

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

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

national, state, and local funding streams and responses to the problem of child maltreatment are directed at a case-by-case approach to detecting, investigating, prosecuting, and providing CPS or court supervised services to the "perpetrators" of abuse and neglect and to protecting children who have already been abused or neglected from future abuse and neglect by providing services to families or placing children in foster care.

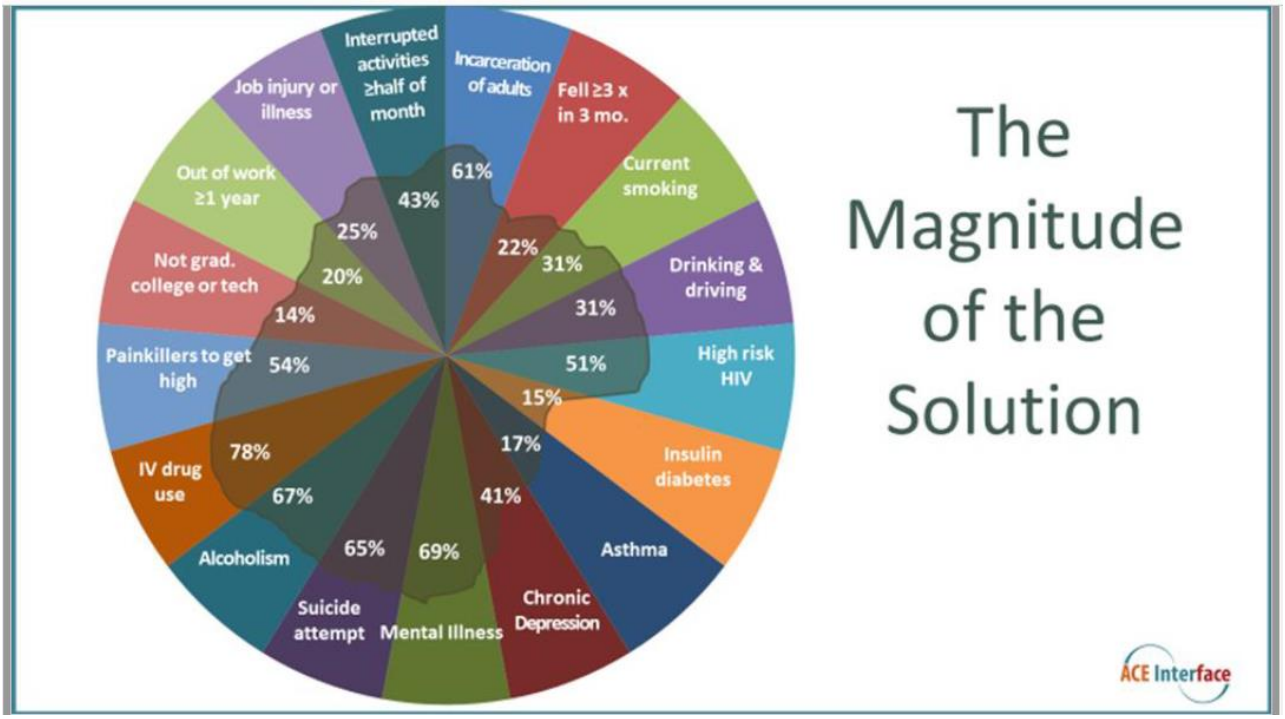
A broader public health approach is needed to prevent child maltreatment *before it occurs.* The public health approach extends our criminal justice and case-based approaches by fostering a better understanding of the complex causes of child maltreatment in order to more effectively and preemptively intervene at all levels of the socio-ecological model (individual, family, community, and societal). Current prevention programs, policies, and practices in Maryland are fragmented across public and private agencies; and, vary both qualitatively and quantitatively from jurisdiction to jurisdiction. While many states, including Tennessee, Wisconsin, Iowa, Minnesota, Washington, Colorado, California, North Carolina, Massachusetts, among others are developing a coordinated approach to addressing childhood adversity and its impacts, **Maryland has no state agency that is specifically mandated to focus on primary prevention of child maltreatment. With the absence of mandated leadership, there is no formal cross-sector statewide strategy for promoting child well-being and preventing child maltreatment and other ACEs before they occur, leaving current prevention efforts are fragmented across agencies.** That is why SCCAN and its partners joined together to form Maryland Essentials for Childhood Initiative, a statewide collective impact[10] initiative that promotes safe, stable, nurturing relationships and environments for children and prevents, mitigates ACEs, and builds resilience in children, families, and communities.

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

THE SCIENCE OF THE DEVELOPING BRAIN, ACES & RESILIENCE: A STRONG CASE FOR A PROSPEROUS MARYLAND[11]

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

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



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

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

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

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

2. Experiences Build Brain Architecture

3. Serve & Return Interactions Shape Brain Circuitry

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

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

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

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

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

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

10. Rethinking Our Policies

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

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

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

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

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

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

BRAIN SCIENCE SERVES AS A STRONG FOUNDATION FOR GOVERNOR HOGAN'S VISION OF ECONOMIC OPPORTUNITY & STRATEGIC GOALS[13]

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

I. **A primary focus on Early Childhood Development is foundational to promotion and prevention efforts, i.e., Brains are built from the bottom up. Skills beget skills. The ability to change brains and behavior decreases over time (brain plasticity).**
II. **Prevention of Childhood Adversity and Early Intervention to Mitigate Trauma is a necessary precursor to effectively preventing many youth problems, including youth homelessness and disconnection.**
III. **Data systems should track the trajectory of children from one state system and/or service to the next.**
IV. **Brain Science should be used to Design Multi-Generation Paths Out of Violence, Poverty, Addiction and Mental Illness**
V. **Understanding brain science, ACEs and how trauma impacts executive function skills is critical to providing the best possible Customer Service in child and family service systems**.
VI. **Understanding neurobiology, epigenetics, ACEs, and resilience changes practice.**

Our failure to prevent children's maltreatment (CM) *before it occurs* is conservatively estimated to cost Maryland's economy, businesses and taxpayers over $1.5 billion each year. Investing in child well-being and preventing CM is not only *humane and just*, but *makes good economic sense*.[14]

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

MAGNITUDE OF THE PROBLEM IN MARYLAND

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

CPS reports are known to underestimate the true occurrence of maltreatment. Non-CPS studies estimate that 1 in 4 U.S. children experience some form of child maltreatment in their lifetimes.[15] It is important to look at multiple sources of data to understand the true scope of the problem. To give the reader some perspective on the problem in Maryland, the Council considers data from three Maryland sources below: Maryland CPS Data (incidence), Behavioral Risk Factor Surveillance System ACE Module data (childhood prevalence among Maryland adults of all ages), and Youth Risk Behavior Survey data (prevalence to date among adolescents).

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

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

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

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

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

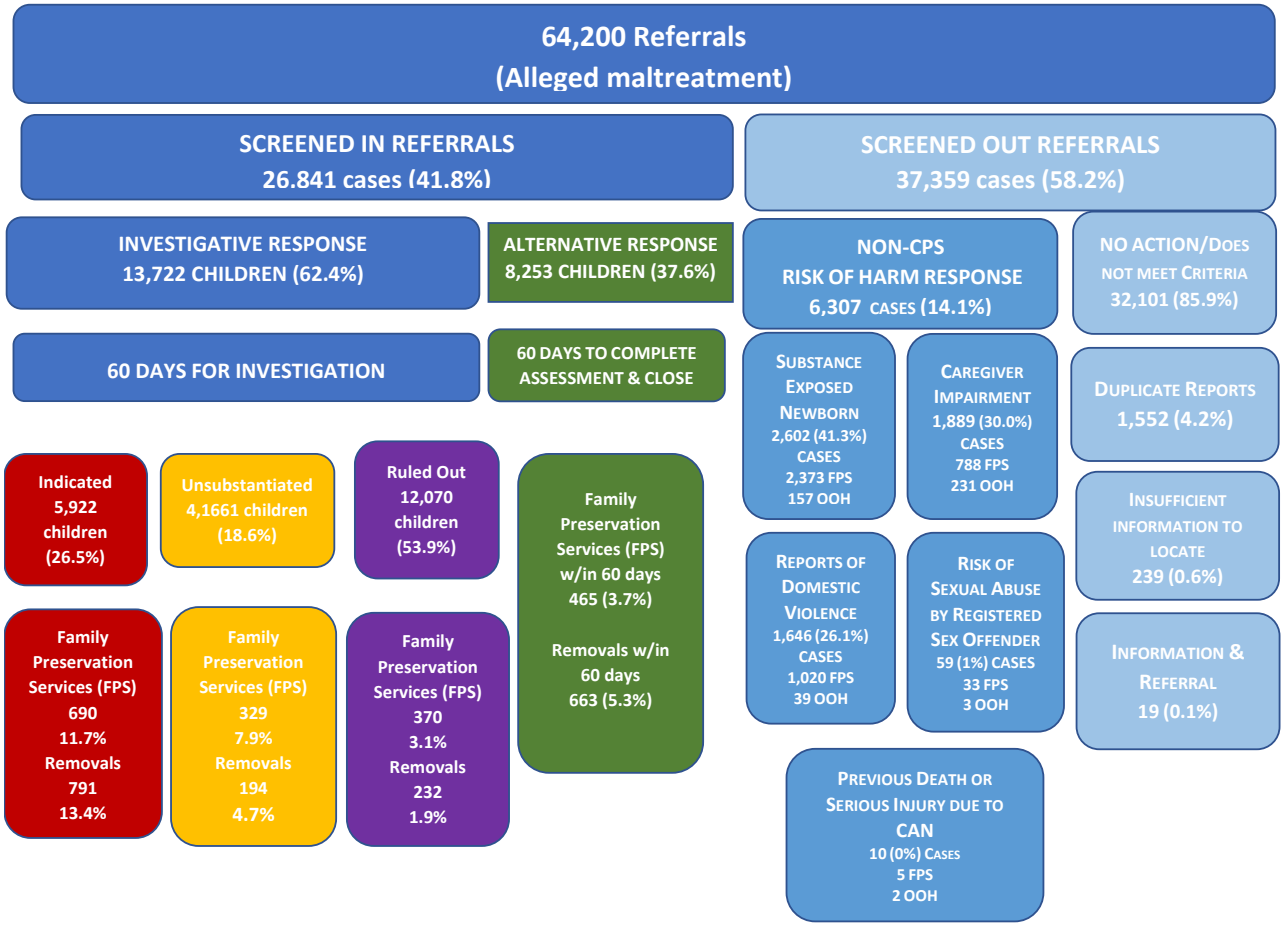
(or 8% of AR cases) ended up with a removal; and, the majority of AR cases (86.4%) received neither services nor ended up in a removal.

- Data was not readily available to indicate what, if any, services were offered to and accepted by children and their families. This is unfortunate as many of the children referred to child welfare experience significant risk factors (multiple types of maltreatment, parental mental illness, substance abuse, incarceration, domestic violence) that result in poor short and long-term outcomes. ***It is unclear from available data the extent to which children and families are not only referred for services but linked and provided those services.***
- Of particular concern to both SCCAN and the Citizen's Review Board for Children is the absence of data to verify the extent to which children are receiving necessary health and mental health services and care coordination. Almost 60% of cases reported to child protective services (CPS) by mandated reporters and concerned citizens go unaddressed according to the data provided by DHS, SSA (Figure A). Even cases that receive a child welfare response lack accurate tracking and reporting services and outcomes. This is particularly troubling as children involved with child welfare face complex challenges of chronic and extreme stress that threaten their long-term health and well-being; and, being known to CPS is a risk factor for child maltreatment fatalities[17].

Data from SCCAN's 2013-2018 Annual Reports emphasized the importance of tracking health services and outcomes for children involved with child welfare. Gathering and analyzing this data should be a high priority for ensuring our state's appropriate care of these our *most* vulnerable children. Because children and families involved in child welfare are often involved in multiple public systems − public health, behavioral health, primary care, Medicaid, child welfare, criminal and juvenile justice, education, public assistance, and child support enforcement—**it is essential that these systems work in unison and share data effectively to meet these children's health care needs.** Brain science and the ACE Study indicate that leaving these needs unmet leads to poor behavioral, health, educational, employment, and relational outcomes in the future. **A comprehensive state plan to prevent and mitigate ACEs should include gathering, sharing and analyzing data to help understand the magnitude of the problem and ensure data-driven solutions.**

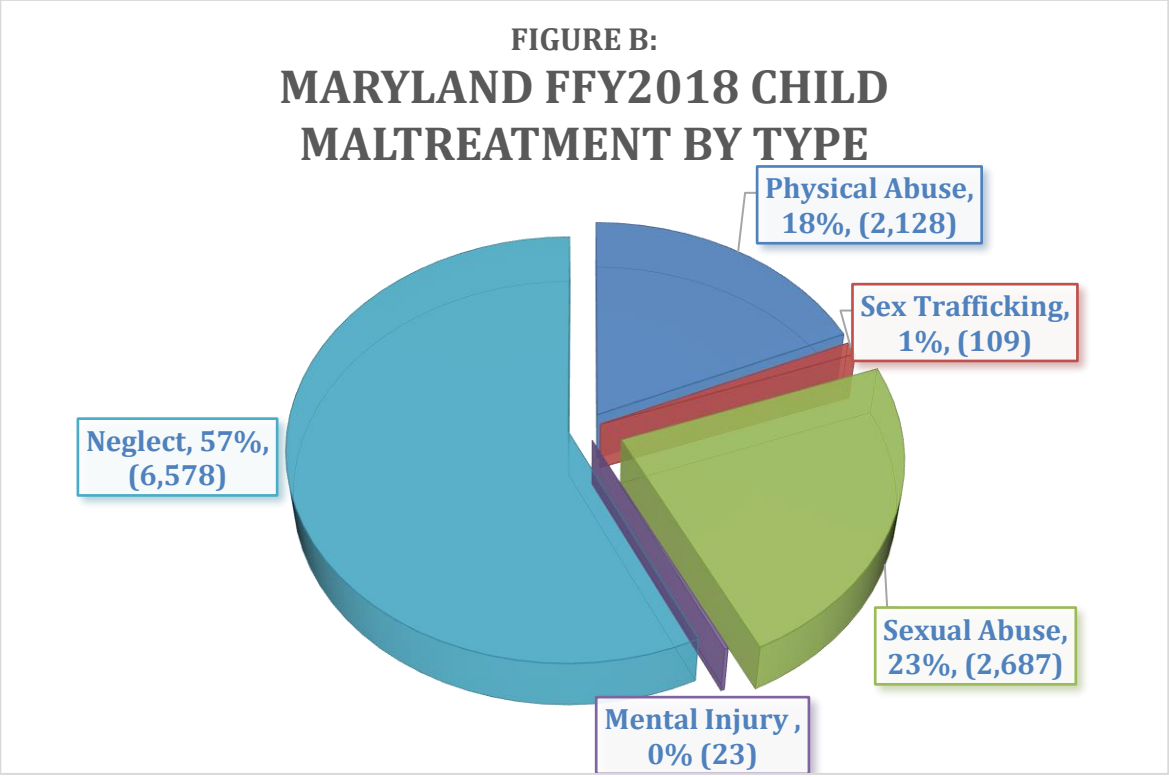
[17] Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, p. 14.

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



Child Maltreatment by Type:

- Neglect is the largest category of child abuse/neglect at 57% (down from 63% in 2017), followed by sexual abuse at 23% (up from 11% in 2017), physical abuse at 18% (down from 26% in 2017), sex trafficking at 1% (1st reported period) and mental injury at 0%. See Figure B below.
- Chronic neglect is given less attention in policy and practice, however can be associated with a wider range of damage than physical or sexual abuse. Science tells us that young children are especially vulnerable to poor physical and mental health outcomes of neglect. A broad range of developmental impairments can occur, including cognitive delays, stunting of physical growth, impairments in executive function and self-regulation skills, and disruptions of the body's stress response.[18]
- Sexual abuse was up from 11% of indicated cases in 2017 to 23% of indicated cases in 2018. SCCAN asked for a deeper dive into this data to begin to understand the significance of this increase. Due to demands for data analysis concerning COVID-19 issues, the data and analysis could not be provided by SSA. Further analysis of this data would be helpful, especially if this trend continues.



Caregiver Risk Factors for Child Maltreatment:

Caregiver risk factors are characteristics of a caregiver that may increase the likelihood that their children will be victims of abuse and neglect. Parental drug and alcohol abuse are documented risk factors. However, the extent of the problem in Maryland is challenging to ascertain because different data sources provide very different statistics. The U.S. Department of Health and Human Services, Administration for

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

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

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

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

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

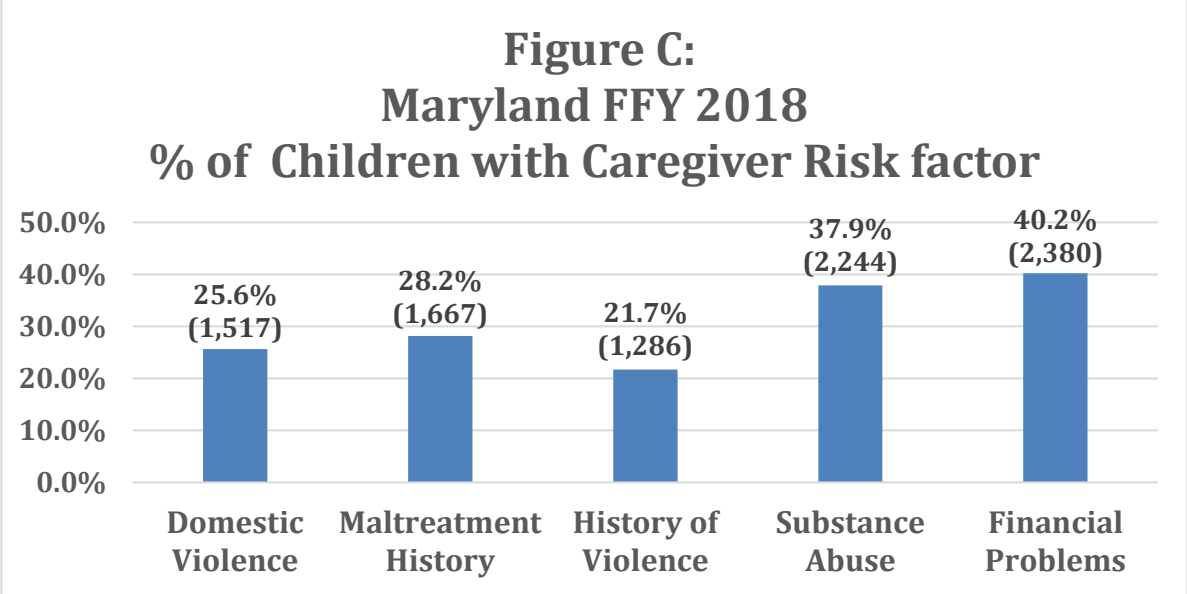
Parental **Risk Factors Among Maryland Children Who Receive an Investigative Response from DSS no matter the finding (as reported to SCCAN by DHS)**:

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

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

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

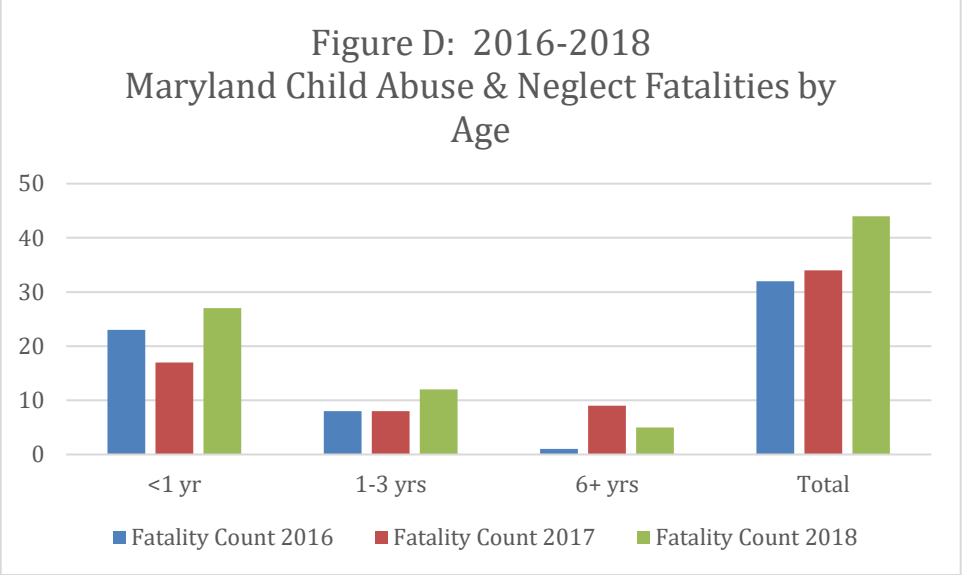
[21] https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html



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

Child Abuse & Neglect Fatalities as Reported by DHS:

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



COLLECTING ACE DATA in MARYLAND:

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

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

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

BRFSS and the ACEs Module

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

Since 2009, states have been collecting ACEs data through their BRFSS. In 2013, SCCAN and MD EFC recommended adding the ACEs module to Maryland's BRFSS and successfully advocated in 2014 for inclusion of the module in the 2015 BRFSS. SCCAN and MD EFC recommended inclusion of the ACE

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

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

Physical Abuse	"Before the age of 18, how often did a parent or adult in your home ever hit, beat, kick or physically hurt you in any way? Do not include spanking." Response options: Never, Once, More than once.
Emotional abuse	"Before age 18, how often did a parent or adult in your home ever swear at you, insult you, or put you down?" Response options: Never, Once, More than once.
Sexual abuse	"Before the age of 18, how often did anyone at least 5 years older than you or an adult ever touch you sexually?", "Before the age of 18, how often did anyone at least 5 years older than you or an adult ever try to make you touch them sexually?" or "Before the age of18, how often did anyone at least 5 years older than you or an adult ever force you to have sex." For analysis Maryland classified an adult to have been sexually abused if they answered once, or more than once to at least one of these questions Response options: Never, Once, More than once. Responses of "once" or "more than once" to one or more of these questions were classified as sexual abuse.
Household Mental Illness	"Now, looking back before you were 18 years of age, did you live with anyone who was depressed, mentally ill, or suicidal?"

Household Substance Abuse	"Before you were 18 years of age, did you live with anyone who was a problem drinker or alcoholic?" or "Before you were 18 years of age, did you live with anyone who used illegal street drugs or who abused prescription medications?
Divorce & Separation	"Were your parents separated or divorced?" Response options: Yes, No, Parents not married. Responses of "parents not married" were excluded from analysis due to small numbers (<2% of sample).
Household Incarceration	"Before you were 18 years of age, did you live with anyone who served time or was sentenced to serve time in a prison, jail or correctional facility?"
Witnessing Domestic Violence	"How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?" Response options: Never, Once, More than once.

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

YRBSS and the ACEs Module

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

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

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

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

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

The following questions were asked of Maryland high school students:

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

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

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

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

PREVALENCE OF ACEs IN MARYLAND ADULTS:

Maryland collected baseline ACE data in 2015 and 2018. In the collection of this data, important insights into prevalence of ACEs were gained by examining the following characteristics of those impacted by ACEs:

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

Limitations to the Data

- BRFSS data does not survey adults living in institutions such as nursing facilities, group homes, or prisons. These populations may be disproportionately affected by ACEs and their exclusion may result in an underestimate of the true prevalence.
- Data does not indicate the severity or frequency of each ACE, but rather whether each ACE occurred or did not occur.
- Data does not indicate the temporality of each ACE; data indicates whether an ACE happened, not when it happened. Because data are cross sectional, we can only say the ACEs happened before the age of 18.
- In some instances, the sample size is small. This can increase variance and corresponding confidence intervals, thereby decreasing the precision of estimates. It can also limit the ability to look at prevalence of other state-added questions, such as sexual orientation by abuse type, as this stratification would further reduce the number of individuals in each category, making estimates even less precise.

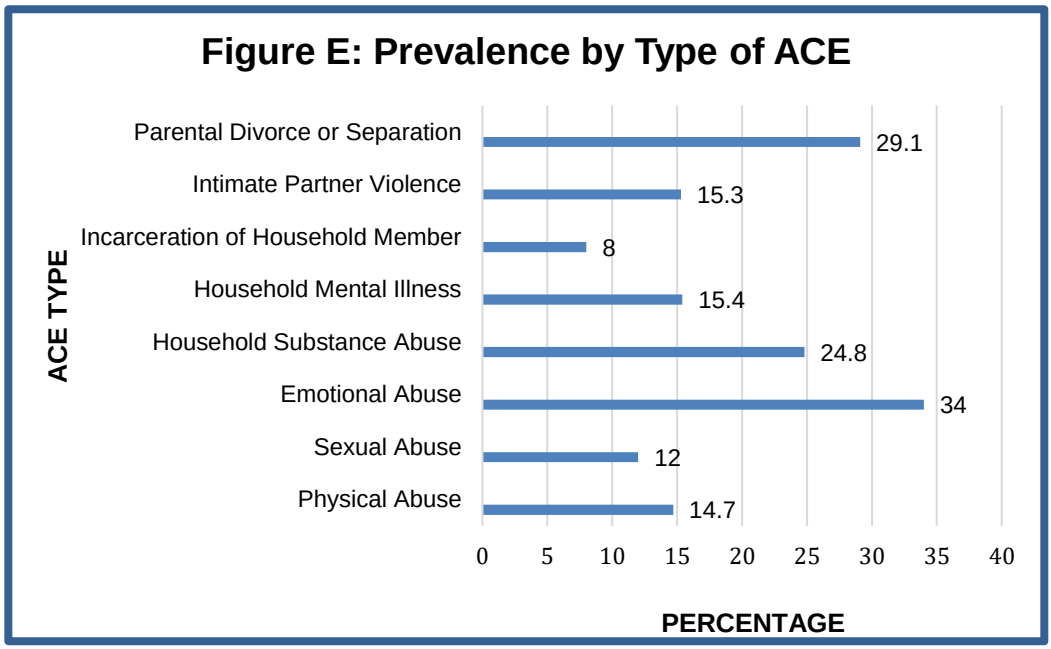
KEY FINDINGS in MARYLAND:

ACEs are COMMON:

Three fifths of the 12,000 BRFSS participants who completed the ACE module in Maryland in 2018 reported having at least one ACE at some point during their childhood. Approximately 24%, almost a quarter, reported three or more ACEs.

Prevalence by Type of ACE

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



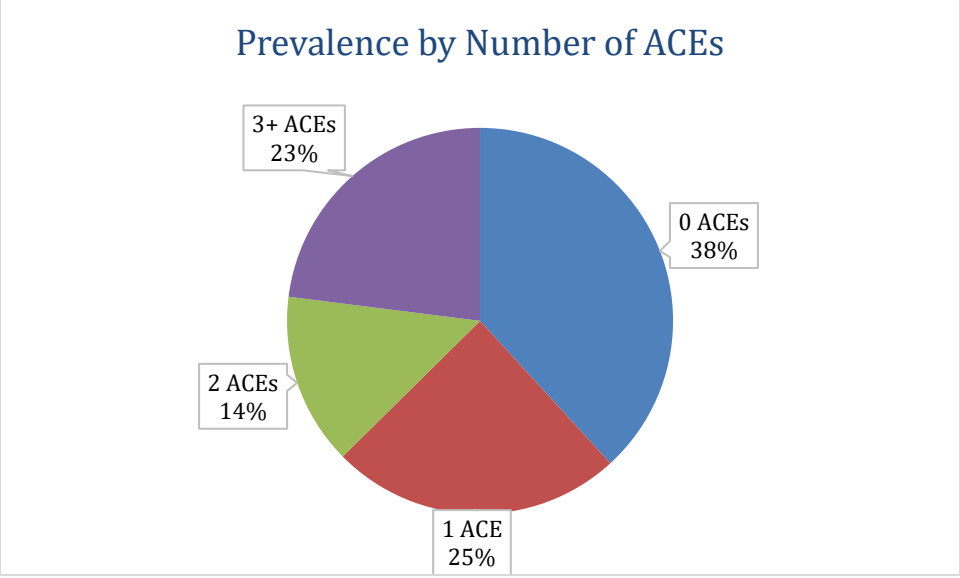
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

ACEs are RARELY FOUND IN ISOLATION− ACEs TEND TO OCCUR IN CLUSTERS:

The cumulative impact of ACEs is captured in the “ACE Score”. If an individual has experienced one ACE, they are likely to have multiple; 24.4% reported one ACE compared to 37.4% reporting 2 or more ACEs. The ACE score captures the potential extent of neuro-developmental disruption as a result of traumatic stress.

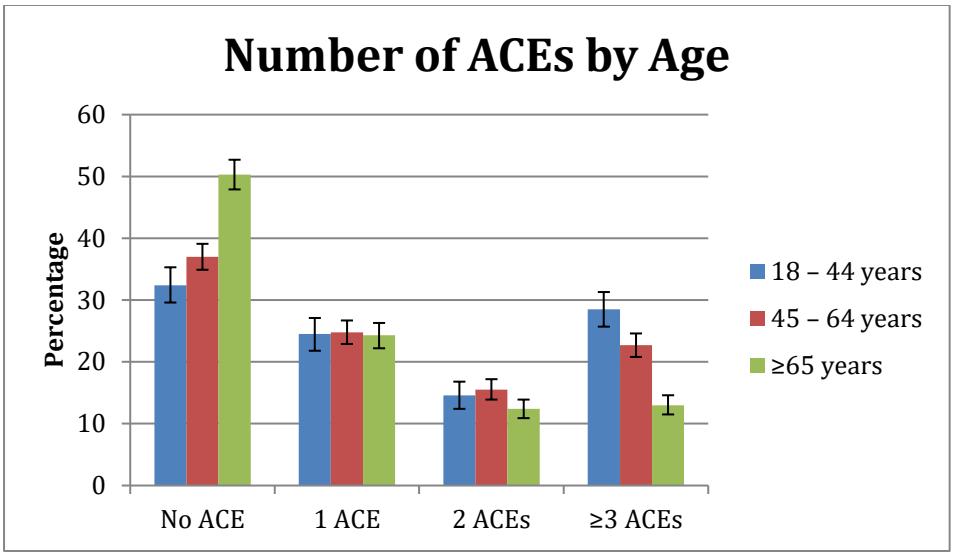
Prevalence by Number of ACEs

As reported in the 2018 Maryland BRFSS, approximately 38% of respondents reported zero ACE exposures, 25% reported 1 ACE, 14% reported2 ACEs, and 23% reported experiencing 3 or more different types of ACEs. For simplicity, we can think of this as no ACE exposure, low ACE exposure, or high ACE exposure. It is important to remember this does not give us information on which ACEs are occurring together.



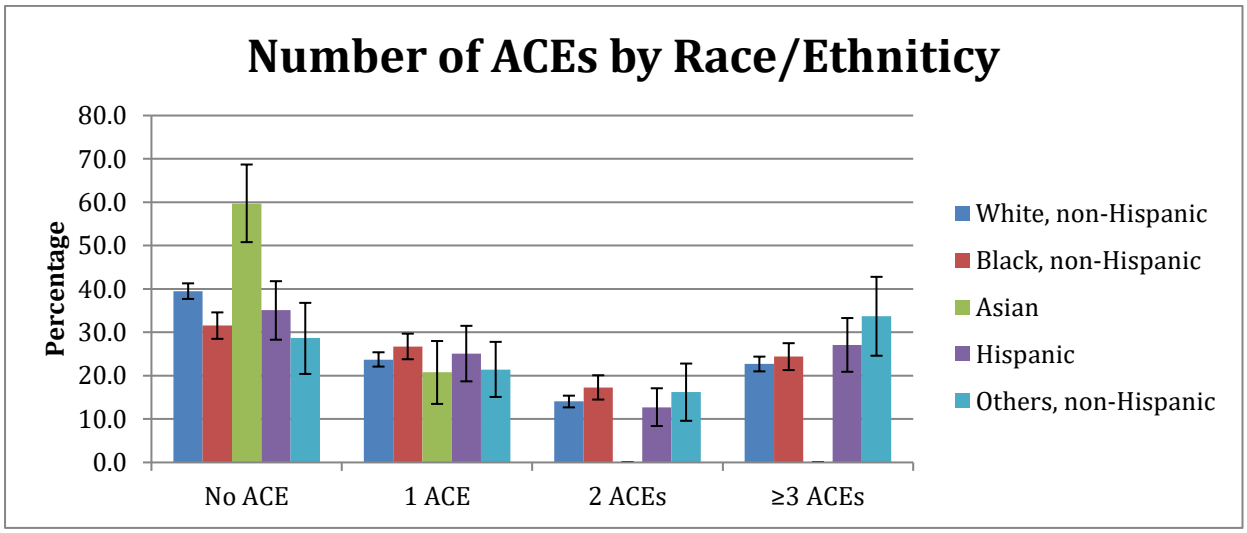
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

DEMOGRAPHICS



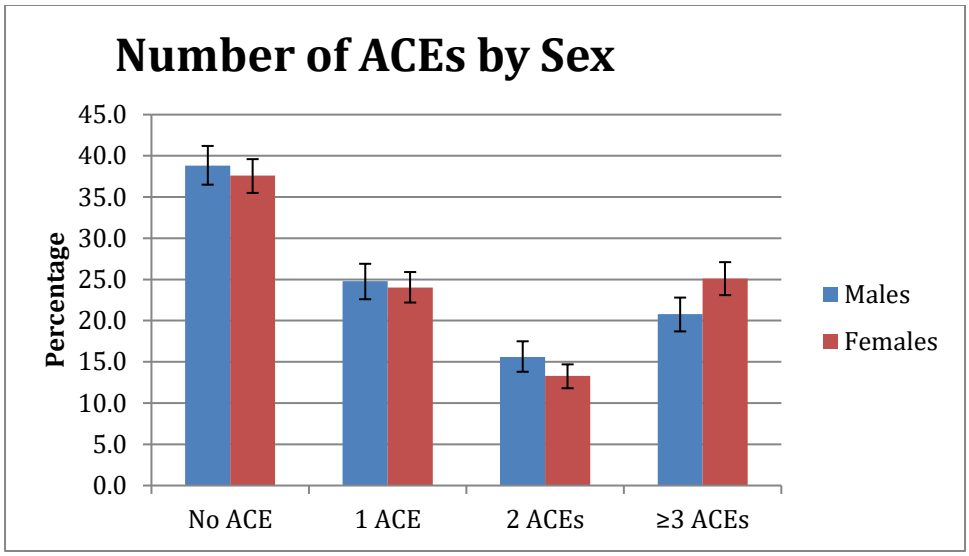
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

As respondent age increases, the frequency of reporting multiple ACEs decreases. Individuals over 65 are significantly more likely to report no ACE exposure and less likely to report greater than 3 ACEs compared to younger respondents. We can speculate that this could be a result of recall bias or more specifically, that as age increases our recollection decreases. Alternatively, we could hypothesize that younger generations are more aware of ACEs due to current discussions/information sharing about its importance to understanding health, and thus are more likely to report them. This data is interesting, yet we must be careful not to overstate its meaning.



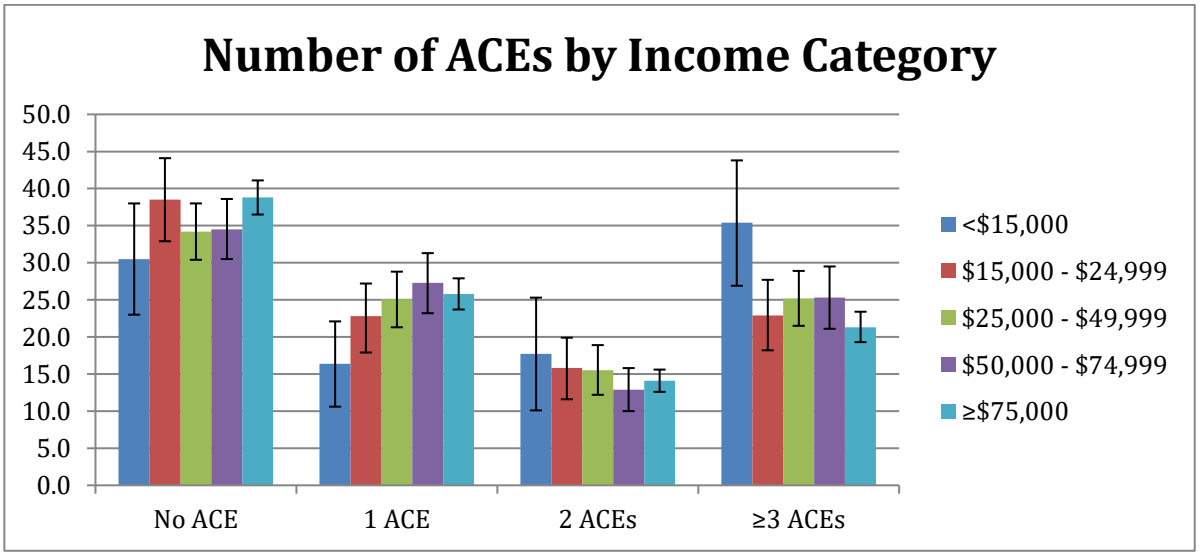
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.
Note: The sample size for Asian populations are too small to provide reliable estimates.

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



Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

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



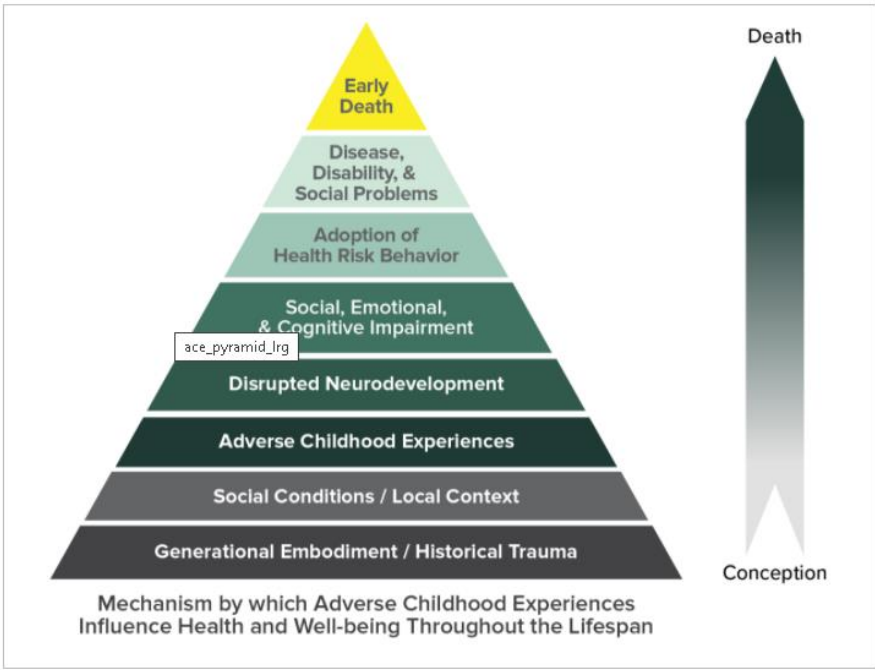
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

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

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

ACE-related problems have a strong, graded relationship to numerous health, learning, social, and behavioral problems *throughout a person's lifespan*. Many studies have shown as the number of ACEs increase in the life of an individual, there is an increased likelihood of risky behaviors and chronic physical and mental health conditions.[23]

ACEs and Poor Life Outcomes in Maryland:[24]



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

The ACE Study tested their hypothesis that multiple forms of childhood adversity could be a major determinant of health. The ACE Study concept is that ACEs disrupt neurodevelopment, which in turn leads to social, emotional, and cognitive adaptations that can then lead to the risk factors for major causes of

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

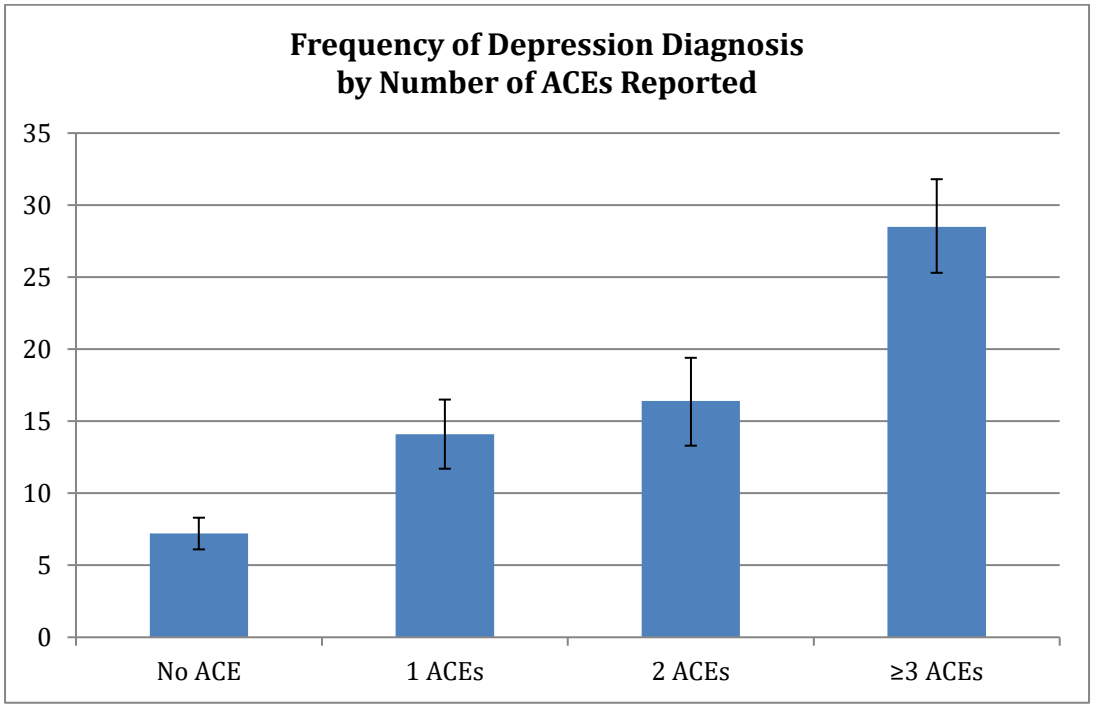
[24] Centers for Disease Control and Prevention. (2016). Adverse Childhood Experiences (ACE) Study. National Center for Chronic Disease Prevention and Health Promotion. Retrieved from https://www.cdc.gov/violenceprevention/acestudy/ACE_graphics.html.

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

disease, disability, social problems, and early death. Since the time of the ACE Study, breakthrough research in developmental neuroscience and epigenetics show us that the hypothesis of the ACE Study is biologically sound. Neuroscience and epigenetic discoveries help us to understand the progression of adversity from preconception throughout the life course. Historical trauma and generational adversity increase risk for ACEs, which in turn, generate risk for disease, disability, and social problems.

Social, Emotional, and Cognitive Impairment

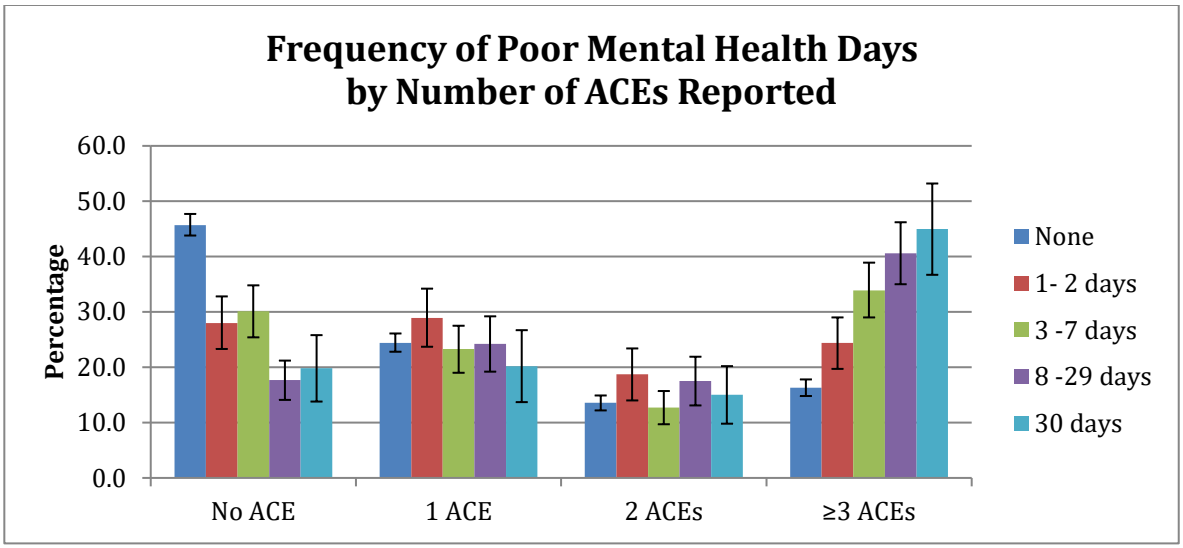
Science tells us healthy brain development is disrupted when there are no adults to buffer a child from adverse experiences. Moving up to the third tier from the bottom of the ACEs pyramid, the result of ACEs can be "social, emotional and cognitive impairment." The Maryland Department of Health (MDH)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



Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

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

[25] A dose response relationship is defined as a relationship in which a change in the amount, intensity, or duration of exposure is associated with a change in risk of a specified outcome
[26] See SCCAN's 2018 Annual Report.

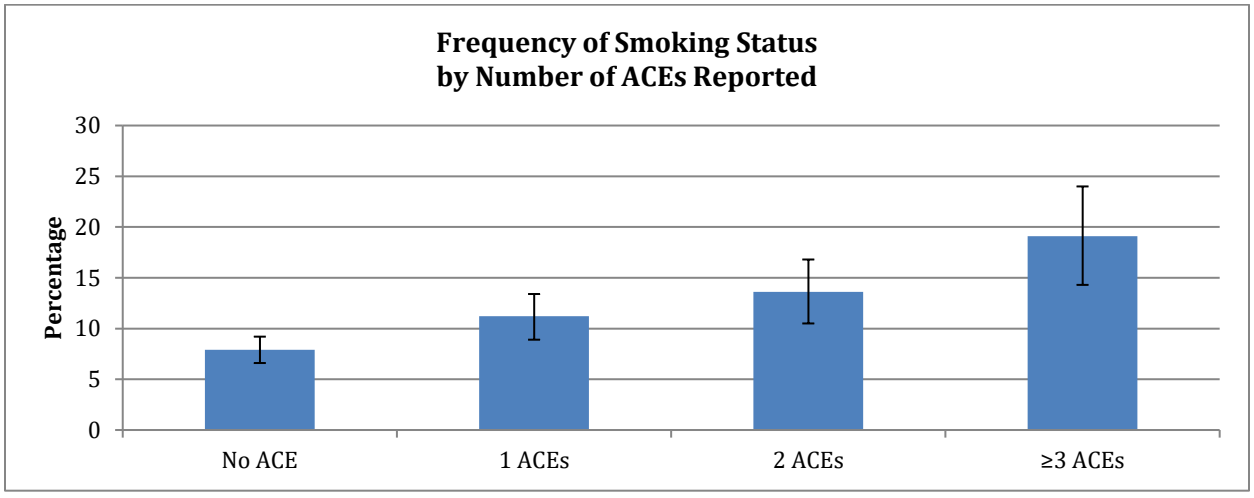


Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

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

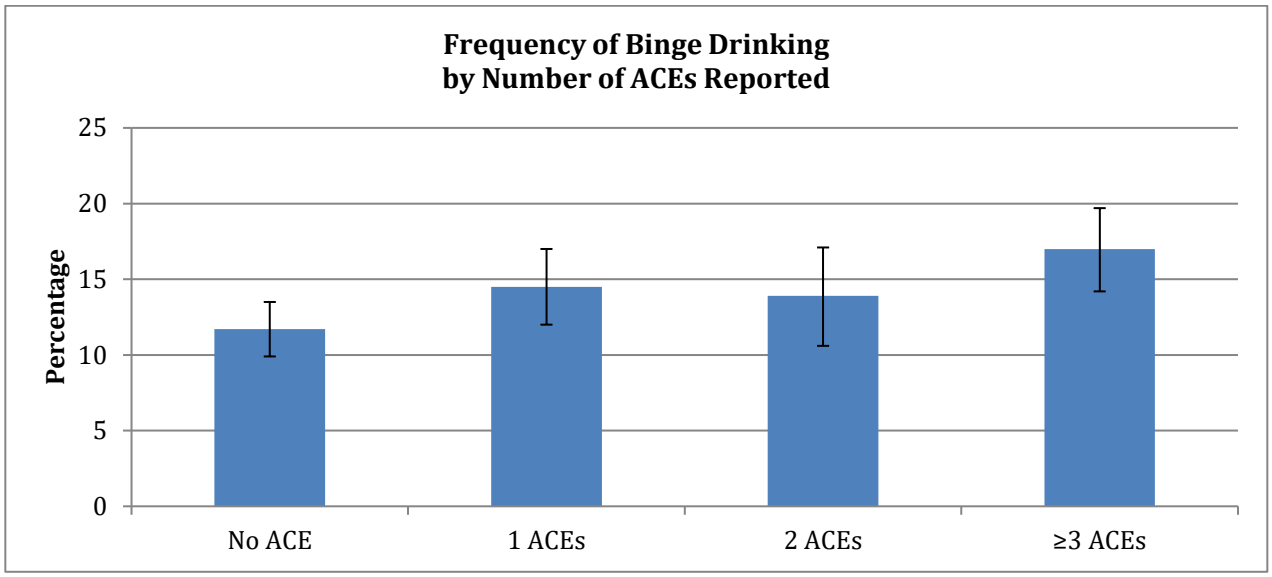
Adoption of Health-risk Behaviors

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



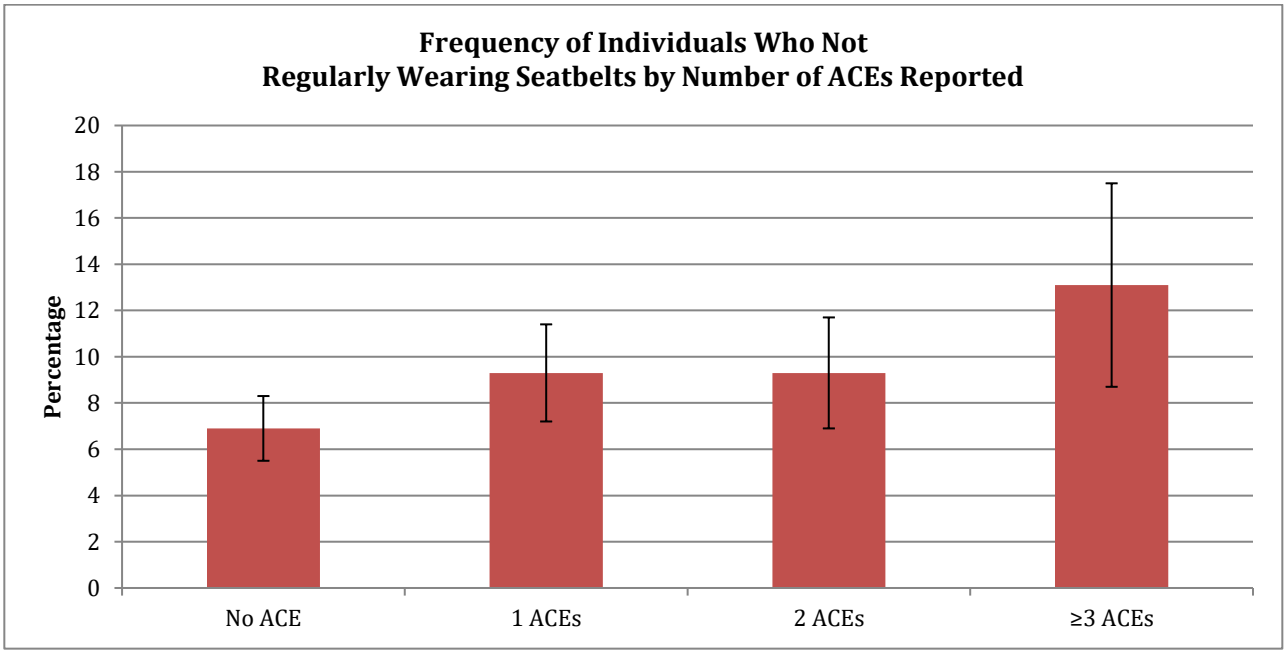
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

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



Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

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

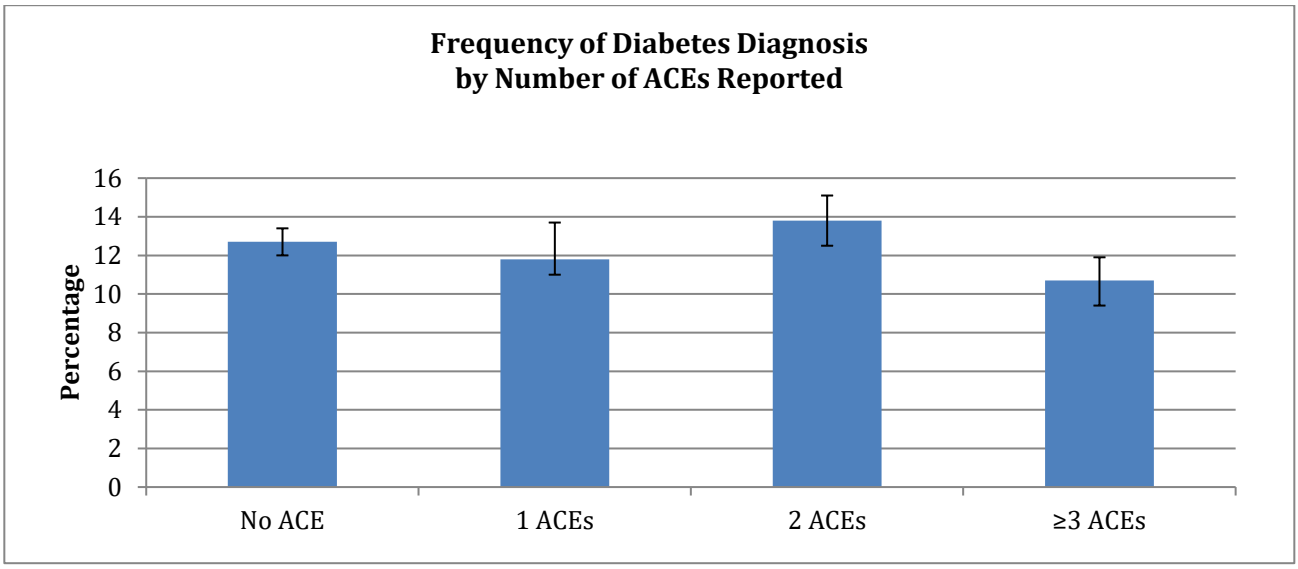


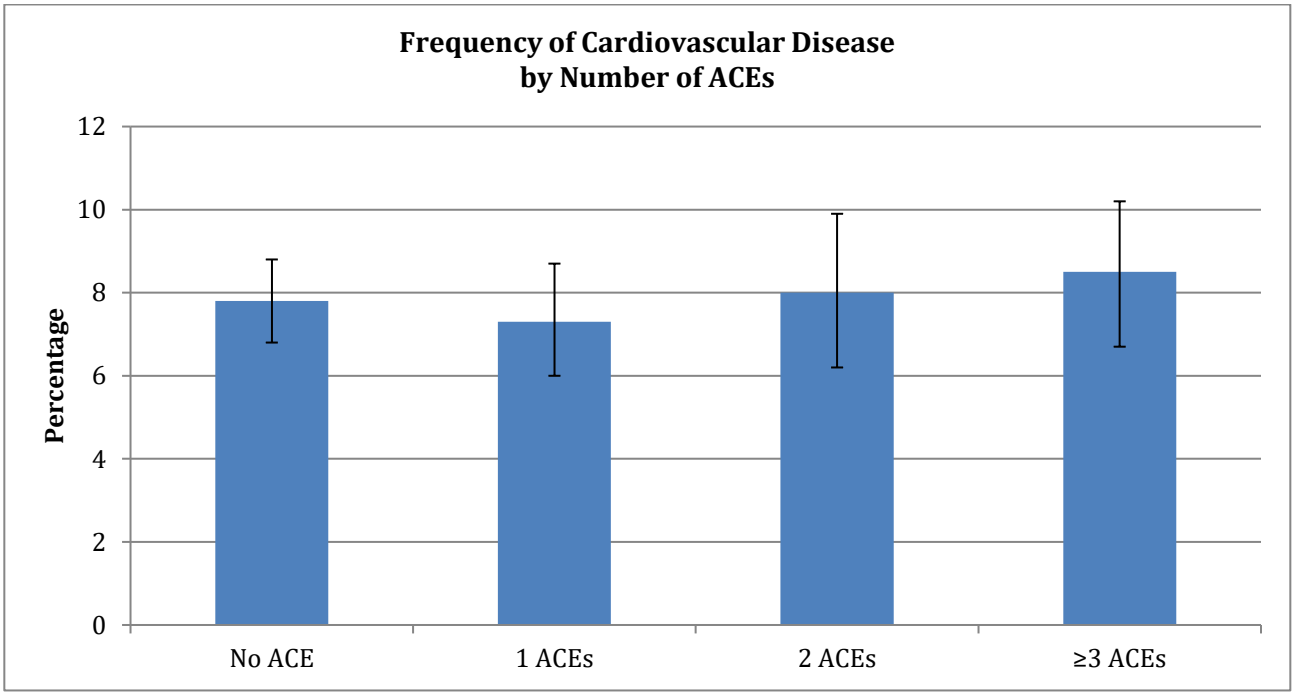
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

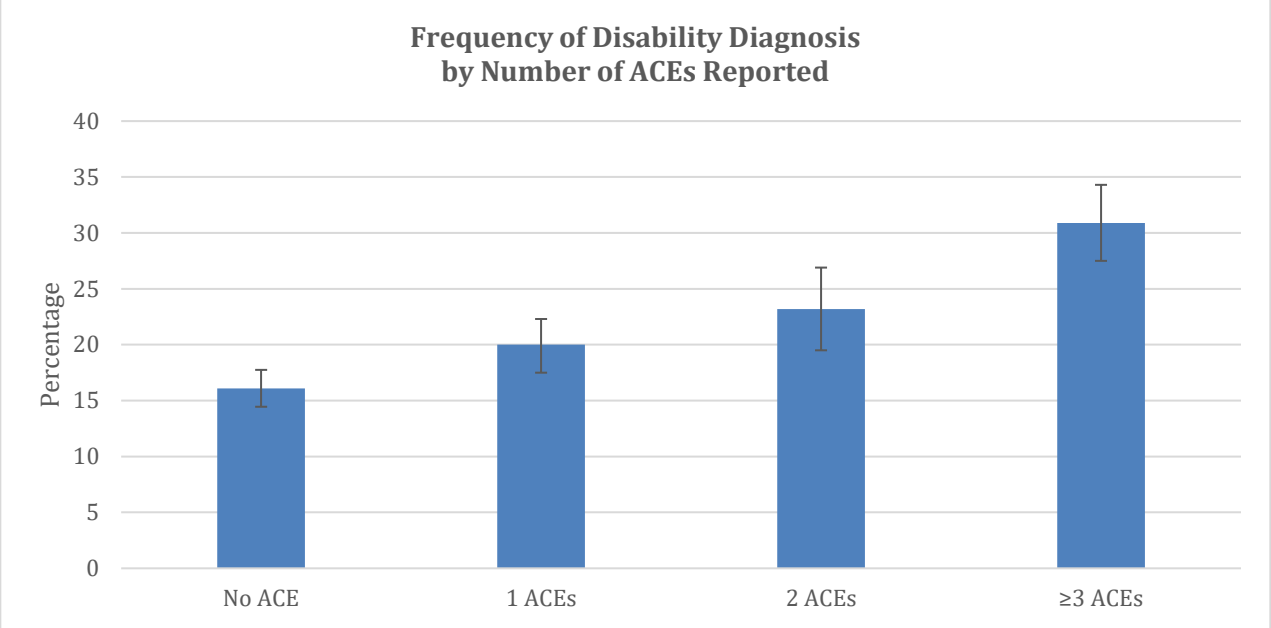
There appears to be a dose response relationship between ACE exposure and seatbelt use, although the relationship is not statistically signficiant. Individuals with 3 or more ACEs were less likely to wear seatbelts regularly than those with no ACEs.

Disease, Disability, and Social Problems

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







Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

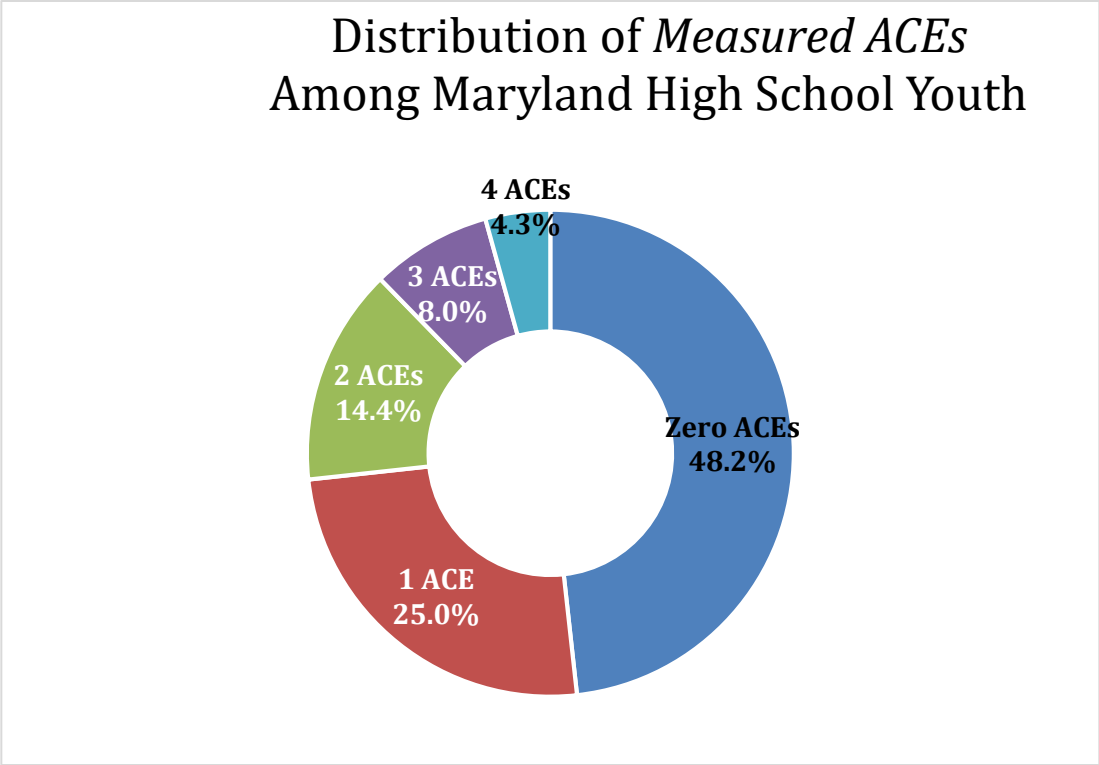
As can be seen in the previous graphs, although there are some differences in chronic disease prevalence by ACE exposure, they are not statistically significant for many chronic diseases. In the 2018 BRFSS analyses, one differing point is the rates by disability status. There appears to be a dose response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

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

PREVALENCE OF ACEs IN MARYLAND YOUTH:

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

ACEs are Common:

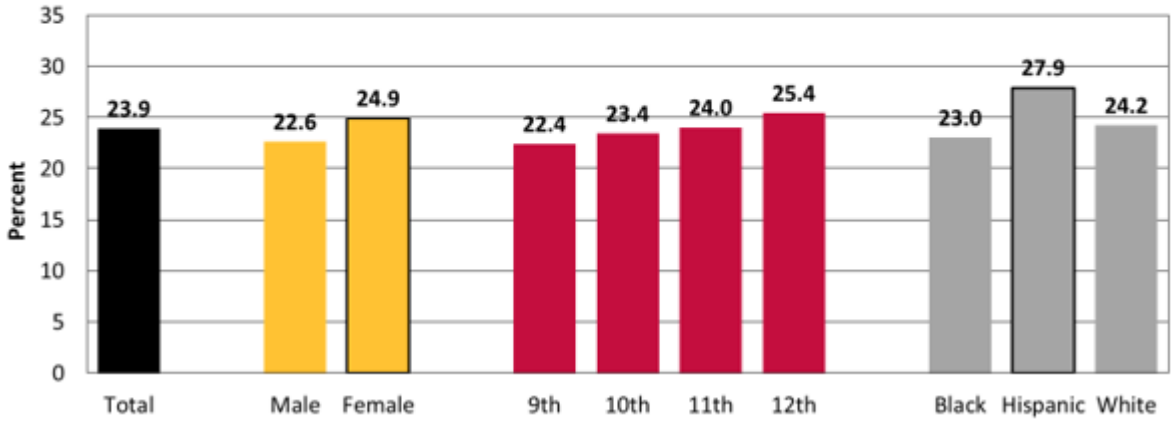


A little *more than one in two students were exposed to the measured ACEs*. 25% had one ACE, 14.4% had two ACEs, 8% had three ACEs and 4.3% had all four measured ACEs.

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

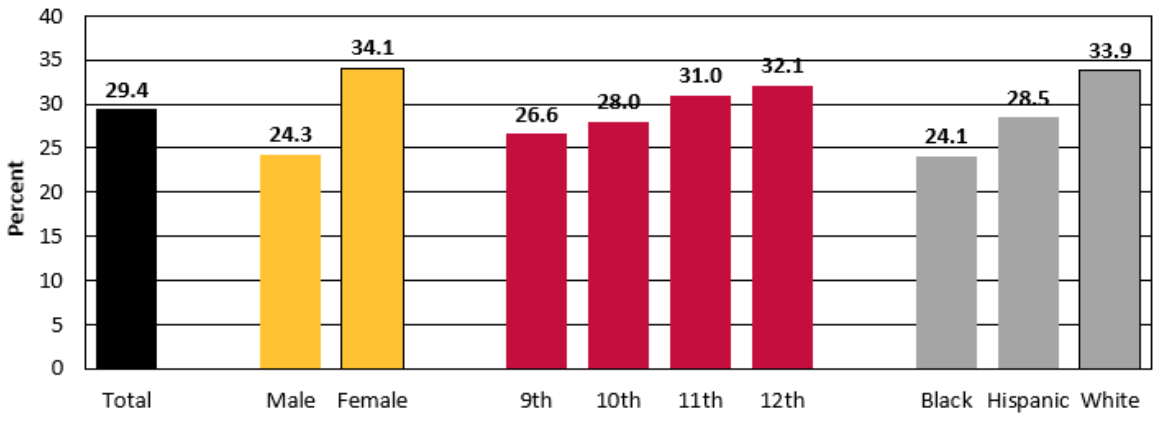
High Schoolers Exposure to the Four Measured ACEs:

Percentage of High School Students Who Have Ever Lived with Anyone Who Was an Alcoholic or Problem Drinker, Used Illegal Street Drugs, Took Prescription Drugs to Get High, or Was a Problem Gambler, by Sex,* Grade, and Race/Ethnicity,* 2018



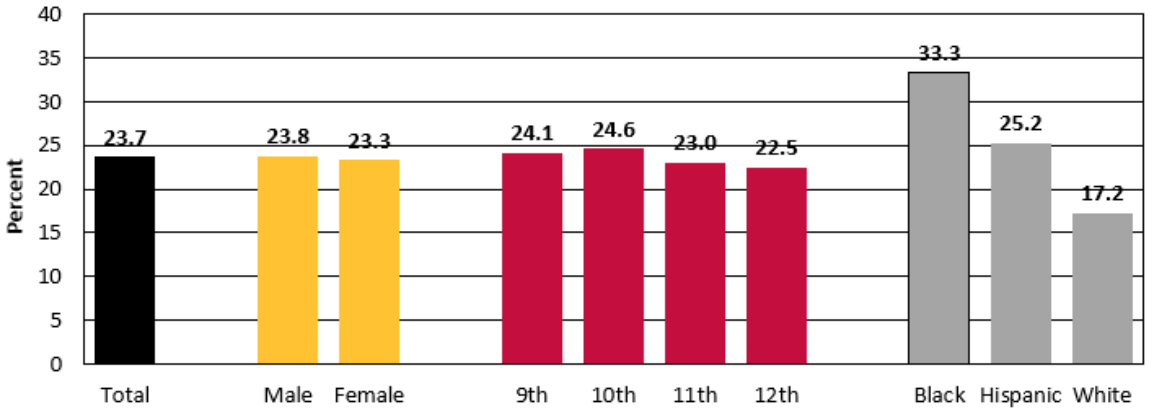
Not surprisingly, teens in higher grades were more likely to report living with someone with an addiction problem than those in early years of high school, as they had more time for potential exposure. Female teens were more likely than males to report living with someone with an addiction problem, and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

Percentage of High School Students Who Ever Lived with Anyone Who Was Depressed, Mentally Ill, or Suicidal, by Sex,* Grade,* and Race/Ethnicity,* 2018



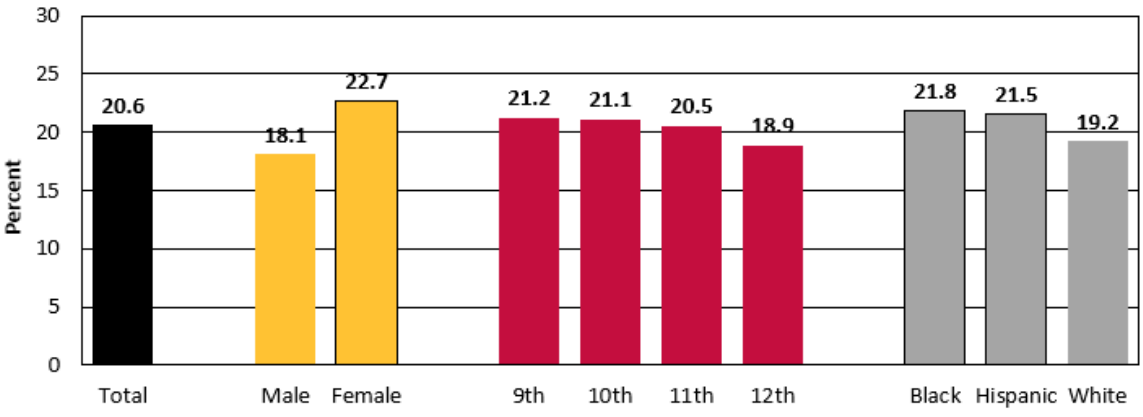
Females were more likely than males to report living with someone with a mental health issue. White teens were more likely to report living with someone with a mental health issue than Black or Hispanic teens.

Percentage of High School Students Who Reported Someone in Their Household Has Ever Gone to Jail or Prison, by Sex, Grade, and Race/Ethnicity,* 2018



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

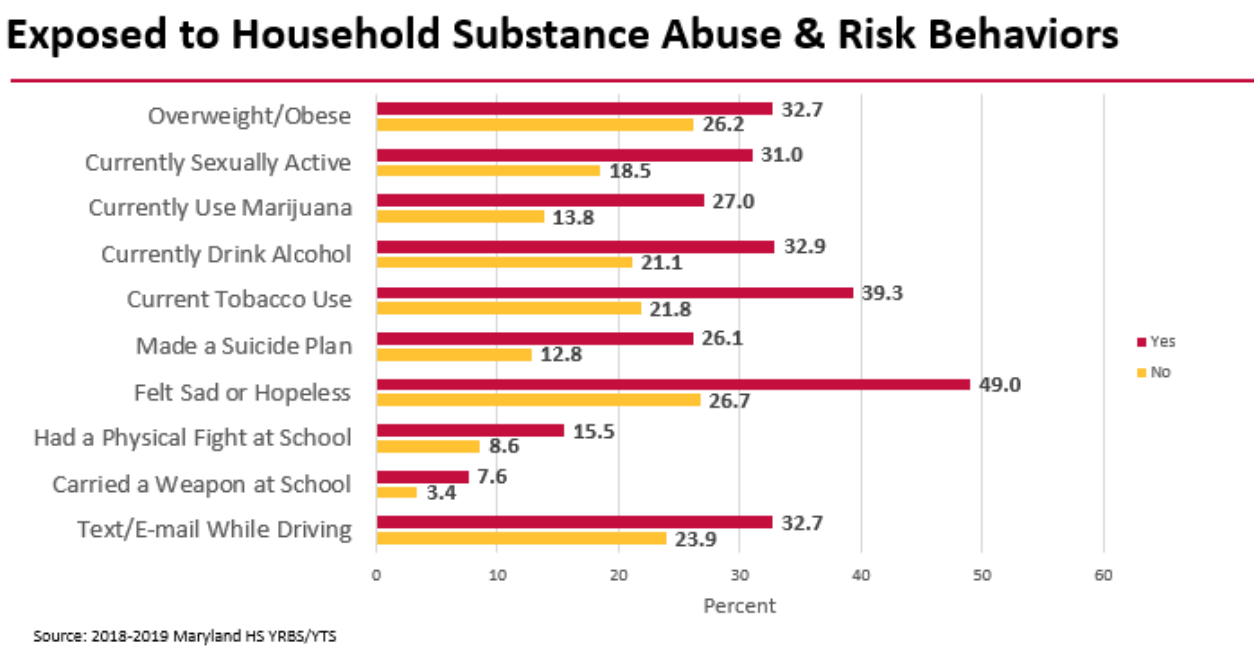
Percentage of High School Students Who Reported a Parent or Other Adult in Their Home Regularly Swears at Them, Insults Them, or Puts Them Down, by Sex,* Grade,* and Race/Ethnicity,* 2018



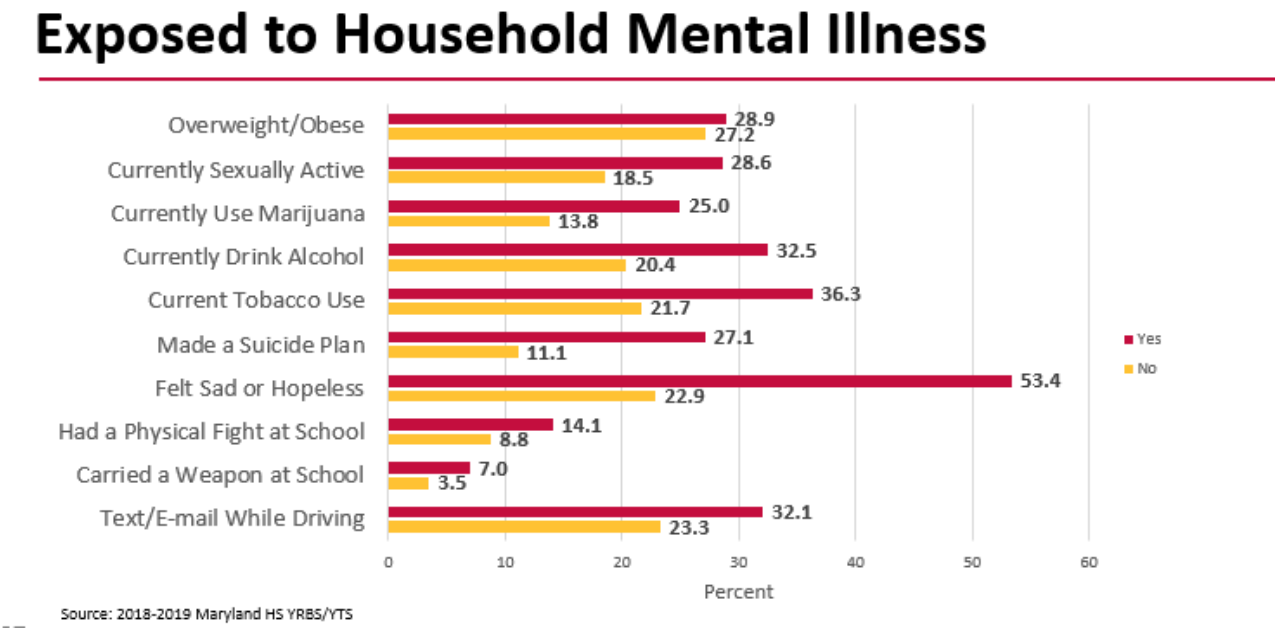
Approximately one in five Maryland teens reports regular emotional abuse by adults in their household. This is important because emotional abuse can have more deleterious effects on teen's mental health than even physical abuse.[29]

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

ACEs and Adolescent Risk Behaviors:

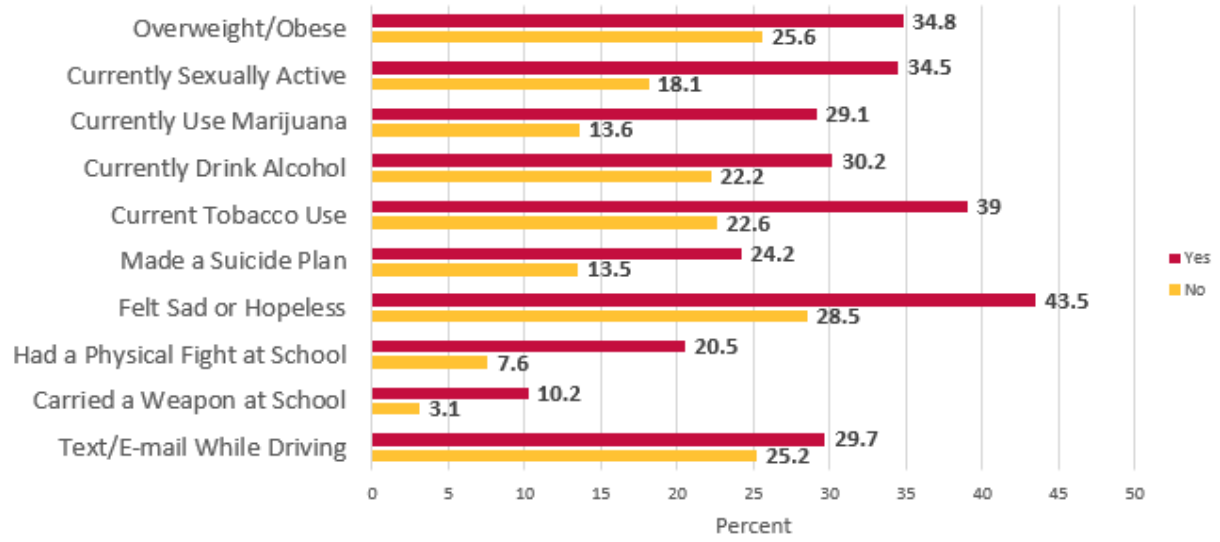


Teens exposed to household substance abuse have higher rates of obesity, risky behavior, and mental health issues compared to those not exposed to household substance abuse.



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

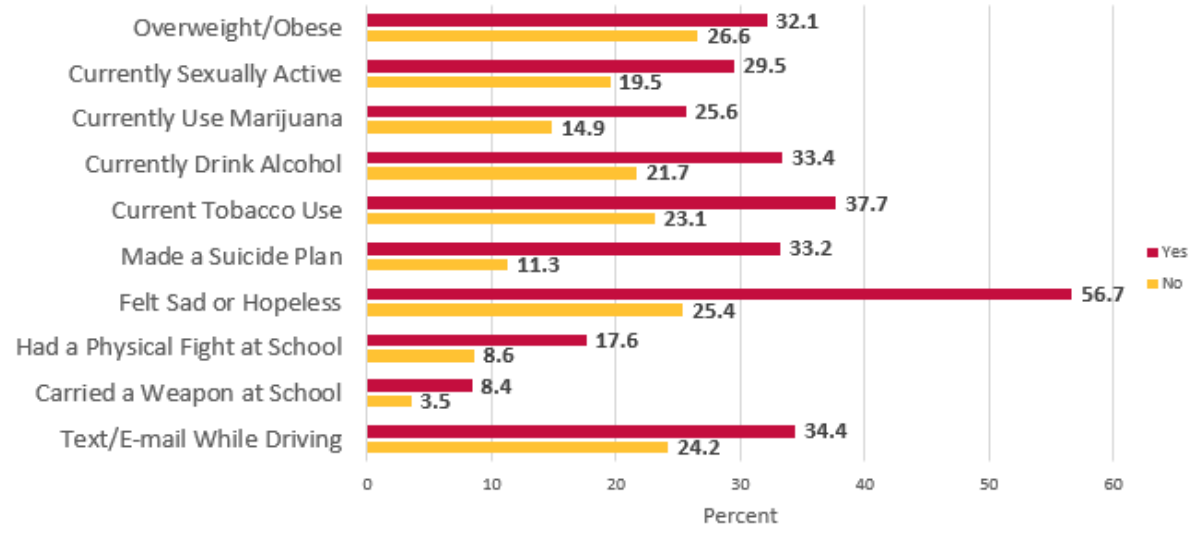
Exposed to Household Incarceration



Source: 2018-2019 Maryland HS YRBS/YTS

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

Exposed to Emotional Abuse

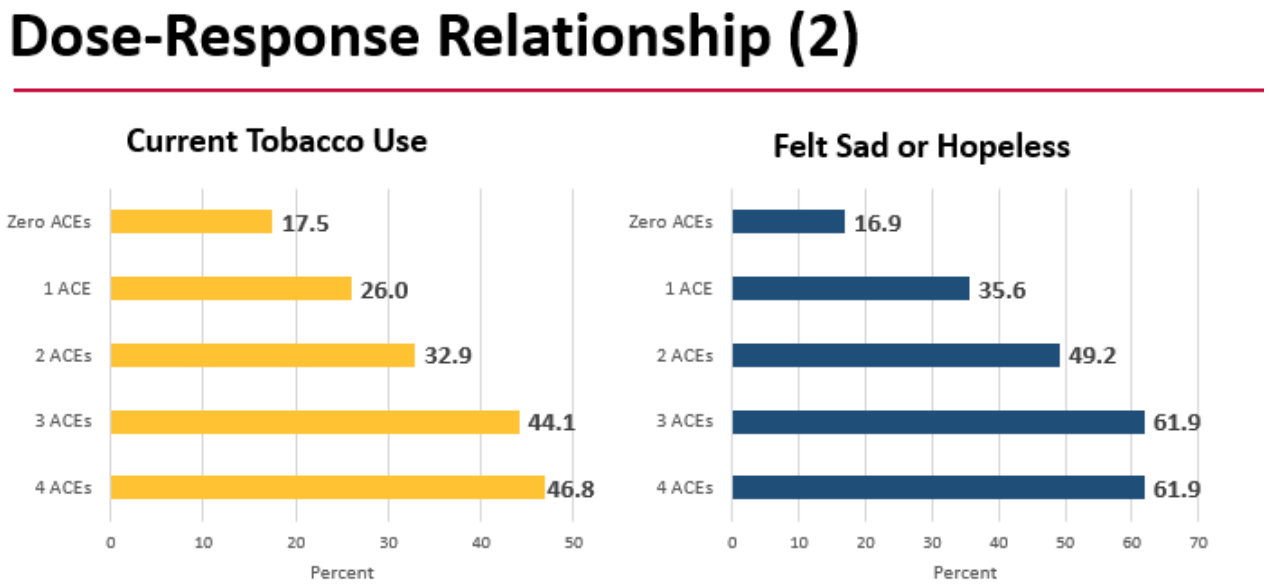


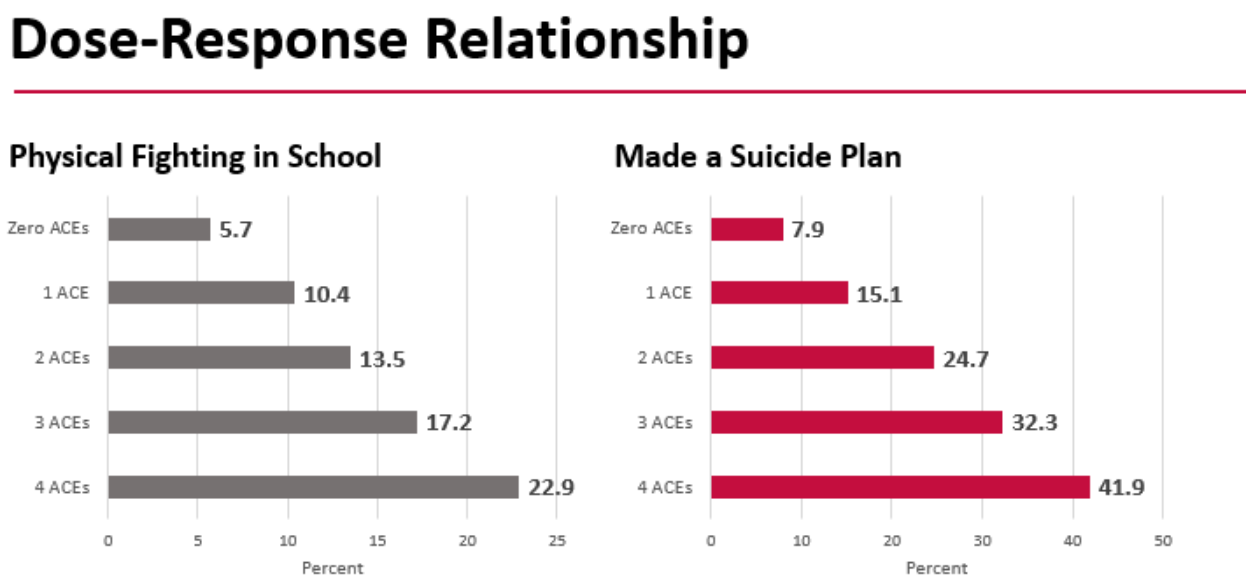
Source: 2018-2019 Maryland HS YRBS/YTS

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

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

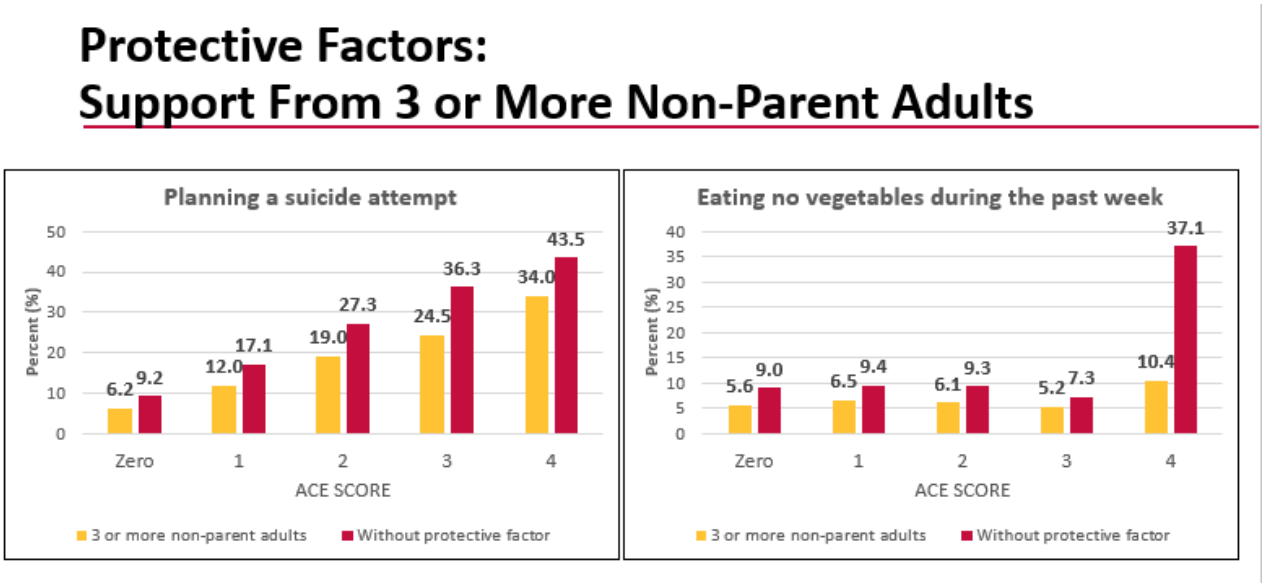
Dose Response Relationship ACEs and Risk Behaviors:





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

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



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

Conclusions:

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

Maryland Department of Health (MDH), Division of Health Promotion Administration should conduct a more in-depth analysis of Maryland's ACE data. At a minimum, a complete examination of the association between ACEs and health outcomes should be undertaken. Ideally, expanded analysis of ACE data should be completed. This should include:

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

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

SCCAN'S ACTIONS & ACCOMPLISHMENTS 2019

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

Maryland Essentials for Childhood Initiative:

Maryland Essentials for Childhood (EFC) is a statewide collective impact initiative to prevent child maltreatment and other adverse childhood experiences (ACEs).[30] It promotes relationships and environments that help children grow up to be healthy and productive citizens so that *they*, in turn, can build stronger and safer families and communities for *their* children (a multi-generation approach). Maryland EFC includes public and private partners from across the state and receives technical assistance from the U.S. Centers for Disease Control. The initiative provides members the opportunity to learn from national experts and leading states. Using advances in brain science, epigenetics, ACEs, resilience and principles of collective impact, the EFC leadership and working groups are advancing the following goals:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[34] See 2018 SCCAN Annual Report for prior info

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

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

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

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

3. **Education- Guidelines on Trauma-Informed Approach HB 277/SB 367 (2020) passed both Houses unanimously.** The law requires MSDE, in consultation with MDH and DHS, to develop guidelines for schools on a trauma-informed approach. MSDE must distribute the guidelines to local school systems and publish the guidelines on its website. SCHOOL-BASED PROGRAMS THAT ADDRESS TRAUMA SYMPTOMS IMPROVE EDUCATIONAL OUTCOMES FOR CHILDREN.
4. **$15 Minimum Wage- HB 16/SB 280 (2019) passed both Houses unanimously and became law.** Increases Maryland's minimum wage to $15/hour by 2023. INITIATIVES THAT INCREASE FAMILY INCOME REDUCE RATES OF CHILD MALTREATMENT
5. **2019 Time to Care Act- HB 341/SB 500 (2019) and HB 839/SB 539 (2020) died in the respective Economic Matters and Finance Committees**. Provides up to 12-weeks of paid family leave. PAID FAMILY LEAVE IS ASSOCIATED WITH DECREASED INFANT MORTALITY, IMPROVED CHILD HEALTH, IMPROVED PARENT-CHILD BONDING, & REDUCED CHILD MALTREATMENT
6. **Education – Child Care Subsidies – Mandatory Funding Levels- SB 379/HB 430 was signed into law in 2018.** The Maryland Family Network, a Maryland Essentials for Childhood partner, led the efforts on SB 379 which increases Maryland's child care subsidy rates to give parents access to quality care and establishes a new "floor" so that rates never again fall so low. Adequate child care subsidies with no waiting list for access are known to decrease rates of child abuse and neglect[35]
7. **Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations- SB 567 (2019) passed both Houses unanimously and was signed by Governor Hogan.** Establishes the Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations and requires the Workgroup to study State child custody court proceedings involving child abuse or domestic violence allegations. SCCAN's E.D., the ACE Interface Project Director, and other ACE Interface Master Presenters were represented on the Workgroup. The Workgroup's role will be to make recommendations about how State courts could incorporate the latest science regarding the safety and well-being of children and other victims of domestic violence into court proceedings. The final report will be submitted to the Governor and General Assembly in September of 2020.
8. **Child Advocacy Center Defining Legislation- HB 1007/SB 739 passed both Houses unanimously and was signed by Governor Hogan.** Makes sure that every abused or victimized child in Maryland has access to an accredited children's advocacy center. CACs are a critical first stop after an allegation of abuse is made. CACs PROVIDE EVIDENCE-BASED, TRAUMA-INFORMED SERVICES THAT HELP CHILDREN COPE WITH AND RECOVER FROM CHILDHOOD TRAUMA.
9. **Temporary Cash Assistance (TCA) Funding- HB 339/SB 456 died in Appropriations**

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

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

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

- Follow Up on Implementation of 2018 Bills Passed:

1. HB 1582-Human Services Children Receiving Child Welfare Services-Centralized Comprehensive Health Care Monitoring Program to Meet the Health Needs of Children involved in the Child Welfare System passed unanimously out of both houses of the General Assembly and was signed into law by Governor Hogan on May 8, 2018. The statute mandates the creation of a Child Welfare Medical Director at DHS and the creation of an electronic health passport for foster youth.

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

- Facilitate accurate and up-to-date medical information sharing amongst the child's various care providers/caregivers to prevent fragmented care and medical errors.

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

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

SCCAN RECOMMENDATIONS BY AGENT/AGENCY:

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

Dr. George Albee,

The science is clear; our children's pain, both current and generational unfolds daily before our eyes if we are willing to look; innovation and prosperity are possible; and require courage to create a seismic shift in how our child and family serving agencies care for those they are meant to serve.

GOVERNOR

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

1.Take meaningful action to raise awareness of brain science, adverse childhood experiences (ACEs) and resilience and build community commitment to prevent, reduce, and respond to ACEs by launching an ACEs Initiative similar to Governor Bill Haslam and First Lady Chrissy Haslam's Launch Building Strong Brains Tennessee's ACEs Initiative or First Lady Tonette Walker's Fostering Futures, including Trauma-Informed State Agencies.[36] Maryland's Governor should take the following actions, similar to sister states, to create a trauma-informed and resilient state through an executive order or legislation::

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

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

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

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

environments for children, build strong brains, prevent ACEs, and promote resilience. Building upon efforts of Maryland's Essentials for Childhood Initiative and local ACE community initiatives in Frederick, Washington, Harford Counties, and Baltimore City, designate a state lead agency for the Maryland Essentials for Childhood Initiative[38]

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

4. Call upon key leaders in Maryland's business and faith-based communities to join in the Initiative.[39]

5. Support legislation and funding of a Children's ACEs Prevention Trust Fund administered by a public-private board of directors to lead innovative interventions and financing across the state.[40]

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

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

1. Review the Tennessee and Wisconsin examples of statewide models to create a culture change in child and family serving agencies to focus on a multi-generation approach to responding to childhood adversity based on the science of the developing brain, ACEs (trauma/toxic stress), and Resilience. Support Governor or General Assembly led action to create a trauma-informed and resilient state through the:
    - Establishment and participation in a state lead coordinating body
    - Development and implementation of a State Plan for Preventing and Mitigating ACEs to
        - Incorporate the six strategies and evidence-based programs and approaches listed in the CDC's *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence* resource tool.
        - Incorporate trauma-informed best practices across state child and family serving agencies
        - Provide executive level awareness trainings and opportunities
        - Enhance the State's ACEs surveillance system, data collection and analysis
        - Develop ACE awareness campaigns, employing science-based communication strategies
        - Make budgetary commitments to prevent and mitigate ACEs
        - Make use of the expertise and build upon the cross-sector and interdisciplinary

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

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

[40] https://ctfalliance.org/

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL ASSEMBLY

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

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

3. Pass a joint resolution mandating child and family serving agencies' participation in collective impact efforts to promote safe, stable & nurturing relationships and environments for children (Essentials for Childhood (EFC)) & preventing ACEs.[44]

[43] See Appendix B

[44] Examples of State Legislation:

- 2013 Wisconsin passed Senate Joint Resolution 59. https://docs.legis.wisconsin.gov/2013/related/proposals/sjr59
- 2014 California Legislature, Assembly Concurrent Resolution No. 155, relative to childhood brain development passed.
- 2011 Washington House Bill 1965, passed creating the Washington State ACEs Public Private Initiative.
- 2014 Massachusetts passed a Safe and Supportive Schools Act within their gun violence reduction law:
- 2017 Vermont passed legislation to establish an Adverse Childhood Experiences Working Group of key legislators to consider future legislation. Four bills were introduced as a result of the report and Act 204 passed in 2018 based on the report.
- 2015 Minnesota HF 892/ SF 1204 Resolution on childhood brain development and ACEs.
- 2016 Alaska House Resolution 21
- 2017 Utah House Concurrent Resolution 10

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

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

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

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

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

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

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

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

   Child sexual abuse is a complex problem requiring a comprehensive approach. All adults in child and youth serving organizations play a role in preventing child sexual abuse *before it occurs.* Failing to

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

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

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

9. Pass legislation to change the Medicaid eligibility categories to make identification of children in foster care more transparent.

   - Currently, the state uses eligibility categories that include subsidized adoption and subsidized guardianship cases to identify the foster care population. In addition, kinship care cases that are receiving TCA are excluded. Medicaid data that the state uses in reports and that could potentially be used to monitor the health of the foster care population is not an accurate reflection of the youth in foster care. Improving or redefining eligibility codes would allow the state to more accurately monitor health care utilization (including psychotropic medication) use for children in foster care. In addition, more transparent eligibility codes will allow programs that use these codes the ability to easily identify youth in foster care. Identification will result in improving coordination with the child welfare agency and will assist the state in providing Medical Assistance to former foster care youth until age 26.

JOINT DHS & MDH

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

   Establish an ongoing Child Welfare Health Coordination Expert Panel led by the Child Welfare Medical Director to ensure communication and coordination between the multiple agencies that provide health services to children with the child welfare system. Suggested members of this panel are included in the footnote[48].The Panel's responsibilities should include:

[48] Suggested Members: Interagency Child Welfare Health Coordination Expert Panel

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

- Maryland Children's Cabinet;
- Maryland Children's Alliance;
- Maryland Chapter of the American Academy of Pediatrics;
- Maryland CHAMP program (CHAMP physician and nurse affiliates);
- Maryland Forensic Nurses;
- DHS Out of Home Services;
- DHS Child Protective Services and Family Preservations Services;
- DHS Resource Development, Placement, and Support Services;
- MDH, Maternal and Child Health Bureau;

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

- Medicaid;
- Behavioral Health;
- DHS and MDH representatives with expertise in their agency's child fatality review processes;
- Maryland State's Attorney's Association;
- County health department representatives;
- County DSS agency representatives;

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

DHS

- See Children's Cabinet agency recommendations above.

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

- Embed the brain, ACEs, and resilience science and a multi-generational approach into policies across administrations at DHS. Implement strategies to prevent and mitigate ACEs (trauma-informed) and build resilience to create safe, stable, and nurturing environments for the children of parents receiving DHS services (CSE, FIA and SSA)[49]

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

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

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

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

· Maryland Legal Aid Bureau;

· Maryland CASA;

· Programs that currently contribute to medical and forensic services funding for children involved in the child welfare system

o Maryland Medicaid,

o MDH Center for Injury and Sexual Assault Prevention,

o GOCCP/VOCA).

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

- Integrate child-welfare, birth, and death data in order to analyze fatal maltreatment risks.
- Collect longitudinal data on foster youth and their families so that well-being and long term outcomes can be tracked. These outcomes should include frequency of placement changes, frequency of school changes, and medical and mental health services needed and received. This was a repeated recommendation included in DHR's Quality Assurance Processes in Maryland Child Welfare.[50]
- Determine how often children involved with child welfare end up involved with the Department of Juvenile Services, how their educational achievement and health compares to their non-system involved peers, and for older foster youth who transition out of care, whether they have stable housing as adults.
- Comply with the MOU in place between DHS and MSDE to allow for the sharing of data regarding foster youth since September 27, 2013 and the federal requirement pursuant to the Every Student Succeeds Act for states to track educational outcomes for foster youth.
- Track the quality of the experience for foster youth while they are in care. Currently, we don't know basic information, such as: how often they have to change placements, how often they change schools, whether they are hospitalized, and whether they need in-patient psychiatric treatment.
- Track when families are determined to need services, determine whether those services were received, and if not received, identify the reasons why not.[51]

Social Services Administration

1. See Children's Cabinet recommendations above.

2. See Joint MDH-DHS recommendations above.

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

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

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

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

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

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

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

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

MDH

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

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

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

4. Fund the baseline collection of child maltreatment Awareness, Commitment, and Norms Survey[54] initiated by the CDC's Essentials for Childhood and implemented by the five EFC funded states, as well as, several unfunded states. Collection of this data in other states cost approximately $10,000.

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

6. Ensure that all home visiting programs (MIECHV, MOTA grants, Community Health Specialists, etc.) engage fathers, as well as, mothers. Purposefully recruit fathers as home visitors.[55]

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

7. Maryland's Medicaid program should develop a system to generate a regularly updated list of all prenatal care providers serving Medicaid recipients and their MPRA (Maryland Prenatal Risk Assessment) completion rates for purposes of conducting ongoing provider education on MPRA procedures.[56]

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

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

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

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

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

13. Medicaid should eliminate some of the billing barriers that behavioral health providers serving young children face including:

    - allowing behavioral health providers working with young children up to five appointments before they need to have a diagnosis since it takes longer than one visit to diagnose young children.
    - allowing behavioral health providers to use the DC:0-5 for diagnosing young children as it is better tailored for their developmental milestones.

MSDE

1. See Children's Cabinet recommendations above.

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

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

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[56] Ibid.

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

[58] Ibid.

[59] See Appendix E

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

DJS

1. See Children's Cabinet recommendations above.

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

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

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

APPENDIX A

DHS RESPONSE TO SCCAN'S 2018 ANNUAL REPORT

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

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

The Council received a response to its 2018 report from the Executive Director of the Social Services Agency at DHS in September 2019. The Agency responded by enumerating current agency efforts that might address some Council recommendations in the2018 report:

DHS's response specifically addressed:

- State hotline for reporting child abuse and neglect
- SSA efforts on trauma, resiliency, and brain science
- SSA efforts to promote the voice of all family members
- Data sharing and reporting
    - SSA is looking for opportunities to improve data gathering and reporting within its CJAMS project.
- Health of children
    - Child Welfare Medical Director hired
    - Medical Director is a member of State Task Force on Maternal and Child Health
        - Examining Medicaid coverage for screening of ACEs and social determinants of health and appropriate referrals for positive screens
        - Task Force to make recommendations to MDH to prevent poor health outcomes
    - Medical Director serves on SSA Service Array Implementation Team focusing on health, education, well-being, and access to services
        - Team is considering a Child Welfare Health Coordination Expert Panel as an extension of the Team to assist in the formation and implementation of a statewide centralized health care monitoring program, including the appropriate prescribing of psychotropic medication.
    - Medical Director is serving as a consultant to the CJAMS project

Significantly DHS SSA did not respond as to whether, how, and or when the following DHS and SSA-specific recommendations would be addressed, nor how they were coordinating with their fellow

Children's Cabinet agencies on cross-agency recommendations:

- "Embed the brain, ACEs and resilience science and a multi-generational approach into policies across administrations at DHS. Implement strategies to prevent and mitigate ACEs (trauma-informed) and build resilience to create safe, stable, and nurturing environments for the children and parents receiving DHS services (Child Support Administration and Family Investment Administration, as well as SSA.)" *While SSA generally discusses its efforts to become a trauma-informed system, there is no mention of efforts within the sister administrations within DHS, nor any cross-agency work with the other child and family serving agencies in the state.*
- 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.
- Ensure that all children who are referred to the local DSS are screened for child sexual abuse and are referred and linked to service for treatment. Cases should remain open until linked to treatment services. Case records should indicate 1) child sexual abuse and 2) documentation that the child is receiving treatment.
- In support of effective implementation of HB 1582, Human Services-Children Receiving Child Welfare Services-Centralized Comprehensive Health Care Monitoring Program, 2018:
    - Establish an ongoing Child Welfare Health Coordination Expert Panel led by the Child Welfare Medical Director to ensure communication and coordination between the multiple agencies that provide health services to children with the child welfare system. *While there is mention that an expert panel is being considered, no timetable is offered for when a decision will be made on this proposal.*
- Increase efforts that promote fathers' and mothers' male partners' emotional support, rather than solely financial support, of their children and families. *DHS's response regarding "Promot[ing] the voice of all family members" notably does not address specific attention to fathers. As historically fathers' voices have been overlooked, it would be helpful to know the specifics of how DHS/SSA is remedying this critical systems issue.*
- Involve fathers in child welfare cases as a matter of course. *DHS's response regarding "Promot[ing] the voice of all family members" notably does not address specific attention to fathers. As historically fathers' voices have been overlooked, it would be helpful to know the specifics of how DHS/SSA is remedying this critical systems issue.*
    - Collaborate with partners to further infuse fatherhood and male responsibility initiatives into settings with boys and men.
    - Make deliberate and special efforts to include male caregivers in attachment and parenting skills programs (e.g., Circle of Security Parenting, home visiting sessions).
- Ensure that MD THINK makes data improvements listed below. *While DHS/SSA suggests that it is looking for opportunities to improve data gathering and reporting within its CJAMS project, there is no mention of any specifics and no response regarding the requests for improved data below:*

    - Integrates child-welfare, birth, and death data in order to analyze fatal maltreatment.
    - Collects longitudinal data on foster youth and their families so we can track both their long term outcomes and the quality of their well-being while they are in care. This was a repeated recommendation included in DHS's Quality Assurance Processes in Maryland Child Welfare.
    - MD CHESSIE's focus on point-in-time data has been a significant barrier in having a true picture of how children and their families who touch our child welfare system do. We

need to know how often foster youth end up involved with the Department of Juvenile Services, how their educational achievement and health compares to their non-system involved peers, and for older foster youth who transition out of care, whether, as adults, they have stable financial, employment, housing, and parenting (i.e., their children do not end up in child welfare) outcomes.
    - Complies with the MOU in place between DHS and MSDE to allow for the sharing of data regarding foster youth since September 27, 2013 and the federal requirement pursuant to the Every Student Succeeds Act for states to track educational outcomes for foster youth.
    - Tracks the quality of the experience for foster youth while they are in care. Currently, we don't know basic information, such as: how often they change placements, how often they change schools, whether they are hospitalized, and whether they need in-patient psychiatric treatment.
    - Tracks when families are determined to need services, whether they receive those services, and if not, why not, and what follow up occurs.
- Screen in all children under 5 as Risk of Harm cases and do an in-home assessment of risk. Provide services for families at risk for child fatality or near fatality.
- As plans for the new hotline for reporting child abuse are implemented:
    - Ensure that de-identified aggregate data is collected and analyzed to inform decision-making to improve the reporting and screening system.
    - Ensure that local DSS have updated phone technology, sufficient staff, and standardized training to implement the statewide hotline.

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

Maryland essentials for childhood

TOWARD A MORE PROSPEROUS MARYLAND

Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities

TABLE OF CONTENTS

INTRODUCTION

In Maryland, we take seriously our role as stewards of the next generation. We know that preparing Maryland for a prosperous future begins with recognizing that our ability to raise healthy children, who will lead the communities and economy of tomorrow, requires smart and innovative thinking today. The good news is that developmental science is clear about what children need to thrive.

We now know that the brain's architecture is built over time and from the bottom up, much like a house. Sturdy architecture is built when children have safe, stable, and positive experiences and relationships with caring adults at home and in the community.

> However, severe or repeated exposure to harmful or adverse childhood experiences (ACEs) without the support of caring adults can cause toxic stress responses in children, weakening brain architecture, and leaving children vulnerable to a range of health, learning, and behavior problems across their lifespan. [1]

Fortunately, research also suggests that there are things we can do to buffer toxic stress, preventing or reversing its effects. Safe, stable, and nurturing relationships and environments serve as protective factors and are essential for the health and well-being of our children, ensuring that every child in Maryland has equal opportunity to thrive. All Marylanders play a role in ensuring the health and well-being of the next generation and a prosperous future for all. No one individual, organization, sector, or branch of government alone can prevent ACEs and trauma or mitigate their impact. As lawmakers, Members of the General Assembly can promote lifetime success and responsible citizenship by advancing safe, stable, and nurturing environments through ACE- and resilience-informed policy and investment.

> Lawmakers around the country are educating themselves on cutting-edge neuroscience, epigenetics, the ACE study and resilience (NEAR Science) and taking policy actions to promote healthy development and a prosperous future for their constituents. This brief will share the basics of the NEAR Science, along with the evidence-based and innovative policies being implemented by federal and state governments to prevent and mitigate childhood trauma and promote family and community resilience.

Research is clear that parent and child well-being are inextricably linked.

The needs of parents and children overlap, but unfortunately, those needs are too often served in separate, siloed state systems. These systems do not often consider the inextricable link between parent and child. In order to develop effective policies, legislators must consider how multiple policies and systems interact with one another to create environments that promote the healthy development of children and their families. The implications of decisions in one system, impact another. It is critical to address not only the substantive issue (opioid epidemic, teen pregnancy, suicide, cancer, for example), but at the same time strengthen cross-system collaboration in order to effectively prevent and mitigate childhood trauma and build more resilient communities.

Health, education, social, and public safety policies at the federal, state, and local levels need to be updated to reflect what science has taught us about the causes, effects, mitigation, and preventability of childhood, adult, community, historical and intergenerational trauma. Achieving policy change of this meaning and magnitude requires multiple strategies. Ensuring that policies reflect scientific evidence requires a strategic long-term effort that, like any sound investment, will provide significant return over time. Each step will build on the ones before it, making sustained progress toward a full integration of resilience and trauma-informed principles into the policies and practices of government, private industry, and non-profits across health, education, housing, justice, child welfare, and other sectors. This requires a "legacy mindset" by legislators and other policy makers.

N.E.A.R. SCIENCE 101

Converging developments in the rapidly growing sciences of neurobiology, epigenetics, ACEs, and resilience vis a vis healthy child development point to major implications for policy and practice across systems and the lifespan.

Throughout this document we will refer to "NEAR" science, coined by The Foundation for Healthy Generations in Washington State, to describe the body of science that explains the impact of adverse childhood experiences on human development, health, and well-being across the lifespan.

NEUROBIOLOGY OF TOXIC STRESS - TEN CONCEPTS EVERY LEGISLATOR SHOULD KNOW [2]

1	**Healthy Development Builds a Strong Foundation for Kids and Society**
2	**Experiences Build Brain Architecture** A strong foundation in the early years increases the probability of positive outcomes. A weak foundation increases the odds of later difficulties. It is easier and less costly to form strong brain circuits during the early years than it is to intervene or "fix" them later.
3	**Responsive Relationships - "Serve & Return Interactions"** Shape Brain Circuitry Richly responsive, back-and-forth interactions between caregiver and child establish a sturdy architecture on which future learning is built. If a caregiver's responses are unreliable or inappropriate, the brain's architecture does not form as expected, which has negative implications for later learning and behavior.

4	**Brains are Built from the Bottom Up** Skills Beget Skills 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.
5	**The Biology of Toxic Stress and Adverse Childhood Experiences (ACEs) Derails Healthy Development** In early infancy and even prenatally, the body engages in a "fight, flight, or freeze" response when exposed to stress that stimulates a surge of stress hormones and other biophysical responses throughout the body. This response is normal and not harmful to a child in small doses. However, when a child is exposed to repeated adversity for a prolonged period, this stress becomes toxic. Such chronic and unrelenting stress in early childhood derails development by setting the body's default 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 and brain of the developing child.
6	**Biological Responses to Toxic Stress During Childhood are Adaptive, Not Maladaptive. "The Child May Not Remember, But the Body Remembers." - Jack Shonkoff** Humans possess brains that are exquisitely sensitive to their environments and are equipped to adapt to early stress."3 "A behavior is adaptive insofar as it helps an organism survive. Within a violent context, hyper-arousal, vigilance, and aggression are clearly useful. However, many associated features of these adaptations confer risk in other contexts." [4]
7	**The Presence of Responsive Adults at Home & in the Community Lessens the Impact of Toxic Stress** The good news is that potentially toxic stressors can be made tolerable if children have access to stable, responsive adults – parents, home visitors, childcare providers, teachers, coaches, mentors, etc. Additionally, the brain has the ability to change continuously throughout an individual's life, a concept known as neuroplasticity. Innovative States and communities design high-quality programs to prevent Adverse Childhood Experiences from occurring in the first place and to effectively respond to them with strong, nurturing supports to ameliorate their impact when prevention is not possible.

8	**Executive Function & Self- Regulation Skills Are Critical for Learning and for Life** Science has identified a set of skills that are essential for school achievement, positive behavior, good relationships, 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 families and communities either strengthens or undermines these budding skills.
10	**Rethinking Our Policies: What is Predictable, is Preventable** Childhood experiences build the foundation for a skilled workforce, a responsible community, and a thriving economy. As Marylanders understand the impact of ACEs, 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 reflect what the N.E.A,R. science teaches us. To bring about population level change for children facing adversity and stem the tide of ever-more costly social problems, it is key to focus on building healthy brain architecture for every child and coordinating our efforts across all our child and family-serving systems. This investment improves outcomes for children now and is a significant foundation for solutions to many of the long-standing and systemic challenges we face as a state.

EPIGENETICS: THE INTERGENERATIONAL TRANSMISSION OF TRAUMA

The new scientific field of epigenetics explains how experience "gets under our skin." New research tells us that trauma can attach a chemical mark to a person's DNA at particular genes. The chemical mark can be passed down from one generation to the next. While the chemical mark does not mutate or damage the gene directly, it alters the mechanism by which the gene's message is able to be opened or not, allowing its instructions to be read and expressed. The hopeful part of epigenetics is that positive life experiences may reverse the negative impacts of ACEs and have positive effects on human development, health and well-being[5].

ADVERSE CHILDHOOD EXPERIENCES (ACES) STUDY:

> "The largest public health discovery of our time, perhaps of all time."
>
> –Dr. Robert Anda, Laura Porter

In 1995, the U.S. Centers for Disease Control and Prevention (CDC) and Kaiser-Permanente (KP) conducted the Adverse Childhood Experiences (ACEs) study. Therein, 17,000 participants - mostly white, middle-class adult patients at Kaiser-Permanente in San Diego - were surveyed about their health and well-being.

Participants were asked about ten ACEs, including all forms of child abuse and neglect, and five family dysfunctions, including divorce, parental incarceration, parental mental health or substance abuse disorders, and domestic violence.

10 ACE Categories Examined in the CDC Study on Childhood Adversities

After advocacy by member organizations of Maryland Essentials for Childhood, including SCCAN, Maryland joined other states in collecting state and county-level ACE prevalence data through the Behavioral Risk Factor Surveillance System (BRFSS). In 2018, Maryland became the first of 2 states to collect ACE data in middle and high schools through the Youth Risk Behavior Surveillance System (YRBSS).

THE MAGNITUDE OF THE PROBLEM: ACE STUDY FINDINGS IN MARYLAND AND BEYOND

ACEs are COMMON:

INITIAL ACE STUDY FINDINGS (SAN DIEGO, 1995): 67% of study participants reported having at least one ACE. 26% reported having three or more ACEs.[6]

MARYLAND ACE FINDINGS (2015): Approximately 60% of survey participants reported at least one ACE. 24% reported having three or more ACEs.[7]

CHILD ABUSE & NEGLECT			FAMILY DYSFUNCTION		
ACE	% Within Population		ACE	% Within Population	
Study	K-P (1995)	MD (2015)		K-P (1995)	MD (2015)
Physical Abuse	28%	16.9%	Substance Abuse	27%	24.9%
Sexual Abuse	21%	11.1%	Parental Separation/ Divorce	23%	27.5%
Emotional Neglect	15%	Not Collected	Mental Illness	17%	15%
Emotional Abuse	11%	31.2%	Battered Mother	13%	17.4%
Physical Neglect	10%	Not Collected	Criminal Behavior	6%	7.6%

ACEs are Rarely Found in Isolation and Tend to Occur in Clusters:

The cumulative impact of ACEs is captured in the "ACE Score:" the number of ACEs an individual has experienced. If an individual has experienced one ACE, they are likely to have multiple. An individual's ACE score indicates the likelihood of experiencing consequences of toxic stress during development.[8]

ACE SCORE	PREVALENCE	
	K-P (1995)	MD (2015)
0	33 %	40%
1-2 ACEs	42 %	36%
3 or More	26 %	24%

ACEs are Strong Determinants of adolescent & Adult Social Well-Being and 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.[9]

AN ENHANCED UNDERSTANDING OF THE TYPES OF ACES

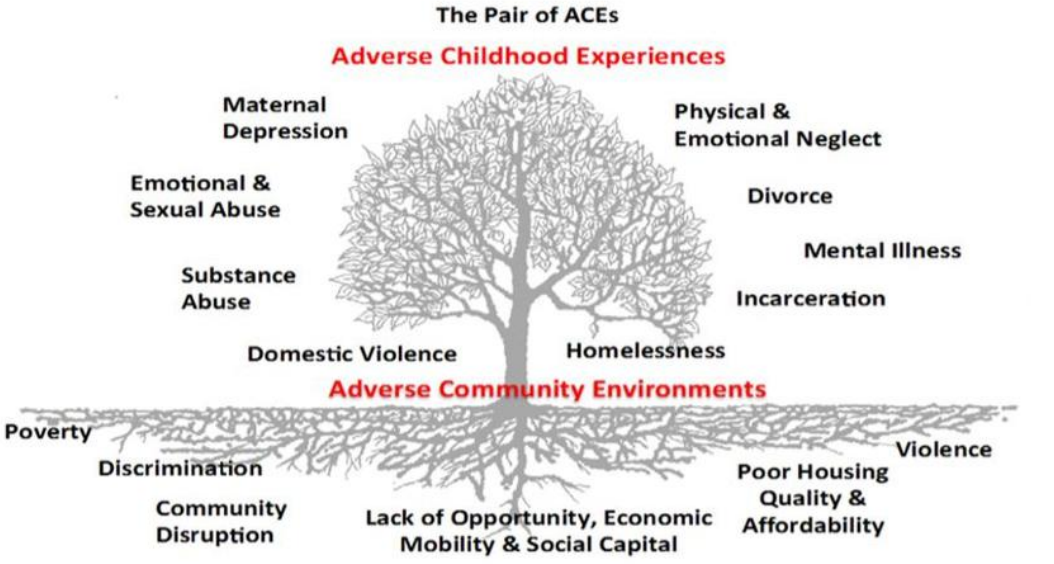
In designing the ACE Study, Dr. Anda and Dr. Felitti had to make some hard choices in order to keep the length of the questionnaire manageable, so that study participants could complete it. They chose experiences where there are organizations set up to prevent or treat specific ACEs such as child abuse and neglect and domestic violence and substance abuse. Some stressful experiences, like parental death or illness, are not directly addressed as "preventable" by existing organizations. Since the original ACE study, research has revealed additional adverse experiences that like the original ten ACEs, engage a child's brain and body in a chronic "fight, flight, or freeze" response and lead to poor social, educational, and health outcomes across the lifespan.

Philadelphia or Urban ACE Study

The Philadelphia ACE Study expanded the original ACE study to include an additional five adverse community experiences: witnessing violence, racism, neighborhood safety, bullying, and living in foster care. Researchers found that almost 40 percent of Philadelphians had experienced four or more of these expanded, community-level ACEs with similar impacts on risk behaviors and poor health outcomes.[10]

Adverse Community Environments

Drs. Wendy Ellis, PhD and William Dietz, PhD developed the Pair of ACEs tree depiction below that illustrates the relationship between adversity within a family and adversity within a community.

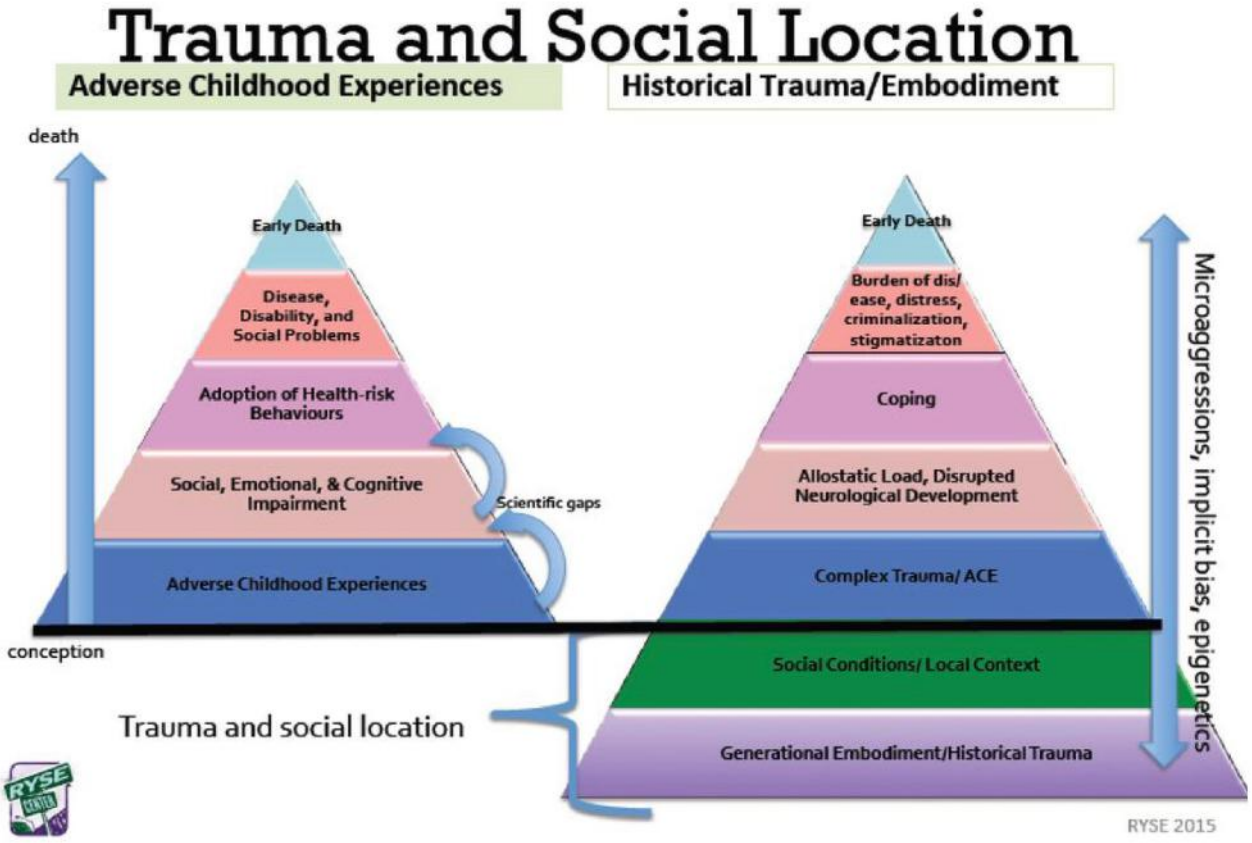


Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

The leaves on the tree represent the 'symptoms' of ACEs that are easily recognized in clinical, educational and social service settings, such as well-child visits or pre-school classrooms. The tree is planted in poor soil (or a community) that is steeped in systemic inequities, robbing it of nutrients necessary to support thriving individuals and communities. Adverse community environments such as unaffordable and unsafe housing, community violence, systemic discrimination, and limited access to social and economic mobility compound one another, creating a negative cycle of ever-worsening soil that results in withering leaves on the tree.

Historical and Intergenerational Trauma

The ACE Pyramid and the Expanded ACE Pyramid below are life course models, from pre-conception to death that are designed to help us understand how Adverse Childhood Experiences (ACEs) influence human development in predictable ways. This is important because **what is predictable is preventable**. The hypothesis of the original ACE Study was that ACEs disrupt neurodevelopment, which in turn leads to social, emotional and cognitive adaptations that can then lead to the risk factors for major causes of disease, disability, social problems, and early death.



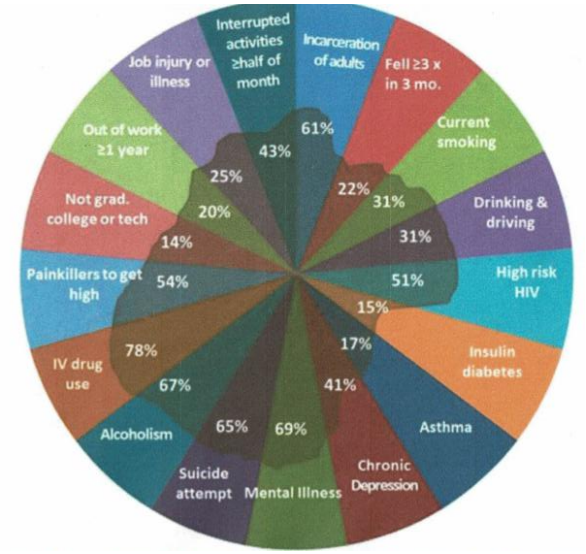
Since the time of the ACE Study, the breakthrough research in developmental neuroscience and epigenetics, mentioned above, has shown us that the hypothesis of the ACE study is biologically sound. Neuroscience and epigenetic discoveries help us to understand the progression of adversity from preconception throughout the life course. Historical trauma and generational adversity increase the risk for ACEs, which in turn generate risk for disease, disability, and social problems.[11]

THE MAGNITUDE OF THE SOLUTION

Preventing and Mitigating Multiple Health and Social Problems at the Same Time

From the findings of the ACE study and subsequent research, we understand that ACEs are common and have a strong cumulative impact on the risk of common health and social problems across the lifespan. Preventing ACEs and their intergenerational transmission is the greatest opportunity for improving the well-being of human populations. In fact, many believe this is the greatest opportunity of our time... perhaps of all time. The diagram below shows the percentage of various health and social problems that epidemiologists estimate are

caused by ACEs. The calculation that is commonly used to do this in public health studies is called Population Attributable Risk; this is displayed as a percentage of an "oil spill" on the diagram. The percentage of a problem coated by the oil spill represents the percentage of each problem that is potentially preventable by preventing ACEs. The percentages are quite large. In fact, these figures are rarely seen in public health studies. The cumulative effects of ACES reflect a powerful opportunity for prevention – whether working to prevent heart disease or cancer, end homelessness, or improve business profitability – as legislators align a portion of their work around a common goal of preventing ACEs and moderating their effects, they will reduce all of these problems, and many others, all at once.



Underperformance in schools and in jobs, poor mental health, substance abuse, and a variety of adverse health outcomes can all be partially attributed to childhood adversity. This wide scope of impact means that there are multiple opportunities to prevent and mitigate the harmful consequences of childhood adversity through numerous avenues of public policy. If lawmakers enact policies that prevent childhood adversities and mitigate their effects, each one of these problems will grow smaller.

The CDC conservatively estimates lifetime costs associated with child maltreatment at approximately $2 trillion nationwide.[12] This estimate does not include the cost of ACEs associated with family dysfunction, urban ACEs, and other childhood trauma known to chronically activate the biological "fight, flight, freeze response." Legislation aimed at preventing and mitigating childhood trauma not only works to improve the public health of our state, but can significantly reduce costs across all systems-- health care, education, criminal and juvenile justice, and welfare—over the long term.

THE ROAD TO RESILIENT INDIVIDUALS & COMMUNITIES

HOPE: HEALTH OUTCOMES OF POSITIVE EXPERIENCES

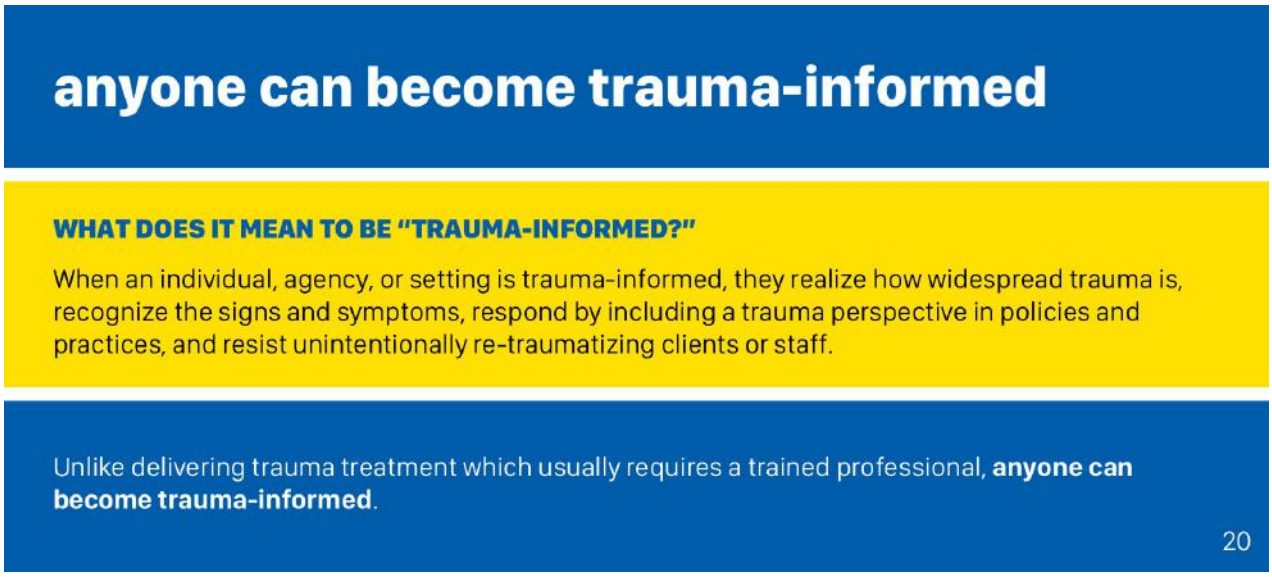
While the ACE study shows that adversity in childhood has lifelong impacts, subsequent studies have also shown that there are successful interventions not only for preventing exposure to ACEs, but also for mitigating their effects once they occur. **Positive experiences in childhood have also been shown to impact health across the lifespan**.[13] Positive experiences have been measured alongside ACEs in at least one state (Wisconsin) through their Behavioral Risk Factor Survey (BRFSS). Results showed that health is positively impacted by positive experiences, reflected in the following measures: (1) felt able to talk to their family about feelings; (2) felt their family stood by them during difficult times; (3) enjoyed participating in community traditions; (4) felt a sense of belonging in high school (not including those who did not attend school or were home schooled); (5) felt supported by friends; (6) had at least 2 non-parent adults who took genuine interest in them; and (7) felt safe and protected by an adult in their home. In considering responses to the health, social, and economic outcomes of ACEs and trauma, equal "attention should be given to the creation of those positive experiences that both reflect and generate resilience within children, families, and communities."[14]

Building resilience to traumatic experiences is a crucial factor in preventing the onset of negative health consequences as a result of exposure to ACEs, as resilience has been shown to provide the needed buffer to return the body to its base-line state following a stress response.[15] Skills required to build resilience can be taught and include fostering positive, supportive relationships, developing strong coping skills, and developing a sense of competence, character, and control in both children and parents.[16]

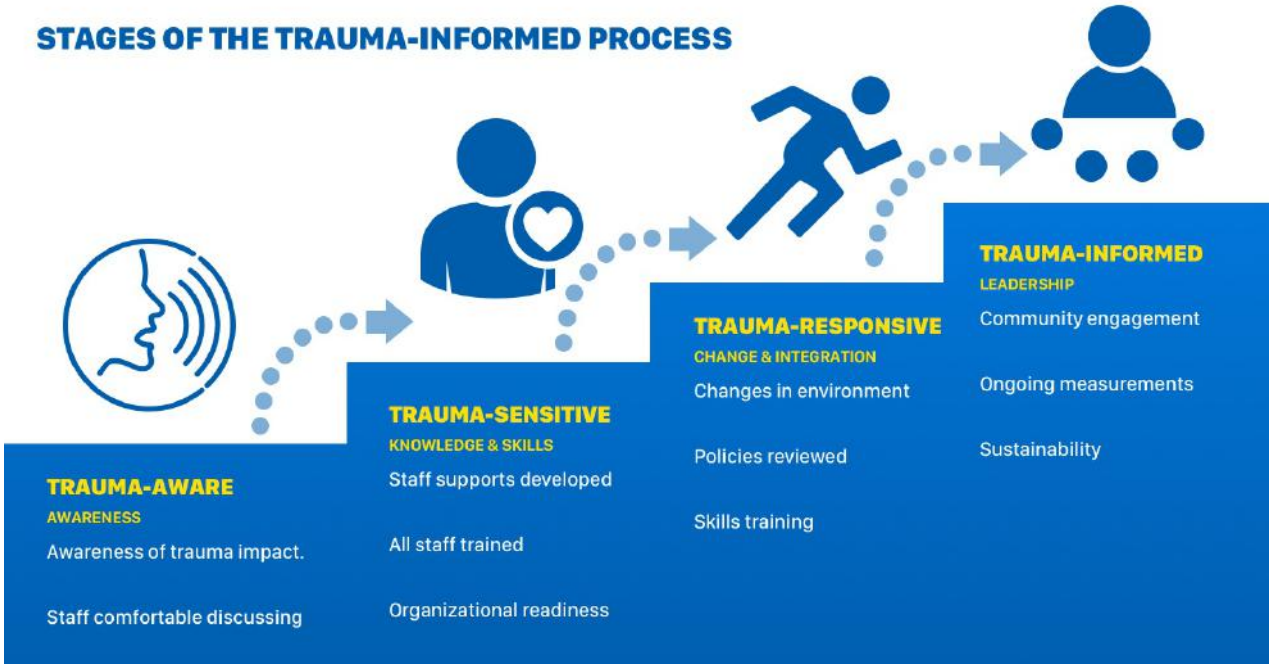
MITIGATING CHILDHOOD TRAUMA: TRAUMA-INFORMED SYSTEMS OF CARE

An important component of effective health, behavioral health, education, human, justice, and correctional service delivery is addressing the trauma of those served and serving. At a population level, effectively responding to trauma requires a multi-pronged, multi-agency public health approach that includes public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment.[17] In order to maximize impact, states must ensure that services to the public are trauma-informed, i.e., based on the knowledge and understanding of trauma and its far-reaching implications. Research indicates that with trauma-informed supports and intervention, people can recover and heal. Unfortunately, most systems are not trauma-informed and people go without needed services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders as well as chronic physical diseases.[18]

Additionally, many organizations and public agencies provide services in ways that are often themselves trauma-inducing. "The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems."[19] These systems are beginning to reassess and adjust how they offer services by becoming trauma-informed.



Becoming a trauma-informed system happens in multiple stages depicted in the illustration of the Missouri Model for becoming trauma-informed, below. **The first step in addressing trauma is for an individual, organization, system, or community to become aware of how trauma affects members and clients of the organization, system, or community**. The fundamental shift in providing support using a trauma-informed approach is to move from thinking 'What is wrong with you?' in response to the behavior of a client or colleague to considering 'What happened to you?'



SELF-HEALING & RESILIENT COMMUNITIES

The Washington Family Policy Council (FPC) has made groundbreaking efforts over a decade to disseminate NEAR (Neurodevelopment, Epigenetics, ACEs, and Resilience) science and provide technical assistance and coaching to local communities. The FPC employed a Self- Healing Communities Model (SHCM) to build upon the capacity of communities to generate new cultural norms and thereby improve health, safety, and productivity for current and future generations. **As Washington communities developed the capacity to shift typical cultural patterns, individuals within the community gained new knowledge and skills, and the communities as a whole became learning environments that continued to invite growth and wellbeing.** The SHCM demonstrated success in improving the rates of many interrelated and intergenerational health and social problems, resulting in incredible reductions in key child outcomes within those communities. As an example, in just one county over a ten-year period there was a:

- 62% reduction in teen births;
- 43% decrease in infant mortality;
- 98% decrease in teen suicide;
- 53% decrease in juvenile arrests for violent crimes;
- 47% decrease in high school dropout rates

The monetary savings to the state for that period are estimated at $1.4 billion.[22]

RESEARCH INFORMED POLICY STRATEGIES & APPROACHES TO PREVENT AND MITIGATE ACES

Our greatest public health problem requires a policy response at the federal, state and local level.

POLICY RESEARCH

Researchers at the U.S. Centers for Disease Control and Prevention (CDC) have worked to identify policies that are most effective in preventing ACEs from occurring in the first place. **Promoting safe, stable, nurturing relationships and environments, at a population level, is key**. Effective policies and interventions aimed at preventing and mitigating ACEs generally fall into six strategies: strengthen economic supports for families; promote social norms that protect against violence and adversity; ensure a strong start for children; teach skills to caregivers, children, and youth; connect children and youth to caring adults and activities; and intervene to lessen immediate and long-term harms of ACEs.[23]

6 EVIDENCE INFORMED STRATEGIES TO PREVENT ACES

1. Strengthen Economic Supports for Families

Research has shown that policies that **strengthen household financial security** and **family-friendly work policies** increase economic stability and family income, increase maternal employment, and improve parent's ability to meet children's basic needs and obtain high quality childcare. These types of policies can also prevent ACEs by reducing parental stress and depression and by protecting families from losing income to care for a sick child or family member.[24] Strengthening economic supports for families is a multi-generation strategy that addresses the needs of parents and children so that both can succeed and achieve lifelong health and well-being.[25]

Policies may include:

- Living wage
- Paid sick and safe leave
- Paid family and medical leave
- Flexible and consistent schedules
- Child support pass-through
- Increased tax credits
- Increased enrollment in social benefits - SNAP, TANF
- Assisted housing mobility
- Subsidized childcare
- Family-friendly work policies in government and private industry

2. Promote Social Norms that Protect Against Violence & Adversity

Norms are beliefs and expectations held by groups that inform how members of the group should think and behave. The CDC explains that "changing social norms that accept or allow indifference to violence and adversity is important in the prevention of ACEs. There are a number of norms that can protect against violence and adversity, including those that:

- Promote community norms around a shared responsibility for the health and well-being of all children
- Support parents and positive parenting, including norms around safe and effective discipline
- Foster healthy and positive norms around gender, masculinity, and violence to protect against violence towards intimate partners, children, and peers
- Reduce stigma around help-seeking
- Enhance connectedness to build resiliency in the face of adversity."[26]

Suggested approaches in shifting social norms toward preventing ACEs include:

- Public education campaigns
- Legislative approaches to reduce corporal punishment
- Bystander approaches and efforts to mobilize men and boys as allies in the prevention of violence and abusive behaviors

3. Ensure a Strong Start for Children

A strong educational foundation greatly increases a child's resilience and chance to prosper throughout their childhood and adulthood. Policies may include:

- Support for effective home visiting programs
- High quality Pre-K and preschool enrichment programs with family engagement
- Increased licensing and accreditation standards for childcare facilities
- Increased access to trauma-informed services in childcare and education facilities
- Increased childcare subsidies to make care accessible to all children.[27]

4. Teaching Skills to Caregivers, Children, & Youth

When parents are supported and educated in positive parenting practices, they can thrive as parents and create safe, stable, and nurturing homes for their children. Policies that promote positive parenting include:

- Evidence-based home visitation services
- Evidence-based parenting classes and family building programs that improve developmental outcomes in children and decrease instances of abuse and neglect[28]

Parents, teachers, and other caregivers, as well as children, youth, and young adults in settings from childcare to higher education can benefit from being taught:

- Social Emotional Learning (SEL)
- Healthy relationship skills: programs such as Dating Matters®, Safe Dates, and the Fourth R teach healthy relationship skills to adolescents
- Skill-based parenting and family relationship approaches, e.g., The Incredible Years® and Strengthening Families[29]

- Trauma-informed and responsive skills and systems[30]
- Executive function and self-regulation skills, which are foundational to school readiness, academic success, and healthy relationships in adults and children. These are mental processes that enable us to plan, focus attention, remember instructions, and juggle multiple tasks successfully. When children experience ongoing trauma without the buffering of supportive adults, these skills are less likely to fully develop. [31]

5. Connect Children & Youth to Caring Adults and Activities

It is important to both prevent and mitigate ACEs by connecting youth to other caring adults and activities. These experiences buffer against other difficulties in the home, parental absence, frequent moves, and exposure to negative influences in school and the community. Opportunities to develop and practice leadership, decision-making, self-management, and social problem-solving skills have documented benefits. Supportive policies and funding promote:

- Mentoring programs
- After-school programs[32]

6. Intervene to Lessen Immediate & Long-Term Harms of Childhood Trauma and Adversity

Primary prevention of violence and maltreatment has been proven to be the best way to avoid the harmful social, health, and economic costs of childhood adversities.[33] By stopping the problem before it starts, we can greatly reduce the costs associated with ACEs. However, studies have shown that a large population of Maryland's children and adults have already experienced some form of childhood adversity or trauma.[34] To avoid the harmful health outcomes that result from this exposure, policies must provide appropriate, trauma-informed care and treatment for childhood adversity. These policies include:

- Enhanced primary care, including:
    - Early screening and detection of childhood trauma
    - Expansion of insurance coverage for mental, behavioral, and social-emotional healthcare treatments
    - Safe Environment for Every Kid (SEEK) model, an evidence-based intervention developed at the University of Maryland School of Medicine, which screens for ACE exposures in the family environment.
- Victim-centered services
- Treatment to lessen the harms of ACEs
- Treatment to prevent problem behavior and future involvement in violence
- Family-centered treatment for substance use disorders may be used to simultaneously address substance misuse by parents and the needs of their children with this ACE exposure
- Training and skill building programs for childcare providers, healthcare professionals, and educators on the signs, symptoms and effects of trauma, and increased access to these resources[35]

FEDERAL AND STATE ACE-INFORMED LEGISLATIVE ACTION

National, state, and local legislators are employing at least five legislative mechanisms to prevent and reduce ACEs, mitigate their impact, and promote the safe, stable, and nurturing relationships and environments that build resilient communities:

CREATING INFRASTRUCTURE TO TACKLE ACEs - FIVE LEGISLATIVE MECHANISMS

1. **ACEs Resolutions:**
   Many states have passed ACE Resolutions that recognize NEAR science, the importance of preventing ACEs and mitigating their impact, and the need to consider research when developing state policy. While resolutions may not require specific action, recognition by federal, state, and local legislative bodies increases awareness of ACEs in households, communities, and the government alike. This is a crucial step in getting science into the hands of the general public, in developing innovative legislative strategies to prevent and mitigate ACEs, and creating a system of public services that is ACE-Trauma-and-Resilience-Informed.
2. **ACE & Trauma-Informed Legislative Caucuses:**
   At least two states, Hawaii and Wisconsin, have created Children's Caucuses which they use as a mechanism to develop comprehensive strategies to integrate NEAR science into all policies that impact children and their families.
3. **ACEs Task Forces/Workgroups:**
   ACE-informed task forces and workgroups operate to review and analyze the research, both scientific and policy, to develop coordinated and strategic policy recommendations to address ACEs as a public health epidemic.
4. **Encourage and Coordinate Cross-System Collaboration:**
   policies and practices and achieving improved outcomes for children, families, communities, and the State, requires coordination across public and private systems that serve children and families. Systems reform must use a multi-generational approach to solving the complex problems associated with childhood trauma, including strengthening the core capabilities of all adults who care for children. Coordination must take place at both the state and local levels.
5. **Dedicated Funding:**
   Dedicated state and local prevention funding to work across systems is critical. With a small investment, the Washington Family Policy Council was able to support significant change in local communities.[36] Most states across the country have developed robust prevention trust funds with combined annual revenues in excess of $100 million dedicated to prevention. Robust Children's Trust Funds in other states generate $1-18 million annually from the corpus of their Funds. Children's Trust Fund Boards actively raise funds to support statewide prevention efforts.[37] The absence of such a trust fund is a significant gap in Maryland's infrastructure to support prevention.

FEDERAL LEGISLATION

Beginning in 2017, Congress has passed the following ACE-Informed legislation:

- Passed A Resolution Recognizing the Importance and Effectiveness of Trauma-Informed Care (H.Res. 443/S.Res. 346) during the 2017-2018 legislative session.
- Passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.Res. 6 or previously titled the Opioid Crisis Response Act). Enacted in 2018, the SUPPORT Act offers significant provisions taken from or aligned with the goals of the Heitkamp-Durbin Trauma-Informed Care for Children and Families Act (S. 774), including the creation of an interagency task force to identify trauma-informed best practices and grants for trauma-informed practices in schools.

- U.S. Government Accountability Office issued a report "CHILDREN AFFECTED BY TRAUMA: Selected States Report Various Approaches and Challenges to Supporting Children" in April 2019.
- Introduced the bipartisan Resilience Investment, Support, and Expansion (RISE) from Trauma Act (H. Res. 3180/S. 1770) in June 2019. The "RISE from Trauma" Act would expand and support the trauma-informed workforce in schools, health care settings, social services, first responders, and the justice system, and increase resources for communities like Chicago to address the impact of trauma.

MARYLAND ACE-INFORMED LEGISLATION

Enacted Legislation

Members of the Maryland General Assembly have passed the following legislation that will help reduce children's exposure to ACEs in a variety of issue areas, including healthcare, family and social services, education, and more. While all of these bills may have an impact on the prevention of ACEs according to the research literature, only three of the bills were formulated with ACEs in mind and mention the impact of the legislation to reduce ACEs and their consequences.

1. Strengthen Economic Supports to Families

Increasing Minimum Wage

- Passed Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen) (H.B. 166/S.B. 280) in 2019. Raises the minimum wage to $15/ hour by 2024. Increasing Earned Income Tax Credit
- Passed Income Tax – Child and Dependent Care Tax Credit - Alteration (H.B. 810/S.B. 870) in 2019. Expanded Maryland's Child and Dependent Care Tax Credit for the first time in nearly two decades—increasing the income threshold from $50,000 to $143,000 for married couples (and to $92,000 for individuals), indexing these limits annually for inflation, and making the credit refundable for low-income filers.

2. Promote Social Norms that Protect Against Violence & Adversity

- ***None Identified***

3. Ensure a Strong Start for Children

- Passed Education – Child Care Subsidies – Mandatory Funding Levels (H.B. 430/S.B. 379) in 2018. Increases Maryland's low childcare subsidy rates to give parents access to quality care, and establishes a new "floor" so that rates never again fall so low. In terms of investment, breadth of benefit, and lasting impact, this was the most significant victory for early care and education in more than a decade.
- Passed Education – Child Care Subsidies – Mandatory Funding Level (H.B. 248/S.B. 181) in 2019. Building on landmark legislation from 2018 to give parents access to quality care, this bill accelerates a mandated increase of childcare subsidy rates. Beginning in July 2020, subsidy rates must equal or exceed 60 percent of market rates—and must remain at or above the 60th percentile in the future
- Passed Education – Commission on Innovation and Excellence in Education (H.B. 1415/S.B. 1092) in 2018. Preserves $22.3 million in pre-K expansion dollars that might otherwise have been lost when a federal grant expired.
- Passed State Employees – Parental Leave (H.B. 775/S.B. 859) in 2018. Provides up to 12 weeks of paid leave for State employees following the birth or adoption of a child.

- Passed Education – Head Start Program – Annual Funding (The Ulysses Currie Act) (H.B. 547/S.B. 373) in 2018. Restores a $1.2 million budget cut imposed in 2009, potentially increasing services for more than 2,100 Head Start children.
- Passed Maryland Prenatal and Infant Care Coordination Services Grant Program Fund (Thrive by Three Fund) (H.B. 1685/S.B. 912) in 2018. Creates a grant program to expand the coordination of direct services for jurisdictions with a high percentage of births to Medicaid-eligible mothers.

4. Teach Skills to Caregivers, Children, & Youth

Home Visitation Services

- Passed The Home Visiting Accountability Act of 2012 (H.B. 699/S.B. 566). Requires the state fund only evidence-based and promising home visiting models; and, that 75% of funding go to evidence-based models.

5. Connect Children & Youth to Caring Adults and Activities

- ***None Identified***

6. Intervene to Lessen Immediate & Long-Term of Childhood Trauma and Adversity

Trauma-Informed and Responsive Schools

- Passed The Blueprint for Maryland's Future (S.B. 1030) in 2019. Endorses the sweeping policy recommendations of the Kirwan Commission and requires a 3-year "down-payment" on the implementation of those recommendations, totaling approximately $1 billion. State funding for pre-kindergarten will expand by $31.7 million in FY 2020 and an estimated $53.6 million in FY 2021. The teacher professional development program established under the bill may include "training in trauma-informed approaches to meet student needs."

Ensure Childhood Trauma and Associated Health Outcomes are Addressed by the Child Welfare System

- Passed Human Services – Children Receiving Child Welfare Services - Centralized Comprehensive Health Care Monitoring Program (H.B. 1582) in 2018. Creates a Centralized Comprehensive Health Care Monitoring Program for Children in the Child Welfare System, including an electronic health passport for children in out-of- home placement. The law recognizes ACEs and their associated long-term outcomes on physical and mental health of children within the child welfare system.

Ensuring Quality and Expanding the Access, and Scope of Child Advocacy Centers (CACs)

- Passed Child Advocacy Center - Expansion (S.B. 739) in 2019. Requires the Governor's Office of Crime Control and Prevention establish, sustain, and ensure that all children have access to multi-disciplinary child advocacy centers and that those centers meet or exceed national accreditation standards. Further it requires that child advocacy centers must assist in the response to or investigation of allegations of sexual crimes against children and sexual abuse of minors; and, may assist in the response to or investigation of allegations of child abuse and neglect or a crime of violence in the presence of a minor. The bill recognizes both the importance of a multi-disciplinary response to children's exposure to trauma, including expanding the types of trauma/adversity to which CACs may respond.

Preventing Child Abuse & Fatalities

- Passed an Expanded Birth Match law: Child Abuse and Neglect – Disclosure of Identifying Information (S.B. 490) in 2018. Expands from 5 to 10 years cross-checking of birth records of newborns (Vital Statistics) to information held by the Department of Human Services (DHS) on biological parents who have had their parental rights terminated by a court due to the abuse of a previous child. This allows for an offer of preventative services, or in egregious cases, removing the newborn to a safe environment. It also requires the courts to provide identifying information regarding an individual who has been convicted of the murder, attempted murder, or manslaughter of a child. And finally, it adds a requirement for the Department of Human Services (DHS) to contract with an independent entity to develop a data collection process.
- Passed Child Abuse and Neglect – Substance-Exposed Newborns – Reporting (H.B. 1744) in 2018. Requires hospitals to report cases of substance exposure in newborns to local Department of Social Services. There must be both an oral report immediately following contact with the newborn and a written report filed within 48 hours.[38]

Preventing Child Sexual Abuse

- Passed HB1072 Education - Child Sexual Abuse Prevention - Instruction and Training (H.B. 1072) in 2018. Defines "sexual misconduct." Requires County Boards of Education and nonpublic schools that receive State funds to train all employees who have direct contact with minors in the primary prevention of child sexual abuse. Requires County Boards of Education to establish policies and codes of conduct to prevent child sexual abuse by school employees.
- Passed Education - Personnel Matters - Child Sexual Abuse and Sexual Misconduct Prevention (SESAME) Act (H.B. 486) in 2019. Bans nondisclosure agreements involving sexual abuse for school employees who have direct contact with children and requires prospective employers to conduct a thorough review of the applicant's employment history, requiring applicants to disclose and instances which they were investigated (unless found false), disciplined, discharged or lost license, provides immunity for employers from civil and criminal liability for providing information in good faith about potential misconduct.[39]

2019 ACE-Informed Legislation Introduced, Not Enacted

In 2019, additional legislation was proposed, but not enacted that were NEAR Science Informed:

Strengthening Economic Supports to Families:

- H.B. 341 was introduced to provide 12 weeks paid family or medical leave to parents with newborns (including adoptive or foster children), individuals who must care for sick family members, and those who are themselves experiencing a serious medical condition.[40] Providing paid leave combats ACEs by reducing parental stress and allowing new parents the time to create lasting bonds with their young children, both of which can prevent abuse and neglect later on in a child's life.
- H.B. 339 would have, if passed, increased Temporary Cash Assistance (TCA) from 61% to 71% of minimum living income level in Maryland by 2025.[41] Legislation that aims to increase TCA, along with other social benefits, is useful in combatting ACE exposure because it reduces financial burden and parental stress, which in turn allows parents to provide for their children and thrive as a family.

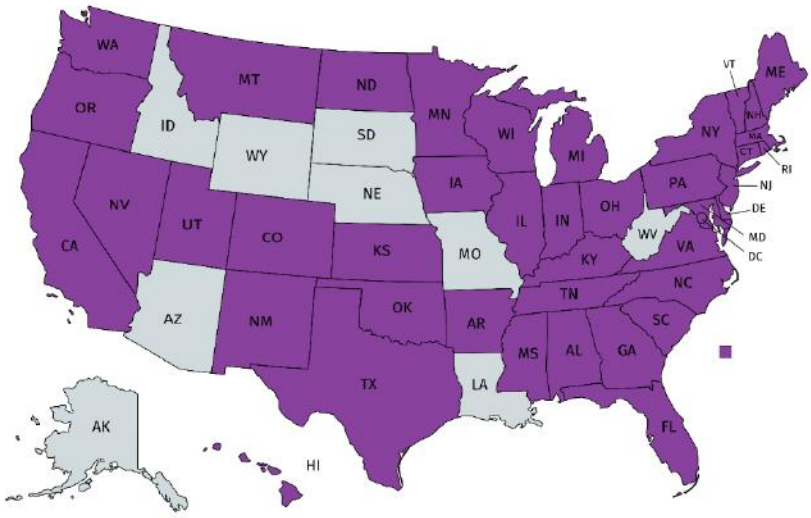
Intervene to Lessen Immediate & Long-Term of Childhood Trauma and Adversity

- H.B. 256 established a definition for "trauma-informed approaches" and proposed funding to help implement trauma-informed practices in schools. Training aims to both identify trauma and address its impacts for students and teachers.[42] This legislation deserves bipartisan support from Maryland lawmakers because it takes large steps towards creating trauma-informed schools, which have been shown to reduce student dropout rates, suspensions, and absences, contributing to the wellbeing of our students and teachers alike.
- H.B. 687, Civil Statute of Limitations Reform, Hidden Predator Act of 2019, Limitations for Child Sexual Abuse. Including a "look back window" promotes community norms against violence toward children, provides justice and healing for victims of child sexual abuse, and exposes hidden predators still living in communities.[43]

SISTER STATES LEGISLATION

ACE science has been recognized in over 280 proposed bills and 60 enacted statutes in 42 states across the country. These efforts focus on policy solutions in a variety of contexts, including health, education, social services, economic development, public safety, and more.44 In 2019 alone, over forty states introduced ACE- Informed legislation.

Map of States that Introduced ACE Legislation in 2019 [45]



This legislation builds awareness of science among policy makers and their constituents; assists in lifting the stigma surrounding trauma, mental illness, and substance abuse; provides an environment in which to freely discuss the consequences of exposure to ACEs; and encourages innovative solutions to reduce ACEs and mitigate their impact.

The appendix to this document, "State Legislative Strategies to Prevent and Mitigate ACEs," outlines and provides links to many key bills passed in Maryland and sister states. The legislative bills are organized according to **five legislative mechanisms** states have used to prevent and respond to ACEs; and, the **six evidence-informed strategies** outlined by the Centers for Disease Control and Prevention in its' recent publication, "Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence."

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Appendix

STATE LEGISLATIVE STRATEGIES TO PREVENT & MITIGATE ACES*

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

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

1. Joint resolutions establishing statewide policy on ACEs
2. Funding for primary prevention of ACEs
3. ACE- or trauma-informed caucus
4. ACE task forces/workgroups
5. Creation or use of an existing coordinating body for cross-sector collaboration

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

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

SECTION A:

CREATING INFRASTRUCTURE TO TACKLE ACEs - FIVE LEGISLATIVE MECHANISMS

JOINT RESOLUTIONS ESTABLISHING STATEWIDE POLICY ON ACES

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

Rationale:

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

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
JOINT RESOLUTIONS ESTABLISHING STATEWIDE POLICY ON ACES		Alaska: HCR 21 (2016). Urging Governor Bill Walker to join with the Alaska State Legislature to respond to the public and behavioral health epidemic of adverse childhood experiences by establishing a statewide policy and providing programs to address this epidemic. Alaska: S105 (2018). Revises licensure of martial and family therapists and creates a state policy directive that "policymakers, administrators, and those working within state programs and grants to make decisions based on the principles of early childhood and youth brain development and, whenever possible, consider the concepts of early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, supports, self-regulation, and services."

		California: ACR155 (2014) recognizes ACEs and urges Governor to identify evidence-based solutions to reduce exposure to ACEs, address the impacts of ACEs, and invest in prevention of ACEs. And, ACR 235 designates a specified date as Trauma Informed Awareness Day, in conjunction with National Trauma Informed Awareness Day, to highlight the impact of trauma and the importance of prevention and community resilience through trauma informed care. Delaware: Executive Order 24 (2018), "Making Delaware a Trauma-Informed State" declares Delaware a trauma informed state and recognizes significance of early intervention for children and caregivers exposed to ACEs. Minnesota: HF892/SF1204 (2015) "Resolution on Childhood Brain Development and ACEs". Calls on the Governor to create a cross-sector task force and to support a voluntary tax checkoff on the income tax return form, other dedicated appropriations, or other state resources designated for child abuse prevention services with a percentage set aside for program evaluation. New Jersey: SCR100, (2019). Urges Governor to develop strategies to reduce children's exposure to ACEs. (pending)

		Wisconsin: SJR59 (2013) recognizes the effects of ACEs and resolves that the legislature will consider principles of early childhood brain development, toxic stress, adversity, buffering relationships, and the importance of early intervention when creating policy. Utah: Concurrent Resolution 10 (2017), "Identification and Support of Traumatic Childhood Experiences Survivors". Encourages state officers, agencies, and employees to become informed regarding well-documented detrimental short-term and long-term impacts to children and adults from serious traumatic childhood experiences; and to implement evidence-based interventions and practices that are proven to be successful in developing resiliency in children and adults currently suffering from trauma-related disorders.

FUNDING FOR PRIMARY PREVENTION OF

MGA COMMITTEE: Appropriations | Budget & Taxation | Finance

Rationale:

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

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
CHILDREN'S PREVENTION TRUST FUNDS	Maryland Code, Health General, Sec. 13-2207, (2010) Established Maryland's	Hawaii: HI Rev Stat § 350B-4 (2016). Kansas: Children's Trust Fund Statute. Massachusetts: S2130, General Laws Sec. 202 (1987) and Sec. 50.

	Children's Trust Fund.	Oklahoma: Act No. 231 (2018). Creates the Children's Endowment Fund to stimulate new programs, activities, research or evaluation that will improve the well-being and reduce the ACEs of Oklahoma's children. South Carolina: SC Code § 63-11-910 (2012) through SC Code § 63-11-960. Proposed Amendments to current Trust Funds: Colorado: H1044 (2018). Amends current statutory language in the ""Colorado Children's Trust Fund Act"" to place a greater priority on preventing child maltreatment fatalities and continuing to prevent child maltreatment. This includes reducing the occurrence of prenatal drug exposure and drug endangerment and reducing the occurrence of other adverse childhood experiences.
APPROPRIATE FUNDING FOR STATE & LOCAL ACE INITIATIVES "Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings"		Washington: RCW 70.190.010 (1994.) Establishes the Washington Family Policy Council to facilitate services at the local level. Despite significant improved outcomes for children and families, this program was eliminated during the Great Recession.
APPROPRIATE FUNDING FOR ACE EVIDENCE BASED PROGRAMS (EBPs) AND INNOVATION		California: S1004 (2018). Provides that the Mental Health Services Oversight and Accountability Commission, on or before January 1, 2020, will establish priorities for the use of prevention and early intervention funds. These priorities will include childhood trauma prevention and early intervention to address the early origins of mental health needs. A1812 (2018). Establishes the Youth Reinvestment Grant Program. Provides funds to local jurisdictions and Indian tribes for the implementation of trauma-informed diversion programs for minors. Colorado: S10 (2019). Allows grant funds to be used for behavioral health care services, including

		services to support social-emotional health, at recipient schools or through service contracts with community providers. Pennsylvania: S1142 (2018). Establishes the School Safety and Security Grant Program and related Fund. Funds can be used for the administration of evidence-based screenings for adverse childhood experiences and to provide trauma-informed counseling services as necessary to students based upon screening results.

ACE or TRAUMA-INFORMED CAUCUS

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

Rationale:

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

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

ACE TASK FORCES/WORKGROUPS

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

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

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
ACE/ TRAUMA- INFORMED TASK FORCES "Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings"	No general Task Force on ACEs. State Council on Child Abuse and Neglect (SCCAN) focuses its' efforts and recommendations on ACEs. SB567 (2019). Establishing a Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations. Requires the Workgroup to study available science and best practices pertaining to children in traumatic situations, including trauma-informed decision making. and make recommendations about how State courts could incorporate the science into child custody proceedings. HB666 (2020) Establishing a Workgroup on Screening Related to Adverse Childhood Experiences; requiring the Workgroup to update, improve, and develop certain screening tools, submit screening tools to the Maryland Department of Health, and study and make recommendations on the actions primary care providers	Georgia: HR421 (2019). Creates the Committee on Infant and Toddler Social and Emotional Health. Illinois: H2649 (2019.) Amends the Code of Criminal Procedure, creates the Task Force on Children of Incarcerated Parents, provides that the Task Force shall review available research, best practices, and effective interventions to formulate recommendations. Maine: Act 63 (2019). Convenes a task force to develop guidance for kindergarten-12th grade educators and administrators on appropriate training for and responses to addressing childhood trauma, including ACEs training, trauma informed care, health screenings, and a social-emotional curriculum from K-8th grade. New York: A2451(2019). Establishes a task force to identify evidence based and evidence informed solutions to reduce children's exposure to adverse childhood experiences.

	should take after screening a minor for mental health disorders that may be caused by or related to ACEs.	Oklahoma: Act 112 (2018). Establishes the Task Force on Trauma-Informed Care to identify, evaluate, recommend, maintain, and update a set of best practices for youth who have experienced/ are at risk of experiencing trauma (ACEs). Vermont: No.42 (2017). "An Act Relating to Building Resilience for Individuals Experiencing Adverse Childhood Experiences". Establishes an Adverse Childhood Experiences Working Group of key legislators to consider future legislation. Four bills were introduced as a result of the report and Act 204 passed in 2018 based on the report. Washington: H1482 (2018). Establishes the Work First Poverty Reduction Oversight Task Force, which will collaborate with an advisory committee to develop and monitor strategies to prevent and address adverse childhood experiences and reduce intergenerational poverty. S5903/ Act 360 (2019). Creates the Children's Mental Health Workgroup to identify barriers to accessing mental health services, monitor the implementation of legislation and policies relating to children's mental health and consider strategies to improve coordination between education and health systems.

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

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

Rationale:

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

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
ESTABLISHED COORDINATING BODY FOR ACE SCIENCE WORK "Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings"	No designated agency lead on coordinating NEAR Science interventions statewide.	California: Executive Order N-02 (2019). Solidifies the state's promise to address ACEs by creating the position of the Surgeon General, which allows for the creation of health-informed legislation. A887, (2019). Requires the Office of Health Equity to advise and assist other state departments in their mission to increase the general well-being of all state residents and to work toward eliminating adverse childhood experiences. Prescribes the qualifications of the Surgeon General. Eliminates the position of Deputy Director of the Office of Health Equity. Colorado: S195 (2019). Creates the Office of Children and Youth Behavioral Health Policy Coordination in the office of the Governor, creates the Children and Youth Behavioral Health Policy Coordination Commission and the Children and Youth Behavioral Health Advisory Council in the office, provides for the duties, powers, and

		composition of the commission and the council, makes an appropriation. Vermont: Act 204 (2018). Creates the permanent position of Director of Trauma Prevention and Resilience Development within the Office of the Secretary in the Agency of Human Services. The role of the Director is to direct coordinated public health approaches to addressing ACES, toxic stress, and resilience. Washington: RCW 70.190.010 (1994.) Establishes the Washington Family Policy Council to facilitate services at the local level. HB1965 (2011) "An Act Relating to Public and Private Partnership in Addressing Adverse Childhood Experiences". Creates the Washington State ACEs Public Private Initiative
		Washington: RCW 70.190.010 (1994.) Establishes the Washington Family Policy Council to facilitate services at the local level. Despite significant improved outcomes for children and families, this program was eliminated during the Great Recession.

SECTION B:

THE CDC'S SIX RESEARCH INFORMED POLICY STRATEGIES TO PREVENT OR MITIGATE ACEs

STRENGTHEN ECONOMIC SUPPORTS FOR FAMILIES

MGA COMMITTEE: Economic Matters | Finance

Rationale:

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

Parental stress compromises effective parenting and increases the risk of family violence and other ACEs.

Furthermore, 4 in 10 children live in low-income households,1 in 10 live in deep poverty, and research consistently links low incomes to ACE exposure and poor long-term health, educational, and social outcomes.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
LIVING WAGE Research has shown that increased wages can lead to lower instances of child abuse and neglect, as releasing families of financial burden can reduce parental stress and allow parents to provide for their children.	Increased Minimum Wage Passed HB166/ SB280 "Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)" in 2019, Raises the minimum wage to $15/ hour by 2024.	Illinois: SB81 (2018). Increases minimum wage to $15/hour by 2025. Massachusetts: H4640 (2018) Increases minimum wage to $15/ hour over five years. New Jersey: A15 (2019), Raises minimum wage to $15/ hour by 2024, with tipped workers earning a minimum of $9.87 by 2024.
PAID FAMILY LEAVE The time after the birth or adoption of a baby is an essential time of development	Paid Family Leave Passed SB 859 / HB 775 "State Employees – Parental Leave" in 2018. Provides up to 12 weeks	California: Act 686 (2017). Establishes aid family leave and disability insurance across the state.

for babies and families. Because early relationships nurture early brain connections that form the foundation for all learning and relationships that follow, parents and caregivers are on the front line of preparing our future workers, innovators, and citizens. Paid Family Leave supports babies' health & development. Newborns reap the benefits of paid family leave, including: better bonding with parents, increased breastfeeding and health benefits for mother and child, vaccination completion, decreased infant mortality, increased placement in high quality stable childcare, and a reduction in child abuse.	of paid leave for State employees following the birth or adoption of a child. Proposed: HB341/SB500 Labor and Employment - Family and Medical Leave Insurance Program – Establishment- Time to Care Act of 2019. Died in Committee.	Massachusetts: H4640 (2018). Provides family leave to individuals to bond with their newborn, foster or adoptive child for up to twelve weeks; to provide care in the case of a family member's deployment; or to care for a family member who is a covered service member. The bill also provides medical leave to anyone with a serious health condition for up to 20 weeks. New Jersey: A3975 (2019). Paid family leave was established in 2014 and expanded in 2019. Provides paid family leave in order to "to maintain consumer purchasing power, relieve the serious menace to health, morals and welfare of the people caused by insecurity and the loss of earnings, to reduce the necessity for public relief of needy persons, to increase workplace productivity and alleviate the enormous and growing stress on working families of balancing the demands of work and family needs, and in the interest of the health, welfare and security of the people" New York: Chapter 54 (2016). Provides paid family leave, allotting 10 weeks for paid family leave at 55% average earnings, and 12 weeks at 67% average earnings beginning in 2021.

		Washington: SP.L.5975 (2017). Passed paid leave finding it is associated with health benefits, including reduced infant mortality and increased well-baby visits, increased child development and reduced child health problems, as well as increased paternal engagement with children. Provides a paid family and medical leave insurance program for placement of a child/ birth of a child, care of a family member with a serious health condition, and for one's own serious health condition. Maximum leave is 12 times the typical amount of workweek hours per 52 weeks.
PAID SICK & SAFE LEAVE	Paid Sick & Safe Leave Passed HB1 (2018) "Maryland Health Working Families Act." Employers with fewer than 15 employees must provide unpaid sick and safe leave.	None known or reported by NCSL that reference N.E.A.R. Science.
INCREASED EARNED INCOME TAX CREDITS (EITC) Research has shown that tax credits, such as EITCs increase income for working families, lift millions of families above the poverty line, offsets the costs of child care, decreases infant mortality, maternal stress and mental health problems, and child behavioral problems (e.g., aggression, anxiety, and hyperactivity that impact later perpetration of violence) ;and, increases health insurance coverage, school performance, and parents' ability to provide	Increased Earned Income Tax Credit Passed HB 810 / SB 870 "Income Tax – Child and Dependent Care Tax Credit - Alteration" in 2019. Expanded Maryland's Child and Dependent Care Tax Credit for the first time in nearly two decades—increasing the income threshold from $50,000 to $143,000 for married couples (and to $92,000 for individuals), indexing these limits annually for inflation, and making the credit refundable for low-income filers.	Colorado: HB17-1002 (2017). Grants an earned income tax credit expansion for child care expenses for families who earn an adjusted gross income of $25,000 or less. The tax credit is equal to 25% of child care expenses during the tax year up to $500 for one child and $1,000 for two or more children. South Carolina: Act 40 (2018). Establishes an earned income tax credit, which is shown by research to encourage workforce participation and increase earnings.

for their children physically and emotionally.		Virginia: Chapter 29 (2016). Provides annual notice to recipients of state benefits of the availability of federal and state earned income tax credit to increase outreach and claiming of the tax credit.
AFFORDABLE EARLY CHILD CARE Increased Child Care Subsidies Childcare subsidies tend to promote parents accessing higher quality childcare. This increases the likelihood that children will experience safe, stable, nurturing relationships & environments. Access to affordable childcare reduces parental stress and maternal depression, key risk factors for child abuse and neglect and other risk behaviors associated with ACEs.	Passed SB 379 / HB 430 (2018) Increases child care subsidy rates, establishing mandatory funding levels so that rates never again fall so low. Passed HB 248 / SB 181 (2019). Accelerates the mandated increase of child care subsidy rates. Beginning July 2020, subsidy rates must equal or exceed and remain at 60 percent of market rates.	California: Act 108 (2018). Creates county-based child care subsidy plan to decrease the cost of child care for low income families. District of Columbia: A22-0453 (2018). Expands the income eligibility for subsidized child care to increase access to child care and develops a competitive compensations scale for educators in child development centers to increase quality of care. Louisiana: Act 354 (2015). Establishes an Early Childhood Education Fund to provide funding for early childhood care placements for low income families through child care assistance programs.
FLEXIBLE AND CONSISTENT WORK SCHEDULES Provide parents with a predictable pattern of work, making it easier to access quality childcare. Children whose parents work unpredictable schedules have more cognitive deficits. Parents with irregular shift times are also more prone to work-family conflict and stress, which are		None known or reported by NCSL that reference N.E.A.R. Science.

risk factors for multiple forms of violence.		
AFFORDABLE HOUSING A major component of creating family stability is ensuring that each family and child has a safe, stable place to live. Affordable housing policies, such as rent controls and inclusionary zoning. which requires a specified percentage of new housing construction to be affordable to people with low or moderate incomes, help ensure that each child has a safe place to live.		Louisiana: RS33 (2006). Permits municipalities to use inclusionary zoning to promote development of affordable housing for low income families, given the lack of affordable housing and the health and wellbeing concerns that come with it.
MULTI- GENERATIONAL APPROACH TO HUMAN SERVICES BENEFITS		Hawaii: SB1227 (2019). Recognizes the connection of intergenerational poverty and ACEs and requires the Human Services agency implement an integrated and multigenerational approach designed to improve the social well-being, economic security, and productivity of the people of the State[.], and to reduce the incidence of intergenerational poverty and dependence upon public benefits. (pending)

PROMOTE SOCIAL NORMS THAT PROTECT AGAINST VIOLENCE & ADVERSITY

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

Rationale:

"Norms are group-level beliefs and expectations about how members of the group should behave. Changing social norms that accept or allow indifference to violence and adversity is important in the prevention of ACEs."

Pieces of legislation that promote community norms around a shared responsibility for the health and well-being of all children; support parents and positive parenting, including norms around safe and effective discipline; foster healthy and positive norms around gender, masculinity, and violence to protect against violence towards intimate partners, children, and peers; reduce stigma around help-seeking; and

enhance connectedness to build resiliency in the face of adversity , help families and communities prevent ACEs and other forms of childhood trauma.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
PUBLIC EDUCATION CAMPAIGNS have been shown to help parents understand the cycle of abuse; Campaigns targeting child physical abuse positively impact parenting practices, reduce children's exposure to parental anger and conflict and reduce child behavior problems.		None known or reported by National Conference of State Legislatures (NCSL) that reference N.E.A.R. Science.
LEGISLATIVE APPROACHES TO REDUCE CORPORAL PUNISHMENT are associated with decreases in the use of harsh physical punishment to discipline children and help to establish social norms around safer, more effective discipline strategies. Experiencing harsh physical punishment as a child increases mental health problems, weakens school performance, lowers self-esteem and increases risk for involvement in crime and violence in adolescence and later perpetration of violence toward a partner and one's own children.		None known or reported by NCSL that reference N.E.A.R. Science.
BYSTANDER APPROACHES & EFFORTS TO MOBILIZE MEN & BOYS AS ALLIES "Bystander approaches and efforts to mobilize men and boys as allies in prevention change the social context for violent and abusive behavior. Programs such as Green Dot and Coaching Boys into Men®, for instance, have		None known or reported by NCSL that reference N.E.A.R. Science.

been shown to reduce violence against dating partners, negative bystander behaviors (such as laughing at sexist jokes or encouraging abusive behaviors), as well as sexual violence perpetration and victimization."		

ENSURE A STRONG START FOR CHILDREN

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

Rationale:

The knowledge and understanding of core concepts of neuroscience, ACEs, and resilience should serve as a foundation for public policies that affect the lives of children, their families, and their communities. Building strong healthy families and communities requires that we make investing in early childhood a high priority to ensure social, emotional, behavioral, cognitive, and physical health throughout the lifespan. It is much easier and less expensive to support caregivers, families and communities to build a strong foundation in early childhood than to wait and address weaknesses in the foundation later. Waiting to address symptomatic behaviors (e.g., youth disconnection, homelessness, school failure, substance abuse, etc.) and illness (e.g., depression, anxiety, suicide, etc.) until children enter school, their teen years, or adulthood requires expending more resources and producing less satisfactory results for both the individuals and the communities in which they live.

High quality early investments (e.g., evidence-based home visiting, early child care and education, pre-K, and infant mental health programs, all with an effective family engagement component) in children prenatal to 5, i.e.," going upstream," is essential to healthy brain development and preventing the intergenerational transmission of the impact of childhood trauma.

Evidence-based (EBP) and promising home visitation program models. Effective programs include services such as parent-child therapy to build the parent-child relationship, which has been shown to be a key factor in decreasing early stress and adversity, developing supportive parental practices, which are associated with positive child behavior and development. Because no child or family is immune to ACE exposure, extensive, universal home visitation programs which allow service providers to identify the needs of families and refer them to the proper resources, as well as provide education and support to families, can drastically decrease instances of childhood trauma, particularly exposure to a parent with mental health disorders, substance abuse disorder, or domestic violence in the home.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
EVIDENCE- BASED & PROMISING HOME VISITING PROGRAM MODELS Not only have home visitation programs been shown to be effective in reducing ACEs, but they have also been shown to offer a high rate of return on investment, offsetting the costs of implementing the programs themselves.	Passed HB699/SB566-The Home Visiting Accountability Act of 2012., Requires - the state fund only evidence-based and promising home visiting models; and, that 75% of funding go to evidence-based models. Passed SB 373 / HB 547 "Education – Head Start Program – Annual Funding (The	Arkansas: Act 528 (2013). Establishes a statewide voluntary home visiting service to promote prenatal care and healthy births, requires that state agencies develop protocols for collecting and sharing program data with providers to include in child welfare and health data systems.

Studies show that, when provided with home visitation services, families with children between three and six years of age who had been exposed to multiple ACEs were two times less likely to have referrals to child protective services, four times more likely to develop at an age appropriate pace, and five times less likely to show signs of aggression compared to families that did not participate in any home visitation programs.	Ulysses Currie Act)" in 2018. Restores a $1.2 million budget cut imposed in 2009, potentially increasing services for more than 2,100 Head Start children. Passed SB 912 / HB 1685 "Maryland Prenatal and Infant Care Coordination Services Grant Program Fund (Thrive by Three Fund)" in 2018. Creates a grant program to expand the coordination of direct services for jurisdictions with a high percentage of births to Medicaid-eligible mothers.	Kentucky: Chapter 118 (2013). Provides voluntary home visit for at-risk parents during the prenatal period-3rd birthday, establishes goals for statewide home visiting system, and requires programs to adhere to research based or promising models. Maine: Chapter 683 (2011). Requires that the Department of Health and Human Services offers voluntary universal home visiting for new families regardless of family income. Texas: Chapter 421 (2013). Establishes the voluntary Texas home visiting program for pregnant women and families with children under the age of 6, requiring that home visit programs be evaluated and submit reports biannually. Proposed Policies Vermont: H500 (2019). Would establish a universal home visiting program and parenting classes for families caring for a newborn infant and calls for the evaluation of current home visiting services in each district to determine where there are unmet needs and which evidence-based and home visiting models are appropriate. The bill also provides $100,000 in grants to three parent child centers for the creation of pilot programs offering parenting classes, with the hope of

		preventing multigenerational childhood trauma.
ACCESSIBLE HIGH QUALITY CHILD CARE Invest in early childhood development: Reduce deficits, strengthen the economy., Heckman, J. J. (2013). High quality childcare programs with family engagement help children build a strong foundation for future learning and help build physical, social, emotional, and cognitive skills. They buffer young children from ACEs by creating safe, stable, nurturing, and supportive environments for the child and parent or caregiver.	Passed SB 379 / HB 430 (2018) Increases child care subsidy rates, establishing mandatory funding levels so that rates never again fall so low. Passed HB 248 / SB 181 (2019). Accelerates the mandated increase of child care subsidy rates. Beginning July 2020, subsidy rates must equal or exceed and remain at 60 percent of market rates.	None known or reported by NCSL that reference N.E.A.R. Science.
HIGH QUALITY AFFORDABLE PRE-K High quality affordable Pre-K help children build a strong foundation for future learning and help build physical, social, emotional, and cognitive skills. They buffer young children from ACEs by creating safe, stable, nurturing, and supportive environments for the child and parent or caregiver.	Passed SB 1030 (2019). As part of "The Blueprint for Maryland's Future," requires a 3 year "down payment" on the implementation Kirwan Commission recommendations totaling approximately $1 billion of State funding for pre-kindergarten will expand by $31.7 million in FY 2020 and an estimated $53.6 million in FY 2021. Passed HB 1415 (2018). Preserves $22.3 million in pre-K expansion dollars that might otherwise have been lost when a federal grant expired.	None known or reported by NCSL that reference N.E.A.R. Science.

TEACH SKILLS TO PARENTS, CAREGIVERS, CHILDREN, & YOUTH

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

Rationale:

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

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

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
EVIDENCE-BASED (EBP) & PROMISING HOME VISITATION PROGRAMs Studies show that, when provided with home visitation services, families with children between three and six years of age who had been exposed to multiple ACEs were two times less likely to have referrals to child protective services, four times more likely to develop at an age appropriate pace, and five times less likely to show signs of aggression compared to families that did not participate in any home visitation programs.	Passed HB699/SB566-The Home Visiting Accountability Act of 2012., Requires - the state fund only evidence-based and promising home visiting models; and, that 75% of funding go to evidence-based models.	Arkansas: Act 528 (2013). Establishes a statewide voluntary home visiting service to promote prenatal care and healthy births, requires that state agencies develop protocols for collecting and sharing program data with providers to include in child welfare and health data systems. Kentucky: Chapter 118 (2013). Provides voluntary home visit for at-risk parents during the prenatal period-3rd birthday, establishes goals for statewide home visiting system, and requires programs to adhere to research based or promising models.

		Maine: Chapter 683 (2011). Requires that the Department of Health and Human Services offers voluntary universal home visiting for new families regardless of family income. Texas: Chapter 421 (2013). Establishes the voluntary Texas home visiting program for pregnant women and families with children under the age of 6, requiring that home visit programs be evaluated and submit reports biannually. Proposed Policies Vermont: H500 (2019). Would establish a universal home visiting program and parenting classes for families caring for a newborn infant and calls for the evaluation of current home visiting services in each district to determine where there are unmet needs and which evidence-based and home visiting models are appropriate. The bill also provides $100,000 in grants to three parent child centers for the creation of pilot programs offering parenting classes, with the hope of preventing multigenerational childhood trauma.
EB & PROMISING PARENTING AND FAMILY SKILL BUILDING PROGRAMS Shown to decrease early stress and adversity and develop supportive parental practices,		Vermont: H500 (2019). Provides $100,000 in grants to three parent child centers for the creation of pilot programs offering parenting classes, with the hope of preventing

which are associated with positive child behavior and development.		multigenerational childhood trauma.
EB & PROMISING PROGRAMS FOR PARENTS WITH A HISTORY OF SUBSTANCE USE DISORDER Providing comprehensive care to parents who struggle with substance use disorder has been shown to increase parent and child welfare.		None known or reported by NCSL that reference N.E.A.R. Science.
EB & PROMISING PROGRAMS & VISITATION PROGRAMS FOR INCARCERATED PARENTS AND THEIR CHILDREN Research has shown strong links between parent-child relationships and childhood development, meaning that it is crucial to enact programs that allow for visitation between children and their incarcerated parents when possible.		Oregon: SB241 (2017). Establishes a bill of rights for children with incarcerated parents, including the right to be protected from additional trauma at the time of parental arrest, the right to remain informed about their parent's arrest in an age appropriate manner, the right to see, speak with and touch their incarcerated parent, and more. Texas: S1356 (2013). Requires all juvenile probation and supervision officers receive training on trauma informed care administered by the Department of Human Resources. In H650 (2019). Requires correctional officers to be trained on issues relating to the physical and mental health of pregnant inmates, including appropriate care, the impact of incarceration on a pregnant inmate and the unborn child, the use of restraints, the placement of administrative segregation, and invasive searches. The Act also includes provisions for reviewing visitation policies and

		evidence-based visitation practices that enhance paternal bonding and engagement and allow for age-appropriate visiting activities for children who visits their parents in correctional facilities. Missouri: Chapter 217 (2018). Creates a women offender program to ensure that female offenders are provided with trauma-informed and gender responsive supervision strategies, including physical and mental health care, child visitation, and more. Hawaii: SCR7 (2019). Establishes that human services and public safety work to develop a plan for the establishment of visitation centers at all state correctional facilities and jails for children to visit their incarcerated parent. The resolution recognizes that the incarceration of a parent is seen as an ACE and can lead to adverse outcomes for children and that parental bonding is essential for children's development. Illinois: H2444 (2019). Amends code of corrections to expand consideration of factors such as whether the defendant is the parent of a child or if the defendant serves as a caregiver to someone who is ill, disabled, or elderly in sentencing, recognizing the parental incarceration is an ACE and can

		have adverse effects on the child. Proposed: Texas: H2168 (2019). Would require screening of each inmate during the diagnostic process to determine whether the inmate has experienced ACEs or other significant trauma and refer the appropriate care when needed. The bill also requires screening and care for defendants. Washington: S5876 (2019). Would create a women's division of correctional system to develop a system of gender responsive, trauma informed practices within the department of corrections, informed by individuals with training in ACEs and trauma informed practices.

CONNECT CHILDREN & YOUTH TO CARING ADULTS & ACTIVITIES

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

Rationale:

Research suggests that mentoring and after school programs improve outcomes across behavioral, social, emotional and academic domains. Opportunities to develop and practice executive function skills, including impulse control, emotional control (self-regulation), flexible thinking, working memory, self-monitoring, planning and prioritizing, task initiation, and organization help to provide the experiences that strengthens parts of the brain that tend to be less developed in children who experience chronic adversity.

Experiences that improve executive function, improve the leadership, decision-making, self-management, and social problem-solving skills of children and youth and are important components of mentoring and after-school programs with documented success; and, help kids to be attain success in relationships, in school, and in their careers.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE

MENTORING PROGRAMS		None known or reported by NCSL that reference N.E.A.R. Science.
AFTER SCHOOL PROGRAMS		None known or reported by NCSL that reference N.E.A.R. Science.

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

MGA COMMITTEE: All Standing Committees

Rationale:

Recognizing and effectively responding to lessen the immediate and long-term harms of childhood trauma and adversity is the responsibility of all adults in the community, as well as state and local child and family serving agencies.

Primary care, mental and behavioral health, Medicaid and private insurance, public health, schools and other youth serving organizations, higher education, child welfare, juvenile and criminal and civil justice systems, along with neighborhood and businesses and faith-based communities, should align their policies and practices with NEAR Science.

Children and youth with ACE exposure are at risk for school failure, behavior problems, suspension and expulsion, teen pregnancy, depression, anxiety, suicide, youth violence, as well as physical health problems.

Early family centered interventions with evidence-based and promising treatments for children and parents, trauma-informed policies and practices within child and family serving systems, as well as connection to at least one safe, stable, and nurturing adult has been proved to reduce ACEs and their impacts in communities across the country.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
ENHANCED PRIMARY CARE CREATION OF STATE SURGEON GENERAL		California: Executive Order N-02 (2019). Solidifies the state's promise to address ACEs by creating the position of the Surgeon General, which allows for the creation of health-informed legislation. A887 (2019). Requires the Office of Health Equity to advise and assist other state departments in their mission to increase the general well-being of all state residents and to work toward eliminating adverse childhood experiences. Prescribes the qualifications of the Surgeon General.

ENHANCED PRIMARY CARE TRAINING FOR MEDICAL PROFESSIONALS		CA: AB 1340 (2017). Requires Medical Board to consider including a course for primary care providers on integrated mental and physical health care, expressly to identify and treat mental health issues in children and young adults. Medi-Cal (Medicaid) Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). Proposed New York: A2754 (2019). Would require doctors to complete education regarding screening for ACEs in children before they can re-register to practice medicine. This bill is still pending in the legislature.
ENHANCED PRIMARY CARE EARLY SCREENING & DETECTION OF ACES may be used to identify and address ACE exposures with brief screening assessments and referral to intervention services and supports. For children, assessments are completed with parents/caregivers to identify risks such as parental substance use, intimate partner violence, depression, stress and the use of harsh punishment. Screening and assessing adults would identify a history of ACE exposures and help mitigate risk and improve treatment outcomes. Strong policies would ensure that intervention services are tailored to assessment findings and coordinated with and between community agencies.		California: AB340 (2017). Establishes a working group to address the provision of trauma screening under Medi-Cal. Chapter 843 (2018). Requires the Mental Health Services Oversight Commission to create a plan to implement and monitor mental health and trauma screening and detection services. Since then, the state has approved an allocation of $45 million for the 2019-2020 fiscal year to reimburse pediatricians for participating in ACE screening of their patients, and another $50 million to train pediatricians in conducting the screenings. In this way, doctors are encouraged to screen their patients for ACEs and other traumatic events, which will allow them to refer patients to

		the proper behavioral and mental health services if necessary to prevent the onset of long-term negative health outcomes as a result of high trauma exposure. District of Columbia: Act 179 (2018). Requires that the Mayor for Health and Human Services expand and coordinate health care for infants and toddlers under three years of age, including early screening for ACEs and related health outcomes. A22-0453 (2018). Requires the Department of Health to implement Healthy Steps, a primary care program which promotes healthy development and provides parenting support, medical care, and resources for mental health, domestic violence, food and shelter, and more to ensure that the needs of children ages 0-3 are met. Hawaii: HB908 (2013). Establishes a statewide hospital-based home visiting program to identify families of newborns at risk for poor health outcomes and to promote healthy child development through universal screening of newborns and referral of high-risk families to evidence-based home visit services. Maine: Act 63 (2019). Convenes a task force to develop guidance for kindergarten-12th grade educators and administrators on

		appropriate training for and responses to addressing childhood trauma, including ACEs training, trauma informed care, health screenings, and a social-emotional curriculum from K-8th grade.
EXPANSION OF INSURANCE COVERAGE TO MENTAL, BEHAVIORAL, & SOCIAL-EMOTIONAL HEALTH CARE TREATMENTS, INCLUDING MULTI-GENERATIONAL PROVISION OF SERVICES (INFANT MENTAL HEALTH) Various forms of counseling, including Trauma Informed Cognitive Behavioral Therapy, have proven to be successful in mitigating the harmful impacts of ACE exposure, both in children and adults. However, often services are not covered by insurance plans, including Medicaid. By expanding Medicaid and Insurance program coverage to support behavioral and mental health services, more people will be able to access needed services. Behavioral and mental health services designed to address trauma exposure show considerable long term saving on many public service programs, as they work to prevent chronic health conditions, response to domestic abuse and substance abuse, and more.		California: Chapter 855 (2018). Modifies the definition of "medically necessary services" to include early screening, diagnosis and treatment programs such as screening for mental health disorders, behavioral health disorders, and trauma. Connecticut: S1085 (2015). Requires health insurance policies to cover mental and nervous conditions, maternal, infant and early childhood home visitation services, and other home-based interventions for children. New Jersey: A3035 (2017). The Mental Health Access Act of 2017 increases Medicaid reimbursement rates for evidence-based behavioral health services. North Carolina: Act 57 (2019). Provides Medicaid and NC Health Choice coverage for home visits to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development.
FUNDING EVIDENCE – BASED PROGRAMS IN PRIMARY CARE –	SEEK is a model created and tested in Maryland by Dr. Howard Dubowitz, MD and his	None known or reported by NCSL that reference N.E.A.R. Science.

SEEK (Safe Environment for Every Kid) MODEL "Randomized trials of the Safe Environment for Every Kid (SEEK) model (which screens for ACE exposures in the family environment), have demonstrated a number of positive effects including fewer reports to child protective services, fewer reported occurrences of harsh physical punishment by parents, better adherence to medical care, and more timely childhood immunizations. SEEK is also associated with less maternal psychological aggression, fewer minor maternal physical assaults, and improvements among providers in addressing depression, substance misuse, intimate partner violence, and serious parental stress."	team at the University of Maryland, School of Medicine.	
PREVENTING & MITIGATING THE HARMS OF CHILD SEXUAL ABUSE STATUTE OF LIMITATIONS REFORM promotes community norms against violence toward children, provides justice and healing for victims of child sexual abuse, and exposes hidden predators still living in communities. Child sexual abuse affects one in four girls and one in six boys across the United State-s. In 2019 alone, 21 states have passed statute of limitations reforms to better reflect the average age of disclosure.	No Criminal SOL Civil SOL: HB687, (2019). **Hidden Predator Act.** Passed the House and failed in the Senate Judicial Proceedings Committee. It would eliminate the civil statute of limitations for child sexual abuse and provide a two-year lookback window for survivors.	In 2019 alone, nineteen states have passed statute of limitations reforms to better reflect the average age of disclosure. California: AB218 2019. 3-year window: 3-year window will open on January 1, 2020 for expired claims against perpetrators, private organizations and government. Connecticut: SB3 (2019). Extends the civil statute of limitations for sexual abuse victims to thirty years after age twenty-one. The law also extends the criminal statute of limitations for offenses involving sexual abuse,

Seventeen states (nine this year) have passed civil SOL "windows of justice "to allow civil claims previously barred to proceed for a set period of time. Civil SOL Windows also present an opportunity to prevent incidents of child sexual abuse by exposing hidden predators.		sexual exploitation, and sexual assault of a victim under sixteen years of age and extends the criminal statute of limitations for victims ages eighteen-twenty to fifty-one years old. New Jersey: S477 2019. 2-year window: 2-year window will open on December 1, 2019 for expired claims against perpetrators, private organizations and government. Window applies to child sex abuse victims and those sexually assaulted as adults. New York: A2863 2019. 1-year window: 1-year window opened on August 14, 2019 for expired clams against perpetrators, private organizations and government. North Carolina: H37 (2019). 2-year window: 2-year window will open on January 1, 2020 for expired claims against perpetrators, private organizations and government. Rhode Island: H5171 (2019) extends the statute of limitations from seven to thirty-five years in cases of child sexual abuse, including a seven-year discovery window to allow victims more time to commence action against their abuser.
TRAUMA-INFORMED CARE FOR VICTIMS CHILD ADVOCACY CENTERS	Sb739, (2019). Child Advocacy Centers (CACs)Expansion bill defined and strengthened CACs across the state to ensure trauma-informed services to	Florida: Act 151 (2017). Provides for trauma informed care for children who have been sexually exploited. Establishes an accountability system for

Child Advocacy Centers are a crucial component of trauma-informed care for children who have experienced abuse. CACs bring together a myriad of services, including child protective services, law enforcement, medical and mental health professionals, and prosecutors in a child-friendly, trauma-informed environment to allow for an inter-agency investigation and response to instances of child and family abuse.	child victims of child sexual and physical abuse.	residential group care providers based on quality standards, including promotion of high-quality services and accommodations, considerations of the level of availability of trauma informed care and mental and physical health services, the level of provider's engagement with school and extra circular activities, and a following report on the findings and how they will be used to improve residential group care. Currently, over 34 states, including Maryland, have some form of legislation surrounding CACs. Legislation on CACs that is supported by the National Children's alliance includes legislation which defines child advocacy centers and their role in the investigation process, the expansion of services and resources for CAC, and state funding for CACs through government funds. Proposed: New Jersey: A3558 (2019). Children Animal Assisted Therapy Pilot Program which would establish a pilot program in Department of Children and Families providing animal-assisted therapy to victims of childhood violence, trauma, or children with behavioral health care needs, appropriates funds.
INCREASE MENTAL & BEHAVIORAL HEALTH SERVICES IN SCHOOLS: Children with an ACE score of four or more are:		Colorado: H1017 (2019). Requires the department of education to select a school district to partake in a pilot

• 4 times more likely to develop depression 2 times more likely to attempt suicide 32 times more likely to experience behavioral problems in the classroom than children who have an ACE score of zero. Providing mental and behavioral health services in schools allows access to resources to address the impact of ACEs in a familiar, easily accessible environment that is comfortable and easily accessible. Studies show that the implementation of mental health services in schools has: • increased academic success and graduation rates • decreased rates of truancy and discipline improved overall school climate and community.		program that provides a social worker dedicated to each grade from kindergarten to 5th grade to prevent, reduce, and resolve ACE exposure and ACE- related stress. Illinois: SB565 (2017). Requires health examinations for school entrance to include age appropriate social, emotional, and developmental screenings; performed by the child's primary care provider; proof of examination must be provided to the child's school annually. The examination form is not required to disclose the results but may include suggested services based on the results of the evaluation that may be provided by the school with parent's consent. Iowa: Chapter 225.54 (2015). Provides state block grants for school- based mental health projects and crisis intervention services in schools offered through partnerships with community mental health organizations. Utah: H264/ Act 412 (2018). Provides grants for school-based counselors and social workers to provide school-based mental health supports in elementary schools, including for trauma-informed care. Washington: S5903/ Act 360 (2019). Creates a Children's Mental Health Workgroup to identify barriers to accessing

		mental health services, monitor the implementation of legislation and policies relating to children's mental health and consider strategies to improve coordination between education and health systems. The Act also mandates that educators have additional professional days to cover trauma-informed care, social-emotional learning, and ACEs training.
TRAUMA INFORMED SCHOOLS: TRAINING, PRACTICES, CURRICULUM, POLICIES, AND DISCIPLINE When children have experienced trauma, they are more likely to act impulsively, have problems focusing, and regulating their emotions, leading to serious behavioral problems or lack of engagement. Creating trauma - informed schools has been shown to result in positive outcomes for students and teachers, including fewer disciplinary incidents and office referrals. Oftentimes, toxic stress and anxiety which results from ACE exposure causes adverse physical and emotional responses, such as violent behavior or aggressive outbursts by children in the classroom. This response, in turn, leads to punishment and disciplinary action, which only adds to the stress experienced by the child. Multiple studies of trauma-informed programs in schools have found that these programs reduce aggressive behavior,	HB256/SB233 State Department of Education - Guidelines on Trauma-Informed Approach proposed in 2019. Creates a pilot project to create trauma-informed schools. Died in Committee. Trauma Informed language from the bill was included in the Blueprint for Maryland's Future.	Iowa: S2133/ Act 1051 (2018). Requires school districts to implement employee training and establish rules and best practices on suicide prevention, the identification of ACEs, and strategies to reduce toxic stress. Tennessee: S1386 (2018). Requires the Department of Education to develop an evidence-based training program on ACEs for school teachers and leadership. Resolution 166, (2019) was enacted to urge local education agencies to provide the training developed by the Department of Education to all teachers. New York: A11081 (2019). Requires ACEs training for licensed day care providers. Tennessee: S64 (2019). Requires local boards of education to adopt a policy requiring all K-12th grade teachers, principals, and assistant principals to be part of an ACEs training on an annual basis.

crime, and conduct problems, results which also produce large returns on the investments made in the programs themselves.		District of Columbia: Act 22-398 (2018). Requires the Department of Education to implement measures to reduce out of school suspension and expulsion and foster trauma informed, positive school environments. Indiana: HB1421 (2018). Requires schools to reduce out of school suspension and expulsion and requires a legislative committee to be assigned the task of studying the use of positive discipline and restorative justice in schools and determine the extent to which these forms for discipline are utilized in schools currently. Massachusetts: HB4376 (2014). Within the context of reducing gun violence, establishes a framework for safe and supportive schools, which considers the findings of the ACEs study and utilizes trauma informed practices. The framework aims to create schools that foster healthy relationships between children and the peers and teachers, provide mental, physical and behavioral health services, and integrate practices and services that promote social and emotional learning and reduce instances of truancy, suspension and expulsion, and dropout. Pennsylvania: S1142 (2018). Establishes School Safety and Security Grant Program and

		Fund, to be used for the administration of ACEs screening and trauma-informed counseling services for students based on screening results. HB1415 (2019). Defines trauma-informed approaches, requires development training for school administrators and staff on trauma informed approaches, and amends the requirements for post-baccalaureate certification to teach primary and secondary education to include coursework on trauma informed approaches. Tennessee: Act No 421 (2019). Requires local Boards of Education to adopt a policy requiring schools to perform an ACEs screening before taking disciplinary actions against a child, including suspension, in-school suspension, expulsion, or transfer to an alternative school. Washington: Act 231 (2018). Directs the Department of Children, Youth and Families to develop a 5-year strategy on expanding training in trauma informed child care for early learning providers and reducing expulsion from early learning environments. Act 386 (2019). Creates the Social-Emotional Learning Committee to promote social emotional learning that will help students build awareness and skills in managing emotions, setting goals, establishing relationships, and supporting student success. The

		legislation also notably includes benchmarks which educators must meet regarding training for trauma informed practices and consideration of ACEs. S5903/ Act 360 (2019). Creates the Children's Mental Health Workgroup and mandates that educators have additional professional days to cover trauma-informed care, social-emotional learning, and ACEs training. Wisconsin: A843/ Act 143 (2018). Creates Office of School Safety and requires the office to train school staff on school safety, trauma-informed care and how adverse childhood experiences have an impact on children and increase the need for support.
SCHOOL SAFETY PLANS School safety plans are a method of preventing violence, suicide, and major crises in schools. Though not included in the original study, The Philadelphia ACE Study added and studied bullying as an ACE, as it results in the same toxic stress response and can lead to the same negative mental and physical health outcomes. Children who have been bullied are more likely to use drugs and alcohol, experience anxiety, depression, and suicide, and engage in violent behaviors themselves. To address the possibility of student crises, some states have enacted school safety plans that		Arkansas: Act 1064 (2019). Recognizes Arkansas has the highest percentage of ACEs in its students and requires that the University of Arkansas for Medical Sciences establish a pilot program that creates a school safety and crisis line that can be accessed by phone, text, application, or program participation, providing students with the ability to report anonymously unsafe activity, abuse, bullying, thoughts of suicide, drug issues, and other threatening behaviors in order to address the problems associated with high ACE scores. Also, provides for crisis intervention services, such as

include methods for students to report violence and bullying in schools, training for teachers on addressing trauma, and programs for violence and suicide prevention.		counseling. Texas: Act 464 (2019). Requires all schools to develop a plan of improvement, which includes assessment of need for various groups of students, district performance objectives for programs including suicide prevention, violence prevention, conflict resolution, and training on how trauma can affect student behavior and trauma-informed strategies to support affected students. The Act also includes provisions for teaching students about mental health and providing mental health services in schools. Utah: Act 446 (2019). Authorizes the State Board of Education to distribute money to local education agencies for personnel who provide school-based mental health support. The Act also establishes the Safe UT Crisis line to provide means for anonymous reporting of unsafe, violet, or criminal actives, bullying, physical or sexual abuse by a school employee/volunteer, and crisis intervention.
FAMILY-CENTERED SUBSTANCE USE TREATMENT FOR PARENTS Growing up in a home where a parent experiences a substance abuse disorder was one of the ten ACEs in the original ACE study, as it often leads to dysfunction and instability within the family. States have		Florida: Act 151 (2017). Creates a pilot program for shared family care residential services to families that have a member experiencing substance use disorder. Establishes an accountability system for residential group care providers based on quality standards, including promotion of high-

created family-centered programs that offer assistance to parents with substance use disorder to help them recover, provide EBP parenting support and provide programming for the children to buffer them from the negative consequences of parental substance use.		quality services and accommodations, considerations of the level of availability of trauma informed care and mental and physical health services, the level of provider's engagement with school and extra circular activities, and a following report on the findings and how they will be used to improve residential group care. Indiana: SB446 (2017). Creates an opioid addiction recovery pilot program to assist pregnant women and new mothers that have a substance abuse disorder by providing residential facility treatment and home visitation services. Massachusetts: H4742, (2018). Establishes the Community Behavioral Health Promotion and Prevention Trust Fund to issue grants to community organizations establishing or supporting evidence-based programs relating to substance abuse disorder for children and adults. Programs will be selected for funding based on the program's use of the science of prevention, ACEs, and trauma informed care.
STATE POLICY DIRECTIVE TO ADDRESS CHILDHOOD TRAUMA All State Child & Family Serving Systems to Address Childhood Trauma		Alaska: S105 (2018). Revises provisions on licensure of martial and family therapists. Additionally, it establishes a state policy directive to policymakers, administrators, and those working within state programs and grants to make decisions that "take into account

		the principles of early childhood and youth brain development and, whenever possible, consider the concepts of early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, supports, self-regulation, and services."
BILL OF RIGHTS OF CHILDREN OF INCARCERATED PARENTS Preventing and mitigating ACEs caused because of system involvement by parents. Parental incarceration is one of the ten ACEs initially identified in the original ACEs study, as separation from the parent for prolonged periods of time disrupts the relationship between the child and the parents, hindering the child's development and often causing toxic stress for the child. Ensuring support for children when a parent is incarcerated, including arrest, sentencing, visitation and parent-child contact policies, and mentoring programs, help to buffer children from the negative consequences of parental incarceration.		Oregon: SB241 (2017). Establishes a bill of rights for children of incarcerated parents, including the right to be protected from additional trauma at the time of parental arrest, the right to remain informed about their parent's arrest in an age appropriate manner, the right to see, speak with and touch their incarcerated parent, and more. Texas: S1356 (2013). Requires all juvenile probation and supervision officers receive training on trauma informed care administered by the Department of Human Resources. H650, (2019). Requires correctional officers to be trained on issues relating to the physical and mental health of pregnant inmates, including appropriate care, the impact of incarceration on a pregnant inmate and the unborn child, the use of restraints, the placement of administrative segregation, and invasive searches. It also includes provisions for reviewing visitation policies and evidence-based visitation practices that enhance paternal bonding and engagement and allow for age-

		appropriate visiting activities for children who visits their parents in correctional facilities. Missouri: Chapter 217 (2018). Creates a women offender program to ensure that female offenders are provided with trauma-informed and gender responsive supervision strategies, including physical and mental health care, child visitation, and more. Hawaii: SCR7 (2019). A resolution requesting that human services and public safety work to develop a plan for the establishment of visitation centers at all state correctional facilities and jails for children to visit their incarcerated parent. It recognizes that the incarceration of a parent is an ACE and can lead to adverse outcomes for children and that parental bonding is essential for children's development. Illinois: H2444 (2019). Expands consideration of factors such as whether the defendant is the parent of a child or if the defendant serves as a caregiver to someone who is ill, disabled, or elderly in sentencing, recognizing that parental incarceration is an ACE for the child and can have negative impacts on the child. H2649 (2019). Amends the Code of Criminal Procedure, creates the Task Force on Children of Incarcerated Parents, provides

		that the Task Force shall review available research, best practices, and effective interventions to formulate recommendations. Proposed: Texas: H2168 (2019). Would require screening of each inmate during the diagnostic process to determine whether the inmate has experienced ACEs or other significant trauma and refer the appropriate care when needed. The bill also requires screening and care for defendants. Washington: S5876 (2019). Would create a women's division of correctional system to develop a system of gender responsive, trauma informed practices within the department of corrections, informed by individuals with training in ACEs and trauma informed practices.
POLICIES & PROGRAMS FOR CHILDREN WHO WITNESS DOMESTIC VIOLENCE		Illinois: HR751 (2018). Declares domestic violence a public health priority given the trauma caused both to victims and their children and urging the state to provide all the necessary resources to prevent and address domestic violence.
POLICIES & PRACTICES TO ENSURE TRAUMA-INFORMED RESPONSE IN CHILD CUSTODY COURT PROCEEDINGS Recognizing that divorce and separation, all forms of child abuse and neglect, and witnessing domestic violence are ACEs for the child, the court, in	SB567, (2019). Establishing a Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations. Requires the Workgroup to study available science and best practices pertaining to children in traumatic situations, including	

order to meet "the best interest of the child" standard," must ensure that custody and visitation proceedings and decisions are informed by ACE science and do not exacerbate harm to the child.	trauma-informed decision making. and make recommendations about how State courts could incorporate the science into child custody proceedings.	
POLICIES & PRACTICES TO ENSURE NEXT GENERATION PREVENTION & TRAUMA-INFORMED RESPONSE IN CHILD WELFARE	HB1582, (2018). Recognizing the high prevalence of ACEs for children involved in child welfare, it creates a Child Welfare Medical Director and electronic health passport for children in the child welfare system. Mandates a report by the Child Welfare Medical Director to the General Assembly annually on the health and well-being of children in out-of-home placement.	Arizona: 8-471 (2014). Requires that child welfare workers and child safety workers receive training on the impact of ACEs and interventions to prevent negative outcomes associated with ACE exposure. California: S1460 (2014). Requires that recruitment include efforts to find adoption and foster care individuals who reflect the ethnic, racial and cultural diversity of foster children and adoptive children. A819 (2019). Amends child welfare code to require that core services be trauma informed and include specialty mental, physical, behavioral, transitional, and educational services be provided to children as needed. Replaces previous licensing process for foster families with unified resource family approval process and requires that resource family applicants are trained in trauma informed practices to support children impacted by ACEs. Oklahoma: S141 (2019).Establishes the Successful Adulthood Act, which is meant to ensure that all eligible individuals who have been or are in the foster care program due

		to abuse or neglect receive the protection and support necessary to allow those individuals to become self-reliant and productive citizens and break the cycle of abuse and neglect through services such as transitional planning, education, housing, medical care, and tuition waivers.

Endnotes

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

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43. Research has shown adverse childhood experiences to have multiple negative impacts throughout an individual's life. More ACEs reduce the likelihood of high school graduation and holding a skilled job (Giovanelli et al, 2016). More ACEs also increase the likelihood of teen pregnancy and fetal death in pregnancy (Hillis et al, 2004); behavioral problems (Greeson et al, 2014); juvenile arrest, and felony charges (Giovanelli et al, 2016). Moreover, ACEs can negatively impact a wide range of health and social factors including an increased risk of homelessness (Herman et al, 1997), illicit drug use (Dube et al, 2003) and depression (Giovanelli et al, 2016; Anda et al, 2005). Anda, R. F., V. J. Felitti, J. D. Bremner, J. D. Walker, Ch Whitfield, B. D. Perry, Sh R. Dube, and W. H. Giles. 2005. "The Enduring Effects of Abuse and Related Adverse Experiences in Childhood." European Archives of Psychiatry and Clinical Neuroscience 256 (3): 174–86. Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, and Anda RF. 2003. "Childhood Abuse, Neglect,

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Maryland Essentials for Childhood

Maryland Essentials for Children is a statewide collective impact initiative to prevent child maltreatment and adverse childhood experiences (ACE's). We promote relationships and environments that help children grow up to be healthy and productive citizens so that they, in turn, can build stronger and safer families and communities for their children.

Maryland Essentials for Children includes public and private partners from across the state; and, receives technical assistance from the U.S. Centers for Disease Control.

www.mdessentialsforchildhood.org

Our Mission

To develop a common agenda across multiple agencies and stakeholders to align activities, programs, policies and funding so that all Maryland children, youth and their families have safe, stable, nurturing relationships and environments.

Special Thanks

This report was produced through the generous support of:

No More Stolen Childhoods

Sondheim Nonprofit Leadership Program

July 2020

HIDDEN PREDATOR ACT (HB974)

Will Maryland protect its children or protect its predators?

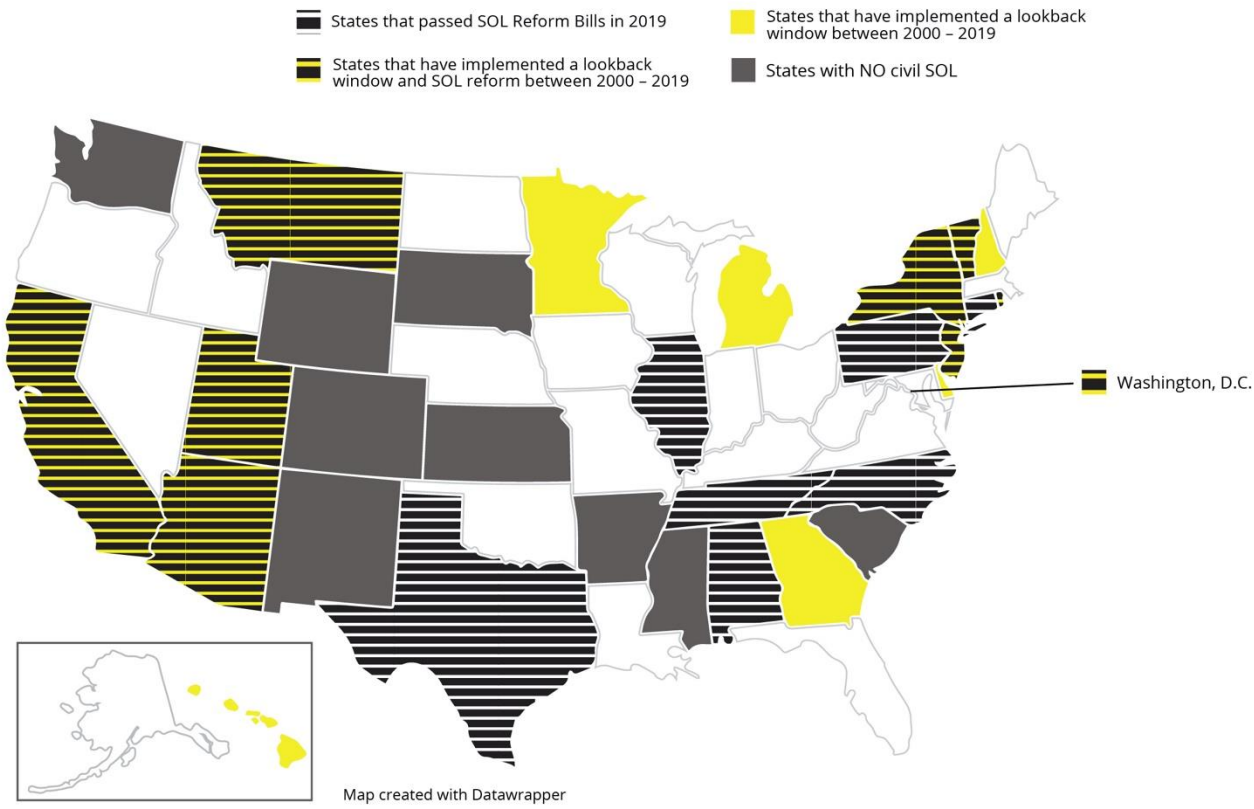
GOALS OF HIDDEN PREDATOR ACT (HB974)

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

WHAT WILL THE HIDDEN PREDATOR ACT (HB974) DO?

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

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



HIDDEN PREDATOR ACT (HB974)

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

In 2019, Washington D.C.:

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

In 2019, New Jersey:

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

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

In Delaware:

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

In Minnesota:

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

In California:

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

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

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

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

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

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

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

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

The Hidden Predator Act (HB974) removes the "statute of repose" language making it clear to the courts, the public, and survivors that the Maryland General Assembly did not intend to vest constitutionally protected property rights in child sexual predators nor the individuals and organizations that hid predators from discovery and prosecution.

Q: How will this bill help Maryland prosper?

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

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

SCCAN

MARYLAND essentials for childhood

No More Stolen Childhoods

APPENDIX E

Tier 1

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

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

Tier 2

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

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

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

APPENDIX F

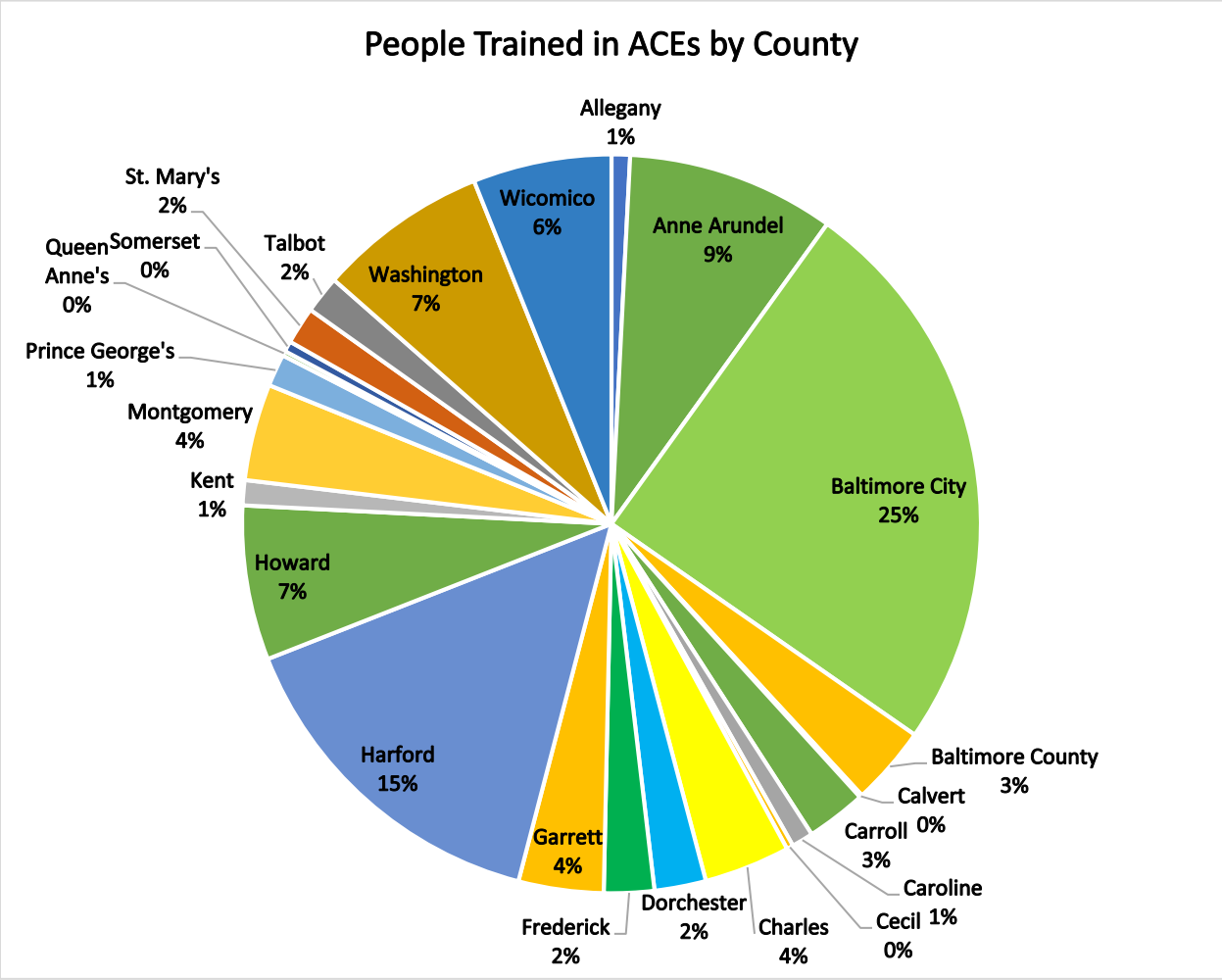
Select strategic ACE Interface Presentations January 2019-March 2020 included:

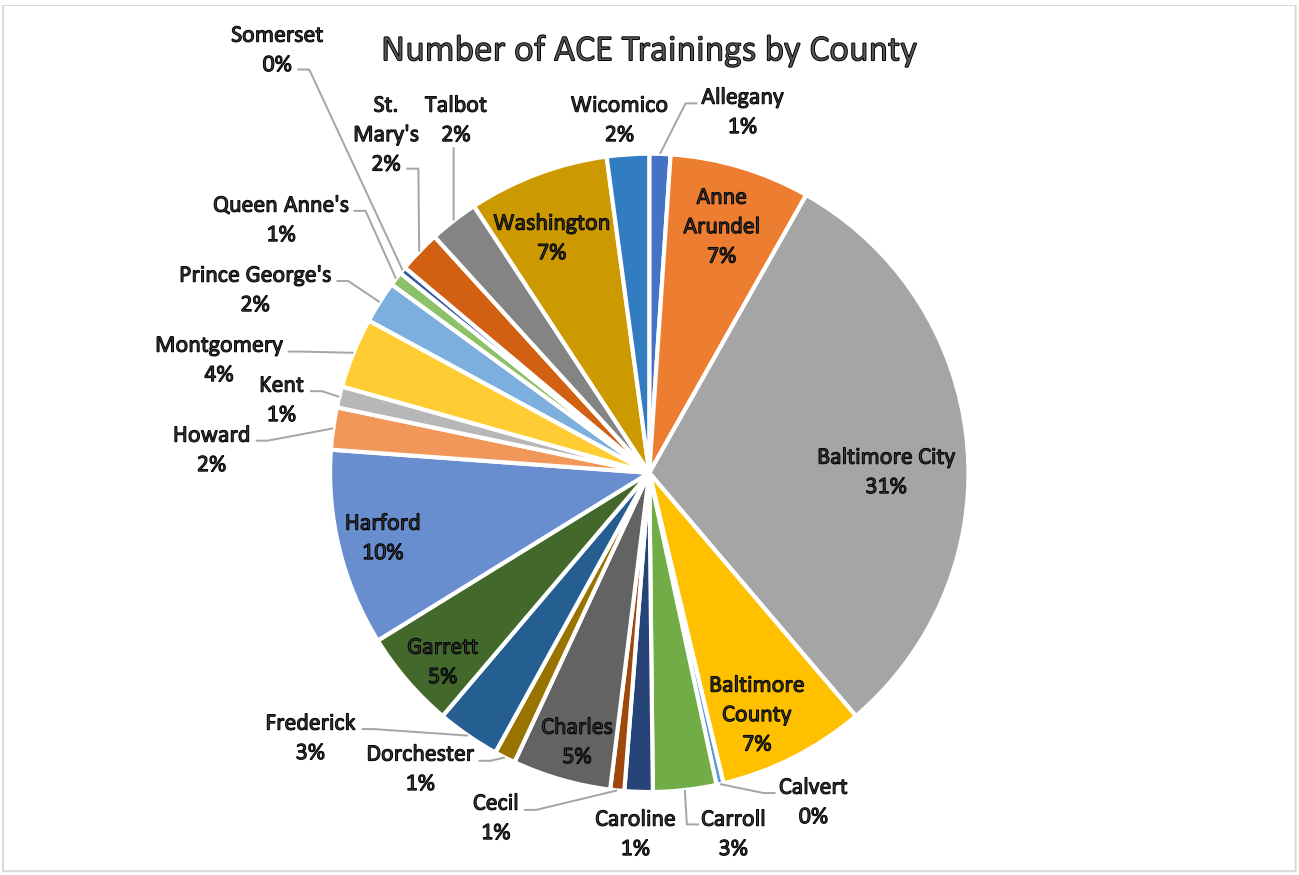
- MARYLAND GENERAL ASSEMBLY ACES ROUNDTABLE
- OPIOID OPERATIONAL COMMAND CENTER MEMBERS
- OPIOID OPERATIONAL COMMAND CENTER BEST PRACTICES CONFERENCE
- CANCER COUNCIL CONFERENCE
- MARYLAND STATE POLICE
- MARYLAND CHIEFS OF POLICE ASSOCIATION ANNUAL PROFESSIONAL DEVELOPMENT SEMINAR
- ENOCH PRATT LIBRARIES
- MARYLAND CASA CONFERENCE
- LOCAL DEPARTMENTS OF SOCIAL SERVICES: BALTIMORE COUNTY, CARROLL, GARRETT. MONTGOMERY, HOWARD, TALBOT
- CHILD WELFARE ACADEMY – UNIVERSITY OF MARYLAND, SSW: RESOURCE (FOSTER) PARENTS
- LOCAL HEALTH DEPARTMENTS: BALTIMORE CITY, FREDERICK, GARRETT, MONTGOMERY
- PUBLIC SCHOOLS: BALTIMORE CITY, HARFORD, MONTGOMERY, WICOMICO, MD ASSOCIATION OF PUPIL PERSONEL
- MIECHV CONFERENCE
- MOST NETWORK
- FAITH-BASED ORGANIZATIONS: CATHOLIC CHARITIES, EPISCOPAL, KINGDOM RESTORATION, METHODIST, OPEN CHURCH
- COLLEGE & UNIVERSITIES: UM, SSW, HOOD COLLEGE OF NURSING, SOUTHERN MD
- MARYLAND STATE ADVISORY COUNCIL ON HEALTH & WELLNESS
- MARYLAND STATE ADVISORY COUNCIL ON CANCER CONTROL

APPENDIX G

ACE Interface Training Locations by Maryland County

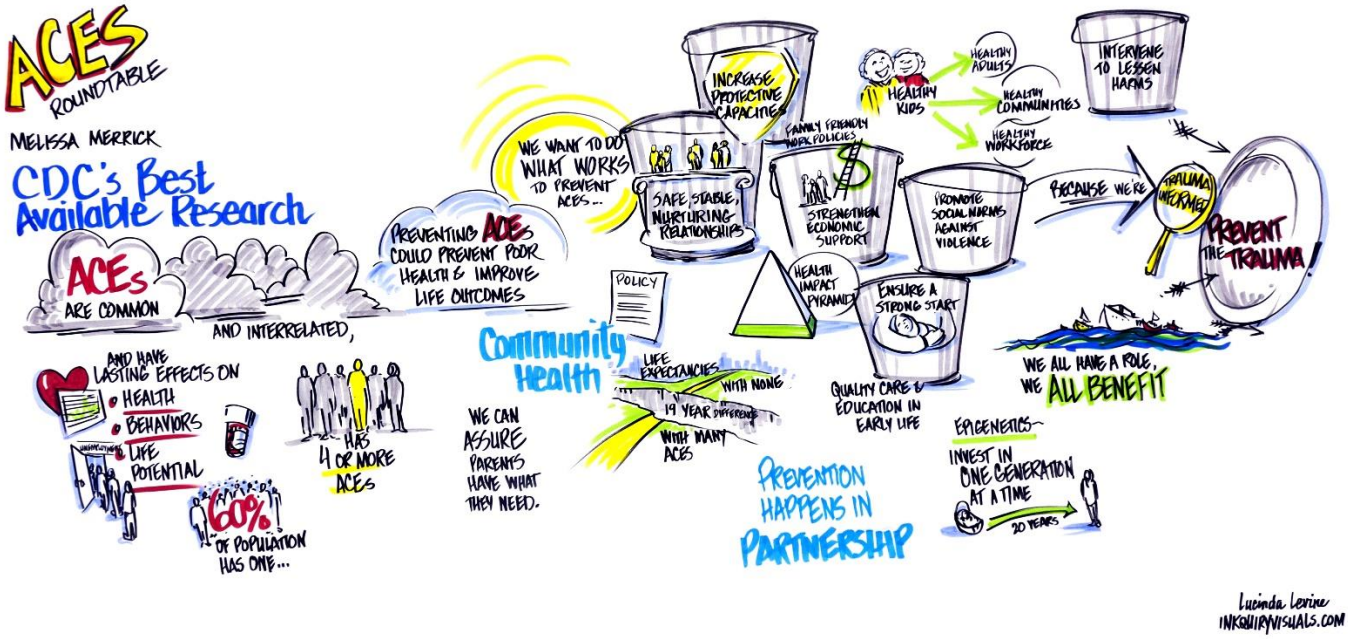
Between December 2017 and March 2020 ACE Interface Master Trainers have given 281 ACE Interface presentations to more than 8652 attendees across all of Maryland's 24 jurisdictions. The graphs below show the percentage of trainings by number of people trained and number of trainings per jurisdiction.

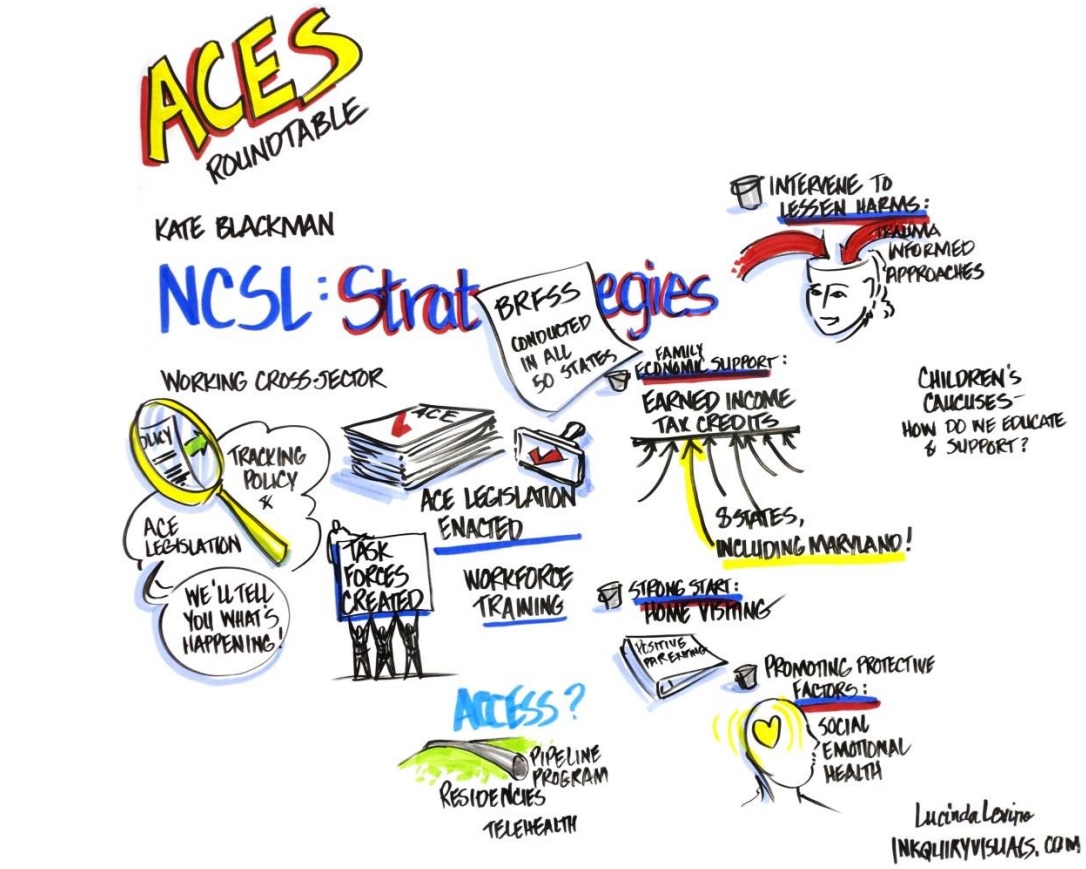


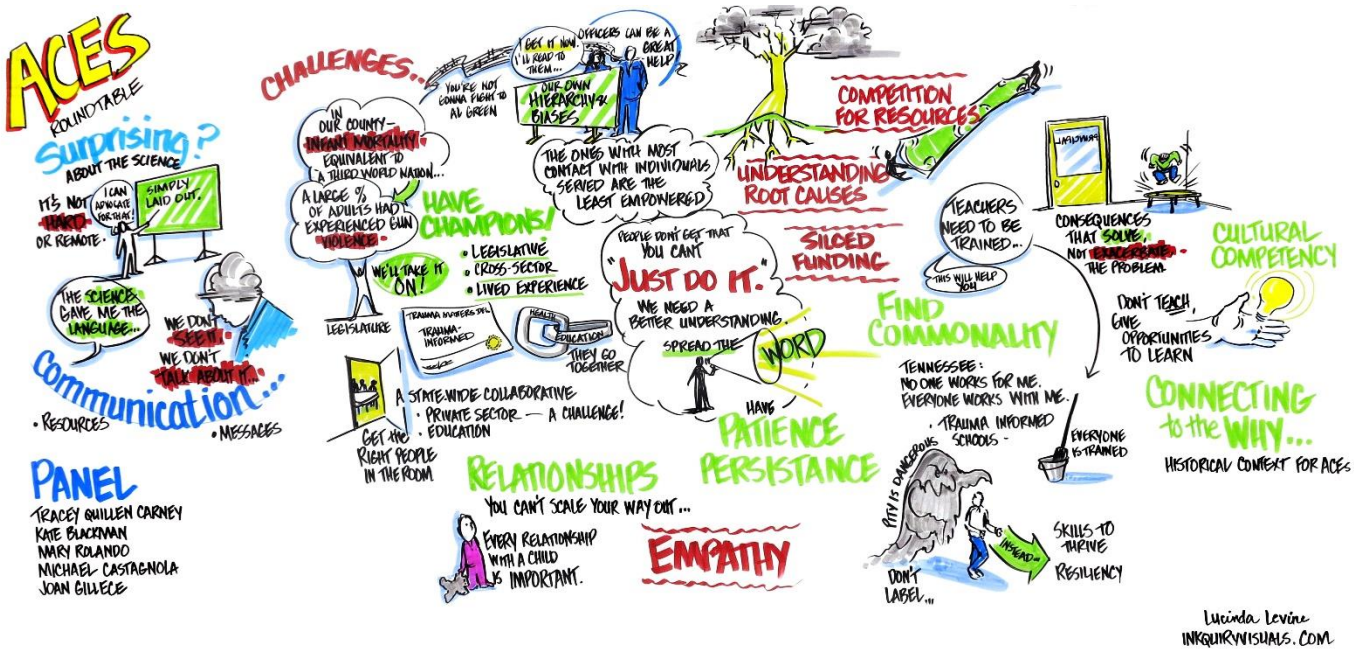

Number of ACE Trainings by County
Somerset 0%
St. Mary's 2%
Talbot 2%
Wicomico 2%
Allegany 1%
Queen Anne's 1%
Washington 7%
Anne Arundel 7%
Prince George's 2%
Montgomery 4%
Kent 1%
Howard 2%
Baltimore City 31%
Harford 10%
Garrett 5%
Baltimore County 7%
Frederick 3%
Dorchester 1%
Charles 5%
Calvert 0%
Cecil 1%
Caroline 1%
Carroll 3%

APPENDIX H

Maryland General Assembly ACEs Roundtable Graphic Recordings




ACES
ROUNDTABLE
KATE BLACKMAN
NCSL: Strategies
BRFSS
CONDUCTED IN ALL 50 STATES
INTERVENE TO LESSEN HARMS:
TRAUMA INFORMED APPROACHES
WORKING CROSS-SECTOR
POLICY
TRACKING POLICY
ACE LEGISLATION
WE'LL TELL YOU WHAT'S HAPPENING!
ACE
ACE LEGISLATION ENACTED
TASK FORCES CREATED
WORKFORCE TRAINING
FAMILY ECONOMIC SUPPORT:
EARNED INCOME TAX CREDITS
3 STATES, INCLUDING MARYLAND!
CHILDREN'S CALCULUS-
HOW DO WE EDUCATE & SUPPORT?
STRONG START:
HOME VISITING
POSITIVE PARENTING
PROMOTING PROTECTIVE FACTORS:
SOCIAL EMOTIONAL HEALTH
ACCESS?
PIPELINE PROGRAM
RESIDENCIES
TELEHEALTH
Lucinda Levine
INKQUIRYVISUALS.COM


ACES
ROUNDTABLE
Surprising?
ABOUT THE SCIENCE
IT'S NOT HARD OR REMOTE
I CAN ADVOCATE FOR THAT!
SIMPLY LAID OUT.
THE SCIENCE GAVE ME THE LANGUAGE...
WE DON'T SEE IT
WE DON'T TALK ABOUT IT...
Communication...
• RESOURCES
• MESSAGES
PANEL
TRACEY QUILLEN CARNEY
KATE BLACKMAN
MARY ROLANDO
MICHAEL CASTAGNOLA
JOAN GILLECE
CHALLENGES...
IN OUR COUNTY- INFANT MORTALITY EQUIVALENT TO A THIRD WORLD NATION...
A LARGE % OF ADULTS HAD EXPERIENCED GUN VIOLENCE
WE'LL TAKE IT ON!
LEGISLATURE
HAVE CHAMPIONS!
• LEGISLATIVE
• CROSS-SECTOR
• LIVED EXPERIENCE
TRAUMA INFORMED
EDUCATION
THEY GO TOGETHER
A STATE-WIDE COLLABORATIVE
• PRIVATE SECTOR — A CHALLENGE!
• EDUCATION
GET THE RIGHT PEOPLE IN THE ROOM
BEST OF LUCK I'LL ROOT FOR THEM...
YOU'RE NOT GONNA FIGHT TO AL GREEN
OFFICERS CAN BE A GREAT HELP
OUR OWN HIERARCHY & BIASES
THE ONES WITH MOST CONTACT WITH INDIVIDUALS SERVED ARE THE LEAST EMPOWERED
COMPETITION FOR RESOURCES
UNDERSTANDING ROOT CAUSES
SILOED FUNDING
PEOPLE DON'T GET THAT YOU CAN'T "JUST DO IT."
WE NEED A BETTER UNDERSTANDING.
SPREAD THE WORD
HAVE PATIENCE PERSISTANCE
RELATIONSHIPS
YOU CAN'T SCALE YOUR WAY OUT...
EVERY RELATIONSHIP WITH A CHILD IS IMPORTANT.
EMPATHY
TEACHERS NEED TO BE TRAINED...
THIS WILL HELP YOU
CONSEQUENCES THAT SOLVE, NOT EXACERBATE THE PROBLEM
CULTURAL COMPETENCY
DON'T TEACH, GIVE OPPORTUNITIES TO LEARN
FIND COMMONALITY
TENNESSEE: NO ONE WORKS FOR ME. EVERYONE WORKS WITH ME.
• TRAUMA INFORMED SCHOOLS -
EVERYONE IS TRAINED
CONNECTING to the WHY...
HISTORICAL CONTEXT FOR ACES
PAIN IS DANGEROUS
DON'T LABEL...
INSTEAD...
SKILLS TO THRIVE
RESILIENCY
Lucinda Levine
INKQUIRYVISUALS.COM

APPENDIX I

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

To what extent do the statements below describe you?

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

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

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

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

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

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

APPENDIX J

Essentials for Childhood Survey on Awareness, Commitment, Norms

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

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

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

RESPONSE OPTIONS:

extremely important
somewhat important
neither important or unimportant
somewhat unimportant

not at all important

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

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

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

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

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

- I shared information about their importance with others
- I signed a petition or e-mailed a prewritten letter to decision-makers
- I asked friends or family to sign a petition or write to decision-makers
- I donated money to an organization supporting these ideas
- I made phone calls or went door to door to gather support for them

I attended a meeting with business or community groups to urge they support them
I attended a town hall meeting or public rally to support them
I met with an elected official or his/her staff to talk about them
I did none of the above

46. Sometimes we can feel passionate about issues in our community but not have enough time to take action. Again, thinking about the ideas you **strongly** supported to increase the opportunity for **all children** to succeed, how likely are you in the next 12 months to do the following ? (Check all that apply)

I would share information about their importance with others
I would sign a petition or e-mail a prewritten letter to decision-makers
I would ask friends or family to sign a petition or write to decision-makers
I would donate money to an organization supporting these ideas
I would be willing to pay more taxes or higher prices at the register to support them
I would make phone calls or go door to door to gather support for them
I would attend a meeting with business or community groups to urge they support them
I would attend a town hall meeting or public rally to support them
I would meet with an elected official or his/her staff to talk about them
I would do none of the above

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

47. How many children live in your household? ____
48. This past year, was there a child under the age of 5 in your home or do you care for children under age 5 at least once a week?

☐ YES ☐ NO (If NO, skip to Q54).

In the past year, how often have you:

49. Let your child (or the child you cared for) know when you liked what he/she was doing?

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

50. Responded to your crying infant (or infant you cared for) by trying to comfort them?

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

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

51. Played with or read a story to your child (or child you cared for) under the age of five?

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

52. Spanked your child (or child you cared for) on the bottom?

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

53. Yelled at or fought with another adult in front of your child (or child you cared for) or where the child could hear

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

54. Asked or searched for help with parenting or caring for children when needed?

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

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

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

56. Been a mentor (like a Big Brother or Big Sister) to an unrelated child?

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

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

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

57. Let their children know when they liked what they are doing

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

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

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

58. Play with or read a story to their child under the age of five

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

59. Yell at or fight with another adult in front of their child or where their child could hear

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

60. Spank their child on the bottom with their hand

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

61. Help their child express themselves with words when they are angry or frustrated

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

62. Asked or searched for help with parenting when they needed it

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

63. How often do adults in your state mentor an unrelated child (like being a Big Brother or Big Sister)

☐ Every time it's needed ☐ Most of the times it's needed ☐ sometimes ☐ Rarely

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

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

64. Letting children know when you like what they are doing is a good way to teach a child how to behave

☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

65. Always trying to comfort a crying infant will spoil the baby

☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

66. Playing with or reading a story to young children every day will help the child's brain develop

☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

67. Yelling at or fighting with another adult in front of your child or where the child could hear is bad for the child's health

☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

68. Spanking your child on the bottom is a necessary part of parenting

☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

69. Helping children express themselves with words when they are angry or frustrated is better than getting mad at them

☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

70. Asking or searching for help with parenting means there's something wrong with you because you should know how to parent your child

☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

71. Being a mentor (like a Big Brother or Big Sister) to an unrelated child is a good use of your time

☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

APPENDIX K

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@adoptiontogether.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
Elizabeth Letourneau, PhD	Director, The Moore Center for the Prevention of Child Sexual Abuse, Johns Hopkins University, Bloomberg School of Public Health	Baltimore City	eletourn@jhsph.edu	Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe Street Baltimore, MD 21205

Name	Representing	Jurisdiction	Email	Address
Veto Anthony Mentzell, Jr.	Law Enforcement Officer, Harford County Sheriff's Department Program Director, Harford County Child Advocacy Center	Harford County	mentzellv@harfordsheriff.org	Harford County Sheriff's Office 45 South Main Street P.O. Box 150
Catherine Meyers	Director, Center for Children, Inc.	Charles County	meyers@center-for-children.org	Center for Children, Inc. 6100 Radio Station Road, P.O. Box 2924, La Plata, MD 20646
Linda Ramsey	Deputy Director, Family Support/HR Officer, Maryland Family Network (Maryland's CBCAP lead agency)	Baltimore City	lramsey@marylandfamilynetwork.org	Maryland Family Network 1001 Eastern Avenue, Second Floor Baltimore, MD 21202-4325
Linda Robeson	Business Community Representative	Anne Arundel County	lindasrobeson@gmail.com	306 Fairtree Drive Severna Park, MD 21146
Melissa Rock, Esq	Director, Child Welfare, Advocates for Children & Youth (ACY)	Baltimore City	mrock@ac y.org	Advocates for Children & Youth, One N. Charles Street, Suite 2400, Baltimore, MD 21201
Hillary Hollander	The Body Image Therapy Center	Baltimore County	hillaryshankman@gmail.com	8514 Countrybrooke Way, Lutherville, MD 21093
Danitza Simpson	Director, Adelphi/Langley Family Support Center	Prince George's County	Dsimpson@pgcrc.org	Adelphi/Langley Family Support Center, 8908 Riggs Road Adelphi, Maryland 20783
Joan Stine	The Family Tree (Prevent Child Abuse, Maryland), Children's Justice Act Committee Liaison, Public health expert	Howard County	stinejg@yahoo.com	2614 Liter Court, Ellicott City, MD 21042-1729

8 POSITIONS FILLED BY DESIGNATION OF THEIR ORGANIZATIONS

Name	Representing	Email	Address
Stephanie Cooke, LCSW-C	Supervisor, Child Protective Services and Family Preservation, Social Services Administration, Maryland Department of Human Services	Stephanie.Cooke@maryland.gov	Maryland Department of Human Resources Social Services Administration, 5th Floor 311 W. Saratoga St. Baltimore, MD 21201
VACANT.	State's Attorney Association		
Delegate Susan K.C. McComas	Maryland House of Delegates	susan_mccomas@house.state.md.us	Maryland House of Delegates 9 West Courtland Street P.O. Box 1204 Bel Air, MD 21014
VACANT	Department of Juvenile Services		State of Maryland Department of Juvenile Services 120 W. Fayette St. #505 One Center Plaza Baltimore, MD 21201
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 Education200 West Baltimore St. Baltimore, MD 21201
Courtney McFadden, MPH	Deputy Director, Prevention and Health Promotion Administration, Maryland Department of Health	courtney.mcfadden@maryland.gov	Maryland Department of Health 201 W Preston Street Baltimore MD 21201
VACANT	Maryland Senate		

SPECIALLY DESIGNATED MEMBERS OF CHILDREN'S JUSTICE ACT COMMITTEE

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

SCCAN EXECUTIVE DIRECTOR

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