Maryland State Council on Child Abuse & Neglect Annual Report

January 1, 2024- December 31, 2024

Acknowledgments

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Executive Summary

The Maryland State Council on Child Abuse and Neglect (SCCAN) is pleased to present its 2024 Annual Report, reflecting the Council's steadfast commitment to improving the prevention of child abuse and neglect and promoting the safety and well-being of all Maryland children and families. Throughout the past year, SCCAN has convened leaders, collaborated across sectors, and advocated for systemic changes that address longstanding disparities and structural challenges in child welfare.

This report outlines the Council's work over the last year, including its strategic retreat, review of 2024 legislative session outcomes, and forward-looking planning. Notable accomplishments include the continued development of a statewide strategic plan to prevent child abuse and neglect, informed by the recommendations from the December 2023 Statewide Prevention Convening. SCCAN has also prioritized data-informed decision-making, exploring ways to better use data to identify racial disparities in an effort to promote more equitable outcomes for children and families across Maryland.

The Council has remained deeply engaged in addressing complex and urgent issues facing the state's children, such as youth behavioral health, child fatality prevention, and the well-being of children and families impacted by the child welfare and juvenile justice systems. This report includes updates from SCCAN's core committees, highlights opportunities for interagency collaboration, and shares critical insights from the 2023 Maryland Child Fatality Review.

SCCAN recognizes that preventing child abuse and neglect requires a comprehensive, multidisciplinary approach grounded in equity, partnership, and community engagement. As Maryland looks ahead, the Council remains committed to lifting the voices of youth and families with lived experience, driving systemic change, and ensuring every child has the opportunity to grow up safe, healthy, and supported.

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

Overarching Recommendations:

(1) Improve the collection and strategic use of data to guide decision-making, track outcomes, and inform funding priorities. It is important that the data be transparent, aligned across systems, and focus on identifying and addressing racial, geographic, and service-related disparities.
(2) Educate state leaders, agencies, and communities on brain science, the impact of Adverse Childhood Experiences (ACEs), and the value of Positive Childhood Experiences (PCEs). Ensure this science is not only understood but fully integrated into Maryland's policies, programs, and public messaging. Use developmental science as the foundation for systems design, training, and service delivery across sectors.
(3) Ensure that each State agency has a Trauma and Resilience-Informed Action Plan for Preventing and Mitigating Childhood Trauma/ACEs. The plan should include budgetary commitments, public/private collaboration to develop infrastructure, promotion, and creation of local community-based cross-sector coalitions.

Observation Recommendations:

(1) Data on ACEs and Positive Childhood Experiences provide invaluable insights into the children of Maryland. **Ongoing** data collection through statewide surveys such as BRFSS and YRBS/TYS **is essential**.
(2) Data from Child, Juvenile and Adult Management System (CJAMS), Youth Risk Behavioral Survey (YRBS/YTS), Behavioral Risk Factors Survey (BRFSS), and other sources are vital to determining priorities for services.
(3) CJAMS continues to have operability issues. Personnel and financial resources need to be provided immediately to address CJAMS operability issues.
(4) Work collaboratively to gather data on the timely and effective educational services received by children in out-of-home care and track educational outcomes for foster youth.
(5) Pass legislation to amend Md. Code Ann., Family Law § 5-1312 (2021) to include additional data to be collected by the Department of Human Services (DHS) and Maryland State Department of Education (MSDE) on youth in foster care.
(6) Also see Racial Equity recommendations (1) – (4).

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

(1) Require race demographic data on all cases accepted by the Department of Human Services (DHS), in order to examine disparate outcomes. Attempts should be made

to gather data for all families referred to CPS, screened out, received Investigative Response, received Alternative Response or Non-CPS Risk of Harm Response, as well as those referred to and receiving services.

(2) DHS should make Child welfare and health-related data publicly available. This should include data that is disaggregated by race, gender, ethnicity, age and geographic region. The data should also be disaggregated at the system level (i.e., referrals, pathways, and services).

(3) Neglect referrals should be disaggregated by risk factors (substance abuse, mental health, history of child maltreatment, poverty and economic hardship, domestic abuse, etc.)

(4) Compliance with the 2013 MOU allowing data sharing for foster youth between DHS and MSDE, as well as the requirements of Every Student Succeeds Act, to track educational outcomes for foster youth.

(5) Amend current statutes to expand data currently collected by Maryland's Department of Human Services and published in their Child Welfare Indicators Report.

(6) Pass legislation that requires all employees and family services workers, particularly child welfare workers, in the state of Maryland to receive racial bias training. This training should focus on the role of bias and racism in child abuse and neglect reporting.

(7) Pass legislation that requires all DHS employees and local Department of Social Services (DSS) supervisors and caseworkers in the state of Maryland to receive racial bias training focused on the role of bias and racism in decision-making throughout the continuum of child welfare cases.

(8) Continue to fund and support future Visioning Sessions. This should include "mini sessions," dedicated to different areas of the State, as well as different populations, such as current, and former, foster youth, to allow for a more open dialogue.

(9) Assemble a Commission that is tasked with identifying clear criteria and methods to address how prejudiced and discriminatory practices have impacted the current state of child and family welfare. The Commission should be tasked with creating mechanisms for publicly acknowledging historical harms and their ongoing effects.

(10) Evaluate possible unintended consequences of mandatory reporting laws without sacrificing child safety and well-being.

Child Sexual Abuse Prevention Recommendations:

(1) HB 1072 and HB 486 should be amended requiring MSDE to provide annual oversight of each jurisdiction's Code of Conduct, annual training program and staff screening policies and to share this information with the Maryland General Assembly.

(2) CPS background checks should be required of all school employees to help identify individuals who have been found “Indicated,” for child maltreatment, but may not have been criminally convicted.

(3) The above expanded requirements should also include other child serving organizations to ensure that potential child predators do not have access to Maryland’s children.

Healthcare Committee Recommendations:

(1) In accordance with Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), an electronic health passport should be created. This will ensure that not only the foster youth themselves, but everyone providing services will have access to this important information. Without a fully operational Maryland Total Human Services Integrated Network MD THINK/CJAMS platform, key tools like data linkages and a health passport cannot move forward.

(2) To meet the requirements of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), Medicaid and CRISP data should be linked to CJAMS. This data should include tracking health care outcomes using HEDIS, or other quality measures.

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

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

(5) Create at least 2 additional positions at DHS for physicians or nurse practitioners to assist the Medical Director in reviewing health care data, assessing quality of care, and providing input to local DSS agencies. One of these positions should

be filled by a child psychiatrist to address psychotropic medication prescribing, including informed consent.

(6) Convene Key Stakeholders listed above as an “Expert Panel” to review system gaps and develop solutions. Maryland Department of Health (MDH) could serve as a convener to bring other stakeholders to the table, potentially through the Children’s Cabinet, or could propose amendments to the CHAMP legislation that would reconstitute and re-purpose the “Expert Panel” created by the legislation to serve this purpose. Children’s Cabinet members would need to determine specific next steps such as meeting frequency, structure, and invitees.

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

Child Abuse Medical Professionals (CHAMP) Recommendations:

In accordance with Maryland Family Law § 5–7A–09, SCCAN is required to include information on the activities of the Maryland CHAMP (Child Abuse Medical Providers) Initiative in its Annual Report. This includes data on child abuse and neglect diagnoses and treatment. The inclusion of CHAMP content reflects its statutory role in advancing child protection through clinical expertise and ensures alignment with SCCAN’s broader oversight and policy responsibilities.

The CHAMP has several key recommendations to improve the identification and evaluation of child abuse and neglect victims in Maryland:

1. Strengthen Medical Expertise in child abuse investigations by mandating an expert medical review of child abuse cases.
2. Ensure that all medical professionals involved in child maltreatment cases participate in peer review, continuous quality improvement, and ongoing training.
3. Expand the role of Child Advocacy Centers (CACs) in physical abuse investigations.
4. Improve system level support by developing a coordinated and stable funding system for child maltreatment evaluations.
5. Streamline processes for multidisciplinary maltreatment investigations and medical service delivery.
6. Work with MCA to ensure that each CAC in the State is accredited.

7. Stronger collaboration is needed among stakeholders, including MDH, DHS, CACs, MCA, and healthcare providers, to address system gaps and develop solutions.
8. Direct the Child Welfare Medical Director to work with Maryland CHAMP (Child Abuse Medical Professionals) to ensure best practice medical review and evaluation of cases of suspected abuse or neglect to meet the requirements of the statute.

The Magnitude of the Problem: Adverse Childhood Experiences in Maryland

Understanding the full scope of child abuse, neglect, and household adversity is essential for crafting effective, equitable policy solutions that protect Maryland's children and strengthen families.

Adverse Childhood Experiences (ACEs)—such as physical and emotional abuse, neglect, parental incarceration, substance use, or exposure to domestic violence—are linked to long-term negative outcomes in physical and mental health, education, employment, and public safety. The growing body of national and state research underscores the urgent need to identify, address, and prevent these experiences early.

In Maryland, ACEs are central to child maltreatment prevention and intervention efforts. The State Council on Child Abuse and Neglect (SCCAN) prioritizes understanding how widespread these experiences are, how they affect children and families, and how state systems can better respond.

Why Data Matters: The Foundation for Prevention and Accountability

Preventing child maltreatment and addressing the effects of ACEs requires accurate, timely data on:

- **Incidence of abuse and neglect**
- **Service delivery across child- and family-serving agencies**
- **Disparities in access, outcomes, and accountability**
- **Prevalence of ACEs among both children and adults**

Maryland has some useful tools in place—such as the **Behavioral Risk Factor Surveillance System (BRFSS)** and the **Youth Risk Behavior Survey (YRBS)**—that capture information about ACEs among adults and adolescents. Additionally, child maltreatment fatalities are tracked through the Office of the Chief Medical Examiner and the Maryland Vital Statistics Administration.

However, **significant data gaps remain**. Critical information—such as CPS reports disaggregated by race, or what services were provided to families—is not easily accessible or systematically collected.

MD THINK & CJAMS: Missed Potential Without Full Implementation

In 2016, SCCAN supported the creation of the **MD THINK** platform and **CJAMS** (the new child welfare data system) with the goal of unifying data across agencies, replacing outdated systems, and improving child and family outcomes.

Legislation passed in 2018 (**Md. Code Ann., Human Services §§ 8-1101–1103**) required DHS to integrate child welfare data with key health systems like:

- **CRISP** (Chesapeake Regional Information System for Our Patients),
- **ImmuNet**, and
- **Medicaid**.

Nearly a decade later, this integration has not been achieved.

This failure limits our ability to:

- Track and meet children's health and behavioral health needs,
- Reduce administrative burden on caseworkers,
- Share key information with foster youth, caregivers, and providers,
- Assess system performance and identify gaps across health, education, housing, and justice sectors.

Maryland lags behind other states that have already integrated their child welfare and Medicaid data to improve oversight and care coordination.

A Clearer Picture of Child Maltreatment in Maryland

Reports to Child Protective Services (CPS) are known to significantly underreport the actual rate of child maltreatment. Independent studies suggest that **1 in 4 U.S. children** experience maltreatment at some point.

To better understand and respond to the scope of adversity in Maryland, SCCAN relies on data from:

- **CPS reports** (for current incidence),
- **BRFSS ACE module** (childhood adversity among Maryland adults), and
- **YRBS data** (self-reported adversity among adolescents).

The effectiveness of prevention and intervention strategies is only as strong as the data behind them. Without accurate and integrated data, fully implemented statutory mandates and cross-agency collaboration to break down silos and ensure a coordinated response, Maryland cannot fully understand the scope of adversity or measure the effectiveness of its child welfare systems. It is critical that we act now to close these gaps and ensure that every child has the opportunity to grow up in a safe, healthy, and supportive environment.

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

Figure A: FFY2024 Child Maltreatment Referral, Pathways, and Services

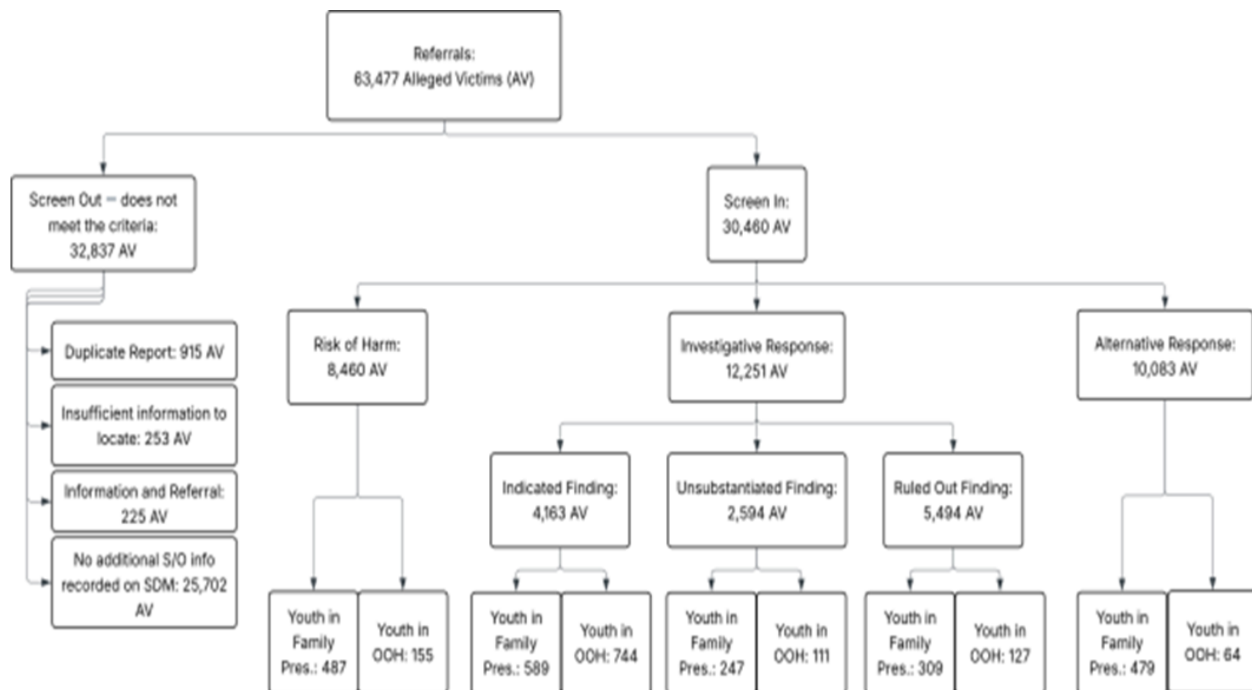


Figure A illustrates the number of referrals (alleging suspected maltreatment), reports (screened-in referrals), their pathways (investigation, alternative response or risk of harm), dispositions, and service provision.

- During 2024, DHS SSA reports that it received 63,477 referrals of suspected child maltreatment. Of those, 22,374 reports or 35.2% were screened in for a CPS response (either investigative or alternative response).
- During 2024, 22,374 investigations were completed. 4,163 were indicated, which represents 18.6% of investigations. Once a case is indicated, the alleged victim is considered to be a maltreated child.
- During 2024, 10,083 cases were assigned an alternative response. 479 (4.7%) of the cases assigned as an alternative response were referred for continuing services. 64 (0.6%) of the alternative response investigations resulted in a removal.
- Data was not made available to indicate the types of services, if any services were offered, or accepted by, families. Many of the children that are referred to

child welfare services have experienced several significant risk factors that lead to a greater likelihood of poor short term and long-term outcomes.

Figure A illustrates the pathway for referrals received by DHS in 2024, displaying unique counts of alleged victim youth. It shows the pathway of response to the initial referral. The final step displayed in the graphic tracks whether youth entered a service case (i.e., out-of-home care or an in-home case) within 60 days of the referral.

While Risk of Harm (ROH) referrals are screened in, it's important to note that DHS does not initiate a Child Protective Services (CPS) response for ROH cases. Instead, ROH referrals are routed directly to a service case. This means ROH cases are screened in for a service case, not a CPS case. If a youth in an ROH service case requires further assistance, they may receive family preservation services or enter out-of-home care, as depicted in the chart.

Note that the total number of alleged victim children across ROH and CPS response is higher than the count of alleged victim children at screen in. The Department often identifies more alleged child victims during CPS investigations and risk of harm assessments than were documented at the time of the initial screening. This occurs because, as the Department engages with families, additional children within the household or family composition may be identified that were not reported at intake. It is common for these children to come to the agency's attention only after the initial screening process, resulting in a higher number of alleged victims reflected in investigations and assessments.

Figure B: Youth Receiving a CPS Response by Maltreatment Allegation Type in FFY2024

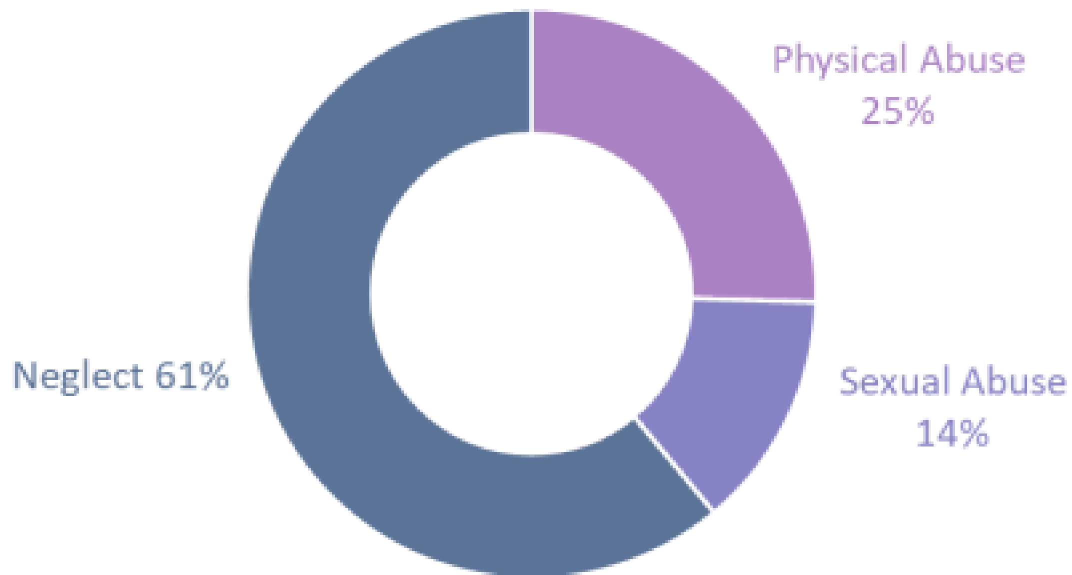


Figure B displays youth who received a CPS response, either Investigative Response (IR) or Alternative Response (AR), by their maltreatment allegation type. Note that allegations of sexual abuse cannot be referred to an AR case; they must be assigned as an IR.

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. Previous maltreatment history is the biggest predictor of future child maltreatment, followed by mental health issues, substance abuse, and then domestic violence. It is worth noting that when reporting federal data, alcohol abuse and drug abuse are seen as two separate risk factors. For purposes of State level data collection, substance abuse includes both drug abuse and alcohol abuse.

The incidents of maltreatment do not necessarily happen while the child is in the care of their custodial caregiver. The person responsible for the act of maltreatment is referred to as the perpetrator. The extent of the problem in Maryland is challenging to ascertain because different data sources provide very different statistics. The U.S. Department of Health and Human Services, Administration for Children and Families *Child Maltreatment 2023* report on National Child Abuse and Neglect Data (NCANDS) analyzed data for nine caregiver risk factors, however four were broken down to the state level, those factors are, and are defined as:

- Alcohol abuse: The compulsive use of alcohol that is not of a temporary nature.
- Domestic Violence: Any abusive, violent, coercive, forceful, or threatening act or word inflicted by one member of a family or household on another. In NCANDS, the caregiver may be the perpetrator or the victim of domestic violence.
- Drug abuse: The compulsive use of drugs that is not of a temporary nature.
- Inadequate Housing: A risk factor related to substandard, overcrowded, or unsafe housing conditions, including homelessness.

Table 1: The Number and Percentage of Maryland Child Victims with Specific Risk Factors Reported by the Maryland Department of Human Services, Social Services Administration (SSA) to NCANDS, FFY2023.

CAREGIVER RISK FACTOR	# of children with risk factor reported by MD SSA to NCANDS	% of children with risk factor reported by MD SSA to NCANDS
Alcohol abuse	199	3.3%
Drug abuse	356	5.9%
Substance Abuse	NCANDS did not report this factor	NCANDS did not report this factor
History of Maltreatment	2100	33.3%
History of Violence	NCANDs did not analyze this factor	NCANDs did not analyze this factor
Financial Problems	Not Reported	Not Reported
Inadequate Housing	370	6.1%
Public Assistance	Not Reported	Not Reported
Any Disability	Not Reported	Not Reported
Domestic Violence	264	4.3%

Data submitted to NCANDS by the Maryland Department of Human Services showed that in 2023, 3.3% of child maltreatment victims (i.e., cases with an indicated finding) in Maryland had a caregiver risk factor of alcohol abuse, and 5.9% had a caregiver risk factor of drug abuse. Maryland's caregiver alcohol abuse and drug abuse risk factor percentages remain smaller than those in most other states. For example, the percentage of victims with alcohol abuse as a caregiver risk factor ranges from 44.9% in Massachusetts to Maryland's 3.3% and Wisconsin's 2.2%. Similarly, the percentage of victims with drug abuse as a caregiver risk factor ranges from 52.2% in Alabama to Maryland's 5.9%, Florida's 2.3%, and Pennsylvania's 2.0%.

Figure C: Maryland FFY 2024 Risk Factors among MD Children with a Risk of Harm (ROH) response.

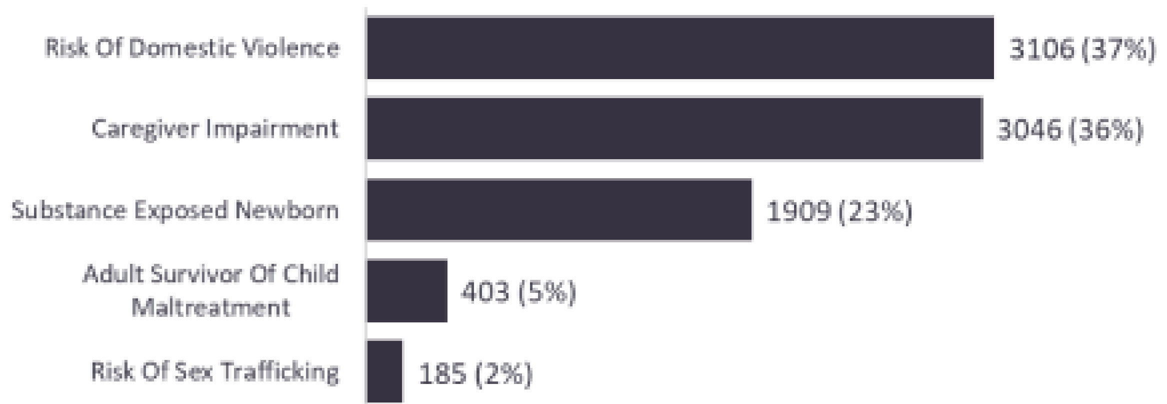


Figure C displays risk factors identified for youth with a Risk of Harm (ROH) case. The data presents a distinct count for each risk factor identified using the Structured Decision Making (SDM) tool. The SDM may identify multiple risk factors per youth.

Figure D: Maryland FFY 2024 Risk Factors among MD Children with an indicated finding

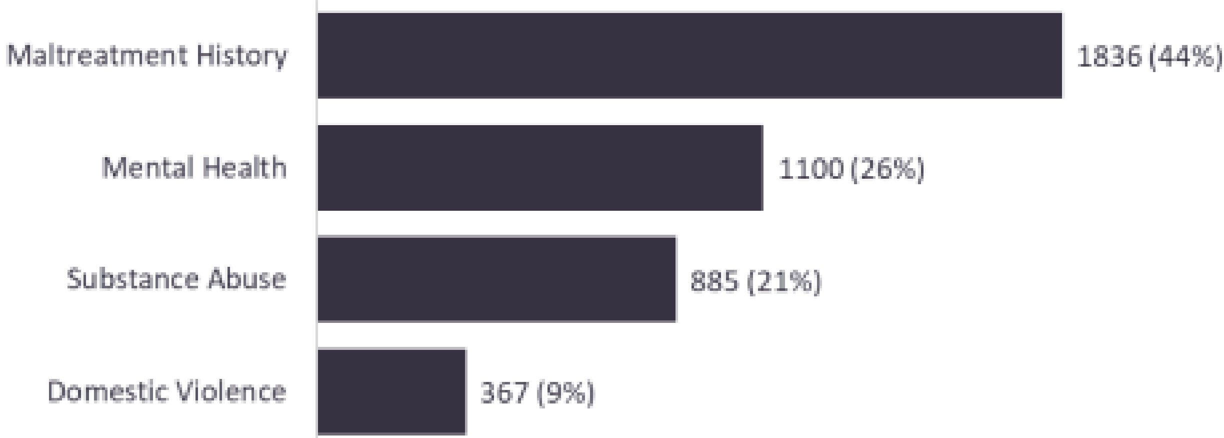


Figure D displays caregiver risk factors identified for youth with indicated maltreatment in FFY2024. These factors were identified using the MFRA, an assessment tool that may identify multiple risk factors per youth.

Table 2: CPS Cases in FFY2024 by Race/Ethnicity

	CPS Responses		
	AR	IR	Total
Black	4,724	6,085	10,809
White	2,704	3,396	6,100
Hispanic	1,560	1,922	3,482
Other	184	119	303
Declined	3	9	12
Missing/Unknown	908	720	1,628
All Races/Ethnicities	10,083	12,251	22,334

Table 2 shows that in FFY2024, Maryland received and screened in 22,334 CPS cases, with racial and ethnic data recorded in most cases. Of these, 10,083 cases were routed through Alternative Response (AR), and 12,251 through Investigative Response (IR).

Black families represented the largest portion of the total caseload at 10,809 cases, followed by White families with 6,100 cases and Hispanic families with 3,482 cases. Across all identified racial groups, the number of Investigative Responses consistently exceeded the number of Alternative Responses. Specifically, for Black families, there were 6,085 IR cases compared to 4,724 AR cases, while White families saw 3,396 IR cases against 2,704 AR cases. Smaller subsets of the data included 303 cases categorized as "Other," 12 where information was declined, and 1,628 cases where race or ethnicity was missing or unknown.

Table 3: CPS Indicated Findings in FFY2024 by Race/Ethnicity

	Sexual Abuse	Physical Abuse	Neglect	All Indicated
Black	343	483	1,156	1,982
White	289	159	703	1,151
Hispanic	379	103	298	780
Other	10	13	22	45
Declined	1	1	0	2
Missing/Unknown	66	43	94	203
All Races/ Ethnicities	1,088	802	2,273	4,163

When indicated cases are disaggregated by race/ethnicity. Black children represented 343 indicated sexual abuse cases, and over half of all indicated findings for physical abuse (483) and neglect (1,156). White children accounted for 289 indicated sexual abuse cases, 159 indicated physical abuse cases and 703 indicated neglect cases for a total of 1,151 indicated cases. Hispanic children were involved in 379 cases that were indicated for sexual abuse, 103 indicated for physical abuse, and 298 indicated neglect cases.

This data highlights ongoing racial disparities in child protective services involvement—particularly the overrepresentation of Black children in investigative response and in indicated maltreatment findings, especially for neglect. It also underscores the need for improved data completeness and strategies to address racial disparities within Maryland's child welfare system.

Fatalities

Child deaths are a critical public health concern in Maryland, and the alarming trend of increasing fatalities in recent years demands immediate action. The Maryland State Child Fatality Review (CFR) Team plays a vital role in reviewing unexpected child deaths and making recommendations to prevent future fatalities. However, the COVID-19 pandemic and a recent data breach at MDH have presented challenges to data collection and analysis, potentially limiting the availability of comprehensive and timely information. The CFR is part of CAPTA as well as SCCAN.

Recent attention has been directed toward concerns regarding statewide reporting practices related to child fatalities. The data presented in this report are derived from official Child Fatality Review (CFR) case-level analyses and represents deaths referred to and reviewed by CFR teams during 2020. This was the most recent data provided to SCCAN. While broader systemic reporting challenges may persist, SCCAN continues to rely on CFR data as a critical source of detailed, case-based insights into preventable child deaths. These reviews remain instrumental in identifying patterns, informing prevention strategies, and guiding policy recommendations aimed at reducing preventable child deaths across the state.

Data from the Maryland Child Fatality Review Annual Report highlights the continued impact of child maltreatment fatalities across the state. In 2020, Maryland recorded 19 child deaths where maltreatment was identified as a contributing factor, reflecting a decrease from 23 cases in 2019. These cases were determined based on autopsy reports, Department of Human Services (DHS) investigations, and law enforcement findings confirming the role of abuse or neglect in these fatalities. Analysis of racial disparities among child maltreatment deaths reveals that 58% of the victims were Non-Hispanic Black children, despite this group making up a smaller proportion of Maryland's child population. This disparity mirrors broader trends in child welfare data, where Black children are disproportionately represented in maltreatment investigations and foster care placements.

The leading causes of maltreatment-related child fatalities in Maryland included homicides, unsafe sleep environments, and severe neglect. Some of these deaths occurred in households with prior involvement in child welfare services, underscoring the urgent need for enhanced prevention and intervention efforts.

The findings from the CFR report complement previously published data from the 2022-2023 SCCAN Report, which documented 84 child maltreatment-related fatalities in FFY 2021 based on NCANDS data. Together, these reports highlight ongoing concerns regarding child safety and the importance of strengthening family support systems to prevent future tragedies.

Despite these challenges, the CFR team has worked diligently to review available data and provide insights into the circumstances surrounding child deaths in Maryland. In 2020, the Office of the Chief Medical Examiner (OCME) referred 160 unexpected child deaths to local CFR teams for review. The majority of these deaths occurred among infants (61) and children aged 15 to 17 (44). Non-Hispanic Black children experienced a disproportionately high number of unexpected deaths with 93,a rate 5.5 times greater than Hispanic children, with 17, and 2.3 times greater than Non-Hispanic White children, with 41 cases.

The leading causes of death were undetermined (48; 30%), accidents (39; 24.4%), homicide (25; 15.6%), suicide (23; 14.4%), and natural causes (23; 14.4%), with 2 not reviewed. Motor vehicle accidents were the leading cause of accidental deaths, while

undetermined causes accounted for a significant portion, highlighting the need for further investigation and understanding of these deaths.

Recommendations for the 2024 SCCAN Report

- **Support CFR Teams:** Advocate for continued support and resources for local CFR teams to ensure comprehensive review of unexpected child deaths and effective implementation of prevention strategies.

- **Address Disparities:** Prioritize efforts to reduce racial and ethnic disparities in child fatality rates, particularly among Non-Hispanic Black children, through culturally responsive, community-based interventions and equity-focused policy and systematic reforms.

- **Data Collection and Analysis:** Improve accurate data collection and analysis to better understand the circumstances surrounding undetermined deaths and inform prevention efforts.

- **Collaboration:** Foster coordinated and consistent collaboration among CFR teams, state agencies, and community organizations to implement evidence based recommendations and develop comprehensive multi-agency strategies to prevent child fatalities.

- **Address the Upward Trend:** Develop and implement targeted interventions to address the specific causes of the increasing child death rate, such as unintentional injuries, homicide, and suicide. Emphasize early identification of risk factors and timely access to supportive services.

Additional Considerations for the 2024 SCCAN Report

- **Trends Over Time:** Examine trends in child fatality data over time to identify patterns and inform long-term prevention strategies.

- **Jurisdictional Data:** Include jurisdictional data on child fatalities to highlight regional variations and inform targeted interventions at the local level.

By incorporating this updated information and recommendations into the 2025 SCCAN Annual Report, the report can provide valuable insights and guidance for preventing child deaths and promoting child well-being in Maryland

CHAMP Report

The Child Abuse Medical Professionals (CHAMP), a child abuse and neglect expert panel, was created to enhance the quality of medical diagnosis and treatment for child abuse victims in Maryland. Key activities include training medical professionals, offering consultations, and reviewing cases. The following was provided by CHAMP:

Maryland CHAMP was created in 2005 by House bill 1341, Md. Code, Health – General § 13-2201-2205 and amended in 2008. CHAMP faculty are tasked with:

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

Since its inception, CHAMP has accomplished the following:

- Offered trainings three times a year to Maryland physicians and nurses practicing in the field most recently in June 2023 with nearly 60 attendees.
- Established a web-based, secure, and HIPAA compliant peer review system for medical professionals to submit cases for review.
- Developed a website with practice templates (consent forms, exam documentation forms, etc.), practice guidelines, and links to local, regional, and national resources.
- Collaborated with Maryland Children's Alliance (MCA) to train Child Advocacy Center (CAC) leaders on medical standards.
- Provided technical assistance to local CACs, Departments of Social Services, and law enforcement agencies about the medical evaluation of child maltreatment.
- Trained 14 physicians and more than 30 nurses to conduct medical evaluations for children with suspected maltreatment.

In 2024, CHAMP organized three half-day training sessions for medical professionals, covering topics such as problematic sexual behavior in preteen children, online child sexual victimization, and changes in genital exams during infancy and childhood. These sessions saw participation from 181 professionals, including doctors, nurses, and other members of the medical community.

The CHAMP Buddy Program, piloted in FY 2024, paired local physicians and nurses with CHAMP faculty to provide support on issues like court testimony preparation and handling emotionally challenging cases.

CHAMP is actively involved in the accreditation process for Child Advocacy Centers (CACs) in Maryland, ensuring they meet the medical standards set by the National Children's Alliance (NCA). As of January 2024, there are 17 NCA-accredited CACs in Maryland.

In addition to training and consultation services, CHAMP offers on-call support to medical professionals seeking advice or guidance on specific cases. CHAMP faculty are available during standard work hours on business days.

For 2025, LifeBridge Health will continue to support the CHAMP Initiative, with a focus on system building, collaboration, and outreach to local CACs and key stakeholders. MDH will work closely with CHAMP and other stakeholders to address gaps in the identification and evaluation of child abuse victims.

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

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

A needs assessment conducted by CHAMP in 2024 revealed variations in the level of medical services provided across the state, a lack of medical providers in certain counties, and inconsistencies in the involvement of medical experts in physical abuse investigations.

The CHAMP website, developed in 2022, continues to be a valuable resource for medical professionals and others involved in child maltreatment cases. It provides clinical information, local CAC contacts, referral guidelines, and mental health resources.

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

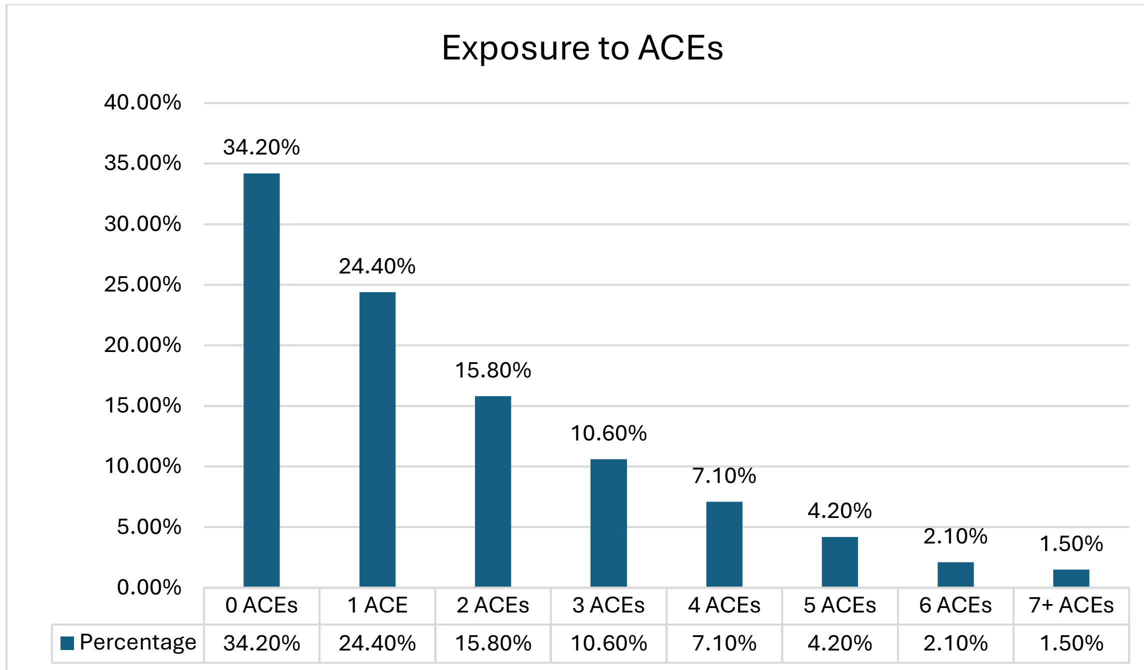
Background: The Adverse Childhood Experiences Study

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

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's prevalence of chronic health conditions, risk factors, and the use of preventive services.

Several states began collecting ACEs data through their state BRFSS survey in 2009. In 2013, SCCAN and MD EFC recommended adding the ACEs module to Maryland’s BRFSS and successfully advocated in 2014 for inclusion of the module in the 2015 BRFSS. The ACEs module was included in the 2018 and 2020 Maryland BRFSS. SCCAN and MD EFC recommend inclusion of the ACE module in the BRFSS every three years. The BRFSS Module collects data on eight of the original ten ACEs. These included physical abuse, emotional abuse, sexual abuse, household incarceration, and witnessing domestic violence. It does not include the original ACE questions on physical neglect and emotional neglect.

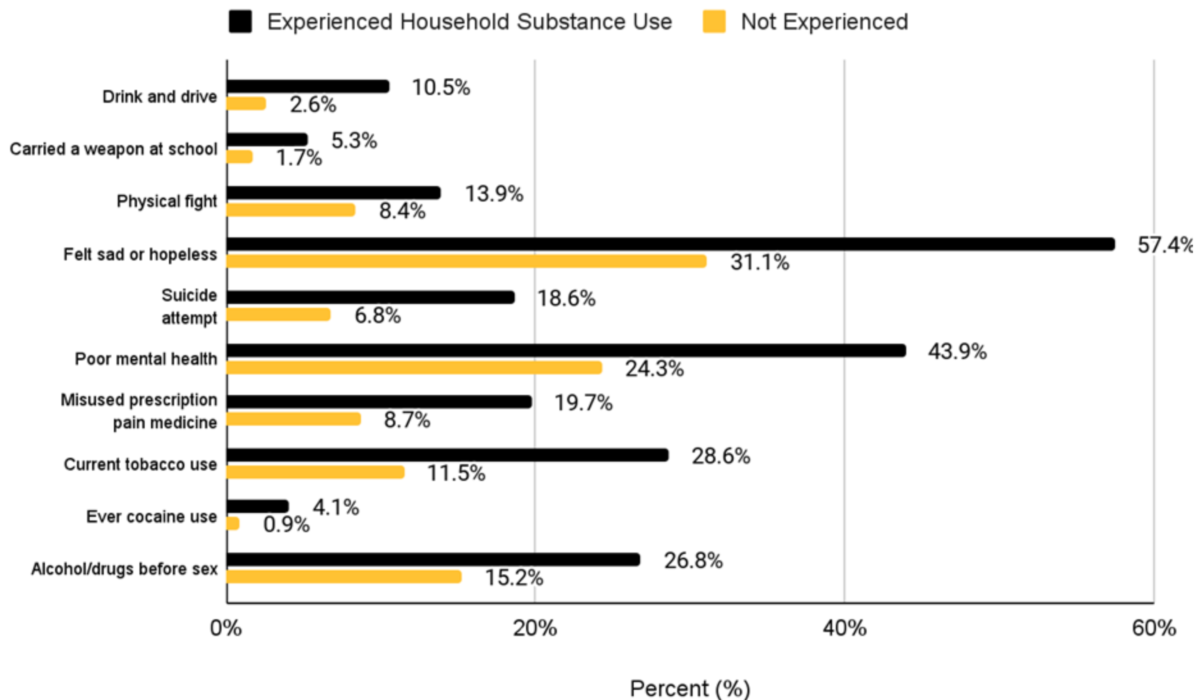
Figure E: Marylanders Exposure to ACEs



	0 ACEs	1 ACE	2 ACEs	3 ACEs	4 ACEs	5 ACEs	6 ACEs	7+ ACEs
Percentage	34.20%	24.40%	15.80%	10.60%	7.10%	4.20%	2.10%	1.50%

As illustrated above the prevalence of Adverse Childhood Experiences among Marylanders, revealing that 65.8% of the population has been exposed to at least one ACE. While 34.20% of respondents reported zero ACEs, nearly a quarter (24.40%) have experienced one, and 15.80% reported two. The data shows a steady decline in frequency as the number of ACEs increases: 10.60% reported three, 7.10% reported four, and 4.20% reported five. A smaller but significant segment of the population faces even higher levels of adversity, with 2.10% reporting exposure to six ACEs and 1.50% experiencing seven or more.

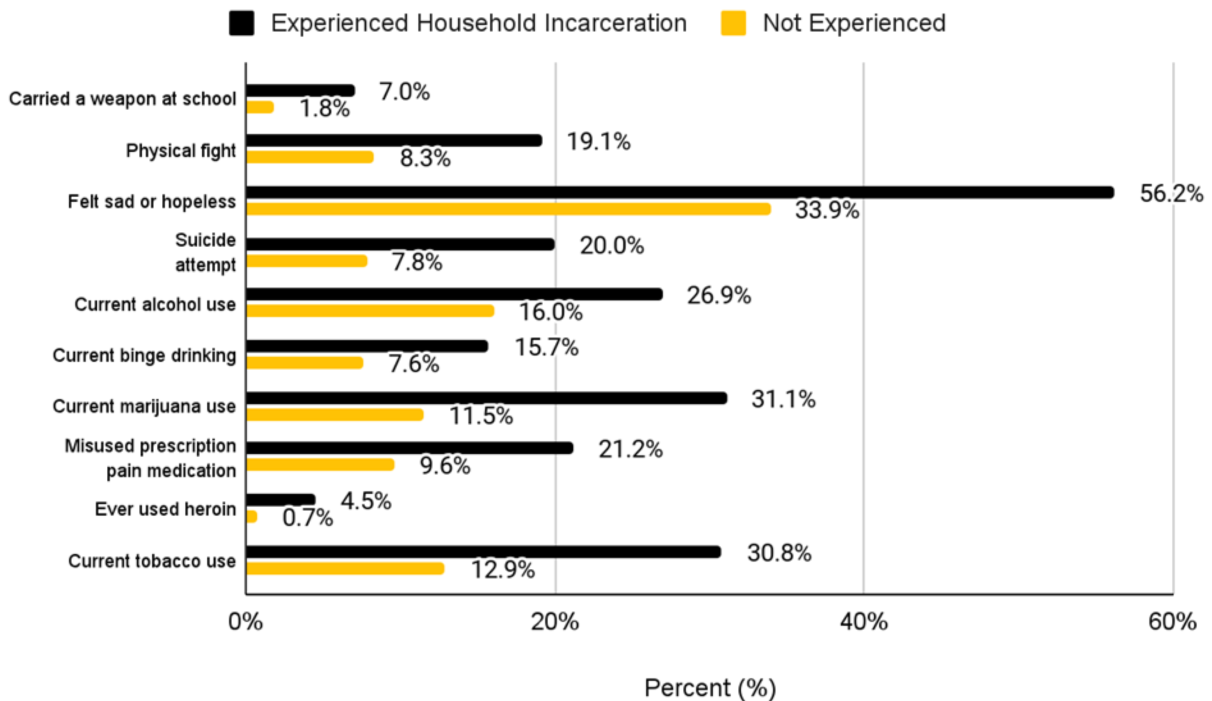
Figure F: Maryland High School Students with Exposure to Household Member with Substance Use, YRBS



As illustrated above, Maryland high school students who reported exposure to a household member's substance use demonstrated higher rates across all risk behaviors assessed in the Youth Risk Behavior Survey (YRBS). More than half (57.4%) who reported exposure to household substance use reported feelings of sadness or hopelessness, significantly more than those who did not experience household substance use (31.3%). Nearly half (43.9%) reported having poor mental health compared to students who were not exposed to household substance use (24.3%).

The 2022-2023 Maryland YRBS/YTS household substance use was defined as students reporting living with a household member with a substance use problem. In high schools, the prevalence of students experiencing household substance abuse was 19.9%, with higher rates among Multiracial (29.6%), White (23.7%), and female (23.6%) students. In middle schools, 14.3% of students reported household substance abuse, with higher prevalence among Native American (20.2%), Other Race (18.9%), Multiracial (18.7%), and female (16.9%) students.

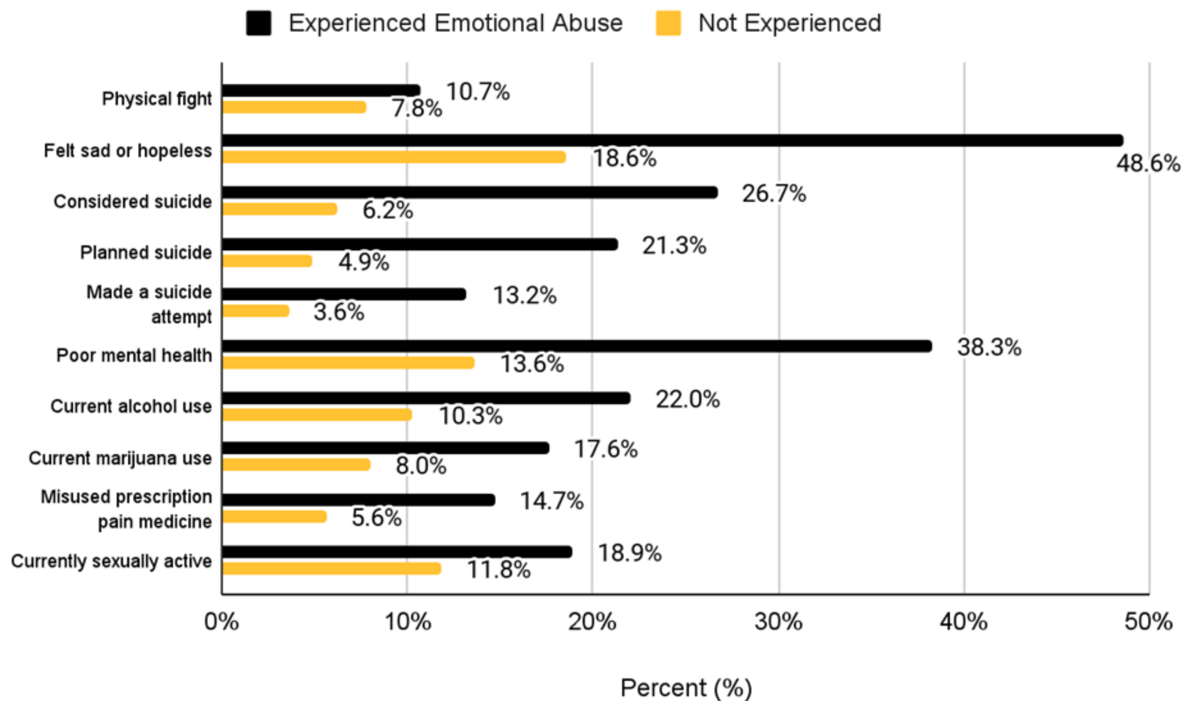
Figure G: Maryland High School Students with Incarcerated Household Member, YRBS



As illustrated above, Maryland high school students who reported living with a household member who has been incarcerated demonstrated higher rates across all risk behaviors assessed in the Youth Risk Behavior Survey (YRBS). High school students with a household member who has been incarcerated are much more likely to feel sad or hopeless (56.2%) than those who do not have an incarcerated household member (33.9%). They are also much more likely to engage in tobacco use (30.8% compared to 12.9%), prescription pain medication misuse (21.2% compared to 9.6%), and binge drinking (15.7% with exposure compared to 7.6% of those without).

The 2022-2023 Maryland YRBS/YTS household incarceration was defined as students reporting living with an incarcerated household member. Among high school students,10.7% reported household incarceration, with higher rates among Native American (19.2%), Multiracial (18.8%), and Black (14.6%) students. Middle school students reported a prevalence of 11.6%, with higher rates among Native American (16.4%), Black (14.7%), and Multiracial (14.6%). These findings highlight the urgent need for interventions and support to mitigate the impact of household incarceration on Maryland's youth.

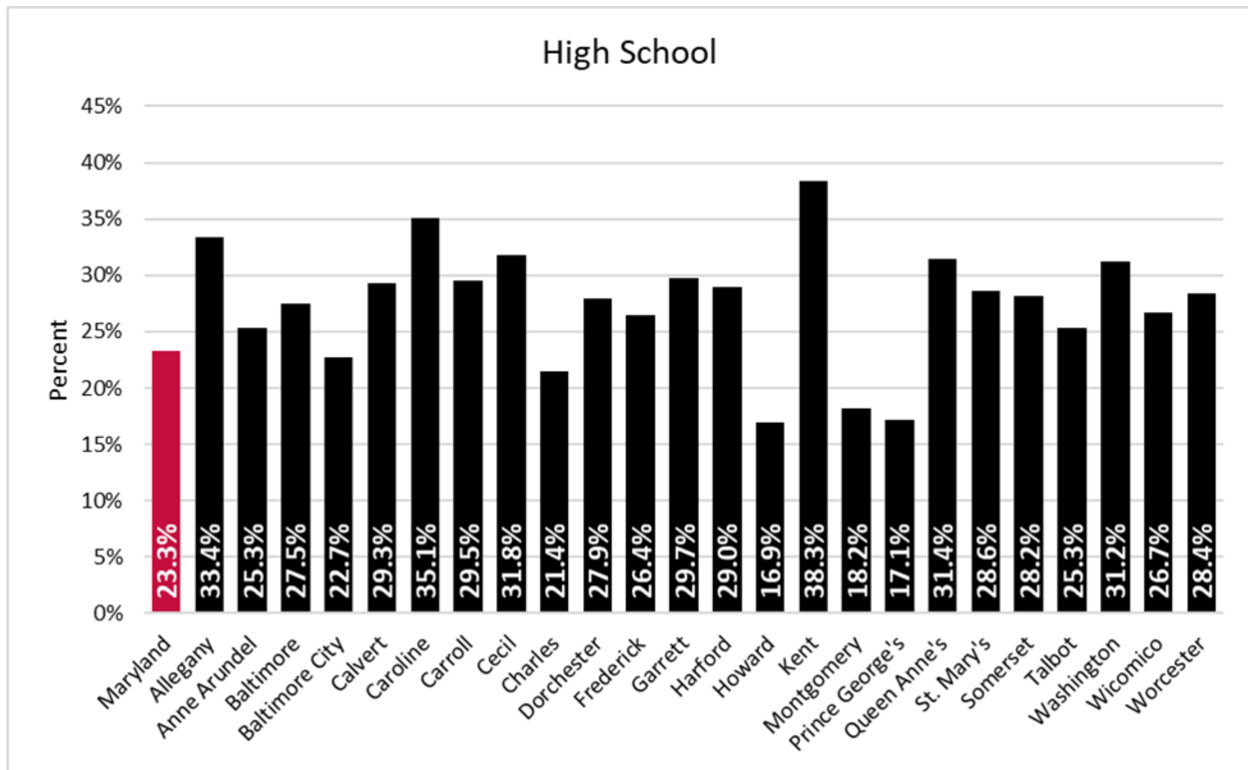
Figure H: Maryland High School Students and Exposure to Emotional Abuse, YRBS



As illustrated above, Maryland high school students who reported having experienced emotional abuse demonstrated higher rates across all risk behaviors assessed in the Youth Risk Behavior Survey (YRBS). High school students who have experienced emotional abuse are significantly more likely to feel sad or hopeless (48.6%) compared to those who have not been exposed to emotional abuse (18.6%). The toll that emotional abuse takes on the mental health of Maryland's high school students is also significant with 38.3% of high schoolers reporting poor mental health and 26.7% considering suicide when they have experienced emotional abuse compared to 13.6% reporting poor mental health and 6.2% having considered suicide, of those who have not experienced emotional abuse.

The 2022-2023 Maryland YRBS/YTS identified high school students who reported having a parent or other adult in their home who insulted them or put them down. 59.1% of high school students have experienced emotional abuse. While 27.8% of students reported these experiences as occurring rarely, 21.1% reporting it sometimes, 7.3% most of the time, and 2.9% always. When examining these experiences by race and ethnicity, 67.7% of students identifying with Multiple Races report exposure to this ACE (rarely 24.8%, sometimes 27.0%, most of the time 10.7% or always 5.1%) and 67.4% of Asian students (rarely 33.1%, sometimes 24.1%, most of the time 7.4% and always 2.8%) reported exposure to this ACE.

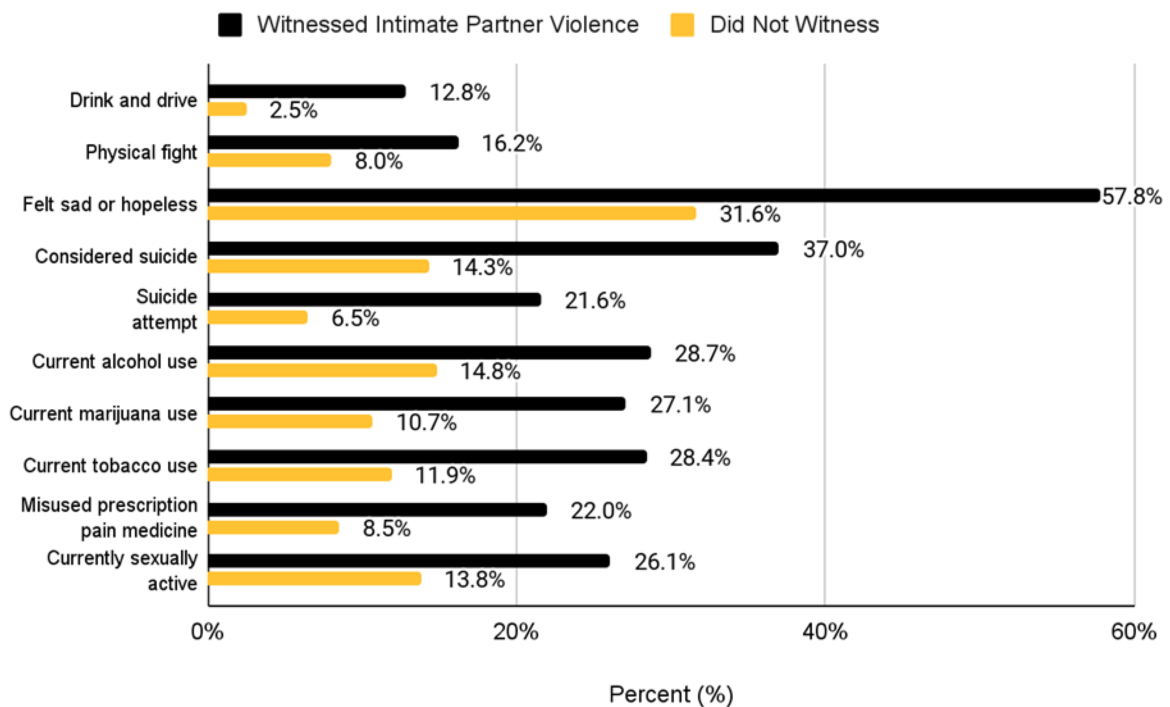
Figure I: Percentage of Maryland High School Students Exposed to Mental Illness in the Home by Jurisdiction, YRBS



As illustrated above, Maryland high school students who reported having been exposed to mental illness in their home demonstrated higher rates across all risk behaviors assessed in the Youth Risk Behavior Survey (YRBS). Exposure to the adverse childhood experience (ACE) of household mental illness varied by demographic group. Among Maryland high school students 23.3% reported that they had been exposed to mental illness in their home. This exposure is most common in Kent County at 38.3%, Allegany County with 33.4% and 31.8% in Cecil County. Exposure to mental illness in the home is least common in Howard County (16.9%), Prince George's County (17.1%) and Montgomery County (18.2%).

The 2022-2023 Maryland YRBS/YTS identified high school students who reported living with a parent or guardian with severe depression, anxiety, another mental illness, or who has been suicidal demonstrated higher rates across all risk behaviors assessed in the Youth Risk Behavior Survey (YRBS). 23.2 % of Maryland high school students reported exposure to this ACE Multiracial (34.8%), White (28.9%), and female (29.7%) high school students were more likely to report exposure to mental illness in their home.17.6% of middle school students in Maryland reported exposure to mental illness in the home. Among middle school students, Native American (26.6%), Multiracial (24.3%), and female (22.5%) students were more likely to report exposure to this ACE.

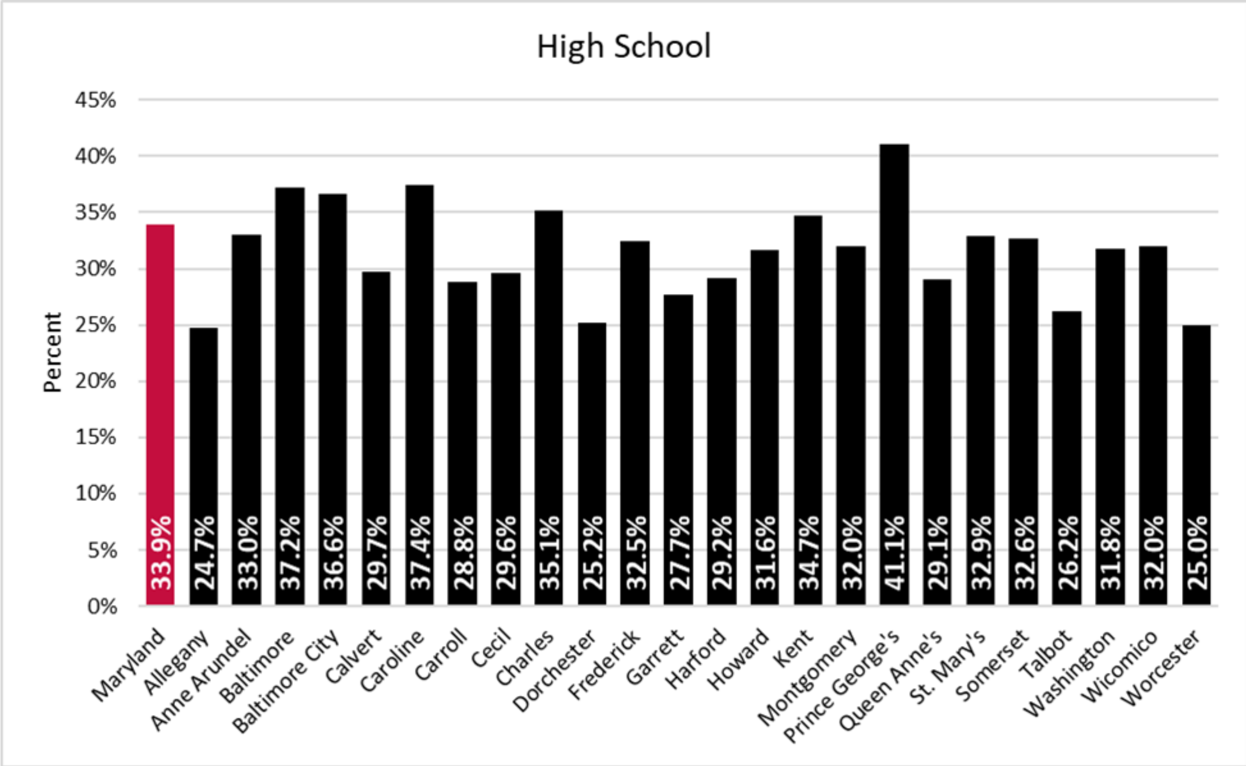
Figure J: Maryland High School Students Witnessing Intimate Partner Violence and Behavior, YRBS



As illustrated above, Maryland high school students who reported having witnessed intimate partner violence in their home demonstrated higher rates across all risk behaviors assessed in the Youth Risk Behavior Survey (YRBS). Among Maryland high school students, witnessing intimate partner violence increases risk taking behaviors and has a negative influence on mental health. 57.8% of students who have witnessed intimate partner violence feel sad of hopeless compared to 31.6% of students who have not witnessed intimate partner violence.

The 2022-2023 Maryland YRBS/YTS identified high school students who reported having witnessed intimate partner violence in their home demonstrated higher rates across all risk behaviors assessed in the Youth Risk Behavior Survey (YRBS). Witnessing intimate partner violence (IPV) was reported by 18.1% of high school students in Maryland with varying frequency, including 10.9% who experienced it rarely, 5.0% sometimes, 1.5% most of the time, and 0.6% always. Distinct racial and ethnic disparities are visible in the data, 25.8% of high school students identifying as Native American reported exposure to this ACE (5.8% rarely,15.8% sometimes, 1.4% most of the time, and 2.8% always). 24.1% of high schoolers identifying as multi-racial report exposure to this ACE (14.3% rarely, 6.8% sometimes, 2.0% most of the time and 0.9% always). Youth who witness IPV have an increased risk of poor social skills, behavioral issues, and unhealthy caregiver relationships.

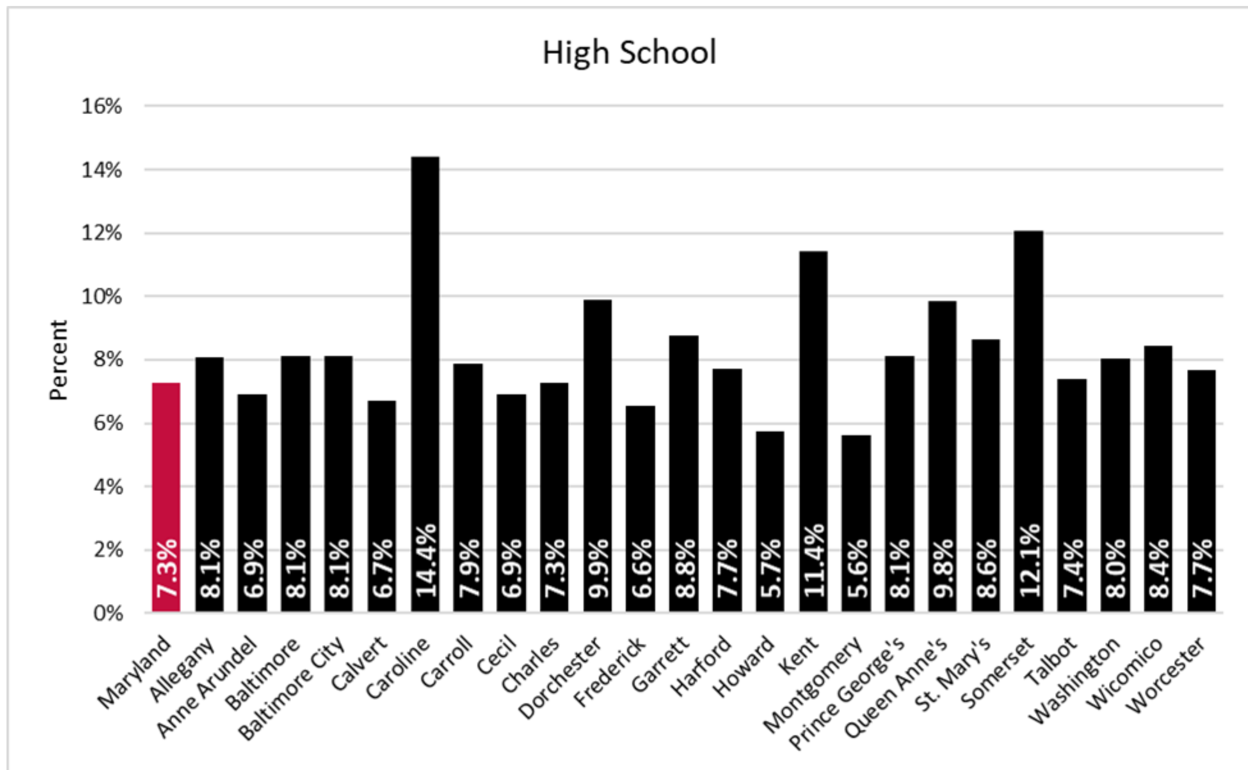
Figure K: Percentage of Maryland High School Students Being Physically Abused, YRBS



As illustrated above, rates of physical abuse are higher in several counties, including Prince George's (41.1%), Caroline (37.4%), and Baltimore County (37.2%).

The 2022-2023 Maryland YRBS/YTS introduced a new question assessing physical abuse, defined as a parent or other adult in the home ever hitting, beating, kicking, or physically hurting the youth. Physical abuse emerges as a major ACE, affecting one in three high school students (33.8%). Specifically, 21.4% reported such incidents occurring rarely, 9.6% sometimes, 2.0% most of the time, and 0.8% always. The racial group with the highest exposure is black with 41.4% (24.1% rarely, 13.4% sometimes, 3.0% most of the time and 0.9% always), followed by multi racial with 41.1% reporting exposure (26.4% rarely, 11.3% sometimes, 1.7% most of the time, and 1.8% always).

Figure L: Percentage of Maryland High School Students Being Sexually Abused by Jurisdiction, YRBS



As illustrated above, high school students who reported being sexually abused varied between jurisdictions, with the most occurring in Caroline (14.4%), Somerset (12.1%), and Kent (11.4%) Counties. It is found least often in Montgomery County (5.6%), Howard County (5.7%), and Frederick County (6.6%).

The 2022-2023 Maryland YRBS/YTS revealed that sexual abuse is a concerning issue among high school students, with 7.4% (3,049) reporting experiencing sexual abuse in their lifetime. The data showed significant disparities, with females (11.3%) and males (3.5%) reporting experiencing sexual abuse. Students with a racial identity of “other,” (14.3%), multiracial students (10.8%), and Hispanic/Latino students (9.1%) reported higher rates of sexual abuse compared to their counterparts. These findings highlight the urgent need for targeted interventions and support services to address sexual abuse and its potential long-term consequences for Maryland youth, particularly for vulnerable population.

Trauma Informed Care Commission

The Trauma Informed Care Commission, established by the Maryland General Assembly in 2021, plays a crucial role in advancing the state's commitment to trauma-responsive care. For administrative reasons it was placed under DHS and since that time the meetings have not taken place stalling this important work. To ensure the Commission's effectiveness, meetings should resume, with the existing membership to preserve the valuable expertise and experience of the members. A consistent meeting schedule should be reestablished, ensuring continuity and predictability.

SCCAN recommends the following:

- **Public Accessibility:** Continue the practice of holding open public meetings and archiving them on a public platform, fostering transparency and accountability.
- **Focus Areas:** Prioritize the Commission's focus on developing and implementing evidence-based policies and practices related to trauma-informed care.

The Trauma-Informed Care Commission held its final meeting in February 2024, concluding several years of dedicated work to advance trauma-responsive systems across Maryland. Although the Commission has formally ended, many of its members continue to emphasize that significant work remains. Ensuring that every Maryland agency adopts trauma-informed policies and practices is essential to effectively recognizing, preventing, and responding to the pervasive impact of trauma. Sustained commitment and coordinated, evidence-based action is necessary to build a statewide system that supports positive outcomes for all Marylanders.

The trauma-informed care commission meetings demonstrated commitment to open communication, public engagement, and the advancement of trauma-informed care. By reinstating the Commission, DHS can leverage its existing strengths and build upon its past successes.

The Commission's work aligns with broader state goals related to mental health, child welfare, and social justice. By prioritizing trauma-informed care, the state can improve the well-being of its citizens and create a more equitable and inclusive society.

By reinstating the Trauma Informed Care Commission, DHS can demonstrate its commitment to the well-being of individuals who have experienced trauma. We urge DHS to provide the necessary support for the Commission's work and ensure its continued success.

SCCAN's Accomplishments in 2024

In 2024, SCCAN successfully filled most open positions. While a few members resigned during the year, the majority of vacancies were promptly filled and remained occupied throughout the year.

The only longstanding vacancy was the seat designated for the Department of Juvenile Services, SCCAN continues to emphasize the importance of full agency participation to support its mission of coordinating and strengthening Maryland's child protection system.

Achieving Racial Equity Workgroup

Background: A full review of the history of racism in the U.S. child welfare system can be found in the preamble of SCCAN's antiracism statement in Appendix D. During the course of writing the Anti Racist Statement for the Essentials for Childhood Workgroup, the SCCAN Anti Racist Statement was reviewed. It was determined that the statement was not in need of revision, which speaks to the dedication of the Workgroup as they were composing the Anti Racist Statement years ago.

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

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

The Workgroup:

- Developed an Anti-Racism statement which was adopted by SCCAN. (See Appendix D).
- Prioritized 2021 Child Welfare Data Bill, HB258/SB592 which requires the Maryland Department of Human Services and Maryland Department of Education to provide disaggregated data by race, gender, age, and geographic region on outcomes for children and youth in Maryland's Child Welfare System. The bill passed both the House and Senate unanimously.

- Provided education to SCCAN and MD EFC members on the history and impact of systemic racism in child welfare and related systems through expert presentations by Dr. Adrianne M. Fletcher, Alexandra Citrin, MSW, MPP, and Maya Pendleton, MPP of the Center for the Study of Social Policy.

Visioning Session:

The Achieving Racial Equity in Child Welfare committee has continued its work by holding a Visioning Session, which took place on December 11, 2023, at Morgan State University. The goal of the Visioning Session was to develop recommendations to address racial inequities at all levels of child welfare. The committee sought input from individuals with lived experience as well as professionals who work in or collaborate with child welfare agencies. The goal was to have equal representation from individuals with lived experience and professionals so that the voices of both groups were heard and incorporated into recommendations. Participants were asked to wear name badges which most prominently displayed their first name, and made no reference to their personal experience, or professional title.

The report was intended to be a reflection of the thoughts and feelings of the participants and not the members of the Workgroup.

Invited speakers included Mr. Rafael Lopez, Secretary of the Maryland Department of Human Resources and Maryland State Delegate C.T. Wilson. Much of the day was devoted to breakout discussions where key questions about improving child welfare were discussed and debated.

Following the Visioning Session, all participant input was thoroughly reviewed and evaluated. Participants were invited to take part in this review process, ensuring that the findings accurately reflected the collective perspectives and priorities shared during the session. A comprehensive report was then developed to summarize the results.

Several key outcomes emerged from the Visioning Session. Participants identified patterns of experience and outcomes, as well as practices and beliefs, that should be eliminated to foster more equitable and trauma-responsive systems. They highlighted community needs and persistent equity challenges, noted critical system breakdowns that require attention, and offered insights on effective strategies to influence meaningful change. In addition, participants underscored the importance of cultivating a culture of coalition building, advancing racial progress, and promoting racial justice as central components of long-term, sustainable improvement.

During 2024 qualitative data and feedback were analyzed, and recommendations were created. Feedback from the Visioning Session was overwhelmingly positive. The Session provided an insight into the child welfare system that would not have been possible otherwise. Additionally, it does not appear as though a similar session has ever been held.

All of the participants encouraged a second session to take place. It was even suggested that the Visioning Session become a regularly held event. One of the most common suggestions was to seek out perspectives from other areas of the State, and perhaps even specific professional and personal perspectives alone.

It is worth noting that some of the former foster youth participants stated that they did not feel as though they could speak as freely as they wanted.

It was also stated that many communities feel as though they are over policed and that their families are undervalued. There were several reasons given for this perspective, and among them was their perceived lack of access to resources. A prevalent perception among many participants was that struggling families who seek out resources would be reported to social services and run the risk of having their children removed from their care.

A recurring theme that emerged from the Visioning Session was the belief that many communities are over-policed. Participants shared that noticeable law-enforcement presence often creates an environment where residents feel distrusted or viewed with suspicion. Importantly, the term "over-policing" was not limited to interactions with police officers. Many participants explained that they also felt over-surveillance and unnecessary interventions from social services, child welfare agencies, and other systems that disproportionately monitor certain communities. These dynamics contribute to feelings of stigma, lack of autonomy, and strained relationships between families and the institutions intended to support them.

It became clear that many of the participants did not feel as though the history of racist practices and the impact that they have had on current family and child serving organizations has been properly recognized.

One suggestion included updating the definition of mandated reporting. During the course of the visioning session several ideas were mentioned ranging from eliminating mandated reporting requirements to implementing stricter reporting requirements. it was suggested that mandated reporting laws, while clearly well-intentioned, have had outcomes that appear to suggest that some filed reports are influenced by cultural biases rather than actual child maltreatment.

A data-driven analysis needs to be conducted in order to learn where the problems exist, how they manifest themselves and to measure successes as they come.

Based on the outcomes of the Session the Workgroup made three recommendations:

1. **Truth Telling and Reconciliation Commission:** Participants clearly stated that the legacy of racist policies has not been adequately addressed. Though efforts have been made by various organizations at various times, their work does not appear to have impacted the lives of many of the Participants. This Commission

should be tasked with identifying ways to acknowledge and address the legacy of racist policies in a way that is recognized by Maryland citizens.

2. **Review Mandated Reporter Laws:** Many participants expressed concern that these laws are often applied in ways that feel punitive and contribute to distrust between families and the systems meant to support them. It was also noted that community members are often better positioned to understand and respond to the challenges they face—without relying on approaches that may unintentionally harm or destabilize families.

3. **Future Visioning Sessions:** Participants universally agreed that the Visioning Session was productive and led to many important conversations that otherwise may not have taken place. Participants with lived experience such as foster youth, while appreciating the opportunities to engage in meaningful dialog, felt restrained in how honest they could be. Holding a Visioning Session for foster youth would provide unique insight and ideas that would not otherwise be known. Another group highlighted during the Visioning Session was front-line workers, many of whom appeared unable to fully devote their attention to the work at hand. Members of the Workgroup discussed possible reasons for this disengagement; however, in keeping with the values of the Visioning process, the only way to gain an accurate understanding is to hear directly from those front-line workers themselves. Their perspectives are essential to identifying barriers, strengthening participation, and ensuring that their lived and professional experiences meaningfully shape the work. In addition, the first Visioning Session was held in Baltimore, and despite significant outreach efforts, it proved challenging to secure participation from individuals in other regions of the state. To ensure more equitable representation and to capture the diverse challenges faced by communities across Maryland, future sessions should be hosted in various locations. Doing so will increase accessibility, broaden participation, and reveal region-specific issues that may not otherwise come to light.

The workgroup continues to make the following recommendations:

(1) Require caseworkers to input race demographic data on all cases brought to the attention of the Department of Human Services.

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

(3) DHS and MSDE should work collaboratively to gather data on educational services received by children in out-of-home care. Comply with the September 27, 2013, MOU in place between DHS and MSDE to allow for the sharing of data regarding foster youth and the federal requirement pursuant to the Every Student Succeeds Act for states to track educational outcomes for foster youth.

(4) Amend current statute to expand data currently collected by Maryland's Department of Human Services and published in their Child Welfare Indicators Report.

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

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

Maryland Essentials for Childhood Initiative

Since 2006, SCCAN has focused its efforts and recommendations on preventing child abuse and neglect *before it occurs* and promoting public and systems awareness of Adverse Childhood Experiences (ACEs) science to inform policy and practice changes in Maryland systems to improve the lives of our children. In 2012 SCCAN adopted the goals of *the Center for Disease Control and Prevention's state level implementation of Essentials for Childhood* as a framework for its efforts and recommendations, working side-by-side with its partners, to create a statewide collective impact initiative—Maryland Essentials for Childhood (MD EFC). The mission of MD EFC is to prevent and mitigate child maltreatment and other ACEs. The overarching strategic goals of MD EFC are as follows:

1) Educate key state leaders, stakeholders, and grassroots organizations on brain science, ACEs, and resilience; in order to build a commitment to put science into action to reduce ACEs and create safe, stable, and nurturing relationships and environments for all Maryland children.

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

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

4) Integrate the Science into Policy and Financing solutions.

The Maryland Essentials for Childhood Initiative has worked statewide toward achieving the four strategic goals above with the purpose of creating the safe, stable, and nurturing relationships and environments that support the healthy development of all Maryland children, i.e., becoming a trauma-informed and resilient state. While MD EFC meetings have been on hold until the Governor's Appointment's Office completed appointment of new SCCAN members, work has continued on priorities initiated in response to the pressing global events of 2020 and 2021, including the impact of the COVID-19 pandemic and systemic racism on Maryland's children. As the pandemic and racial inequity are significant adversities in the lives of Maryland's children, SCCAN and MD EFC members formed two working groups to develop potential solutions to mitigate short and long-term harms of the pandemic and systemic racism within the child welfare system. These include the Achieving Racial Equity within Maryland's Child Welfare System Workgroup and the Childhood Resiliency Workgroup. Below is a brief description of key actions by SCCAN and MD EFC Partners to achieve our collective goals:

- Through a grant from the Maryland Department of Health, Maryland EFC partnered with Maryland Information Network and Frameworks Institute to build a robust website. The website shows the long history of the collaborative effort of the group and explains its mission, vision and values. The development of the website was a team effort led by Jenn Strathman, Claudia Remington and Vanessa Milio.

- Maryland EFC Childhood Resilience Action Team gathered resources from leading experts, our backbone organizations and community partners to give parents and trusted adults easy access to the latest tips to support children. That work helped shape the Brain Building Toolkit which serves as a resource for grownups across the state to access information delineated by age group and developmental milestones. This effort was spearheaded by Claudia Remington with guidance from Frank Kros and the Frameworks Institute.

- In partnership with the Maryland Department of Health and the Frameworks Institute, Maryland EFC developed *Maryland: The State of Resilience, Agencies Working for Everyone (AWE)*. EFC continued the effort, working with Frank Kros to develop a series of training, assessments and implementation strategies for state agencies to become trauma informed; implementation for that phase was expected to be rolled out in 2025.

- Maryland Information Network joined EFC as a backbone organization and developed a customized search database aligned with our mission. The

database, on the MarylandEFC.org website, is a zip-code specific searchable database that allows users to access resources in real time in their community.

- EFC supported the work of the Maryland Commission of Trauma Informed Care

Healthcare Workgroup

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

The workgroup is an interdisciplinary, cross-sector group that aims to bring together members of SCCAN with child health interests, health professionals with child welfare expertise, social workers from DHS, and representatives from other child health serving agencies to improve the health and well-being for children involved with the child welfare system.

SCCAN medical workgroup members meet twice monthly to discuss ongoing priority areas and any more time sensitive issues related to the health of children in out-of-home care. Participating pediatricians included Drs. Wendy Lane, Rebecca Seltzer, and Rachel Dodge, all with expertise in medical care for children in foster care. Additional regular members included Susan DosReis (pharmacist researcher with foster care expertise), the Medical Director for Child Welfare (Dr. Rich Lichenstein) and his team members (Lisa Horne and Shawnett Mills).

In 2024 the Workgroup focused on two priority areas, population level focus and individual level focus.

Population Level Focus:

The data sharing between DHS and the various sources of health data (ie. MDH, CRISP, the various MCOs, etc.) was reviewed to better understand the quality of the care that children in out-of-home care are receiving.

Currently data sharing is limited, and it has not been possible to answer basic questions about health care quality and delivery for children in out-of-home care. It is also unclear what quality health care metrics are available for this population.

Efforts have included reaching out to other States to learn what data use agreements currently exist, and what methods were used to address any barriers, or potential barriers. Dr. Lichenstein is a member of a national child welfare medical director working group, which is a potential source of support in this work.

Several meetings and conversations have taken place to better learn what meaningful delivery methods and data collection methods are being used that would be meaningful in Maryland.

Currently, the Health Choice report published by MDH shares some pediatric quality measures. Existing data (analyzed by Hilltop) could be used to pull out the population of children in OOH care to get a better look at their data from a specific population level---and compared to other pediatric populations, is currently being evaluated.

The Workgroup has been working to identify other relevant parties that need to be involved in this work from relevant health care data/analytic systems--- MDTHINK, CJAMS, MDH, Hilltop Institute.

Of note, some states have all children in out of home (OOH) care enrolled in a single MCO. In discussions about this model, we have asked for information on how many children in OOH care are within each MCO to try to understand how health care measures may differ by MCO. We have not been able to secure that information.

Individual child level focus (data monitoring and clinical care):

Data sharing between child welfare and health care at the individual child level needs to improve to provide better healthcare delivery. This includes improving the timely sharing of health care encounter data with child welfare and improving notification to medical providers that a patient is in out-of-home placement.

The Medical Director and his team now have access to **information from CRISP**, the state designated Health Information Exchange for Maryland. Lists of children in foster care can now be submitted to CRISP, and notifications can be received about visits and hospitalizations. This access to CRISP has improved access to some child-level health data (e.g., immunizations, ED visits and hospitalization, select outpatient visits, some lab and medication data).

(1) There continues to be no way for medical providers to be made aware in a timely fashion that a child is in out-of-home care or has a change in placement (to another OOH placement or reunified with family). This has implications for timely care, effective care coordination, and healthcare monitoring. While special needs coordinators within MCOs are able to see a child's e-track status to know if they are in OOH care, the direct care provider (i.e., physician, NP) is not made aware of this status in any proactive manner. Currently medical providers learn that a patient is in OOH care because their child shows up to the appointment with a case worker or the resource parent.

(2) States such as Ohio have implemented near real-time data sharing between child welfare and health care system EMRs using a platform called Cordata. This platform has been explored by Maryland child welfare, but the current plan is to use a different platform to create the Health Passport.

(3) Some relevant data may be found in the Medicaid e-track code. The Workgroup has tried to better understand the e-track codes, also known as e-codes within Medicaid (see Appendix E) and have found it challenging to identify the children

and youth in OOH as a distinct population in the data because the e-codes combine several groups together----including those receiving adoption/guardianship subsides and those with other special health care needs.

(4) Within DHS, the Audit Compliance and Quality Improvement (ACQI) unit continues to monitor compliance with standards. Information is gathered from CJAMS and through one-on-one meetings with local department leadership. Guidance on improving oversight is provided to LDSS agencies by the team when needed.

Ongoing Barriers:

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

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

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

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

(2) There has been little progress toward integrating information from Medicaid, and/or CRISP with CJAMS (a HB 1582 requirement). Many other states and jurisdictions, including Texas, Washington, Oregon, Illinois, Washington, D.C., Milwaukee, WI, Allegheny County, PA, San Diego County, CA, and Dade and Monroe Counties, FL have found ways to electronically link Medicaid records with child welfare records, enabling child welfare professionals to have easy access to information about health visits and medications.[2] Without this data, it is difficult, if not impossible to assess whether children are receiving quality care by HEDIS or other valid measures.

(3) Foster care workers continue to have primary responsibility for health care oversight of the children in their caseload. A survey of LDSS Assistant Directors completed in October 2021 respondents indicated that they would like additional assistance, particularly for mental and behavioral health issues, health and developmental issues, informed consent for psychotropic medication use, case management, and completion of required health visits. The pilot program in Harford County using Medicaid Case Managers, if successful, could serve as a model for other jurisdictions.

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

Although ensuring best practice medical review and evaluation of cases of suspected child abuse and neglect (**HB 1582 requirement 1 above**) has not been a major focus of the Medical Director for Child Welfare, efforts are underway by Maryland Child Abuse Medical Professionals (CHAMP) to work with the Maryland Department of Health on these issues.

High-quality, effective systems for providing health care to children with suspected abuse and neglect require expert oversight, continuous quality improvement, continuing education for providers, and stable funding. Multiple agencies, organizations, and experts have established these criteria as best practices for the evaluation of children with suspected child abuse and neglect.[3]

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

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

Jenny C, Crawford-Jakubiak JE, and Committee on Child Abuse and Neglect. The evaluation of children in the primary care setting when sexual abuse is suspected. Pediatrics. 2013;132:e558.

While CHAMP provides training and CQI to providers and CACs around the state, the following *structural issues inhibit optimal care*:

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

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

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

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

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

Key Stakeholders:

National Children's Alliance. National Standards of Accreditation for Children's Advocacy Centers 2023 Edition. Online at: https://www.nationalchildrensalliance.org/wp-content/uploads/2021/10/2023-RedBook-v5B-t-Final-Web.pdf;

National Optional Standards of Accreditation for Children's Advocacy Centers 2023 Edition. Online at: https://www.nationalchildrensalliance.org/wp-content/uploads/2022/03/2023-Optional-Standards-Book.pdf.

U.S. Department of Justice Office on Violence Against Women. A National Protocol for Sexual Assualt Medical Forensic Examinations Adults/Adolescents, 2nd Ed. Washington: D.C.: U.S. Department of Justice, April 2013. Online at: https://www.ojp.gov/pdffiles1/owv/228119.pdf

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

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

Stakeholders and their potential roles may include, but are not limited to:

- *Maryland Children's Alliance (MCA)* – Can assist CACs in meeting NCA medical standards for physical and sexual abuse investigations. MCA can continue to partner with CHAMP to educate about NCA medical standards and can develop templates for medical linkage agreements which require participation in training and peer review.
- *Maryland Department of Human Services* – Can mandate that local DSS agencies use child abuse experts to perform medical exams or review exams done by non-experts. DHS can also require that multidisciplinary investigations of physical and sexual abuse include medical input.
- *Maryland Department of Health –* Can convene other stakeholders for system improvement, guide Maryland Board of Nursing to enforce standards for training/peer review of providers and can support the CHAMP program through collaborative partnership.
- *Maryland Medicaid* – Can create billing code modifiers that enable payment for services regardless of Medicaid MCO.
- *Governor's Office of Crime Prevention, Youth and Victim Services (GOCPYVS)* – Can work with other agencies to streamline medical services and funding for child maltreatment. The Maryland Children's Cabinet, responsible for coordinating the state agencies that serve Maryland children, is chaired by the GOCPYV Executive Director, and includes Secretaries from the Departments of Health, Human Services, Juvenile Services, Budget and Finance, as well as the State Superintendent of Schools.
- *State's and County Attorneys* – Can pay for expert testimony for child abuse cases in CINA and criminal courts or contribute dollars to a single funding stream.
- *Maryland Chapter of American Academy of Pediatrics (MDAAP):* Can educate pediatricians about the health needs of children being evaluated for suspected abuse or neglect and those in foster care and can provide feedback to DHS and MDH on the implementation of new protocols or policies. The MDAAP can also advocate for legislative changes that can address system issues.
- *Children's Cabinet* - Can implement specialized protocols for identifying and reporting suspected abuse or neglect among youth under its supervision, custody, or care. Additionally, DJS can ensure that intake assessments for "Children in Need of Assistance" (CINA) include rigorous screening for maltreatment to facilitate early intervention and appropriate service referrals.
- *Department of Juvenile Services* - Can lead the coordination of cross-agency strategies to improve child safety and well-being by establishing a unified three-year plan for interagency service delivery. Through the Children's Cabinet

Interagency Fund, it can also target financial resources toward local community-based programs that address service gaps for vulnerable families.

- *Maryland State Department of Education (MSDE)* – Can ensure that school-based health centers and counselors are trained to identify the long-term impact of ACEs and coordinate with local CACs to support the educational stability of children in transition. MSDE also plays a vital role in data sharing to help the Children's Cabinet track outcomes for youth in foster care or unlicensed settings.
- *Local Management Boards (LMBs)* – Can act as the local arm of the Children's Cabinet to identify jurisdiction-specific gaps in service and redirect Interagency Fund dollars toward community-based prevention programs, such as safe sleep ambassadors or mental health supports.

Maryland CHAMP is currently working to financially support more CACs and to work more collaboratively with hospital-based forensic nurse examiner programs. CHAMP is also working with MDH to address structural issues.

(1) The issues with CJAMS operability, including problems with data entry and creation of reports must be fixed as soon as possible; data system linkages and an electronic health passport cannot be created without a fully functional CJAMS system. Personnel and financial resources must be dedicated to this effort.
(2) Create an electronic health passport to replace the current paper passport, as is required by Md. Code Ann., Human Services § 8-1101- 8-1103 (2018). This electronic passport is vital to ensure that foster youth, foster care workers, foster parents, biologic parents, and health care providers have access to critical health information.
(3) Direct Maryland Medicaid, CRISP, and the Child Welfare Medical Director to link Medicaid and CRISP data to CJAMS to meet the requirements of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the tracking of health care outcomes using HEDIS or other quality measures.
(4) Mandate access to foster youth health care information by necessary personnel at Medicaid, CRISP, and DHS in order to carry out the purposes of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018). Require CRISP to notify PCPs of changes in placement so that the PCP can more effectively serve as a medical home for children in foster care.
(5) Direct the Child Welfare Medical Director, Medicaid, Medicaid Managed Care Organizations, and their special needs case managers to identify ways in which case managers can assist with ensuring health care needs of foster youth are met beyond the initial and comprehensive health screenings, including analyzing health care quality measures for children in care to meet the requirements of the statute.
(6) Direct the Child Welfare Medical Director to work with Maryland CHAMP (Child Abuse Medical Professionals) to ensure best practice medical review and evaluation of cases of suspected abuse or neglect to meet the requirements of the statute.
(7) Create at least 2 additional positions at DHS for physicians or nurse practitioners to assist the Medical Director in reviewing health care data, assessing quality of

care, and providing input to local DSS agencies. One of these positions should be filled by a child psychiatrist to address psychotropic medication prescribing, including informed consent.

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

(9) Consider legislation passed in other states (e.g., Florida, New Jersey, Kansas) as a model to centralize and coordinate funding for hospital and CAC-based medical services provided by physicians, advanced practice nurses, and forensic nurse examiners. Include mandated expert consultation as a condition of funding, as this is required for CAC accreditation by the National Children’s Alliance. Maximizing use of MCO special needs coordinator in more proactive way to ensure medical providers are aware when a child is foster care and offer more proactive care management for all kids in OOH care

(10) MDH should work to reclassify e-track codes to better separate out children and youth in OOH care vs those receiving adoption/guardianship subsidies and other special needs populations. This would support better data analysis and healthcare monitoring for the OOH population specifically.

(11) Identify an MDH representative(s) to serve on this SCCAN medical subcommittee workgroup.

Appendix A

DHS Response

Wes Moore, Governor . Aruna Miller, Lt. Governor . Gloria Brown Burnett, Interim Secretary

March 31, 2026

Stacey Brown, M.Ed, LCPC, Chair
State Council on Child Abuse and Neglect (SCCAN)
The Family Tree
1800 Washington Blvd, Suite 445
Baltimore, MD 21230
sbrown@familytreemd.org

Dear Ms. Brown and SCCAN Members:

The Department of Human Services (DHS), Social Services Administration (SSA) values the advocacy of the State Council on Child Abuse and Neglect (SCCAN) does on behalf of Maryland's children and families. DHS is committed to achieving a new era of child welfare—one that is trauma-responsive, family-centered, outcomes-driven, community-focused, and individualized; this requires the dedicated partnership of various stakeholders. We are pleased to provide an update on our four focus items from last year:

1. Prioritizing kinship care;
2. Increasing our share of federal funds;
3. Implementing rate reform so children have the care they need; and

4. Reducing hospital overstays and other stays in unlicensed settings.

Prioritizing Kinship Placements

In state fiscal year 2024, fewer than one quarter of young people in Maryland's out-of-home care lived with kin. In December 2024, we launched Family Matters, a bold new approach to strengthening family connections for youth experiencing foster care and increasing the number of youth who live with kin. Family Matters is grounded in research that highlights the importance of familial bonds to child development and well-being. Family Matters reflects our belief that every child deserves a safe, loving, and stable home with people they know and trust while staying in their communities of origin whenever possible.

Key features of Family Matters include a kin-first philosophy and support that meets the needs of kinship families. The passage of House Bill 1499 / Senate Bill 708 (2024) provides a mechanism to increase kin support. Family Matters shifts our culture and practices across the agency to strengthen and support familial relationships, cultural, and community ties.

Through the Family Matters initiative, DHS moved quickly to implement the state's new kinship law. At the end of February 2026, 33% of kids in Maryland out-of-home care were placed with kin, which is an increase from 25% in November 2024 (the month preceding the launch of Family Matters), representing approximately 300additional children living with family by blood or by choice. Additionally, 87% of kinship caregivers are now licensed, which means they can receive additional financial support, compared to 25% last December.

Increasing our Federal Fund Drawdown

In the first quarter of calendar year 2024, Maryland claimed an additional $5.1 million in federal funds over federal claims in prior quarters. During the calendar year 2024, Maryland claimed $6.2 million in federal foster care prevention services administrative costs through the Family First Prevention Services Act (FFPSA). These increases are a result of a deliberate effort to review and improve practice. **Implementing Rate Reform**

Thanks to the support of the budget committees and the Governor's Office, new rates for Residential Child Care providers went into effect on October 1, 2024. Our $27 million dollar investment created a class-based rate structure that is improving providers' ability to meet the needs of Maryland children and families.

Our new way of compensating out-of-home care providers is already improving the breadth of services. A wider range of services reduces out-of-state placements, hospital admissions, and hospital overstays. With the new rates came clear expectations aligned with the Moore-Miller Administration Values, rooted in being responsive, moving urgently, being data-driven, heart-led, and challenging the status quo. Our provider partners are held accountable for timely response to our referrals, accepting Maryland youth to prevent out-of-state placements, and offering innovative and evidence-based services Maryland youth need.

Reducing Hospital Overstays and Other Stays in Unlicensed Settings

Since January 2023, we've taken major steps forward to limit the number of youth who experience a hotel or hospital overstay. We are building on that momentum and continuing our work in 2025.

We have lowered the number of youth experiencing hospital overstays by increasing communication and closing systemic gaps in our system. A pediatric hospital overstay is currently statutorily defined as 48 hours or more beyond medical necessity. As of March 27, 2026, there are eleven DHS youth in hospital overstay status, with five having a plan for transition, and zero DHS youth in hotels. For comparison, in July 2024, 32 youth were in hotel stays .

We have eliminated hotel stays through a directive issued on October 22, 2025 that clarifies that we will not facilitate the use of hotels or other unlicensed settings for youth experiencing out-of-home care. This memorandum directed all LDSS to immediately stop facilitating stays in unlicensing settings and to move all youth which were in a hotel stay to a licensed placement setting appropriate to their needs no later than November 24, 2025. Since that date, no youth has experienced a hotel stay.

We hired a hospital liaison whose sole purpose is coordinating efforts and communicating with all of the hospitals serving our youth. The DHS case team and respective hospital staff meet weekly to ensure effective communication and to enhance responsiveness.

DHS is committed to working with our partners to meet the needs of our youth with timely and appropriate services and placement options.

Data Integrity and Transparency

Prior to the Moore Miller Administration, data on child fatalities, family preservation services, hotel stays, and hospital stays were either not tracked or were tracked manually. We continue to discover where data was routinely released without any validation or reconciliation in the child welfare data reporting processes we inherited.

We prioritized improving the data integrity and validation practices, launching a Data Office using existing budgetary allocations. One of the Data Office's priorities was the development and publication of an interactive digital dashboard showcasing key statistics about SSA's work with children and families. The dashboard went live with data points on placements, lengths of stay, and other child welfare indicators, published in ways that protect privacy and confidentiality. DHS temporarily took down the dashboard in 2025 to refine the report and enhance its functionality; it was republished January 2, 2026.

Our work over the past year has been significantly aligned with many of the recommendations SCCAN has outlined in the 2024 SCCAN Annual Report.

Please see our response below to several of the report's recommendations:

1. **<u>Observation Recommendation #3:</u> CJAMS continues to have operability issues. Personnel and financial resources need to be provided immediately to address CJAMS operability issues.**
    - **DHS Response:** DHS continues to partner with MD Benefits to ensure all systems in the Department's portfolio, specifically CJAMS, operates at maximum capacity.
2. **<u>SCCAN Observation Recommendation #4:</u> Work collaboratively to gather data on the timely and effective educational services received by children in out-of-home care and track educational outcomes for foster youth.**
    - **DHS Response**: The Moore-Miller Administration, since taking office, has prioritized urgent collaboration and partnership across state agencies, emphasizing a data-driven and heart-led approach. While the previous Administration let the prior Memorandum of Understanding (MOU) on educational data sharing lapse, DHS continues to work with Maryland State Department of Education (MSDE) to enhance data sharing opportunities. We are continuing discussions with MSDE to finalize a path forward.
3. **<u>SCCAN Observation Recommendation #5:</u> Pass legislation to amend Md. Code Ann., Family Law § 5-1312 (2021) to include additional data to be collected by DHS and Maryland State Department of Education (MSDE) on youth in foster care.**
    - **DHS Response**: As mentioned in the previous response, DHS continues to work with Maryland State Department of Education (MSDE) to enhance data sharing opportunities. DHS is always willing to partner with our sister agencies and the General Assembly on proposed legislation.
4. **<u>SCCAN Achieving Racial Equity Recommendation #1:</u> Require race demographic data on all cases accepted by the Department of Human Services (DHS), in order to examine disparate outcomes.**

Attempts should be made to gather data for all families referred to

CPS, screened out, received Investigative Response, received Alternative Response or Non-CPS Risk of Harm Response, as well as those referred to and receiving services.

- **DHS Response**: DHS currently captures race demographic data related to Child Protective Services (CPS) investigations in the CJAMS system. This includes cases that receive an Investigative Response, Alternative Response, or Non-CPS Risk of Harm Response. However, it is important to note that viable demographic data for CPS reports that are "screened out" is not currently available.

5. **SCCAN Achieving Racial Equity Recommendation #2: DHS should make Child welfare and health-related data publicly available. This should include data that is disaggregated by race, gender, ethnicity, age and geographic region. The data should also be disaggregated at the system level (i.e., referrals, pathways, and services).**

    - **DHS Response**: Health-related data is already included in the annual statutory report authorized in Human Services Article §8-1102(c), formerly known as the Medical Director's Report. This data is separated by geographic region and health services utilization. However, DHS currently does not disaggregate and report on all health services based on race, age, or ethnicity. The public dashboard for SSA includes disaggregated information by race, gender, age and geographic region for youth in Out-of-Home care. Further, the Child Welfare Systems report, completed pursuant to Family Law § 5-1312(b), includes data disaggregated by race, gender, age and jurisdiction across services types and for outcome measures.

6. **SCCAN Achieving Racial Equity Recommendation #3: Neglect referrals should be disaggregated by risk factors (substance abuse, mental health, history of child maltreatment, poverty and economic hardship, domestic abuse, etc.**

- **DHS Response**: To determine what data is available and feasible to collect, SCCAN would need to clarify the question it seeks to answer with this information.

7. **SCCAN Achieving Racial Equity Recommendation #4: Compliance with the 2013 MOU allowing data sharing for foster youth between DHS and MSDE, as well as the requirements of Every Student Succeeds Act, to track educational outcomes for foster youth.**

    - **DHS Response**: Please see response provided in #2 and #3 as this is a duplicative recommendation.

8. **SCCAN Achieving Racial Equity Recommendation #6: Pass legislation that requires all employees and family services workers, particularly child welfare workers, in the state of Maryland to receive racial bias training. This training should focus on the role of bias and racism in child abuse and neglect reporting.**

    - **DHS Response**: DHS is collaborating closely with legal partners to interpret the ramifications of recent federal Administration Executive Orders and other emerging stipulations concerning Diversity, Equity, and Inclusion, particularly as they relate to the utilization of federal funding.

9. **SCCAN Trauma Informed Care Commission Recommendation: By reinstating the Trauma Informed Care Commission, DHS can demonstrate its commitment to the well-being of individuals who have experienced trauma. We urge DHS to provide the necessary support for the Commission's work and ensure its continued success.**

    - **DHS Response**: DHS conducted a thorough review of the

      Commission on Trauma-Informed Care's work to date after its transfer via Executive Order and concluded that the Commission has achieved its statutory purpose. We are deeply grateful to Commission members for their leadership and service. For additional information, please see the Commission's 2024 Annual Report.

10. **<u>Healthcare Recommendation #1:</u> In accordance with Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), an electronic health passport should be created. This will ensure that not only the foster youth themselves, but everyone providing services will have access to this important information. Without a fully operational Maryland Total Human-services Integrated Network MD THINK/CJAMS platform, key tools like data linkages and a health passport cannot move forward.**

    - **DHS Response:** In 2024, DHS began to work on a procurement for an Electronic Health Passport which would not only include real-time data from CRISP but would also allow a caregiver and medical professionals to have real-time portal access to view key information, upload documents. Once implemented this will be the first of its kind in Maryland. The procurement for the Electronic Health Passport platform was approved by the Board of Public Works on December 3, 2025.

11. **<u>CHAMP recommendation #8:</u> Direct the Child Welfare Medical Director to work with Maryland CHAMP (Child Abuse Medical Professionals) to ensure best practice medical review and evaluation of cases of suspected abuse or neglect to meet the requirements of the statute.**

    - **DHS Response:** The Child Welfare Medical Director has had and maintains a strong working relationship with the Maryland CHAMP. DHS will be working closely with Maryland CHAMP to educate Local Department staff on the program and how to access services and resources.

Additional responses to the SCCAN report:

1. Page 14 of the report states, "Data was not made available to indicate the types of services, if any services were offered, or accepted by, families. Many of the children that are referred to child welfare services have experienced several significant risk factors that lead to a greater likelihood of poor short term and long-term outcomes."

    - **DHS Response:** There was no request made by SCCAN for this data, despite our efforts to clarify their needs.

2. Page 24 of the report expresses a need for fatality for the FFY 2025 report.

   - **DHS Response:** In response to the Joint Chairman's Report (JCR) from the General Assembly, DHS submits an annual fatality report and would recommend SCCAN obtain data from that publicly available report.

We remain committed to transforming our child welfare system to a child and family well-being system and invite SCCAN to be partners in this work, as we aim to ensure successful outcomes for the children and families of Maryland.

Sincerely,

Dr. Alger M. Studstill, Jr.
Executive Director, Social Services Administration
Maryland Department of Human Services

CC: Gloria Brown Burnett, DHS Interim Secretary
Web Ye, DHS Chief of Staff
Heather Zenone, DHS Assistant Secretary of Policy and Data
Tennille Thomas, SSA Principal Deputy Executive Director
Remonte Green, SSA Deputy Executive Director
Angelique Salizan, SSA Chief of Staff
Edward "Ted" Gallo, SCCAN Executive Director

Appendix B

State Council on Child Abuse and Neglect (SCCAN)

SCCAN
Membership

15 MEMBERS APPOINTED BY THE GOVERNOR

Name	Representing	Jurisdiction	Email	Term Expires
Stacey Brown	The Family Tree	Baltimore City	sbrown@familytreemd.org	1st-7/2025
Jody Burghardt	JSSA	Montgomery County	jburghardt@jssa.org	1st-7/2026
Kelly Jaskiewicz	Maryland State Police		kelly.jaskiewicz@maryland.gov	1st-3/2024
Erica LeMon	Maryland Legal Aid	Statewide	elemonesq@gmail.com	1st- 7/2026
Paul Marziale	Harford County Sheriff	Harford County	marziale@harfordsheriff.org	1st-7/2026
Ademola Oduyebo		Prince George's County	odubeyond@gmail.com	1st-7/2026
Rebecca Seltzer	American Academy of Pediatrics	Baltimore County	rseltze2@jhmi.edu	1st-7/2026
Jamie Sheppard	Personal experience	Baltimore County	jsmithshepard@gmail.com	1st -7/2026

Lisa Weah	New Shiloh Baptist Church	Baltimore County	drweah@gmail.com	1st-7/2025
Rowan Willis-Powell	Personal Experience	Baltimore City	rowan.willis.powell@gmail.com	1st-7/2025
Taniesha Woods	Maryland Family Network		twoods@marylandfamilynetwork.org	1st-7/2025
VACANT				
VACANT				
VACANT				
VACANT				

8 POSITIONS FILLED BY DESIGNATION OF THEIR ORGANIZATIONS

Name	Representing	Email	Address
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Appendix C

Final Definitions Adopted by the Commission on Trauma-Informed Care

(Adopted 09.18.23)

Trauma:
Trauma is one possible response to adversity. A traumatic event can be an experience, series of experiences, or circumstances. (Some examples of possible traumatic events include natural disasters, violence, child neglect). A person may experience a traumatic event directly or indirectly. If a person experiences a traumatic event as overwhelming or life-changing, it may have lasting negative effects on that person. The negative effects may be physical, emotional, mental, or spiritual. The lasting effects are related to the person's experiences, including the support they get after the traumatic event.

Trauma-Informed:
Because the impact of trauma is widespread, it makes sense for programs, organizations, and systems to be trauma-informed. Being trauma-informed starts with learning about the impact of trauma and the possible paths for recovery from it. It also involves recognizing the signs and symptoms of trauma. A trauma-informed program, organization, or system builds in effective ways of acting on this knowledge. That could mean changing policies, procedures, practices, or culture in ways that respond effectively to trauma. A trauma-informed organization actively works to avoid re-traumatizing people. For a system to respond most effectively to trauma, it may require agencies to work together, secure and share resources, and develop or adapt services.

Trauma-Responsive:
Organizations are trauma-responsive when they adopt ongoing processes to change their culture to highlight the importance of trauma and resilience. All levels of staff begin rethinking routines and the infrastructure of the organization. Discussion among staff and leadership takes place to consider improved routines and how to implement them. Ongoing training is provided for staff as the agency engages those with lived experiences to participate in the change process to include their perspectives.

Secondary Traumatic Stress:
Staff and volunteers may be negatively affected by hearing about the traumatic events that others experience. When this happens, it is called secondary traumatic stress. Secondary traumatic stress can affect staff and volunteers' emotions, thoughts, and actions.

Sometimes the effects can be so strong that it undermines the quality of the staff and volunteers' work or life. The risk of secondary traumatic stress is related to the staff and volunteers' overall wellbeing and their own history with trauma.
It is important that organizations and supervisors are aware of the risk of secondary traumatic stress. This awareness allows them to protect workers' wellbeing and ensure that people with trauma get the best possible care from those who support them.

Equity:
Equity means fairness and justice. It involves ensuring that every individual and group gets what they need to thrive and participate fully in society. Achieving equity often asks us to rethink uniform, one-size-fits-all treatment. It sometimes involves devoting more resources or different resources in communities that face injustice, to correct imbalances caused by unfair or unequal treatment.

Protective Factors:
Protective factors are conditions or attributes that build health or well-being. Protective factors work by reducing the chance of experiencing adversity, buffering against the stress caused by adversity, or limiting the impact of adversity. Protective factors can come from individuals, families, or communities. They include nurturing relationships, supportive social networks, tangible resources, and social and emotional skills.

Resiliency:
Resilience is an adaptive (positive) response to serious hardship. Resilience is the result of a combination of protective factors that reduce the chance of experiencing adversity or buffer against the stress caused by adversity. People may have individual strengths and resources that make resilience more likely, but resilience is always influenced by a person's surroundings and circumstances. The active ingredients in building resilience are supports from family, caring adults, community, and systems.

Racial Equity:
Racial equity means fairness, justice, and equal outcomes for people and communities of color. Achieving racial equity involves an intentional, continual, practice of eliminating racial and ethnic disparities. This work focuses on changing unfair or uneven policies, practices, systems, and structures. Working toward racial equity improves outcomes for everyone, while making it a priority to create measurable, positive change in the lives of people of color. Everyone benefits when every community member is allocated the resources and opportunities needed to build well-being.

Family Lens:
A family lens involves looking at trauma and resilience from the perspective of families, not just individuals. Through a family lens, we can see that a build-up of traumatic events for even one member of a family can affect other family members. For example, family dynamics, communication, or relationships could be affected. In turn, a family's

shared trauma response can have a ripple effect on communities. Likewise, families can serve as protective factors that can reduce the chance of experiencing adversity or buffer against the stress caused by adversity.

Cultural Humility:

Cultural humility means aiming to honor other people's beliefs, customs, and values. To do this, it requires a willingness to learn from others and to think about one's own beliefs, biases, assumptions, and actions. Acknowledging differences and accepting others for who they are involves cultural humility.

Intergenerational Trauma:

Genes work like packages of instructions for the body. Experiences can leave a chemical mark on a person's genes, which works like a signature authorizing the genes' instructions to be followed in a certain way. Chemical signatures from trauma can harm people's health by weakening the immune system, increasing the risk for cancer and other diseases, and more.

When people experience trauma, the chemical signature can be passed down to future generations. This is known as an "epigenetic change". Epigenetics helps to explain why the descendants of a person with trauma may show signs and symptoms of trauma or experience negative health outcomes. When this happens, this is known as intergenerational trauma.

Historical trauma:

Historical trauma is a shared reaction to adversity that affects a specific group or community.

Some examples of historic traumatic events include enslavement, the Holocaust, forced migration, and bans on cultural practices. Social and economic systems that last over time, like colonization or systemic racism, are also examples. Sometimes historical trauma affects a particular generation that lives through events like pandemics, wars, or famines.

Appendix D
SCCAN Anti Racist Statement

Preamble

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

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

By 1935, mothers' pension laws had been adopted in 46 states. Similarly, the Social Security Act established Title IV-A, known as Aid to Dependent Children (ADC). However, many states instituted "home suitability clauses" [5], "illegitimate child clauses" and "substitute father in the house clauses". These clauses were established to weed out "immoral homes" and often excluded African Americans from receiving any public welfare benefits. Consequently, states like Mississippi, Florida and Louisiana were notorious for removing African American children from their families because their families were, in their opinion, too poor to take care of children.[6]

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

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

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

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

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

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

SCCAN ANTIRACIST STATEMENT

1. **Racism exists.**

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

In our role as a citizen review panel mandated by CAPTA, SCCAN *"evaluate[s] the extent to which State and local agencies are effectively discharging their child protection responsibilities."*[10] As an advisory body by Maryland law, we *"make recommendations*

annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs."[11] In these roles *SCCAN* is particularly allied with black children and families who are disproportionately represented in and impacted by the child welfare system.

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

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

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

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

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

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

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

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

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

are committed to identify and unlearn dominant narratives in the child welfare and other child and family serving systems.

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

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

6. **White Supremacy Exists**

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

7. **Acknowledgment**

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

8. **Reconciliation and Forward Progress**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix E

Visioning Session Executive Summary

Introduction:

The Achieving Racial Equity for Children and Families Visioning Session (AREV), a collaboration between the Maryland State Council on Child Abuse and Neglect (SCCAN) and Morgan State University (MSU), aimed to inform the SCCAN Annual report on racial equity within child welfare and supporting systems. The visioning session, focused on reimagining equitable responses to families and communities in promoting safe, stable, and nurturing environments for children.

On December 11, 2023, the session held at Morgan State University featured three phases. Phase one delved into perceptions of Child Protective Services'(CPS) responses to Black and non-white families in Maryland, considering the historical legacy of family separation. Phase two centered on imagination and dreaming as tools for empowerment, prompting participants to envision antiracist communities and solutions. Phase three engaged participants in crafting recommendations at individual, systemic, and institutional levels to address entry points that currently lead to racist outcomes. The sessions encouraged introspection, examination of institutional barriers, and the cultivation of a vision for a more just future.

Key Strategies:

To achieve the stated objectives, the AREV Session employed several key strategies, including the inclusion and participation of those with lived experience which was crucial to our endeavor. It was paramount to respect the experience of persons with lived experience in child welfare. We were intentional with including a wide variety of stakeholders in child welfare and supporting agencies including, education, physical and mental health, courts, law enforcement and others. These strategies were designed to leverage strengths, mitigate weaknesses, capitalize on opportunities, and address potential harms.

Outcomes:

The Achieving Racial Equity for Children and Families Visioning Session identified several key outcomes and recommendations:

1. Patterns of Experience and Outcomes: Participants recognized systemic issues such as white advantage gaps, lack of community resources, and oversurveillance and intervention as perpetuating racist outcomes across various sectors of society.

2. Practices and Beliefs to Eliminate: Recommendations highlighted the need to address Anti-Blackness and appreciation of cultural differences, benevolent narratives, punishment models, and other deeply ingrained beliefs perpetuating injustice.

3. Community Needs and Equity Challenges: Identified needs including access to resources, high quality, appropriate and equitable education, quality and affordable childcare, and housing, reflecting a focus on addressing social determinants of health.

4. Confronting System Breakdowns: Strategies such as advocacy, accountability, and self inquiry and deeper understanding of the child welfare system (including historically) were suggested to address systemic issues leading to racially disproportionate outcomes.

5. Ideas for Influencing Change: Recommendations included truth-telling, community building and organizing, identification of supporting systems and effective storytelling to shape policies and practices towards achieving an anti-racist future.

6. Culture of Coalition-Building: Participants envisioned a culture characterized by brave spaces without fear of repercussions, shared decision-making power, and transparency, emphasizing the importance of collaboration and inclusivity and an understanding of supporting systems.

7. Imagining Racial Progress: Aspirations included abolition of the school to prison pipeline industrial complex, the perception of a family policing system, and reparations, reflecting a commitment to transformative change.

8. Advancing Racial Justice with Support: Individuals expressed a desire to invest in families and communities, advocating for resources and an end to punitive practices like involuntary termination of parental rights and incarceration based on poverty.

Conclusion

The Achieving Racial Equity for Children and Families Subcommittee proposes a set of action oriented steps based on feedback from the visioning session attendees:

• Organize and finance ongoing community listening sessions at the neighborhood level.

• Establish pathways for a statewide truth and reconciliation process to acknowledge past harm.

• Develop participatory research initiatives involving leaders from redlined neighborhoods.

• Generate resources for non-punitive alternatives to address mandated reporting concerns and safety measures.

• Enhance skills in restorative approaches to addressing harm prior to resorting to family separation.

• Facilitate discussions among those with similar lived experiences and stakeholders to address issues and find resolutions, potentially within the SCCAN framework or through other channels.

• Challenge Eurocentric cultural norms that exclude certain groups, particularly impacting children's safety and ensure inclusivity is considered.

• Consider legislative actions to support equity initiatives.

• Provide a session exclusively for foster youth. The current and former foster youth attendees indicated a need for a session solely for and focused on foster youth so that they would feel safe, comfortable, and free to share their thoughts and provide input. However, the foster youth appreciated being included and being able to hear others' opinions.

In conclusion, the Achieving Racial Equity for Children and Families Visioning Session marks a strategic effort to incorporate the perspectives of individuals with lived experience and stakeholders in prevention and improvements pertaining to child neglect and abuse. While this session is a starting point, ongoing community involvement and collaboration among relevant organizations and agencies are crucial for sustained progress and effective solutions.

Appendix F

E-Track Codes

Foster Care, Subsidized Adoptions & Former Foster Care - E-Track

E01 Title IV-E or SSI, Foster Care or Subsidized Adoption

Medical Assistance is provided to a foster care or subsidized adoption child who receives. Supplemental Security Income (SSI) or is determined eligible for assistance under Title IV-E of the Social Security Act

E02 Non-Title-IV-E, Foster Care or Special Needs Subsidized Adoption & Subsidized Guardianship Medical Assistance is provided to non-IV-E foster care children who meet the Medical Assistance technical eligibility requirements (e.g., citizenship or eligible alien status, Social Security number). Children eligible for subsidized adoption and subsidized guardianship are also included in this group if they are technically eligible for Medical Assistance and have special needs for medical, mental health, or rehabilitative care. This group also contains independent foster care adolescents not eligible for federal (IV-E) benefits but eligible for state after-care benefits, who can retain MA coverage, without regard to income, until age 21.

E03 State Funded Foster Care
Maryland funds coverage equivalent to Medical Assistance for children in foster care who are not IV-E or SSI eligible and do not meet the Medical Assistance technical eligibility requirements (e.g., citizenship or eligible alien status, Social Security number). Children in this group may not be enrolled in Health Choice or Rare and Expensive Case Management (REM).

E04 State Funded Subsidized Adoption & Subsidized Guardianship
Maryland funds coverage equivalent to Medical Assistance for children in State subsidized adoption and subsidized guardianship who are not IV-E or SSI eligible and either do not meet the Medical Assistance technical eligibility requirements (e.g., citizenship or eligible alien status, Social Security number) or do not have special needs for medical, mental health, or rehabilitative care. Children in this group may not be enrolled in Health Choice or REM.

E05 Former Foster Care up to 26 years old (Mandatory Adult Group Eff. 1/1/2014). Medical Assistance coverage provided without regard to income for individuals up to age 26 who were in foster care (and concurrent Medicaid) in Maryland on their 18th birthday.

Appendix G

Current sources of funding for medical evaluation of child maltreatment

- Sexual Assault Reimbursement Unit (SARU) based at GOCPYVS – reimburses $80/hour up to 5 hours for sexual abuse/assault exams. This rate was established in COMAR about 30 years ago and has not been increased since

- Victim's of Crime Assistance (VOCA) grants – also through GOCPYVS. Most of this money comes from the federal government. The amount of money varies from year to year, and grants are competitive, so there is no guarantee of stable program funding. However, VOCA grants can support provider salaries.

- Maryland CHAMP Program – In addition to providing training and peer review, Maryland CHAMP has funding to support 3-4 medical professionals on a very part-time basis (~5% FTE each)

- Medicaid or other insurance – Most CACs do not have a mechanism for billing insurance. Children who need subspecialist follow-up in an outpatient setting (e.g. x-rays, orthopedic care, genetics, hematology) cannot receive this care if the provider does not accept their insurance or MCO.

- Line-item funding in hospital, local health department, DSS, or law enforcement budget – unstable; based on local budgets.

- Local State's Attorney's Offices, County Attorneys, and DSS Attorneys – may pay for expert review of cases and court testimony.