Subject | 19-0410 The Baltimore City Trauma Responsive Care Act

Prepared by |
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Kimberly Rubens, Fiscal Legislative Analyst, Office of the Council President.

Date |

Policy Objectives

• Ensure that staff working in agencies who deliver services such as after school programs, connections to careers, housing support, among others to youth and families become trauma-responsive, trauma responsiveness is defined as:
  o Understanding the prevalence of trauma,
  o Recognizing its impacts and effects, and
  o Responding by providing services and resources in a manner that does not cause re-traumatization.

• Agencies impacted by this legislation include:
  o Recreation and Parks
  o Mayor’s Office of Employment Development
  o Enoch Pratt Free Libraries
  o Mayor’s Office of Criminal Justice
  o Department of Housing and Community Development
  o Fire Department
  o Parking Authority
  o Department of Finance
  o Department of Law
  o Department of Public Works
  o Department of Transportation
  o Mayor’s Office of Human Services
  o Department of Planning

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1 Re-traumatization is a phenomenon whereby “one’s reaction to a traumatic exposure is colored, intensified, amplified, or shaped by one’s reactions and adaptational style to previous traumatic experiences”. (Duckworth, M. and Follette, V. (May 22, 2012). Retraumatization: Assessment, Treatment, and Prevention. Routledge.)
• The Mayor’s Office of Children and Family Success, in partnership with the City Council, will convene a Baltimore City Trauma-Responsive Workgroup, consisting of representatives of City agencies, service providers, community members, youth, public officials, and additional stakeholders. The Trauma Workgroup will guide the implementation of this plan, providing oversight, guidance, and consultation. The workgroup, along with the Baltimore City Health Department (BCHD), will establish metrics to track progress and ensure results.

• Baltimore City Agency Directors will select at least 2 members of their team to act as Trauma-Responsive Champions
  o Champions will participate in an ongoing training collaborative, facilitated by the BCHD
  o Champions will develop, in partnership with the BCHD, an MOU outlining an agency-specific strategy to include roles, responsibilities, and metrics that will be regularly reviewed

• BCHD will train all trauma champions, facilitate working groups, provide ongoing technical assistance, and develop assessment tools to track the efficacy of this legislation

Fiscal Summary

*City Effect*

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<thead>
<tr>
<th>Bill Component</th>
<th>Number of Participants</th>
<th>Frequency</th>
<th>FTE hours</th>
<th>Projected Cost</th>
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<td>Task Force</td>
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<td>Training</td>
<td>20 (will likely be amended to 24)</td>
<td>At least 1x/year</td>
<td>Total Hours Per Year Per FTE: 7 hours/FTE</td>
<td>The Health Department can accommodate this training with existing staff and resources and predicts no fiscal impact of this training.</td>
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<td>Agency/City Staff on the Workgroup (4 Agency Directors, 2 City Council Members and the Council President)</td>
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<td>Meetings</td>
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<td>At least 6x/year</td>
<td>Total Hours Per Year Per FTE: 9 hours per FTE</td>
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<td>Total Hours for all Agency/City Staff on the Workgroup: 49 hours/year</td>
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<td><strong>Agency Designees</strong></td>
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<td>predicts no fiscal impact of this training.</td>
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<td>Review of Agency Policies and Procedures + Review of training and technical needs</td>
<td>28</td>
<td>Ongoing</td>
<td>Total Hours per year per FTE: 15</td>
<td>Total Hours per year: 420</td>
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<tr>
<td>TOTALS</td>
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<td>Total Hours per year per FTE: 47 hours per FTE</td>
<td>Total Hours per year for all Agency Designees: 1316 hours per year</td>
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**Agency Staff**

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<tr>
<th>Training</th>
<th>Variable depending on the agency designee review of training and technical needs</th>
<th>Variable depending on the agency designee review of training and technical needs</th>
<th>FTE Hours = Variable depending on the agency designee review of training and technical needs</th>
<th>TBD</th>
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**Small Business Effect**

This ordinance has no projected impact on small businesses.
Recommended Amendments

1. Increase the number of days agency heads have to replace an agency designee.
2. Add the following Mayoral appointees to the workgroup: 1 Member of the Research Community, 1 young person, 1 Representative from an organization with an Explicit Focus on Racial Equity in their Mission Statement.
3. Add the following Council President appointees to the workgroup: 1 Representative from an organization with an explicit focus on racial equity in their mission statement.
4. Add the following Ex-Officio (Or Designate) Members: Planning Commissioner.
5. Require the agency designees to work in partnership with equity coordinators at each agency (Council Bill 18-0223) and to review each agency’s equity assessment program in their trauma-informed review of agency policies and procedures.
6. Appoint the Director of the Mayor’s Office of Children and Family Success and the Chair of the Education and Youth Committee as Co-Chairs of the Workgroup.
7. Require that of the 2 agency designees, one must be at the administrative level and one must be a staff person whose daily work brings them in contact with community members.
8. Assign enforcement authority to the Department of Human Resources to ensure agency compliance with the ordinance.

Background

19-0410 was introduced in response to high rates of trauma in Baltimore City.

Prevalence of Trauma

- An estimated 42% of adults in Baltimore have experienced three or more traumatic events in childhood, compared to 24% statewide.
- A total of 56% of children in Baltimore City have experienced one or more instances of trauma, including extreme economic hardship, a parent serving time in jail, the death of a loved one, among others. One-third of children have experienced two or more.

Impact of Trauma

- There is a strong relationship between the number of exposures to many of the traumas discussed in the above section and several of the leading causes of death including: ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.

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2 “Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being. In the United States, 61 percent of men and 51 percent of women report exposure to at least one lifetime traumatic event, and 90 percent of clients in public behavioral health care settings have experienced trauma. If trauma goes unaddressed, people with mental illnesses and addictions will have poor physical health outcomes and ignoring trauma can hinder recovery.” (https://www.integration.samhsa.gov/clinical-practice/trauma)
• Individuals with multiple Adverse Childhood Experiences (ACEs)\(^3\) are at an especially high risk for negative health and other outcomes. Compared to individuals with no experiences of trauma, individuals with 4 or more traumatic experiences are:
  o 4-12 times more likely to experience substance abuse, depression, and suicide attempts
  o 2-4 times more at risk for smoking and sexually transmitted infections.
  o 1.4-1.6 times more at risk for physical inactivity and obesity.
• In additional to the added healthcare costs associated with the health outcomes discussed above, unaddressed trauma also has social ramifications including reduced academic achievement, increased criminal activity, and interpersonal violence. Child abuse, neglect, and household dysfunction have been found to increase the risk of violent or aggressive behavior later in life.

**Trauma-Informed Care**

Trauma Informed Care (TIC) is one approach to addressing the impact of trauma on young people and adults. The Substance Abuse and Mental Health Services Administration (SAMHSA) sees an organization or institution as being “trauma informed” when it not only is aware of the impact of trauma and able to recognize its signs and symptoms but when it is able to respond to trauma by integrating language and knowledge about trauma into its policies, procedures, and practices. SAMHSA promotes the use of six broad principles for Trauma Informed Care:\(^3\):

1. **Safety**: ensuring that all who engage with the organization or institution are physically and emotionally safe.
2. **Trustworthiness and transparency**: organizations and institutions must approach decisions with transparency so as to ensure both staff and those who interact with staff have trust in the organization or institution.
3. **Peer support**: utilize individuals who have lived experience with trauma as a source of knowledge and support.
4. **Collaboration and mutuality**: recognize that all members of an organization or institution can contribute to supporting young people who have been impacted by trauma.
5. **Empowerment, voice, and choice**: provide opportunities for young people, community members and frontline staff to design, inform, and evaluate programming.
6. **Cultural, historical, and gender issues**: programming must recognize and respond to cultural differences and be free from biases and stereotypes.

**Current Law**

**Federal Law**

There have been 49 federal legislative bills introduced in Congress that use trauma-informed language over the past 8 years. The first of these bills was the Domestic Minor Sex Trafficking Deterrence and

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\(^{3}\) Adverse Childhood Experiences (ACEs) is the term used to describe all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18. The ACE score is the total sum of the different categories of ACEs reported by participants. Study findings show a graded dose-response relationship between ACEs and negative health and well-being outcomes. In other words, as the number of ACEs increases so does the risk for negative outcomes. ([https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html](https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html))
Victims Support Act of 2010. Just two of these bills were passed into law, one of which was a bipartisan law known as the SUPPORT for Patients and Families Act (H.R. 6). Within the past two years, several bills and resolutions were introduced but either died in one chamber or, in the case of the most recently introduced legislation, are still in Committee, that explicitly reference trauma-informed care:

1. The Trauma-Informed Care for Children and Families Act of 2017 (S774/HR1757).
2. The Recognizing the Importance and Effectiveness of Trauma-Informed Care Act (H.Res.443).
3. The RISE (Resilience Investment, Support, and Expansion) from Trauma Act of 2019.

**State Law**

There are no bills on the state level that reference a trauma-informed approach. During the 2019 session, Delegate Wilkins introduced HB256 that would have required the State Department of Education, in consultation with the Maryland Department of Health and the Department of Human Services, to develop a definition of and guidelines on a trauma-informed approach. The bill did not pass.

**City Law**

There have been few ordinances or resolutions that explicitly call for or reference a trauma-informed approach in Baltimore City. In 2015 Resolution 15-0235R called on the Mayor and the CEO of Baltimore City Public Schools to ensure that all of Baltimore’s children who have been affected by the recent violence of the uprising have access to trauma counseling. This call was specific to this period of time. In 2018, ordinance 18-0237 passed, which provides a Supplementary Federal Fund Operating in the amount of $1,059,448 to the Health Department. The funds were to support a demonstration project for HIV/STD prevention programs and to help implement a systems-wide organizational trauma-informed care.

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4 The SUPPORT for Patients and Families Act (H.R. 6) was aimed at addressing the opioid crisis but included three key trauma-informed policies and practices:

1. Ensures that prevention services must be available in settings where the effects of ACEs are visible, including in day care institutions and schools.
2. Establishes a Task Force to identify best practices in supporting children and families who have experienced trauma.
3. Allows the CDC to collect and report data demonstrating the impact and prevalence of adverse childhood experiences.

5 The Trauma-Informed Care for Children and Families Act of 2017 (S774/HR1757) introduced in Congress in December of 2016. The primary goals of the legislation are to increase understanding and awareness of trauma and to identify best practices for prevention and treatment. While the bill has received significant support, it did not pass.

6 The Recognizing the Importance and Effectiveness of Trauma-Informed Care Act (H.Res.443) was introduced in July 2017 by Mike Gallagher (R-WI) and Danny Davis (D-IL) with a goal of increasing awareness and encouraging the use of trauma-informed approaches among existing programs and agencies at the federal level.

7 The RISE (Resilience Investment, Support, and Expansion) from Trauma Act of 2019 was introduced by Senators Dick Durbin (D-IL) and Shelley Moore Capito (R-WV). The primary goals of this legislation are to: increase funding for mental health clinicians, hospital-based trauma interventions, and community-based coalitions; enhance federal training programs at HHS and the Department of Education to ensure that there are more tools for professionals who interact with youth and families; improve the monitoring and enforcement of health insurance parity requirements for coverage of infant and early childhood mental health services; and strengthens the AmeriCorps program to prioritize recruitment in communities that have experienced trauma.
approach and cultural shift to support client health. The scope of these funds, however, was limited to the Health Department and its demonstration project.

**Implementation Recommendations**

**Buy-in from Leadership**

The Substance Abuse Mental Health Services Administration (SAMHSA) puts governance and leadership buy-in at the top of their list of factors that are essential to the implementation of trauma-informed initiatives. In Philadelphia, Pennsylvania, the Department of Behavioral Health and Intellectual Disability Services found that executive leadership buy-in and involvement was critical during the implementation process. Hummer et al. see the buy-in of agency leadership as critical to the successful creation of trauma-informed care environments. At the outset, leadership must address cultural and policy barriers, externally and internally, including the prioritization of punitive-based policies that may impede implementation. The Center for Health Care Strategies notes that agency leadership must establish strategies for rolling out the changes and for clearly communicating the rationale and benefits to both staff and community members. Leaders will also need to identify resources, prioritize the trauma-informed care initiative in the allocation of resources, and determine how staff time is designated to the implementation of the initiative.

**Community-Driven Process**

Both SAMHSA and the San Francisco Department of Public Health have identified community collaboration and empowerment as critical components of any trauma-informed care strategy. Including community voice in the creation of a trauma-informed policy is particularly important because of the disempowerment that is often associated with trauma. Involving individuals who have experienced trauma in the design of the policy has two main benefits: 1) it contributes to the healing process and 2) it produces a more robust and ultimately a higher quality product.

**Establish Common Measurements and Standards**

The field of trauma-informed care is relatively new. Thus, there is a lack of consensus around what outcomes can be achieved and how success should be measured. Measurements should be determined prior to implementation. An assessment should be conducted to set a baseline to which future assessments can be compared. The San Francisco Department of Public Health administered a Trauma Informed Systems (TIS) scale prior to training and after training was introduced to assess changes in staff attitudes towards trauma. The Department focused their evaluation on the extent to which participants executed plans to better align their work with the TIS model.

**Have a Designated Point Person**

In Philadelphia, the Department of Behavioral Health and Intellectual Disabilities found that a point person was critical to the success of the implementation. The point person could be generated through the creation of a new position or by providing an incentive to an existing staff member to serve.
as the liaison between the implementation team and the frontline workers. These individuals were critical in communicating out messages to frontline workers and in serving as a resource for those charged with implementing the program.

Plan for Staff Turnover

Researchers evaluating the implementation of a trauma-informed public behavioral health system in Philadelphia found that staff turnover was a significant barrier to implementation. In Philadelphia, turnover was not limited to frontline staff but included supervisors at high rates as well. Training staff requires resources and thus turnover must be factored into the planning process both in the allocation of resources and in ensuring the sustainability of the initiative. When staff members turned over in Philadelphia, 50% did stay in the public system, suggesting that the investment was not entirely lost.

Ongoing training

The San Francisco Department of Public Health found that while trainings were effective in producing statistically significant improvements in pre- to post-test scores in all categories that were tested, the gains appeared to be temporary. The Department found that ongoing learning communities and champions within the organization were crucial in supporting organizational leaders and frontline staff in building and implementing new skills. Research on implementation science suggests that most skills can be introduced in training but are learned on the job with the help of a coach. Studies have found that about 10 percent of what is taught in training is transferred to the job. When on the job coaching was added to the training, 95 percent of trainees used the skills they were taught in the training.

Build the Capacity of the Organization

The Trauma Transformed Initiative in San Francisco relied on a Train the Trainer model to build the capacity of the agencies to sustain and build upon the initiative. This model embeds trauma experts within the agencies, ensuring that in future fiscal years the initiative will not be dependent on resources to fund outside consultants. The Center for Health Care Strategies (CHCS) has put out recommendations for successful trauma-informed care implementations. Included in the recommendations is the utilization of learning collaborative groups made up of staff members, each led by a staff “champion” to lead and guide the change process. Through this process, champions learn about organizational change, project implementation, evaluation, and participatory decision-making.

Recommended Amendments, Detailed

This section explains in detail each of the recommended amendments.

1. Increase the number of days agency heads have to replace an agency desigee.

Currently, the ordinance states that, in the event of a vacancy of one or both of the agency desigees, agency heads must appoint replacements within 30 days. This amendment to
increase the time agency heads have to appoint replacements to 90 days will allow agencies the effort to fill a vacancy doesn’t put a strain on their day to day operations.

2. **Add the following Mayoral appointees to the workgroup: 1 Member of the Research Community, 1 young person, 1 Representative from an organization with an Explicit Focus on Racial Equity in their Mission Statement.**

   The Mayor has requested additional appointees for the workgroup. The appointees that will be added each represent a population whose voice is critical to lift up. It is vital that this process is subject to a robust evaluation, which would be aided by an additional research representative on the workgroup. This is an opportunity to institutionalize youth voice in the legislative process. While we have three young people who are members of youth-led organizations and one youth commissioner on the workgroup, we should extend the invitation to a young person who has not had the opportunity to get involved in a structured organization. Lastly, trauma disproportionately impacts people of color. It is imperative that we have people who are intimately aware of and knowledgeable about systems of oppression and racial inequality that too often lay the foundation for trauma.

3. **Add the following Council President appointees to the workgroup: 1 Representative from an organization with an explicit focus on racial equity in their mission statement.**

   As noted above, because trauma disproportionately impacts people of color, it is imperative that we have people who are intimately aware of and knowledgeable about systems of oppression and racial inequality that too often lay the foundation for trauma. With the Council President’s commitment to equity, he is well positioned to appoint one of the two representatives from organizations with an explicit focus on racial equity in their mission statement.

4. **Add the following Ex-Officio (Or Designate) Members: Planning Commissioner.**

   Currently, there is no representative from the Planning Department on the task force. The Office of Sustainability, housed in the Department of Planning, has received a Cities Connecting Children to Nature grant. The grant is geared towards cities confronting pressing child development issues like unsafe neighborhoods preventing outdoor play and higher rates of mental and physical health challenges related to the resulting indoor, sedentary lifestyle. Research has demonstrated that regular access to nature brings multiple benefits to children, including improved mental and physical health and increased opportunities for social and emotional learning. Including the Department of Planning in this workgroup would leverage the existing resources of the Cities Connecting Children to Nature grant and strengthen important cross-agency connections.
5. **Require the agency designees to work in partnership with equity coordinators at each agency (Council Bill 18-0223) and to review each agency’s equity assessment program in their trauma-informed review of agency policies and procedures.**

Council President Scott introduced Council Bill 18-0223 in 2018, requiring agencies to implement Equity Assessment Programs. Through this assessment, agency staff would review existing and proposed policies and practices for disparate outcomes based on race, gender, sexual orientation, or income and to proactively develop policies, practices, and investments to prevent and redress those disparate outcomes. As it stands now, there is no coordination between the Baltimore Trauma Responsive Care Act and President Scott’s Equity Assessment Program Bill. Because we know that systemic and structural inequality often create conditions that foster trauma, collaboration between the taskforce and the equity coordinators at each agency will prevent the duplication of work as the agency designees review agency policies and procedures and make recommendations for trauma-informed alternatives or improvements.

6. **Appoint the Director of the Mayor’s Office of Children and Family Success and the Chair of the Education and Youth Committee as Co-Chairs of the Workgroup.**

Currently, there is no designated chair of the task force created by the bill. In Philadelphia, the Department of Behavioral Health and Intellectual Disabilities found that a point person was critical to the success of the implementation. With a task force of over 20 individuals it will be vital that there is an identified leader responsible for holding members accountable for their agreed upon responsibilities. Sharing responsibility between the Mayor’s Office of Children and Family Success and the City Council Chair of the Education and Youth Committee will ensure that both the executive and legislative branches of City Government are invested in this strategy.

7. **Require that of the 2 agency designees, one must be at the administrative level and one must be a staff person whose daily work brings them in contact with community members.**

As it stands now, agency heads can appoint any agency staff person to the task force. It is critical, however, that the agency designees represent a broad swath of the agency. An individual at the administrative level of the agency will have the knowledge of the agency budget, policies and procedures that the frontline employee may not be privy to. Whereas an employee who has regular contact with families will have a more intimate knowledge of how agency policies impact agency staff and community members and what supports and training agency staff need. Both perspectives are critical to the success of this ordinance.

8. **Assign enforcement authority to the Department of Human Resources to ensure agency compliance with the ordinance.**
Currently, there is no mention of enforcement in the bill. Oversight and enforcement are critical to ensure that the bill is being implemented as intended. This authority should be assigned to the Department of Human Resources (DHR). Currently, within DHR, there is a Policy and Compliance division, which focuses primarily on drafting, implementing, and auditing City-wide HR policies and practices to ensure compliance with federal, state, and local government laws and regulations.

Positive Externalities

**Reduction in Violent Crimes**

Johnson City, Tennessee received a three-year $800,000 grant to create a Targeted Community Crime Prevention Program community-oriented crime prevention initiative in 2013\(^{\text{xx}}\). The results have been significant. In 2018 violent crimes and property crimes were down by 9.2% since the initiative started. The city’s clearance rate (the percentage of crimes that are solved) is 58.5% in comparison to the 31.5% state average. Similarly, over the 15-year implementation of the trauma-informed Self-Healing Community Model in Washington State, Cowlitz County saw youth arrests for violent crime drop by 53 percent\(^{\text{xii}}\).

**Improved Social, Emotional, and Physical Health**

In Connecticut, the Connecticut Department of Children and Family’s Collaborative on Effective Practices for Trauma (CONCEPT) has seen 84 percent of children who have been screened for trauma and provided with appropriate treatment show improvement in symptoms\(^{\text{xiii}}\). Similarly, over the 15 year implementation of the trauma-informed Self-Healing Community Model in Washington State, Cowlitz County saw youth suicide and suicide attempts go down by an impressive 98 percent\(^{\text{xiv}}\). The trauma-informed Self-Healing Community Model implemented in Cowlitz County, Washington saw teen pregnancy go down by 62 percent and infant mortality go down by 43 percent. In Pueblo, Colorado, emergency room visits dropped by 29 percent after rolling out a trauma informed model of care at the St. Mary-Corwin Medical Center\(^{\text{xv}}\).

**Improved Academic Outcomes**

In Walla Walla, Washington, the first trauma-informed high school in the country, Lincoln Alternative High School, has seen positive outcomes for its students. Within the first year of implementation the graduation rate increased by almost 30 percent and suspensions decreased by almost 85 percent. The school’s success has led to leaders in other fields to adopt trauma-informed care including the Division of Children and Family Services as well as the Police Department\(^{\text{xvi}}\). The trauma-informed Self-Healing Community Model implemented in Cowlitz County, Washington saw high school dropout rates decrease by 47 percent\(^{\text{xvii}}\).

**Reduction in Staff Burnout**
In Waupaca, Wisconsin, the benefits of trauma-informed training extended to the staff and to the organization as a whole. Prior to implementation, just over 90 percent of employees with 5 years of service or less self-reported medium to high burnout and 90 percent reported low to medium compassion satisfaction. Following the implementation of trauma-informed care training, the County saw below average secondary traumatic stress and burnout and higher than average compassion satisfaction scores, as compared to national rates. Complaints against the Waupaca County Health and Human Services Department declined from 10 per year prior to implementation to 0 following implementation xxvii.

**Improved Quality of Services**

In Waupaca, Wisconsin, the services the Waupaca County Health and Human Services Department provided improved in quality demonstrated by a reduction in the average time it took to reunify youth with families from 11.5 months to 7.7 months and a reduction in the percentage of youth who re-entered foster care after being returned home from placement from 31 percent to 13 percent in just four years xxviii. In San Diego an evaluation found that the kids whose cases were heard before trauma-informed judges in “Safe Babies Courts” reached permanency in their placements two to three times faster, left foster care a year earlier on average, and ended up with family more often (62.4 percent vs. 37.7 percent of the comparison group) xxx.

**Savings for City and State Budgets**

Experts in Washington estimate that the 15-year implementation of the Self-Healing Community Model saved $3.4 million per year from reductions in caseload costs in child welfare, juvenile justice and public medical costs associated with births to teen mothers xxxi. In the San Diego “Safe Babies Courts” with trauma-informed judges, an evaluation demonstrated that each child that passed through the court had a direct cost of $10,000. However, more than 70 percent of the program’s direct costs are returned in the first year alone due to these children leaving foster care more quickly. While additional savings cannot be predicted with confidence due to a host of external factors, the benefits of reaching permanency in placements more quickly, spending less time in foster care, and ending up with family are likely to save considerably more than the remaining 30 percent of the program’s direct costs xxxi.

**Negative Externalities**

**Increased burden on agencies and agency staff**

A review of the statewide introduction of trauma-informed care into the Arkansas child welfare system found that time constraints, heavy caseloads, lack of staff and limited resources were all barriers to implementation xxxii. Agencies in Baltimore City, whether the Department of Public Works or the Department of Recreation and Parks, are already overburdened and staff-limited and struggle to effectively accomplish their day to day responsibilities in an efficient manner. Adding on additional
responsibilities for staff persons may create undue stress or may hinder the effective delivery of services.

**Stigma of Trauma**

There is significant stigma around mental health and trauma. Simply preparing agency employees to recognize and respond to trauma by no means ensures that community members will be amenable to suggestions from government workers that they have experienced trauma. Studies have shown that particularly women who have experienced interpersonal violence tend to distrust caseworkers and frontline government workers. There is a potential when agency staff are armed with information on trauma that they could unintentionally stigmatize community members if they publicly identify an individual as having experienced trauma.

**Increased Knowledge with no Increase in Resources**

Researchers investigating the benefits and drawbacks of increased screening for adverse childhood experiences caution that an increase in awareness of trauma will likely result in an increase in referrals to resource that can mitigate its impact. In the absence of sufficient resources to meet the increase in need, the increase in awareness can unintentionally result in worsening symptoms without adequate support.

**Other Jurisdictions**

The San Francisco Department of Public Health has implemented a Trauma-Informed Systems Initiative that is aimed at developing and sustaining organizational and workforce change by training its entire workforce. Participants in the San Francisco training strongly agreed that it is important for everyone to be trauma informed and that the initiative will improve their lives. In a three-year evaluation of the initiative conducted by the San Francisco Department of Health, 94 percent of staff who completed training saw the value of becoming trauma informed and appreciated the information provided. Other jurisdictions have followed suit with Cleveland training all staff at Recreation Centers across the city as part of an initiative to transform Recreation centers into Trauma-Informed Community Support Centers. In 2016 Milwaukee Mayor Tom Barrett announced a plan to provide trauma-informed care training to every city employee. Training was coordinated by the City’s Office of Violence Prevention. The initial round of training went to firefighters and emergency medical staff with plans to expand to law enforcement in the second round.

**Appendix**

**Additional Information**

Prior Introduction: none

Information Sources


4 https://www.billtrack50.com/BillDetail/1037719


6 https://baltimore.legistar.com/LegislationDetail.aspx?ID=3503402&GUID=E8ABC357-0ECC-4C74-9962-EE1BOA04549B&Options=ID|Text|&Search=trauma


9 Ibid.


11 Ibid.

12 Ibid.


15 Beidas, R. et al. (2016).

16 Ibid.

17 Learning for Action. (September 2017)


CITY OF BALTIMORE
COUNCIL BILL 19-0410
(First Reader)

Introduced by: Councilmembers Cohen, Clarke, President Scott, Councilmembers Dorsey, Henry, Burnett, Schleifer, Sneed, Bullock, McCray, Stokes, Reisinger, Pinkett, Costello

Introduced and read first time: July 22, 2019

Assigned to: Health Committee

REFERRED TO THE FOLLOWING AGENCIES: City Solicitor, Health Department, Fire Department, Baltimore City Parking Authority Board, Department of Finance, Department of Housing and Community Development, Department of Planning, Department of Public Works, Department of Recreation and Parks, Department of Transportation, Enoch Pratt Free Library, Mayor’s Office of Criminal Justice, Mayor’s Office of Employment Development, Mayor’s Office of Homeless Services, Mayor’s Office of Human Services

A BILL ENTITLED

AN ORDINANCE concerning

The Baltimore City Trauma-Responsive Care Act

FOR the purpose of establishing the Trauma-Informed Care Task Force and its members; setting forth certain duties of the Task Force; requiring certain agencies to designate certain individuals to undergo formal training in trauma-informed care and to perform certain other duties related to ensuring that certain agencies are delivering services in a manner consistent with best practices in trauma-informed care; requiring certain agencies to submit periodic progress reports to the Task Force; requiring the Task Force to submit an annual report to the Mayor and City Council regarding the re-orientation of certain city services to focus on trauma-informed care; re-constituting the current Office of Children, Youth, and Families to be the Office of Children and Family Success; making a primary duty of the Office of Children and Family Success to lead a citywide initiative to prioritize the trauma-responsive and trauma-informed delivery of services; defining certain terms; correcting and conforming related provisions; and generally relating to providing trauma-informed services to the citizens of Baltimore.

BY repealing and re-ordaining, with amendments

Article 1 - Mayor, Council, and Agencies
Sections 22-1 and 22-11
Baltimore City Code
(Edition 2000)

BY adding

Article 1 - Mayor, Council, and Agencies
Sections 22-15 to 22-22
Baltimore City Code
(Edition 2000)

EXPLANATION: CAPITALS indicate matter added to existing law.
[Brackets] indicate matter deleted from existing law.
Council Bill 19-0410

SECTION 1. BE IT ORDAINED BY THE MAYOR AND CITY COUNCIL OF BALTIMORE, That the Laws of Baltimore City read as follows:

Baltimore City Code

Article 1. Mayor, Council, and Agencies

Subtitle 22. Children, Youth, and Families

PART I. DEFINITIONS.

§ 22-1. Definitions.

(a) In general.

In this subtitle, the following terms have the meanings indicated.

(b) Children.

“Children” means individuals under the age of 14 years.

(c) Commission.

“Commission” means the Baltimore City Youth Commission.

(d) Office.

“Office” means the Office of Children[,] Youth[,] and [Families] FAMILY SUCCESS.

(e) TASK FORCE.

“TASK FORCE” MEANS THE BALTIMORE CITY TRAUMA-INFORMED CARE TASK FORCE.

(f) Youth.

“Youth” means an individual between the ages of 14 and 25, inclusive

PART III. OFFICE OF CHILDREN[,] YOUTH[,] AND [FAMILIES] FAMILY SUCCESS

§ 22-11. Director – powers and duties.

The Director shall:

(1) identify the needs of children and youth according to age, location, and special services required;

(2) identify public and private services available to children, youth, and families;

(3) identify changes in public policy, service delivery, and funding necessary to improve the services available to children, youth, and families;
(4) serve as a community voice for children and youth;

(5) develop and implement programs to benefit children and youth;

(6) provide staff and serve as advisor to the Commission;

(7) serve as ex-officio member and advisor to the task force;

(8) generally promote the well-being of all children and youth of Baltimore City;

(9) be represented on any other special committee or task force [established in the Mayor’s Office which] that considers matters relating to children and youth, and work with the various boards, commissions, and municipal agencies [which] that interact with the office as deemed appropriate;

(10) perform such other duties as required by the Mayor; and

(11) review proposed legislation referred to the Office by the City Council, assessing its probable effect on the physical, social, emotional, and intellectual welfare of the children of this City.

§§ 22-13 to 22-14. {Reserved}

PART IV. TRAUMA-INFORMED CARE AND TRAUMA-RESPONSIVENESS.

§ 22-15. TRAUMA-INFORMED CARE INITIATIVE.

In addition to any other duties set forth in this subtitle, it is the duty of the office to coordinate a citywide initiative to prioritize the trauma-responsive and trauma-informed delivery of city services impacting children, youth, and families.

§ 22-16. BALTIMORE CITY TRAUMA-INFORMED CARE TASK FORCE – ESTABLISHMENT.

There is a Baltimore City Trauma-Informed Care Task Force.

§ 22-17. BALTIMORE CITY TRAUMA-INFORMED CARE TASK FORCE – COMPOSITION.

(A) IN GENERAL.

The Task Force comprises 20 members, 16 of whom are appointed by the Mayor under Article IV, § 6 of the City Charter and 4 of whom are ex-officio members.

(B) APPOINTED MEMBERS.

Of the 16 members appointed by the Mayor:
Council Bill 19-0410

(1) 2 SHALL BE YOUTH REPRESENTATIVES FROM A YOUTH-LED ADVOCACY GROUP IN BALTIMORE CITY;

(2) 2 SHALL BE INDIVIDUALS WITH AT LEAST ONE CHILD ENROLLED IN THE BALTIMORE CITY PUBLIC SCHOOL SYSTEM;

(3) 1 SHALL BE A LICENSED CLINICIAN WITH AN EXPERTISE IN TRAUMA;

(4) 1 SHALL BE A MEMBER OF THE RESEARCH COMMUNITY WITH AN EXPERTISE IN TRAUMA;

(5) 3 SHALL BE REPRESENTATIVES FROM COMMUNITY ORGANIZATIONS, NONPROFIT ORGANIZATIONS, OR YOUTH ORGANIZATIONS THAT HAVE AN EXPERTISE IN TRAUMA; AND

(6) 7 SHALL BE RECOMMENDED BY THE CITY COUNCIL PRESIDENT AS FOLLOWS:

   (I) 2 CITY COUNCILMEMBERS;

   (II) 1 YOUTH REPRESENTATIVE FROM A YOUTH-LED ADVOCACY GROUP IN BALTIMORE CITY;

   (III) 1 LICENSED CLINICIAN WITH AN EXPERTISE IN TRAUMA; AND

   (IV) 3 REPRESENTATIVES FROM COMMUNITY ORGANIZATIONS, NONPROFIT ORGANIZATIONS, OR YOUTH-LED OR YOUTH-ORIENTED ORGANIZATIONS THAT HAVE AN EXPERTISE IN TRAUMA.

(C) Ex-officio (or designate) members.

The 4 ex-officio members of the Task Force are:

(1) the Director of the Office;

(2) the Commissioner of the Baltimore City Department of Health or the Commissioner’s designee;

(3) the City Council President; and

(4) the Youth Commission Chair.

§ 22-18. Baltimore City Trauma-Informed Care Task Force – Terms, Organization, etc.

(A) Terms.

Appointed members serve for a term of 4 years concurrent with the term of the Mayor’s term of office.
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(B) **COMPENSATION.**

MEMBERS SERVE ON THE TASK FORCE WITHOUT COMPENSATION.

(C) **VACANCIES.**

1. At the end of a term, an appointed member serves until a successor is appointed and qualifies.

2. A member who is appointed after a term has begun serves out the rest of the term and until a successor is appointed and qualifies.

(D) **MEETINGS; QUORUM.**

1. The Task Force shall meet on the call of the Task Force Chair or the Director of the Office as frequently as required to perform its duties, but not less than 6 times a year.

2. A majority of the members of the Task Force constitutes a quorum for the transaction of business, and an affirmative vote by the majority of a quorum is sufficient for any official action.

(E) **CHAIR.**

The Mayor shall designate a Chair from among the Task Force’s appointed members.

§ 22-19. **Baltimore City Trauma-Informed Care Task Force – Staff.**

The Office shall provide adequate staff for the Task Force to carry out its duties.

§ 22-20. **Baltimore City Trauma-Informed Care Task Force – Duties.**

The Task Force shall:

1. Assist in the identification of all City programs and services that impact children and youth;

2. Assist in the development of a citywide strategy toward an organizational culture shift into a trauma-responsive City government;

3. Establish metrics, in collaboration with the Baltimore City Department of Health, to evaluate and assess the progress of the citywide trauma-informed care initiative;

4. Coordinate and develop with the Baltimore City Department of Health any formal or informal trauma-informed care training;
(5) DISSEMINATE INFORMATION WITHIN CITY GOVERNMENT REGARDING BEST PRACTICES FOR PREVENTING AND MITIGATING THE IMPACT OF TRAUMA ON CHILDREN, YOUTH, AND FAMILIES;

(6) ADVISE AND ASSIST THE MAYOR AND CITY COUNCIL IN PROVIDING OVERSIGHT AND ACCOUNTABILITY IN IMPLEMENTING THE REQUIREMENTS OF THIS PART;

(7) PERFORM ANY OTHER DUTIES AS REQUIRED BY THE MAYOR.

§ 22-21. TRAUMA-INFORMED CARE TRAINING; AGENCY DUTIES.

(A) DEFINITIONS.

(1) IN GENERAL.

IN THIS SECTION, THE FOLLOWING TERMS HAVE THE MEANINGS INDICATED.

(2) AGENCY.

“AGENCY” MEANS:

(I) THE BALTIMORE CITY FIRE DEPARTMENT;

(II) THE BALTIMORE CITY PARKING AUTHORITY;

(III) THE DEPARTMENT OF FINANCE;

(IV) THE DEPARTMENT OF LAW;

(V) THE DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT;

(VI) THE DEPARTMENT OF PLANNING;

(VII) THE DEPARTMENT OF PUBLIC WORKS;

(VIII) THE DEPARTMENT OF RECREATION AND PARKS;

(IX) THE DEPARTMENT OF TRANSPORTATION;

(X) THE ENOCH PRATT FREE LIBRARY OF BALTIMORE CITY;

(XI) THE MAYOR’S OFFICE OF CRIMINAL JUSTICE;

(XII) THE MAYOR’S OFFICE OF EMPLOYMENT DEVELOPMENT;

(XIII) THE MAYOR’S OFFICE OF HOMELESS SERVICES; AND

(XIV) THE MAYOR’S OFFICE OF HUMAN SERVICES.
(3) **FORMAL TRAINING.**

“FORMAL TRAINING” means a didactic course or curriculum in trauma-informed care that is:

(i) developed by the United States Department of Health and Human Services, Maryland Department of Health, or the Baltimore City Department of Health; and

(ii) provided by the Baltimore City Department of Health or its designee in collaboration with the Task Force.

(B) **Task Force Members.**

Each Task Force member shall participate in at least 1 formal training each year.

(C) **Agency Staff Designation.**

(1) Each agency head shall designate 2 agency staff members to:

(i) participate in at least 1 formal training each year;

(ii) collaborate with other agency designees in periodic worksessions and other informal trainings as organized by the Baltimore City Department of Health from time to time;

(iii) serve as the principal advisors to the agency head and agency staff in trauma-responsiveness and trauma-informed care;

(iv) assess the agency for training and technical assistance needs related to trauma-responsiveness and trauma-informed care; and

(v) review and make appropriate recommendations to the agency head to align agency policies and practices with a trauma-intensive approach.

(2) In the event of a vacancy of one or both of the staff members, the agency head shall, within 30 days of the vacancy, designate another staff member to carry out the duties of this subsection.

(D) **Health Department Cooperation.**

The Baltimore City Department of Health shall provide any technical advisory support to designated agency staff in order for those individuals to carry out their duties under subsection (C)(1) of this section.
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(E) PROGRESS REPORT TO TASK FORCE.

ON OR BEFORE MARCH 31 OF EACH YEAR, EACH AGENCY HEAD SHALL SUBMIT TO THE
TASK FORCE A PROGRESS REPORT DETAILING ITS AGENCY’S PROGRESS AND COMPLIANCE
WITH SUBSECTION (C) OF THIS SECTION.

§ 22-22. ANNUAL REPORT.

ON OR BEFORE JUNE 30 OF EACH YEAR, UTILIZING ITS ESTABLISHED EVALUATION AND
ASSESSMENT METRICS AND ITS EXPERTISE, THE TASK FORCE SHALL SUBMIT A REPORT TO THE
MAYOR AND CITY COUNCIL CONTAINING:

(1) AN ASSESSMENT OF THE IMPLEMENTATION OF TRAUMA-INFORMED CARE WITHIN EACH
AGENCY AS DEFINED IN § 22-21(A)(2) OF THIS SUBTITLE;

(2) AN ASSESSMENT OF THE TRAUMA-RESPONSIVENESS OF EACH AGENCY AS DEFINED IN §
22-21(A)(2) OF THIS SUBTITLE; AND

(3) ANY RECOMMENDATIONS REGARDING IMPROVEMENTS TO EXISTING LAWS RELATING
TO CHILDREN, YOUTH, AND FAMILIES IN BALTIMORE CITY.

SECTION 2. AND BE IT FURTHER ORDAINED, That the catchlines contained in this Ordinance
are not law and may not be considered to have been enacted as a part of this or any prior
Ordinance.

SECTION 3. AND BE IT FURTHER ORDAINED, That this Ordinance takes effect on the 30th day
after the date it is enacted.
AMENDMENTS TO COUNCIL BILL 19-0410
(1st Reader Copy)

Proposed by: Councilmember Cohen
{To be offered to the Health Committee}

Amendment No. 1 {Renaming bill}

On page 1, strike line 2 in its entirety and substitute “The Elijah Cummings Healing City Act”.

Amendment No. 2 {Technical amendments; Conforming Office name}

On page 1, in lines 17 and 22, and on page 2, in line 4, in each instance, after the first comma, insert “City”; and, on page 1, in lines 17 and 22, and on page 2, in line 4, in each instance, after “and”, insert “Municipal”; and, on page 1, in line 18, after “22-1”, insert “, 22-9,”; and, on page 2, after line 20, insert:


There is an Office of Children[, Youth,] and [Families] FAMILY SUCCESS in the Office of the Mayor.”.

Amendment No. 3 {Composition of Task Force}

On page 3, in line 26, strike “20” and “16”, respectively, and substitute “31” and “26”, respectively; and, on that same page, in line 27, strike “4” and substitute “5”; and, on that same page, in line 30, strike “16” and substitute “26”; and, on page 4, in line 1, strike “2” and substitute “26”; and, on that same page, in line 6, strike “1” and substitute “2”; and, in that same line, strike “A MEMBER” and substitute “MEMBERS”; and, on that same page, after line 7, insert:

“(5) 1 SHALL BE A REPRESENTATIVE OF AN ORGANIZATION WITH AN EXPLICIT FOCUS ON RACIAL EQUITY IN ITS ORGANIZATIONAL MISSION STATEMENT;

(6) 1 SHALL BE AN INDIVIDUAL BETWEEN 14 AND 25 YEARS OF AGE;
(7) I SHALL BE A INDIVIDUAL LICENSED TO PRACTICE IN THE STATE OF MARYLAND AS A PHYSICIAN WITH A SPECIALTY IN PEDIATRICS;

(8) I SHALL BE A REPRESENTATIVE OF AN ORGANIZATION WITH AN EXPLICIT FOCUS ON LESBIAN, GAY, BISEXUAL, TRANSGENDER AND QUEER (LGBTQ) ADVOCACY IN ITS ORGANIZATIONAL MISSION STATEMENT;

(9) I SHALL BE A NATURALIZED CITIZEN OR A RESIDENT ALIEN;

(10) I SHALL BE AN INDIVIDUAL WHO HAS RECENTLY EXITED FROM THE MARYLAND CORRECTIONAL SYSTEM;

(11) I SHALL BE AN EMPLOYEE OF THE BALTIMORE CITY PUBLIC SCHOOL SYSTEM;

and, on that same page, in lines 8 and 11, strike the paragraph designators “(5)” and “(6)”, respectively, and substitute “(12)” and “(13)”, respectively; and, on that same page, in line 11, strike “7” and substitute “8”; and, on that same page, in line 12, after “COUNCILMEMBERS”, strike the semi-colon and substitute:

“, AS FOLLOWS:

(A) 1 COUNCILMEMBER SHALL BE THE CHAIR OF THE YOUTH AND EDUCATION COMMITTEE OR OF ANY CITY COUNCIL COMMITTEE SUCCEEDING TO THE DUTIES OF THE YOUTH AND EDUCATION COMMITTEE; AND

(B) 1 OTHER COUNCILMEMBER RECOMMENDED AT THE COUNCIL PRESIDENT’S DISCRETION;”;

and, on that same page, after line 14, insert:

“(III) 1 REPRESENTATIVE OF AN ORGANIZATION WITH AN EXPLICIT FOCUS ON RACIAL EQUITY IN ITS ORGANIZATIONAL MISSION STATEMENT;”;

and, on that same page, in lines 15 and 16, strike“(III)” and “(IV)”, respectively, and substitute “(IV)” and “(V)”, respectively; and, on that same page, after line 23, insert:“(3) THE DIRECTOR OF PLANNING OR THE DIRECTOR’S DESIGNEE;”; and, on that same page, in lines 24 and 25, strike “(3)” and “(4)”, respectively, and substitute “(4)” and “(5)” respectively.
Amendment No. 4 {Task Force Co-Chairs}

On page 5, in line 9, strike beginning with the second “THE” down through and including “OFFICE” in line 10 and substitute “ONE OR BOTH OF THE TASK FORCE CO-CHAIRS”; and, on that same page, strike lines 15 through 17 in their entireties and substitute:

“(E) TASK FORCE CO-CHAIRS:

(1) IN GENERAL.

AS PROVIDED IN THIS SUBSECTION, THE TASK FORCE SHALL HAVE 2 CO-CHAIRS DESIGNATED.

(2) AT-LARGE CO-CHAIR.

EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, THE MAYOR MAY DESIGNATE ANY MEMBER OF THE TASK FORCE TO SERVE AS 1 OF THE CO-CHAIRS.

(3) CHAIR OF THE CITY COUNCIL YOUTH AND EDUCATION COMMITTEE.


Amendment No. 5 {Clarification of agency staff designees}

On page 7, in line 13, strike “EACH” and substitute “SUBJECT TO PARAGRAPHS (2) AND (3) OF THIS SUBSECTION, EACH”; and, on that same page, after line 24, insert:

“(2) OF THE 2 AGENCY STAFF MEMBERS DESIGNATED UNDER PARAGRAPH (1) OF THIS SUBSECTION:

(i) 1 STAFF MEMBER SHALL BE AN INDIVIDUAL WHO:

(A) HAS DECISION-MAKING AUTHORITY IN DEVELOPING CITY POLICY; OR

(B) SERVES AS A PRINCIPAL ADVISOR TO THE AGENCY HEAD; AND
(II) 1 STAFF MEMBER SHALL BE AN INDIVIDUAL WHO, WITHIN THE COURSE OF THE INDIVIDUAL’S CITY EMPLOYMENT, ROUTINELY AND DIRECTLY INTERACTS WITH COMMUNITY MEMBERS.”;

and, on that same page, in line 25, strike the paragraph designator “(2)” and substitute “(3)”.

Amendment No. 6 {Requiring agency staff designees to collaborate with equity coordinator}

On page 7, after line 19, insert:

“(IV) COLLABORATE WITH THE AGENCY’S EQUITY COORDINATOR AS DESIGNATED UNDER § 39-8 {“AGENCY IMPLEMENTATION – EQUITY COORDINATOR”} OF THIS ARTICLE TO ENSURE THAT THE AGENCY’S EQUITY ASSESSMENT PROGRAM IS TRAUMA-INFORMED AND TRAUMA-RESPONSIVE;”;

and, on that same page, in lines 20 and 22, strike “(IV)” and “(V)”, respectively, and substitute “(V)” and “(VI)” respectively.

Amendment No. 7 {Extending time required for agency head to substitute designees}

On page 7, in line 26, strike “30” and substitute “90”.

Amendment No. 8 {Assigning to Dept. of Human Resources compliance responsibilities}

On page 7, in line 28, strike “HEALTH DEPARTMENT” and substitute “DEPARTMENTAL”; and, on that same page, at the beginning of line 29, insert the paragraph designator “(1)”; and, on that same page, after line 31, insert:

“(2) THE DEPARTMENT OF HUMAN RESOURCES SHALL ENSURE COMPLIANCE WITH THE REQUIREMENTS OF THIS SECTION AND REPORT TO THE TASK FORCE AS NECESSARY ANY DIFFICULTIES REGARDING AGENCY IMPLEMENTATION.”.

Amendment No. 9 {Adding Environmental Control Board to agency list; omitting the Mayor’s Office of Human Services}

On page 6, after line 21, insert “(X) THE ENVIRONMENTAL CONTROL BOARD;”; and, on that same page, in line 24, after the semi-colon, insert “AND”; and, on that same page, in line 25, strike “; AND” and substitute with a period; and, on that same page, strike line 26 and, on that same page, in lines 22, 23, 24, and 25, strike the sub-paragraph designators “(X)”, “(XI)”,

“(XII)”, and “(XII)”, respectively, and substitute “(XI)”, “(XII)”, “(XIII)”, and “(XIV)”, respectively.

**Amendment No. 10 {Inclusion of “healing” terminology}**

On page 4, in lines 5, 7, 10, 15, and 18, in each instance, after “TRAUMA”, insert “AND HEALING”; and, on page 6, in line 2, after “ON”, insert “ AND FACILITATING HEALING WITH”.