APPROVED BY COMMITTEE JULY 23, 2019

Office of the Child Advocate
Childhood Trauma Task Force Meeting Minutes
Tuesday, June 4, 2019
9:00am-11:00am

Task Force Members or Designees Present:
Maria Mossaides, Child Advocate, Chair (OCA)
Representative Carolyn Dykema (House)
Laura Brody (DCF)
Yvonne Sparling (DYS)
Tom Capasso (Juvenile Court)
Kate Lowenstein (CFJJ)
Kathryn Cohen (Children's League)
Claudia Dunne (CPCS)

Other Attendees:
Elizabeth Walk (Representative Dykema's Office)
Margot Tracey (MassHealth)
Members of the Public

OCA Staff:
Melissa Threadgill (OCA)
Melissa Williams (OCA)
Lindsay Morgia (OCA)
Alexis Yohros (OCA)

Meeting Commenced: 9:11am

Welcome and Introductions:

Ms. Threadgill welcomed the attendees to the sixth Childhood Trauma Task Force (CTTF) meeting and each person introduced themselves.

Ms. Threadgill noted that the Task Force would hold a formal vote for the approval of the minutes from the May 14, 2019 CTTF meeting during the July CTTF meeting.

Ms. Threadgill reviewed the agenda.

Department of Youth Services Presentation on Agency Trauma Practices:

Ms. Threadgill introduced Yvonne Sparling, the Director of Clinical Services for the Department of Youth Services.

Dr. Sparling provided a brief overview of the continuum of services and placements offered by the Department of Youth Services (DYS) depending on the legal status of the youth:

1. Detention
2. Commitment
3. Discharge from DYS or YES Program

During "commitment," the assessment phase includes clinical, education, and health casework. Each youth is provided with a caseworker during this time. Treatment options during "commitment" include hardware secure facilities for youth with the highest level of offenses as well as staff secure residential programs. Some youth may also be placed on community supervision following residential placement.

DYS prioritizes supporting youth who are being discharged from their programs, as youth are in their highest risk period within six months after leaving a state program. In an effort to reduce repeat offenses, DYS engages youth in the YES program (Youth Engaged in Services). Youth who sign up for YES have access to case management services, including support in attending college classes. Dr. Sparling started that about 50-60% of youth have voluntarily stayed in the YES program and continued to say that the youth in this program have better outcomes with regards to recidivism than the youth who do not participate.

Dr. Sparling explained that all youth going through DYS intake are assessed for trauma through the MAYSI-2. If they are committed, youth participate in further assessments. The assessments include:

1. PTSD-Screen
2. Limbic System Checklist
3. ACES (Adverse Childhood Experiences)
4. Youth Level of Service (YLS-CMI); this looks at risk factors for reoffending

Ms. Mossaides asked if youth ever refuse to participate in the assessments. assessments. In her experience, youth involved with DCF do not want to take the assessments being offered.

Dr. Sparling stated that right now, youth do participate in the assessments. DYS has more leverage given that youth are confined while taking the assessments.. DYS explains that the assessments are there to keep them safe. Staff have 30 days to complete the assessments.

Dr. Sparling stated that given the high rate of trauma and neglect experienced by juvenile justice system-involved youth, DYS has adopted DBT as the primary clinical approach. She explained that DBT is a cognitive behavioral therapy which teaches skills in self-regulation: mindfulness, distress tolerance, emotional regulation and interpersonal skills. It is integrated across all DYS programs and is used as both a therapeutic modality and a behavior management approach.

DBT has youth look at their thoughts and feelings and learn how that affects their own actions. There are four different modules of DBT used. In order to measure the effectiveness of DBT, DYS tried the approach with both boys and girls and had control groups as well. Since 2006, DBT has been used across the board in DYS programs.

Within residential programs, various clinical therapy services are provided to youth, including individual therapy (at least weekly) and family therapy (offered to all families). There are also mandatory and specialized clinical groups for youth with certain offenses. The groups include twice-weekly DBT, weekly Offender Groups for youth with sex or violent offenses, and substance abuse/substance prevention groups.

Ms. Lowenstein asked if all staff are trained in DBT.

Dr. Sparling responded that all staff are indeed trained. In 2015, DYS collaborated with UMass Medical Center and completed the Child Trauma Training. During that year, 1441 state employees were trained on trauma-informed care. Since 2015, this training has become a part of their "Basic Training" for all new DYS employees through a National Child Traumatic Stress Network grant. Along with that, DYS held various conferences which included training on racial trauma in 2016 and 2017.

Dr. Sparling briefly discussed the current direct care workforce initiatives.

1. Youth Engagement Strategies
2. Revamping of Restraint Technique
3. Room Confinement Policy; limit the use of room time for non-compliance and for punishment.
4. Develop Behavior Management Systems; focus on incentives and repair processes that allow for choice by youth.

Dr. Sparling mentioned that DYS prioritizes the importance of family engagement through various efforts within the agency. The purpose of family engagement has been a part of a strategy to decrease the overall effects of trauma.

In 2008, the Garret Lee Smith Grant allowed two funded positions for Family Engagement Specialists. Since 2014, Family Engagement Specialists have been a part of the DYS community casework team with one per region to help the family with resources. There are currently five Specialists.

Another effort taking place at DYS is the Second Chance Grant in Metro Boston. This grant funded family partner positions for parents of committed youth. As a result, the Parent Cafe program developed as a place for parents to meet with one another. In the JDAI initiative, DYS has partnered with PPAL as a service option for parents of youth in detention. This initiative is similar to family partners. Along with the Parent Cafe and family partners, DYS developed Family Guidelines and updated the Visitation Policy in 2018 to increase access for families.

Dr. Sparling explained that DYS has outsourced various research projects to study the effectiveness of their initiatives. One of their research projects focused on the effectiveness of DBT on committed DYS youth. The study was done by Dr. David Burton. The findings concluded that there were significant differences after six months of DBT treatment in secure facilities.

Dr. Sparling discussed two additional research projects that were completed at DYS.

1. **Million Adolescent Clinical Inventory**
    a. Findings: Youth were less impulsive, less depressed, less oppositional, less suicidal, and more willing to comply.
2. **Behavior Rating of Executive Function (BREF)**
    a. The test measured cognitive functioning: the ability to shift attention, plan and organize, and maintain attention.
    b. When comparing pre and post test results, the following findings were made:
        i. Youth in the Average range remained in Average range;
        ii. Youth in the Critically Concerning range improved to the Average range.
    c. Youth were able to opt out of the test if they wanted to.

Dr. Sparling described the 2014 research on family engagement efforts. 300 Families were interviewed (60 families from each of the five regions.) One-third of the families had a child in detention, one-third of the families had a child in residential programs, and one-third of the families had a child in the community. The findings showed that once families became engaged in services, they reported a high rate of satisfaction. Overall, average scores were in the Satisfied to Very Satisfied range. Parents indicated they felt respected and thought their child benefitted from the services provided to them. Many parents said that having their child committed was the best thing for them.

In 2017, a second research initiative on family engagement was completed through an anonymous online family survey developed for families to fill out when they visited their child at one of the DYS programs. The results tended to be positive, and policies were updated to include their feedback and suggestions. One of the changes included the increased family visitation policy. DYS is currently re-starting the surveys.

Dr. Sparling stated that the next steps for DYS include beginning a broader training on trauma-informed care for staff as well as continuous training so that staff understand the importance of integrating services across disciplines, programs, and into the community

Ms. Kaban asked if DYS is having to tweak the programs and involvement for gang-involved youth.

Dr. Sparling commented that DBT was originally designed for adults, but they have adapted this practice for DYS youth including gang-involved youth. Youth are saying that it has helped them integrate back into the community.

The CTTF thanked Dr. Sparling for presenting.

Presentation and Discussion on Results of Trauma Services Survey:

Ms. Threadgill introduced Lindsay Morgia, the Research and Policy Analyst for the Office of the Child Advocate. Ms. Morgia discussed the trauma services survey results.

Ms. Morgia briefly discussed the purpose of the survey, which was to better understand what services are available in Massachusetts. She explained that the mapping survey had a total of 178 responses. The Office of the Child Advocate was able to reach as many respondents as they did thanks to the help of the CTTF members and their colleagues.

Ms. Morgia briefly discussed the results of the community-based organizations and then continued to discuss the results from juvenile justice system practitioners. At the end of her presentation, Ms. Morgia compared the two types of institutions for similarities and differences. The key takeaways for each type of institution included:

Community-Based Interventions:

1. Similar evidence-based tools are being used across the state.
2. Overall low availability of specific services for very young children and school aged children (ages 0-12 years old).
3. Low availability of gender-specific programs for all genders.
4. Regional variations in working with specific populations and language capacities.

Juvenile Justice:

1. Trauma screenings may be more available than assessments or interventions.
2. There may be less of a distinction between a trauma screening and trauma assessment within the juvenile justice system.
3. Trauma interventions are similar to those used in the community, but in reverse order. The primary intervention used within the juvenile justice system appeared to be DBT, while CBT seemed to be the preferred intervention in the community-based programs.

For a more in-depth understanding of the survey results, please refer to the June 4, 2019 CTTF meeting PowerPoint.

Ms. Kaban asked if organizations were able to explain their answers in the survey and Ms. Morgia replied that there was not an opportunity for organizations to give qualitative responses, but this is because the initial hope for the survey was to get a general understanding of what services are available. There was an opportunity at the end of the survey for the participatants to check off that they would be interested in participating in a follow-up interview.

A member of the public asked if the lack of services for 0-4 years old could be because this age group is served through early interventions.

Ms. Mossaides commented that some of the Commonwealth's early intervention centers offer screenings.

Ms. Dunne asked if the survey include pediatricians and Ms. Morgia replied that they tried to reach out to healthcare providers but were not successful. She had a good conversation with representatives from the American Academy of Pediatricians, but they didn't participate in the actual survey.

Mr. Capasso stated that the juvenile court system is worried about the young children in the 0-3 age group. Due to their concerns, they are currently looking to pilot a separate court that focuses on the 0-3 age range, especially looking at Care & Protection. The Chief Justice has seen this age specific court program in other jurisdictions. The idea is to move cases as quickly as possible so there is more stability in the child's early years, especially for reunification cases. The difficulty with this idea is when there are multiple children in the home that vary in age range or have different fathers.

Ms. Mossaides commented from the child welfare side, in collaboration with DCF, the OCA has been looking at children who have been exposed/witnessed a traumatic event. There has been an increase in the number of children who witnessed a parent or caregiver overdose, both non-fatal

and fatal. She stated that it would be interesting to look at these children over an extended period of time to see if they go in and out of care. Research shows that children who are constantly moved from in and out of state care are worse off than having an open adoption due to the instability.

Mr. Capasso stated that he has heard the same thing through the court system from foster parents and parents who have tried to get their children back, and when they do, they don't have that same connection with them anymore.

Ms. Lowenstein commented that DCF children who end up in juvenile justice system have had multiple home referrals, which is much different than multiple foster home placements.

Ms. Mossaides reiterated the importance of stability, which is partially outside of the Commonwealth's control.

Ms. Dunne stated that children lose or fall behind in their education every time they are removed from the home, especially if they have to change school districts multiple times throughout a schoolyear.

Ms. Threadgill thanked Ms. Morgia for presenting the survey findings and stated that any follow-up questions can be directed towards either of them.

Discussion on Task Force Next Steps and Future Meeting Topics:

Ms. Threadgill discussed that when the CTTF met for the first time in January 2019, the group agreed upon a six-month work plan that included the survey and presentations from various professionals in the childhood trauma field. Now that it's June, it is time for the task force to create a work plan for the next six-months.

Ms. Threadgill asked the task force what topics they would like to focus on for the first annual report that is due to Legislature December 2019. Ms. Threadgill started the discussion with three ideas for the report.

1. Trauma-Informed Practices
2. Identification and Referral
3. School-Based Approaches

Ms. Threadgill recommended that the task force waits to focus on school-based approaches until there is adequate representation from the school community in the group. She stated that the task force could recommend in the annual report to expand the board by including school partners.

Dr. Sparling shared that she was shocked on the research that states there are a lack of services for ages 0-4 ,and that this could be an area of focus.

Ms. Morgia stated that this is something the OCA will be looking into to see what other states are doing in terms of services for the 0-4 age range.

Ms. Threadgill commented that this topic would go nicely into the focus on “identification and referral.”

Ms. Dunne shared that she has thought about the issue of domestic violence and that children who witness DV are more likely to be diagnosed with trauma, ADHD, and other behavioral diagnoses as a result.

Ms. Threadgill said that children who witness domestic violence is a separate population that can be focused on as well.

Ms. Mossaides asked how do we reach out to all of the different populations. In terms of domestic violence, DPH is focusing on this topic instead of the child focused agencies such as DCF and DYS.

Ms. Brody stated that DCF has been involved in partnering with various domestic violence organizations in different regions. There is currently a four-year plan set in place and DCF is in the beginning stages.

Ms. Tracy stated that in MassHealth, they are hearing that physicians are often uncomfortable treating and diagnosing children 0-5 years old. DC 0-5 does have diagnostic codes for very young children and Intensive Care Coordinators as well as in-home therapists are being trained in this age group. Along with this, DPH has an early childhood program and they are working together with MassHealth to pilot programs in various areas of Massachusetts. In MassHealth, they are looking for options on how to increase DC 0-5 and physicians who feel comfortable with this age range.

Ms. Threadgill asked the task force if she is understanding correctly that the group wants to focus on identification and referral. The task force members said yes.

Ms. Threadgill asked the group what questions they still have on the topic chosen (identification and referral). She asked if there any additional speakers the task force like to invite to help answer those questions. She also asked what research support the OCA can provide that would be helpful to answering questions or informing the discussion at hand.

Dr. Sparling commented that she is still not sure what the best practices are for 0-4-year-olds.

Ms. Mossaides stated that the OCA has contacts within Harvard medical school that could be of help.

Mr. Capasso said that in terms of witnessing overdose, substance abuse has been around for a long time so there has to be knowledge somewhere regarding best practices.

Ms. Brody replied that since Narcan became widely available, DCF has seen an increase in children's exposure/witness to non-fatal overdoses instead of fatal overdoses.

Ms. Dunne commented that domestic violence and alcoholism may also relate to overdose exposure.

Ms. Mossaides stated that family therapy could be considered a best practice.

Ms. Threadgill agreed to include best practices for children ages 0-4 as well as best practices for children who have been exposed to overdoses, domestic violence, etc.

Ms. Tracey mentioned that DMH works with parents who have mental health conditions, and this could be an area of focus as well.

A member of the public brought up that many agencies claim to be trauma-informed but not all of their staff are trained on being trauma-informed. He asked if it would make sense to start with trauma-informed practices so there is a universal definition before looking at the organizations that are doing the work and where children should be referred to.

Ms. Mossaides asked if the task force could do a quick survey on state agencies to see if there is a shared definition of trauma-informed to see what they include in their RFRs.

Ms. Morgia stated that they asked survey participants if they are interested in participating in a follow-up interview about trauma-informed care and this could be an opportunity to get more definitive answers on their definition of trauma-informed care within their individual organization.

A member of the public stated that there has been a Federal approach to having a universal definition of school-based trauma-informed care.

Ms. Mossaides mentioned that Kate Roper from DPH has been working on this topic.

Ms. Threadgill asked the task force how do we make this as simple as possible. How do we make a clinical definition relevant to all sectors including law enforcement?

A member from the public noted that there is a difference between trauma-informed care (services) and having a trauma-informed environment.

Ms. Lowenstein stated that the CTTF has an opportunity to define trauma-informed care and trauma responses. She said that attending trainings can only go so far, and sometimes the trainings can do more harm than good. The person who was trained may not have a full understanding of the topic but once the training is over, they do not have the opportunity to ask questions. In her opinion, she wants the CTTF to take the Commonwealth beyond trauma-informed and more towards trauma responsive. In order to do this, there needs to be a universal definition of what trauma responsive means. There is also a need to make sure that the trainings are more than just trauma-informed so people have a better understanding of the difference between single-incident trauma and complex trauma.

Ms. Threadgill asked if, based on this conversation, the group would prefer to start with developing guidelines on what trauma-informed/trauma-responsive case looks like first, and then move on to various topics such as the 0-4 age group throughout the upcoming months.

The group agreed with this plan of action. Ms. Threadgill said that OCA would prefer questions for a longer discussion on the topic of guidelines for the July meeting .

Closing Comments:

The next meeting will be held on July 23rd, 2019 from 1:00pm-3:00pm. The location is to be determined.

Adjournment: 10:45am