APPROVED BY COMMITTEE JULY 23, 2019

Office of the Child Advocate
Childhood Trauma Task Force Meeting Minutes
Tuesday, May 14th, 2019
9:00am-11:00am

Task Force Members or Designees Present:
Maria Mossaides, The Child Advocate, Chair (OCA)
Linda Spears (DCF)
Laura Brody (DCF)
Yvonne Sparling (DYS)
John Millett (MA Probation Services)
Stacy Cabral (EOE/DESE)
Thomas Capasso (Juvenile Court)
Tammy Mello
Rebecca Hamlin (Representative Whelan's Office)
Elizabeth Walk (Representative Dykema Office)

Other Attendees:
Margot Tracy (Mass Health)
Joshua Dankoff (CfJJ)
Cynthia Koskela (MGH)
Elizabeth Badger (PAIR Project)
Fiona Danaher (MGH)
Michelle Lee (Harvard Medical School)
Jordan Meehan (LGBTQ Youth Commission)
Anne Fox (Partners Healthcare)
Mark Hutchinson (JRI)
Osob Issa (BCH)
Emma Cardeli (BCH)
Other members of the public

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

Meeting Commenced: 9:08am

Welcome and Introductions:

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

Ms. Threadgill held a formal vote for the approval of the minutes from the April 10, 2019 CTTF meeting. There were no objections. The April 10, 2019 CTTF meeting minutes were approved.

Ms. Threadgill reviewed the agenda.

Addressing Trauma Experienced by Refugee and Immigrant Youth - Boston Children's Hospital Refugee Trauma and Resiliency Center (RTRC) Presentation:

Ms. Threadgill introduced Osob Issa and Emma Cardeli from the Boston Children's Hospital Refugee Trauma and Resiliency Center.

Ms. Cardeli described her role as a clinical psychologist and Ms. Issa's role as a clinical social worker at the Refugee Trauma and Resiliency Center (RTRC). She explained that the RTRC works in all of North America including Canada.

Ms. Cardeli talked about the importance of understanding sequential traumatization in terms of migration. This means that trauma occurs at many different points of migration starting from pre-migration, during migration, and post-migration. Some examples of traumatic experiences related to migration include:

1. Torture and detention (pre-migration)
2. Lack of access to basic resources (pre-migration)
3. Violence (pre-migration)
4. Sexual assault (pre-migration)
5. Displacement (during migration)
6. Loss/Separation from Family (during migration)
7. Community violence (post-migration)
8. Poverty (post-migration)
9. Discrimination (post-migration as discrimination can be a traumatic trigger - retraumatized)
10. The trauma continues post-migration during resettlement

Ms. Issa continued the conversation by discussing the four core stressors in Resettlement. At the RTRC, they refer to the core stressors as push factors that push children and families in the system. The four core stressors include:

1. Resettlement

    a. Legal
    b. Healthcare
    c. Financial
    d. Basic Needs
2. Isolation
    a. Discrimination
    b. Loneliness
    c. Alienation
3. Trauma
    a. Emotion Regulation
    b. Social Support
    c. Environment
4. Acculturation
    a. Family Relationships
    b. Cultural learning
    c. Language Learning

Ms. Cardeli explained that according to their statistics, of those with posttraumatic stress disorder, 92% of people did not seek services while 8% did seek services (ex: kids forced to be in the office). Service utilization rates are low and usually result from youth and families being pushed into the system instead of searching for services themselves.

Instead of utilizing services, a family may take many different pathways to "healing" their traumatic experiences. The RTRC demonstrated a Pathways to Healing reference map that shows how a youth might deal with coping. The map included the ideas that a youth may tell their friends, try to solve their problems on their own, or tell a family member. If they choose to tell a family member, the family may turn to religion as a coping mechanism, or if the situation intensifies, may send the youth back to their birth country. Another pathway a youth could take is talking to their teacher, which may escalate to involving the school counselor.

Ms. Issa discussed the barriers to mental healthcare and the strategies the RTRC uses to address those barriers.

Barriers to Mental Health Care → strategies to address barriers:
1. Distrust of Authority/Power → Community engagement
2. Linguistic and cultural barriers → Partnership of providers and cultural experts
3. Stigma of mental health services → Embedding services in service system
4. Primacy of Resettlement stressors → Integration of concrete services

Ms. Issa and Ms. Cardeli spoke about RCTR's Trauma Systems Therapy for Refugees (TST-R) model. TST-R is a multi-tiered model that integrates services by working in partnership with a cultural broker. A cultural broker is someone who is an expert in a specific culture that acts as a middle person to tie the family and services together. The model tiers are as follows:

1. Bottom Tier: Community - Outreach and engagement
2. Middle Tier: School - Skill building groups
3. Top Tier: Child - intensive intervention such as home-based services and/or school-based counseling (if needed)

RCTR also has developed a program model called Community Connect. The most important factor in the success of this model is making sure that the right people are at the table and involved in helping the youth. This model requires the collaboration of many different sectors and establishing a connection with the youth. Community Connect is a working example of this model and includes the following practices:

1. Engaging youth in needed services
    a. Outreach workers/trusted liaisons
    b. Consideration of primary source of pain
    c. Broad range of services
2. Increasing provider capacity
    a. Consultation to providers about cultural/social issues
    b. Linking services (school, law enforcement, social worker)
3. Ongoing connection
    a. Monthly meetings, outreacher maintains check-in contact
    b. Case closed when engaged in effective services and "green" for six months

Community Connect is a multidisciplinary approach.

Ms. Issa and Ms. Cardeli thanked the CTTF for inviting them to speak about their work at the Boston Children's Hospital Refugee Trauma and Resiliency Center.

Massachusetts General Hospital Presentation:

Ms. Threadgill introduced Cynthia Koskela, the School Program Coordinator for Newly Arrived Children and Families for Massachusetts General Hospital Chelsea campus.

Ms. Koskela briefly discussed her role as the School Program Coordinator and explained how the purpose of the Newly Arrived Children and Families program out of MGH Chelsea is to provide school and healthcare center-based services for immigrant/refugee children. The

program works within both the school and healthcare system as they interconnect in order to make sure that youth have the services they need to succeed. The program receives referrals from Chelsea Public School District social workers, the Parent Information Center, and health care center providers.

One of the main services that the Newly Arrived Children and Families program offers is providing healthcare navigation and advocacy to assist with school related concerns such as complex medical needs, school registration, and special education. They also provide referrals to outside resources that the youth or family may need. Examples of outside resources include KIND (Kids in Need of Defense), PAIR, Harvard Law, and Chelsea Behavioral Services.

As School Program Coordinator, Ms. Koskela develops and implements support groups within public schools for students in order to establish healthy peer relationships, obtain resources, process acculturative stress, support resiliency, celebrate culture, and provide a committed supported from an adult.

From July 2018 to present, 519 contacts have been made with students and parents/guardians enrolled in the program. Through this experience, Ms. Koskela provided recommendations for the Task Force to consider when discussing childhood trauma. She mentions the importance of understanding resiliency and protective factors such as family, religion, and education. Other recommendations include:

1. Increasing behavioral healthcare services for refugees; refugees currently have limited access to culturally responsive behavioral healthcare services due to limited insurance coverage (MassHealth Limited). Right now, the Chelsea Health Center has a 150-person waitlist.
2. Support Children's Health Access Coalition and Bill HB2615.
3. Increase access for culturally responsive social service supports and resources for newly arrived children and parents/guardians.
4. Increase funding for collaborative roles within the public schools that work specifically with immigrant children to provide healthcare navigation/advocacy.

Ms. Koskela thanked the CTTF for the opportunity to speak and provide legislative recommendations.

Mr. Capasso asked both presenters if their programs refer parents in need of services as well.

Ms. Cardeli explained that the RTRC does make referrals to mental health specialists for parents if they need it. They ask the parents what they need and who they would like to connect to. Although the child is the direct client, working with the parents and family unit is just as

important. This is the reason why they implemented cultural brokers as they build a trusting relationship with the family and then work as a liaison to outsider services (very similar to Family Partners).

Ms. Koskela discussed the importance of translators being present for family members and parents as English is either their second language or not understood at all.

Mr. Capasso asked about the collaboration of services process.

Ms. Cardeli responded that collaboration is key to having successful services. In order to do this, cross-sector partnership is necessary.

Ms. Mossaides commented that if cross-sector collaboration comes out as a recommendation, this would be a great chance to add both programs to the resources list on the website that is being developed. She discussed the issue of needing someone to keep all the contact/agency information up to date.

Ms. Mello suggested working with IT to set up a unique profile for each partner listed on the website so they can individually update their own information instead of placing the responsibility on one person. If this is possible, she recommended having a search tool that allows website visitors to search services by demographics.

Ms. Mossaides stated that the website could potentially really help Family Resource Centers.

Ms. Tracy brought up 211 and asked how services can placed onto the 211 list.

Ms. Mello suggested speaking with IT to see if there is current mechanism in place.

Ms. Issa informed the task force that they can reach out to the RTRC directly and speak with her if anyone has any questions or needs a formal consultation. Unfortunately, they do not currently provide direct services in greater Boston area.

Ms. Threadgill asked if either the MGH or RTRC programs work directly with the juvenile justice system.

Ms. Cardeli responded that RTRC does work with the juvenile justice system but sometimes it's a little bit too late if someone is already incarcerated. She explained that often times, a youth has been exposed to so much trauma that they are constantly triggered and feel unsafe even after immigration. Sometimes the coping strategies are maladaptive and can lead a youth into the

juvenile justice system. She believes that the isolation stressor is the leading factor that pushes kids into the juvenile justice system.

Ms. Koskela added that school attendance is another issue that leads to lack of services because if a child isn't attending school, there is a smaller chance of having someone notice that they need services.

An attorney from PAIR commented that police, school resource officers, and other law enforcement personnel need to be culturally responsive and understand the manifestation of trauma. She asked if school resource officers are trained. She stated that if so, they need to enforce the training models for law enforcement officials.

Ms. Cardeli stated that there is no functioning universal definition for culturally responsiveness and trauma-informed. She agreed that training is key, especially for front-line workers.

Ms. Threadgill wrapped up the discussion and turned the meeting over to the next presentation.

Department of Children and Families Presentation:

Ms. Threadgill introduced Commissioner Spears from the Department of Children and Families to speak about selected trauma initiatives within DCF.

Commissioner Spears briefly discussed the past Massachusetts Child Trauma Project (MCTP) and its purpose, which was to improve placement stability and outcomes for children in care experiencing complex trauma through capacity building for DCF staff, foster parents, and providers. The target population was youth ages 0-18 years old in DCF care presenting with complex trauma.

The MCTP launched evidence-based interventions and activities including the following:

1. Provider/Clinician training
2. DCF Staff/Foster Parents, Youth and Families Training
3. Child Welfare Took Kit
4. Resource Parent Curriculum
5. Psychological First Aid
6. Trauma Informed Leadership Teams - some teams still exist, some do not - project ended two years ago
7. Resiliency Conference

The MCTP identified three key indicators of success.

1. Caregivers were highly satisfied with the trauma training they received and experienced an increase in their knowledge of trauma.
2. Training/use of EBPs led to fewer trauma systems for children but also higher number of 51As due to the "surveillance effect."
3. Improvements in placement stability and permanency were less clear.

Commissioner Spears discussed current trauma related initiatives within DCF.

1. **New England Trauma and Resiliency Convening (NECWCD)**
   a. An annual convening of public child welfare agencies (has occurred the past eight years).
   b. Key themes include building a safety culture and racial justice.
2. **Trauma Series for Agency Leaders and Staff**
   a. 2019 Resiliency Summit
   b. Cultural Humility/Trauma Informed CW Practice: Using cultural humility can be a tool to proactively engaging children during their trauma disclosures and work. Wants to build skills of cultural humility for all front-line workers
   c. Trauma Informed Systems Development
3. **Trauma Supports for Foster Parents**
   a. MAPP Training
   b. MSPCC KidsNet Trauma Training
   c. MAFF Trauma Conference
   d. Permanency Mediation; Foster parents experience separation and loss when their foster child is either reunified with their parents or moved to a new placement. It can be an extremely stressful experience. Providing mediation is key for everyone involved. It helps the foster parent go through the separation, helps the biological parents who are upset that their child is with another family, and helps the child keep a sense of connectedness. It also establishes a collaborative relationship to support the child on an ongoing basis. Although work supporting the foster parent experience has been done, more work is still needed.
   e. UMass Trauma Coaching; Based out of Central Massachusetts, this program Trains foster parents on trauma as well as peer support with skills.
   f. Training is essential but if the clinicians and other providers don't know to implement the knowledge, it will not be as effective. It's necessary to map the trainings to the work that they do on a daily basis. Some will be trained and have the knowledge but do not have the interaction skills. Missing the piece about how they actually do the job after receiving the training and knowledge.
4. **Clinical managers for each area office and mental health specialists.**

   a. Originally, clinical managers were focused on providing administrative support on cases but now they are more clinically involved and play a key role.
   b. Mental health specialists have the ability to work with ongoing staff to provide support.

5. **Harvard Center for the Developing Child**
   a. Initial Goal: Develop an approach to build purposeful integration of the brain science in a public child welfare setting.
   b. Current Project goal: Integrate the Science of Child Development in child placement decisions, placing children, and supporting foster/kinship families.
      i. Support responsive relationships for children and adults
      ii. Strengthen core life skills
      iii. Reduce sources of stress in the lives of children and families
   c. Placement is not only the most stressful time for all involved, it is also the least supported function. There is stress on the social workers saying that they are removing the children and stress on the children removed from family. Acute and toxic stress affects everyone involved.
6. **In-Service Trauma Trainings**
   a. Child Welfare Institute
      i. Tailors the trauma training to the job that the person is involved in.
      ii. Development of New Social Worker Pre-Service Training Curriculum
      iii. Developmental and Neurobiological Impact of Child Maltreatment
      iv. Building Resiliency through Psychological First Aid
      v. Trauma Certificate Programs - Specifically for DCF staff
         1. Simmons College
         2. Bridgewater State University

A member of the public asked what happens to the sibling of a child who needs services and why DCF doesn't intervene.

Commissioner Spears explained DCF's legal mandate. The family would need to agree to voluntary services if DCF doesn't have enough of a case to bring them to court. She stated that 80% of services are families and children who are in-home.

Mr. Dankoff brought up the case study that was read during Ms. Koskela's presentation on a child who was struggling with trauma and mental health as a result of immigration-related stress. The case study mentioned that DCF was involved as a last resort, and to him, it seemed like the system failed the child.

Commissioner Spears explained that DCF has an Unaccompanied Minors services program for children who come to Massachusetts under that program. Children come into contact with DCF

either through voluntary services or through a CRA. DCF has contracts with various legal resources for immigration services and they work with community-based services focusing on immigration, but of course there are not enough services available. DCF tries to keep the children with the families and relatives if possible. Along with this, DCF also has a Youth Advisory Board for youth who are in group care. Lastly, she noted that issues of isolation are compounded when entered into foster care.

Closing Comments:

Ms. Threadgill wrapped up the meeting and noted that the next Childhood Trauma Task Force meeting will be held on June 4th, 2019 from 9:00am-11:00am at One Ashburton Place, 21st floor, Boston, Massachusetts.

Adjournment: 11:04am