Approved at May CTTF Meeting

Office of the Child Advocate
Childhood Trauma Task Force Meeting Minutes
Wednesday, April 10, 2019

Task Force Members or Designees Present:

Maria Mossaides, The Child Advocate, Chair (OCA)
Laura Brody (DCF)
Claudia Dunne (CPCS)
Yvonne Sparling (DYS)
Kate Lowenstein (CFJJ)
John Millett (MA Probation Services)
Stacy Cabral (EOE/DESE)
Thomas Capasso (Juvenile Court)
Emily Sherwood (DMH)
Stacy Cabral (DOE)
Michael Glennon (MA District Attorney's Association)
Rebecca Hamlin (Representative Whelan's Office)
Elizabeth Walk (Representative Dykema Office)

Other Attendees:

Andria Amador (BPS)
Shella Dennery (Boston Children's Hospital)
Michael Gregory (Trauma and Learning Policy Initiative)
Members of the Public

OCA Staff:
Melissa Threadgill (OCA)
Christine Palladino-Downs
Melissa Williams (OCA)
Lindsay Morgia (OCA)

Meeting Commenced: 1:00pm

Welcome and Introduction from the Child Advocate:

Ms. Threadgill welcomed the attendees to the fourth 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 March 13, 2019 CTTF meeting. There were no objections. The March 13, 2019 CTTF meeting minutes were approved.

Ms. Threadgill reviewed the agenda.

OJJDP Grant Opportunity - Comprehensive School-Based Approach to Youth Violence and Victimization:

Ms. Threadgill announced that the federal Office of Juvenile Justice and Delinquency Prevention recently released a grant opportunity that will support a comprehensive approach to address youth violence and victimization through implementing prevention, intervention, and accountability efforts in a school-based setting. The comprehensive approach should include new and/or existing efforts in the following core areas:

1. Provision of evidence-based mental health services for youth who experience trauma and exposure to violence in a school setting.
2. Universal bullying prevention and conflict resolution programming.
3. Student engagement to provide peer support networks.
4. Youth competence building interventions for accountability across the continuum of least intensive (innovative diversion/treatment programs) to more intensive (suspension, expulsion, arrest) with proper considerations for campus safety and promotion of an appropriate learning environment.
5. School safety and climate measures.

Any public agency may apply but the project site must be in a school setting. The grant will fund up to $775,000. The deadline to apply is May 20th, 2019.

Trauma Service Mapping Project Update and Initial Findings:

Ms. Threadgill introduced Lindsay Morgia, Research and Policy Analyst for the Office of the Child Advocate, who will provide an update on the trauma service mapping project.

Ms. Morgia stated that as of right now, individuals who work for the juvenile court (21%), community-based agencies (18%), state agencies (17%), and mental health service providers represent the highest response rate thus far. There are a total of 128 responses so far. The Department of Youth Services represented most of the state agency responses. The survey is missing responses from early intervention programs, early education programs, family shelters, CACs, Family Resource Centers, and community health centers. There have been no responses from anyone affiliated with a hospital, law enforcement, or probate/family court.

From the survey responses received, thirty-two respondents stated that their institution served the Cape and Islands. Less than twenty respondents stated that their institution serves Orange, Fitchburg, Cambridge, Chelsea, Salisbury, and Needham.

When asked if their institution considers themselves trauma-informed, the majority of respondents said “yes” (84%). 6% of respondents said “no” and 10% of respondents were not sure. When asked if staff members have been trained on trauma-informed care, over half (53%) of respondents said that some staff members have been trained, while 37% of respondents stated that all staff members have been trained.

When asked if their institution specializes in conducting trauma screenings, assessments, and interventions with specific populations of youth, 20 or more respondents work with homeless youth, youth with developmental disabilities, LGBTQ youth, Hispanic/Latino youth, and African-American youth. Ms. Morgia explained that the organizations might be answering this question by listing the populations they serve instead of listing the special populations they focus on. This question will need further clarification.

When asked about trauma screening, forty-five (out of 128) of the respondents said that they offer trauma screenings for children and youth. Of these respondents, 29% said that a referral is required in all cases, and 47% shared that no referral is required. The most common reported screening tools used were the ACES screening tool and MAYSI. CANS tied with the “other” category. The “other” category includes other screening tools not listed as options such as Mississippi PTSD, the ACEs survey, and in-house intake forms.

When asked about trauma assessment, thirty-six (out of 128) respondents said that they offer trauma screenings for children and youth. Almost half require referrals in all cases. The “other” category is the most common response at this point in time. Clinical interviews are often cited, as are other tools that were also identified in the screening category (Mississippi, MAYSI). Ms. Morgia stated that it might be worth exploring how providers understand the difference between screening and assessment.

When asked about trauma interventions, forty-five respondents (out of 128) said that they provide trauma intervention services to children and youth. 50% reported that referrals are not required. The most common intervention tools reported were Attachment, Self-Regulation and Competency (ARC), Dialectical Behavioral Therapy (DBT), and Cognitive Behavioral Therapy (CBT). Ms. Morgia stated that in order to get a better understanding of the trauma-interventions used, she will need to further explore the responses in the “other” category.

Ms. Morgia discussed the next steps for the survey. She explained that although we have a total of 128 responses, 13 of these respondents do not serve the geographic regions the CTTF was hoping to look at. Also, 46 of the respondents reported that they do not provide trauma services at all. The remaining 69 respondents may include people from the same agency or organization. She stated that we need to make sure there is a larger geographic representation in the survey respondents.

Ms. Morgia explained that we need to gather more responses from early intervention/early education, Family Resource Centers, hospital-based programs, CACs, CBHI, and LINK-KID. The Office of the Child Advocate has done some outreach to school-based health centers as well as the Massachusetts League of Community Health Centers.

Ms. Morgia said that the new survey deadline is April 30th, 2019. There are a few outside organizations that she needs contact information for. Ms. Morgia sent around the list of those organizations for task force members to look at and see if they have contact information for them.

Department of Elementary and Secondary Education Presentation on Trauma-Related Initiatives:

Ms. Threadgill discussed the legislative mandate which requires the CTTF to review the current means of identifying school-aged children who have experienced trauma and providing services to help children recover from the psychological damage caused by trauma. The legislative mandate also requires the CTTF to consider the "feasibility of providing school-based trainings on early, trauma-focused interventions, trauma-informed screenings and assessments, and the recognition of reactions to victimization, as well as the necessity for diagnostic tools."

In an effort to focus on this section of the mandate, Ms. Threadgill noted that today's meeting would focus on presentations from leaders in the field, starting with Stacy Cabral, from the Executive Office of Education, to discuss the Department of Elementary and Secondary Education's trauma-related initiatives.

Ms. Cabral provided an overview of the Safe and Supportive Schools (SaSS) program through the Department of Elementary and Secondary Education.

To begin, Ms. Cabral explained that the Safe and Supportive Schools Commission was created as a part of the SaSS Framework Law through an Act Relative to the Reduction of Gun Violence. There are a total of 18 voting members on the commission. The priorities of the Commission include the following:

1. Make recommendations to DESE's board on updating the framework and Tool;
2. Identify strategies to increase school's capacity in the realm of behavioral health;
3. Propose steps to improve school's access to clinically, culturally, and linguistically appropriate services; and
4. Provide funding sources to support the framework & Tool.

Ms. Cabral discussed the Safe and Supportive Schools Self-Reflection Tool. The goal of the tool is for school-based teams to go through a year-long self-reflective analysis of their current school and district in order to create and enhance the school's work to become more safe and supportive. The Self-Reflection Tool does not keep track of how each school is doing. As of 2010, over 200 usernames were created and there have been approximately 75 Grantees (schools).

Ms. Cabral provided a brief overview on the Safe and Supportive Schools grants. The grants provide funding to schools to support their initiative to organize, integrate, and sustain district-wide effort to create safe and supportive school environments.

Grant FC335, also known as the Action Planning Grant, has been designed for schools who have not gone through the Self-Reflection Tool. The purpose of the grant is to convene a school team composed of various stakeholders to review and respond to the questions in the Tool. The goal is to identify school and district areas to prioritize for improvements related to creating safer and more supportive learning environments. The grant also supports the work to finalize a school and district action plan that aligns with their priorities. The school creates their own action plan.

Grant FC337, also known as the Implementation Grant, is for districts that have already used the Self-Reflection Tool.. The purpose of this grant is to support these districts to allow them to begin or continue to implement their school-based action plans that were previously created. The grantees also serve as mentors for new Tool users.

During 2017-2018, the Safe and Supportive Schools initiative held various professional development series to further their work and understanding. They held a webinar hosted by Dr. Jayne Singer on "The Impact of Trauma on the Brain." They also held a webinar hosted by Joe Ristuccia titled "Small is the New Big." Winter regional meetings were also held in Holyoke, Bedford, and Worcester. Along with regional meetings, there was a statewide convening on Social Emotional Learning.

Ms. Cabral mentioned that a few anticipated activities for 2018-2020 include mentor/grantee presentations at the SaSS Commission meetings, another statewide convening on safe and supportive learning environments, and integrating cultural competency and implicit bias into the work of Safe and Supportive Schools.

Ms. Mossaides asked Ms. Cabral to discuss what issues the schools are coming up with through the grant process.

Ms. Cabral stated that schools get a sense of their needs through the grant application and their action plans. However, the issues vary by community. Some issues include the increase of poverty in their community, the issue of family engagement, suicide, and illicit drug use. One issues that has come in schools that are close to medical centersis increased trauma as many students have siblings who are going through treatment are at these medical centers.

Mr. Gregory said that it was pleasing to hear as an advocate the number of grants that are available to various school districts, and that action plans are being are implemented in more than one school in the district.

Ms. Sparling asked if there have been differences in needs between age groups such as elementary, middle, and high schools.

Ms. Cabral stated that some school districts apply for all their schools and some districts apply for just one area or school. Most school districts want to implement the action plans in multiple schools in their area.

Ms. Walk asked how many implementation grants have been awarded thus far.

Ms. Cabral responded that about 15 grants have been awarded at this point.

Trauma and Learning Policy Initiative Presentation:

Ms. Threadgill introduced Michael Gregory, a Clinical Professor of Law at Harvard Law School as well as the managing attorney of the Trauma and Learning Policy Initiative at Massachusetts Advocates for Children.

Mr. Gregory started off by providing a brief explanation of the Trauma and Learning Policy Initiative at Massachusetts Advocates for Children. He explained that the project is a collaboration between Massachusetts Advocates for Children and Harvard Graduate School of Education and has existed since 2004. The mission of the initiative is to ensure that children traumatized by exposure to violence and other adverse childhood experiences succeed in school. They do this by representing individual families, partnering direction with schools, and by looking into policy changes that benefit both families and educators. Lawyers on the team help represent families during school meetings to make sure the school understands the impact of the family's trauma. Non-lawyers and former school clinicians are also on the team.

The initiative's website is www.traumasensitiveschools.org.

The Trauma and Learning Policy Initiative defined trauma-sensitive school as a school in which all students feel safe, welcomed, supported, and where addressing trauma's impact on learning on a school-wide basis is at the center of its education mission. In other words, a school approach where educators address not only their role as teachers, but creating a safe and stable school for children who experience trauma outside of school hours. He displayed an example of a trauma-sensitive school by showing the task force a video clip about the Baker School in Brockton, Massachusetts.

Mr. Gregory discussed the initiative's view on the appropriate role of schools when it comes to addressing trauma and trauma screening. He stated that schools might not be the appropriate place to screen children. There are other settings where screening is less problematic and more effective, such as the primary-care physician's office. He explained that policy makers need to make sure their policies do not inadvertently stigmatize children who have experienced trauma. It can cause more harm to identify the children who have experienced trauma and treat them. There is a need to create a whole trauma-sensitive environment instead.

Mr. Gregory continued to explain that a school's role is to create a whole-school safe and supportive environment with collaborative services. He believes that universal screening in schools is problematic because not all students who have experienced adversity will struggle in school. Along with this, due to the high potential for stigma, screening for experiences is more problematic than identifying clusters of symptoms in students who are exhibiting observable difficulties in school.

Finally, Mr. Gregory read a statement from Ryan Powers, Assistant Superintendent at Bridgewater-Raynham Public School, about school-based screenings. Mr. Powers had hoped but was unable to attend the meeting:

> *"While the notion of screening students for traumatic events could be a beneficial process, I do believe it is premature to include this as part of legislation that would mandate schools to do this. Not all schools are "trauma sensitive" and ready to deal with the results of such a screening. I understand the intent behind it, but I also see the negative impact it could have if not rolled out properly or to schools and/or districts that are ready.*
>
> *I equate it to screening children for academics. We often screen all students for fluency. Some of these students score in the "red" or in at risk category requiring interventions to boost and bolster their reading skills. Imagine if we didn't have trained educators to*

provide those interventions. Who would teach our children to read? Who would help them make effective progress? I worry this very scenario would come true if we begin to prematurely start screening all students for trauma. Are schools and/or districts ready to provide interventions to students that score in the "red" for having multiple traumatic experiences? The answer is no. While some schools and/or districts have transformed themselves to become trauma sensitive and may be ready to take this next step, most districts are not. Also, unlike academics, this kind of screening doesn't make sense for all students. It only makes sense where students are already experiencing some form of academic or social/emotional difficulty at school and we need to understand more about what might explain these challenges. It doesn't make sense to disrupt a child's school experience when it is going well by asking invasive questions about potentially shameful topics.

If you are looking for a place to start, do not make it mandatory and do not suggest it be used for all students. Make it a resource for schools that are ready to use it or that see it as a valuable tool and resource. Not all schools, even if they are ready, will want to use this screener. Mandating this screener, but not providing the financial resources to districts to then deal with the results will unfortunately be seen as just another unfunded mandate and be thought of poorly."

Behavioral Health Services (Boston) Presentation:

Ms. Threadgill introduced Andria Amador, the senior director for the crisis team in Boston through Behavioral Health Services in partnership with Boston Children's Hospital.

Ms. Amador briefly described the Comprehensive Behavioral Health Model (CBHM) as a preventative model to build capacity within Boston Public Schools to meet the behavioral health and social emotional needs of all students. She explained that every child deserves a safe and supportive school. The CBHM incorporates the use of a universal screener to identify students at risk for social, emotional and/or behavioral health concerns early, and monitors student progress throughout intervention services. Implementation in Boston Public Schools began in ten schools during the 2012-2013 school year. Currently, the model is being implemented in 60 BPS schools, serving over 24,000 students. Only 10% of schools in the United States are using Universal Screening.

The CMHM supports universal screening within the school environment as children are in school for about 35 hours a week. It used evidence-based practices to assess the essential components of effective universal screening. The model is based on a three-tier system approach.

1. **Tier One:** Prevention (For All Students); Takes about three to five years for the school environment to change. The screening/progress monitoring occurs twice a year at this tier.
2. **Tier Two:** Targeted (For Some Students); The screening/progress monitoring occurs monthly at this tier.
3. **Tier Three:** Intensive (For a Few Students); The screening/progress monitoring occurs weekly at this tier.

Ms. Amador provided a brief explanation of the Behavior Intervention Monitoring Assessment System (BIMAS). She discussed the different aspects of the BIMAS Scale and what it measures.

Ms. Amador explained that as of right now, 80 schools in the Boston Public School district have a mental health partner, while 45 schools do not. The mental health partners are not full time, as some only come one or two days a week. Because of this, many of the students do not get services through the mental health partners. Instead, they are seen by their guidance counselor. She stated that schools shouldn't have to choose between hiring teachers or mental health professionals and believes that the Commonwealth should have funding set aside for child mental health professionals within schools.

Boston Children's Neighborhood Partnership Presentation: Shella Dennery

Ms. Threadgill introduced Shella Dennery from Boston Children's Hospital Neighborhood Partnerships (BCHNP). The program is a community behavioral health program through the Department of Psychiatry at Boston Children's Hospital. The program began in 2002 and currently has a team of 21 staff members including social workers, psychologists, and psychiatrists. They are partners with 17 schools and two community health centers in Boston. The program has five main goals:

1. Increase access to high quality, culturally relevant behavioral health services for children and adolescents.
2. Promote children's healthy social emotional development in youth.
3. Build the sustainable behavioral health capacity of partner organizations.
4. Promote systemic change in behavioral health service delivery.
5. Provide services that achieve a high rate of satisfaction with all stakeholders.

The program also provides depression awareness curriculum to high schools across the nation as many teachers do not have an educational background or training in child mental/behavioral health. They do this through the Training and Access Project (TAP) which has online trainings and workshops on various behavioral health topics. The trainings can found at www.childrenshospital.org/TAPonline.

Task Force Discussion:

Ms. Threadgill thanked the three presenters and opened the floor for task force members to ask questions.

Ms. Sparling asked how long it takes for educators to go through BIMAS.

Ms. Amador stated that the first step is to teach educators about trauma and BIMAS. This is completed during the Fall and Spring of the school year. When teachers do the universal screenings, it takes about 2 minutes per child. As of right now, the overall screening rate is 89%. They have piloted self-assessment screenings in the middle and high schools.

Ms. Sherwood asked Ms. Dennery if there a plan to get the video trainings out to the public. Ms. Dennery said that there is no current marketing plan to get the word out. Ms. Sherwood stated that DMH would love to help and be a part of the outreach.

Ms. Dunne commented that not all children who experience trauma develop PTSD. The majority of children she works with experience chronic trauma. She asked if chronic trauma is addressed.

Ms. Dennery responded that chronic trauma is addressed but not in a overly clinical way. Teachers want to watch a video about how it affects them in the classroom.

Ms. Amador explained that they send home an information sheet on universal screening to parents to explain the process and reasoning. They also hold an information session in the beginning of the school year during open house to address any questions or concerns. She explained that the universal training does not only focus on trauma, and they do not advocate for trauma-specific universal screening.

Mr. Gregory agrees with this approach as trauma-specific screening can have many negative unintended consequences.

Ms. Amador explained that they do not have the capacity to effectively trauma screen. She stated that Boston is under resourced and it would be irresponsible to screen when they do not have the resources to provide effective treatment responses when trauma is identified.

Ms. Mossaides asked how often the universal screenings result in the filing of a 51A report.

Ms. Amador said that they have no way to know how many Boston students are in DCF custody or how many teachers have filed a 51A. She explained that they do not collect this data. They

only work on screening. When a child is screened and the next step is assessment, DCF may become involved if necessary.

Ms. Mossaides explained that is the Office of the Child Advocate is launching a rewrite of mandated reporting laws. She stated that a recent audit showed that two Massachusetts hospitals could not identify how many 51As were filed. There is currently no way to track this information down. As a child protective issue, it's necessary to make sure that the 51A is filed and not just given to higher management where it's not actually filed in the end.

Ms. Amador said DCF would need to work with DOE to see where the 51As should be stored. If the 51A report is stored in the student file or nurse's file, she asked who should have access to that information.

Mr. Glennon stated that from the perspective of someone who works with higher risk system-involved youth, many high-risk youth do not attend school as much. If a student only attends school 10% or 20% of the time, will the school still provide these services?

Ms. Amador said that it would be hard to provide services if the student doesn't show up. However, studies show that student dropout occurs most often when the student doesn't feel connected to a teacher or the school community. Younger children with trauma will always attend school. It's different when the students are older.

Ms. Dunne asked about middle school students.

Ms. Amador stated that middle school is hard for everyone. Boston Public Schools is adopting more K-6 and 7-12 grade school to help eliminate the frequency of school change so students don't lose the sense of community they are used to.

Closing Comments:

Ms. Threadgill wrapped up the meeting with a few closing questions regarding other school-based approaches to trauma screenings and assessment. She asked about the challenges and barriers to improving school responses to trauma.

Ms. Amador responded that schools should conduct trauma-screenings but these should only be administered through mental health professionals. Schools should not conduct universal trauma-specific screenings. Overall, universal school-based behavioral health screenings should occur. No school is appropriately staffed to conduct effective universal trauma screenings and Massachusetts has not made it a requisite to have the necessary mental health professionals to do so. She believes that there needs to be a state mandate surrounding the hire of mental health

professionals in schools. She does not think that pediatricians are the appropriate person to administer the screenings either.

Mr. Gregory explained that not all screening tools are the same and there can often be a misunderstanding about the different types of trauma screening. Schools are currently doing a more administrative screening. Some people may feel more comfortable building a deeper dive into their trauma with someone in a mental health profession instead of someone with an education background.

Ms. Dunne reiterated her opinion that primary care physicians should not be the ones screening for trauma.

Ms. Mossaides explained that to legislators, schools are a logical place for trauma screening. She asked, how do we address the issues that arise when schools are the place for trauma screenings? Schools appear to be the only common denominator at this point in time. We do not want youth to move in the direction of the juvenile justice system. We need to start trauma screenings as early as possible and schools might be the most appropriate place to start.

Mr. Gregory agreed that there is such a need for trauma assessment and treatment, but the workforce is just not there to be able to effectively do so.

Ms. Threadgill thanked everyone for today's meeting. She ended the meeting with a note that the next meeting will be held on May 14th, 2019 at 9:00am-11:00am (One Ashburton Place, 13th Floor, Room 1306).

Adjournment: 2:59pm