Office of the Child Advocate
Childhood Trauma Task Force Meeting Minutes
Monday July 18, 2022
1:00pm-3:00pm
Meeting held virtually

Task Force Members or Designees Present:
Maria Mossaides (OCA)
Rachel Wallack (Juvenile Court)
Rachel Gwaltney (CLM)
Janice Lebel (DMH)
Andrea Oliveira (DMH)
Kate Lowenstein (CfJJ)
Brian Jenney (DPH)
Shawna Boles (DYS)
Claudia Dunne (CPCS)
Dawn Christie (Parent Representative)
Laura Brody
Claudia Dunne

OCA Staff:
Melissa Threadgill
Alix Rivière
Jessica Seabrook
Morgan Byrnes

Other:
Katherine Hughes (Parent Child Trauma Resources)
Shaplaie Brooks (MA Commission on LGBTQ Youth)
Brooke Arrigo (Suffolk DA)
Erin Spencer (Cambridge Public Schools)
Jillie Santos (CfJJ)
Courtney Chelo (MSPCC)
Kathleen Bitetti (SAO)
Jennifer Urff (MAMH)
Other Members of the Public

Meeting Commenced: 1:01 pm

Welcome and Introductions:

Ms. Threadgill welcomed the attendees to the Childhood Trauma Task Force (CTTF) meeting. CTTF members and guests introduced themselves.

Review and Approval of Minutes from June 27, 2022 Meeting:

Ms. Threadgill held a formal vote on the approval of the June 27, 2022, meeting minutes. Maria Mossaides, Dawn Christie, Brian Jenney, Rachel Wallack and Janice Label all voted in the affirmative. Kate Lowenstein and Shawna Boles abstained. No one was opposed.

The meeting minutes for June were approved.

Update: Information on MAYSI-2 Administration

During the June meeting, members had questions regarding the administration of the MASYI-2, including the completion time and general best practices around administering it to youth with reading difficulties (e.g. dyslexia). In response to those questions, OCA staff met with the creator of the MAYSI-2 who explained that that MAYSI takes 5-10 minutes to complete and was read aloud by staff (if administered via paper/pencil) or read aloud by the computer (if administered online).

Review of Draft Recommendations for Trauma Screening in K-12 Settings

Ms. Threadgill began presenting on the draft findings including the need to think of trauma screening within an overall behavioral health screening strategy, the need to present different approaches for screening in schools and an overview of existing structures to facilitate implementation. Ms. Threadgill then presented the draft recommendations at both the school level and the state level, including

- Schools should be trauma responsive, have tiered supports in place and screen for behavioral health prior to screening students for trauma
- If schools are prepared to trauma screen, they should provide training and caregiver consent, and pilot a culturally appropriate, strength-based program. Schools should also collect and analyze data.
- Because of the varied financial and logistical capacities in schools, the CTTF should provide multiple models of trauma identification.
- When implementing screening processes, schools should also follow the group's recommendations detailed in the General Requirements section.
- The Commonwealth should support schools in their efforts and provide training and technical assistance.

Members discussed the recommendations, including how bias could impact which students get screened and which do not. Members discussed possible oversight of implementation.

Discussion of Trauma Screening in Pediatric Primary Care

Ms. Threadgill introduced trauma screening in pediatric primary care settings, reminding the group that they have previously heard a presentation on the topic from the Utah Pediatric Integrated Post-trauma Services (PIPS) Team.

Ms. Rivière began giving background on the topic, including:

- where the OCA sourced the presentation's information from, which included interviewing pediatricians and conducting a literature review
- arguments in favor for screening in pediatrics, which included the near universal coverage (90% of children go to their annual well-child visits), the existing infrastructure (pediatricians already use other screening tools) and pediatrician's holistic approach to children's health
- concerns reported by pediatricians, including the limited time of the average well-child visit and the ethics around screening without the ability to provide services
- existing models of trauma screening, including how some primary care providers have incorporated trauma screening into their practice (Team UP for Children in Boston, Utah PIPS and ACEs Aware in California)
- existing alternative models to universal screening, including observation or conversation and selective screening

One member asked if the existing models presented on took into consideration the trauma specific to certain identities, such as LGBTQ-specific trauma. It was explained that the screener, because it is brief, does not delve deeply into the causes of trauma. If implemented correctly, the provider will then have a broader conversation and recommend appropriate services.

Members also discussed concerns reported by pediatricians, with some members noting how few reported feeling as though they only had adequate knowledge of childhood post-traumatic stress disorder (PTSD). It was explained that pediatricians are not specialists and therefore might feel less prepared compared to someone who is trained in trauma identification and screenings.

Ms. Threadgill then began to present on the American Academy of Pediatrics (AAP)'s Policy recommendations on trauma screening, including:

- For providers: "Surveillance and standardized screening to assess staff and patients for trauma exposure, symptoms, and strengths are important components of trauma-informed pediatric care. . . Formal screening should always be for the benefit of children and adolescents, avoid re-traumatization, and identify protective as well as risk factors"
- For health systems: "Expand and improve system-wide strategies for identification and treatment of all children and adolescents affected by traumatizing experiences."

- For government: "Mandate coverage for TIC services by government and private payers, including screening, diagnosis, office-based management, counseling, case management, community collaboration, and home visiting."

She then presented on the group's draft recommendations, including:

- For providers: in line with the AAP, the group could recommend that providers adopt a structured model of trauma identification that could include observation, selective screening or universal screening.
- For MassHealth and commercial health plans: the group could recommend insurances offer guidance on what screening tools providers could use, reimburse providers for the use of trauma screening tools, and consider opportunities to pilot and evaluate initiatives that include the use of screening tools.
- For the state: the group could recommend the mandated coverage of trauma screening as well as services necessary to support a trauma-responsive screening process (e.g. in-office management, training, referrals), support efforts to integrate behavioral health care into pediatric primary care, as well as support and expand existing training initiatives.

Members discussed the recommendations, including the possible net widening effect of these recommendations and the current lack of trauma-informed services available. One member noted that this could lead to doctors overprescribing medication in place of treatment.

Members also discussed what recommendations the group could make to help support pediatricians feel more comfortable discussing and addressing trauma. It was decided that the group would investigate current training practices and look into what pediatricians identify as needing to feel supported.

Ms. Threadgill thanked members for their discussion and explained that the feedback provided will be incorporated into the draft recommendations, and reviewed by the group at the September meeting.

Closing Comments:

Ms. Threadgill thanked the members and other attendees for their time and their continued efforts and set the next meeting date for September 12, 2022.

A**djournment**: 2:17 pm