Childhood Trauma Task Force

July 18, 2022

1pm-3pm

Agenda

- Welcome & Introductions
- Approval of June Meeting Minutes
- Update: Information on MAYSI-2 Administration
- Review of Draft Recommendations for Trauma Screening in K-12 Settings
- Discussion of Trauma Screening in Pediatric Primary Care

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MAYSI-2 Administration

- MAYSI-2 completion time:
  - 5-10 min for paper/pencil
  - Less than 5 min online

- Reading difficulties (e.g. dyslexia):
  - Online MAYSI-2 has capacity to read the items to the youth aloud
  - Paper/pencil version: youth reads aloud the first question. If the youth has any difficulty reading, the staff person reads each item aloud while the youth circles yes/no on their own copy of the questionnaire. (But the youth does not answer aloud).

- MAYSI-2 is not administered over several sessions

DRAFT RECOMMENDATIONS FOR TRAUMA IDENTIFICATION/ SCREENING IN K-12

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Draft Findings

- Discusses the relevance and impact of BH issues among students and the need to think of trauma screening within an overall BH screening strategy

- Presents different existing approaches for BH/trauma identification in schools: universal screening, selective screening, surveillance (no screening)

- Details existing structures and resources to facilitate implementation

Draft Recommendations for Trauma Identification and Screening Processes in K-12 Settings

- While there are many benefits to adopting a structured process (e.g. screening) to identify students who may be impacted by trauma, the CTTF strongly believes that establishing a trauma screening process is not the first, second or even third step a school should take to better support students

- Trauma screening should take place only after the following have been implemented:
  - TIR environments
  - Tiered systems of support and established pathways for connecting students who are in need of services
  - BH screening

Draft Recommendations for Trauma Identification and Screening Processes in K-12 Settings

- The CTTF believes there is no one-size-fits all approach to trauma screening, but instead recommends schools consider each of the following methods:
  - Universal screening
  - Selective screening
    - Data (student meet cut-off scores of BH screener or other data “red flags”)
    - School personnel observation
    - Student or caregiver referral

- When implementing screening processes, school should also follow recommendations detailed in Part 1 (“General requirements”)

Draft Recommendations for Trauma Identification and Screening Processes in K-12 Settings

- The CTTF recommends the state continue to provide:
  - Implementation training and technical assistance (TTA) to ensure BH and trauma screening can be done efficiently and in a trauma-responsive way, and expand TTA availability to meet demand as needed
  - Supports for schools seeking to adopt TIR practices and/or establish tiered systems of support

TRAUMA SCREENING IN PEDIATRIC PRIMARY CARE

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Trauma Screening in Pediatric Primary Care: OCA Sources of Information

- **Interviewed ten pediatricians** (and their teams)
  - In MA and other states (CA + UT)
  - Working in different types of practices (primary care, integrated BH)
  - With diverse clinical/implementation experience
- **Conducted literature review**
  - Peer-reviewed studies
  - Grey literature
- **Consulted with MassHealth on current practices**

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Arguments for Why Pediatricians Should Screen for Trauma

- Near universal coverage: more than 90% of children go to their well-child visits.
- Screening for health concerns (e.g. autism, oral health) is a routine part of pediatricians' practice
- Pediatricians are trained to take a holistic approach to children's wellbeing
- Within integrated healthcare systems, screening for trauma at the pediatrician's office provides an opportunity for immediate links to behavioral health care if needed

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Arguments in favor of *structured* methods of trauma identification in pediatrics

- Pediatricians are not always confident they can identify and manage trauma-related issues among children
  - A 2008 study of 597 pediatricians in Massachusetts revealed that only 18% of pediatricians within a pediatric primary care clinic reported feeling they had “adequate knowledge” of childhood PTSD
  - While there has been much progress in the field of TIC, conversations OCA had with pediatricians revealed this is still the case for many providers

- Even when providers focus specifically on behavioral health, studies show that they can miss trauma-related concerns

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Pediatrician Concerns re: Universal Trauma Screening

Most pediatricians in Massachusetts did not enthusiastically support implementing trauma screening in pediatric primary care and offered arguments also seen in the literature:

- It would be unethical to screen without being able to refer to services (lack of referral networks + lack of available trauma-focused services)
- Providers have limited time (15 min consultations)
- Surveillance (i.e., observation of toxic stress response or discussion) is sufficient
- The fee-for-service system does not include reimbursement for trauma screening

Existing Models of Trauma Screening in Pediatric Primary Care

- Some primary care providers have incorporated trauma screening into their practice:
  - Team UP in Boston, MA
  - Utah PIPS
  - ACEs Aware in CA

- Providers use different types of trauma screening tools. Those usually identify:
  - PTSD symptoms
  - Potentially traumatic events
  - Impacts of trauma on child's overall functioning: developmental or psychosocial concerns
  - Environmental risk factors

TEAM UP FOR CHILDREN

Transforming and
Expanding
Access to
Mental Health Care in

Urban
Pediatrics

8-year initiative to build capacity of 7 community health centers to deliver integrated BH care to children and their caregivers

- Training teams to map out what to do to support children's BH issues, emphasize a strength-based parenting approach
- Identify risks, notably by using screening tools (SWYC, PSC, SDOH screener)
- Deliver a brief trauma-informed assessment & intervention for children 0-6 (BRANCH initiative)

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TEAM UP FOR CHILDREN

BRANCH initiative was developed in response to PCPs and BH clinicians' low confidence to identify and manage trauma-related issues in young children.

BRANCH seeks to:

- Train providers on IECMH (attachment theory, social emotional dev't, impact of trauma)
- Facilitate usage of screening tools (ASQ, trauma questionnaire and symptom checklist)
- Provide reflective consultation
- Expand BH services to young children

1 of the first 3 health centers where BRANCH was implemented decided not to use trauma screeners. The 2 other centers reported continued discomfort using them.

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PIPS

- The Pediatric Integrated Post-trauma Services (PIPS) developed the **Care Process Model for Pediatric Traumatic Stress** (CPM-PTS) in collaboration with NCTSN, AAP, American Academy of Child and Adolescent Psychiatry
- Incorporates a screening tool for:
  - Trauma exposure (UCLA Brief Screen)
  - Symptoms of traumatic stress (UCLA Brief Screen)
  - Suicidality (PHQ-9 Question #9)
- Includes a roadmap for providers:
  1. Report if required
  2. Respond to suicide risk
  3. Stratify treatment response
     - Depending on score + observation + shared decision-making
     - Brief in-office intervention
     - Referral + follow-up at regular interval

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PIPS team presented 4 key findings for primary care:

1. CPM-PTS finds trauma exposure, suicidality & traumatic stress symptoms in children seen in pediatric settings (13% of 1,472 screened children presented with traumatic stress symptoms)

2. CPM-PTS highlights areas for primary care response missed by other screening practices

3. CPM-PTS triages response for primary care by distinguishing between high risk and no risk of PTSD

4. More than screening, the CPM-PTS guides decision-making and trauma-informed care response

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aces aware
SCREEN. TREAT. HEAL.

- California-wide effort to screen children and adults for Adverse Childhood Experiences (ACEs) to prevent and treat toxic stress – implemented in January 2020

- In a fee-for-service system, providers are reimbursed $29 for every child screened annually. To participate, providers must:
  - Complete a 2-h online training in the administration and interpretation of ACEs screening
  - Use the Pediatric ACEs and Related Life-events Screener (PEARLS) tool
  - Use an ACE-associated health conditions checklist (e.g., asthma, allergies, anxiety, depression)
  - Complete a wellness exam

- Between January 2020 and September 2021:
  - 20,600 providers completed the training
  - Over half a million Medi-Cal beneficiaries screened (80% were children)

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aces aware
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- There has been much criticism (detailed in *Interim Report*) on the usage of an ACEs questionnaire to assess risk of toxic stress, namely:
  - ACEs do not necessarily equate trauma or toxic stress
  - There are no proven interventions based on one's ACEs score
  - ACEs questionnaires are a poor predictor of future health outcomes at the individual level

- Currently, there is a 2021-2023 NIMH-funded project developing and testing a strategy designed to support the implementation of ACEs Aware policy in 6 health centers providing care for underserved children and families. The study expands on the ACEs Aware initiative by:
  - Adding the Pediatric Symptom Checklist to assess potential behavioral manifestations of trauma
  - Incorporating a more robust clinical workflow (i.e. roadmap) for staff

Alternative Models of Trauma Identification

1. Surveillance, which includes observation or conversation ("Has anything scary or upsetting happened to you?")
   - AAP defines **detection** as involving "**both surveillance and screening**" (2021 Clinical Report on TIC)

2. Selective screening, based on:
   - Youth or caregiver self-referral
   - Observation of possible PTSD symptoms
   - Scores on other screening tools (e.g. BH or developmental)

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Alternative Models of Trauma Identification

3. Screening parents/caregivers for trauma and/or psychosocial issues to focus on the caregiving relationship

- Past traumatic experiences impact the caregiving relationship
- Issues, such as substance use, depression, or intimate partner violence can disrupt the home environment and family relationships

4. Multiple providers highlighted Social Determinants of Health (SDOH) screening as a better alternative, as providers can more effectively refer to needed services

Additional Cautions When Implementing Trauma Screening

- Trauma screening should only be implemented within a trauma-informed care framework
  - AAP 2021 Policy Framework highlights that screening/surveillance is one of three trauma-informed practices (Realize the impact of trauma; Recognize signs; Respond to mitigate impact)

- Screening should not only emphasize deficits; it should also build on child and family protective factors
  - Screening should take place within a strength-based approach (For ex, using the HOPE framework)
  - For parents who have experienced maltreatment themselves, helping them draw from PCEs can greatly benefit their relationship with their children ("Angels in the Nursery," 2005)

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AAP Policy Recommendations re: Trauma Identification (Aug 2021)

- **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 retraumatization, 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."

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Draft Recommendations for Providers

In line with AAP 2021 policy recommendations, the CTTF could recommend that pediatric primary care providers adopt a structured model of **trauma identification** as a critical part of trauma-informed care, such as:

- Surveillance (includes asking patients/caregivers “Has anything scary or upsetting happened?”)
- Selective screening when:
    - Patient presents with symptoms of toxic stress or reveals experience of potentially traumatic event
    - Patient is at increased risk based on results of developmental, BH, or environmental factors screener
- Universal screening, which could be particularly appropriate in integrated BH care practices (e.g. PIPS model)

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Draft Recommendations for Providers

- Providers using a trauma screening tool should do so as part of trauma-informed care, as delineated by the AAP's 2021 Clinical Report

- Providers should use an established, structured roadmap (e.g., Care Practice Model developed by PIPS team) to identify and stratify treatment response, refer child if necessary, and follow up at regular intervals

Draft Recommendations for MassHealth & Commercial Health Plans

- Reimburse providers for the use of a trauma screening tool
- Offer guidance to pediatricians on what trauma screening tools to use and when
- Consider opportunities to pilot and evaluate initiatives that include the use of screening tools and training (such as Team UP or the Utah PIPS model)

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Draft Recommendations for State Support

The CTTF could recommend the state:

- In line with AAP recommendations, mandate coverage for TIC services, including screening, office-based management, case management, community collaboration

- Support efforts to integrate behavioral health care into pediatric primary care settings to increase availability of pediatric behavioral health support

- Support and expand on existing training initiatives on TIC in health care settings and the use of screening tools

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Next Meeting

September 12, 2022
Virtual Meeting
For virtual meeting information, email Morgan Byrnes at Morgan.Byrnes@mass.gov

2022 CTTF meetings will be on the
1st Monday of the month 1:00pm-3:00pm

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