Office of the Child Advocate
Childhood Trauma Task Force Meeting Minutes
Monday July 19, 2021
1:00pm-3:00pm
Meeting held virtually

Task Force Members or Designees Present:
Dawn Christie (Parent)
Tammy Mello & Rachel Gwaltney (Children's League of MA)
Laura Brody (DCF)
Rachel Wallack (Juvenile Court)
Maggie Randall (Sen. Boncore's Office)
Yvonne Sparling (DYS)
Nicole Daley (DPH)
Claudia Dunne (CPCS)
Kate Lowenstein (CfJJ)

OCA Staff:
Melissa Threadgill
Alix Rivière
Marcella Familiar-Bolanos (Summer Research Fellow)

Other:
Brooks Keeshin (Utah PIPS)
Kara Ann Byrne (Utah PIPS)
Lindsay Shepard (Utah PIPS)
Erin Spencer (student at Lesley University)
Rebecca Pries (Massachusetts Alliance of Juvenile Court Clinics)
Aditi Subramaniam (MSPCC)
Edward Jacoubs
Jacki Reinert (LUK Inc)
Heather Forkey (UMass Medical)
Audrey Smolkin (UMass Medical)
Katherine Hughes
Kathy Reboul
Other Members of the Public

Meeting Commenced: 1:02pm

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 2021 Meeting:

Ms. Threadgill held a formal vote on the approval of the June 7, 2021 meeting minutes. No one was opposed or abstained from voting on the June meeting minutes. The meeting minutes for June were approved.

Update on Center for Child Wellness & Trauma

Ms. Threadgill told the group that as a direct result of this group's work and recommendation in the 2020 CTTF report, the Legislature has granted the OCA $1 million to develop the Center for Child Wellness & Trauma (CCWT). She invited Audrey Smolkin, Director of Children and Family Policy at UMass Medical, to describe to the group plans for the CCWT. Ms. Smolkin has been collaborating with the OCA for the last half dozen months to develop the Center concept. The group heard about the planned core components of the Center and the goals and objectives of the Center, including the adoption of a racial equity lens and a focus on stakeholder engagement and feedback. Ms. Smolkin praised the group for their policy work and their effort to push for ideas to be implemented on the ground.

Presentations on Trauma Screening in Pediatric Settings

1. Dr. Heather Forkey (UMass Medical)

Dr. Forkey presented on the identification of children with trauma symptoms from a pediatric health perspective. She first discussed ACEs, toxic stress, and resilience. She then explained that some children suffer more than others. The role of pediatricians is to identify which child can tolerate the stress or trauma. She explained that pediatricians should recognize and prioritize buffering protection from adult caregivers. She presented the spectrum of symptoms and explained that pediatricians are trained to understand patterns.

She then presented on three levels of pediatric care to address childhood trauma, which are also laid out in an upcoming American Academy of Pediatrics policy statement for providers and organizations:

- Primary prevention, when pediatricians support resilience and conduct routine surveillance for trauma by asking questions such as "has anything scary of upsetting happened to you/your child?"
- Secondary prevention and intervention, when pediatricians look for symptoms of trauma
- Tertiary care, when pediatricians actively address the effects of trauma and identify what the child and family need to recover

2. Pediatric Integrated Post-trauma Services (Utah PIPS)

Ms. Shepard presented on identifying and responding to children at risk for traumatic stress in pediatric settings and the Care Process Model developed by Intermountain Healthcare and the University of Utah. She began by describing the prevalence of trauma and the need to identify and respond to traumatic stress in children. She then presented on the science behind screening, identifying, and responding to child trauma and traumatic stress and highlighted the importance of evidence-based treatments. She explained that in the last three to five years there has been an increase in tools that can be used, but they are often either limited to identifying potentially traumatic events (rather than symptoms) or don't incorporate a care response to connect families with services that will help them.

The Care Process Model (CPM) is meant to bridge the above-mentioned gap by providing psychoeducation and parenting skills as well as train pediatric providers to understand and support children who have experienced trauma. She presented the roadmap Intermountain Healthcare developed for pediatricians.

Dr. Byrne then gave an overview of the Care Process Model for Pediatric Traumatic Stress (CPM-PTS). She explained that CPM is meant for providers working with children 6-18 years old during well-child visits, mental health visits as well as forensic interviews. The CPM pediatric traumatic stress screening tool was developed for children 6-10 years old and 11 years and older. It incorporates a screening tool for trauma exposure (UCLA brief screen), suicidality (PHQ9), and symptoms of traumatic stress (UCLA Brief Screen). She then went over the step-by-step process pediatric providers use to identify and respond to childhood trauma.

At this point the group asked about screening children 0-5 for trauma and how to mitigate trauma from involvement with state services (e.g. child welfare). Dr. Keeshin explained that they have adopted the SEEK model for young children, looking at risk factors and exposure, rather than symptoms, to identify traumatic stress, to focus on a preventative approach for this age group. As for involvement with the child welfare, he agreed that many children seen in pediatric settings who suffer trauma reported involvement with child protective services. Dr. Keeshin explained that in their collaboration with Dr. Forkey they have explored how best to deal with trauma related to involvement with state systems.

Next, Dr. Keeshin presented some key findings from research on CPM-PTS:

1. The CPM-PTS finds trauma exposure, suicidality, and traumatic stress symptoms in children seen in pediatric settings and CACs and is sensitive to both low and high risk populations.
2. CPM-PTS highlights area for primary care response missed by other or previous screening practices. He explained that depression screeners often miss traumatic stress
3. CPM-PTS distinguishes and triages response for primary care, differentiating between different levels of risk. It is important to differentiate these in order to prioritize acute

mental and behavioral health needs, given the paucity of providers in many regions of the U.S.

4. The CPM-PTS introduction of suicide screening and response to CACs appears critical. Data from Children's Advocacy Centers, primarily staffed by non-licensed clinicians who received training in the CPM, shows that screening via the CPM-PTS identified that about 1 in every 10 adolescents is at high risk for suicidality. Additionally, three quarters of these high-risk youth received higher level suicide prevention response from CACs.
5. More than screening, the CPM-PTS guides decision-making and a trauma-informed care response that can be used by clinicians and non-clinicians.

Members then discussed CACs and the model introduced in Utah PIPS's presentation. Dr. Forkey explained that in Massachusetts not all CACs have access to SANE nurses and there is a variation in terms of their mental health resources. Dr. Jessica Wozniak at Bay State was awarded a grant to ensure that CACs are effectively responding to children's trauma, as many of the kids are not seen by a regular pediatric health provider. Another member asked about how the model helps providers think about race equity. Dr. Keeshin explained that the team looked at this process for Latinx youth vs. White youth and saw that the screening led to an equitable response from providers. Additionally, Utah PIPS has just started collaborating with a team in Pennsylvania and is hoping to integrate research results in the CPM model.

Ms. Threadgill asked Dr. Forkey if she could explain to the Task Force her work with PIPS. Dr. Forkey explained that they used to have a trauma checklist but there were important limitations. About six months ago they adopted the CPM-PTS in Foster Care Clinic and Child Protection Program in an electronic format (iPad) to automatically identify the risk of trauma and suicidality. They have found that the screener facilitates conversations because it is objective. In terms of racial issues, it also allows youth and families to visualize symptoms that have often led to labelling for some youth of color. The group talked about how the screener can identify neglect factors. Dr. Forkey explained that the symptoms for neglect are the same as abuse, but that the outcomes of neglect are often far worse for children. Dr. Keeshin also highlighted that when developing the screener they wanted to ensure that the questions were open-ended so that the youth or caregiver could be the ones to identify the root of their trauma. Dr. Shepard added that the CPM was designed for both pediatric settings and CACs, which meant they needed the model to work for both low and high-risk settings.

Ms. Threadgill asked if there is data on improved outcomes and, if not, how they are trying to get to the effectiveness of this model. Dr. Keeshin explained that they do not have data yet, but are doing a trial study to measure referral to appropriate trauma treatments. To collect this data, Utah PIPS has adopted a multi-step and years-long approach. As discussed in the presentation, they first evaluated if the screener effectively identifies symptoms. Currently, they are trying to find out if the model helps pediatricians and providers' better assess suicide and trauma, Next, they will tackle the question of this model's effectiveness in terms of referral to appropriate treatment.

The group asked if the CPM roadmap could be adapted for policy work and help guide larger system policies and legislation. Members also wondered if the model could be used in schools or

other child-serving settings. Dr. Keeshin explained that some schools in Utah have worked to adopt it, but Utah PIPS has not been able to evaluate its implementation in different settings. Dr. Forkey added that the CPM creates an opportunity to have discussions with caregivers, who themselves could be struggling with trauma-related problems. Hearing "your child has a problem" after a screener is very different from the approach CPM adopts. Dr. Shepard added that the model has a lot of flexibility and there is shared decision making with caregivers, youth, and providers. Members also discussed in the chat box how this model can help with upstream prevention.

Finally, the group discussed barriers to this model. Dr. Forkey listed numerous challenges to implementing CPM, including funding, logistics, getting reimbursed, and training providers. Nevertheless, she added that the field of pediatrics has really learned a lot and is more willing to identify trauma than it was even five years ago. Dr. Keeshin shared that a good strategy is to start small, identify champions, and take the time necessary to implement the model well before broadening its reach.

Closing Comments:

Ms. Threadgill thanked the group for their time and engaging conversation. She explained that the CTTF will not be meeting in August and will reconvene on September 13, 2021 from 1 to 3pm.

A**djournment**: 3:00pm