Office of the Child Advocate
Childhood Trauma Task Force Meeting Minutes
Tuesday, October 22nd, 2019
1:00pm-3:00pm

Task Force Members or Designees Present:
Maria Mossaides, Chair (OCA)
Laura Brody (DCF)
Stacy Cabral (DESE)
Claudia Dunne (CPCS)
John Millet (MA Probation Services)
Kate Lowenstein (CFJJ)
Tammy Mello (Children's League of MA)
Yves Singletary (DPH)
Janice LeBel (DMH)
Maggie Randall (Senator Boncore's Office)

Other Attendees:
Dr. Laurie Leitch
Members of the Public

OCA Staff:
Melissa Threadgill (OCA)
Melissa Williams (OCA)
Karen Marcarelli (OCA)
Christine Palladino-Downs (OCA)

Meeting Commenced: 1:07pm

Welcome and Introductions

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

Ms. Threadgill held a formal vote on the approval of the October 1st, 2019 Childhood Trauma Task Force meeting minutes. The October 1st meeting minutes were approved.

Ms. Threadgill reviewed the agenda.

Presentation and Discussion with Dr. Laurie Leitch: Moving Beyond "Trauma-Informed" Care to Neuroscience-Based Action

Ms. Threadgill introduced Dr. Laurie Leitch, Director of Threshold GlobalWorks, who will be speaking about the importance of understanding the neuroscience behind addressing trauma.

Dr. Leitch spoke briefly about her background and experience. She co-founded the Trauma Resource Institute, based in California, in 2005, and then started Threshold GlobalWorks in 2011 where she currently practices neuroscience-based resilience models. Her model can be used by non-clinicians and is based on what it takes for the brain to build and maintain resiliency.

Dr. Leitch provided a brief overview on the effects of trauma on the human body. She explained that the body can experience the following after going through a series of distressing events or after one single traumatic event:

1. An alteration in the cycle of balance in the nervous system.
2. Produce a self-perpetuating process even in the absence of ongoing external stressors of threats.
3. Can compromise the immune system.
4. Can impair the capacity for self-regulation.

However, Dr. Leitch stated that neuroplasticity allows the brain to continuously change every day, either for better or for worse. In other terms, the brain can adapt to outside stressors. She mentioned that all people are "wired" with the potential to be resilient.

Dr. Leitch talked about the language of the nervous system being a "sensation level experience." Everyone has a resilient zone where the charge is sympathetic, and the release is parasympathetic. She discussed the science behind resiliency which is a focus on rewiring the mind-body balance to control reactivity and amplify pro-social behaviors in children and adults.

Stressful events or "triggers" can cause a child to be bumped out of their resilient zone. When a child bounces outside of their resilient zone and experiences hyper-arousal, the result is hyperactivity, hypervigilance, mania, and anxiety. Children can also bounce into hypo-arousal mode which may result in depression, a feeling of disconnection, exhaustion, fatigue, and numbness. Children who are bouncing between hyper and hypo arousal are often diagnosed with ADHD or bi-polar disorder. However, when a child is bumped out of their resilient zone due to trauma, they should not be diagnosed with either of those conditions. Dr. Leitch explained that children who have experienced trauma are usually misdiagnosed.

Dr. Leitch explained that on a systems-level, relentless demands can cause hyper or hypo arousal, and therefore, bumped out of the resilient zone. When stuck in hyper arousal, the result can be a lack of compassion, fear-driven reactivity such as aggression, violence, harassment, bullying, and moral distress. When stuck in hypo arousal, the result can be isolation, apathy, social fragmentation, and disengagement.

Dr. Leitch discussed how specific skills can help individuals take control of resilience and people can learn to stay inside their resilient zone without bouncing out or around or learn how to return to their resilient zone more quickly. To begin the process, Dr. Leitch stated that when she talks about a person's trauma, she uses the phrase "stress, distress, and trauma" in order to include more people who would otherwise not feel comfortable identifying as having trauma.

Dr. Letich then discussed how a person's sensory que can trigger and result being bumped out of the resilient zone. She continued to say that a person's sense of smell is the most potent trigger. As a result, she decided to focus her model on shifting a person's attention to another subject on a consistent basis in order to change how the brain is wired, and therefore, stay within their resilient zone. A phrase she often uses to describe this process is "where your attention goes, your energy flows, and your resilience grows."

Dr. Leitch talked about attachment and how in species without attachment, only 1-2% reach adulthood. She also said that in mammals, the success rate is extremely high because attachment presents tremendous advantages for survival. This is especially true for newborns and infants.

Dr. Leitch discussed the stages and milestones of infant brain development. She explained that smell and hearing are fully developed by the second trimester. She also stated that brain development is altered by certain chemicals while in utero. For example, when a mother is stressed during gestation, she produces stress chemicals that can block connections in the fetus' developing brain. Cortisol also decreases memory and attentional ability and norepinephrine can increase neuronal excitability in a baby's brain.

Dr. Leitch explained the importance of nutrition for pregnant women. She stated that when a pregnant woman does not consume enough food/nutrition, the food she does get goes to the fetus's brain development at the expense of the other organs. The brain takes primacy in the development of the fetus. She explained that the mother is the tuning fork for the fetus's development.

After birth, Dr. Leitch explained that the child's environment continues to shape their brain development. Infants absorb the self-regulatory system of the parent, meaning that a child may have deficits in social and emotional information processing from early experiences depending on the parent's experiences. She stated that a child's "goodness may get buried under an armor

of fear, freeze, and aggression" and that it is our task to figure out what it takes to get the child underneath to appear as if there wasn't any trauma. It is possible to reshape the reactivity of children who experienced trauma during fetus development and their early years of infancy. She explained that it's harder to change a child's emotional and social processing as they get older as the child has already been processing information in a certain way.

Dr. Leitch talked about the importance of paying attention to post-partum depression as the child will mirror the parent's actions such as having a flat affect. She spoke about a program that she worked with that helped women who were using drugs while pregnant. She stated that the program was wonderful, but they were having difficulty engaging mothers. Dr. Leitch realized that it was due to the intake form that the program was using, as it was focused on the negatives instead of the positive changes that the mother's were trying to make. She said that the key is to create a relational field and a place where the worker and the client can talk to each other in their resilient state. In order to do this, it's necessary to start the conversations on a more positive level. When you do this, activation levels come down and clients are more likely to open up more.

Dr. Leitch referred to the human brain as a social organ and stated that children who experience maltreatment are at risk for social-emotional deficits such as lower social competence, less empathy, and difficulty recognizing emotions in themselves and others. She talked about the amygdala and how this part of the brain is quick to learn, but slow to forget in terms of social-emotional experiences. When a child is exposed to a chronic threat, their state of emotions and reactions can become more permanent traits.

Dr. Leitch discussed one of her assignments in Washington, DCF where she worked with the child welfare system there and the agency referred to foster parents as "foster care providers." They did this so foster parents would have a more professional look towards their role instead of having biological parents view foster parents as a competing parent instead of a professional care provider. She stated that the name change changed the dynamic between the biological parents and foster parents.

Dr. Leitch talked about her opinions on the ACEs Survey. She stated that the problem she has with the survey is that it focuses on the inside-the-family events and does not include anything about positive experiences. It focuses too much on the negative experiences a person faces which is well-suited to the amygdala's negativity bias. On the other hand, she commented that the benefit of the ACEs survey is that it sampled more than 17,000 people and showed that reactive behaviors in childhood trauma shape physical and psychological health.

Dr. Leitch stated that trauma-informed care has focused more on the actual trauma experienced rather than the possibility of resiliency. She talked about secondary trauma and how workers can

experience trauma after working with their clients. She stated that judges often have a lot of secondary trauma. She also stated that workers can retraumatize their clients depending on the practices that they use.

In order to reduce the risk of retraumatizing clients, Dr. Leitch created the "SRM Skills Card" which is a sensory resilience model. She created the skills card to help build resilience using practical skills. She also created various versions of the skills card depending on the population she was working with. The model focuses on teaching people to focus on their senses and sensations to strengthen resilience. The skills card has four main steps:

1. Tracking
2. Grounding
3. Resourcing and Resource Strengthening
4. Shift Attention and Stay

The steps of the skill card bring the nervous system back to balance. She stated that the skills are ageless, and anyone can do it, regardless of their background. Lastly, Dr. Leitch talked about health literacy and how using appropriate technology (technology that ordinary people can use without become dependent) should be used to harness the assets of the human brain.

Dr. Leitch opened the discussion for questions.

Ms. Dunne asked about the intersection of the trauma field and Dr. Leitch's mindfulness work.

Dr. Leitch stated that both fields use similar skills, however, SRM is easier than meditation. Both practices use self-direction attention and that is the intersection. She stated that the SRM skills work is more compatible and easier for people to use compared to meditation/yoga.

Ms. Lowenstein discussed workforce challenges and stated that we really struggle with the training of the workforce and with having enough clinicians while making sure the clinicians reflect the community they are working with. She asked how to make sure the workforce is doing the work accurately and how to make sure the workforce is well trained and look like the people they serve.

Dr. Leitch stated that usually we need clinical work to work through trauma. As a clinician, this was made to build a more reliable resilient zone. Thinking and feeling is secondary to their senses. Training people in the SRM skills can, at a minimum, make better use of their therapy. Anybody can use these skills as they do not send anyone into a hyperactive state. The SRM skills promote safety.

Ms. Mello stated that it's important for the task force to know that our current systems are not built in a way to acknowledge resiliency first.

Dr. Leitch talked about BACH (Boston Alliance for Community Health) and how this community created a program leading to resilience-trained community members so they can use the SRM skills. She stated that people understand the skills because they realize that they can change their reactivity and shift their attention to positivity. She said that it's all about shifting attention.

Review of Annual Legislative Report Outline

Ms. Threadgill reviewed the annual legislative report outline.

Ms. Threadgill explained that the introduction and background section will include a description of the statutory mandate/directives, a description of the CTTF work process, definitions of key terms (i.e. trauma), and background information on childhood trauma.

Ms. Threadgill stated that the report will include four main findings.

1. **Finding One:** Significant Awareness and Training Efforts Have Already Been Made
    a. There have been numerous, significant and impactful efforts in recent years to make services and systems "trauma-informed."

2. **Finding Two:** Next Steps - Solidifying Understanding of What "Trauma-Informed" Means in Practice
    a. While these efforts have succeeded in raising awareness about the impact trauma can have on children and families, there is not widespread agreement/understanding of what it means to be trauma-informed in practice.

3. **Finding Three:** There is a Role for the State to Play in Helping Organizations/Systems Become Fully TIR
    a. Massachusetts can do more to help support child-serving organizations in becoming fully trauma-informed and responsive (TIR).

4. **Finding Four:** More Investigation Needed on Best Practices for Identifying/Responding to Childhood Trauma
    a. There is not a consistent statewide approach to identifying and responding to children who have experienced trauma, and there is disagreement amongst professionals about the best ways to do so.

Ms. Threadgill discussed each finding in greater detail and asked the task force for their comments. She stated that she is relying on various members of the task force to assist her on editing the report.

Finding One

Ms. Threadgill stated that finding one will list out as many of the individual state agency efforts, cross-agency efforts, community-based efforts, and provider-level efforts and training as possible. She said that it's important to acknowledge that a lot of work has already been done in MA.

The CTTF task force had no comments or edits.

Finding Two

Ms. Threadgill stated that she will include the findings from the survey that was completed in finding two. She said the findings concluded that many agencies and providers report being trauma-informed, but there is no clear/consistent/universal definition of what this means in practice. She will also talk about the lack of effectiveness of one-time trainings and recommend that we get away from the "one and done" idea as the continuous training of workers is key.

The CTTF task force had no comments or edits.

Finding Three

Ms. Threadgill stated that trauma-informed and responsive (TIR) practice is still relatively new, and our understanding of "what works" and how to best implement it continues to evolve. She stated that state government can support child-serving organizations by providing the following:

1. **More clarity and guidance.**
    a. What does TIR look like in practice and how does that vary by practitioner type and setting?
2. **More consistency across state agencies.**
    a. Statewide definitions and guidance on TIR care.
    b. Consistency across RFPs/contracts.
3. **More implementation technical assistance.**
    a. Resources that organizations can use for assessing and improving adoption of TIR practices within their work.
    b. Dissemination of research with guidance on what it means for practice.

c. Funding to support workforce development and implementation of evidence-based interventions.

Kate Lowenstein commented in response to Ms. Threadgill stating the state can do more to assist. She said that since we are talking about criminal justice, we need to be mindful that different agencies have different processes and decision points (decision-making informed vs. trauma-informed). The concept of decision making varies from agency to agency.

Ms. Mossaides responded by stating that she is struggling with how to address that. In order for public agencies to understand general trauma, they need to understand the factors that involved the individual consumer, and the implications of the individual decision making. For example, putting someone in a group home when they need to be somewhere else due to the fact that there are no open beds. She stated that we need to think about the overall picture and the effects of what we do. We need to think about this in a more global way and rethink how we approach decision-making.

A member of the public recommended rewording “child-serving organizations” to “child-serving state agencies.”

Ms. Mello agreed and stated that including the words “state agencies” will cause less confusion. She believes that the way it is currently written appears to refer to contracted agencies and providers instead of state agencies.

Ms. Dunne also agreed that child-serving organizations need to include state agencies as they affect do children and need to take accountability. She stated correctional agencies should also be included as parents who are incarcerated affect children.

Ms. LeBel commented that the findings should address racial and ethnic disparities in decision making and stated that we need to hold ourselves accountable to our decisions and decision-making processes.

Ms. Mello agreed with having the finding recognize the concept of racial and ethnic trauma, and then acknowledge a commitment to addressing those issues. We need a clear and intentional statement so that it doesn’t get buried.

Ms. Threadgill stated that she will both explicitly state the concept as well as include it in the introduction. It will also be weaved into the report.

Ms. Lowenstein talked about the school to prison pipeline and how we have a responsibility to talk about decision making, especially through a racial lens.

Ms. Mossaides discussed the importance of understanding the constituent needs. The Commonwealth tracks various services across the state, but there are a lot of space spaces (areas) that do not have any services at all. She explained that it's a question of whether or not state agencies recognize the lack of resources and if they have a plan to address this. She stated we need to look at the towns and figure out what the children need in each specific area and region. We need to look at a range of what each community needs instead of focusing on just one issue.

Ms. Threadgill stated that this is an interim report and we are not going to be able to bring a lot of details into the report. This will just be a starting point and if something comes up that the task force would like to discuss in more detail, we can bring that into our next steps (i.e. parking lot issues). This will also help set the agenda for next year.

Ms. Mossaides commented that this is a reminder the legislature did not sunset this commission and give the JJPAD an end date as they recognized there will always be more work to be done.

Finding Four

Ms. Threadgill explained that the survey results showed the limited availability of trauma services. There are disagreements among researchers, advocates, and practitioners about the use of trauma screenings/assessments and stated that this is an area that needs further investigation and discussion.

Dr. Leitch asked if Massachusetts uses learning modules that can be accessible over computers for hard to access areas such as small towns. She stated that using online courses would make trainings more accessible and could reach more people. She said this is especially effective for parents.

Ms. Mossaides responded and said that Massachusetts currently does not have a platform to do this yet and the capacity to do so is not yet available This is something that is being worked on. EEC will be doing this for their specific trainings for licensees. There is a platform being built that will be used by the Child Sexual Abuse Prevention Task Force to focus on child sexual abuse as well. The platform should be live within the next six months.

Dr. Leitch commented that there are so many great things that can be done with platform-based learning.

Ms. Dunne stated that we need to include language about the resiliency model on both community and individual scales.

Ms. Threadgill said the concept of resiliency will be present, however, she noted there are some people in the survivor community that have objections for the specific usage of the word resiliency. There was a robust conversation on this last meeting.

Recommendations/Next Steps

Ms. Threadgill reviewed the three recommendations and next steps for the CTTF.

1. Massachusetts should develop and adopt Guidelines for Trauma-Informed and Responsive Practice.
2. Massachusetts should provide more support for child-serving organizations seeking to adopt the TIR Practice guidelines.
3. CTTF should continue investigating best/promising practices for identifying/responding to childhood trauma, and issue additional recommendations as needed.

Ms. Mello commented on the third bullet point about best and promising practices. She wondered if we should add the word “policy” as that is different than practice. We should look at policies that support best practice.

Ms. Threadgill agreed with Ms. Mello.

Ms. Mossaides stated that we need to clarify this is not a one and done adoption of policy/practice. It will be updated as changes arise. We have a commitment to continuous quality improvement and that should be more explicit in bullet points two and three.

Ms. Threadgill stated that she will make the change to note continuous improvement in bullet point two.

Ms. Lebel stated that the word “should” in all three bullet points does not result in action. She recommended using language such as “must” and “will” when the task force makes recommendations as that creates action and accountability.

Ms. Threadgill stated that she doesn't think the CTTF can speak for the Commonwealth; ultimately all we can do is make recommendations.

Ms. Dunne agreed with Ms. Threadgill.

Ms. Mello said that she doesn't want to lose the part of tracking what we are doing. We need to work on developing metrics even though we don't know what those metrics are as of yet. She stated that it's also important to remember that the CTTF is part of the larger JJPAD Board.

Ms. Mossaides talked about her commitment to the best available data and the importance of having decisions made based on the best available data.

Ms. Dunne recommended saying "based on ongoing research."

Ms. Threadgill agreed with that edit.

Closing Comments:

Ms. Threadgill discussed the task force's next steps.

The next meeting will be held on November 7th, 2019 from 10:00am-12:00pm. During that meeting the task force will review the draft report and provide feedback. Ms. Threadgill will send out a draft to everyone on November 1st for review. The OCA will then incorporate the feedback for the December meeting.

The December meeting is TBD and Ms. Threadgill asked for everyone to fill out the Doodle Poll to set the date. The CTTF will review the final report during this meeting.

Ms. Threadgill stated that everyone received a track changes version of the guidelines document. She asked task force members to review the document and send all feedback to her.

Adjournment: 2:58pm