Childhood Trauma Task Force

October 4, 2021

1pm-3pm

Agenda

- Approval of September 2021 Meeting Minutes
- Updates
- Trauma screening in first responder settings
    - Presentation from Stacey Butler (Trauma and Justice Partnerships Director) and Major Martha Dozier (Commander, Community Services Bureau, Charlotte-Mecklenberg Police Department) on the Child Development-Community Policing (CD-CP) project in Mecklenberg County, NC
- Trauma Screening in Juvenile Justice Settings in Massachusetts (OCA Presentation)

OCA
MASSACHUSETTS
Office of the Child Advocate

Updates

- Center on Child Wellness & Trauma Progress
  - Audrey Smolkin named as Executive Director
  - “Official” launch – including new website – later this month

- JJPAD COVID Report
  - Will be released on Wednesday (10/6)

OCA
MASSACHUSETTS
Office of the Child Advocate

Mecklenburg County Public Health
Charlotte-Mecklenburg Police Department
Child Development-Community Policing (CDCP)

Your Police-Mental Health Team for
Children Exposed to Violence (CEV)

STACEY BUTLER, LCSW
Trauma and Justice Partnerships Director

Major Martha Dozier, CMPD
Community Services Bureau Commander

Charlotte-Mecklenburg CDCP

- New Haven, CT, 1991: Department of Police Service partnered with the Yale Child Study Center
- OJJDP replication began in Charlotte-Mecklenburg in 1996: 5 square miles/1 part-time clinician
- FY'21: 6,432 families/10,231 children/17 full-time clinical positions
- Charlotte-Mecklenburg CDCP is the largest child trauma police-mental health collaborative in the nation, and one of longest running of its kind
- Over 74,000 families referred to-date and counting
- Contributor to IACP sponsored "Protecting and Serving" toolkit distributed nationally to assist law enforcement agencies responding to CEV

CDCP Components:

Partnership & collaboration at all levels (Executive, management, and operational) between Mecklenburg County Public Health & Charlotte-Mecklenburg Police Department, as well as Huntersville, Davidson, and Cornelius Police Departments

Acute Response availability 24/7 (Co-responder model: clinician-officer teams provide services to impacted children and families)

Collaborative management: shared responsibility for program operations, responses, services, information and planning

Clinician-Police Lead Training Teams:

-Officer's class includes CD-CP operations, child development, potential short and long-term impacts of child trauma, ACEs & resilience strategies focusing on officer's role

-Cross-training for clinicians include ride-alongs and observational experiences of police services coordinated by police supervisors

Charlotte-Mecklenburg CDCP

- Serve children Birth-17 years old impacted by violence and their families
- On avg. 34% are <6 years old
- 35% of referrals involve intimate partner violence (DV)
- Assaults without weapons are the #1 reason for referral
- Tracking CharMeck child violence exposure trends

Ex: SIODs up 30% in FY21, or 1 home with child(ren) inside shot into every .67 days on avg.

551	**FY21**	**30%**
423	**FY20**	**16%**
364	**FY19**	**22%**
298	**FY18**	**50%**
198	**FY17**	**24%**

CDCP vs CPCRT: What's The Difference?

CDCP

Child Development-Community Policing

- Primary consumers are children 0-17 yrs. exposed to violence or other potentially traumatic incidents and their caregivers
- 24/7/365 availability
- Licensed child trauma clinicians funded by Public Health partner with patrol officers in every CMPD Division and 3 north Mecklenburg towns
- Child trauma screening and assessment, immediate interventions to address identified symptoms as well as safety planning and resources necessary to stabilize impacted families
- Goal is prevention of myriad of potential long-term impacts of untreated trauma exposure and unmet family needs (mental, physical, educational, economic, legal, etc.)

CPCRT

Community Policing Crisis Response Team

- Primary consumers are adults experiencing a severe mental health or substance abuse crisis and their families (To include consumers impacted by homelessness)
- 1st, 2nd, and 4th shift coverage with call-back
- Community Policing Crisis Response Team (CPCRT): The team is comprised of CIT trained police officers and licensed Mental Health Clinicians providing humane, compassionate, professional and safe law enforcement response to person(s) and families who are in crisis due to mental illness or substance abuse
- The CPCRT consists of 1 Sergeant, 8 CIT Officers, and 6 licensed Clinicians, soon to be 12 teams
- Contracted licensed mental health clinicians employed by Matrix Mental Health Alliance, LLC, doing business locally as CriSys will assist CMPD CIT trained officers responding to calls for service, provide on-site psychiatric assessment and treatment referral
- Primary objective of improved officer safety, decreasing injuries and incarceration, and acting as an entry point into mental health treatment

A CDCP Response Is:

Immediate, or within 24 hr. on average, with primary goal of restoring physical and psychological safety and prevention of potential long-term effects trauma on children

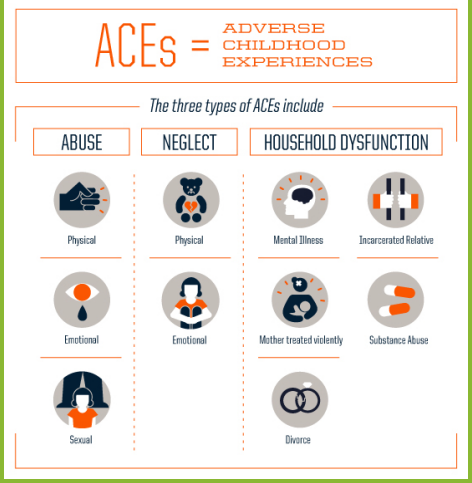
Available 24/7/365

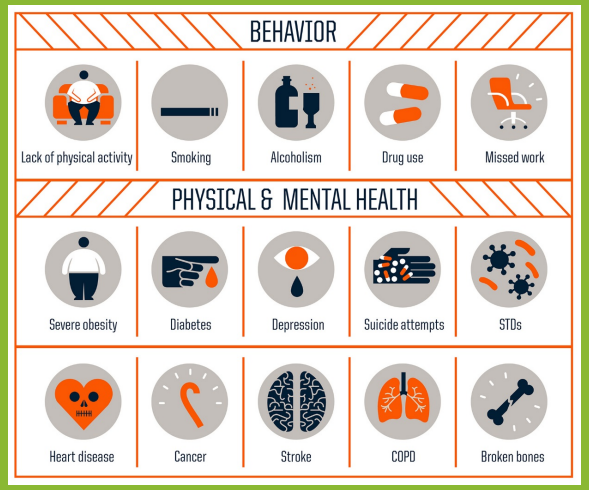
Services are provided in the community by licensed clinicians partnering with CDCP trained officers:

- **Immediate safety concerns of children and families addressed**
- **Screening and assessment for earliest emerging symptoms of child trauma and immediate targeted interventions provided**
- **Parental education and coaching: connecting symptoms to the event, providing parents with support and tools designed to further decrease acute child trauma symptoms and/or prevent emerging symptoms**
- **Therapy referrals when needed for children and/or other family members, other community referrals/resource linkage depending upon needs of individuals**
- **Response protocols in place for forensic referrals or those requiring special investigative services**

CDCP Core Values:

- **No child should have to wait for the best possible trauma-informed police response and coordinated clinical care**
- **Working together we provide something far better than working alone (The partnership IS the intervention)**
- **Adverse Childhood Experiences (ACEs) are the intersection of our nation's #1 public health and #1 law enforcement challenges**
- **Coordinated Resilience-driven responses are the key to a healthier and safer Charlotte-Mecklenburg**

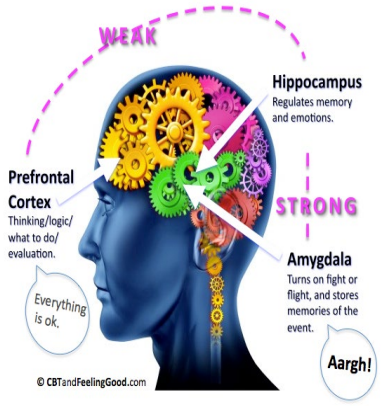




Why Immediate, On-Scene Response Is So Important:

- #1 It builds an immediate connection with the child & family
- #2 It allows the child/family to trust & see first responders as capable of helping them
- #3 It helps the child begin to calm down/relax/gain more control
- #4 It is the first line of defense against potential development of PTSD or other longer-term trauma-related negative mental health, physical health, educational, legal and social outcomes

The Newborn Brain: Fully Equipped Safety Scanner and Alarm System Included!



Is this new? Yes/No

↓

Is this a threat? Yes/No

↓

Sound the alarm!

↓

Fight-Flight-Freeze

Autonomic Nervous System Responses To Threat:

Children are not necessarily "resilient", they are "adaptive", Resilience is the product of supportive, positive relationships

Sympathetic Nervous System: Arousal/Excitatory (Relaxation Techniques Helpful)

Increased: Heart rate, blood pressure, respiration, pupil dilation, facial flush, muscle tension, and energy (Due to release of stored sugars)

Decreased: Digestion (Stomach halts digestion, vomiting may occur), blood flow to extremities due to adrenaline (Cold hands and feet, shivering)

Hypervigilance/Hyperactivity (Psychomotor agitation)

Exaggerated startle response

Inconsolable crying

"Tunnel focus"/"Tune out" non-critical information
(Somatic complaints: Head, stomach, body pain)

SNS arousal **more common in males**

Parasympathetic Nervous System: Dissociative Continuum/Inhibitory (Grounding Techniques Helpful)

Freeze Response associated with escalated threat, advances to dissociation **"Disengage"** from external world (unsafe) to internal world (safe)

In very young children & infants, the **most common adaptive response is dissociation**. "Zoned out" "Daydreaming" or difficulty staying awake, but in infants may also present as inconsolable

Children may have a heart rate **LOWER** than the normal range

Avoidance behaviors typical of this adaptation

Flat affect/Absence of emotion

Disorientation/Confusion/**Difficulty making decisions**

Dizziness/**lack of coordination** or focus

Constricted pupils

Frequent **urination**

PSNS responses **more common in females**

https://mecktech-my.sharepoint.com/personal/stacey_butler_mecklenburgcountync_gov/Documents/ANS%20Checklist%20Form%202-1-17.pdf

mecktech-my.sharepoint.c...

CD-CP ANS Symptom Checklist

Date: _____ Chart #: _____ Clinician: _____

Child: _____ DOB/Age: _____

SNS Symptoms: **Excitatory** *"Fight or Flight"*	Arrival	Departure	PSNS Symptoms: **Inhibitory** *"Restores body to a state of calm"*	Arrival	Departure
Anxiety/Panic – *sensation of worry in conjunction with somatic symptoms (muscle tension, etc.)* Hostility/Rage – *bad attitude/uncontrolled anger, violence and explosiveness*	☐	☐	Flat Affect/Numb – *absence of emotional response*	☐	☐
Hyperactivity/Inability to relax/Restlessness **Psychomotor agitation*	☐	☐	Lethargy/Exhaustion/Sleepiness *May be sleeping when you arrive, or have difficulty remaining awake*	☐	☐
Exaggerated startle/Hyper vigilant **Startle at loud noises or abrupt movement, or overly-focused on personal space & safety**	☐	☐	Dissociation ("zoned out" or "daydreaming") **Infants may present as inconsolable**	☐	☐
Inconsolable/Crying/Rumination *Child may be talkative and speaking of the incident over and over*	☐	☐	Disorientation/Confused *Difficulty making decisions, completing tasks, or confusion about details of events*	☐	☐
Digestive Problems (vomiting) *Stomach has halted digestion therefore vomiting may occur* *Infants: appear uncomfortable during vomiting, projectile or forceful*	☐	☐	Frequent urination *Going to the restroom frequently or a child wetting self*	☐	☐
Increased HR/BP/Respiration *Dilated Pupils*	☐	☐	Low HR/BP Constricted Pupils – *Small as when a light is shone into eyes*	☐	☐
Somaticized Responses (head, stomach, body aches) *Any part of their body that is hurting or aching*	☐	☐	Dizziness *Having a difficult time walking/standing or with coordination and focusing*	☐	☐

9:25 AM
9/27/2021

CDCP Child Trauma Screening Tools

72% of children whose guardians are successfully contacted are screened with one or more of the following:

FY19 (Roughly 5,000 families)

- **ANS** (10%)

Autonomic Nervous System: Immediate/Early Indications of Risk for Problematic Impacts of Traumatic Stress (O-11 hrs)

- **ATQ** (70%)

Acute Trauma Questionnaire: Earliest Emerging Symptoms (12 hrs to 29 days)

- **THQ** (3%)

Trauma History Questionnaire (Polyvictimization, chronic stress)

Acute Trauma Interventions: “Put On The Breaks”

RELAXATION

- Five-finger breathing (Model for child)
- Infant-caregiver tandem breathing
- Blowing bubbles
- Hand over heart, or chest-to-chest holding for infants
- Favorite place five senses exercise
- “Where do you feel it?” Exercise for specific somatic complaints
- Involve and teach safe caregivers, create a plan

GROUNDING

Directive Physical Tasks:

- Name what you see, count objects, find colors, “I spy jar” or “I spy quilt,” holding and describing a favorite toy or a new toy
- Pat-a-cake, pass toys back and forth, hide toys for child to find
- Clap to the beat of a song or move to music
- Color in a coloring book or mandala, play UNO, Go Fish, play ball
- Intentional muscle tension tasks: Stress ball, pushing feet into floor, hands against a wall
- “Body scan” or “Body check”
- Snacks, drinks, especially strong flavors
- Involve and teach safe caregivers, create a plan

This is not the best time for open-ended tasks such as free drawing, nor is it the best time for processing or telling of what happened

Early Signs/Symptoms from A Child's Perspective:

Children communicate distress in different ways. In the days and weeks following a traumatic experience, children may exhibit the following common reactions:

Sleep disturbances: frequent nightmares, waking in the night, bedwetting

Separation anxiety: refusing to go to school, upset when left with babysitter or childcare provider

Hyper-vigilance: worried, fearful, easily startled

Physical complaints: headaches, stomachaches, other aches and pains with no clear medical cause

Irritability: increased aggressive behavior, angry outbursts, difficult to soothe

Emotional upset: tearfulness, sadness, talking about scared feelings or scary ideas

Regression: loss of skills learned at an earlier age, "babyish" behavior

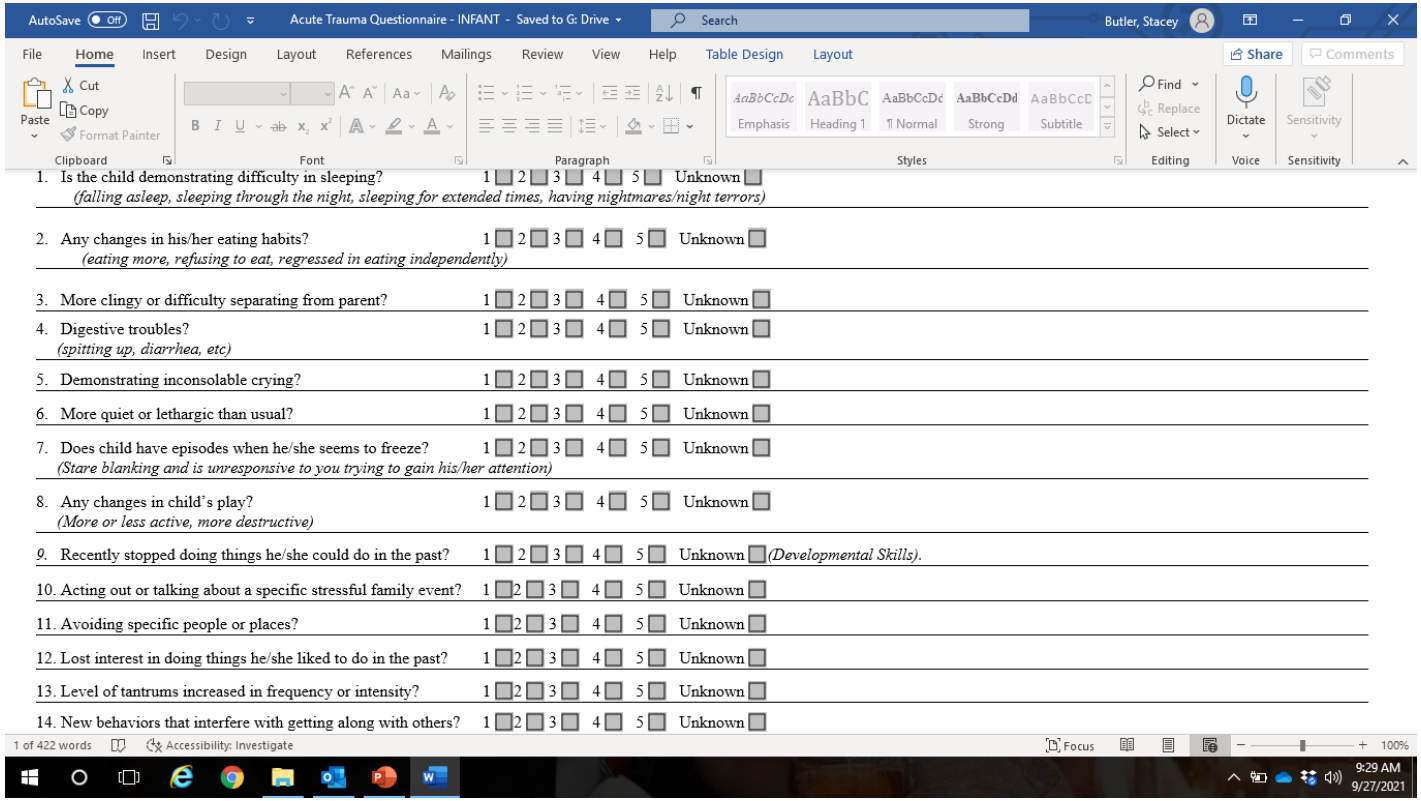
Withdrawal: loss of interest in friends, school or other activities child used to enjoy

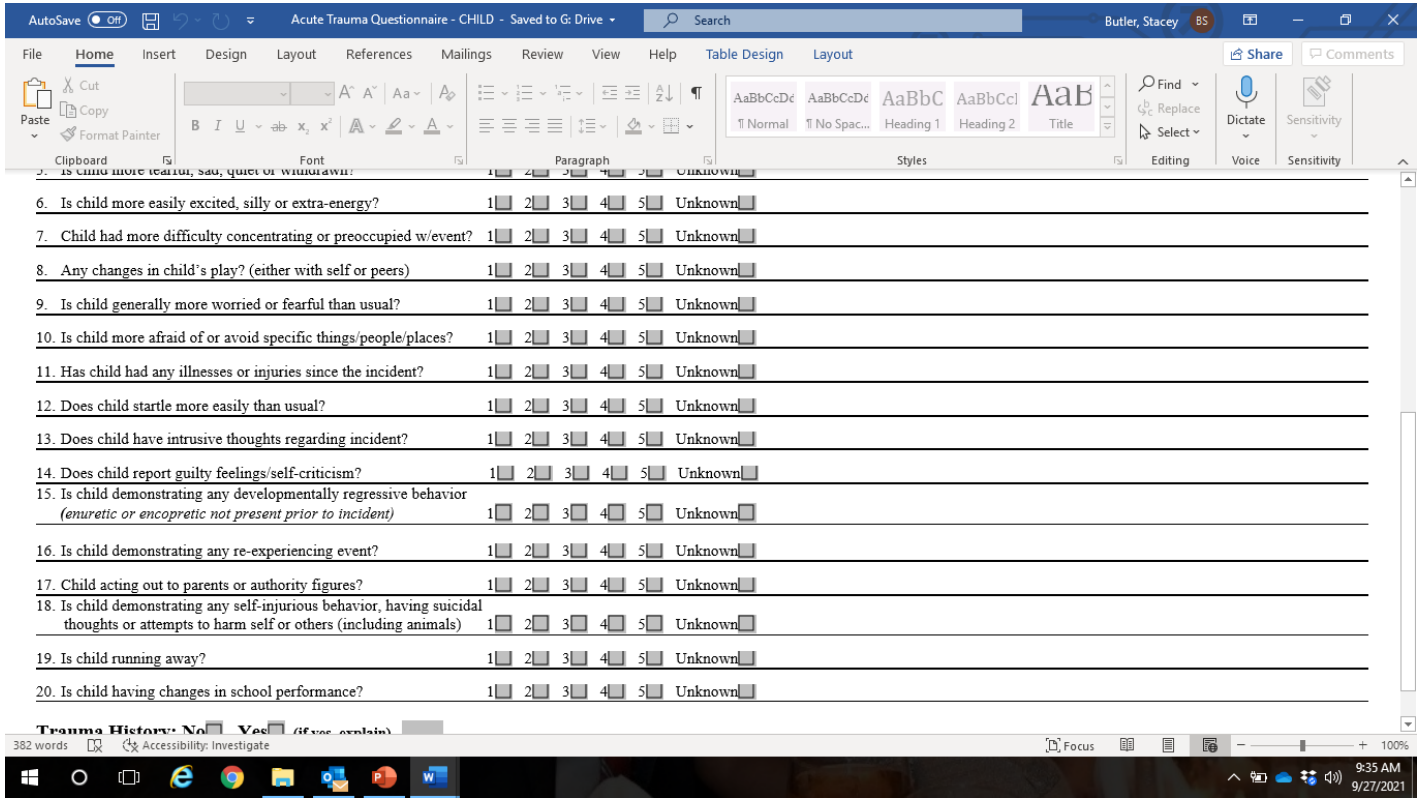
Blunted emotions: shows no feelings at all, not bothered by anything, dissociation

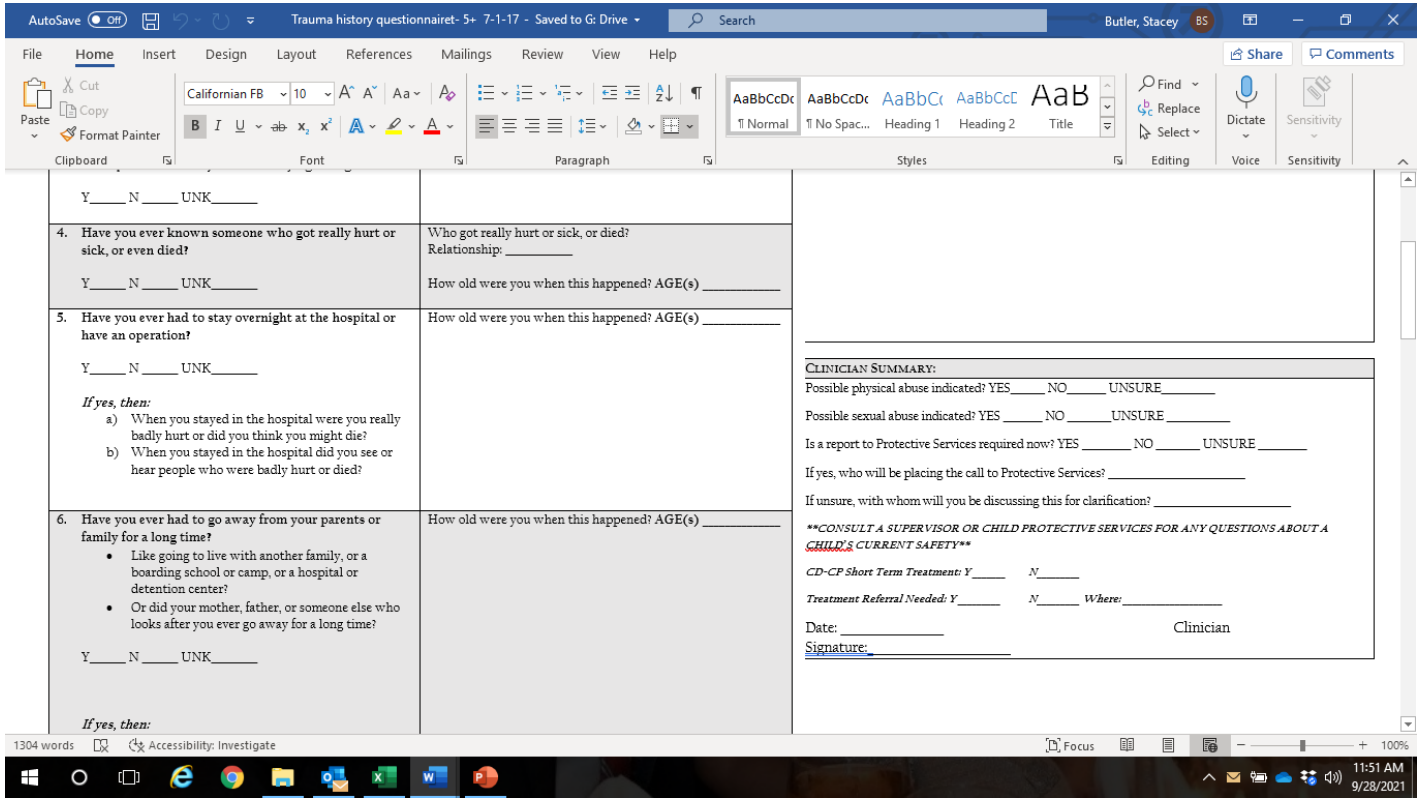
Distractibility: trouble concentrating at school or home, daydreaming

Changes in play: repeatedly acting out violent events in play, less able to play spontaneously and creatively

*With good support, many children will begin to show improvement over several days to several weeks. When these symptoms persist or have worsened after 30 days, traditional therapeutic services are recommended


AutoSave Off
Acute Trauma Questionnaire - INFANT - Saved to G: Drive
Search
Butler, Stacey
File Home Insert Design Layout References Mailings Review View Help Table Design Layout
Share
Comments
Cut
Copy
Format Painter
Paste
Clipboard
Font
Paragraph
Emphasis
Heading 1
Normal
Strong
Subtitle
Styles
Find
Replace
Select
Editing
Dictate
Voice
Sensitivity
Sensitivity
1. Is the child demonstrating difficulty in sleeping? 1 2 3 4 5 Unknown
(falling asleep, sleeping through the night, sleeping for extended times, having nightmares/night terrors)
2. Any changes in his/her eating habits? 1 2 3 4 5 Unknown
(eating more, refusing to eat, regressed in eating independently)
3. More clingy or difficulty separating from parent? 1 2 3 4 5 Unknown
4. Digestive troubles? 1 2 3 4 5 Unknown
(spitting up, diarrhea, etc)
5. Demonstrating inconsolable crying? 1 2 3 4 5 Unknown
6. More quiet or lethargic than usual? 1 2 3 4 5 Unknown
7. Does child have episodes when he/she seems to freeze? 1 2 3 4 5 Unknown
(Stare blanking and is unresponsive to you trying to gain his/her attention)
8. Any changes in child's play? 1 2 3 4 5 Unknown
(More or less active, more destructive)
9. Recently stopped doing things he/she could do in the past? 1 2 3 4 5 Unknown (Developmental Skills).
10. Acting out or talking about a specific stressful family event? 1 2 3 4 5 Unknown
11. Avoiding specific people or places? 1 2 3 4 5 Unknown
12. Lost interest in doing things he/she liked to do in the past? 1 2 3 4 5 Unknown
13. Level of tantrums increased in frequency or intensity? 1 2 3 4 5 Unknown
14. New behaviors that interfere with getting along with others? 1 2 3 4 5 Unknown
1 of 422 words
Accessibility: Investigate
Focus
100%
9:29 AM
9/27/2021


AutoSave
Acute Trauma Questionnaire - CHILD - Saved to G: Drive
Search
Butler, Stacey
File
Home
Insert
Design
Layout
References
Mailings
Review
View
Help
Table Design
Layout
Share
Comments
Paste
Cut
Copy
Format Painter
Clipboard
Font
Paragraph
Normal
No Spac...
Heading 1
Heading 2
Title
Styles
Find
Replace
Select
Editing
Dictate
Voice
Sensitivity
Sensitivity
6. Is child more easily excited, silly or extra-energy? 1 2 3 4 5 Unknown
7. Child had more difficulty concentrating or preoccupied w/event? 1 2 3 4 5 Unknown
8. Any changes in child's play? (either with self or peers) 1 2 3 4 5 Unknown
9. Is child generally more worried or fearful than usual? 1 2 3 4 5 Unknown
10. Is child more afraid of or avoid specific things/people/places? 1 2 3 4 5 Unknown
11. Has child had any illnesses or injuries since the incident? 1 2 3 4 5 Unknown
12. Does child startle more easily than usual? 1 2 3 4 5 Unknown
13. Does child have intrusive thoughts regarding incident? 1 2 3 4 5 Unknown
14. Does child report guilty feelings/self-criticism? 1 2 3 4 5 Unknown
15. Is child demonstrating any developmentally regressive behavior (enuretic or encopretic not present prior to incident) 1 2 3 4 5 Unknown
16. Is child demonstrating any re-experiencing event? 1 2 3 4 5 Unknown
17. Child acting out to parents or authority figures? 1 2 3 4 5 Unknown
18. Is child demonstrating any self-injurious behavior, having suicidal thoughts or attempts to harm self or others (including animals) 1 2 3 4 5 Unknown
19. Is child running away? 1 2 3 4 5 Unknown
20. Is child having changes in school performance? 1 2 3 4 5 Unknown
382 words
Accessibility: Investigate
Focus
100%
9:35 AM
9/27/2021



Y_____ N _____ UNK_____

4. **Have you ever known someone who got really hurt or sick, or even died?** Y_____ N _____ UNK_____	Who got really hurt or sick, or died? Relationship: _____ How old were you when this happened? **AGE(s)** _____
5. **Have you ever had to stay overnight at the hospital or have an operation?** Y_____ N _____ UNK_____ ***If yes, then:*** a) When you stayed in the hospital were you really badly hurt or did you think you might die? b) When you stayed in the hospital did you see or hear people who were badly hurt or died?	How old were you when this happened? **AGE(s)** _____
6. **Have you ever had to go away from your parents or family for a long time?** • Like going to live with another family, or a boarding school or camp, or a hospital or detention center? • Or did your mother, father, or someone else who looks after you ever go away for a long time? Y_____ N _____ UNK_____ ***If yes, then:***	How old were you when this happened? **AGE(s)** _____

CLINICIAN SUMMARY:

Possible physical abuse indicated? YES_____ NO_____ UNSURE_____

Possible sexual abuse indicated? YES _____ NO _____UNSURE _____

Is a report to Protective Services required now? YES _____ NO _____ UNSURE _____

If yes, who will be placing the call to Protective Services? _____

If unsure, with whom will you be discussing this for clarification? _____

*****CONSULT A SUPERVISOR OR CHILD PROTECTIVE SERVICES FOR ANY QUESTIONS ABOUT A CHILD'S CURRENT SAFETY*****

CD-CP Short Term Treatment: Y_____ N_____

Treatment Referral Needed: Y_____ N_____ Where:_____

Date: _____ Clinician

Signature: _____

5,000 Successfully Contacted Guardians:

- 86% Guardians received child trauma psychoeducation, coaching, support
- 72% Children screened using 1 or more tools
- 10% Children completed CDCP short-term trauma intervention as only needed clinical service
- 32% Children provided with longer-term therapy referrals
- 11% Guardians provided with referrals for their own therapy or support
- Additional social determinant service linkages/referrals made for any families with identified need

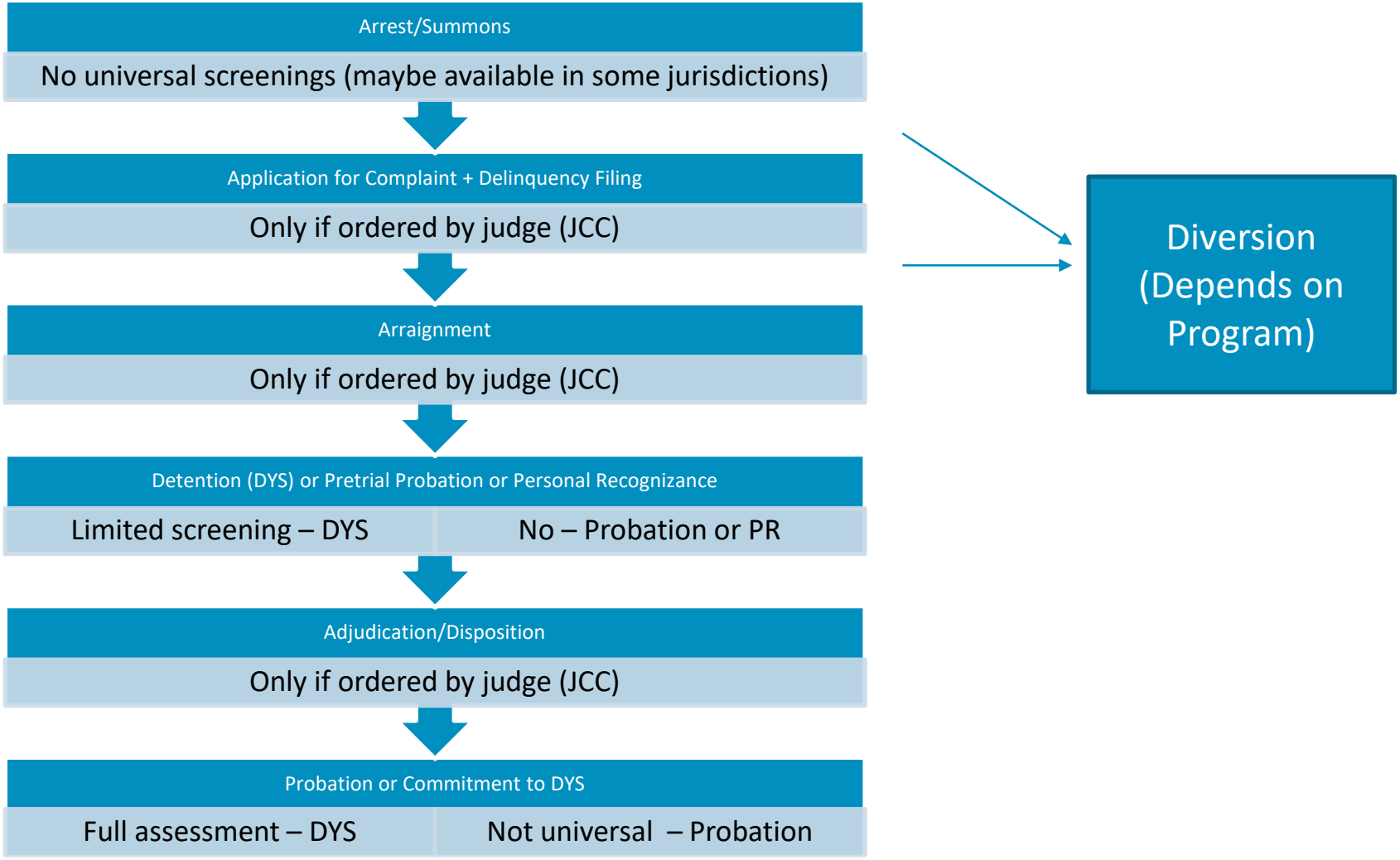
FY19

Protecting and Serving Toolkit Available Online

HTTP://WWW.THEIACP.ORG/CHILDREN-EXPOSED-TO-VIOLENCE

Trauma Screening in Juvenile Justice Settings in Massachusetts

Juvenile Justice Contact Points



Juvenile Court Clinic (JCC) Screening Practices

- JCC screenings can only be initiated with a judicial order
  - Referral orders are completely discretionary and rest entirely with the presiding judge.

- If referral is ordered, assessment is conducted by a juvenile court clinician

- Assessment process:
  - Clinicians conduct a full interview with the child and their family, which focuses on a variety of topics including symptoms/experiences of trauma
  - They may employ trauma-specific tools such as the Trauma Screening Checklist at their discretion.
  - All non-emergency evaluations collect data on adverse childhood experiences (ACEs).
  - After the assessment is complete, a report is written for the court.

- Next steps:
  - Once the report is returned to the presiding judge, the court may choose to follow or ignore the clinician's findings and recommendations at their discretion.

Probation Screening Practices

- No formal or universal practice of screening for trauma symptoms or experiences
- During intake process (which includes an interview), a Probation Officer may inquire about traumatic experiences/symptoms at their own discretion
- Probation Officers regularly consult with Juvenile Court Clinics – this can be an avenue for a more formal assessment
- Probation Officers can make referrals for additional evaluations or services as part of the case planning process
- Many Juvenile POs have received training in trauma-informed care from the UMass Child Trauma Training Center

DYS Screening Practices

- All youth are immediately given a MAYSI-2 behavioral health screening upon entering a DYS facility (detention or commitment)
  - Youth participating in the OCA/DYS Youth Diversion Program will also receive MAYSI-2 screening

- For youth committed to DYS, more intensive assessment process takes place over a ~monthlong assessment period
  - Assessments are conducted by masters' and doctoral level clinicians.
  - Clinicians conduct extensive interviews with the youth and their family members.
  - Youth are also provided with ACEs screenings, PTSD screenings, and a needs and strengths assessment (CANS) during this period.

- Next steps:
  - After the assessment period is complete, a report is generated which outlines the factors (including trauma) which influence a youth's behavior and provides recommendations for placement and treatment.

Next Meeting

(All meetings are virtual; Zoom information is in each calendar invitation. Contact Kristine.Polizzano@mass.gov for more information on how to join meetings)

Monday, November 1st
1:00-3:00pm

MASSACHUSETTS
Office of the Child Advocate

Contact

Melissa Threadgill

Director of Juvenile Justice Initiatives

Melissa.Threadgill@mass.gov

OCA
MASSACHUSETTS
Office of the Child Advocate