Honorable Elijah E. Cummings
Chairman, House Committee on Oversight and Reform
U.S. House of Representatives
Washington, D.C. 20510

July 11, 2019

Dear Chairman Cummings and Honorable Members of the Committee:

Thank you for the opportunity to submit this communication on "Identifying, Preventing, and Treating Childhood Trauma: A Pervasive Public Health Issue That Needs Greater Federal Attention".

The Louis D. Brown Peace Institute is a center of healing, teaching, and learning for families and communities impacted by murder, trauma, grief, and loss. We work to create and sustain an environment where all families can live in peace and all people are valued.

In our work over the past 25 years, we often find ourselves dealing with very young people who are profoundly impacted by the murder of a loved one. In order to serve the unique needs of children, I developed *Always in My Heart: A Workbook for Grieving Children. This workbook was* created to help my own young children cope with the murder of their brother, Louis. These activities can help children understand and express the many feelings and emotions, both good and bad that come with grief.

In addition to this important workbook, we provide a guide for families that helps them navigate the process that occurs in the hours after a loved one's murder. The Peace Institute provides emotional and practical support from the moments after death notification onward. Our programs and services are grounded in the Center for Disease Control's social-ecological framework that interventions are needed at multiple levels in order to interrupt cycles of violence. The heart of our work is with families impacted by murder on both sides. Our impact extends to community and society through tools, training, and technical assistance.

We know that children absorb all that happens around them, positive, negative, and everything in between. They need the safety to express what they are feeling, and they need a way to express it. *Always in My Heart: A Workbook for Grieving Children* is but one tool to help them do that. It is my sincere hope that those who work with children facing the murder of a loved one will use this tool and learn something from it. I will send you a copy in follow-up to this message so that you may review it for yourself.

The extraordinary women and men of the Louis D. Brown Peace Institute thank you for convening this hearing, for remembering the children, and stand ready to work with you to heal our young people.

With Gratitude,
Chaplain Clementina Chery, CEO and Founder
25 years of transforming Society's Response to Homicide

SUFFOLK COUNTY DISTRICT ATTORNEY'S OFFICE
DISTRICT ATTORNEY RACHAEL ROLLINS

July 12, 2019

Members of the Committee on Oversight and Reform
2157 Rayburn House Office Building
Washington, D.C. 20515

To Chair Elijah Cummings, Ranking Member Jim Jordan, and Members of the Committee:

Thank you for the opportunity to testify regarding the impact of gun violence and trauma in Suffolk County, Massachusetts. As the Suffolk County District Attorney, I serve as the chief law enforcement official for Boston, Chelsea, Revere, and Winthrop, Massachusetts, and oversee an office of approximately 300 people handling approximately 35,000 new cases each year. Our mission includes ensuring that Suffolk County is safe and that victims, witnesses, and their families receive the services they deserve and are entitled under Massachusetts law.

Every year, the Suffolk County District Attorney's Office serves hundreds of families who are impacted by homicide and gun violence. When we encounter these families, it is often in the immediate aftermath of violence when they feel helpless, confused, and shocked. Our advocates, investigators, and assistant district attorneys work tirelessly to support families to share their stories, hold offenders accountable, and mitigate the impact of the trauma caused by gun violence by connecting them to resources, such as victim compensation funds and community-based service organizations.

During the Fourth of July long weekend, there were 16 shootings in Boston. Fortunately each of those shootings was non-fatal. However, each shooting left at least one, sometimes more, physically wounded, and each shooting opened up a deep wound in the community as survivors, witnesses, and neighbors grapple with the fear and anxiety that remain. In one of these episodes, an 8-year-old child sustained a non-fatal injury from a gunshot while playing in the park and watching fireworks. We have yet to know the long-term effect this incident will have on the child and her family, but, without doubt, they will need considerable support to heal from, and process, what transpired.

Violence does not occur suddenly, then disappear. It haunts those who are touched by it. Indeed, the aftermath of gun violence can be debilitating, leaving families and communities with emotional, physical, and financial damage that can remain for years. These after-effects are exacerbated by their having to engage in a complicated and cold criminal justice system process that can last for years, does not always result in the desired outcome the families hope

for, and can be re-traumatizing. Families of unsolved cases bear an additional burden of not having closure, and there continues to be limited resources to provide these families with extra support.

As a district attorney's office, we have a deep and multi-faceted understanding of the long-term of effects of trauma, as many of those whom we prosecute themselves have traumatic histories. This is most apparent in the population served by our Juvenile Alternative Resolution (JAR) Program. The JAR program provides individualized service to young people as an alternative to traditional prosecution. Instead of incarceration, juvenile offenders who qualify for the JAR program are placed in community-based organizations aimed at leading them away from the criminal justice system. In assessing juveniles for the program, we see that most of them have a complex set of needs and risk factors that pre-date offense and arrest and often stem from or are impacted by trauma that occurred in early childhood and beyond. The organizations that serve the juveniles in the JAR program have the ability to address risk factors and maladaptive behaviors that are often the root cause of the juveniles' involvement in the criminal justice system. Our goal is to divert young adults outward, away from the criminal justice system, instead of upward and deeper into it, in part by making sure that the youth have access to services in their communities that address their needs around trauma, mental health, and substance use.

In closing the Suffolk County District Attorney's Office supports the efforts of the Oversight and Reform Committee to address the public health issue of childhood trauma and its prevention and treatment. As you consider federal initiatives and legislation to address trauma we recommend the following:

1) Increase funding to build capacity for law enforcement agencies to support victims and survivors of gun violence, homicide and trauma;
2) Increase funding to build capacity for community organizations to innovate and develop programming to address trauma; and
3) Prioritize legislation that addresses gun violence as the public health crisis it is, with a focus on its traumatic effects on children resulting in childhood trauma.

Thank you for your consideration.

Respectfully Submitted,

Rachael Rollins
District Attorney
Suffolk County, Massachusetts

RR/ac

Wellspring Mentors

The Honorable
Congresswoman Ayanna S. Pressley
Massachusetts Seventh District
United States House of Representatives
1108 Longworth HOB
Washington, DC 20515

Dear Congresswoman Pressley,

Per your office's request, I am submitting written testimony pertaining to my limited knowledge of Massachusetts' *Child Behavioral Health Initiative (CBHI)*, a federally and state funded program through the The Center for Medicaid and CHIP Services (CMCS), MassHealth, the Massachusetts Behavioral Health Partnership -- ours state's largest underwriter of wraparound behavioral health services to children eligible to receive such interventions -- and is overseen by the Massachusetts Executive Office of Health and Human Services.

I currently serve as a Therapeutic Mentor for a subsidiary of a national human services provider, The MENTOR Network, and as the founder of a local behavioral health services agency which provides in-home therapy and therapeutic mentoring services to youth and families, Wellspring Mentors. As a Therapeutic Mentor, I hold one of three different bachelors-level clinical roles that can be integral to the whole of wraparound behavioral health service provision.

In this testimony, I will provide several data points which I believe point towards a behavioral health system of care that is drastically underfunded at the federal and state level, and therefore is struggling to hire and retain credentialed bachelors and masters-level behavioral health clinicians, as well as ensure the CBHI program is meeting its mandate to provide critical behavioral health interventions to youth and families who are eligible to receive wraparound services through MassHealth, many of whom have been impacted by traumatic events (such as gun violence) in their communities.

For example:

- **Lacking Current Performance Data on Service Utilization** -- Beginning in the FY2010, the Office of Behavioral Health Staff within Massachusetts Department of Mental Health, generated annual reports which reported on the quarterly outcomes of CBHI services delivered by state certified managed care entities. The data in these reports was based on Managed Care encounter data for members who have received the listed CBHI services. The data is submitted to MassHealth by each MassHealth managed care organization. As of the end of FY2017, these reports (if they

exist) have no longer been released publicly via the EOHHS' website[1].

- **Underserving Youth with Serious Behavioral Health Needs** -- A 2016 NIH study has demonstrated that Massachusetts has had success with their behavioral health screening mandate which requires primary care physicians to provide behavioral health screenings to their Medicaid eligible patients who are under the age of 18, relative to states with similar mandates, such as California. This has helped the state confirm that 27% of Massachusetts high school students self-report that they feel sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities sometime in the last year and that 5% have attempted and 12% have seriously considered suicide in the same time period. In the same period, 2016-2017 Academic Year, the Boston Children's Hospital Neighborhood Partner program (BCHNP), which matches behavioral health clinicians from Boston Children's Hospital with Boston's public and charter schools, noted that *10% of all students enrolled at their partner schools* were referred to BCHNP for Clinical and Early Intervention Services and that almost 90% of these students were determined to be in need of behavioral health interventions. However, as of this most recent CBHI utilization report, which collected data from youth and families who received CBHI services at any point between July 1, 2016 and June 30, 2017, of the 682,586 youth eligible to receive four intensive wraparound behavioral health services through CBHI (Intensive Care Coordination, Family Training and Support, In-Home Behavioral Services, and Therapeutic Mentoring) the utilization rate for each of these services was 1.4%, 1.1%, 0.4%, and 2.5% respectively. In-Home Therapy, which provides family-centered therapy to youth and families through a Masters-level clinician, was utilized at a rate of 2.5%. Mobile Crisis Intervention (MCI), a service specifically designed to provide immediate support to a youth experiencing a behavioral health crisis through a team of clinicians (such as the BEST Team in the Greater Boston Area), was the second-most used service out of all CBHI services with over 15,000 unique utilizers.

- **Underrepresentation and Marginalization of People of Color in Clinical Behavioral Health Roles --** In 2014, the Massachusetts Mental Health Policy Forum published a report titled *The Time is Now: Tackling Racial and Ethnic Disparities in Mental and Behavioral Health Services in Massachusetts*, a report sponsored by Blue Cross Blue Shield of Massachusetts and Havard Pilgrim Health Care Foundation. The report notes, "(Massachusetts) currently lacks the personnel readily trained in evidence-based care to offer behavioral health treatments in languages other than English. Yet similar challenges have been successfully addressed in lower-income countries facing more severe workforce constraints through training of less specialized health workers, including peer providers. Community Health Workers (CHWs) could successfully deliver evidence-based treatments, tackling personnel shortages, increasing diversity, and addressing the lack of bilingual/bicultural clinicians as a potential strategy to reduce disparities. However, to date, Suffolk County, a county in which 24.9% of residents identify as Black and 22.9% identify as Hispanic, has only less than one full-time mental health professional on-staff in their 15 federally designated Health Professional Shortage Areas.

[1] https://www.mass.gov/service-details/cbhi-data-reports

- **A Undercompensated and Under-insured Behavioral Health Workforce** -- Many behavioral health clinicians in the Greater Boston area work more than 30 hours per week but are not contracted as full-time employees by their agencies and do not receive access to health care and other vital benefits.[2] Average salaries for bachelors level clinicians are about $36,000 per year and $50,000 per year for Masters-level clinicians. Given the racial wealth and income gap within Boston, rising housing costs as a percentage of household budgets, and the significant family caretaker responsibilities held by many behavioral health workers (and former or would-be behavioral health workers), behavioral health has become a difficult field of work to maintain as a sole pursuit or progress within. Agencies have only recently begun to push for hire rate payments at the state level to compensate.

Should you have any additional questions or concerns about the data presented herein or conclusions drawn from it, please do feel free to reach out to me.

Sincerely,
Chris

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[2] Anecdotal but can find further evidence.

Doctors Need to Speak Up More

Peter T. Masiakos and John R. McLaren, MD

On a day that marked the start of a new academic year for hospitals around the country, an editorial[1] published by Dr. Paul Hsieh sparked a lively public debate. Titled "Doctors Need to Shut Up More," the article was received by some as sage advice for both newly minted interns and their veteran mentors. However, its thesis, that doctors should limit their scope of practice to the biology and physiology of the human body, was met by many of our colleagues with vocal opposition.

A version of the popular "stay in your lane" reproach, Dr. Hsieh proposed that physicians and medical organizations should not comment on contemporary, hot-button issues like immigration or nuclear disarmament, as these are outside of their field of "expertise" and may harm their institutional credibility. Yet, what the author neglected to consider is that physicians are bound by an oath to protect the health of *all* humans, not just those in the exam room.

Physician advocacy is not a new phenomenon. For as long as the profession has existed, humanity has depended on doctors to be sentinels against hidden societal dangers and advocates for policies that protect us against such dangers. On the front lines of patient care, we are routinely exposed to the faces affected by modern ills such as unemployment, food insecurity, drug addiction, gun violence, and racism; understanding and addressing these social determinants of health are also fundamental components of our vocation.

The foundation of this drive is spelled out plainly in the Hippocratic Oath[2], opening the door for a broader recognition of the human experience, and thus, an extension of our "lane":

"I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick."

"I will prevent disease whenever I can, for prevention is preferable to cure."

"I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm."

These words remind us to not just provide patients with the immediate services they need, but address the root causes of the problems they face. As such, we reject Dr. Hsieh's premise that physicians ought to remain sidelined from political and social discourse. To the contrary, we believe that doctors are obligated to speak up more.

Doctors must continue to shape legislation at both a local and national level by sharing their experiences to influence a conversation so often divorced from the realities our patients face. It is in this relationship between a physician and a patient where public health policy and individual well-being intersect.

In the late 1970s, for example, after examining a nearly comatose 3-year-old girl in his office, Dr. Herbert Needleman[3] made the connection between her illness and toxic levels of lead in her blood. By speaking up, suggesting that even small amounts of the heavy metal could result in chronic learning disabilities, he brought global awareness to a previously unrecognized problem. His advocacy was instrumental in ushering through a federal ban on lead-based products, and since it was passed, lead levels in children have decreased by more than 90 percent.

A decade later, during the height of the Cold War, the physician led organization, International Physicians for the Prevention of Nuclear War[4], shared the Nobel Peace Prize for "creating an awareness of the catastrophic consequences of atomic warfare." None of its members were physicists, but these doctors focused the world's attention on the pathologic manifestations of nuclear proliferation and played a meaningful role in the denuclearization talks that followed.

Since then, hundreds of editorials have appeared in our medical journals, penned by physicians attempting to shape the debate on a range of issues previously viewed as taboo. Dr. Joseph Sakran, a trauma surgeon and gunshot victim, has frequently advocated for the reform of our nation's firearm laws[5]. Dr. Fiona Danaher, a pediatrician familiar with the physical and psychological effects of toxic stress, has publicly condemned the current administration's systematic separation of migrant children from their parents[6]. Sharing these personal, human stories, grounded in scientific truths, helps to shape public policy in a way that only those with our experience can.

Moreover, speaking up may be good for *our* psyches too. As Leo Eisenstein recently suggested, advocacy for our patients can help to reduce the moral distress that contributes to physician burnout[7]. While the collective action of campaigning can provide a valuable service to society at large, it may also serve as an important act of self-care. The longer we are able to stay motivated, engaged in this important work, the more society serves to reap the benefits of our labor.

This is not to say that we should we speak up reflexively, or without thought. However, as a diverse group of individuals with numerous physical, spiritual, economic, social, and cultural backgrounds, we should feel comfortable using these perspectives to improve the lives of our patients.

The societal impact we make when we lend our voices is well documented. If we stay silent, we may miss important opportunities for intervention and, in doing so, may betray the commitments we made when we chose to enter the profession.

Moving forward, we should not censor each other, but rather take positions that empower one another to speak up outside of the exam room. We have learned over the years that the doctor-patient relationship extends far beyond the chief complaint, and what we don't say may be deafening.

References:

[1]https://www.forbes.com/sites/paulhsieh/2018/06/29/doctors-need-to-shut-up-more/

[2]https://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html

[3]http://www.pbs.org/wgbh/nova/next/body/herbert-needleman/

[4]https://www.nobelprize.org/nobel_prizes/peace/laureates/1985/physicians-acceptance.html

[5]http://www.baltimoresun.com/news/maryland/baltimore-city/bs-md-ci-shoot-to-kill-surgeons-20161127-story.html

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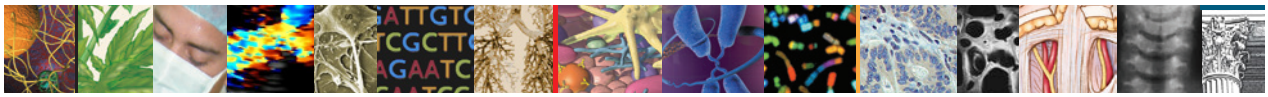

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

The Quiet Room

Peter T. Masiakos, M.D., and Cornelia Griggs, M.D.

At the end of an inconspicuous hallway and strategically placed far from the controlled chaos of the trauma room lies a dimly lit waiting area that we in the medical field call "the quiet room." It is a bland spot; a few soft chairs surround a table that holds a box of crisp institutional tissues. There may be a picture or two on the wall, but generally it is an unassuming room where we physicians tell mothers about the deaths of their children, far too often because of firearm violence.

As we make our way to this room, we recite a careful script; we use words intended to ease this painful first-and-only meeting. The reality is that over the years, we have found that there is no good way to tell a mother that her child has died, especially when the unexpected death might have been avoidable.

We introduce ourselves as the doctor who took care of their child. We take a deep breath, look into their eyes, and quickly break the devastating news — there is no reason to delay. What follows is the visceral, piercing shriek of a mother's wailing, "Please God, not my baby!" We often weep with these mothers, we sometimes quietly blame ourselves for not being able to do more to save their baby's life — and when they are alone, as is often the case, we hold them up while they cry.

We walk away from the encounter, our stomachs churning from the stale, metallic scent of a child's blood barely dried on our clogs, our faces streaked with tears, and our hearts gripped in a vise as we tell ourselves that this senseless dying must end. But it doesn't end. Another child is shot, and another mother is heartbroken.

There is nothing quiet about this room.

In the month since the mass shooting in Las Vegas, over 1300 more Americans have been killed, and more than twice that number have been injured, by firearm violence. Every day, 46 children and teenagers are shot and 7 of them die. The overwhelming majority of those shootings and deaths are the result of interpersonal violence, though some are from an accidental discharge of an unsecured firearm and some are suicides and are attributed to underlying mental illness.[1] Sometimes the shooting is described in a bylined article in the local newspaper, but most of the time it is not reported at all. What does get reported skews toward senseless acts of terror, with the blame placed squarely on the shoulders of a mentally ill monster. But gun violence in the United States is not primarily a mental health problem.

Nearly a month after the deadliest mass shooting in modern American history, which killed 58 people, we predictably find ourselves witness to another mass

shooting, this time in a small town near San Antonio, Texas. In this attack, 25 Americans, including a pregnant woman and up to 14 children (the most children affected since the shooting in Newtown, CT, in 2012), were murdered by a single perpetrator during Sunday prayer services. On the evening news, only hours after the tragedy, we are told once again that it is time for "a national conversation about guns."

From the vantage point of a trauma surgeon, conversation seems a terribly feeble response. Gun violence, whether on the streets of Chicago or in the churches of Charleston and Sutherland Springs, is a national health emergency. It is an epidemic as deadly as the global Ebola crisis or the opioid epidemic in this country. But in those emergencies, a call for action has been followed by at least some action, not simply by the ritual and empty call for thoughts and prayers and, at most, a mere discussion. Congress appropriated $5.4 billion for the Ebola response as part of its final fiscal year 2015 spending package. The Centers for Disease Control and Prevention is awarding more than $40 million to support state efforts to address the opioid-overdose epidemic. After the introduction of the Dickey Amendment in 1996, government funding for research into firearm injuries and deaths has been restricted.

President Donald Trump has said that gun violence in America is a mental health problem, but the issue is far more complicated. Only if funding for research on firearm-violence prevention and public health surveillance is reinstated can we determine the best approach to addressing the public health crisis of firearm violence. Furthermore, expanding the National Violent Death Reporting System from 40 states to all 50 states plus Washington, D.C., would provide more information about where we should be focusing our attention.

In addition, the American Academy of Pediatrics has laid out three key priorities for confronting the crisis[2]: access to appropriate mental health services, particularly to address the effects of exposure to violence; enactment of firearm legislation that includes stronger background checks, banning assault weapons, addressing firearm trafficking, and encouraging safe firearm storage; and protecting the crucial role of physicians in providing anticipatory guidance to patients about the health hazards of firearms.

It is time for more than a discussion. Surely there is, in our collective power, some more concrete way to address the public health crisis that is gun access. We can no longer allow one mother after another to know the pain of losing a child to senseless gun violence. We remain haunted by their screams.

Disclosure forms provided by the authors are available at NEJM.org.

From Massachusetts General Hospital, Boston.

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