March 21, 2019

Ms. Jennifer Kent, MPA
State of California
Director, Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Director Kent:

Hathaway Sycamores is submitting public comments in response to the Department of Health Care Services' proposal on trauma screening tools, specifically the Bay Area Research Consortium (BARC) tool for children. As a participant on the AB 340 Work Group convened by the DHCS, I am deeply concerned about the majority's recommendation to select the BARC instrument instead of a validated and research supported tool such as the UCLA Child/Adolescent Brief Screen for Trauma and PTSD. I recommend that the DHCS postpone its effective implementation date for the BARC tool; ask the Legislature to hold hearings focused on childhood trauma and stress; re-convene the AB 340 Work Group with expansion of the members to include practitioners in the field with specific specialty in childhood trauma; and re-examine all tools to select only the best tool with support from scientific research.

As the largest child welfare non-profit organization in Los Angeles County, Hathaway-Sycamores offers a continuum of services in various settings (residential, schools, and communities) to foster children, adolescents, and their caregivers. Based on our experience serving these populations, and our participation in the Continuum of Care Reform (CCR) planning process, we are well aware of how complex trauma histories and post-trauma reactions factor into the emotional, behavioral, and functional lives of many of these traumatized youth.

We are taking this opportunity to highlight the many substantial shortcomings of the BARC. First, it does not provide for an adequate periodic screening of trauma exposure across early childhood, school age, and adolescence that would meet the need of the Medi-Cal program. Second, a brief assessment of trauma-related distress, which is missing from the BARC, is a critical complement to mapping trauma exposure in screening for risk for health and mental health conditions, and consequently, for selection of appropriate prevention, early intervention, and treatment options. It is proving important to be able to identify key traumatic stress reactions, such as sleep disturbance and reactivity to trauma reminders, for which there are early interventions appropriate for use in primary care. Third, in settings where there are high levels of trauma exposure (i.e. children in the child welfare or juvenile justice system), it becomes even more important to implement a brief measure of traumatic stress reactions to provide a well-founded clinically relevant tiered response of acute intervention and referral. Among the tools that can provide an updatable screen for trauma exposure and distress, the most widely used and evidence supported measure is the UCLA PTSD Reaction Index for DSM-5 (UCLA PTSD RI), which is now complimented by an evidence-based brief version-the UCLA Child/Adolescent Brief Screen for Trauma and PTSD. Currently, our organization utlizes the UCLA PTSD RI in the majority of our programs. The UCLA PTSD RI has also been identified and selected for implementation by the Los Angeles County Department of Mental Health as one tool in the MHSA Prevention and Early Intervention Evidence Based Practices.

Overall, in reviewing the BARC tool, although it screens for a limited number of adverse childhood experiences, it lacks the needed component for screening for post-trauma reactions. The use of the BARC tool among youth, especially those in settings where there will likely be complex trauma histories, will mean that a significant subset will be over-referred for additional assessment or for specific trauma

100 West Walnut Street, Suite 375, Pasadena, CA 91124 (626) 395-7100 Fax (626) 395-7270 www.hathaway-sycamores.org

informed treatment. That is to say, the tool lacks the sensitivity and specificity required for an efficient and cost effective method for identifying and referring at-risk truamatized youth.

Additionally, in our robust academic review to better understand the research and outcomes of the BARC as a screening tool, we failed to find significant studies that would outweigh the sensitivity and specificity of the UCLA PTSD RI in detecting likely PTSD. With regard to the remaining trauma screening tool implementation proposal developed by DHCS, Hathaway-Sycamores believes that the minimum frequency for how often the trauma tool is re-administered seems inadequate. Research has shown that children who have experienced trauma are at a higher risk to being re-exposed or re-victimized.[1],[2] Therefore, we believe that the minimum time frame for re-administering any trauma tool should be quarterly to every six months, and/or as often as clinical judgement suggests readministration (e.g., therapist suspects re-exposure may have occurred).

Thank you for considering my comments. We look forward to working with you, DHCS colleagues, and other children advocates to ensure that all Medi-Cal children receive the most appropirate screening and care that they need and deserve.

Sincerely,

Debra Manners, LCSW
President and Chief Executive Officer

[1] Weisel, D. L. (2005). Analyzing repeat victimizations. In The Office of Community Oriented Policing Services (Ed.), *Problem oriented guides for police: Problem-solving tool series.* Washington, DC: U.S. Department of Justice.

[2] Finkelhor, D., Ormrod, R., & Turner, H. (2007). Re-victimization patterns in a national longitudinal sample of children and youth. *Child Abuse & Neglect: The International Journal, 31(5)*, 479-502.