Testimony of Susan Hall

The Vermont Psychological Association and the Vermont Association of Mental Health Counselors

House Health Care Committee – February 27, 2014

Susan Atwell-Hall – MA, LCMHC nearly 40 years of master's level experience in the mental health field. Starting at Children's Hospital in Boston, later I worked for Services Against Family Violence and the Sexual Assault Investigation Team for Middlesex County in MA,. the SAFE and SAIN team, where I provided sexual assault investigation, determination of court readiness. I directed Child and Family Services in an urban community mental health center that included crisis intervention for victims of domestic violence, with the MA DMH I worked with chronically involved families serving both perpetrators and victims. I have many years supervisory trauma treatment and delivering direct care. Currently working as a clinical care manager with Vermont Collaborative Care at Blue Cross Blue Shield VT.

I would like to speak from my own clinical experience in sexual assault investigation, determination of court readiness, and hospital and community mental health treatment of children and families. This testimony also reflects the shared experience of many of my mental health counselor psychologists and social work colleagues who have worked with children and families experiencing domestic crises.

Although H.762 does addresses a profound gap in protecting children, as written it does not effectively address the complexity of either the administration nor the interventions that will likely be required as a result of the ACE survey. We support the positive intentions screening, but question the benefit of administering the ACE survey as written on several counts: location, family impact and community based services.

Location of the screening:

Experience shows that victims of, and witnesses to, domestic violence or sexual assault, or victims of any of the myriad events in which a child's very survival is threatened by those caring for them, can react in so many different and complex ways. They often try to protect those who harm them. Children learn not to bite the hand that both feeds and punishes them. However well intentioned, the idea that a child might experience a sufficient sense of safety in a doctors' office to disclose even the mildest level of family violence while accompanied by an abuser or a caregiver who has failed to protect them is just not consistent with clinical experience. In fact, we have found that the less charged atmosphere of school may offer a safer environment.

Family impact:

As in any survey, the circumstances of questioning influence the responses and results. Unfortunately the impact of simply administering the ACE survey could place the child in greater jeopardy. A non-protective, abusive or even regretful parent accompanying a child to a medical appointment may be less likely to take that child for medical care in an effort to avoid the risk of exposure. The mere act of questioning can inhibit a families' willingness to seek medical services.

Additionally , given the complexity of family dynamics, the immediate impact on the family of both the suggestion of impropriety or actual disclosure can be understood as a line of falling dominoes. The right question at the right time can send an entire family into crisis. The interviewer needs significant skill to recognize and manage discreet reactions that may appear safe enough in the office, but later behind the closed doors of home place all

of the family members at risk. In my experience this is a rare skill, not the product of a brief training. Trauma informed interviewing requires specialist who are well trained in both individual and family trauma.

What happens after any actual disclosure is an obvious and immediate concern:

What are the community supports, legal services, respite care, residential care, or clinical care available? We need infrastructure to support each family member. That structure needs to be immediately available at the time of disclosure.