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I want to start with a story.

One of our Family Support Workers in Children's Integrated Services, we'll call her Jane, started working with a client we'll call Sam who was looking for support around housing. She initially came to us in October 2016 but had only one meeting before going to a rehab program in another state. At that meeting she shared that she had been an addict since she was 13, that her mother was still an active user, and got her addicted to heroin at a young age. Sam was pregnant, due in March 2017, and had 4 other children who had all been terminated from her care voluntarily. She was determined to have this baby and parent him or her well.

Sam returned to Brattleboro after finishing her rehab program and was living with her mother for a couple months. She realized this was not a safe environment for her or her soon-to-be-born child, so she found an apartment and agreed to rent it sight unseen out of desperation. She did not feel like she had anyone to turn to for help.

The apartment she moved into was very substandard, unclean and filled with items from previous tenants, which were infested with bed bugs which hatched shortly after she moved in. This was the point where Jane got involved again, in March 2017, 2 weeks after Sam's son was born. Jane and Sam filled out affordable housing applications and worked with the health inspector to get the bed bug situation addressed. In the meantime the father of Sam's child became threatening, so the Women's Freedom Center helped her get to a shelter in Bennington to stay safe. Sam and Jane worked long distance on housing options.

An apartment became available at a WWHT property specifically for single women and their children. Tenants agree to more defined rules and to work with a housing case manager in order to live there. Jane advocated for Sam to get the apartment, and after a phone interview she was accepted.

Sam moved at the beginning of May and is safely and sustainably housed with her now 6-month-old son. She has support from other women in the house, and throughout the community.

While I do not have Sam's ACEs score, clearly she was at high risk as a child for experiencing the kind of trauma we have identified as leading to adverse childhood experiences, and very at risk for repeating the pattern. The supports she received demonstrate some of what we can do in our service system to address ACEs, and my goal is to share what we can do together to make progress on this complex challenge in our communities.

Overview

As you are already aware, years of research have demonstrated that ACEs – Adverse Childhood Experiences – have an impact on child development and ultimately adult health outcomes. Prolonged exposure to trauma creates an environment of toxic stress which can change the architecture of the brain due to the physiological response stress produces. Fortunately, the human brain is elastic, particularly in the early years, and there are things we can do in our work with young children and their families to decrease exposure to ACEs or decrease the negative impact they may have. I am going to highlight four key concepts we use in our work to contribute to more positive outcomes. These include a trauma-informed approach, The Strengthening Families Framework, the importance of integrating services, and understanding investment in upstream services.

One of the tools we use to address the impact of ACEs is a "trauma-informed approach." I have often said that you should not go into early childhood work just because you like children – you have to like adults, too, because we do not work with young children in isolation from their families. Understanding that parents may have experienced ACEs helps us implement a trauma-informed approach throughout our programs. This approach highlights a multi-generational perspective and is based on a set of principles versus prescribed practices or procedures and includes: safety, trustworthiness and transparency, peer support, mutuality and collaboration, empowerment, voice and choice, and cultural, historical and gender issues ((https://www.samhsa.gov/nctic/trauma-interventions). These broad principles can be applied in specific ways depending on the work being done. For instance, providing a safe environment in a school setting or in a home visit might look very different, but understanding what safety means for someone who has experienced trauma will inform how you work with them in that setting. This gives us a tool for joining families to help them build their capacity and resiliency. Our job is to collaborate with families, meet them where they are, share our perspective and expertise and support them to make goals and carry out a plan. It cannot be our goals. In the example with Sam, understanding her history shaped our partnership with her to support her to make choices that felt safe for her and helped her make progress toward her goals.

Building capacity and resiliency are key components of another framework we use in our work to combat ACEs and their negative effect. The Strengthening Families Approach from the Center of Study for Social Policy identifies five protective factors that contribute to families having what they need to successfully support their child's development, and ultimately reduce child abuse and neglect. These factors include: parents who are resilient and have the skills they need to deal with stress; families who are connected to a larger community, families with access to concrete supports when needed; parents who have an understanding of child development and have effective parenting skills; and children whose social emotional skills are developed (https://www.cssp.org/reform/strengthening-families/basic-one-pagers/Strengthening-Families-Protective-Factors.pdf). What does this look like in our day to day work? It means families having access to prenatal and postpartum support, like a nurse

from Children's Integrated Services being able to visit them at home to help with breastfeeding. It means bringing parents of 3 to 5-year old children together in a "Positive Parenting Solutions" training, offering learning and connection with other parents. It means teachers trained and coached in implementing The Pyramid Model in the classroom to support social-emotional development. It means developmental specialists available to help a family who has a child with Down's Syndrome learn about their child's development and what they can do to support her. It means Family Support Workers who can help families access resources to meet their basic needs. The access to concrete supports is clear in Sam's story, particularly around her housing, and there are other protective factors demonstrated as well, such as her own resilience in dealing with really challenging circumstances and beginning to form social connections in the larger community. With this strong foundation Sam will be able to continue learning about her baby and learn effective parenting strategies.

One of the reasons we have success in supporting families is because of a focus on integrated systems, and we are fortunate to have Children's Integrated Services to model how this can be done by establishing formal infrastructure and payment mechanisms. CIS is being recognized within health cre reform as a way to make our systems of care more effective and efficient. Children's Integrated Services in this region is mostly provided by The Winston Prouty Center with the designated agency (HCRS) providing some as well. When a family has an intake to CIS it is done in a way that maximizes the information needed regardless of what specific service they may end up using. This minimizes the number of times a family needs to tell their story and allows for a warm hand-off or even re-entry if they have previously been involved. This is also made more seamless by the fact that HCRS staff are housed at Winston Prouty. A weekly clinical team meeting keeps communication flowing, and a monthly systems team meeting helps address larger issues that might be interfering with services. These groups include representation from community partners like DCF Family Services, local supervisory unions, and Children with Special Health needs. Some of this type of integration can be accomplished even if services are not formally integrated by a payment mechanism. Establishing agreement about how different providers can work together across disciplines and organizations allows families to seamlessly access what they need. One example of how this is happening in CIS is the Nurse Family Partnership, or NFP. NFP is an evidence-based home visiting program that has to done by a nurse and run out of a Visiting Nurses Association. In our region the NFP nurse is part of the CIS Clinical team and participates in the referral process so that we can ensure families are accessing the service that best fits their need. In another example of this kind of 'integration' Family Support Social Workers form DCF Family Services spend one day a week on-site with CIS. There are many other opportunities like this that can help create a more seamless system of care for families which reduces barriers and increases the chance of their success in providing stable, nurturing environments for their children. This also reflects a multi-generational approach. Families do not live in silos, and our systems need to reflect that. In fact, it will take a systemic response to address these complex, challenging and intertwined issues. Frameworks like collective impact can bring together the diverse partners needed to make change in our communities. Building Flourishing Communities is one example of how that

could happen. In Sam's story we don't know if she needed to access help for breastfeeding support, if she had concerns about her child's development, or whether she needed help finding early care, but if she did, Jane's colleagues on the CIS team were readily available and easily accessible without more intakes and hoops to jump through.

Finally, understanding that we need to focus efforts and investment upstream and not just on treatment of adults is imperative. Our current service system, which is more siloed and fragmented than integrated, creates an environment of competition for limited resources. When we talk about investing more in early childhood and family development the question is: "How are we going to pay for that? We need treatment too!" The shift in thinking we need to make is that they are not mutually exclusive. If we do not invest in the continuum of promotion, prevention, intervention and treatment we are doomed to continue the cycle, and costs will continue to rise. Our hope is that investing earlier will decrease the resources required for intervention and treatment. There will be a time as we make the shift that more resources may be needed, but ultimately, we would expect a to get back to equilibrium and perhaps even a decrease as we invest more in upstream activities. If there were not supports available for Sam the potential for the cycle to continue would be greater, and her son would be at risk for having a high ACEs score, increasing the chances that he will experience poor outcomes. As a new mother she is motivated to be successful this time, and the supports of Children's Integrated Services were ready to help her build her capacity to achieve her goals. Investing more in early childhood, including community based services like family support, early intervention, and nursing, is an important piece of the equation to decrease ACEs, build resilience and ameliorate the harmful impact of childhood trauma and toxic stress.

I would like to finish by saying again that families do not live in silos and our supports and services need to reflect that if we want to make progress on this complex issue. Integrating services is a critical piece of the puzzle to continue working on, not just in our practice but also in our values and approach, using evidence-based and evidence-informed models like a trauma-informed approach and Strengthening Families. We do not have to re-create the wheel, we just need to use it.

Thank you for the opportunity to speak with you today.