AHS Testimony to the Act 43 Working Committee
9/8/17

Introduction:

As noted in the introduction to the legislative report AHS is taking a public health approach to addressing trauma and resilience. This will allow AHS to engage the entire population across the continuum from promotion and prevention to intervention and recovery.

We are here to ask this committee to help us with this approach. To do this we believe we need to shift the discussion to focus more on a long term, population level and multi-generational approach that we believe will help Vermont turn the curve on trauma and resilience.

Trauma is a deeply entrenched social condition that is interconnected to poverty, intimate partner violence, child abuse, substance use, mental health conditions, social isolation, racial and gender inequality and homelessness. Laurin will talk soon about the links between traumatic conditions and particularly how adverse child effects are interrelated. We cannot treat our way out of the effects of trauma. We must address the deeply rooted social conditions and structures that contribute to trauma, while maintaining robust treatment services.

As you saw in our report, AHS works at the program level with individuals and families. Our structure with its six departments helps us to consider issues from multiple viewpoints. We know treatment, intervention and programs are needed because they help individuals and families heal and cope. However, for us, it has become increasingly clear that this is the tip of the iceberg in which the underlying social challenges remain submerged and often unaddressed. We believe it is also at this level in which we need to work and engage.

At AHS we work at the population level with neighborhoods, communities and the state. This work focuses on interrelated conditions, identifies the needs and implements policies and actions to promote resilience and well-being. Some examples of this population level approach include our work with Results Based Accountability (RBA), Community profiles, collective impact and the all payer model. The Department of Health works on increasing immunization rates, reducing tobacco use and reducing chronic diseases. The Department of Mental Health collaborates with schools, through school-based clinicians, to create healthy school environments for all students and provides consultation and education to early care providers so they have effective strategies for promoting healthy behavior.

To apply this public health approach more broadly to trauma and resilience, we need to shift the discussion upstream. How can we change the context in which kids live? How can we improve socio-economic conditions? How can we create new partnerships to streamline services and maximize resources? How can state agencies work better together? How can communities provide social supports? How can we adopt laws and policies that will improve

social conditions and social structures that will reduce trauma and promote resilience? We have waged effective public health campaigns in the past, for instance, we sharply cut tobacco rates over the past few decades. Can we do the same for trauma?

To do this we will have to have a common language. We outlined much of this language with definitions in our report based on research and our best understanding. To do this we will need a common understanding of how we measure trauma and its effects. How will we know when we are turning the curve? How can we apply RBA to this complex social condition?

For AHS RBA is an important tool. It helps us clarify that there are two levels of accountability to improve outcomes: The first is population accountability. This is shared accountability in which no one organization, not AHS or government at large, can do it alone. There is also performance accountability. This is our responsibility to manage our programs and our outcomes. This is what we have done in our report based on the legislative request for an inventory of programs related to trauma.

The population level and program level accountabilities are often conflated. We might assume or pretend that AHS can take responsibility alone for the well-being of a population. But we know that isn't true. Many partners including all of us in this room share responsibility for the social conditions that create trauma or lead to well-being in our neighborhoods, communities and State. To do this we must shift our frame of reference and ask different and broader questions to create a better approach. It is this public health approach that we highlighted in our report.

Committee Question - 1: Why are we seeing increases in the populations of Corrections, Addiction, Mental Health and Special Education if AHS is putting all this money and effort into resiliency?

We think it is best not to correlate increases or even decreases in the number of people with substance use disorders, mental health conditions, poverty or children in need of special education with AHS programs or treatment interventions because these are aimed at the individual or family and not at the underlying social conditions leading to trauma.

For example, we know that children from very low-income parents are more likely to be low income adults than those from wealthier parents because, in certain contexts, poverty can cause stress which effects child development. As you know there is research demonstrating the large and growing gap in school performance between children of low income parents and children of high income parents. These differences can affect adult earnings and work hours later in life. This toxic stress and resulting biological responses can influence social reproduction in which social outcomes are generated from one generation to the next. This in turn fosters and replicates social inequality. The disparity in school readiness between low and higher income kids and replication of social inequality tell us that we need an all "hands-on deck" or comprehensive ecological approach not just a singular or even combined AHS or AOE approach.

We can treat the effects of trauma but we cannot treat our way to the roots causes. We need to change the context in which kids grow up and this will take at least two generations if we do it right to begin to make a difference.

Committee Question – 2: What is working?
In our report, we went through every AHS grant and service domain and applied the strengthening families criteria to understand which programs or service interventions promote resilience. We applied a ranking to each of our programs or service domains to see which ones had more fidelity. Based on this criterion many of our programs have a score of three or more and therefore reduce the impact of trauma and promote resiliency on a programmatic level.

As we noted in the report this was not a perfect process but rather a good start to think cohesively and strategically about our work. There is much more to do particularly in trying to understand performance outcomes for programs and service domains including if and how to measure the effects of these programs on trauma and resilience.

As noted, from a population level, we think a public health and population based approach will be most effective. We have already begun some of this work through the Building Flourishing Communities Initiative that Kathy will be discussing. We also believe that policies that promote social supports, income and social equality, stronger households and families, preschool and childcare will eventually yield better overall results than any program could achieve.

Committee Question – 3: Where are the gaps and problem areas?
How do we all come to a common understanding of trauma and resilience is? How do we create common language? How do we create a shared vision? How do we engage others in this conversation and in this work? Where along the continuum do we apply our limited resources: Prevention? Treatment?

We think the greatest gap is that we have not taken a population approach to this work and this includes working across state government with communities and partners to foster an ecological approach to trauma and resiliency. To do this effectively we need to have fidelity not to our own organizations or positions but fidelity to a shared vision of reducing trauma and promoting resilience.

Other gaps include the lack of measurement tools to know if we are making a difference. How do we measure resilience? How do you measure if someone is thriving? How do we assess if someone has well-being or is a functioning member of a community? Laurin, has some ideas and will talk more about this. Kathy will talk about the Washington State Model. It is these kinds of questions that should occupy our time.

Committee Question – 4: What are the evidence based practices?

We refer you to our report and the impressive number of programs within AHS and within our partnership with AOE. We have effective programs for individuals and families that reduce violence, provide food security, reduce social isolation, provide housing along with other programs that help people stabilize and grow. These programs however have little impact on whole populations. There may be no vaccine for trauma but there are laws, policies and community based education that help reduce the impacts of trauma and promote well-being.

We hope this committee will help us think holistically, systematically and across generations.