Report to

The Vermont Legislature

Building resilience for individuals experiencing adverse childhood experiences

In Accordance with Act 43 of 2017

Submitted to: **Senate Committee on Health and Welfare**
Senate Committee on Appropriations

House Committee on Appropriations
House Committee on Health Care
House Committee on Human Services

Submitted by: **Al Gobeille, Secretary, Agency of Human Services**

Report Date: **8/15/2017**

The following individuals, listed in alphabetical order, contributed to the development of this legislative report:

Pam Dalley, Director of Operations, Department for Children & Families

Paul Dragon, Director of Policy & Program Integration, Agency of Human Services

CJ Hebert, Business Process Manager, Agency of Human Services

Kathy Hentcy, Mental Health & Health Care Integration Director, Department of Mental Health

Andrew Laing, Director, Business Systems Architecture, Agency of Human Services

Carol Maloney, Director of Systems Integration/Integrating Family Services, Agency of Human Services

Judith Rex, Director of Policy & Planning, Department for Children & Families

Dru Roessle, Director of Performance Improvement, Agency of Human Services

Priscilla White, Child Victim Treatment Director, Co-Chair, Vermont Center for Prevention & Treatment of Sexual Abuse, Department for Children & Families.

INTRODUCTION

Report Summary

The Agency of Human Services (AHS) has the broadest reach in State Government. The direct services and benefits provided by the Agency serve nearly half of all Vermonters. Public health activities provided by AHS serve every Vermonter.

A large body of research tells us that the populations we serve, including children who need protection, individuals in deep poverty, those who have disabilities, are homeless, have serious mental health conditions, substance use disorders, chronic health conditions and/or those who are incarcerated, are highly likely to have experienced trauma. Further, the science indicates that the damage that early and repeated adversity does to developing brain systems is the precipitating factor for the very costly – in both human and financial terms – poor outcomes that tend to follow a childhood steeped in adversity. Science also tells us, however, that resilience, healing and growth are equally possible and widespread and that significant opportunities exist for prevention, intervention and treatment of trauma, while supporting resilient and flourishing communities. This is why AHS invests significantly in these areas, as evidenced in this report. At the same time, AHS recognizes that trauma, like other complex social conditions, cannot be solved by AHS alone and must be approached holistically with both a statewide and community-based approach. For this reason, AHS's partnership with the Agency of Education is that much more important as we continue to view our work through a trauma-informed lens.

AHS and AOE have a long history of working together and coordinating their efforts around trauma and resilience. The two Agencies intersect at the state administrative level and at the individual school district and departmental levels. Existing legislation guides coordination of services between AOE and AHS: Act 1, Act 46, Act 166 and Act 264. Act 264 passed in 1988 has been foundational to our interagency approach to coordinating services for children with severe emotional disturbance and, as expanded by AHS and AOE through an Interagency Agreement in 2005, to include those children and adolescents eligible for special education and disability-related services. Both AHS and AOE have lost resources over the years, but continue to share responsibility and resources through Local Interagency Teams, training, developing trauma-informed toolkits, and by developing community based approaches such as Building Flourishing Communities. AHS and AOE are committed to a future in which we are building state and local leadership, advancing local solutions and functional partnerships, strengthening our shared system of care plan and using data to inform our work.

Key Findings

AHS with its six departments provides 750 grants to community providers. Three hundred and seventy three of those grants, or nearly half, promote resilience and Protective Factors within families. There are five Protective Factors: parents are resilient, have social connections outside the family, have knowledge of effective parenting skills and child development stages, have concrete supports in times of need, and the social and emotional competence of children is developed. Families thrive when these factors are in place, and child abuse and neglect rates decrease significantly, according to research.

At the AHS program level, there are 282 programs, 87 of which support three or more Protective Factors, demonstrating a strong fidelity to principles and practices that prevent, mitigate and intervene in trauma and that

build resilience. Fifty-one programs support all five Protective Factors, demonstrating very high fidelity to those same principles and practices.

Even so, the data compiled for this report suggest some specific areas for improvement. It appears, for example, that programs for those between 25 and 59 years of age (Chart #10), lack support of Protective Factors. Since this group includes many parents, attention to this gap could pay large dividends in improved outcomes for children and families. Other areas for investigation in terms of promoting Protective Factors are programs such as Medication Assisted Therapy for those addicted to opioids, other substance-abuse prevention and intervention programs and homelessness initiatives such as AHS's Ending Family Homelessness by 2020.

In addition, there may be limitations to the data and areas for continued investigation. Chart #11, for example, suggests that office-based programs support more Protective Factors than home or community-based programs. This, on the surface seems counterintuitive and worthy of further analysis of the compiled data, which is necessary to ensure the full benefits of this report are realized.

Next Steps

AHS views this report as the first formal agency-wide step to creating a work plan to increase cross-agency awareness of trauma as a fundamental issue in our work and to support the intentional use of the Protective Factors framework to guide Agency programs and services. The report will support Agency efforts to use evaluation and performance measures, promote evidence-based and evidence-informed services and ensure that its continuum of services, from promotion to recovery, is balanced and effective for Vermonters.

Finally, because the prevalence[1] of Adverse Childhood Experiences (ACEs) in Vermont indicates that toxic stress (or growing up experiencing significant adversity with no supportive adults to help you) likely plays a role in the lives of a majority of Vermonters (children and adults), AHS is taking a public health approach to addressing trauma and resilience. This will allow AHS to engage the entire population in promotion, prevention, intervention, recovery and building flourishing communities.

A. Legislative Request

The Agency of Human Services and the Agency of Education consulted on the best way to respond to this legislative request. The following document reflects the perspective of the Agency of Human Services, while the Agency of Education will submit a parallel report. The Agency of Human Services gathered the following inventory and research to frame and inform the content of the Act 43, Section 3 (d)(2) Joint Report to the Legislature requested of the Agencies of Education and Human Services:

> On or before August 15, 2017, the Agency of Human Services, in consultation with the Agency of Education, shall provide data and background materials relevant to the responsibilities of the Office of Legislative Council, including:
>
> (A) a spreadsheet by service area of those programs or services that receive state or federal funds to provide intervention services for children and families and the eligibility criteria for each program and service;
> (B) a compilation of grants to organizations that address childhood trauma and resilience from the grants inventory established pursuant to 3 V.S.A. § 3022a;

[1] http://www.healthvermont.gov/sites/default/files/documents/2016/12/brfss_data_brief_2010_ace.pdf

(C) a summary as to how the Agencies currently coordinate their work related to childhood trauma prevention, screening, and treatment efforts;
(D) any training materials currently disseminated to early child care and learning professionals by the Agencies regarding the identification of students exposed to adverse childhood experiences and strategies for referring families to community health teams and primary care medical homes; and
(E) a description of any existing programming within the Agencies or conducted in partnership with local community groups that is aimed at addressing and reducing trauma and associated health risks to children.

In addition, but not included in this report:

- Act 43 Section 3 creates the Adverse Childhood Experiences Working Group for the purpose of investigating, cataloguing and analyzing existing resources to mitigate childhood trauma, identify populations served and examine structures to build resilience. The working group will convene on or before September 1, 2017 and end on December 1, 2017.
- Act 43 Section 4 states that on or before January 15, 2019, the Agency of Human Services shall present a plan, in response to the Adverse Childhood Experiences Working Group that addresses the integration of evidence-informed and family-focused prevention, intervention, treatment, and recovery services for individuals affected by adverse childhood experiences.

B. Critical Context

AHS Historical Perspective: The prevalence of trauma in Vermont[2] highlights the importance of identifying and responding sensitively to trauma survivors who access services from AHS. As evidence of the importance of this issue, the 1999 Legislative session created a Commission on Psychological Trauma to study it and make recommendations to the General Assembly. During the summer and fall of 2000 the Commission conducted hearings and reported to the General Assembly. This Commission drew together representatives of the Departments of Aging and Independent Living, Mental Health, Health, Children and Family Services, Corrections, the White River Veterans Administration's National Trauma Center, and survivor and advocacy groups. The report reviewed the literature on psychological trauma, defined a number of concerns involving training and service gaps in the provision of trauma-related services to Vermonters, and made recommendations for broad system change.[i] Appreciating the implications for AHS clients, in March 2001 the Secretary created an AHS Trauma workgroup to examine the issues more closely. In April 2002, in recognition of the important work of this group, the Secretary elevated the workgroup to the status of Policy Cluster. In the fall of 2002, the Trauma Policy Cluster added consumer and direct service provider representatives to enhance its' knowledge and expertise to create a trauma-informed public human services system through inter-departmental strategies. In May of 2003, An Act Relating to Restructuring the Agency of Human Services (ACT 45) was passed by the Vermont legislature stating, "Service delivery systems should recognize the prevalence of the many kinds of trauma, including psychological trauma, and agency staff and service providers should be trained to ensure that client interactions are respectful and sensitive to trauma" (Act 45, section 3(12)). The promulgation of the 2008 AHS Policy provided the framework for AHS to meet this legislative mandate to provide trauma informed systems of care.

Other Relevant Legislation:

Act 1 (2009): This law enhanced Vermont's comprehensive statewide approach to the prevention of child sexual abuse. It required the (then) commissioner of education, in consultation with the commissioner for children and families, to convene a working group to ensure that [Vermont is] devoting appropriate resources and programming to stopping abuse before it happens." As part of the law, DCF's Child Development Division provided trainings for all school employees, including non-teaching staff (bus drivers, custodians, food service staff), on the dynamics of sexual abuse and sexual violence.

Act 264 (1998): This act requires that human services and public education work together, involve parents and coordinate services for better outcomes for children and families. The act developed a coordinated system of care so that children and adolescents with a severe emotional disturbance and their families receive appropriate educational, mental health, child welfare, juvenile justice, residential, and other treatment services in accordance with an individual plan. The last Inter-Agency Agreement was signed in 2005 and expanded access to Act 264 and its components through expansion of who had access and shifting the focus upstream when possible.

Act 45 Section 3(12), (2003): The purpose of this Act is to foster a human services system that employs and practices trauma-informed principles in relation to staff and the individuals and families it serves. We recognize that: Everyone may have experienced trauma: the people we serve, those we encounter while conducting business and staff; It is possible to traumatize or re-traumatize individuals through insensitive systems or interactions that violate a person's sense of safety and control; Trauma-informed services are essential for

[2] http://www.healthvermont.gov/sites/default/files/documents/2016/12/brfss_data_brief_2010_ace.pdf

people to successfully access and benefit from AHS services and supports. People tend to avoid places and situations that make them feel unsafe or disrespected, therefore it is important that AHS staff are skilled in using a trauma-informed approach; For AHS staff to provide effective services, they also need to be supported by a trauma-informed workplace. Toward this end, AHS and its departments will adopt and implement policies and practices created with a trauma-informed and prevention focus.

Act 166 (2014): Provides for universal access to publicly funded prekindergarten education. All public and private prekindergarten education programs, including Head Start and public school operated programs, must meet specific requirements to operate a PreK program in Vermont. The Agency of Education, in collaboration with the Agency of Human Services, created administrative rules to guide Act 166 implementation.

Act 46 (2016): "An act relating to making amendments to education funding, education spending, and education governance." Among other reports requested, **Section 49** of **Act 46** requires the Secretaries of Education and of Human Services to "develop a plan for maximizing collaboration and coordination between the Agencies in delivering social services to Vermont public school students and their families."

Research basis:

Research on service integration and interagency coordination: Extensive research has been conducted nationally and in Vermont, over many decades, on integration of social services into school delivery and interagency coordination. The research is consistent on these conclusions:

- Integration of social services improves mental, emotional, behavioral health, and in turn improves many proxy measures of positive impact. There is strong evidence that integration has multiple positive outcomes, even as these outcomes are difficult to measure uniformly across a varied population of children.
- Coordination of services and implementation of integration is context- and location-dependent. While all areas (rural and urban) struggle with many of the same challenges, implementation success depends on the community in which the effort is based including the commitment of the leadership, staff, and community members; and resources available in that community.
- An effective approach relies on interagency coordination at all levels and is grounded first and foremost in relationships that are formed intentionally for the purpose of effective systems-of-change and outcomes. These relationships require an investment of time and effort to cultivate and maintain.[3]

Research on Trauma Informed Care - SAMHSA Guide: This guide is for "teams working with clients and communities who have experienced trauma", as well as service providers in the criminal justice system. Called a "TIP" for "Treatment Improvement Protocol," the guide provides evidence-based and best practice information for service providers and administrators who want to work more effectively with people who have been exposed to acute and chronic traumas and/or are at risk of developing traumatic stress reactions.

Harvard Center on the Developing Child: A powerful source of new ideas focused on the early years of life. Founded in 2006, the Center catalyzes local, national, and international innovation in policy and practice

[3] (From 2016 Act 46 Section 49 Report) LITERATURE: Adelman 2003 & 2014; CA Dept. Ed. 2007; Blank 2009 & 2015; Am. Acad. Pediatrics 2012; Atkins, Hoagwood, Kutash, Seidman, 2010; Behrens 2013; Boonstra 2015; Cappella 2008; CHHCS 2014; Chomitz 2009; Cournoyer 2012; Holcombe 2014; Jeffords 2012; Kettl 1996; Lifsey, Cash, Anthony, Mathis, Silva 2015; McGinnish 2014; McMahon 2000; Michael 2015; Mockenhaupt, Woodrum, 2015; O'Connell 2009; Rivard 2003; U.S. Gov't Accountability Office 2012; Vincent 2010; VT AHS IFS; VT Success Beyond Six 2008; Williams 2010)

focused on children and families. The Center designs, tests, and implements these ideas in collaboration with a broad network of research, practice, policy, community, and philanthropic leaders. The Center aims for transformational impacts on lifelong learning, behavior, and both physical and mental health.

Resources:

Vermont Child and Family Trauma Workgroup: A collaborative public/private group represented by community partners, all AHS Departments, and AOE which has been meeting since 2002. This workgroup provides policy and practice recommendations to the Agency.

Definition of Terms

ACE: Adverse Childhood Experiences are 10 types of abuse, neglect and other trauma that an adult may have experienced in childhood. It is not meant to be an exhaustive list, and in fact it is not possible to list all potentially traumatizing events. The Adverse Childhood Experiences (ACE) study shows the link between early childhood experiences and physical, mental, and behavioral health outcomes in adulthood. Subsequent research shows links between early adversity and children's difficulties in school and social situations, as well as a strong link to early substance abuse and other risky behaviors.
https://www.cdc.gov/violenceprevention/acestudy/

AFE: Adverse Family Experiences are nine types of neglect and trauma that a child may experience in his or her home or neighborhood. AFE questions are asked of a parent / guardian about his or her child (except questions about physical or psychological abuse). http://www.childhealthdata.org/docs/drc/aces-data-brief_version-1-0.pdf?Status=Master

Epigenetics: Interactions between genes and the environment shape human development. Early experiences can determine whether certain genes are turned "on" or "off," and therefore have strong influences on behavior and health over the lifespan. http://developingchild.harvard.edu/science/deep-dives/gene-environment-interaction/

NEAR Science: A cluster of fields of study (Neuroscience, Epigenetics, ACEs, and Resilience), which provides a holistic framework for understanding the impact of experiences on child development, across the lifespan and over generations. https://thrivewa.org/work/trauma-and-resilience-3/

Population Approach: The population approach looks at the whole population rather than identifying and focusing on programs for specific groups of people.

Public Health Approach: The public health approach assumes that everyone has some level of resilience to overcome adversity, and that everyone has a role to play in promotion, prevention, intervention, and building flourishing communities.

Toxic Stress – Stress becomes "toxic" when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years[4].

[4] http://developingchild.harvard.edu/science/key-concepts/toxic-stress/

Trauma: "Trauma" refers to either a physical injury, such as a broken bone, or psychological injury. Psychological trauma refers to extreme stress that overwhelms an individual's ability to cope. Trauma involves events or experiences that confront the person directly or as a witness to a real or perceived threat of death, bodily harm, coercive exploitation or harassment, sexual violation, violence motivated by ethno-cultural prejudice, gender, sexual orientation, or politically based. Psychological trauma has a direct impact on the brain, development and life-long health outcomes through associated physical, neurological, and stress response systems. These experiences directly and indirectly affect mood, memory, judgment, and involvement in relationships and work. Trauma impacts an individual's perception towards self, others and the world. The potential for reactivity to safety concerns must be consciously and thoughtfully planned to create an environment conducive to building resilience, healing and recovery[5].

Trauma-informed care or services: A strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma [including AHS staff], and it upholds the importance of consumer participation in the development, delivery, and evaluation of services[ii].

Trauma-informed system: A trauma-informed system adheres to key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific. This is reflected in the following RICH[iii] principles of empowering and collaborative relationships: Respect; Information; Connection; Hope; Further, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Services and supports must be trauma-informed, build on the best evidence available and focus on consumer and family engagement, empowerment, and collaboration[6].

Universal Precautions: This is a term used in medical settings to describe the need to assume all individuals seeking services may have been exposed to negative conditions. In trauma informed care, universal precautions *assumes that all individuals presenting for services may have experienced trauma* and may have symptoms from this exposure that are not immediately obvious. The high prevalence of trauma exposure in the general population and especially those served by AHS dictates that a universal precautions approach be used[7].

I. INVENTORY OF GRANTS AND PROGRAMS

In accordance with Act 43, AHS developed a spreadsheet by service area and a compilation of grants that address childhood trauma and resilience (Attachment A). An interdepartmental team reviewed the 750 grants that AHS has with community providers to conduct its overall health and human services mission and work. Using the definition of trauma from the 2017 AHS draft Trauma Policy (Attachment B), the interdepartmental team employed the Strengthening Families Framework™ and Youth Thrive™ Protective Factors,[8] developed

[5] AHS Trauma Policy 2017
[6] AHS Trauma Policy,2017
[7] AHS Trauma Policy, 2017
[8] https://www.cssp.org/young-children-their-families/strengtheningfamilies/about, https://www.cssp.org/reform/child-welfare/youththrive/about

by the Center for the Study of Social Policy, and used across Vermont[9], to determine if the grant or program addresses trauma and resilience. Strengthening Families focuses on parents while Youth Thrive directly focuses on youth.

At first glance, this approach may seem counter-intuitive: Why are we looking at "Protective Factors" instead of simply naming those grants or programs that explicitly address trauma and resilience? Protective Factors are conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk of serious adversity in families and communities, and in turn, increase the health and well-being of children and families. In addition, Protective Factors help parents to find resources ranging from information about child development stages (which helps parents set realistic expectations about their child's behavior), to concrete supports such as employment or food assistance. Parents supported in this way also develop coping strategies that allow them to parent effectively, even under stress[10].

AHS is implementing this approach through grants and programs because a large body of research[11] conducted over more than five decades tells us that the most effective means to prevent child abuse and neglect and build resilience is by building "Protective Factors," focusing on successes and strengths rather than trying to eliminate "problems," and to involve the family and community. AHS specifically uses Strengthening Families/Youth Thrive due to the quality of the frameworks. They are nationally recognized, evidence-informed and can be adapted and applied to many different settings and service delivery models. Further, Strengthening Families/Youth Thrive brings together program-level and system-level partners from multiple sectors that serve children, youth and families, provide a common language and an opportunity for shared outcomes.

While identifying only those grants and programs that explicitly address trauma or resilience would provide some information, it would not accurately reflect the large body of work underway across the Agency and in partnership with our community partners that prevents, mitigates and identifies needs relative to trauma, through the strengths-based lens that is becoming more common in AHS grants and programs. It seemed logical, therefore, to apply the strengths-based lens to this report.

The AHS team met with representatives from each department to review all AHS grants and programs to learn how many of the five Protective Factors, if any, apply to each grant based on the program or outcome expected. After review, AHS finalized a list of 373 grants that address childhood trauma and resilience as well as 282 programs or services areas that receive State or federal funds to provide intervention services for children and families. If a grant or program supported no Protective Factors, it was not included in the inventory. In general, if the grant or program supports one Protective Factor, it is on the lower end in terms of addressing trauma and resilience and if it supports five Protective Factors it is on the higher end of addressing trauma and resilience. The caveat is that one Protective Factor may be addressed with high intensity and conversely more than one may be addressed with relative lower intensity. For this reason, we also applied an intensity of service category (low, medium, high) to each Protective Factor. Of the 282 programs that AHS administers, 87 support three or more Protective Factors, demonstrating a strong fidelity to principles and practices that prevent, mitigate and intervene in trauma and that build resilience. Fifty-one programs support all five Protective Factors, demonstrating very high fidelity to those same principles and practices.

[9] https://www.cssp.org/reform/strengtheningfamilies/about/body/Vermont.pdf
[10] https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/
[11] http://46y5eh11fhgw3ve3ytpwxt9r.wpengine.netdna-cdn.com/wp-content/uploads/2015/05/The-Science-of-Resilience2.pdf

Some Data Examples

The charts below highlight some points of interest in the data gathered for this inventory. Please note that "1PF," "2PF," etc. refers to one, two, or more, Protective Factors. In Chart #1, for example, the bars show the number of programs in each department that support one or three or more Protective Factors. A program represented in that chart, therefore, may support any combination of the Protective Factors. A complete list of the Protective Factors is below. For a detailed description of each protective factor, see: https://www.cssp.org/reform/strengtheningfamilies/about/body/Vermont.pdf

Protective Factors

1. Parental Resilience
2. Social Connections
3. Knowledge of Parenting and Child Development
4. Concrete Support in Times of Need
5. Social and Emotional Competence of Children

When reading the charts, it is important to note when the "N" or base number refers to grants or programs. The total number of AHS grants is 750, and the number of grants that support at least one Protective Factor is 373. The total number of programs is 282, 146 of which support at least one Protective Factor.

Chart #1– Number of Grants Supporting Protective Factors

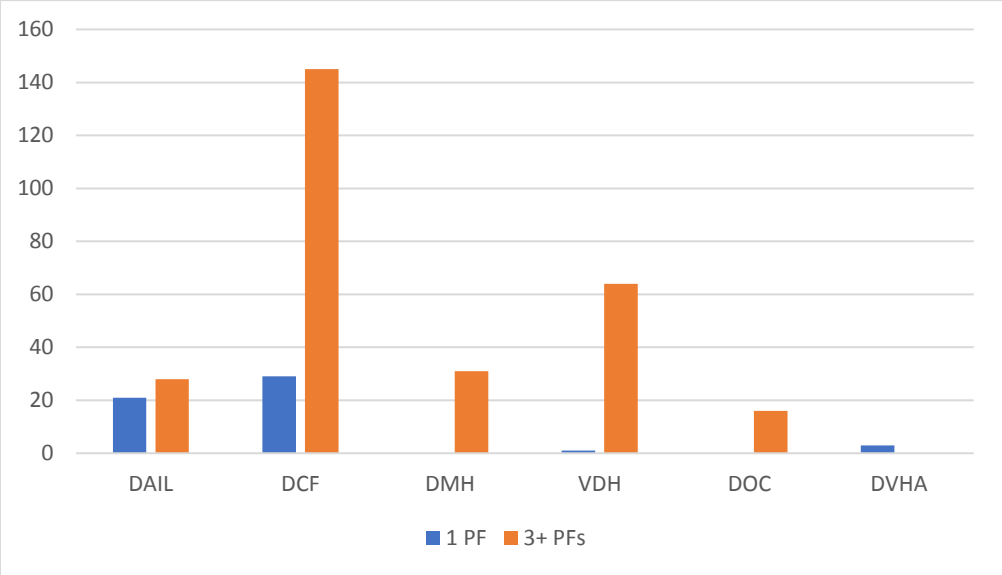


Figure 1 - Of the total 750 AHS grants, 54 support one Protective Factor and 284 support three or more. A total of 373 grants, or nearly half of all AHS grants, support one or more Protective Factors.

Chart #2 – Number of Grants Supporting Protective Factors, by Population Served

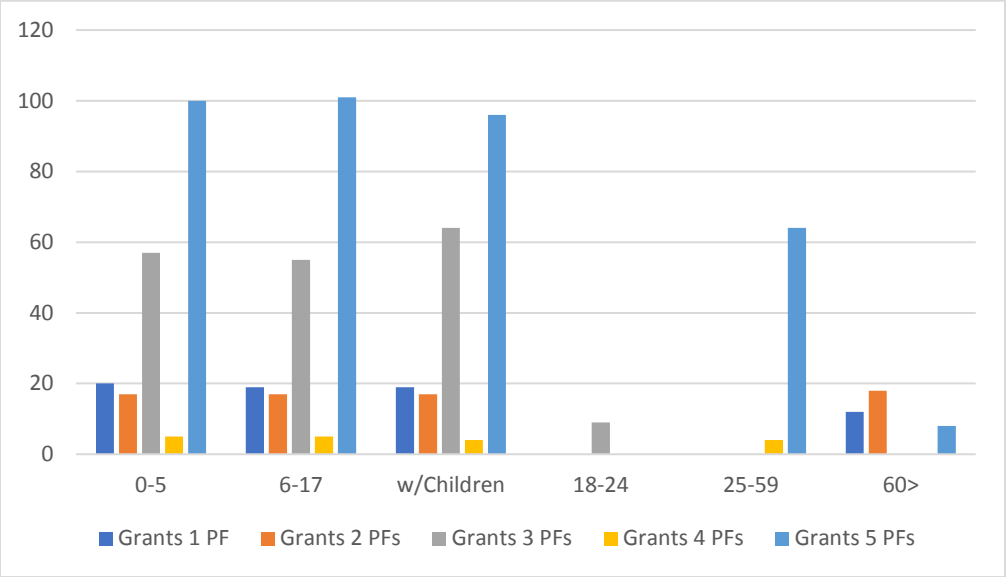


Figure 2 – of the 750 grants AHS awards, 373 support one or more Protective Factors. While the majority of grants for children up to age 18 support all five Protective Factors, it appears that many grants do not effectively address Protective Factors for the 18-24 age group.

Chart #3 – Number and Reach of Grants by Number of Protective Factors Supported

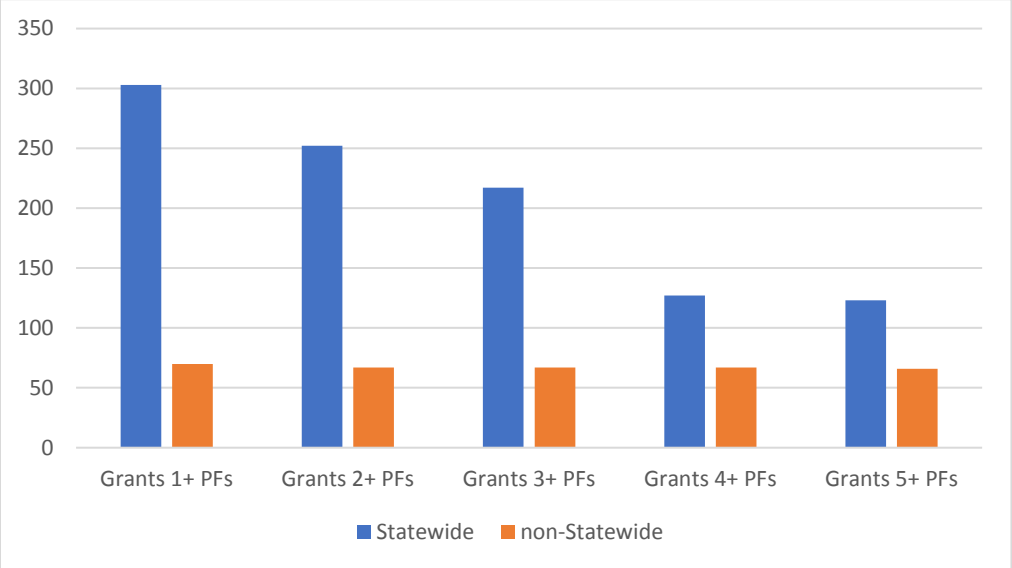


Figure 3 - of 750 grants, 49% support one protective factor, and 25% support all five Protective Factors.

Chart #4 – Number of Programs by Service Setting

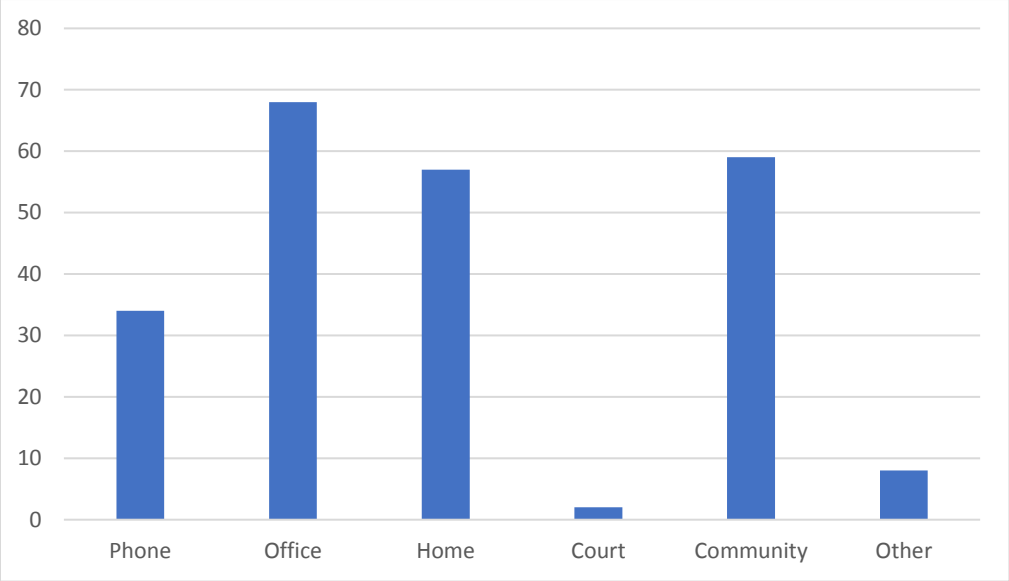


Figure 4 – Of 146 programs with at least one protective factor, this is how service is provided. The total represented here is greater than 146 since some programs offer services in more than one setting.

Chart #5 – Departmental Programs Supporting One and Three or More Protective Factors

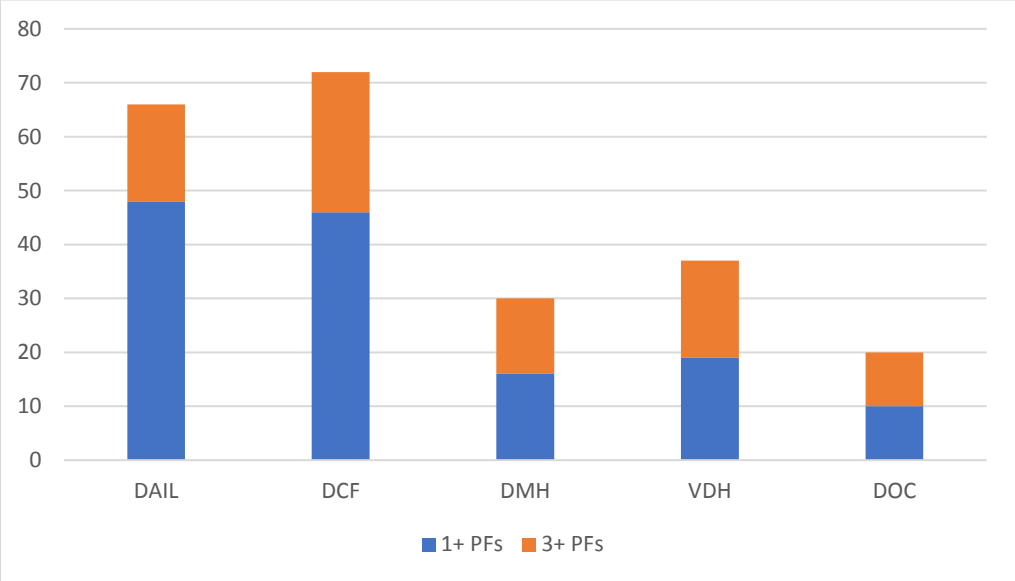


Figure 5- Of a total of 282 programs, 146 support at least one or more Protective Factors, and 87 have three or more.

Chart #6 – By Service Area, Programs That Support One or more Protective Factors

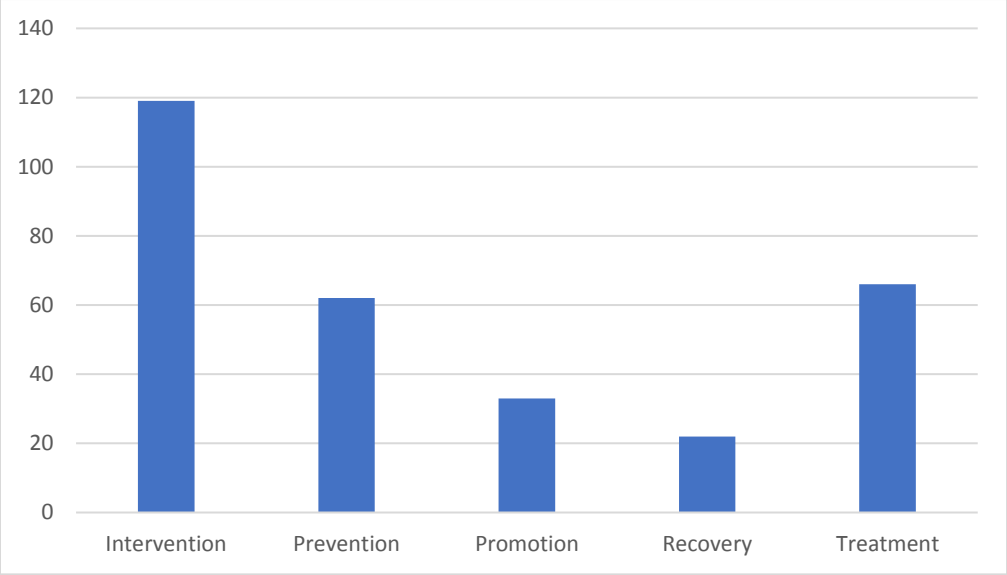


Figure 6 – Of the 146 programs with at least one protective factor, this is how they fall according to service area. The total number represented here is 305, since many of the programs qualify as more than one type of service.

Chart #7 – Programs by Number of Protective Factors Supported

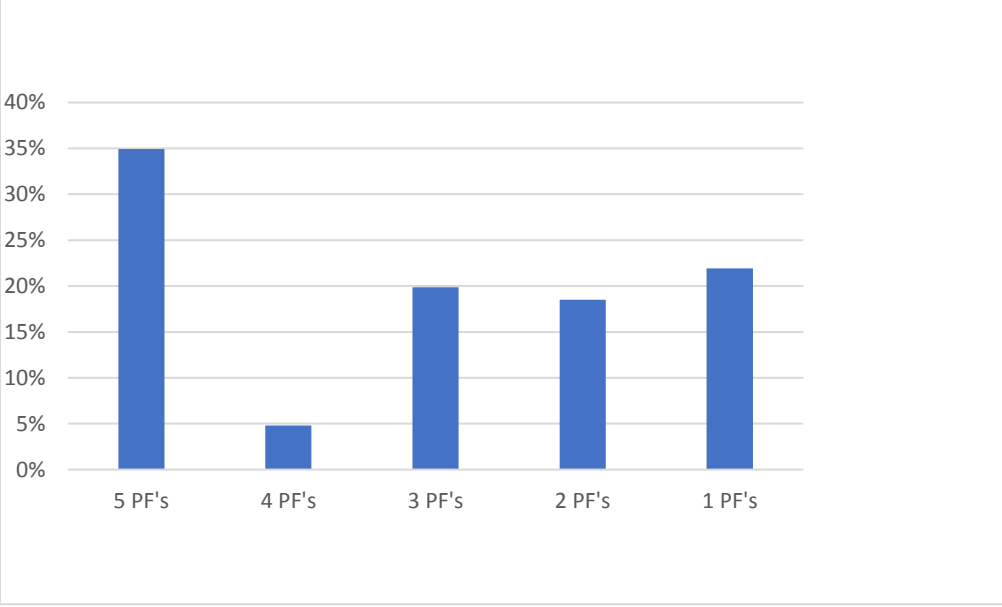


Figure 7 – Of the AHS programs that support Protective Factors, 35% support all five.

Chart #8 – Children's Services Programs and the Number of Protective Factors Supported

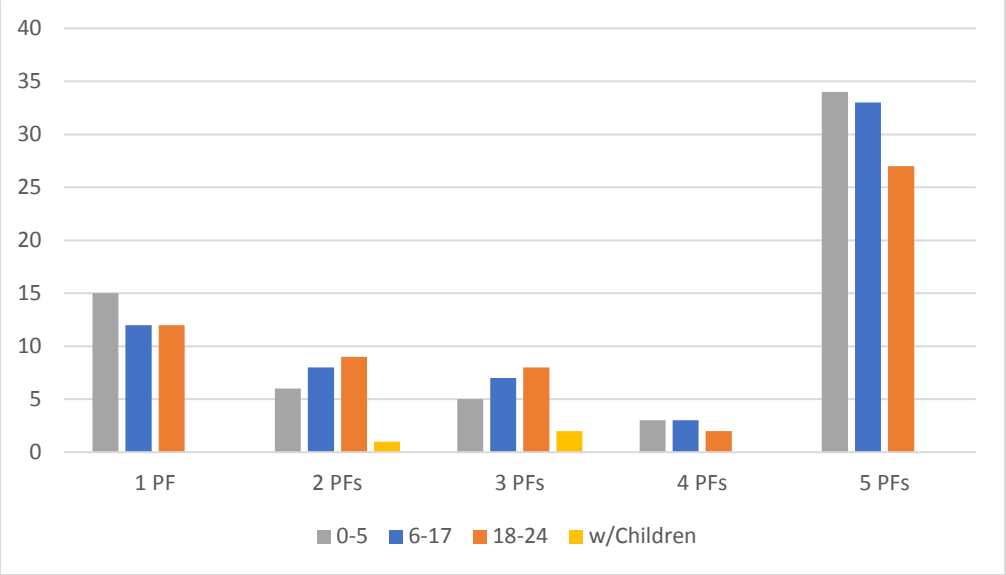


Figure 8 – 33 programs for children ages 6-17 support all five Protective Factors, and 34 support all five for the 0-5 age group. There is duplication in the chart, since several programs cover multiple age groups and therefore are represented in more than one column.

Chart # 9 – Programs for Children, Supporting Protective Factors, by Setting

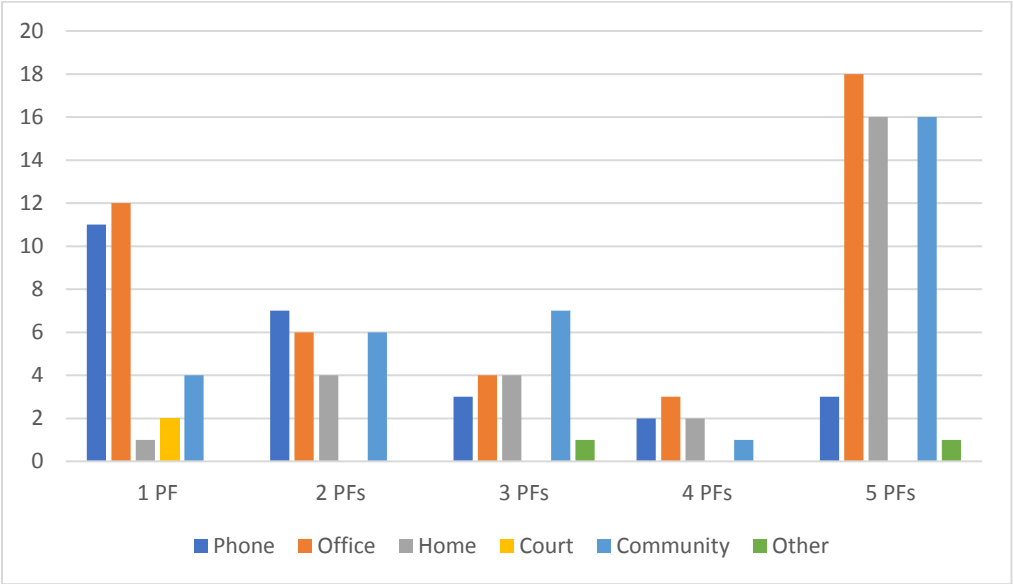


Figure 9 – This represents services for anyone age 18 or under, in one of the 146 programs that support Protective Factors and are for children and youth. There is duplication in the chart, since many programs offer services in more than one setting. As in Chart #10, this data indicates office-based programs often out-perform other settings when it comes to supporting Protective Factors.

Chart # 10 – Programs Supporting Protective Factors by Age Group

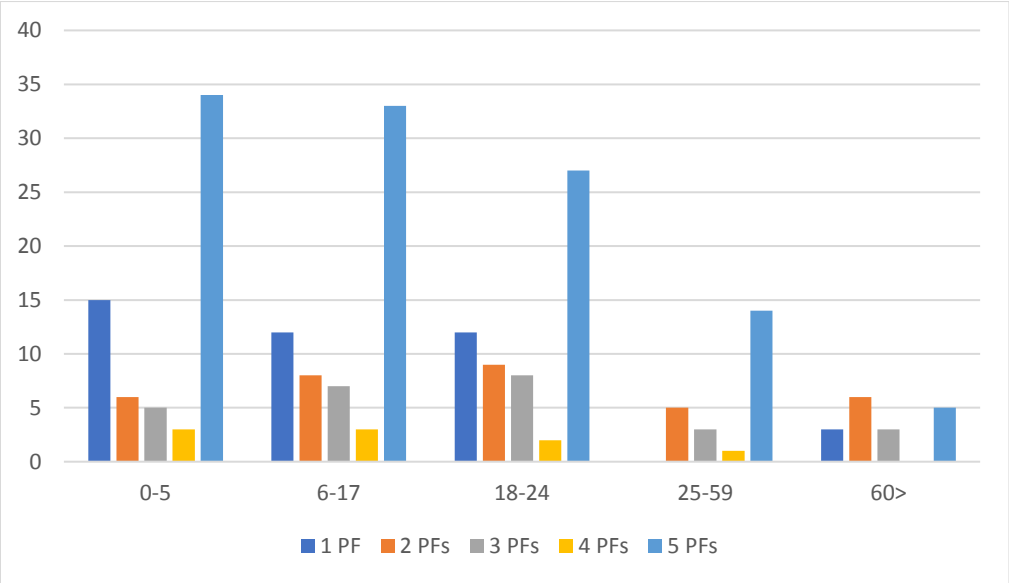


Figure 10 – While 146 programs support at least one protective factor, the majority of children's programs support all five Protective Factors. This chart indicates that increasing support for Protective Factors for adults may be warranted.

Chart #11 – Programs supporting Protective Factors by Setting

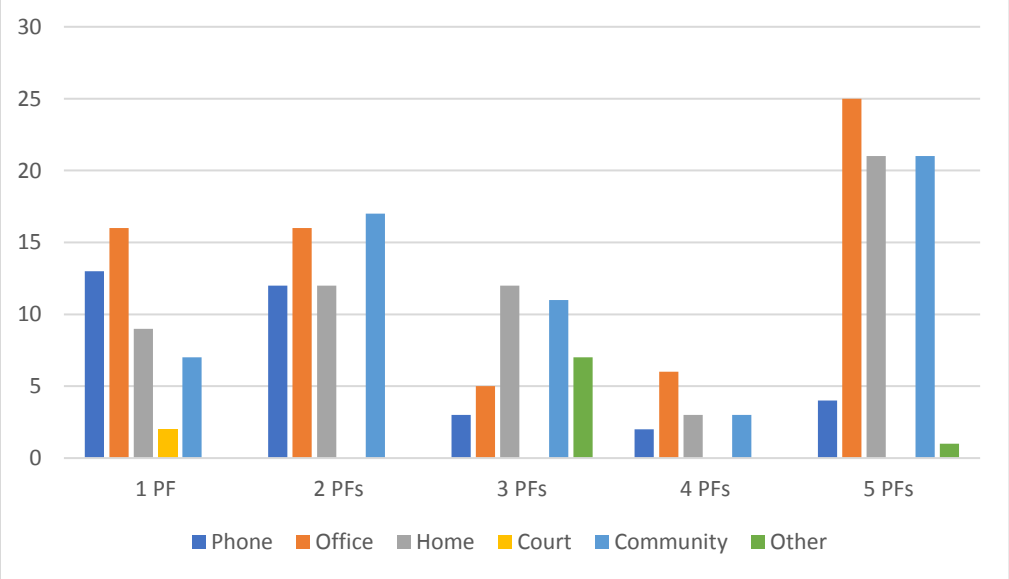


Figure 11 - According to this data, more programs offering services in the office support all five Protective Factors than either home- or community-based services. This is one of many areas that merit further investigation and analysis.

II. Summary: How the Agencies currently coordinate their work related to childhood trauma prevention, screening, and treatment efforts;

Many of the challenges faced by the Agency of Human Services and Agency of Education are the effects of complex, broad-scale societal issues with no simple solution. Because of this complexity, AHS and AOE have a long history of coordinating social services and education. AHS and AOE share the view that we must address issues of trauma and the opportunities for resilience through state, community and multi-sector approaches. We also acknowledge that successfully addressing these entrenched social conditions requires innovative, broad thinking and collective impact approaches in which local champions and teams come forward to "own" the community and the needed redesign to address the negative effects of trauma and conditions for building resilience. The AHS and AOE partnership can be a catalyst in these efforts by exploring ways to expand local leadership and a community-based perspective, while continuing to work at a State leadership level on systems that include policy and planning, and the strategic use of data and Results Based Accountability to support these local efforts.

There are, however, challenges to our coordination and work related to childhood trauma. Resources have been diminished throughout the years to support the work of Act 264. Despite this, the Agencies are refocusing their energies on providing technical assistance to school-based clinicians, developing system-of-care trainings and finding ways to better support and sustain the Local Interagency Teams (LIT). Another challenge is that AHS does much of its work through partnerships at the AHS District level while AOE operates through the Supervisory Union/Supervisory District level. The different geographies can present challenges to decision-making and program design and implementation. Also, the impact of local control and decision-making in the case of schools is critical to understanding how decisions and programs come to scale.

Following is a list of the formal groups, teams and programs that address trauma, resilience and/or Protective Factors in some manner, and that involve staff from both agencies.

State Interagency Team – Act 264

Per 33 VSA § 4302**:** A State-level team of Agency of Human Services and Agency of Education staff and community partners coordinate and provide services for children and adolescents who are eligible for special education and working with another state entity (DMH, DCF or DAIL). This team reports to the Commissioners of each agency and makes recommendations to the Secretaries and Local Interagency Teams (LIT)[12]. If a Local Interagency Team is unable to resolve the difficulties of implementing a child's Coordinated Service Plan, it may refer the situation to the State Interagency Team (SIT) for additional technical assistance. The State Interagency Team is composed of similar representatives from state level offices and family representatives.

Local Interagency Team – Act 264

The Team is composed at a minimum of representatives from the community mental health center, local school districts, the local office of the Department for Children & Families, Division of Family Services and family members. Their purpose is to provide technical assistance to a Treatment Team to implement a successful Coordinated Service Plan and to help develop the system of care in that region. The Coordinator for each Local Interagency Team may be reached at your community mental health center.

The SIT suggests solutions for individual situations and develops solutions to challenges that occur across the system of care. SIT also may make recommendations regarding fiscal policy or programmatic changes at the local, regional or state level necessary to enhance the state system of care for children, adolescents and families.

Child Protection Team - DCF/FSD Policy 59

A child protection team is a group of professional and non-professional community members appointed ("empaneled") by the Commissioner under 33 V.S.A., Chapter 49, for case review, coordination of services, public information and education, and other purposes mentioned in the law. A member of the team is defined as anyone who participates in a meeting of the team (family members who are participating in a team meeting need not be empaneled.)

Coordinated Service Plan – Act 264

Children and adolescents who are eligible for Special Education and who need services from multiple agencies are entitled to a Coordinated Service Plan, although there is no guarantee the local education agency has the capacity and/or funding to provide services. The plan is a written addendum to each individual agency plan; it states a goal and outcomes which help measure progress toward the goal, as well as the services and supports to achieve it. A subgroup of the State Interagency Team and other experts is currently working to update the Coordinated Services Plan process through a survey and other forums for feedback.

Act 166 Implementation Team

Act 166 provides for universal access to publicly funded pre-kindergarten education. All public and private prekindergarten education programs, including Head Start and public school operated programs, must meet specific requirements to operate a PreK program in Vermont. AOE, in collaboration with AHS, created rules to guide Act 166 implementation.

Building Bright Futures Statewide Council's Early Childhood Interagency Coordinating Team

A collaborative effort between AOE and DCF's CDD to ensure the development and implementation of a statewide system of early intervention services for families and their infants and toddlers with special needs.

Vermont Interagency Coordinating Council

A statewide council of families, professionals including local education agencies and AOE, and other early intervention providers advise and assist in the early childhood intervention system statewide.

The Individuals with Disabilities Education Act (IDEA) Part C

IDEA, Part C provides for early intervention services for infants and toddlers with disabilities and their families through an interagency agreement between AOE and AHS.

Vermont's Early Learning Challenge – Race to the Top Grant

A federal grant to help build a high quality and accessible early childhood system. Grant Implementation is led by DCF's CDD, AOE, Vermont Department of Health and Building Bright Futures.

AHS and AOE Coordinating Forum

In 2016 AHS and AOE hosted the second Local Interagency Team Forum to bring together partners from all over the state to create a shared vision, review and create local solutions and further develop local teams and partnerships. The third annual meeting will be held on October 20, 2017.

Interagency Agreement (IA)

The IA is required by US Department of Education Office of Special Education Programs (OSEP), and must meet certain requirements of the Individuals with Disabilities Education Act (IDEA) to retain federal funding. Any changes to the agreement must be approved by OSEP.

The Agencies are renewing and updating the 2005 Interagency Agreement (IA) within these guidelines, and exploring changes to Act 264 to better align with current needs and expectations. The shift will move us toward a systemic response, versus a specific diagnostic category or special education definition.

Success beyond Six

Vermont has been actively developing its partnerships between mental health, education, and students and their families under the Success Beyond Six fiscal mechanism since its official start in December 1992. Today there are mental health clinicians in 200 schools across Vermont.

Success Beyond Six is driven by local needs and the desire to help students with an emotional disturbance succeed in school. Children have needs that often require a team of professionals and families to work as a cohesive unit to achieve the best education and social emotional outcomes for children.

Positive Behavioral Intervention and Supports

In addition, AHS partners with AOE and its providers to implement Positive Behavioral Interventions and Support (PBIS) across the State. DMH's Child, Family & Adolescent Unit has partnered on this work since the PBIS work began. Part of the program allows for bundled billing, which means that the 200 school-based clinicians can engage in preventative aspects of PBIS and still be reimbursed by Medicaid.

PBIS is "a systems approach to establishing the social, culture and behavioral supports needed for all children in a school to achieve both social and academic success. Many schools are working in the introductory "tiers" of the program, and many have a desire to move toward implementing the highest level. Next steps are to ensure that all schools are aware of the PBIS partnership opportunity with their local Designated Agency, and that PBIS is fully coordinating with Success Beyond Six.

Multi-Tiered System of Supports

A multi-tiered system of supports is a comprehensive, evidence-based and systemic approach to teaching and learning, which unifies general and special education in a deliberate, intentional, ongoing collaboration designed to meet academic and non-academic needs, and improve learning for all students through increasingly differentiated and intensified assessment, instruction and intervention provided by qualified professionals with appropriate expertise. AHS and AOE have a robust partnership at the pre-Kindergarten level implementing MTSS.

All public schools are required to have a multi-tiered system of support (Education Title 16, Ch. 99. Section 2902, 2015). Please see the companion Act 43 report from AOE that provides more information about implementation of MTSS in schools.

Vermont Department of Health Whole School, Whole Community, Whole Child (WSCC)Team

The Health Department (VDH) facilitates a WSCC Team with representatives from each of the department's divisions that engage schools, in addition to partners from other state agencies and organizations, such as the Agency of Education and Agency of Agriculture, Food, and Markets. The team meets once a month to discuss opportunities to align program efforts and messaging, support schools in implementing the WSCC model across

local education agencies in Vermont, and to promote health in all policies. In addition, VDH collaborates with a number of AOE staff including the Child Nutrition Program, Health and Physical Education content staff person, the Adolescent Health Program Manager, the Education Programs Coordinator for Tobacco Use Prevention, and others to support school health and wellness and staff professional development needs, while aligning messaging and attempting to break down silos of activity. Following a competitive bid process, VDH has awarded $8,000 each to two Local Education Agencies to implement WSCC in the 2017-2018 academic school year.

School Health Services / School Nurses

The Division of Maternal and Child Health supports Vermont's school health services by directing the School Nurse Advisory Committee which includes an educator from the Agency of Education. The Committee maintains the Standards of Practice: School Health Services Manual upon which all other VDH school nurse supports are built, such as School Nurse Leadership and workforce development and systematic Essential School Health Services. MCH works with school nurses to facilitate access for all students to insurance, a medical, dental, and mental health homes, and for these services to be used according to best practice recommendations (i.e. annual well-care visits according to AAP's Bright Futures Guidelines).

Immunization Services

Technical assistance from Immunization program staff, and Office of Local Health Immunization Designees and School Liaisons to support assessment and reporting of school immunization regulation compliance.

Injury Prevention

Information about pedestrian safety, child passenger safety, teen driver safety - distracted driver presentations, emergency medical services for children and preventing teen suicide.

Tobacco Use Prevention

The Agency of Education has a Comprehensive School-Based Tobacco Use Prevention Program that provides grants to 19 Supervisory Unions to implement six strategies for prevention and intervention of tobacco use. The Health Department supports the Community Engagement Strategy which includes Vermont Kids Against Tobacco (VKAT) and Our Voices Exposed (OVX). The Vermont Department of Health collaborates with its partner on the Youth Tobacco Prevention Summit, the State House Rally, CounterBalance Campaign and Photovoice Project. For the past two years, the youth have been involved in the mass media campaign CounterBalance to educate the community and peers about the dangers of flavored tobacco products. The Agency of Education and the Vermont Department of Health collaborate through an MOU from July 1, 2017 through June 30, 2018, for the amount of $14,250 to support the Community Engagement Strategy.

Sexual Violence Prevention

The Vermont Health Department is part of the Sexual Violence Prevention Task Force, which provides resources to schools. The leadership is primarily Agency of Education and Department of Children and Families staff.

Sexual Education Stakeholders work group

The Sexual Education Stakeholders work group meets quarterly, coordinated by Agency of Education. Representatives from such partners as the Health Department, Primary Care, Planned Parenthood, Health Educators, etc. to discuss sexual health education in schools and community organizations.

Society of Health and Physical Educators of VT (SHAPE)
The Vermont Department of Health partners with SHAPE to offer professional development opportunities for school health and physical educators.

School Nutrition Association (SNA) of VT
Vermont Department of Health partners with SNA VT to offer professional development opportunities for school food service staff.

Vermont Agency of Agriculture and VT Food Education Every Day (VT FEED).
Coordinates technical assistance for schools in wellness policy development and integration of Farm to School.

School Wellness Policy Mini Grants
Collaborate with statewide partners, organizations and schools to support youth, schools, and parents in creating opportunities to be healthy and learn lifelong healthy habits through physical activity and nutrition programs and policies. The Vermont Department of Health (VDH) is providing a three year grant opportunity to thirteen Local Education Agencies (LEA) across Vermont during the 2015-2018 academic school years. Each LEA has been funded in the amount of $4,000 over the course of three years. The grant supports schools in the development and implementation of school wellness policies aimed at increasing physical activity and nutrition environments. The grant also involves technical assistance from the Health Promotion and Disease Prevention, Physical activity and Nutrition staff and Office of Local Health School Liaisons.

School Based Substance Abuse Services Grants
The goal of this grant is substance abuse prevention among youth to decrease likelihood of substance abuse dependence in adulthood. Office of Local Health School Liaisons (public health nurses) and Prevention Consultants provide technical assistance as needed. Competitive RFP in FY 16 with option to renew each year for two additional years. Twenty supervisory unions receive $40,000 each.

Electronic Health Records and Annual Well-Care Visits Grant
Grant provided to one Local Education Agency (LEA) to support the purchase of an electronic health record for all schools in the LEA, and then work on strategies to decrease non-response rates to adolescent responses to well-care visit information on annual health intake forms, as reported on annual Vermont School Nurse Report due January 1 each year. Includes efforts to promote the importance of, and increase general awareness about, annual well-care visits with youth and families. Grant is for $17,000. Grant period is May 1, 2017 – June 30, 2018.

Asthma Program
Support schools asthma resource related needs. Promote use and provide copies of Asthma Action Plans (care plans for students with asthma) to ensure asthma is well managed, and students are not missing school for preventable reasons. Promote the American Lung Association's Open Airways for Schools program (and connect schools with small $200 stipend for participants).

Oral Health Tooth Tutor Program
This program helps to ensure that every child has access to preventive, restorative and continuous care. Schools choose to participate in the Tooth Tutor Program. A dental professional helps the school nurse update dental information in each child's school health file and connects or re-connects families who have not accessed dental care in the previous year with a local source of care. The Tooth Tutor also presents dental health education in the classroom, giving all students the opportunity to learn more about oral health.

Envision Program
Help schools anticipate, identify and address environmental health hazards in schools. School walkthroughs and general technical assistance available (mold, pests, IAQ, drinking water quality, green cleaning, etc.).

Radon Program
Screen Vermont Schools for radon and help reduce radon exposure and increase awareness in school communities. Technical assistance available for screening, result interpretation, further testing/mitigation recommendations by Public health industrial Hygienist and certified RN measurement specialist. Some funds available to support mitigation (variable).

Youth Risk Behavior Survey
Every other year, since 1993, the Health Department and the Agency of Education sponsor the Vermont Youth Risk Behavior Survey (YRBS). The YRBS was developed by the Centers for Disease Control and Prevention in 1990 to monitor priority health risk behaviors that contribute to the leading causes of death, disease, injury and social problems among youth. These behaviors, often established during childhood and early adolescence, include: behaviors that contribute to unintentional injuries and violence, physical activity, nutrition, weight status, tobacco use, alcohol and other drug use, and sexual behaviors.

The survey is part of a larger effort to help communities increase the resiliency of young people by reducing high risk behaviors and promoting healthy behaviors. Vermont collects student responses every two years from nearly every high school and middle school in the state.

Other AHS/VDH Resources

- State School Nurse Consultant: The Vermont State School Nurse Consultant provides consultative support to school nurses. This work is done in coordination with the Health Department's Maternal and Child Health Director and the Office of Local Health School Liaisons in each of the 12 local health offices around the state.
- Office of Local Health School Liaisons: School Liaisons are public health nurses in each of the 12 Offices of Local Health that work with schools and school nurses on efforts including but not limited to, school health, school nursing and school health services, promotion of best practice preventive health services recommendations as outlined in AAP's, Bright Futures, promote insurance, and medical and dental (and mental health) home establishment and access, and coordinate with multiple community partners including healthcare providers and many others to work on school health and wellness initiatives, provide technical assistance for several Division of Maternal and Child Health or Health Department topics, and are often a conduit for information or resources available to schools (and community partners).
- Office of Local Health Prevention Consultants: Regional Substance Abuse Prevention Consultants work with community groups, schools, human service agencies, hospitals, law enforcement, parents, youth and others to strengthen the community's health and decrease substance abuse. They offer five essential services: Community Organizing; Program Planning & Consultation; Presentations & Training; Community Grants Information & Guidance; information & Referral.
- Substance Use Prevention: Programs and services that help communities become as healthy and involved as they can be are a key part of alcohol and drug use prevention in Vermont. Bringing communities together is a job for many people from all walks of life, including law enforcement, the news media, parents, students, community coalitions, and health care providers. Alcohol and drug prevention programs help support communities to grow in wellness and health.

Pre-Employment Transition Services (Pre-ETS) and VocRehab

There were major changes in Vocational Rehabilitation (VR) services for students with disabilities due to the reauthorization of the Workforce Innovation and Opportunity Act (WIOA) in 2014. The new federal law (Pre-ETS) includes a substantial mandate to serve high school students, ages 14 – 22, who have a disability, and are on an IEP or are 504 eligible. There are 5 required activities that VR provides in collaboration with schools and community partners: job exploration counseling; work-based learning experiences; counseling on opportunities for training and post-secondary education; workplace readiness training; instruction in self-advocacy. VR Transition Counselors work directly with the high schools across the state in partnership with VABIR Youth Employment Specialists, Vermont Family Network, and the Vermont Center for Independent Living to provide these vocational services for youth with disabilities.

III. Training materials currently disseminated to early child care and learning professionals by the Agencies regarding the identification of students exposed to adverse childhood experiences and strategies for referring families to community health teams and primary care medical homes.[13]

Department for Children & Families, Child Development Division

What is Child Sexual Abuse? (2 hours)

Participants will learn about what child sexual abuse is, what the grooming process looks like, how to recognize signs of abuse, and how to respond to concerns about a child. Through talking about child sexual abuse and how it happens, participants will develop skills to recognize abusive behaviors and respond to suspected abuse. This training is in partial support of licensed centers and registered childcare homes meeting their Vermont Act 1 requirement.

Child Sexual Abuse Prevention (2 hours)

Effective child sexual abuse prevention reaches from the early development of social-emotional strength and healthy relationship skills, to adults learning methods to intervene before abuse takes place, to appropriate and effective response, to changing social norms and behaviors. Participants will receive an overview of what they can do to help make the world a safer place for children.

Additional Child Sexual Abuse Prevention:

1. Technical Assistance Resource Guide (TARG) including an appendix chapter on trauma informed curriculum use
2. Step UP Child Sexual Abuse Prevention Guide
3. Workshop list of Act One prevention topics on child sexual abuse prevention
4. Act One: Sexual Violence Prevention Guidance for Community Prevention Practitioners
5. Best Practice for Implementing & Sustaining Comprehensive Sexual Violence Prevention in Schools
6. Trauma Chapter for Teachers guide to classroom reading of the book *Speak*
7. On-Line Mandated Reporter Training: *Protecting Vermont's Children: Reporting Abuse and Neglect*

[13] The Agency will include training materials in their companion report

Both the Child Development Division and the Family Services Division funds Prevent Child Abuse Vermont's Nurturing Parent Programs, Shaken Baby prevention program and the SAFE-T programs. SAFE-T programs are child sexual abuse prevention programs.

Nurturing Healthy Sexual Development (3 hours)
Participants gain information and skills to develop and maintain open communication with children, identify and respond to normal as well as concerning sexual behaviors in children, answer children's questions, and give children positive messages. Nurturing healthy sexual development plays an important role in protecting children from sexual abuse and/or developing sexually abusive behaviors.

Overcoming Barriers to Protecting Children from Sexual Abuse (3 hours)
Individuals and communities have a strong desire to prevent child sexual abuse. However, barriers to protecting children include having individuals in the family/community with concerning behaviors. In this workshop, participants consider what adults can do to assist communities in overcoming common barriers to protecting children.

Understanding & Responding to the Sexual Behavior of Children & Adolescents (3 hours)
This promotes adult understanding of the range of children's sexual behavior, including behaviors that are developmentally expected, concerning, and abusive. It explores issues of consent, equality, and coercion among children, and teaches appropriate adult responses in order to intervene earlier in the development of concerning or sexually abusive patterns.

Informed Supervision of Juveniles Who Have Sexually Offended (2 hours)
Participants who have previously attended URSBC (above) and who work with children and/or youth with sexually harmful behaviors explore the cycle of abuse and learn strategies for intervention at different points in the cycle. A model for safety planning is introduced and practiced.

Commit to Kids Act 1 Training (3 hours)
For Parent-Child Center directors who are seeking support to present the sensitive topic of child sexual abuse to their staff using the Commit to Kids program. The training covers the basic education for staff required by Vermont Act 1 legislation.

Care for Kids Curriculum (2 hours)
For programs serving preschool-aged children, a comprehensive community approach to fostering healthy sexual development in early childhood. Orients participants to child sexual abuse prevention, the messages and activities within the curriculum, and adult training options.

Basic Specialized Care (6 hours)
Requirement for early childhood providers wishing to attain "Basic Specialized Care Provider" status. Offers valuable information for anyone supporting children and families when special needs of the family (or child) or abuse/neglect are involved. Topics include typical child development, the impact of stress and abuse on development, red flags, working with families and the system, as well as mandated reporting responsibilities. Resources for working with children with special needs will also be shared.

Advanced Specialized Care:

Advanced Specialize Care build on basic care and includes the following topics:

- Creating Trauma-Informed Communities
- Dealing with Families and Their Stress: Strategies to Handle Compassion Fatigue
- Developmental Trauma in Children
- Domestic Violence 101: How to Support Moms Experiencing Violence in the Home
- Early Childhood Homelessness: Research, Resources & Partnerships
- Fostering Resilience through ARC
- Substance Use & Abuse: Recognizing Red Flags
- Supporting Children Experiencing Separation and Divorce
- Supporting Children Exposed to Substance Abuse
- Supporting Children of Incarcerated Parents
- Supporting Children with Complex Loss and Grief
- Supporting Young Children and Their Families Who are Recently Resettled Refugees
- Why Domestic and Sexual Violence Occurs
- Working with Multi-Stressed Families

Strengthening Families Core Early Learning/Child Care Training Series (17 hours):
The *Strengthening Families* basic level trainings consist of one 3-hour "Overview" module plus seven 2-hour modules.
These seven strategies support the five Protective Factors which are the basis of the *Strengthening Families* framework.

- Module 1-Overview
- Module 2-Value and Support Parents
- Module 3-Facilitate Friendships and Mutual Support
- Module 4-Facilitate Children's Social and Emotional Development
- Module 5-Strengthening Parenting
- Module 6-Link Families to Services and Opportunities
- Module 7-Respond to Family Crises
- Module 8-Observe and Respond to Early Warning Signs of Child Abuse and Neglect

Promise Communities Initiative
Provides supports to help communities (with at least one elementary school) to work across sectors including health, education, human services and community planning. The support provided includes technical assistance from the Promise Community team, funding, and information. These collaborations will do ‘whatever it takes’ to improve the educational and developmental outcomes for children in their communities.

Department of Aging and Independent Living (DAIL)

Jump On Board for Success Program
The JOBS program is an innovative supported employment and intensive case management service for youth ages 16–22 with severe emotional difficulties that uses work as a means to engage them. These youth are out of school or at serious risk of dropping out and are also at high risk for involvement with the Department of

Corrections, substance abuse, homelessness, physical abuse or abusive behaviors, and other concerning behaviors. JOBS programs in 14 sites offer career exploration and job placement; mental health and substance abuse treatment; and help completing high school education, learning independent living skills, and getting and keeping health insurance and housing.

Progressive Employment Program

Progressive Employment options such as job shadowing, work experiences, on-the-job training, and temp-to-hire arrangements provide jobseekers and employers a chance to test out employment in a risk-free environment. Originally launched using American Recovery and Reinvestment Act (ARRA) funds, the program was so successful that DVR developed a set-aside fund to continue to offer this program to employers and DVR candidates.

Supported Employment Program

DVR customers with significant disabilities sometimes need ongoing support to maintain employment in the competitive job market. In supported employment, a job coach helps the worker learn or perform certain job duties. The coach can also help ensure ongoing success by arranging for transportation, assistive technology, special training, or tailored supervision. DVR contracts with roughly 40 programs in community-based mental health and developmental disability agencies to provide supported employment services.

Vermont's Jobs for Independence

To administer an $8.9 million 3-year pilot employment and training program to help Supplemental Nutrition Assistance Program (SNAP) participants obtain employment and increase their income, VocRehab is partnering with the Economic Services Division, Department of Labor, Department of Corrections, Community College of Vermont, Capstone Community Action, other community action agencies, the United Ways of Chittenden County and multiple non-profit organizations throughout Vermont.

The Department of Mental Health (DMH)

Early Childhood Mental Health providers at the Designated Agencies offer consultation and education to early child care and learning professionals on social, emotional and behavioral topics which can include trauma/ACEs.

Rock Solid Foundations

The DCF-CDD is currently accepting applications for experienced professionals who want to train and/or mentor specialized home-based child care programs in Rock Solid Foundations: Promoting Social Emotional Competence in Young Children. The Rock Solid Foundations Training uses the pyramid model to teach early childhood professionals ways to promote children's successes through positive relationships with children, families and colleagues; creating supportive environments where every child feels good about learning; and intentionally teaching social-emotional skills that help children manage expectations and routines and reduce challenging behaviors.

Building Flourishing Communities

DMH is the lead department in this public health approach to prevention, intervention and treatment of early childhood adversity. BFC, which is in the early stages of implementation, is a statewide, community-based, interconnected, public health and social service approach, as described in the Act 43 Principles (#3). And as required in principle #3, BFC includes training for local leaders to facilitate a cultural change around the prevention and treatment of childhood trauma. In addition, the BFC initiative addresses trauma in by building resilience in those individuals already affected and preventing childhood trauma within the next generation,

which is noted as necessary in principle #2. The centerpiece of the BFC initiative is a rigorous, science-based training program for 25 Master Trainers who will in turn train community-level coaches in the sciences that explain why unmitigated childhood adversity can be so devastating and the risky behaviors and poor health outcomes it often leads to. These coaches will also receive training in facilitating dialogue, identifying cultural values and instituting and sustaining culture change.

The following are offered for increasing community knowledge about trauma/ACEs and trauma-informed approaches:

- Trauma-informed care training NCTSN grant developed basic 101 training curriculum and trained trainers in each community. Some regions have tailored these to their local needs or have developed their own trauma-informed care training curricula.
- Attachment, Regulation & Competency (ARC) training for caregiving settings (schools, child welfare, etc.)
- Resource Parent Curriculum parent groups for foster, adoptive and biological families with children who have experienced trauma to educate the caregiver about impacts of trauma and effective parenting strategies. Implementation underway to be statewide within the year; currently available in 7 regions.
- Youth Thrive Initiative has been rolled out statewide. There is currently registration for another round of 'Train the Trainers'. Trainings are now being held in every Designated Agency region. https://www.cssp.org/reform/child-welfare/youththrive
- U-matter Youth and Young Adults Mental Health Wellness Promotion and Community Action (U-matter YYA) is excited to offer a significant opportunity this coming winter for schools to engage young people in promoting wellness in their school communities. Students receive training to foster their own Protective Factors and develop critical life skills for resilience. In addition, they engage in prevention work through Community Action Projects that will make a difference. http://mentalhealth.vermont.gov/event/umatter-youth-and-young-adults

IV. Description of any existing programming within the Agencies or conducted in partnership with local community groups that is aimed at addressing and reducing trauma and associated health risks to children

Department for Children & Families

Case Review Committee- DCF/FSD Policy 59:

The Case Review Committee (CRC) is a subcommittee of the statutorily-required State Interagency Team. The team consists of members from the Agency of Education, the Department of Mental Health, the Department for Children and Families, the Department of Disability, Aging and Independent Living, and the Vermont Federation of Families for Children's Mental Health. The CRC was established to identify, review and approve intensive residential treatment for children/youth that need an out-of-home placement. The Case Review Committee (CRC) reviews all applications for admission to all in-state and out-of-state intensive residential programs for children/youth.

Department of Health

Help Me Grow

Maternal and Child health at VDH implements *Help Me Grow (*HMG*),* an effective, efficient system strategy for advancing developmental promotion, early detection and linkage to resources for Vermont's children, families, and providers. The HMG system of universal developmental surveillance, screening and detection serves all children through age eight. HMG proactively addresses families' concerns about their child's behavior, development and learning by making a connection to community-based programs, services and high quality parent education resources. The *Help Me Grow* Vermont system leverages existing resources, like Children's Integrated Services, and builds collaboration across sectors of child health care, early care and education, and family support services including Maternal and Child Health at VDH, DCF, DMH, and AOE.

Home Visiting

The Vermont Department of Health Division of Maternal and Child Health partners with the Department for Children and Families Child Development Division and the Agency of Education to deliver a comprehensive system of voluntary home visiting in Vermont that is evidence based or evidence informed. Evidence based models include: Nurse Family Partnership (NFP), Maternal Early Childhood Sustained Home Visiting (MECSH), Parents As Teachers (PAT), and Head Start (HS) and Early Head Start (EHS). All home visiting includes trained professionals (nurses, social workers, child development specialists) who meet regularly with expectant parents or families with young children in their homes. Home visitors partner with parents to tailor services and resources to best meet the unique needs of each family in order to build on family strengths and promote protective factors. Home visitors teach parenting skills, promote early learning in the home with an emphasis on positive interactions between parents and children, and provide information and guidance on a wide range of topics including breastfeeding, safe sleep position, injury prevention and nutrition. Home visitors also conduct screenings and provide referrals and connections to resources and appropriate services if necessary.

Department of Mental Health

The Department of Mental Health (DMH) provides supports and services where children and families are in their daily lives, such as in child care, schools, primary care offices, teen centers, home, etc. Research tells us children's mental health improves when people surrounding the child, such as parents, teachers and coaches, understand and support the stages of healthy social-emotional development. Any service system must meet the needs at different developmental stages of early childhood, school-age, and young adults transitioning to adulthood. Children and families living with financial, food and/or housing insecurity, exposed to adversity at home, in their community, or at school, are at greater risk for developing mental health issues and need increased attention.

All supports and services are provided within the framework and principles of child & family system of care. These include providing services in a way that is child-centered, family-focused, culturally competent, strength-based, individualized, community-based, and collaborative between and among families, agencies and community.

Promotion, prevention, intervention and treatment are not distinct categories; they provide different functions for the individual. For example, effective treatment for the child's identified mental health condition also serves to prevent further difficulties for the child and their family, while also reducing the future likelihood of adverse experiences for their children. Effective treatment of the child today is prevention of mental health problems for their next generation tomorrow.

Some of the activities that Vermont's mental health system supports to address ACEs and build resilience through strong partnerships follow.

Promotion for All:

- Puppets in Education are life-size puppets performing in elementary schools concerning relevant social emotional topics, statewide.
- Parent Home Companion half-page ad for all parents of newborn and young children stating that being a parent is not an easy job and there are mental health supports in their area that they can rely on.
- DMH works in conjunction with UVM's Vermont Center for Children, Youth and Families to promote the Vermont Family Based Approach, "a strategy that explores how environmental factors influence genetic function, and ultimately brain development, psychopathology and wellness." The model focuses on healthy activities, family relationships, screening and assessment, and access to supports when necessary.

Prevention for those at risk:

- Collaborate with schools, through school-based clinicians, to implement behavioral strategies within Multi-Tiered System of Supports to create healthy school environments for students and to address the needs of those students at risk.
- Provide consultation and education to early care and education providers on healthy social-emotional development and effective strategies for emerging behaviors.
- Provide child psychiatric consultation to primary care providers so that they can meet the needs of their pediatric patients and their families.
- Young Adult Leadership training at teen centers to strengthen youth and young adult voice in creating a community and system that understands and supports their needs as they transition into adulthood.
- Mental health workers located in and consulting with primary care offices to identify and prevent mental health issues.

Intervention for those in need:

- Resource Parenting Curriculum parent groups for foster, adoptive and biological families with children who have experienced trauma to educate the caregiver about impacts of trauma and effective parenting strategies. Implementation underway to be statewide within the year.
- Vermont Federation of Families for Children's Mental Health provides workshops for families on family leadership and empowerment within the Vermont system of care, provided statewide.
- Mental Health First Aid is an educational workshop for community members to understand how to respond to someone in a mental health crisis, provided statewide.
- U-Matter campaign to work with communities to prevent suicide and develop youth and community leadership on the topic, provided statewide.
- Family respite offers a break to families who are caring for a child with mental health challenges, provided statewide.
- Mobile crisis services respond to child and family crises in all settings to address the immediate needs and prevent further distress or complications. This can include individual crises or community tragedy, for example "post-vention" response for a school community following a student's death by suicide. High & Moderate intensity.

Treatment for those in need:

- DMH promotes Evidenced-Based Practices (EBPs) for effective treatment with children, youth and their families.
    - The following approaches directly address the impact of trauma and adverse family experiences:
        - Attachment, Regulation & Competency Framework for children and youth who have experienced complex trauma. Implemented statewide in the DA/SSA system.
        - Child-Parent Psychotherapy is a dyadic attachment-based treatment for young children exposed to interpersonal violence with the goal to strengthen the relationship with the primary caregiver. Implemented in the following regions: Chittenden, Middlebury, Northeast Kingdom.
        - Parent-Child Interaction Therapy is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. Implemented in the following regions: Franklin/Grand Isle, Chittenden, Washington, Rutland, Bennington and Middlebury.
        - Trauma-Focused Cognitive Behavioral Therapy for children and adolescents impacted by trauma and their parents/caregivers. Implemented in four regions.
        - Child and Family Traumatic Stress Intervention (CFTSI) "is a brief (5-8 session), evidence-based early intervention for children 7 to 18 years old that reduces traumatic stress reactions and the onset of PTSD. CFTSI is implemented within 30-45 days following a traumatic event or the disclosure of physical or sexual abuse." Implemented in Franklin/Grand Isle and Washington counties.
    - The following EBPs address building resilience
        - Zero Suicide is a pathway to prevent suicide and includes evidence-based practices such as Dialectical Behavior Therapy (DBT), Counseling on Access to Lethal Means (CALM), and Collaborative Assessment & Management of Suicidality (CAMS). Implemented in Franklin/Grand Isle, Chittenden and Lamoille counties.

Intensive Treatment for the small percentage of children/youth who need short term intensive interventions

- Inpatient psychiatric services
- Residential assessment and treatment services
- Crisis stabilization and hospital diversion services

The following approaches directly address the impact of trauma and adverse family experiences:

- Attachment, Regulation & Competency Framework for children and youth who have experienced complex trauma. Implemented statewide in the Designated Agency/Special Services Agency system.
- Child-Parent Psychotherapy is a dyadic attachment-based treatment for young children exposed to interpersonal violence with the goal to strengthen the relationship with the primary caregiver. Implemented in Chittenden county, Middlebury and the Northeast Kingdom.

- Parent-Child Interaction Therapy is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. Implemented in Franklin/Grand Isle, Chittenden, Washington, Rutland, Bennington counties and Middlebury.
- Trauma-Focused Cognitive Behavioral Therapy for children and adolescents impacted by trauma and their parents/caregivers. Implemented in four regions.
- Child and Family Traumatic Stress Intervention (CFTSI) "is a brief (5-8 session), evidence-based early intervention for children 7 to 18 years old that reduces traumatic stress reactions and the onset of PTSD. CFTSI is implemented within 30-45 days following a traumatic event or the disclosure of physical or sexual abuse". Implemented in three regions.
- Dialectical Behavior Therapy (DBT) is an empirically supported treatment designed to help people manage overwhelming feelings and self-defeating behaviors. Offered in at four regions.

Department of Vermont Health Access - Blueprint for Health

American Academy of Pediatrics Guidelines

The Blueprint for Health pediatric and family medicine practices follow the Bright Futures guidelines for children and families. The Blueprint works with the Vermont Child Health Improvement (VCHIP) and the Maternal Child Health Division of the Vermont Department of Health to implement the new Bright Futures guidelines with primary care providers statewide. The new guidelines devote much more attention to addressing the social determinants of health and the importance of early identification of family risk factors.

Community Collaboratives – Community Health Teams

The Community Collaboratives are important local forums where issues of trauma and building resilience are addressed. These forums, comprised of the Blueprint, Vermont's Accountable Care Organizations, and local partners, commission quality improvement activities and pilot local innovations. Trauma and a coordinated response to mitigate its impacts are the topics of focused initiatives sponsored by the Community Collaboratives in Springfield and Central Vermont.

Women's Health Initiative

A new service developed by the Blueprint and VDH, the Women's Health Initiative, supports women's specialty health providers & OB-GYN practices to implement comprehensive psycho-social screening, evidenced based family planning, and access to dedicated social work staff on Blueprint Community Health Teams (CHT). Positive screens for risky substance use, depression, food insecurity, and/or intimate partner violence result in a referral to the CHT. The CHT staff are now using the ACEs screen or other validated measures (such as the PTSD screen) for these referrals. This is increasing the capacity of the Blueprint Community Health Teams to provide trauma informed care.

Support and Services at Home (SASH)

SASH coordinates the resources of social service agencies, community health providers and nonprofit housing organizations to support Vermonters who choose to live independently at home. Individualized, on-site support is provided by a Wellness Nurse and a trained SASH Care Coordinator.

---

[i] Harris, M., & Fallot, R. EDS. (2001) Using Trauma Theory to Design Service Systems, Jossey-Bass, San Francisco.

[ii] National Center for Trauma Informed Care, SAMHSA

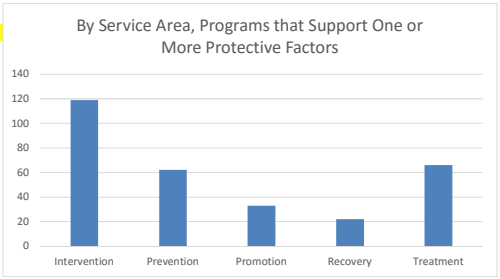
[iii] Risking Connection, Karen Saakvitne

Attachment A - Spreadsheet & Inventory - Act 43 Legislative Report - Building Resilience for Individuals Experiencing Adverse Childhood Experiences
Agency of Human Services August 15, 2017

Version 26

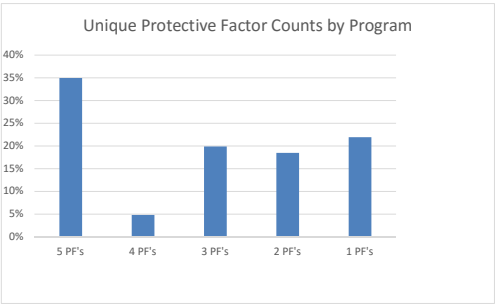
Programs with >= 1 Protective Factor Only

#6



Continuum Of Care	Programs Including
Intervention	119
Monitoring	3
Prevention	62
Promotion	33
Recovery	22
Treatment	66
Regulatory	0

Departments	Program Count
Undefined	0
AHS	0
AG	0
DAIL	48
DCF	46
DMH	16
DOC	10
DVHA	7
VDH	19
	146



Programs	% of Total	Program Count
5 PF's	35%	51
4 PF's	5%	7
3 PF's	20%	29
2 PF's	18%	27
1 PF's	22%	32
	100%	146

Grant Count	
786	(# of Grants)

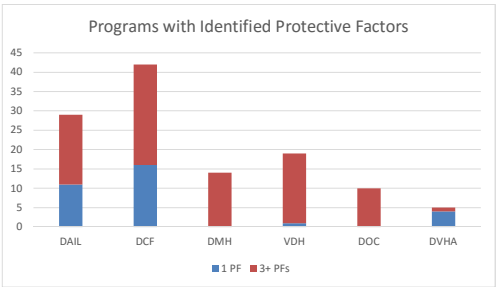
Program Count	
146	(# with at least 1 PF)

Grant Count for 146 PGs	
373	total

Grants Unassigned	
99	

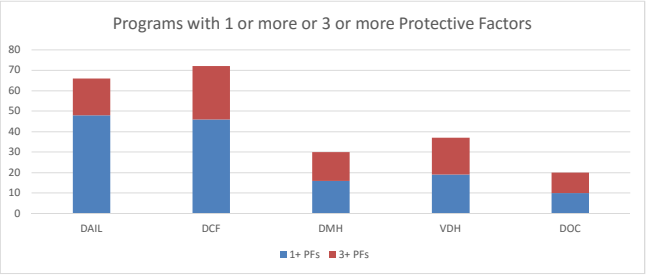
786

Grants to PGs with no PFs	
413	grants not associated with a PF

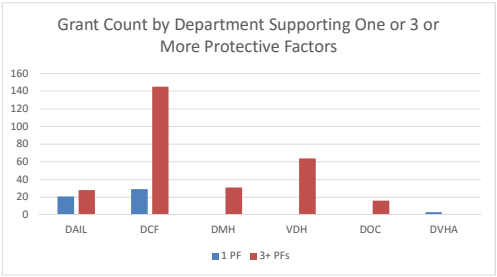


Breakdown by Dept PF=1, PF=3+		Protective Factors			Grants		
Departments	Program Count	1 PF	1+ PFs	3+ PFs	1 PF	1+ PFs	3+ PFs
DAIL	48	11	48	18	21	65	28
DCF	46	16	46	26	29	191	145
DMH	16	0	16	14	0	33	31
VDH	19	1	19	18	1	65	64
DOC	10	0	10	10	0	16	16
DVHA	7	4	7	1	3	3	0
	146	32	146	87	54	373	284

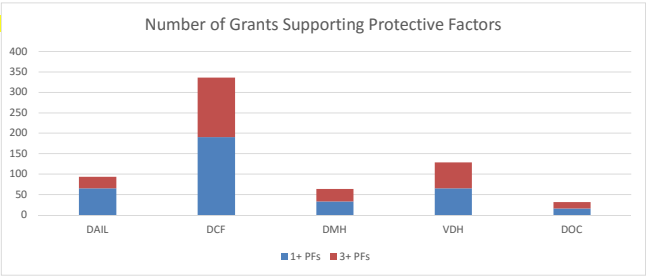
#5

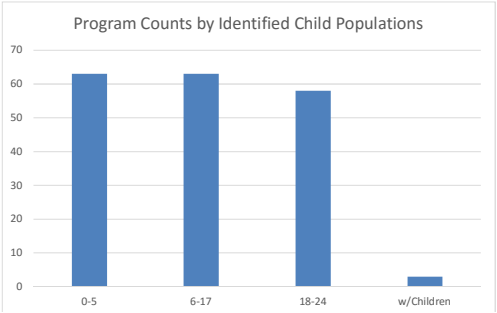


373
35
2



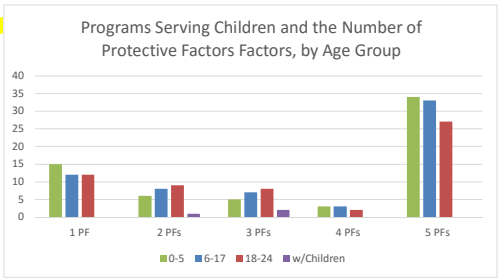
#1



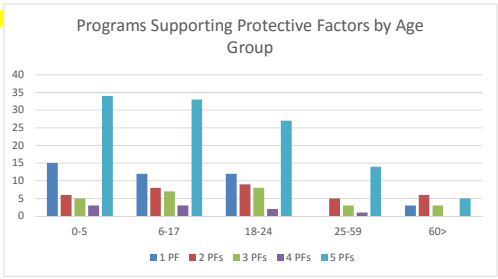


Population	Range	Program Count	1 PF	2 PFs	3 PFs	4 PFs	5 PFs
0-5	$Z:$Z	63	15	6	5	3	34
6-17	$AA:$AA	63	12	8	7	3	33
18-24	$AB:$AB	58	12	9	8	2	27
w/Children	$Ae:$Ae	3	0	1	2	0	0
25-59	$AC:$AC	23	0	5	3	1	14
60>	$Ad:$Ad	17	3	6	3	0	5
low income	$Af:$Af	10	1	0	0	1	8
disability	$Ag:$Ag	4	0	0	1	1	2
diagnosis	$Ah:$Ah	16	1	0	2	2	11
homeless/at risk	$Ai:$Ai	2	0	0	0	0	2
custody/at risk	$Aj:$Aj	1	0	0	1	0	0
Justice	$Ak:$Ak	0	0	0	0	0	0
unemployed	$Al:$Al	9	1	3	3	0	2
providers	$Ao:$Ao	0	0	0	0	0	0

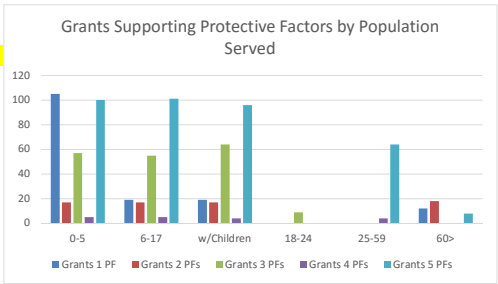
#8



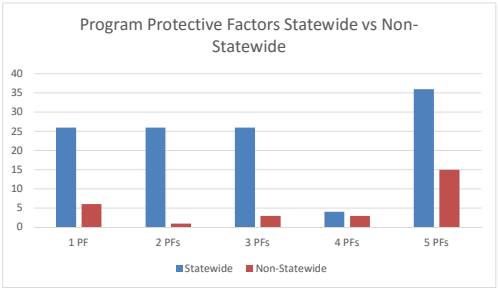
#10



#2

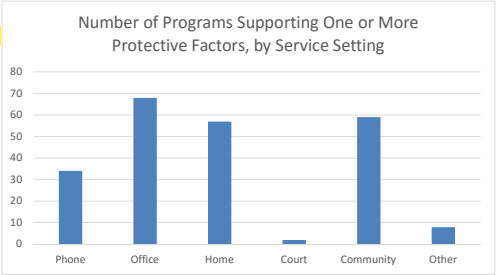


Population	Program Count	Grants 1 PF	Grants 2 PFs	Grants 3 PFs	Grants 4 PFs	Grants 5 PFs	
0-5	63	105	17	57	5	100	347
6-17	63	19	17	55	5	101	260
w/Children	58	19	17	64	4	96	258
18-24	3	0	0	9	0	0	12
25-59	23	0	0	0	4	64	91
60>	17	12	18	0	0	8	55
low income	10	0	0	0	0	23	33
disability	4	0	0	54	1	10	69
diagnosis	16	1	0	1	0	75	93
homeless/at risk	2	0	0	0	0	15	17
custody/at risk	1	0	0	6	0	0	7
Justice	0	0	0	0	0	0	0
unemployed	9	0	2	1	0	11	23
providers	0	0	0	0	0	0	0
	Grant count	156	71	247	19	503	996



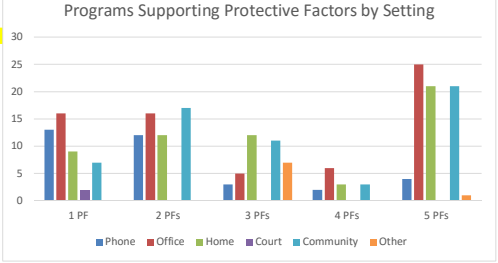
Scope	1 PF	2 PFs	3 PFs	4 PFs	5 PFs	
Statewide	26	26	26	4	36	118
Non-Statewide	6	1	3	3	15	28
						146

#4



Service Setting	Pg Count	1 PF	2 PFs	3 PFs	4 PFs	5 PFs
Phone	34	13	12	3	2	4
Office	68	16	16	5	6	25
Home	57	9	12	12	3	21
Court	2	2	0	0	0	0
Community	59	7	17	11	3	21
Other	8	0	0	7	0	1

#11

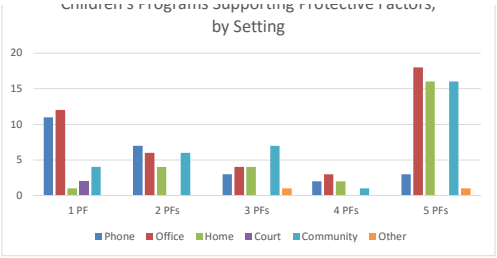


#9

Children's Programs Supporting Protective Factors

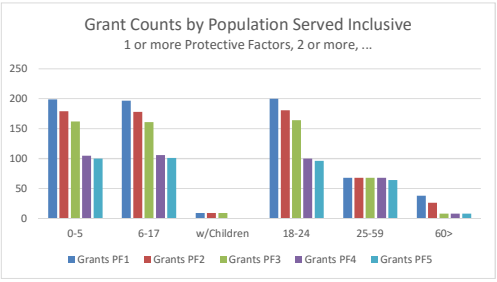
by Program

Service Setting	Pg Count	1 PF	2 PFs	3 PFs	4 PFs	5 PFs
Phone	26	11	7	3	2	3



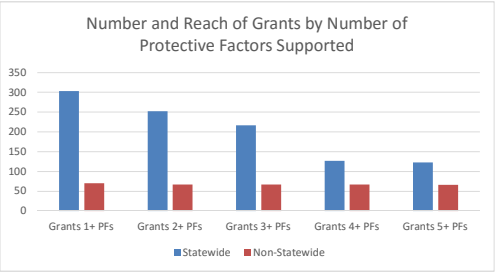
Office	43	12	6	4	3	18
Home	27	1	4	4	2	16
Court	2	2	0	0	0	0
Community	34	4	6	7	1	16
Other	2	0	0	1	0	1

0-5, 6-17, w/childen



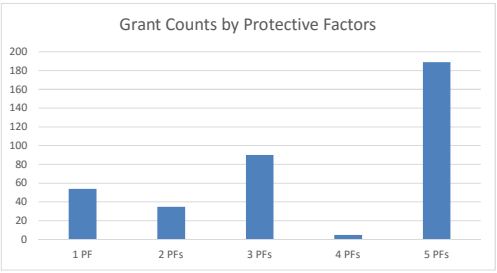
		Grant Counts Inclusive (1 PF or more, 2 PF or more, ...)				
Population	Pg Count	Grants PF1	Grants PF2	Grants PF3	Grants PF4	Grants PF5
0-5	63	199	179	162	105	100
6-17	63	197	178	161	106	101
w/Children	58	9	9	9	0	0
18-24	3	200	181	164	100	96
25-59	23	68	68	68	68	64
60>	17	38	26	8	8	8
low income	10	23	23	23	23	23
disability	4	65	65	65	11	10
diagnosis	16	77	76	76	75	75
homeless/at risk	2	15	15	15	15	15
custody/at risk	1	6	6	6	0	0
Justice	0	0	0	0	0	0
unemployed	9	14	14	12	11	11
providers	0	0	0	0	0	0

#3



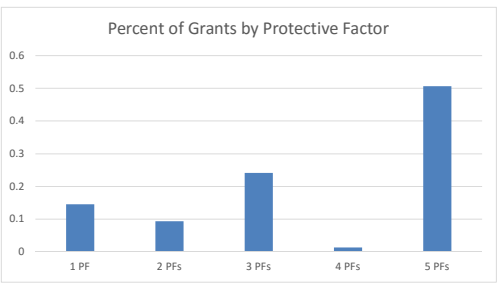
		1	2	3	4	5
		Grant Counts Inclusive (1 PF or more, 2 PF or more, ...)				
Scope	Grant Count	Grants 1+ PFs	Grants 2+ PFs	Grants 3+ PFs	Grants 4+ PFs	Grants 5+ PFs
Statewide	303	303	252	217	127	123
Non-Statewide	70	70	67	67	67	66
	373	373	319	284	194	189

Grants (1 pf or more) cover all 5 PFs 51%



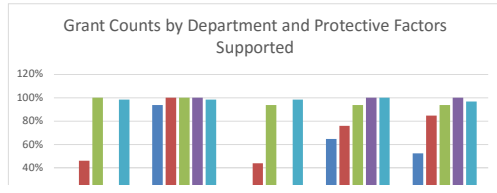
	Grant Counts by PF Count					
Grant Count	1 PF	2 PFs	3 PFs	4 PFs	5 PFs	
373	54	35	90	5	189	373
%	14%	9%	24%	1%	51%	100%

	Grant Counts by Department						
Department	Count	1 PF	2 PFs	3 PFs	4 PFs	5 PFs	
DAIL	65	21	16	17	0	11	
DCF	191	29	17	57	4	84	
DMH	33	0	2	0	0	31	
DOC	16	0	0	16	0	0	
VDH	65	1	0	0	1	63	
DVHA	3	3	0	0	0	0	
AHS	0	0	0	0	0	0	
AG	0	0	0	0	0	0	
Undefined	0	0	0	0	0	0	
	373	54	35	90	5	189	373

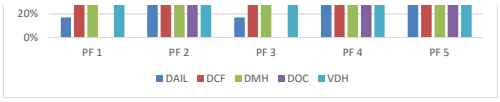


	Grant % by Department						
Department	Count	1 PF	2 PFs	3 PFs	4 PFs	5 PFs	
DAIL	65	32%	25%	26%	0%	17%	100%
DCF	191	15%	9%	30%	2%	44%	100%
DMH	33	0%	6%	0%	0%	94%	100%
DOC	16	0%	0%	100%	0%	0%	100%
VDH	65	2%	0%	0%	2%	97%	100%
DVHA	3	100%	0%	0%	0%	0%	100%
AHS	0	0%	0%	0%	0%	0%	0%
AG	0	0%	0%	0%	0%	0%	0%
Undefined	0	0%	0%	0%	0%	0%	0%
	373	14%	9%	24%	1%	51%	

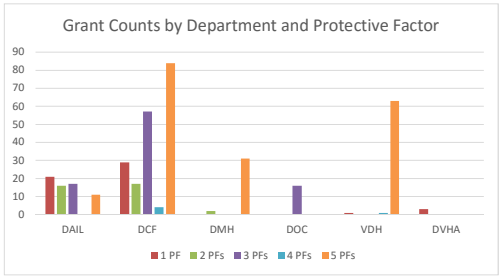
	Grant Counts by Department by Specific PF						
Department	Count	PF 1	PF 2	PF 3	PF 4	PF 5	
DAIL	65	11	61	11	42	34	
DCF	191	88	191	84	145	162	
DMH	33	33	33	31	31	31	
DOC	16	0	16	0	16	16	
VDH	65	64	64	64	65	63	
DVHA	3	0	3	0	0	0	
AHS	0	0	0	0	0	0	
AG	0	0	0	0	0	0	
Undefined	0	0	0	0	0	0	
	373	196	368	190	299	306	1359

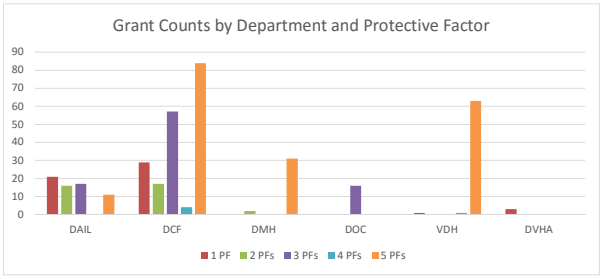


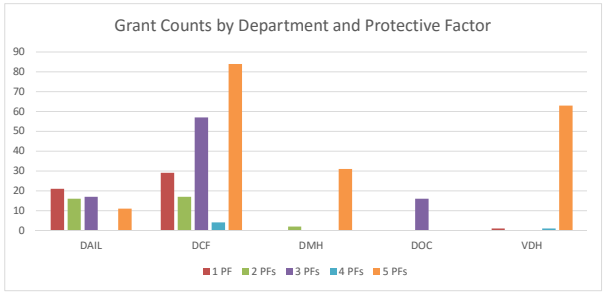
	Grant Counts by Department					
Department	Count	PF 1	PF 2	PF 3	PF 4	PF 5
DAIL	65	17%	94%	17%	65%	52%
DCF	191	46%	100%	44%	76%	85%
DMH	33	100%	100%	94%	94%	94%
DOC	16	0%	100%	0%	100%	100%
VDH	65	98%	98%	98%	100%	97%
DVHA	3	0%	100%	0%	0%	0%
AHS	0	0%	0%	0%	0%	0%
AG	0	0%	0%	0%	0%	0%

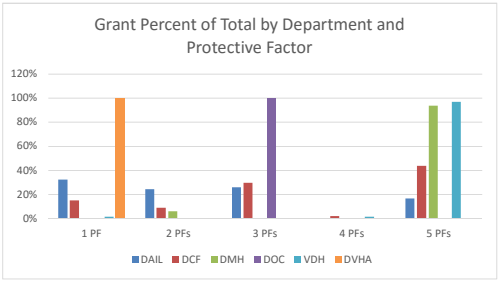


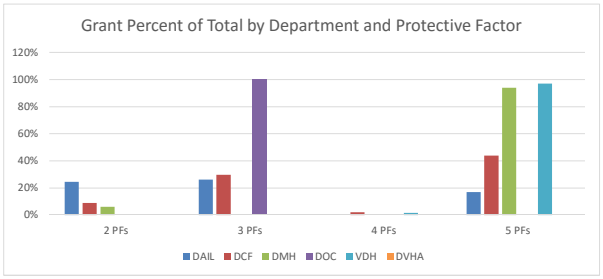
Undefined	0	0%	0%	0%	0%	0%
	373					

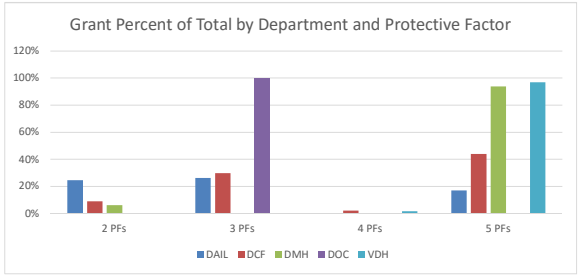


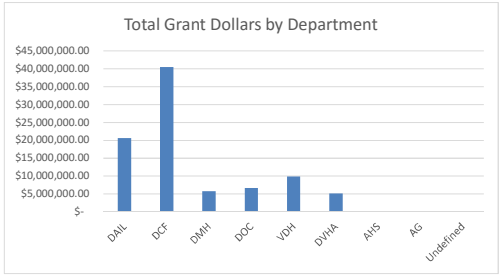




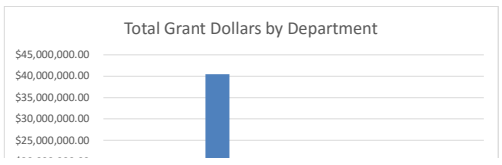


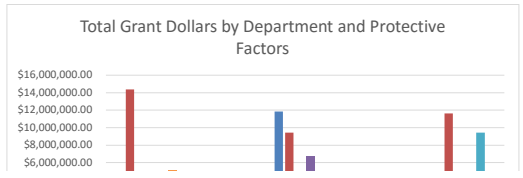


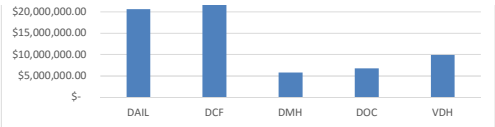


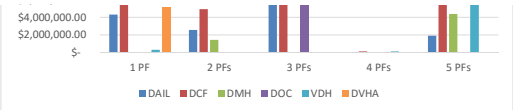


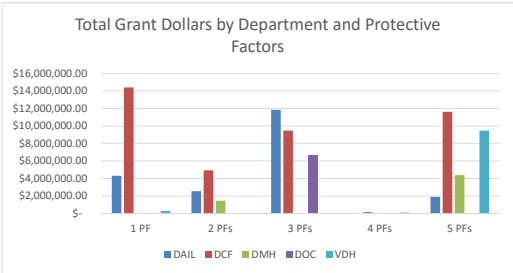
	Grant Dollars by Department by PF						
Department	Total	1 PF	2 PFs	3 PFs	4 PFs	5 PFs	
DAIL	$ 20,623,086.04	$ 4,307,521.00	$ 2,555,016.00	$ 11,846,336.04	$ -	$ 1,914,213.00	
DCF	$ 40,517,141.49	$ 14,388,260.08	$ 4,939,021.00	$ 9,450,201.00	$ 132,903.00	$ 11,606,756.41	
DMH	$ 5,815,976.11	$ -	$ 1,444,995.00	$ -	$ -	$ 4,370,981.11	
DOC	$ 6,737,762.03	$ -	$ -	$ 6,737,762.03	$ -	$ -	
VDH	$ 9,888,526.00	$ 308,000.00	$ -	$ -	$ 130,738.00	$ 9,449,788.00	
DVHA	$ 5,191,693.20	$ 5,191,693.20	$ -	$ -	$ -	$ -	
AHS	$ -	$ -	$ -	$ -	$ -	$ -	
AG	$ -	$ -	$ -	$ -	$ -	$ -	
Undefined	$ -	$ -	$ -	$ -	$ -	$ -	
	$ 88,774,184.87	$ 24,195,474.28	$ 8,939,032.00	$ 28,034,299.07	$ 263,641.00	$ 27,341,738.52	$ 88,774,184.87






$20,000,000.00
$15,000,000.00
$10,000,000.00
$5,000,000.00
$-
DAIL
DCF
DMH
DOC
VDH


$4,000,000.00
$2,000,000.00
$-
1 PF
2 PFs
3 PFs
4 PFs
5 PFs
DAIL
DCF
DMH
DOC
VDH
DVHA


Total Grant Dollars by Department and Protective Factors
$16,000,000.00
$14,000,000.00
$12,000,000.00
$10,000,000.00
$8,000,000.00
$6,000,000.00
$4,000,000.00
$2,000,000.00
$-
1 PF
2 PFs
3 PFs
4 PFs
5 PFs
DAIL
DCF
DMH
DOC
VDH

VERMONT
AGENCY OF HUMAN SERVICES

STATE OF VERMONT Agency of Human Services (AHS)		
Trauma Informed System of Care	REVISION HISTORY:	Chapter/Number
	EFFECTIVE DATE:	Attachments/Related Documents:

Authorizing Signature: _____ Date Signed: _____

Name/Title: _____

THIS POLICY IS IN THE PROCESS OF BEING UPDATED (8/14/17)

POLICY STATEMENT:
The Agency of Human Services is committed to being a trauma-informed and trauma-responsive organization (Act 45. section 3(12), (2003))[i]. The purpose of this policy is to foster a human services system that employs and practices trauma-informed principles in relation to staff and the individuals and families it serves. We recognize that:

- Everyone may have experienced trauma: the people we serve, those we encounter while conducting business and staff;
- It is possible to traumatize or re-traumatize individuals through insensitive systems or interactions that violate a person's sense of safety and control;
- Trauma-informed services are essential for people to successfully access and benefit from AHS services and supports. People tend to avoid places and situations that make them feel unsafe or disrespected, therefore it is important that AHS staff are skilled in using a trauma-informed approach;
- For AHS staff to provide effective services, they also need to be supported by a trauma-informed workplace.

Toward this end, AHS and its departments will adopt and implement policies and practices created with a trauma-informed and prevention focus.

SCOPE: This policy applies to all AHS departments, offices and designees

BACKGROUND:
For nearly two decades, Vermont has recognized the impact of trauma in the lives of Vermonters and has taken steps to develop trauma-informed systems and enhance prevention efforts.
Trauma sensitivity is a governing principle of the Agency of Human Services. AHS continuously works to: realize the widespread impact of trauma and toxic stress and understands potential paths for recovery; recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; respond by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatizing[ii] clients or staff of the agency through use of policies and procedures that may leave people feeling without choice in the situation, their privacy violated, or at risk of emotional or physical abuse.

Systems within each department of the Agency must meet the needs of individuals (including staff) who have experienced trauma by establishing an environment that protects privacy and confidentiality and

minimizes the potential for re-traumatization. AHS shall promote recovery by ensuring staff acquire a working knowledge of trauma, its effects on individuals (including themselves) and families. AHS will provide staff with evidence-informed or best practice training regarding trauma-sensitivity and provision of services in a trauma-informed manner that encourages autonomy and hope. Individual opportunities for building resilience shall be a major focus in supporting recovery for individuals with a history of trauma. Regular self-care[iii] is considered fundamental to providing professional, trauma-informed services, and AHS will provide resources which may include evidence-informed training on appropriate self-care for the workplace.

DEFINITIONS:

Evidence-Informed: The integration of clinical expertise with the best available clinical evidence and the client's values and preferences.

Historical or Intergenerational Trauma: The collective emotional and psychological wounding both over the life span and across generations, resulting from institutional racism, cultural oppression, multigenerational poverty, community violence, war, and a history of genocide, as examples.

Resilience: an individual's ability to adapt or "bounce back" from adverse conditions or challenging life situations. Resilience is not a trait, but a process that involves behaviors, thoughts and actions that can be learned and fostered. A "combination of supportive relationships, adaptive skill-building, and positive experiences is the foundation of resilience."[iv] The interaction between biology and environment creates the conditions for developing resilience.

Re-traumatization: Individuals may be unintentionally traumatized or re-traumatized in agency or provider settings when psychological trauma is not recognized or addressed. Re-traumatization can be either overt, as in the use of seclusion and restraint, or less obvious, as in lack of sensitivity to the potentially triggering impact of words or behavior, or when the physical environment may emphasize control over an individual's comfort and safety.[v]

Toxic stress: results from strong, frequent or prolonged activation of the body's stress response, in the absence of a buffering supportive adult relationship and environment. Multiple stressors frequently resulting in a toxic stress response include child abuse or neglect, caregiver substance abuse or mental illness, and exposure to violence.[vi] For more detail, see the Appendix.

Trauma: "Trauma" refers to either a physical injury, such as a broken bone, or psychological injury. Psychological trauma refers to extreme stress that overwhelms and individual's ability to cope. Trauma involves events or experiences that confront the person directly or as a witness to a real or perceived threat of death, bodily harm, coercive exploitation or harassment, sexual violation, violence motivated by ethno-cultural prejudice, gender, sexual orientation, or politically based.
Psychological trauma has a direct impact on the brain, development and life-long health outcomes through associated physical, neurological, and stress response systems. These experiences directly and indirectly affect mood, memory, judgment, and involvement in relationships and work. The trauma impacts an individual's perception towards self, others and the world. The potential for reactivity to safety concerns must be consciously and thoughtfully planned to create an environment conducive to building resilience, healing and recovery.[vii]

Trauma-informed care or services: A strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma [including AHS staff], and it upholds the importance of consumer participation in the development, delivery, and evaluation of services[viii].

Trauma-informed system: A trauma-informed system adheres to key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific. This is reflected in the following RICH[ix] principles of empowering and collaborative relationships:

Respect
Information
Connection
Hope

Further, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Services and supports must be trauma-informed, build on the best evidence available and focus on consumer and family engagement, empowerment, and collaboration.

Trauma-Responsive/Trauma sensitive: A program, organization, or system that is trauma-informed[x]:

1. *"Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices;
4. Seeks to actively resist *re-traumatization*."

Trauma screening: Screening is used for the early identification of individuals at potentially high risk for a specific condition or disorder; can indicate a need for further evaluation or preliminary intervention; and is generally brief and narrow in scope. Trauma screens can be either functional or event based. Functional screens focus on the impact on an individual's functioning as a result of the traumatic event. Event based tools screen for specific experiences and types of traumatic exposure. Screening may be administered by clinicians, support staff with appropriate training, an electronic device (such as a computer), or self-administered.[xi]

Universal Precautions: "*Universal precautions*" is a term used in medical settings to describe the need to assume all individuals seeking services may have been exposed to negative conditions. In trauma informed care, universal precautions means *assuming that all individuals presenting for services may have experienced trauma* and may have symptoms from this exposure that are not immediately obvious. Some individuals may not be comfortable to disclose or able to recall their trauma. The high prevalence of trauma exposure in the general population and especially those served by AHS dictates that a universal precautions approach be used.

GUIDELINES:

All Departments will take a Universal Precautions approach. Each Department will determine whether their system should also implement an evidence-informed screening protocol. Consultation with the Child & Family Trauma Workgroup and their respective departmental representative is available. The Departments plan will be reviewed for approval by AHS.

AHS and its departments include trauma-informed principles in all grants and contracts.

AHS recognizes the work of the Child and Family Trauma Workgroup as a public/private committee with representation from each department and broad representation of community providers, advocates and people who have been impacted by trauma.

In order to support consumers with trauma histories, professional development shall be based in best practice, and training will be made available:

- For all staff regarding:
  - the potential effects and impact of trauma on self, other individuals, families and communities;
  - core competencies of a trauma-informed approach;
  - use of common terminology
  - personal and professional boundaries and understanding behaviors of individuals with a history of trauma;
  - cultural and gender sensitivity, including racism and economic diversity;
  - the promotion of an Agency that is trauma informed and sensitive through-out; and
  - promotion and support of self-care for employees and for consumers.
- For supervisors to provide trauma-informed supervision to minimize the risk of compassion fatigue or vicarious traumatization among staff

Accountability:

- This policy and measures will be introduced across the Agency via commissioner meetings, staff trainings and other professional development opportunities.
- Each department will designate a lead individual to:
  - participate in the Child and Family Trauma Workgroup
  - assist in creating training plans and materials
- In alignment with the Agency's commitment to accountability:
  AHS shall develop a policy for trauma-informed service delivery and departments shall establish their own protocol to include whether an evidence-informed trauma screening protocol is established. The trauma screening should be appropriate to the service setting. Information from the screening is to inform the effective delivery of services and supports.
  - A training and monitoring plan including performance measures shall be developed to ensure full implementation of this policy.

Appendix

History of Vermont's Trauma-Informed efforts

The widespread prevalence of trauma that individuals and families experience brings the importance of identifying and responding sensitively to trauma survivors who access services from AHS, to the forefront of our priorities as a human service agency. As evidence of the importance of this issue, the 1999 Legislative session created a Commission on Psychological Trauma to study the issue and make recommendations to the General Assembly. During the summer and fall of 2000 the Commission conducted hearings and reported to the General Assembly. This Commission drew together representatives of the Departments of Aging and Independent Living, Mental Health, Health, Children and Family Services, Corrections, the White River Veterans Administration National Trauma Center, and survivor and advocacy groups. The report reviewed the literature on psychological trauma, defined a number of concerns involving training and service gaps in the provision of trauma-related services to Vermonters, and made recommendations for broad system change.[xii]

Appreciating the implications for AHS clients, in March 2001 the Secretary created an AHS Trauma workgroup to examine the issues more closely. In April 2002, in recognition of the important work of this group, the Secretary elevated the workgroup to the status of Policy Cluster. In the fall 2002, the Trauma Policy Cluster added consumer and direct service provider representatives to enhance its' knowledge and expertise to create a trauma-informed public human services system through inter-departmental strategies.

In May of 2003, An Act Relating to Restructuring the Agency of Human Services (ACT 45) was passed by the Vermont legislature stating, "Service delivery systems should recognize the prevalence of the many kinds of trauma, including psychological trauma, and agency staff and service providers should be trained to ensure that client interactions are respectful and sensitive to trauma" (Act 45, section 3(12)). The promulgation of the 2008 AHS Policy provided the framework for AHS to meet this legislative mandate to provide trauma informed systems of care.

Additional Definitions

ACE: Adverse Childhood Experiences are 10 types of abuse, neglect and other trauma that an adult experienced in childhood. The Adverse Childhood Experiences (ACE) study shows the link between early childhood experiences and physical, mental, and behavioral health outcomes in adulthood. https://www.cdc.gov/violenceprevention/acestudy/

AFE: Adverse Family Experiences are 9 types of neglect and trauma that a child may experience in his or her home or neighborhood. AFE questions are asked of a parent / guardian about his or her child (except questions about physical or psychological abuse). http://www.childhealthdata.org/docs/drc/aces-data-brief_version-1-0.pdf?Status=Master

Epigenetics: interactions between genes and the environment shape human development. Early experiences can determine whether certain genes are turned "on" or "off," and therefore have strong influences on behavior and health over the lifespan. http://developingchild.harvard.edu/science/deep-

dives/gene-environment-interaction/

NEAR Science: a cluster of fields of study (Neuroscience, Epigenetics, ACEs, and Resilience), which provides a holistic framework for understanding the impact of experiences on child development, across the lifespan and over generations. https://thrivewa.org/work/trauma-and-resilience-3/

Trauma Screening (additional information)

Principles for screening:

- Ongoing relationship is central
- If we ask the question we 'own the answer'
- Knowing the community's resources is essential
- Screening should be appropriate to the setting and role.

Examples of functional screens:

- Primary Care PTSD Screen (PC-PTSD; Prins, Oulmette, Kemerling et al., 2003);
- Child Stress Disorders Checklist-Screening Form (CSDC_SF; Saxe,G. Ph.D. & Bosquet, M., Ph.D. NCTSN & BU School of Medicine);
- TSI Belief Scale (Traumatic Stress Institute, South Windsor, CT.)
- Trauma Symptom Checklist for Children (TSCC) and for Young Children (TSCYC; Briere, J.)

Examples of event based screens:

Screening questions:

a. Have you ever been in a situation when you thought that you might die or be seriously injured (hurt very badly)?
b. Have you ever seen something terrible happen to someone else and you thought that the person might die or be seriously injured?
c. For children: "Since the last time I saw you, has anything really scary or upsetting happened to you or your family?" For children younger than 8 years, screening optimally relies on parent report, so the analogous question should be asked to parents, ie, "Since the last time I saw your child, has anything really scary or upsetting happened to your child or anyone in your family?" (JAMA 2008)

Or more detailed questions and inventories such as:

- An Interview for Children: Traumatic Events Screening Inventory (TESI-C; National Center for PTSD, Dartmouth Child Trauma Research Group, 2008)
- UCLA PTSD Reaction Index
- ACE questionnaire

For more details on screening tools, National Child Traumatic Stress Network (www.NCTSN.org), SAMHSA (www.samhsa.gov) and Veteran's Affairs National Center for PTSD https://www.ptsd.va.gov/PTSD/professional/assessment/screens/index.asp have up-to-date information.

Toxic stress: Emotional or psychological trauma may result in toxic stress. While adults who grew up in adversity may suffer from toxic stress, the roots of toxic levels of stress are most often found in chronic traumatic events experienced in childhood. A toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance use disorder or mental illness, exposure to violence, and/or the accumulated burdens

of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years[xiii]. Without identification and treatment, children who are exposed to toxic stress and trauma are at increased risk for mental and substance use disorders as well as learning deficits, which in turn predict academic failure, compromised occupational achievement, lower socioeconomic status, and health problems. Adults who experience violence and trauma are also at increased risk for a variety of poor health and social outcomes. Without effective support and intervention, the risk increases for inter-generational exposure to toxic stress and trauma, creating a 'vicious circle' of self-reinforcing mechanisms that undermine population health and well-being.[xiv]
http://developingchild.harvard.edu/science/key-concepts/resilience/

Acute Traumatic Events: Single events that provoke intense feelings of helplessness and fear. Car accidents, assaults, fires, community violence, natural disasters and sudden loss of a loved one are some of the most common acute traumatic events[xv].

Chronic Traumatic Events: Persistently repeated threats or violations of safety and integrity, associated with a complex range of emotions, including fear, shame, distrust, hopelessness and numbness. Examples of such events include chronic physical and/or emotional abuse and/or neglect, family violence, growing up with addicted family members, incarcerated family members, or family members with untreated mental illness.[xvi]

Additional Resources:

A Treatment Improvement Protocol: Trauma Informed Care in Behavioral Health Services, SAMHSA

HTTP://STORE.SAMHSA.GOV/SHIN/CONTENT/SMA14-4816/SMA14-4816.PDF

> While the title names Behavioral Health Services, this guide is for "teams working with clients and communities who have experienced trauma" as well as service providers in the criminal justice system. Called a "TIP" for "Treatment Improvement Protocol," the guide provides:
> …evidence-based and best practice information for…service providers and administrators who want to work more effectively with people who have been exposed to acute and chronic traumas and/or are at risk of developing traumatic stress reactions. Using key trauma-informed principles, this TIP addresses trauma-related prevention, intervention, and treatment issues and strategies…. The content is adaptable across … settings that service individuals, families, and communities—placing emphasis on the importance of coordinating as well as integrating services.

Vermont Child & Family Trauma Workgroup

HTTP://MENTALHEALTH.VERMONT.GOV/SITES/DMH/FILES/DOCUMENTS/CAFU/CHILDTRAUMA/CFTWG_SUMMARY_2016.PDF
A collaborative public/private group with representation from across AHS, AOE and community partners.

Vision: Vermont's communities and social services are trauma-informed. Mission: Building trauma-informed systems. Our works includes:

- identifying and prioritizing unmet needs in the system of care for traumatized children and their families, adults and communities;
- providing trauma-specific best practices to the practitioners in the system of care;
- sharing information about what's happening in Vermont and nationally in the field of trauma services; and
- pursuing funding opportunities to facilitate attainment of these goals.

---

[i] An Act Relating to Restructuring the Agency of Human Services (ACT 45)
[ii] National Center for Trauma Informed Care, SAMHSA
[iii] http://socialwork.buffalo.edu/resources/self-care-starter-kit/introduction-to-self-care.html
[iv] Harvard Center on the Developing Child
[v] Adapted from Oregon Health Authority, Addictions and Mental Health Division, Trauma Informed Services Policy
[vi] Adapted from Oregon Health Authority, Addictions and Mental Health Division, Trauma Informed Services Policy
[vii] Adapted from State of Connecticut, Department of Mental Health & Addiction Services, Trauma Services Policy
[viii] National Center for Trauma Informed Care, SAMHSA
[ix] Risking Connection, Karen Saakvitne
[x] National Center for Trauma Informed Care, SAMHSA
[xi] The American Psychological Association and American Psychological Association Practice Organization Work Group on Screening and Psychological Assessment, 2004
[xii] Harris, M., & Fallot, R. EDS. (2001) Using Trauma Theory to Design Service Systems, Jossey-Bass, San Francisco.
[xiii] Harvard Center on the Developing Child
[xiv] Mental Health America
[xv] Trauma Informed Oregon
[xvi] Trauma Informed Oregon

Attachment C – Strengthening Families Framework

2017 STRENGTHENING FAMILIES™ VERMONT: STATE PROFILE

Infrastructure

The Vermont Agency of Human Services (AHS) leads Vermont's efforts to sustain and integrate the Strengthening Families™ Approach in systems serving children and families across Vermont. In 2016, AHS' Integrating Family Services (IFS) and the Department for Children and Families Child Development Division (DCF CDD) convened Vermont's Strengthening Families™ Leadership Team, a diverse group of leaders from state government, community-based non-profits, and other sectors. Team members gather to deepen and sustain Strengthening Families™ research-informed practices at state, regional and local levels. In 2017, VT's Strengthening Families Leadership Team identified where the Protective Factors Framework is implemented and what additional opportunities exist, then created a strategic action plan to advance collaboration and training across agencies and systems.

Parent Partnerships

Since 2013 Vermont has deployed Race to the Top - Early Learning Challenge (RTT-ELC) grant funds to expand our Strengthening Families™ Child Care initiative to family child care homes, and fund an evaluation of Vermont's Strengthening Families™ Child Care models. This project focuses on embedding the Strengthening Families Framework into the EC service delivery system and aligns with Vermont's Early Childhood Action Plan Result # 2: *Families and communities play a leading role in children's well-being.* Another RTT-ELC project is *Help Me Grow* VT (*HMG* VT), a system that uses developmental screening to identify physically, socially, or emotionally at-risk children; promotes the 5 Protective Factors; and helps families connect with needed community-based programs and services.

In 2016, thirty-one licensed child care centers, serving over 1400 children, received Strengthening Families Child Care grants from CDD to implement Strengthening Families™ informed practices. These high-quality programs have attained the highest levels in Vermont STARS, Vermont's Tiered Quality Rating and Improvement System. The centers use the Strengthening Families™ self-assessment tool to evaluate whether engagement of parents has been successful, and to improve and deepen partnerships with families and their community.

Vermont's fifteen Parent Child Centers continued decades-long efforts to incorporate Strengthening Families™ informed practices; and, seven Head Start Programs' Policy Councils engaged families and adhered to policies aligned with Strengthening Families™. Community and Parent Cafés in VT's 24 Promise Communities provide venues for parents to lead discussions and voice perspectives.

Strengthening Families

Strengthening Families™ is a research-informed approach to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs, and communities in building five protective factors:

- Parental resilience
- Social connections
- Knowledge of parenting and child development
- Concrete support in times of need
- Social and emotional competence of children

Using the Strengthening Families™ framework, more than 30 states are shifting policy and practice to help programs that work with children and families to focus on protective factors. States apply the Strengthening Families™ approach in early childhood, child welfare, child abuse prevention and other systems that serve children and families.

Nationally, the Center for the Study of Social Policy (CSSP) coordinates Strengthening Families™ and works with more than a dozen national partner organizations to create a new vision in which communities, families, institutions, service systems and organizations:

- Focus on protective and promotive factors
- Recognize and support parents as decision-makers and leaders
- Value the culture and unique assets of each family
- Are mutually responsible for better outcomes for children, youth and families

For more information, visit www.strengtheningfamilies.net.

Implementation Checklist

Protective Factors used in Early Childhood Comprehensive Systems projects and other early childhood systems related planning	✓
Protective Factors used in Community-Based Child Abuse Prevention RFP Process	✓
Protective Factors integrated into state Quality Rating and Improvement System	✓
Child Care Resource & Referral Network in state supporting program implementation	✓
Strengthening Families included in State Home Visiting Plan (Manual)	✓
Strengthening Families is being implemented into child welfare system	✓

State Coordinator

Melissa Riegel-Garrett
Director, Statewide Systems and Community Collaborations
Child Development Division,
Department for Children and Families, AHS

DEEPENING KNOWLEDGE AND UNDERSTANDING

The State held Community Cafés to provide skills-based trainings for fifty parents, and trained thirty early care and education (ECE) professionals, including afterschool professionals. Using federal funding from the Child Care Development Fund, the Department of Labor and Vermont's Race to the Top–Early Learning Challenge grant, the State continues to provide Strengthening Families™ trainings for trainers and ECE professionals.

Shifting Practice, Policies, and Systems

In spring 2017 the Vermont legislature passed H.508, "An act relating to building resilience for individuals experiencing adverse childhood experiences." The legislation requires AHS and the Vermont Agency of Education to report on State efforts to prevent and address trauma. AHS will apply the Strengthening Families™ framework to analyze into which SF Protective Factor each of AHS' programs fit. The report will note which Factors are heavily embedded in services; which Factors merit more attention; and where AHS resources might be shifted to improve systems serving children and families. Prevent Child Abuse Vermont provides a 3-hour training and introduction to Strengthening Families™. Using a Strengthening Families™ informed approach, 3 state child welfare offices are collaborating with 3 Parent Child Centers to support families at high risk for child maltreatment. Safe Babies Courts link effectively with Strengthening Families™ child care programs and other community service providers in two Vermont regions. The Vermont Children's Trust fund requires grantees to incorporate at least one Protective Factor into their grant practices. Finally, the DCF Commissioner's Office and the Washington County Youth Services Bureau used a Youth Thrive™ grant to deliver technical assistance, and is providing intensive training on the Youth Thrive Protective Factors to youth-serving professionals statewide.

Ensuring Accountability

Vermont uses CSSP's surveys and assessments to measure impact. Population-based measures like the Youth Risk Behavior Survey, the Child and Adolescent Needs and Strengths (CANS) tool, and other indicators, performance measures and evaluation plans are under consideration.

Evolving Work

The AHS / IFS mission is to bring state government and local communities together to ensure holistic and accountable planning, support and service delivery that will meet the needs of Vermont's children, youth, and families. IFS convened 5 work groups in 2016 to develop a strategic work plan to achieve outcomes defined in Vermont's Act 186. The State and Local Service Delivery work group, and the Community-Based Prevention and Promotion work group aligned their action strategies with the Strengthening Families™ framework.

Updated August 2017