House Human Services Committee

Testimony on Act 43 Report

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Legislative Request
The Agency of Human Services in consultation with the Agency of Education gathered the following inventory and research in response to the request included in Act 43, Section 3 (d)(2) Joint Report to the Legislature.

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;
(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

Definitions

Before I summarize the report, I'd like to take a moment to look at some definitions of the terms I'll be using. If you have the report on your IPad, you will see the definitions on pg 7 of the report. I won't go over all of them – just four key terms for our purposes today.

First is **ACEs**. The term Adverse Childhood Experiences specifically refers to the study by that name that was published in 1998. The study, which included 17,000 mostly white, college educated patients at the Kaiser Permenente medical practice in San Diego, identified 10 types of adversities that had occurred to the study participants before their 18th birthday. The ACEs identified in the study are: physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, losing a parent to death or divorce, growing up with substance abuse, mental

illness and/or domestic violence in the home, and/or having a family member incarcerated. This is not meant to be an exhaustive list. The study exposed the link between early adversity and later poor health and behavioral outcomes. The ACEs study is about the developmental origins of chronic disease and addiction.

Resilience - Science tells us that some children develop resilience, or the ability to overcome serious hardship, while others do not. The single most common factor for children who develop resilience is at least one stable and committed relationship with a supportive parent, caregiver, or other adult. These relationships provide the personalized responsiveness and protection that buffer children from developmental disruption. They also build key capacities—such as the ability to plan, monitor, and regulate behavior—that enable children to respond adaptively to adversity and thrive[1].

Toxic Stress – stress becomes "toxic" when a child experiences strong, frequent and/or prolonged adversity, such as any of the 10 ACEs, without adequate adult support. This kind of prolonged activation of the stress response 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[2]. Toxic stress, in other words, describes the biological response to adversity.

Trauma – The Substance Abuse and Mental Health Services Administration (SAMHSA) describes individual trauma as resulting from "an event, series of events, or set of circumstances **that is experienced by an individual** as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." It's fair to say that the term "trauma" describes the psychological response to adversity.

I'd like to stress the phrase "that is experienced by an individual," – this is one reason we can never have a list that includes every potentially traumatizing event. What is traumatic to one person may not be to another, and at least part of that difference is attributable to the burden of toxic stress the person was exposed to growing up. Those who have less toxic stress in their background are likely to be more resilient, and to experience fewer events as traumatizing. However we know that we can build resilience later in life.

Report Summary – Pg 1

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

To do this we believe we need to shift the discussion to focus more on a long term, population level and multi-generational approach.

[1] https://developingchild.harvard.edu/science/key-concepts/resilience/
[2] http://developingchild.harvard.edu/science/key-concepts/toxic-stress/

Trauma and its effects are deeply entrenched social conditions that are connected to poverty, inter-partner violence, child abuse, substance use, mental health conditions, social isolation, racial and gender inequality and homelessness.

We know treatment, intervention and programs are needed because they help individuals and families heal and cope. However, for us, it has become increasingly clear that this is the tip of the iceberg. When our work remains at the program level, the underlying social challenges remain submerged and often unaddressed. We believe it is at that lower level where we need to engage.

At AHS we do work at the population level with neighborhoods, communities and across the entire state. Some examples of this population level approach include our work with Results Based Accountability (RBA), Community Profiles, connecting health with housing like we have done in SASH (Supports and Services at Home). Other examples of our population approach come from our Department of Health and their work on increasing immunization rates and reducing tobacco use and the Department of Mental Health with its support for whole-school early childhood mental health promotion.

To apply a public health approach to trauma and resilience we need to shift the discussion upstream. How can we change the context in which kids live? How can we improve socio-economic conditions? How can we create new partnerships to streamline services and maximize resources? How can state agencies work better together? How can communities provide social supports? How can we adopt laws and policies that will improve social conditions and social structures that will reduce trauma and promote resilience? We have waged effective public health campaigns in the past. For example, we sharply cut tobacco use over the past few decades. We believe we can do something similar for trauma.

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

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

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

Key Findings – Pg 2
In our report, we went through every AHS grant and service domain and applied the five strengthening families criteria to understand which programs or service interventions promote resilience. Those factors are: parents are resilient, have social connections outside the family, have knowledge of effective parenting and child development stages, have concrete supports in time of need and the social and emotional competence of children is developed.

The Strengthening Families framework is an evidence-based 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 key protective factors: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need and social and emotional competence of children.

We ranked each of our programs or service domains according to how many of those factors each supported.

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. We have 282 programs, 87 of which support three or more protective factors demonstrating a strong fidelity to reducing the impact of trauma and to promote resiliency on a programmatic level. Fifty-one programs support all five Protective Factors.

B. Where are the limitations, gaps and problem areas?

This ranking also allowed us to identify areas where we can improve, and other areas where we need more investigation. As we noted in the report, this was not a perfect process but rather a good start to think cohesively and strategically about our work.

In a larger sense we need to collectively consider how we come to a common understanding of trauma and resilience. How do we create common language? How do we create a shared vision? How do we engage others in this conversation and in this work? Where along the continuum do we apply our limited resources: Prevention? Treatment?

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

Other gaps include the lack of measurement tools to know if we are making a difference. How do we measure resilience? How do you measure if someone is thriving? How do we assess if someone has well-being or is a functioning member of a community? It is these kinds of questions that should occupy our time.

We think a public health and population-based approach will be most effective. We have already begun some of this work through the Building Flourishing Communities Initiative. We also

believe that policies that promote social supports, social equality, stronger households and families, preschool and childcare will eventually yield better overall results than any program could achieve.

How AHS and AOE Coordinate their work (Pg 16)

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 resiliency through state, community and multi-sector approaches.

The AHS and AOE partnership can be a catalyst in these efforts by exploring ways to build 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. AHS and AOE currently coordinate their work related to childhood trauma through the following policies, planning forums, programs and services.

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 (Pg. 22)

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 (Pg 26)

Building Flourishing Communities

Building Flourishing Communities is changing community efforts by grounding them in the science that explains why Adverse Childhood Experiences (ACEs) can be so devastating to health and well-being. We have 24 volunteers working all across the state on building the common language and understanding needed to change the conversation from “what is wrong” with children and adults who struggle, to “what happened” to them. As we do this work, we are also building a foundation for the Strengthening Families work that is key to prevention and early intervention.

We can prevent ACEs, and where adversity occurs, we can intervene earlier and help build resilience. Strengthening families and communities are the most powerful ways to prevent and intervene with ACEs. This approach works with multi-generations to ensure families are seen in their whole context and everyone in a family is included.