Senate Committee on Health and Welfare

Testimony on Act 43 Report

1/24/2018

9:30 AM

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Legislative Request

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 resiliency 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

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 resiliency. 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.

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

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 at AHS don't think we can simply treat our way of the effects of trauma without addressing the deeply rooted social conditions and structures that contribute to trauma.

As you see in our report, AHS works at the program level with individuals and families. Our structure with its six departments helps us to consider issues from multiple viewpoints.

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

At AHS we work at the population level with neighborhoods, communities and the state. Some examples of this population level approach include our work with RBA, Community profiles, connecting health with housing like we have done in Family Supportive Housing and Supports and Services at Home and the All Payer Model. Other examples of our population approach come from our Department of Health and their work on increasing immunization rates, reducing tobacco use and reducing chronic diseases and the Department of Health which supports mental health clinicians in 200 schools.

To apply this 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 instance, we sharply cut tobacco rates over the past few decades. Can we do the same for trauma?

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

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

The population level and program level accountabilities are often conflated. We might assume or pretend that AHS can take responsibility alone for the well-being of a population. But we know that isn't true. Many partners including all of us in this room share responsibility for the social conditions that create trauma or lead to well-being in our neighborhoods, communities and the State. So, if we know this isn't true, 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.

We applied a ranking to each of our programs or service domains to see which ones had more fidelity.

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. At the program level 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?

There are areas of improvement and more investigation needed into AHS programs including the limitations to this data that we are continuing to work on. 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.

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 policies, planning forums, programs and services listed in the report.

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. ACEs are events in a child's life such as physical or emotional abuse or neglect, sexual abuse, loss of a parent through death or divorce, having an incarcerated or mentally ill family member, or living with substance abuse. The more ACEs experienced in childhood, the higher the likelihood we will experience a range of chronic illnesses including cancer, heart disease, diabetes, addiction, and life challenges such as trouble maintaining employment and secure housing, as an adult.

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.