MEETING MINUTES

Children's ACT 264 Advisory Board/SPSC Joint Meeting

Howard Center, Burlington—7/28/2017

ATTENDING: Ron Bos-Lun, Kathy Holsopple, Alice Maynard, Doug Norford, John Pierce, Cinn Smith, and Matt Wolf.

PHONE: Laurie Mulhern

GUESTS: DCF Deputy Commissioner Karen Shea, VDH Commissioner Dr. Mark Levine

MINUTES SUBMITTED BY: Jessica Bernard

Agenda Items	Discussion Points	Decisions/Actions
Joint ACT264 Advisory Board & State Program Standing Committee Meeting (10:00-12:45)		
• VT Department of Health Commissioner Dr. Mark Levine	• Introductions were made and the group welcomed Commissioner Mark Levine from the VT Department of Health (VDH). • Cinn and Alice gave an overview of Act 264. • **Question for Dr. Levine: How would you assess the current ability of your department at obtaining family voice for program design and quality? Do you have additional methods to get this type of information?** • Dr. Levine responded that through the Substance Abuse and Mental Health Services Administration (SAMHSA), members have been involved with focus groups. It has been a struggle to get family voice in the past, but times have changed. VDH tries to have focus groups, but not sure family is always highlighted, to be honest. A big portion of the work in VDH is the Women, Infants, and Children (WIC) program and they provide ongoing connectivity with families. They are the boots on the ground, in the community and get to really know what is going on. The maternal and child health division gets a lot of input from parents through home visitation and other scopes of work. There hasn't been a strong tradition of family involvement, but VDH is working on it and will try to also pull in data to identify what is going on with the populations VDH serves. Matt mentioned that the group *Up for Learning* looks at the Youth Risk Behavior Survey (YRBS) results and then works with youth to come up with solutions to some of the issues identified in the surveys. • **What are VDH's top three challenges at this time?** • Dr. Levine responded that he is amazed at the breadth of what VDH does. The opioid epidemic is a top priority. One word to sum up VDH is prevention, especially when it comes to addiction. Dr. Levine stated that he believes that soon there are no waiting lists for treatment, which is good, but we also need to focus on preventing a new generation of starting to use substances. The third priority could be anything. VT is now the #1 state for Lyme disease, we also have a high usage of alcohol. We have poor rates of maternal use of tobacco and alcohol use while pregnant. • **What are the desired outcomes and performance measures that VDH currently prioritizes for child, adolescent, and family health? How are we doing with them?** • In general, VDH is a leader in a process that the Governor is trying to push on state government, Results Based Accountability (RBA). VDH has a dashboard to measure and report on issues, there are many	

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	measures on the dashboard, from substance use to vegetable consumption. They do have to focus on a few key issues, because trying to tackle all of them would spread the department too thin. The data is all available on the VDH website. This is an aging state and we're not doing a great job on addressing falls for older Vermonters. Youth smoking is down to 11%, which has leveled off, need to look at why it isn't continuing to drop. John asked about low usage rates of hospice. Dr. Levine replied that culturally, people in VT are OK with going to the hospital for end of life care and haven't traditionally looked for other options. We don't have as many facilities as other states and it is something that might expand, as a new facility just opened in Colchester. • **What are VDH's current priorities or areas of focus with the Department of Mental Health for adolescents and young adults with co-occurring mental health/addiction issues?** • It's pretty rare to not have co-occurring disorders when someone is using substance. Both mental health and addiction must be treated together. Housing is a big underlying issue for co-occurring disorders. People need housing to stabilize. Substance use is now the #1 reason that children are being removed from the home. VT is doing well at treating mothers with addiction issues and do a good job of identifying infants that have been exposed and may need treatment. Pregnant mothers with addiction issues are prioritized for treatment. There are a large number of prevention programs throughout the state and on the media. Parent UP VT is a great resource, it is on the VDH website and helps parents have difficult conversations about substances. It has a strengths-based focus. • **Knowing that health care reform is the great unknown in everyone's future, what is VDH currently focused on doing in this area?** • (Alice took notes here) • **We (the Act 264 Board and Standing Committee) believe that public education for health promotion is essential for both a healthy population and a reduction in the overall cost of health care. We appreciate that VDH has done good work in this area.** **1) What is standing in the way of a sustained, global approach with public and private agencies working together to prevent alcohol and drug addiction in Vermont?** **2) Do you have any ideas on how Vermont might succeed in such an approach?** • Dr. Levine responded: Is there something standing in the way? Medicaid? There is a lot of collaboration across prevention and treatment. There is good collaboration and we need to focus on primary prevention for youth up to 25 to make a big impact. Federal money is being used across regions in the state to identify the priorities for each region, because they are all unique, and work on addressing the issues. Businesses, schools, and municipalities work together to address the goals, it is community effort. Programs that look very surface are about bringing the community together, Julie Arel is a director at VDH who could talk more about these initiatives, and the VDH website has all the information as well. The US only spends 2-3% on prevention, while other countries spend 10-15% and don't have the same issues. A repeal of the Affordable Care Act (ACA) would further strip prevention funding. • **Areas of collaboration with VDH and Act 264/SPSC?** Prevention for children and families. Cinn said she would share this information and VDH resources with families to spread the word. The maternal child	

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	health division focuses on similar populations. VDH and DMH are separate departments and it gets easy to lose focus of the vested interests. This group could remind VDH and the community to remember the overlap. Keep Adverse Childhood Experiences (ACEs) in mind and talk about the importance of identifying these issues for families. Kids with high ACE scores need interventions from a whole person perspective. Matt mentioned the need to identify ACEs, but to also look at developing resilience and strengths. How do we take it a step further and prevent it to begin with? That is the challenge. Sometimes mental health has to spend time and resources on the populations that need the highest amount of support and there isn't always time or resources to spend on prevention. • **The group thanked Commissioner Levine for joining the meeting.**	
• DCF Deputy Commissioner Karen Shea	• Introductions were made and Department for Children and Families (DCF) Deputy Commissioner Shea was welcomed to the group. • The group gave an overview of the board and committee purpose and structure, Deputy Commissioner Shea is familiar with Act 264. • Deputy Commissioner Shea shared with the group that she has been with the department for 17 years and started as a social worker, then moved to a supervisor and so on. Being at the system level now, has been an interesting shift. As a mother of 3 and a family member of someone who adopted a child through foster care, she hopes to bring a perspective of understanding to her work and the department. • **How does the DCF/FS currently obtain family voice for program and agency plans?** • It is a challenge, especially around programing. There have been standing committees at times to help weigh in on policy and planning. A lot of feedback comes in through a quality case review process. In 2015, the federal government found that VT was not in full compliance, so we created an improvement plan and review cases every 6 months to increase quality. Documentation and process is reviewed and families and participants are interviewed to get their feedback and input. The interviews are a big part of the overall outcome. It is a labor-intensive process, but worth the time and effort. It isn't a RBA process, but it does look at if people and families are better off and is part of a continuous quality improvement plan. • **What are DCF/FS's priorities or areas of focus within its work with the Agency of EDU and the Department of Mental Health's Child, Adolescent, and Family Unit, the collaboration mandated by Act 264? In particular, how does DCF/FS encourage district office staff to participate in the Coordinated Service Plan process for children entitled to such plans under Act 264?** • In the work with AOE, they've focused on implementing the Every Student Succeeds Act (ESSA). It focused on educational stability, specifically for kids in foster care who may be at risk for moving in and out of multiple schools depending on custody status. Families have been frustrated in the past when kids went into custody and were placed in homes in different school districts and were often moved to a new school because it was easier or thought to be the best choice. However, there is always a look at what is in the best interest of the child and there isn't just one answer. With DMH, they've been looking at use of kids in residential treatment and examine the use and length of placements. Also, looking at prevention of kids going into residential and focusing on the kids in the midrange of need to make sure we can wrap them in supports and keep them in the community. Some of the DAs are not able to put a services package	

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	together immediately to support the kids with an immediate need, so there is room for improvement there. Also, investing in trainings in EBPs. Laurie asked if DCF runs into challenges with trainings and getting families to the table? Yes, there are a lot of barriers, it's a huge investment in time, but it's worth the push. The foster parent training could use a new approach to make is less classroom based learning, perhaps have a mentor or coach. Matt added that getting groups together to share information and support each other is very useful. Doug spoke to the DA challenge to quickly pull together a service package. He encouraged more use of LIT meetings to bring issues to the attention of the DA to try to address issues before they become larger. DCF does try to be as involved as possible and encourages the use of CSPs and usage of resources that exist. It is important to say that DCF is a stretched system and must focus on safety, which means they can't always address things in as focused a way as they would like. Trying to be more forward thinking while they also deal with the daily crises. Cinn shred her family perspective. • **What is your personal vision for DCF/FS's work with children and their families, including children and adolescents with a DD and/or MH diagnosis?** • Personal vision is for there to be enough space for the workers to do the work they need to do and support the families they work with. The unintended consequences of an unsupported system are not ideal. We need more training and for staff and foster parents. Supporting staff and foster parents will create the ability to do the resiliency work instead of just the basics of safety. Focus on SSNRs (safe stable nurturing relationships). DCF can't create public policies, like livable wages to support families, but they have to deal with all of the symptoms of bad policy and lack or supports and resources in the community. Child welfare in VT is very personal because we are a small state and it makes it feel like we can actually make changes and move in new directions. • **How is DCF/FS working to ensure understanding Integrated Family Services, and how are they promoting the success of IFS?** • IFS and DCF are engaged in discussions and conversations are happening regularly. Funding is in a state of flux because the future of health care reform is up in the air, so we'll work on sorting things out when it gets down to the department levels. The collaborative approach to problem solving is great, but we'll see where things go. • **How does DCF/FS currently prioritize funding services for students with mental health and/or substance abuse issues?** • The division tends to utilize the services rather than be a funder. There are times when DCF funds things when there is a need and a lack of resources. DCF looks to the community to identify services that are available or work with a DA to create something unique if needed. DCF typically goes through the preferred provider network. DCF doesn't have funding to create programs, but they may draw federal funds for specific needs that are lacking in the community. Making time and space for quality referrals and assessments will lead to better outcomes for children and families. • DCF is doing more training around trauma and how to respond to kids to be more effective and promote healthy relationships.	

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	• How can we collaborate? Ken, Melissa, and Monica are meeting regularly and talk about the reinvigoration of act 264. Keep talking to leaders and express recommendations and opinions. Understand the needs of kids coming into custody and how they have changed given the younger the kids are in custody.	
• Cheryle Bilodeau, IFS Update	• Cheryle sent her regrets that she was unexpectedly unable to attend.	Cheryle will send IFS update via email
• Minutes	• Review and approve June meeting minutes. The minutes were reviewed and Doug suggested we share the minutes with guests so they can amend them if necessary. No edits proposed, minutes approved.	
• Public comment period for Act 82	• There was a public comment period for feedback about wait times in ERs. There will be another public comment period on 8/17. Data was presented and discussed. There was time for questions and there is a good mix of advocates, leaders, different agencies, VT care partners, VFFCMH, UVM Medical Center, etc.… • The information will be posted on the DMH website, the data is very informative. It was a very good day, DMH seemed very open to comment and suggestions. There are mixed messages happening between systems and there needs to be more clear communication.	
• Update from Matt	• Matt shared that he would still like to give an update abut work around Building Flourishing Communities. He has been selected as a trainer and would like to update the group after that training period. October might be a good time.	
• Public Comment	• None.	
	Break (12:45-1:00)	
	State Program Standing Committee (SPSC) Meeting (1:00-2:45)	
• HCRS Agency Review	• The HCRS Agency Review was shared and discussed. A list of questions was generated for HCRS and Jessica will follow up with the agency and report back to the group.	
• NAMI and • Cannabis in Bellows falls	• NAMI-Ron reached out to NAMI in an effort to have them come to the school he teaches at. Helping youth talk about mental wellness and destigmatizing mental health before there is a need might help down the road if they experience a concern or crisis. Ron shared his family experience. There is a group called Parents and Teachers as Allies through the national NAMI organization that Ron might want to look into. • Cannabis-There is a group that reached out to Ron about pending cannabis legalization. Ron is concerned about the long-term consequences for kids, families, and communities. This group is discussing the issues and trying to open a dialogue about what current research is saying. The VT Public Health Association might be a good partner on this topic.	
• MHBG Update	• The application needs to be submitted 9/1/17 and we anticipate that being a very realistic deadline. There are proposed cuts to the MHBG, but we won't know what the official budget will be until the federal gov passes their budget. If the MHBG is cut, DMH and the planning council have agreed that a 23% cut across all grantees will be the most equitable way to deal with the difference.	
• Membership Update	• Someone from VFFCMH has been identified to take Kathy's place and HC is working on identifying someone to fill her position. This means that there is one parent position open for Act 264. Kim Tardie will not be able to serve on SPSC and we have two parent openings we need to recruit for.	

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• Future Agenda Items	• None identified.	•