Minority Fellowship Program 2021 Webinar Series

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Minority Fellowship Program Webinar

• March 24, 2021 •

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Understanding and Addressing ACEs During and Beyond the COVID-19 Pandemic

April Joy Damian, PhD, MSc, CHPM, PMP
Associate Director, Weitzman Institute

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Today's Presenter

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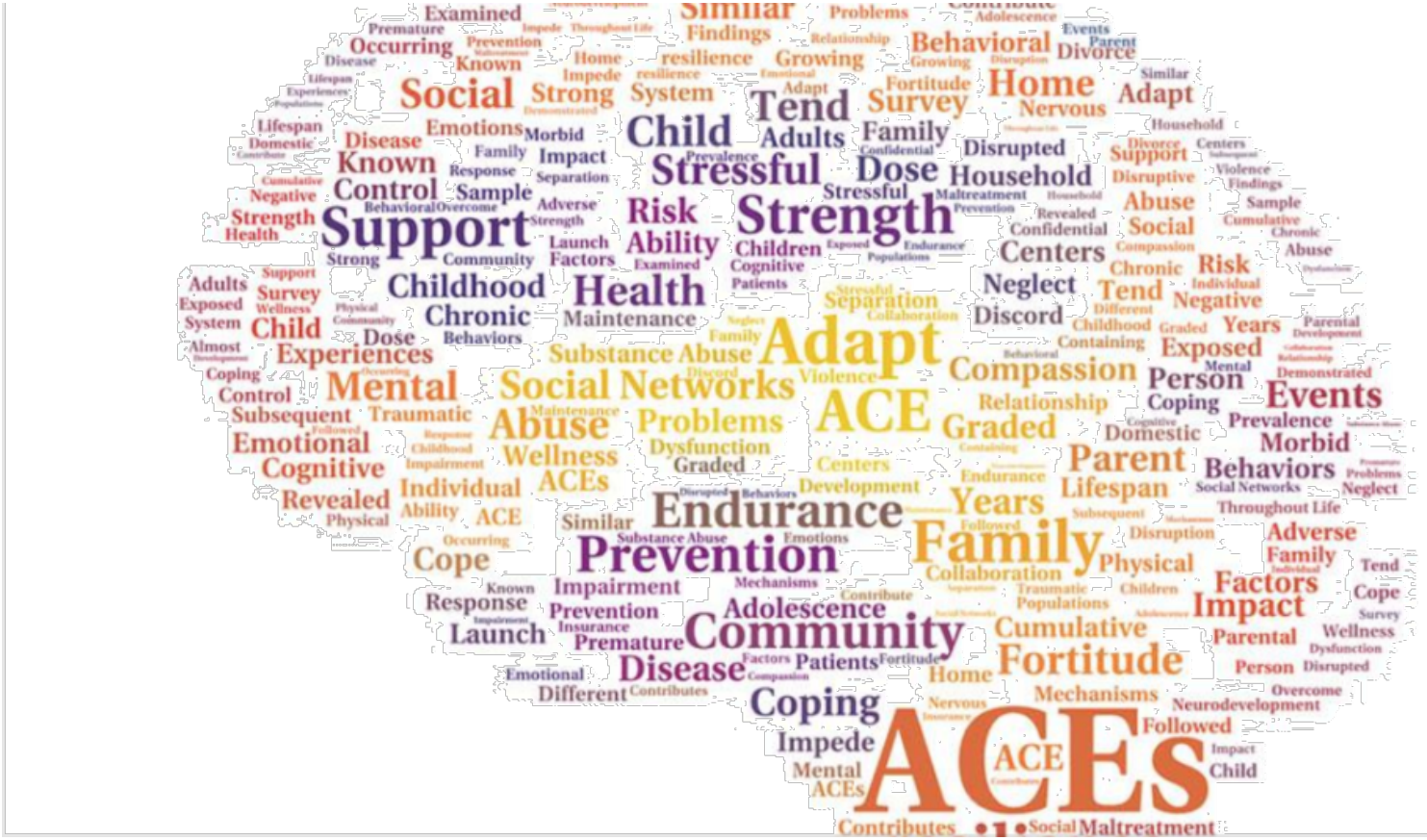
Objectives

1. To understand the epidemiology of adverse childhood experiences (ACEs) and its short- and long-term impact on health outcomes over the life course
2. To examine ACEs in the context of COVID-19
3. To explore recommendations and opportunities for addressing ACEs through research, policy, and practice

Objective 1

To understand the epidemiology of adverse childhood experiences (ACEs) and its short- and long-term impact on health outcomes over the life course



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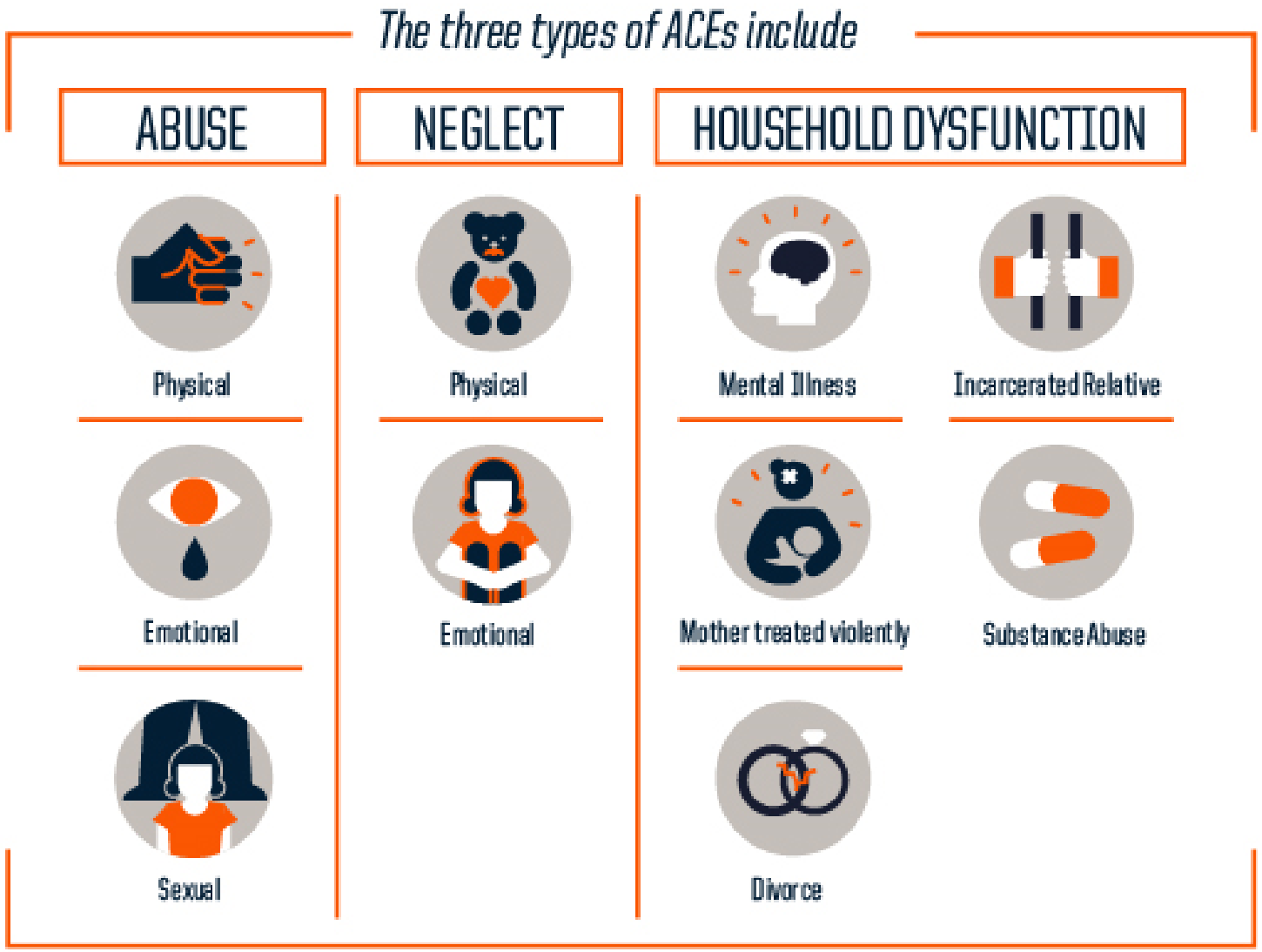
ACEs Primer (courtesy of KPJR Films LLC)

To view the video, go here:

https://vimeo.com/139998006

Three Types of ACEs



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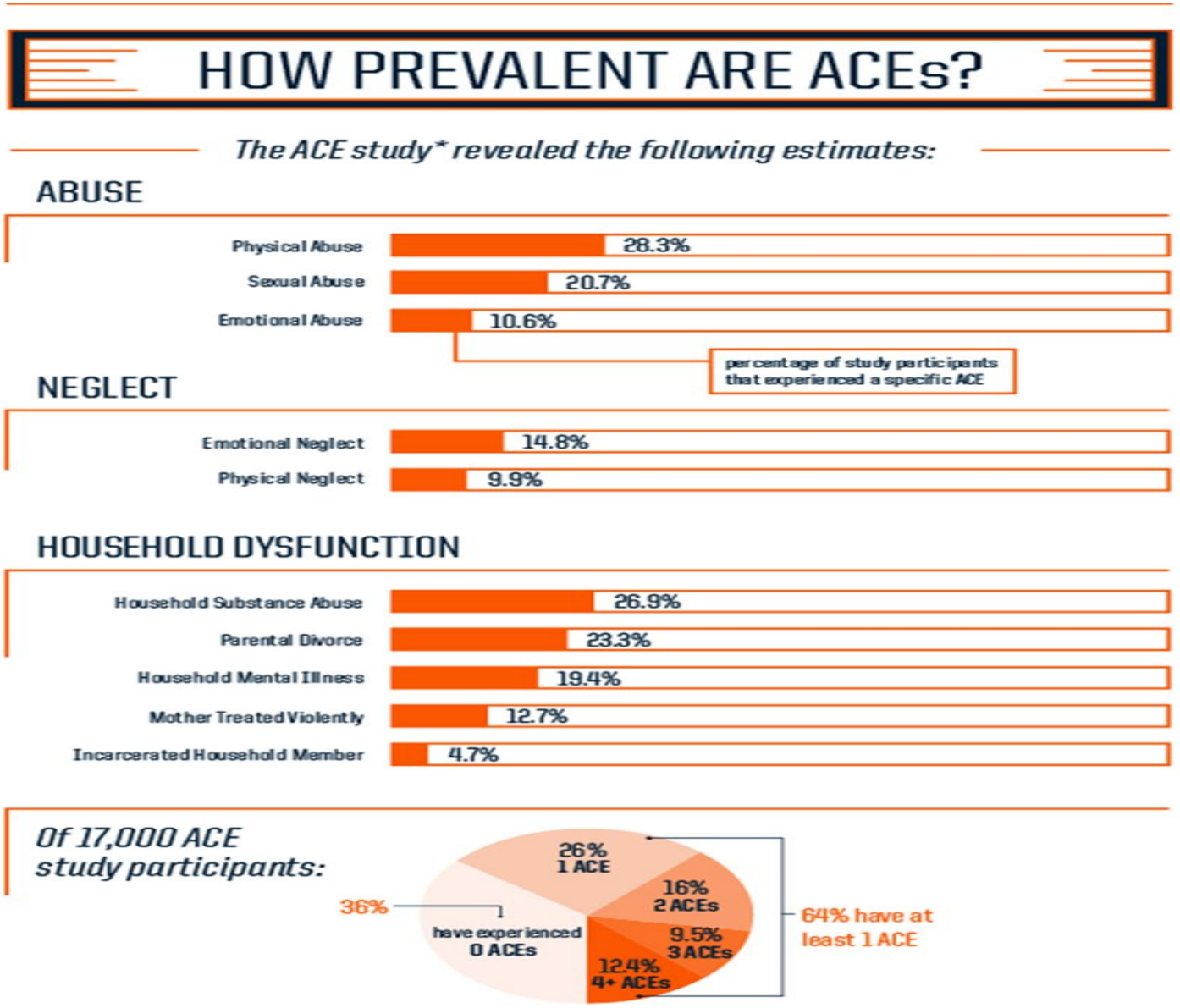
Prevalence of ACEs



Source: RWJF

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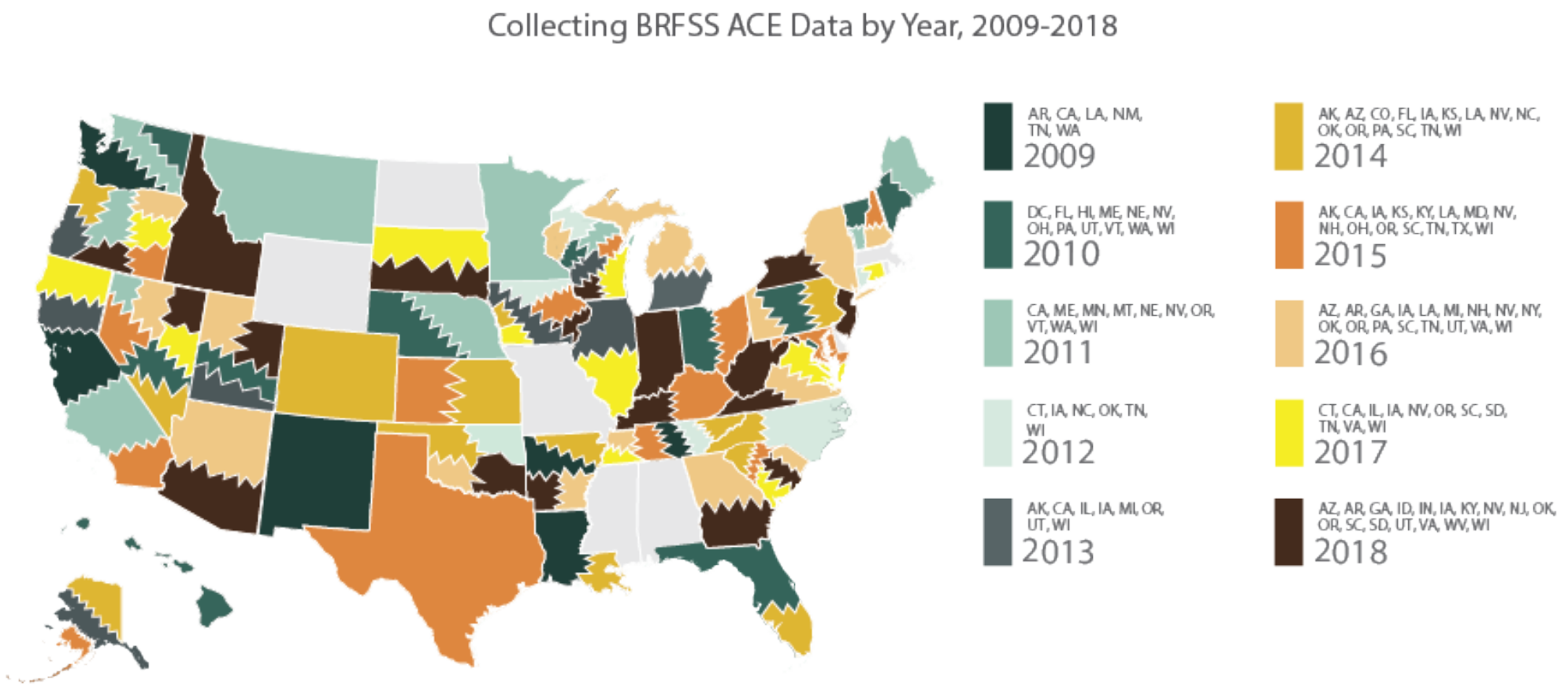
Key findings of the ACE Study and subsequent body of research

- **ACEs are highly prevalent.** Two thirds of respondents in the ACE Study reported at least one ACE and one in eight reported four or more ACEs. Subsequent studies have shown a rate of four or more ACEs that is closer to one in six. (Merrick et al., 2018; Merrick et al., 2019)
- **ACEs are strongly associated, in a dose-response fashion, with some of the most common and serious health conditions** facing our society today, including at least nine of the 10 leading causes of death in the U.S. (CDC, 2017)
- **ACEs affect all communities.** The original ACE Study was conducted among a population that was mostly Caucasian, middle class, employed, college educated, and privately insured. Subsequent studies have found higher prevalence rates of ACEs in people who are low-income, of color, justice-involved, and/or part of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community. (Liu et al., 2019; Maguire-Jack et al., 2019; Vasquez et al., 2019)

ACEs Map, BRFSS



Source: Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System Survey ACE Data, 2009-2018.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2019.

Frequencies and disparities of adverse childhood experiences in the U.S.

ACEs data were collected via BRFSS (Behavioral Risk Factor Surveillance System). Data from a total of 211,376 adults across 34 states were analyzed.

ACE Domain	Prevalence (%)
Emotional abuse	33.5
Parental separation/divorce	28.2
Household substance abuse	26.8
IPV	17.8
Physical abuse	17.5
Household mental illness	16.2
Sexual abuse	11.3
Incarcerated household member	8.1

ACE Score	Prevalence (%)
0	42
1	22.9
2	12.8
3	8.2
4	5.7
5	3.8
6	2.3
7	1.2
8	0.3

Source: (Giano et al, 2020)

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Frequencies and disparities of adverse childhood experiences in the U.S. (con't)

- **Gender**: Females had a significantly higher ACE score compared to males (1.64 to 1.46)
- **Race/ethnicity**: Individuals who identified as Multiracial had a significantly higher ACE mean score than all other races/ethnicities
- **Age**: The 25 to 34 age group had a significantly higher ACE mean score than any other group (1.98)
- **Sexual orientation**: Gay and lesbian individuals had significantly higher mean ACE scores than straight or "other" individuals
- **Household income**: Those making less than $15,000 per year had a significantly higher mean ACE score compared to all other categories
- **Educational attainment**: Those who earned less than a high school degree had a significantly higher prevalence of adversity in physical, IPV, and household substance abuse compared to all other categories
- **Employment status**: Those in the unable to work category had a significantly higher mean ACE score than all other employment categories
- **Census**: Those residing in the West had a significantly higher mean ACE score compared to the other three regions

Four categories showed particular vulnerabilities to ACEs:
females, younger adults, sexual minorities, and multiracial individuals

Source: (Giano et al, 2020)

Overview of Stress in Childhood

Stress in Childhood

Stress is a natural & inevitable part of childhood, but the TYPE of stress can make a difference in the impact on a child's brain & body.

> "STRESS is a mental, physical or biochemical response to a perceived threat or demand"

Positive Stress

Mild stess in the context of good attachment

Temporary, mild elevation in stress hormones & brief increase in heart rate

No buffering  support necessary

Increased **RESILIENCE** and confidence
Development of coping skills

70 30

www.70-30.org.uk
@7030Campaign

Tolerable Stress

Serious, temporary stress, buffeted by supportive relationships

More severe, continuing cardiovascular and hormonal response

Presence of  buffering caring adult

Adaption and recovery with some possibility for physical/emotional damage

Toxic Stress

Prolonged activation of stress response system without protection

Prolonged activation of stress response system & disrupted development of brain and immune system

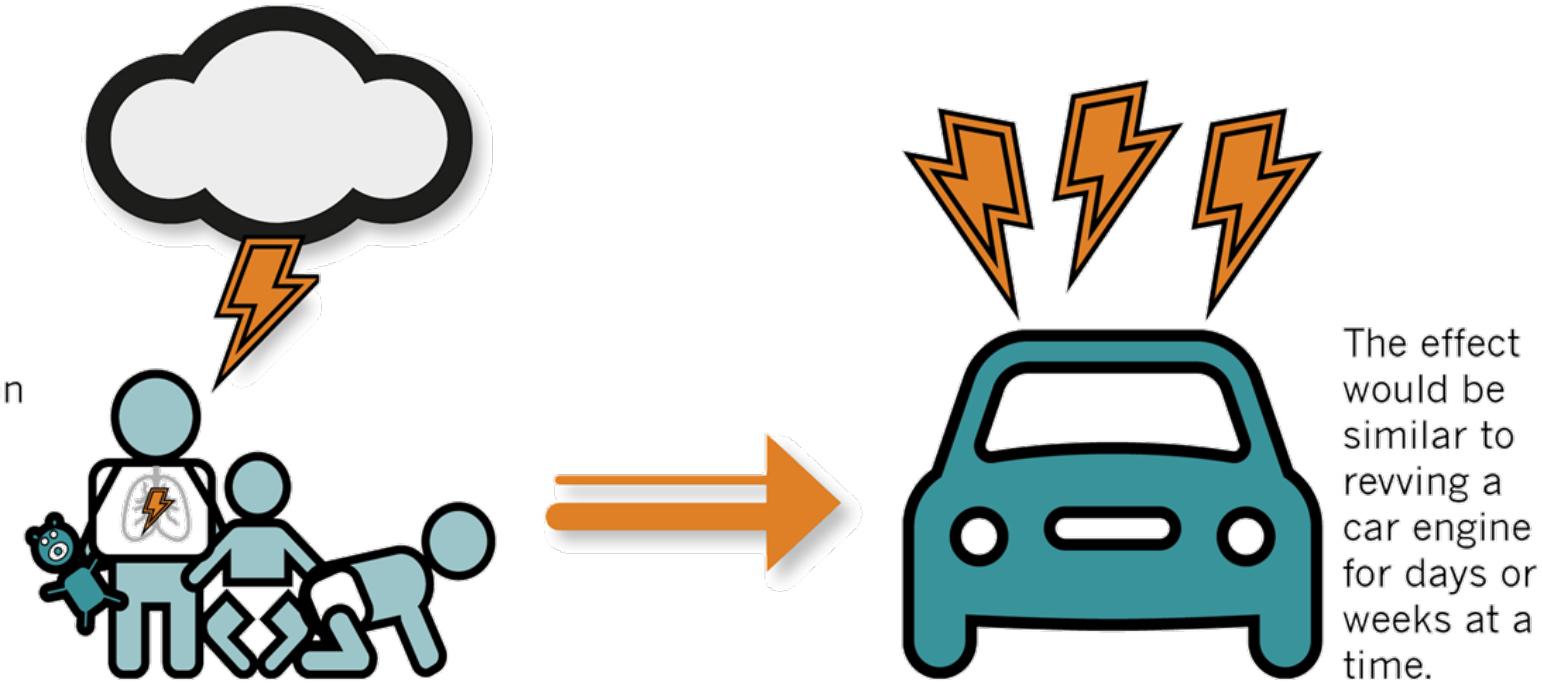
No adult  **buffers**

Lifelong consequences:
- Heart disease
- Alcoholism
- Memory & learning difficulties
- Anxiety/depression
- Cancer

Understanding Toxic Stress

TOXIC STRESS EXPLAINS HOW ACES "GET UNDER THE SKIN."

Experiencing many ACEs, as well as things like racism and community violence, without supportive adults, can cause what's known as toxic stress. This excessive activation of the stress-response system can lead to long-lasting wear-and-tear on the body and brain.



The effect would be similar to revving a car engine for days or weeks at a time.

Source: Centers on the Developing Child, Harvard University

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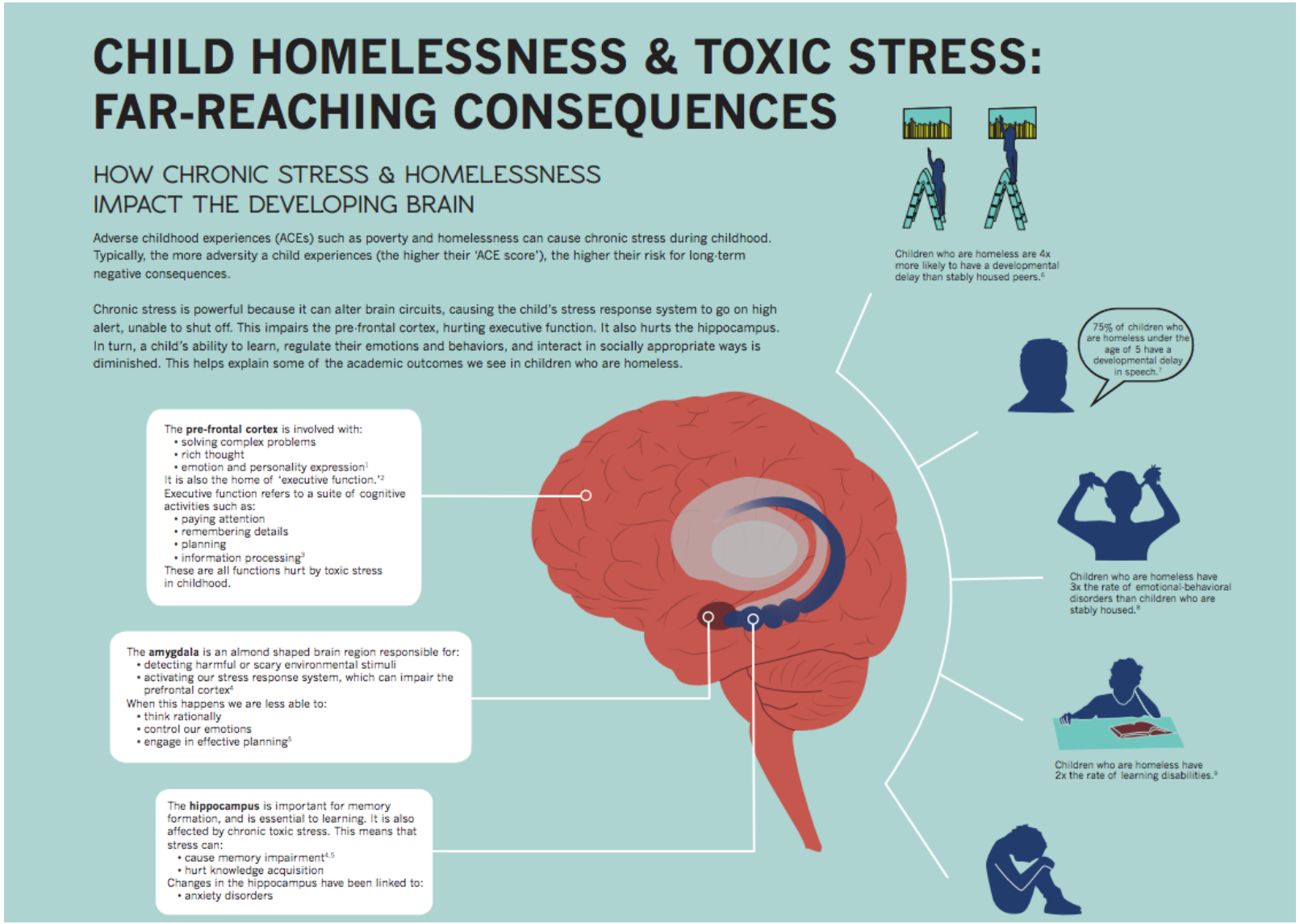
Long-term Consequences of Toxic Stress



Source: Project on Family Homelessness, Seattle University

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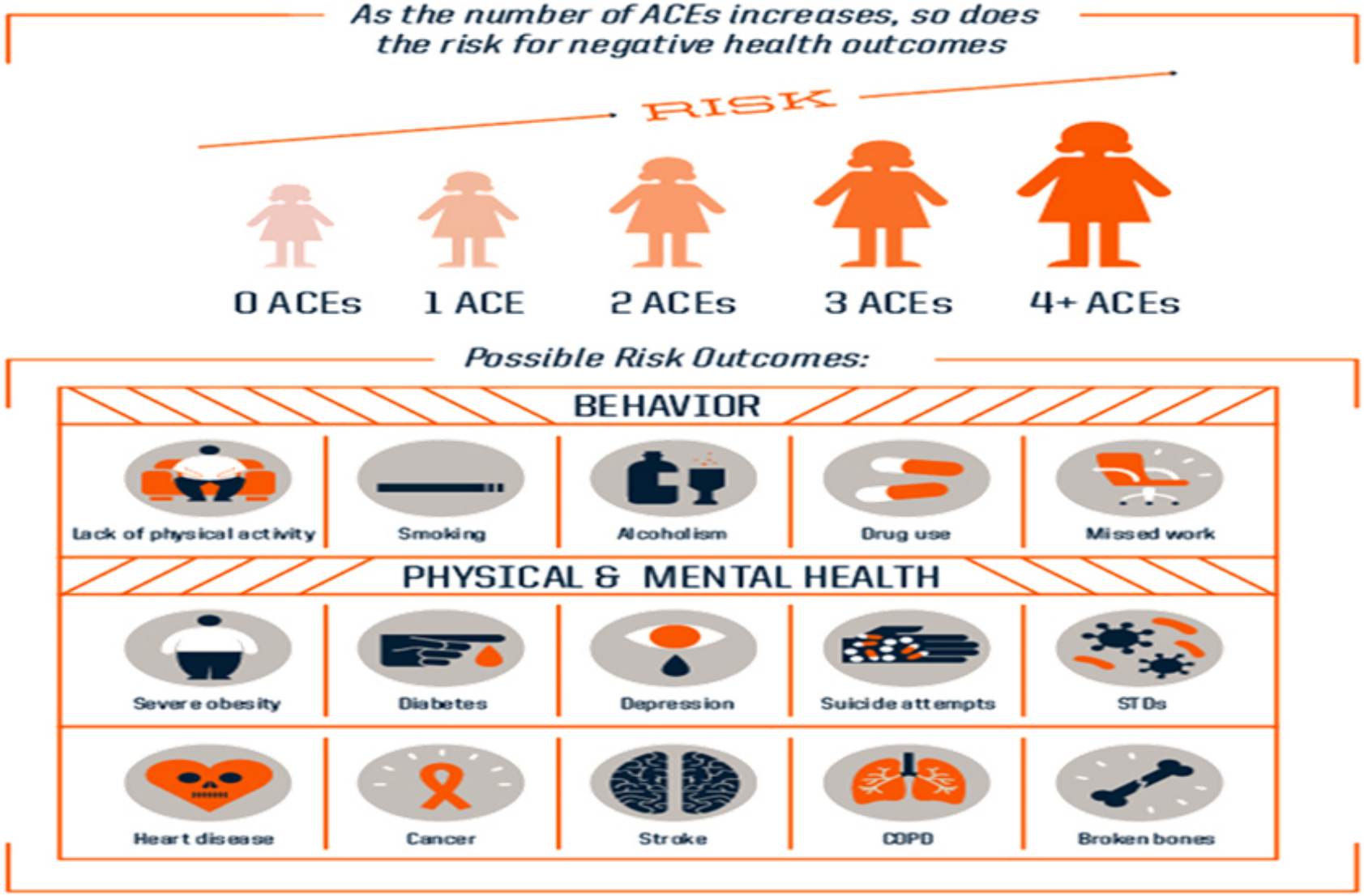
ACEs and Negative Health Outcomes



Source: RWJF

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ACEs and Negative Consequences cont'd

- Failure to thrive
- Growth delay
- Sleep disruption
- Developmental delay

- Increased risk of viral infections
- Pneumonia
- Asthma and other atopic diseases
- Difficulties with learning and behavior

- Somatic complaints – including headache and abdominal pain
- Increased engagement in high-risk behaviors
- Teen pregnancy/teen paternity
- Sexually transmitted infections (STIs)
- Mental health disorders and substance use

Source: Hughes et al., 2017

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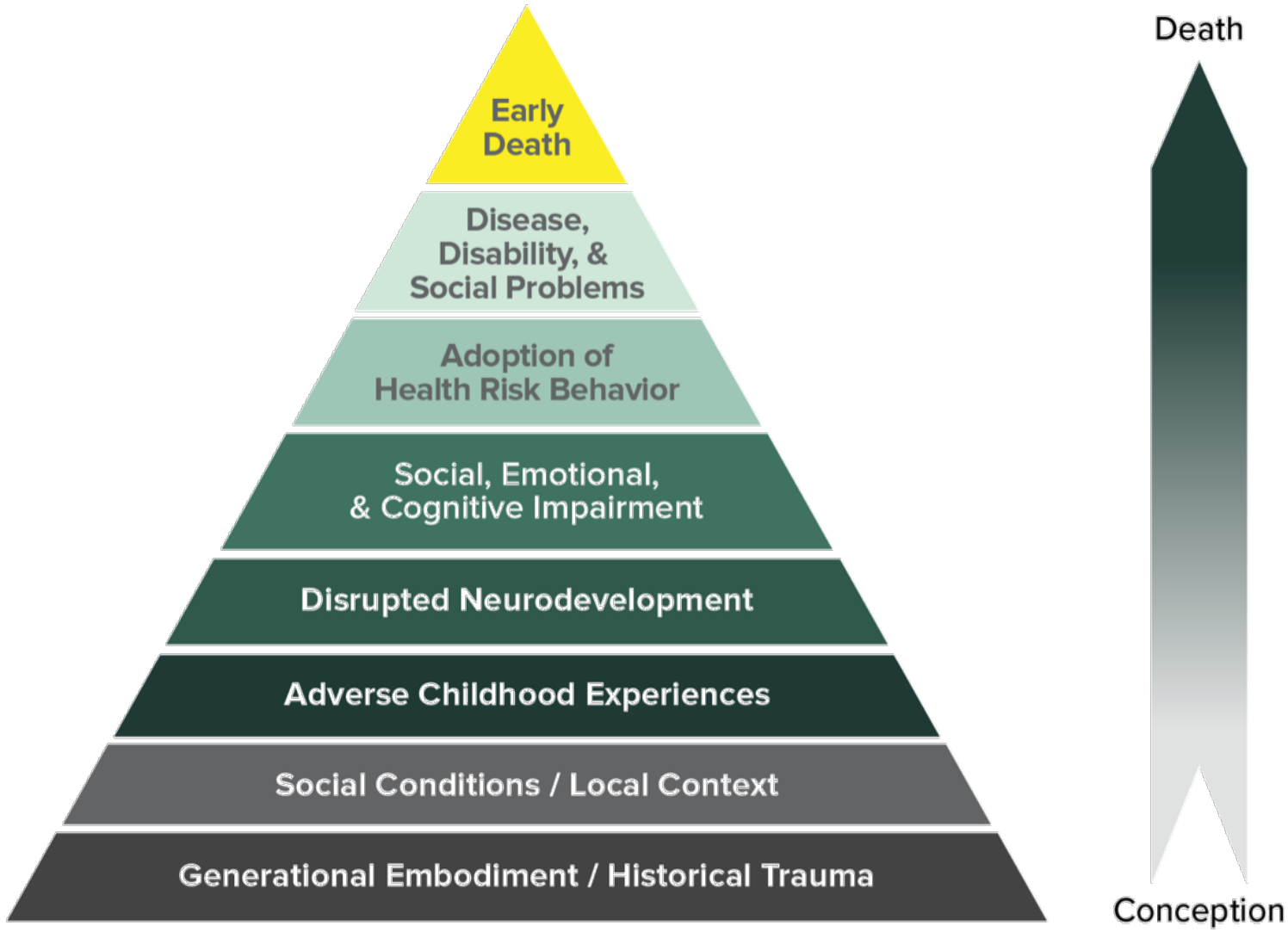
Adult Health (Hughes et al., 2017)

ACEs are associated with some of the most common and serious health conditions facing our communities. People with 4 or more ACEs are:

- 37.5 x as likely to attempt suicide
- 3.2 x as likely to have chronic lower respiratory disease
- 2 to 2.3 x as likely to have a stroke, cancer, or heart disease
- 1.4 as likely to have diabetes

The higher the ACE score, the greater the risk for ACE-associated health conditions.

Impact of ACEs across the Life Course



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Source: Centers for Disease Control and Prevention

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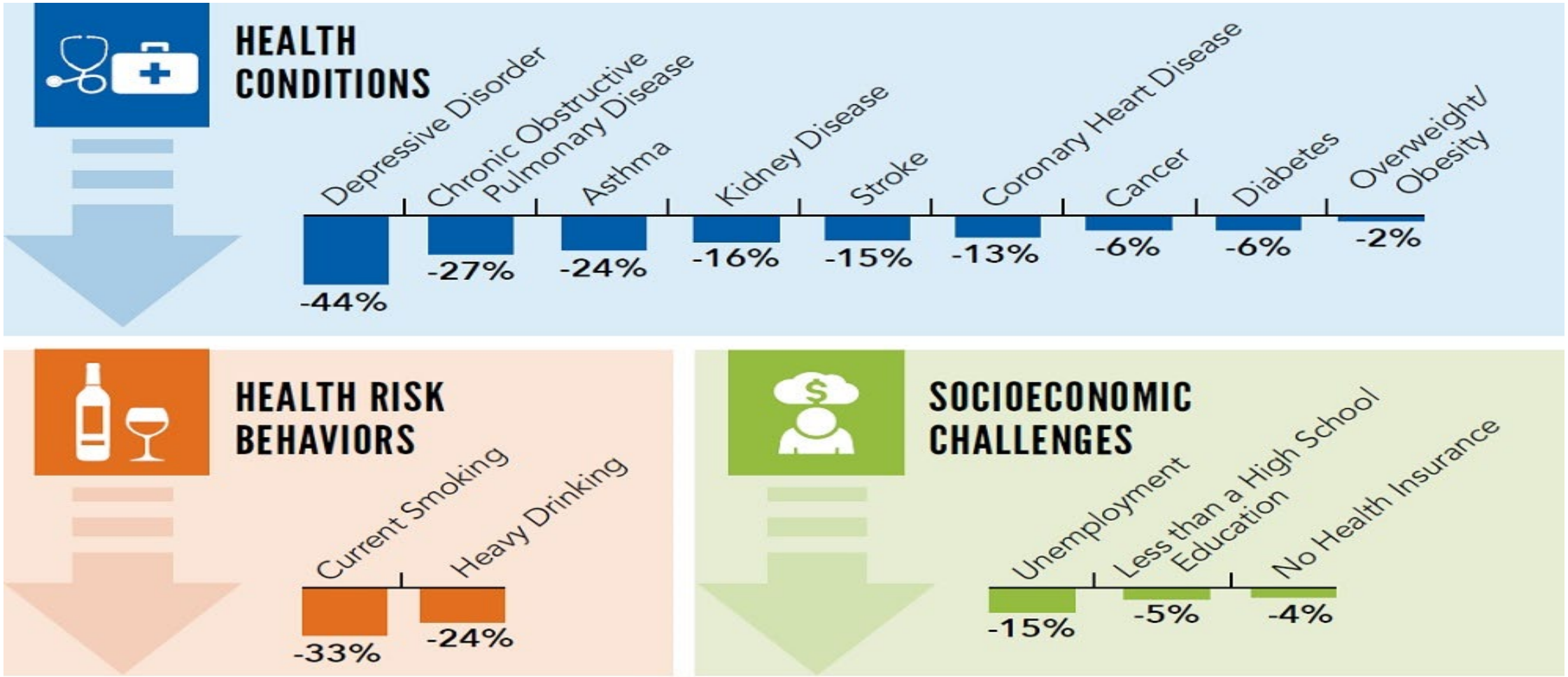
Potential reduction of negative outcomes in adulthood



Source: BRFSS 2015-2017, 25 states, CDC Vital Signs, November 2019.

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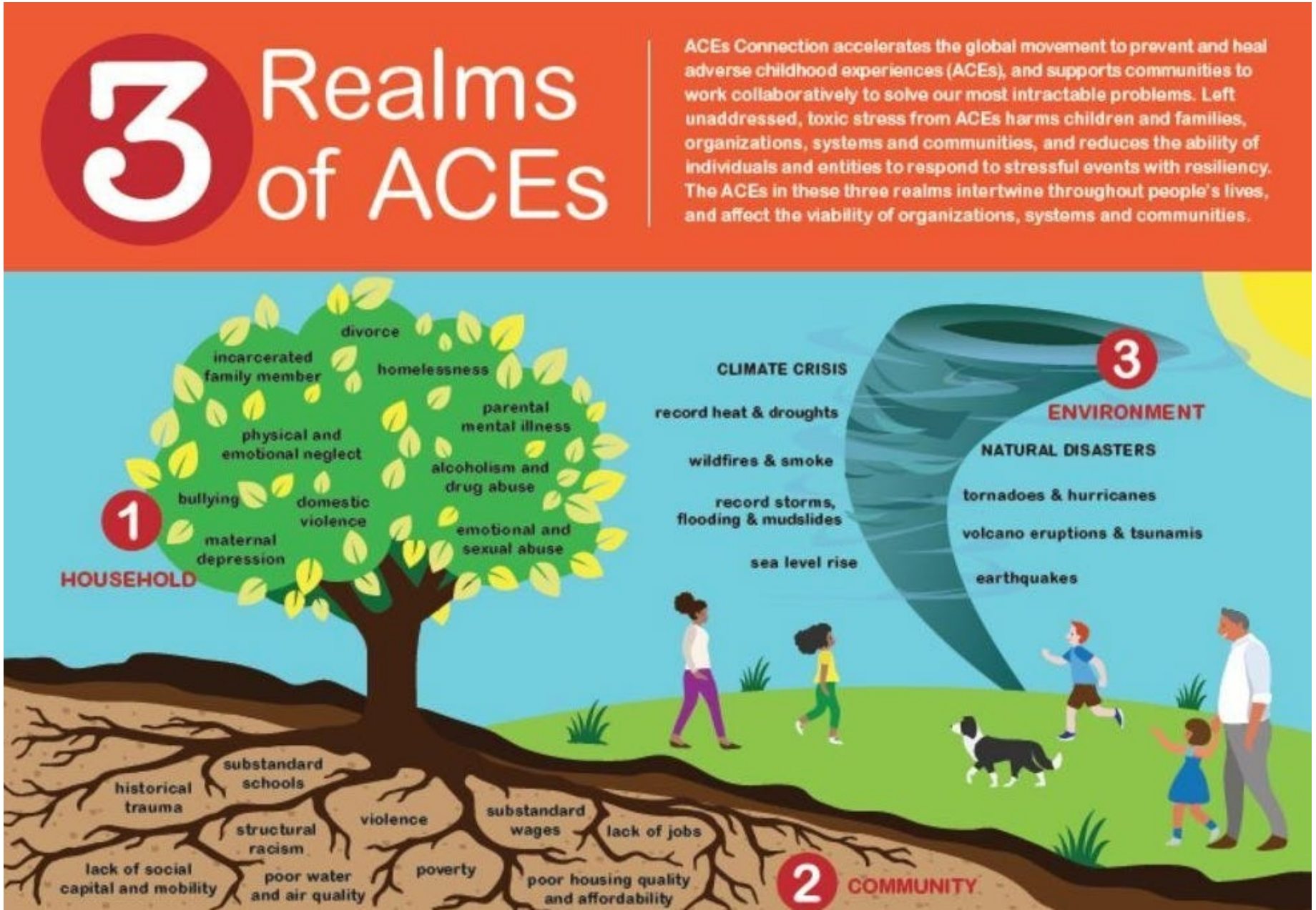
Objective 2

To examine ACEs in the context of COVID-19

- Socio-cultural norms: Stigma and racism against certain ethnic groups from misinformation
- Society: Decrease access to basic services, e.g., access to mandatory reporters as schools close
- Community: Break down of trust and stress from scarcity of resources and support services; e.g., impacts from social isolation
- Family: Heightened risk of domestic violence from caregiver distress from employment concerns, health/illness, isolation, etc.
- Child: Risk of toxic stress and impacted development

Three Realms of ACEs



Source: ACEs Connection

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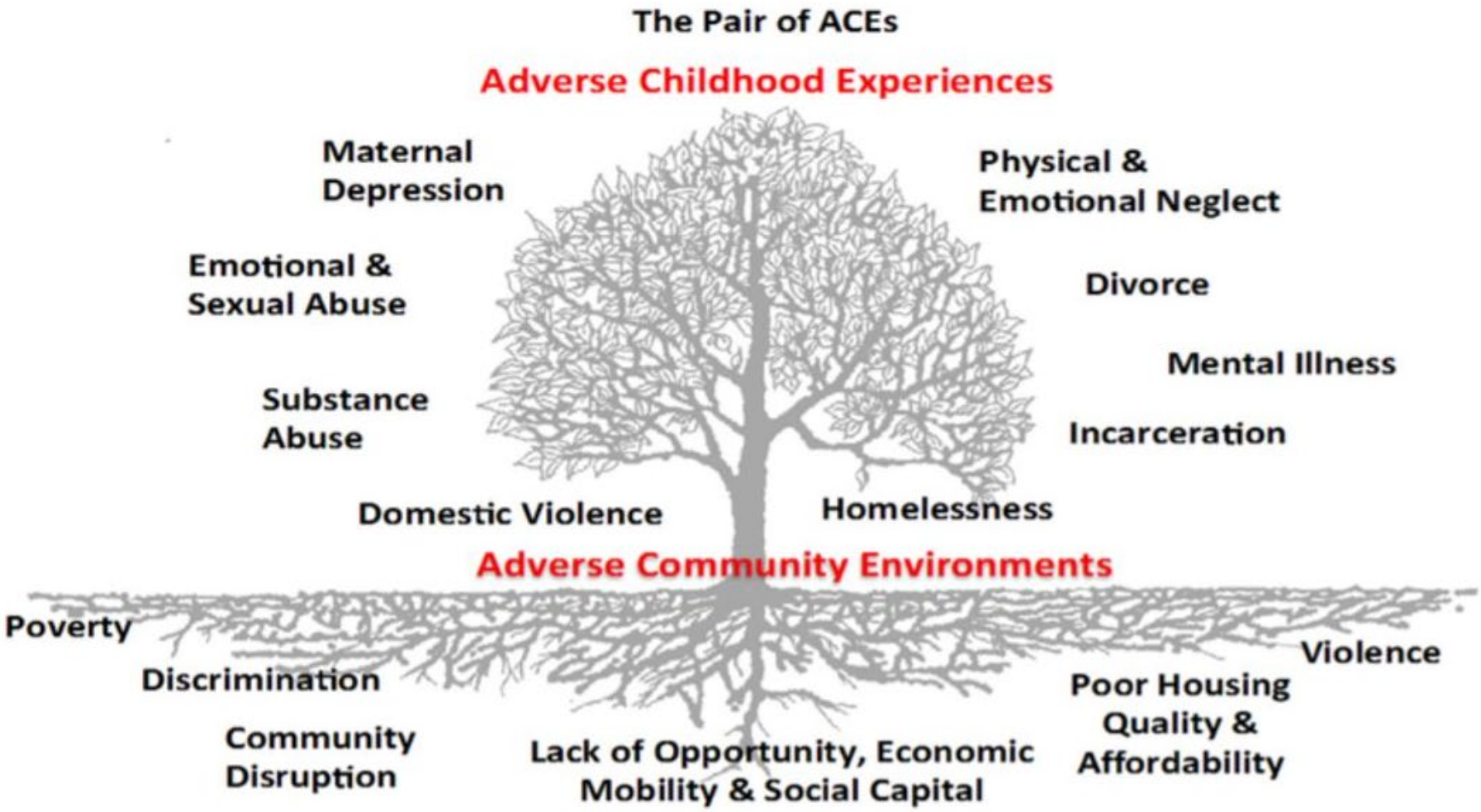
Adverse Community Environments



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

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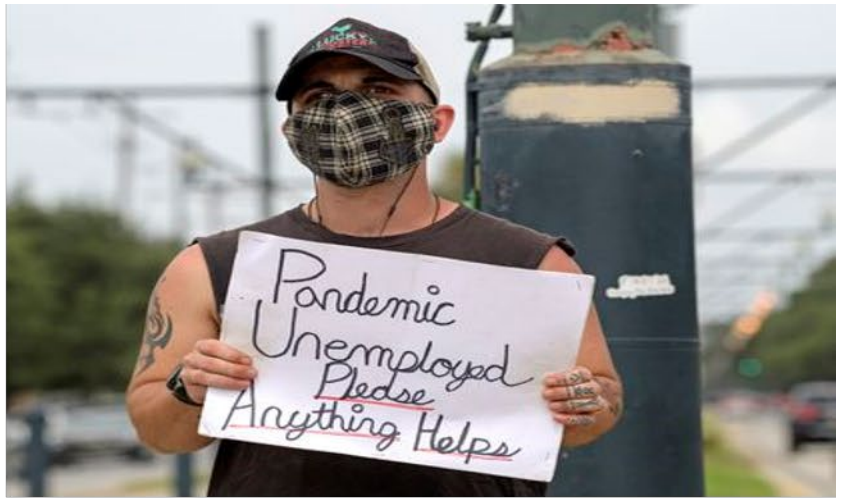
Direct and indirect pathways linking pandemics to ACEs

1. Economic insecurity and poverty-related stress
2. Quarantines and social isolation
3. Disaster and conflict-related unrest and instability
4. Exposure to exploitative relationships due to changing demographics
5. Reduced health service availability and access to first responders
6. Virus-specific sources of violence
7. Inability of women to temporarily escape violent partners
8. Violence perpetrated against health care workers

Economic insecurity and poverty-related stress



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Quarantines and social isolation

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Disaster and conflict-related unrest and instability

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Exposure to exploitative relationships due to changing demographics

Los Angeles Times

CALIFORNIA

Deaths among Latinos in L.A. County from COVID-19 rising at astonishing levels

Elizabeth Garibay prepares a floral cross for a funeral at her family business J & I Florist in Los Angeles in December. (Gary Coronado / Los Angeles Times)

By RONG-GONG LIN II, LUKE MONEY

JAN. 14, 2021 UPDATED 4:33 PM PT

Reduced health service availability and access to first responders

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Virus-specific sources of violence

- Perpetrators may:
  - Use misinformation or scare tactics to control or blame women and children
  - Withhold necessary safety items (e.g., hand sanitizers, soap, disinfectant, protective masks)
  - Withhold health insurance or economic support
- Social and economic repercussions of infection
  - Social stigmatization
  - Violence
  - Destruction of property from family and community members

Inability of women to temporarily escape violent partners

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Violence perpetrated against health care workers

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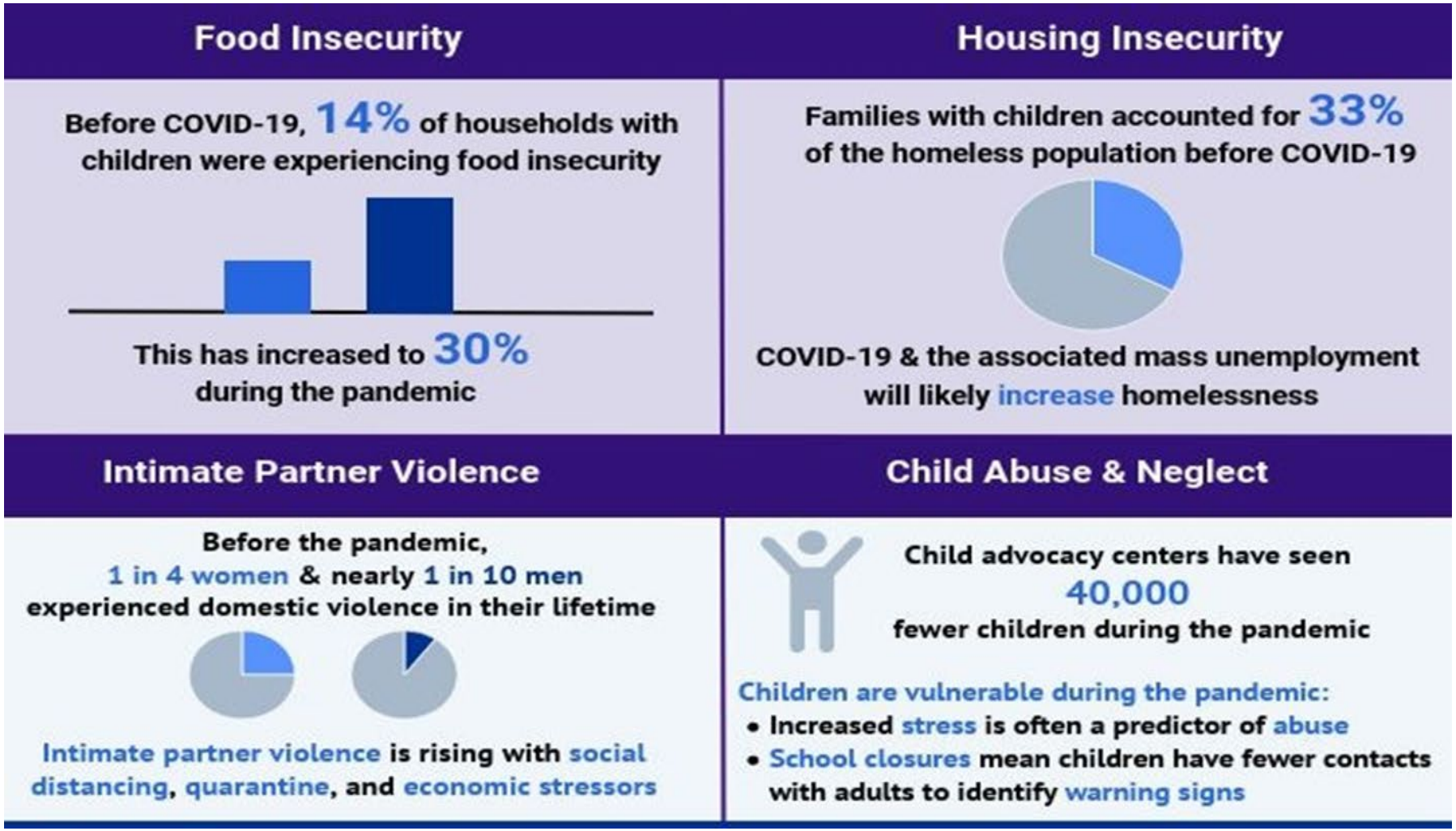
Social Determinants of Health



Source: National Institute for Health Care Management (NIHCM) Foundation

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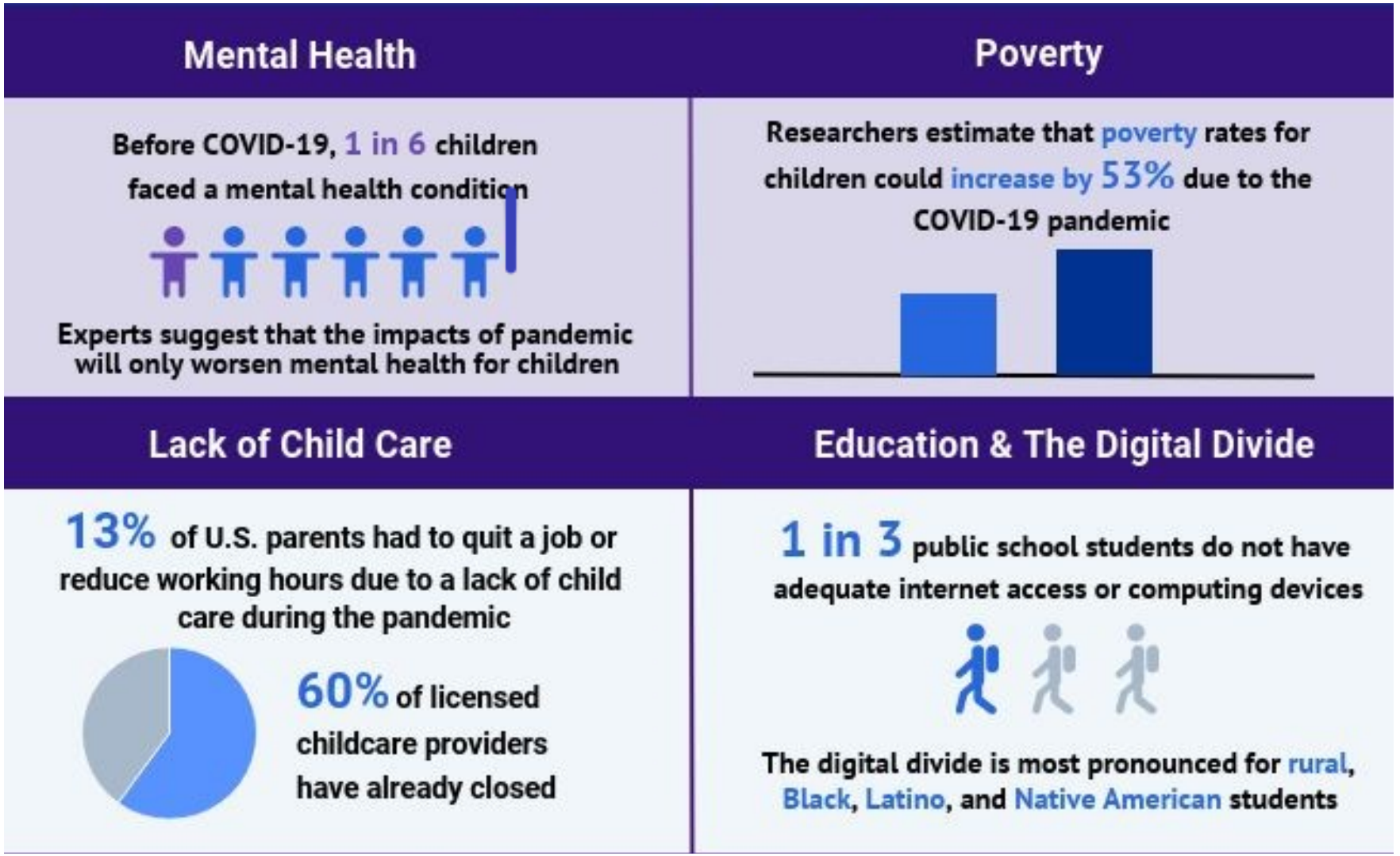
Social Determinants of Health cont'd



Source: National Institute for Health Care Management (NIHCM) Foundation

Converging Public Health Challenges

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Converging Public Health Challenges cont'd

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Objective 3:

To explore recommendations and opportunities for addressing ACEs through research, policy, and practice

Three groups of priority research questions

1. Understand the magnitude of the problem
2. Elucidate mechanisms and linkages with other social and economic factors
3. Inform intervention and response options

1. Understand the magnitude of the problem

- How big is the problem (ACEs)?
  - Additional evidence could help in decisions of how to allocate resources
- Given high levels of pre-pandemic poly-victimization faced by vulnerable populations, does the composition of violence experienced shift for individuals/populations during the pandemic?
  - Remote learning: school-based bullying decreases but prevalence of violence from family members increases?
- Identify pre- and post-pandemic trends
- Challenge: data captured within surveys and administrative data from formal sources is a fraction of the true burden

2. Elucidate mechanisms and linkages with other social and economic factors

- What populations are most at risk for increases in ACEs, and do these map to existing vulnerabilities along economic or social inequalities (e.g., race/ethnicity, SES, age)?
- Use of ethnographic and qualitative research to test specific hypotheses:
  - What evidence of diverse pathways appear important for different populations in linking direct and indirect effects of pandemics to VAW/C?
  - How might social norms and collective behaviors matter for pathways and mitigation of VAW/C experiences?

3. Inform intervention and response options

- Are policies and programs (e.g., emergency cash transfers or unemployment insurance) effective in mitigating against increases in VAW/C?
- What is the cost-effectiveness in implementing successful approaches?
- How does the timing, duration, and intensity of intervention affect short- medium- and long-term experience of VAW/C and future wellbeing?

Supporting Child Development

Source: NIHCM Foundation

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Eight Policy and Program Responses (Peterman et al., 2020)

1. Bolster violence-related first-response systems
2. Ensure violence against women and children (VAW/C) integrated into health systems response
3. Expand and reinforce social safety nets
4. Expand shelter and temporary housing for survivors
5. Encourage informal (and virtual) social support networks
6. Clear communication and support during quarantine mandates
7. Integrate VAW/C programming into longer-term pandemic preparedness
8. Implement and invest in flexible funding mechanisms

1. Bolster violence-related first-response systems

- Increasing staff or temporary operations for existing violence prevention and response hotlines and outreach centers
- Increasing communication and awareness of services through routine news and advocacy efforts
- Explore virtual options
- Re-enforcing training and action plans for pandemic-safe response by police and legal personnel

2. Ensure violence against women and children (VAW/C) integrated into health systems response

- Ensuring there is access to female health care workers, confidential spaces, survivor-centered, non-judgmental, empathetic care
- Health care providers should be trained in identifying W/C at risk of violence present in all testing and screening locations
- Bystander training and other existing violence prevention, mitigation and response strategies should be integrated into existing curricula, on-boarding and training for all levels of health services
- Protections for female health workers to address sexual harassment and violence

3. Expand and reinforce social safety nets

- Rapid expansion of social safety nets, including paid sick leave, unemployment insurance, direct cash or food voucher payments and/or tax relief are all immediate options
- Household and individual level benefits e.g., employment benefits or insurance which will allow victims to maintain control and access to other services
- Consider if targeted economic benefits can be automatic and directed to survivors to address financial needs related to accessing health, legal or psychosocial services and future violence

4. Expand shelter and temporary housing for survivors

- Ensure surge housing available for high risk women and children which is pandemic-safe
- Expanding services to include additional benefits (e.g. waiving of application fees, move in costs, other expenses)
- Increasing funding for emergency shelters and programs that address affordable housing
- Improving communication between housing (homeless services) and violence service providers

5. Encourage informal (and virtual) social support networks

- Key strategy resulting in calls for social network-oriented approaches to services and prevention programming
- Scale-up and leverage existing online and virtual platforms for online support networks
- Options for text (e.g., WhatsApp) based networks, building on existing women's groups and collectives

6. Clear communication and support during quarantine mandates

- Providing clear rationale for quarantine and information about protocols
- Ensuring there are sufficient supply of goods and essential services to the populations under isolation
- Appeal to altruism through messaging about public benefits to communities and society
- Messaging around morale to reduce adverse mental health impacts

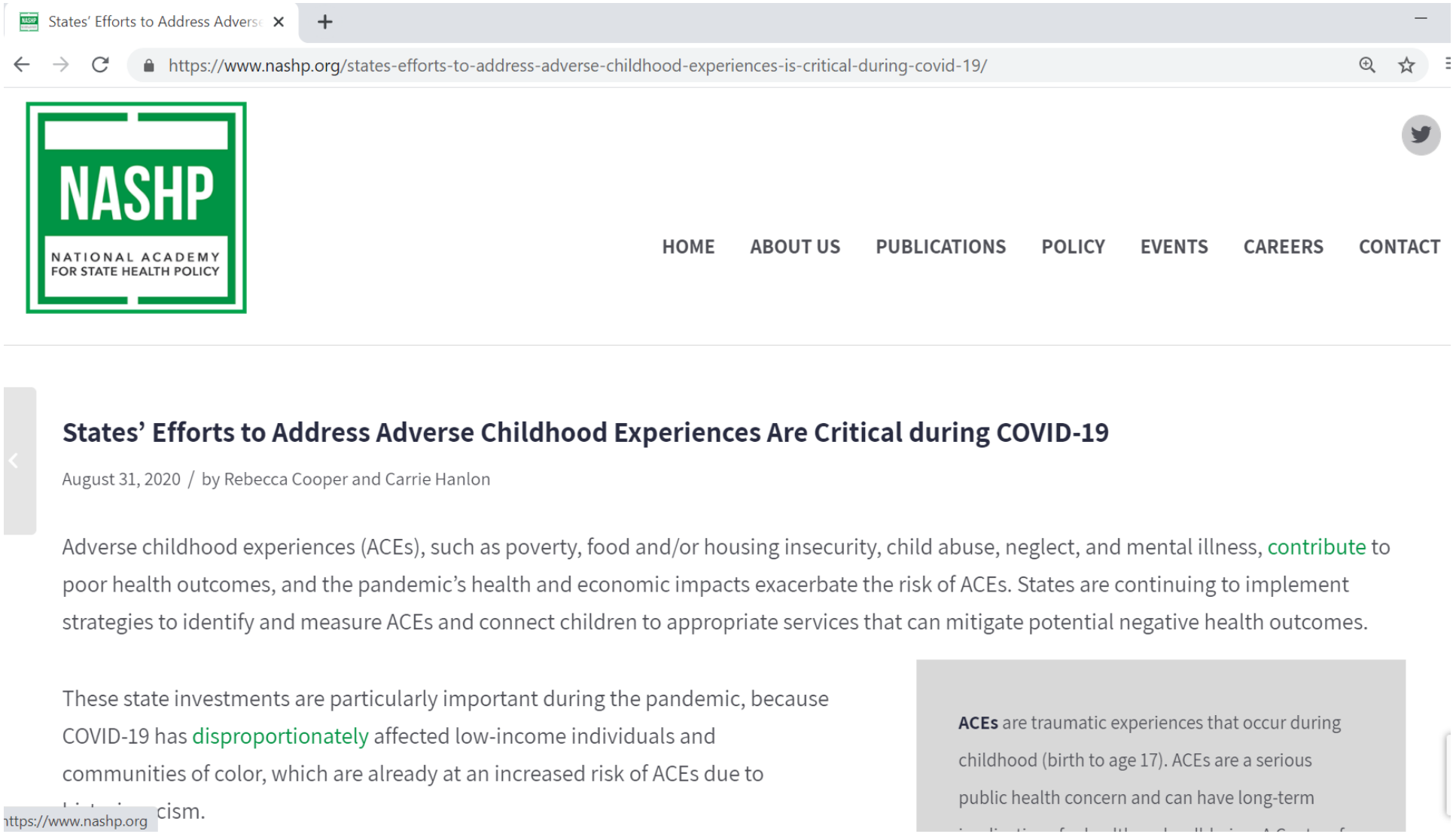
7. Integrate VAW/C programming into longer-term pandemic preparedness

- Incorporate a race, gender, and age lens throughout preparedness efforts
- Ensure women and children are included in preparedness processes and decision-making, and are recognized as persons with skilled roles to play in response

8. Implement and invest in flexible funding mechanisms

- Donors and implementers should reflect timely policies and guidelines for grantees and staff which allow flexible funding
- Prioritize increased and gender-/child-responsive investment to curb the full array of risks brought on by pandemics
- National, state, and city/local government associate relief funds should also include provision of resources and funds to bolster existing organizations providing VAW/C services

State Level Efforts



Source: https://www.nashp.org

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Clinical Screening Tools

aces aware
SCREEN. TREAT. HEAL.

Screen Treat Heal About GET TRAINED

Screening Tools

The Department of Health Care Services approved specific tools to be used and questions to be asked for pediatric and adult ACE screenings. These tools are available for providers to use today.

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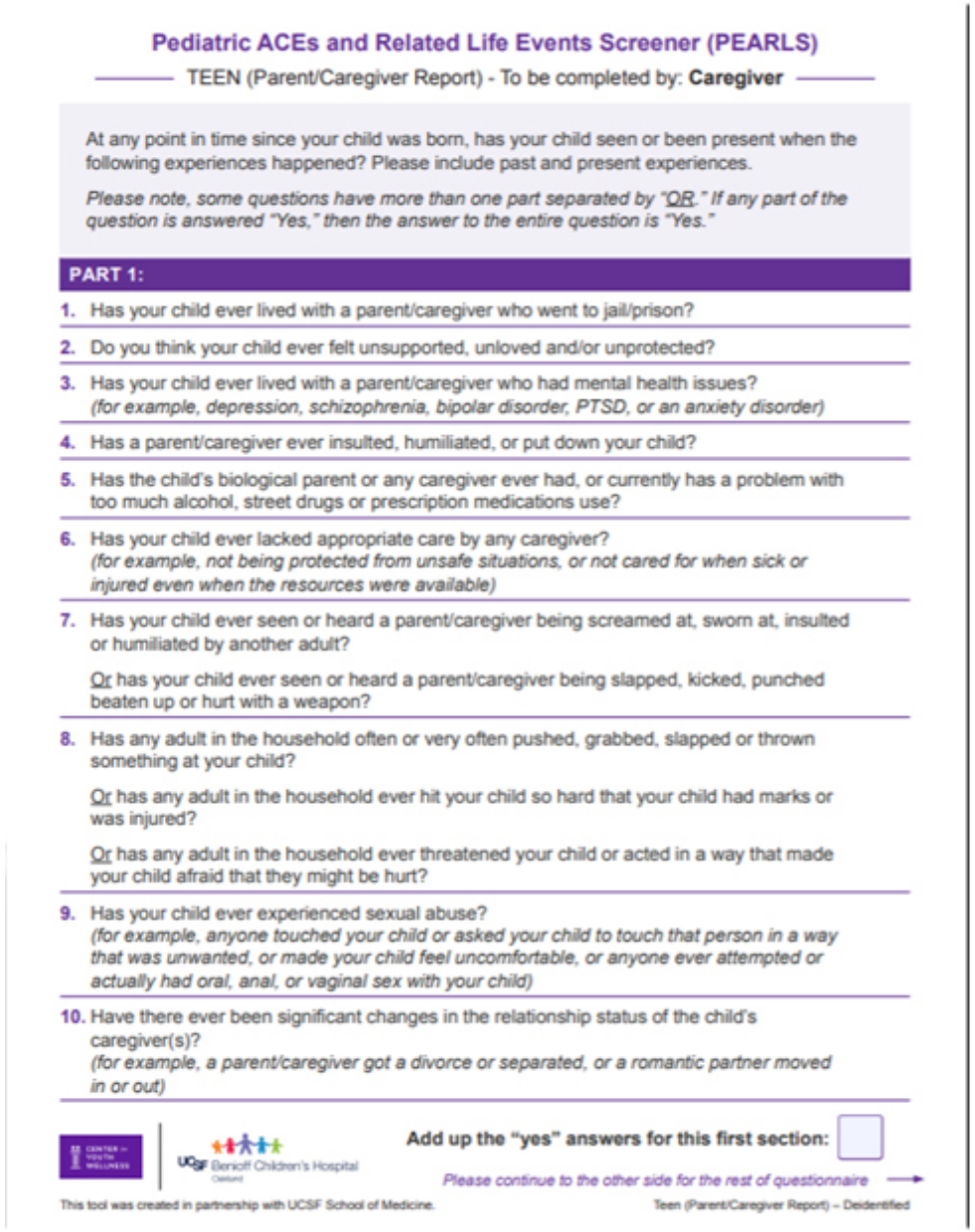
Examples of Clinical Screening Tools



Pediatric ACEs and Related Life Events Screener (PEARLS)

TEEN (Parent/Caregiver Report) - To be completed by: **Caregiver**

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:

1. Has your child ever lived with a parent/caregiver who went to jail/prison?
2. Do you think your child ever felt unsupported, unloved and/or unprotected?
3. Has your child ever lived with a parent/caregiver who had mental health issues?
   (for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?
6. Has your child ever lacked appropriate care by any caregiver?
   (for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult?

   Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child?

   Or has any adult in the household ever hit your child so hard that your child had marks or was injured?

   Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?
9. Has your child ever experienced sexual abuse?
   (for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)?
    (for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)

Add up the "yes" answers for this first section: ☐

Please continue to the other side for the rest of questionnaire →

This tool was created in partnership with UCSF School of Medicine.

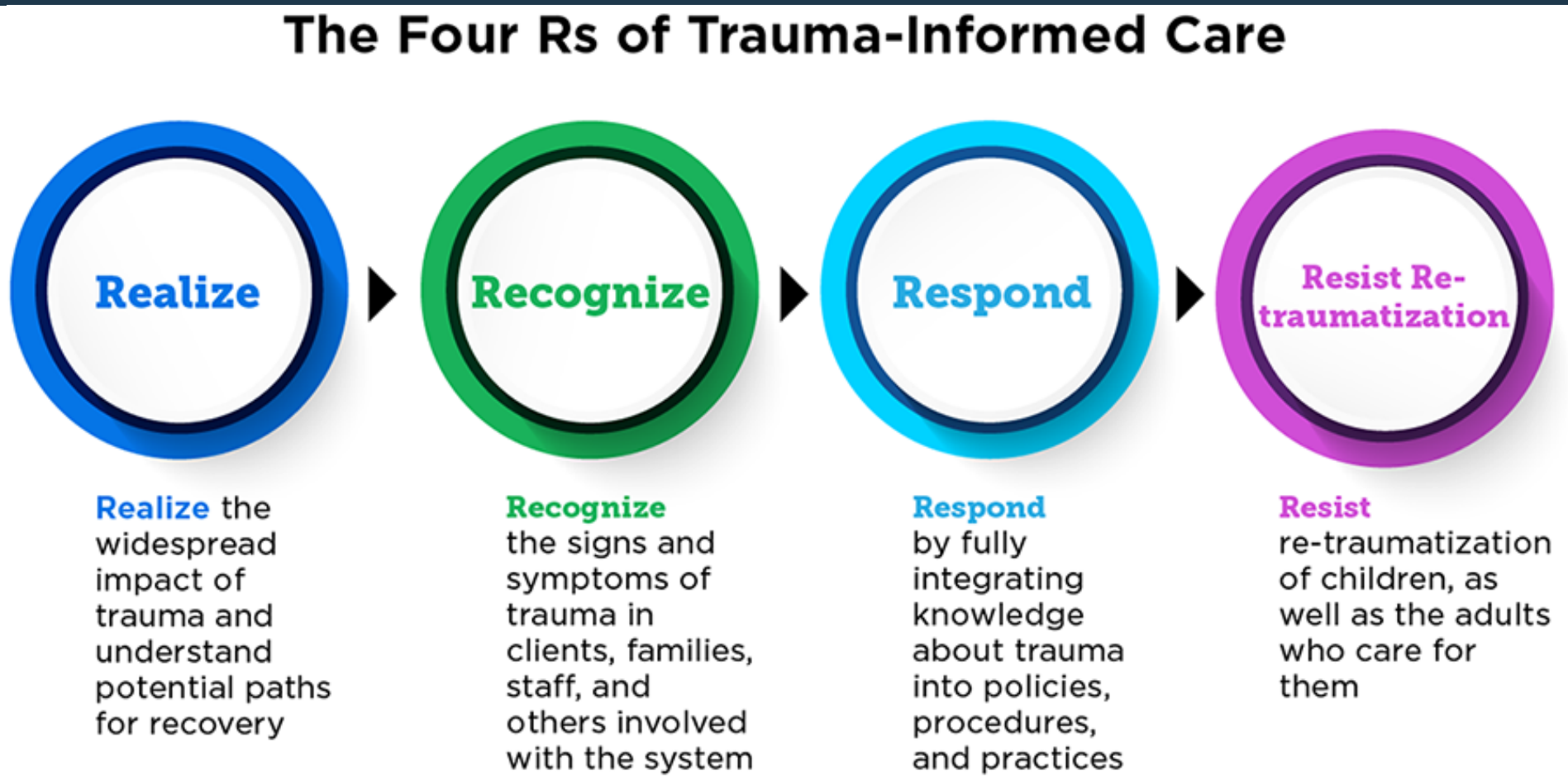
Teen (Parent/Caregiver Report) – Deidentified

PART 2: Please check "Yes" where apply. ☑

1. Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? ☐
   (for example, targeted bullying, assault or other violent actions, war or terrorism)
2. Has your child experienced discrimination? ☐
   (for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)
3. Has your child ever had problems with housing? ☐
   (for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)
4. Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more? ☐
5. Has your child ever lived with a parent/caregiver who had a serious physical illness or disability? ☐
6. Has your child ever been separated from their parent or caregiver due to foster care, or immigration? ☐
7. Has your child ever lived with a parent or caregiver who died? ☐

How many "Yes" did you answer in Part 2?: ☐

The Four Rs



This figure is adapted from: Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and Guidance for a trauma-informed approach. HHS publication no. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

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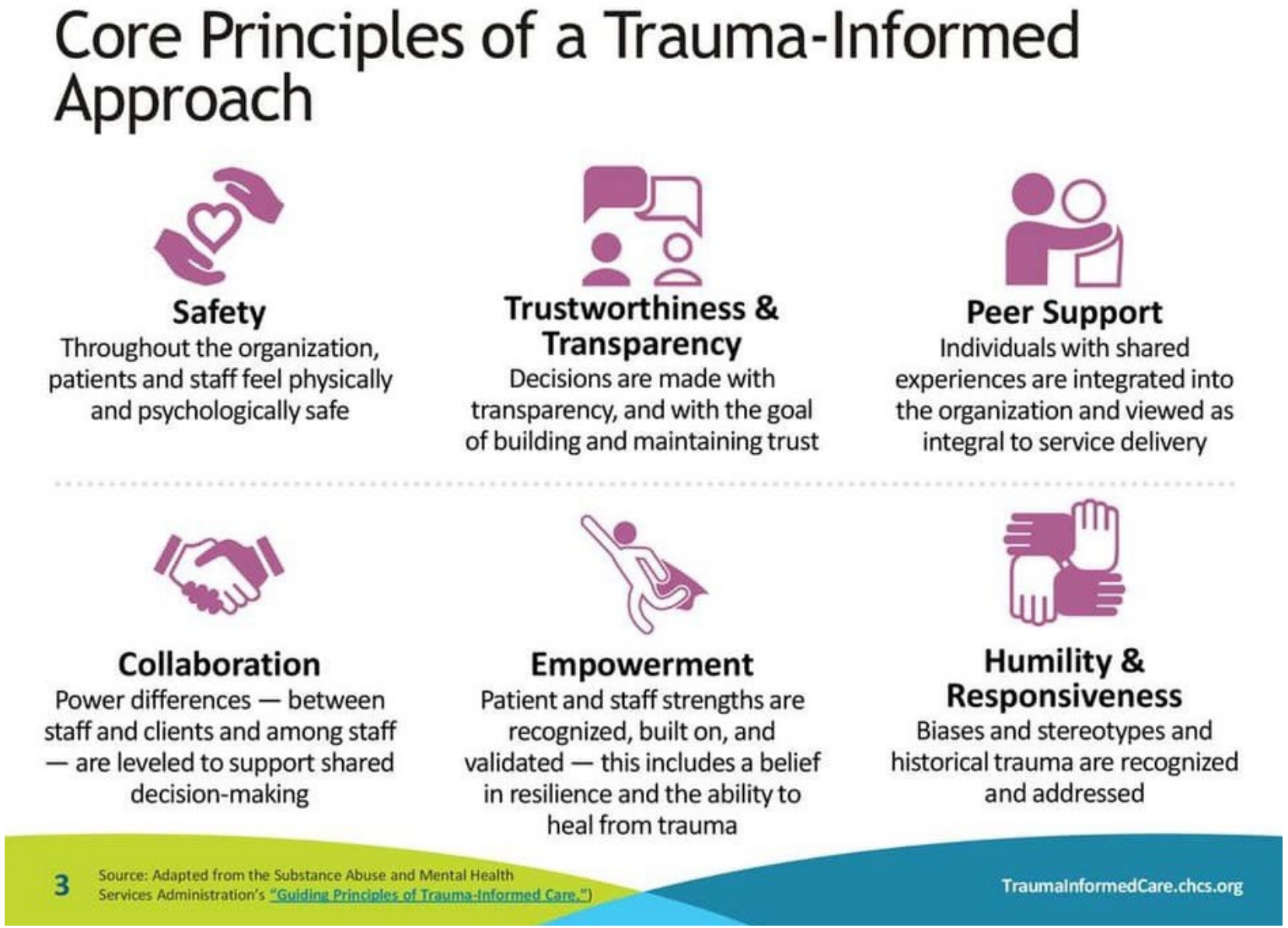
Trauma-informed Care Approach



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Strengths-based Approaches

Source: Mindfulness First

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Secondary Traumatic Stress

NCTSN The National Child Traumatic Stress Network

"...We are stewards not just of those who allow us into their lives but of our own capacity to be helpful..."[1]

Secondary Traumatic Stress

A Fact Sheet for Child-Serving Professionals

INTRODUCTION

Each year more than 10 million children in the United States endure the trauma of abuse, violence, natural disasters, and other adverse events.[2] These experiences can give rise to significant emotional and behavioral problems that can profoundly disrupt the children's lives and bring them in contact with child-serving systems. For therapists, child welfare workers, case managers, and other helping professionals involved in the care of traumatized children and their families, the essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life. Individual and supervisory awareness of the impact of this indirect trauma exposure—referred to as secondary traumatic stress—is a basic part of protecting the health of the worker and ensuring that children consistently receive the best possible care from those who are committed to helping them.

Our main goal in preparing this fact sheet is to provide a concise overview of

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The Way Forward: CDC Recommendations

Healthcare Providers Can:

- Anticipate and recognize current risk for ACEs in children and history of ACEs in adults. Refer patients to effective services and support.
- Link adults to family-centered treatment approaches that include substance abuse treatment and parenting interventions.

States and Communities Can:

- Improve access to high-quality childcare by expanding eligibility, activities offered, and family involvement.
- Use effective social and economic supports that address financial hardship and other conditions that put families at risk for ACEs.
- Enhance connections to caring adults and increase parents' and youth skills to manage emotions and conflicts using approaches in schools and other settings.

Employers Can:

- Adopt and support family-friendly policies, such as paid family leave and flexible work schedules.

Everyone Can:

- Recognize challenges that families face and offer support and encouragement to reduce stress.
- Support community programs and policies that provide safe and healthy conditions for all children and families.

Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

If you have questions or need additional information about this or other webinars

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