Adverse Childhood Experiences (ACE)
Learning Objectives

1. Attendees will understand recent research examining the impact of adverse childhood experiences on adult health outcomes.

2. Attendees will synthesize the increased health risks with associated increased medical and other costs of adverse childhood experiences.

3. Attendees will define best practices for responding to childhood trauma for both investigations and intervention.
Adverse Childhood Experiences Study

- 14-year-old study involves 17,337 adults who became members of Kaiser Permanente, a health care maintenance organization in San Diego, between 1995 and 1997.
- After visiting a primary care facility, they voluntarily filled out a standard medical questionnaire that included questions about their childhood.
- The questionnaire asked them about 10 types of child trauma:
  - Three types of abuse (sexual, physical and emotional).
  - Two types of neglect (physical and emotional).
  - Five types of family dysfunction (having a mother who was treated violently, a household member who’s an alcoholic or drug user, who’s been imprisoned, or diagnosed with mental illness, or parents who are separated or divorced).
Conceptual Framework for ACE Study

Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
<table>
<thead>
<tr>
<th>Demographic Categories</th>
<th>Percent (N = 17,337)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>54%</td>
</tr>
<tr>
<td>Male</td>
<td>46%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
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</tr>
<tr>
<td>White</td>
<td>74.8%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>11.2%</td>
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<tr>
<td>Asian/Pacific Islander</td>
<td>7.2%</td>
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<tr>
<td>African-American</td>
<td>4.6%</td>
</tr>
<tr>
<td>Other</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
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</tr>
<tr>
<td>19-29</td>
<td>5.3%</td>
</tr>
<tr>
<td>30-39</td>
<td>9.8%</td>
</tr>
<tr>
<td>40-49</td>
<td>18.6%</td>
</tr>
<tr>
<td>50-59</td>
<td>19.9%</td>
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<tr>
<td>60 and over</td>
<td>46.4%</td>
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<tr>
<td><strong>Education</strong></td>
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</tr>
<tr>
<td>Not High School Graduate</td>
<td>7.2%</td>
</tr>
<tr>
<td>High School Graduate</td>
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<tr>
<td>Some College</td>
<td>35.9%</td>
</tr>
<tr>
<td>College Graduate or Higher</td>
<td>39.3%</td>
</tr>
<tr>
<td>ACE Category*</td>
<td>Women (N = 9,367)</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>13.1</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>27.0</td>
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<tr>
<td>Sexual Abuse</td>
<td>24.7</td>
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<tr>
<td><strong>Neglect</strong></td>
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</tr>
<tr>
<td>Emotional Neglect¹</td>
<td>16.7</td>
</tr>
<tr>
<td>Physical Neglect¹</td>
<td>9.2</td>
</tr>
<tr>
<td><strong>Household Dysfunction</strong></td>
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</tr>
<tr>
<td>Mother Treated Violently</td>
<td>13.7</td>
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<tr>
<td>Household Substance Abuse</td>
<td>29.5</td>
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<tr>
<td>Household Mental Illness</td>
<td>23.3</td>
</tr>
<tr>
<td>Parental Separation or Divorce</td>
<td>24.5</td>
</tr>
<tr>
<td>Incarcerated Household Member</td>
<td>5.2</td>
</tr>
<tr>
<td>Number of Adverse Childhood Experiences (ACE Score)</td>
<td>Women</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>0</td>
<td>34.5</td>
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<tr>
<td>1</td>
<td>24.5</td>
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<tr>
<td>2</td>
<td>15.5</td>
</tr>
<tr>
<td>3</td>
<td>10.3</td>
</tr>
<tr>
<td>4 or more</td>
<td>15.2</td>
</tr>
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</table>
Adverse Childhood Experiences Study

• More than 50 research papers published since 1998

• Adverse childhood experiences are common – 64% of the study participants had experienced one or more categories of adverse childhood experiences.

• Multiple ACEs connected to early death - people with six or more ACEs died nearly 20 years earlier on average than those without ACEs
  ➢ 60.6 years vs. 79.1 years
Cumulative ACES & Mental Health\textsuperscript{1,2}

Data from the National Comorbidity Survey-Replication Sample (NCS-R).
\textsuperscript{2}Putnam, Harris, Putnam, J Traumatic Stress, 26:435-442, 2013.
Cumulative ACES & Chronic Disease

Prevalence %

Ischemic Heart Disease  Stroke  COPD  Diabetes  Sexually Transmitted Disease

ACES 0 1 2 3 ≥ 4

Cumulative ACES & Impaired Worker Performance

Cost of healthcare for abuse survivors

- Participants - 3,333 women who received insurance from the Group Health Cooperative for at least 12 of the 41 calendar quarters in the study’s time frame.

- 34% reported a history of childhood abuse:
  - Physical Abuse only – 6.5%
  - Sexual Abuse only – 20.1%
  - Physical and Sexual Abuse – 7.2%
Cost of healthcare for abuse survivors

- **Total annual health care costs were higher** for all groups of women who experienced some form of child abuse:
  - Both physical and sexual abuse – 36%
  - Sexual abuse only – 16%
  - Physical abuse only – 22%

Impact of Child Abuse on Medicaid $

• Children with abuse histories had significantly higher healthcare expenses – $2,635 per year.
  ➢ Significantly higher healthcare costs for:
    • Psychiatric care
    • Inpatient hospital
    • Outpatient – physician and clinic
    • Prescription drugs
    • Targeted case management

• Estimated cost related to child maltreatment - $5.9 billion (9% of all Medicaid expenses)

Economic Impact

• Individuals with a history of child maltreatment:
  ➢ were significantly less likely to own a bank account, stock, a vehicle, or a home;
  ➢ earned almost $8,000 less per year than non-abused subjects.

• Women abused in childhood appear to have greater long-term economic impacts than men who were abused in childhood

Economic Burden of Child Maltreatment

• The estimated average lifetime cost per victim of nonfatal child maltreatment is $210,012 in 2010 USD:
  ➢ $32,648 in childhood health care costs
  ➢ $10,530 in adult medical costs
  ➢ $144,360 in productivity losses
  ➢ $7,728 in child welfare costs
  ➢ $6,747 in criminal justice costs
  ➢ $7,999 in special education costs.
Economic Burden of Child Maltreatment

• The estimated average lifetime cost per death is $1,272,900:
  ➢ $14,100 in medical costs
  ➢ $1,258,800 in productivity losses

• Total lifetime economic burden from both in 2008:
  ➢ Approximately $124 billion – possibly as large as $585 billion
The OLD Way
The Agency Centered Approach

What do I need from this kid and family for my case/agency?
1. The “system” intended to protect children should “help” children, not further traumatize or cause lack of trust

2. The protection of children must involve all agencies involved in the investigation and intervention, and these agencies must work together

Bud Cramer
The NEW Way
The Child/Family Centered, Trauma Informed Approach

A collaborative model with a defined mission and unique culture comprised of individuals from diverse agencies

Mission is the “BOSS”
All MDT members are stewards of the mission
Child-Appropriate/Child-Friendly Facility

- A Children’s Advocacy Center provides a comfortable, private, child-friendly setting that is both physically and psychologically safe for diverse populations of children and their families.

- All referrals to the CAC come from either law enforcement or child protective services.
Forensic Interviews

Standard: The CAC promotes forensic interviews which are legally sound, are of a neutral, fact-finding nature, and are coordinated to avoid duplicative interviewing.
Child Forensic Interviewing: Best Practices

Chris Newlin, Linda Cordisco Steele, Andra Chamberlin, Jennifer Anderson, Julie Kenniston, Amy Russell, Heather Stewart, and Viola Vaughan-Eden

Highlights
Medical Evaluation

• Standard: Specialized medical evaluation and treatment services are available to all CAC clients and coordinated with the multidisciplinary team response to provide follow-up referrals and/or treatment as necessary.
Medical Intervention

- Specialized medical provider essential
- Should be offered in every case
- Four Goals:
  1. Obtain evidence, if present
  2. Assure child’s well-being (child and caregiver)
  3. Provide follow-up as needed, related to child abuse
  4. Assess for other medical concerns present
- Extremely unlikely for physical evidence to be found in medical exam
  - Variability in human anatomy
  - Extremely vascular
Colposcope
Multidisciplinary Team

• Standard: A multidisciplinary team for response to child abuse allegations includes representation from the following:

  ➢ *Child Protective Services* – *is the child safe? Are other children at risk?*
  
  ➢ *Medical* – *is there evidence of abuse? Does the child need treatment?*
  
  ➢ *Mental Health* – *does the child/family need mental health services? What type of service would help the most?*
  
  ➢ *Victim Advocacy* – *What else might we be able to do to support this family?*
  
  ➢ *Law Enforcement* – *has a crime been committed?*
  
  ➢ *Prosecution* – *can I prove the case in court?*
Mental Health

• Standard: Specialized trauma-focused mental health services, designed to meet the unique needs of the children and non-offending family members, are routinely made available as part of the MDT response.

  ➢ Evidence-based practice – Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, Problematic Sexual Behavior – Cognitive Behavioral Therapy
Mental Health Intervention

- Strong focus to differentiate Investigation from Treatment

- Transition from long-term, broadly focused treatment to Symptom-focused model
  - Evidence-based practice
  - Focused on trauma symptoms
  - Strong parent/caregiver involvement (60/40)
Victim Support/Advocacy

• Standard: Victim support and advocacy services are routinely made available to all CAC clients and their non-offending family members/caregivers as part of the MDT response.

  ➢ Strong engagement with parents/caregivers
  ➢ Primary Point of Contact for future needs
  ➢ Follow-up with families – need a protocol
Case Review

• Standard: A formal process in which MDT discussion and information sharing regarding the investigation, case status, and services needed by the child and family is to occur on a routine basis.

  ➢ Sharing of information
  ➢ Proactive planning for investigation/intervention
  ➢ When will MDT meet?
  ➢ Identified MDT Facilitator
  ➢ What types of cases included?
Case Tracking

- Standard: CAC’s must develop and implement a system for monitoring case progress and tracking case outcomes for team components.
Organizational Capacity

• Standard: A designated legal entity responsible for program and fiscal operations with sound administrative practices.
  - Organizational Structure?
  - Support for staff and MDT
  - Vicarious Trauma support
  - Wellness Plans
Cultural Competency & Diversity

• Standard: The CAC promotes policies, practices and procedures that are culturally competent.

➢ Cultural competency is defined as “the capacity to function in more than one culture, requiring the ability to appreciate, understand and interact with members of diverse populations within the local community.”
CACs in the USA
Is the CAC/MDT model a Best Practice?

Does using the CAC really help?
Positive Outcomes

• More coordinated investigations
• Increase client satisfaction
• Faster criminal justice charging decisions
• Great access to medical care
• Increased prosecution rates
• Improved mental health outcomes for victims
• Cost-Benefit Analysis
Healing
95% of caregivers agree that CACs provide them with resources to support their children.

Justice
98% of team members believe clients benefit from the collaborative approach of the MDT.

Trust
If caregivers knew anyone else who was dealing with a situation like the one their family faced, 97% would tell that person about the center.
NCAC Offers of Collaboration

• Continue to provide Darkness to Light Stewards of Children Training

• Additional training on child maltreatment

• Consultation on how to create a more trauma-informed care setting

• Medical consultation on child abuse concerns
When you step here, you care Really!

When you step here you are LOVED

When you step here you are NOT Afraid.

When you step here you have HOPE

When you step here you have FAITH
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