Preventing Adverse Childhood Experiences

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Adverse Childhood Experiences

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Salt Lake City, Utah
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Adverse Childhood Experiences (ACEs)

Source: Robert Wood Johnson Foundation
ACEs are common
ACEs are common

**ABUSE**
- Physical Abuse: 28.3%
- Sexual Abuse: 20.7%
- Emotional Abuse: 10.6%

**NEGLECT**
- Emotional Neglect: 14.0%
- Physical Neglect: 9.9%

**HOUSEHOLD DYSFUNCTION**
- Household Substance Abuse: 26.9%
- Parental Divorce: 23.3%
- Household Mental Illness: 19.4%
- Mother Treated Violently: 12.7%
- Incarcerated Household Member: 4.7%

Of 17,000 ACE study participants:
- 26% have 1 ACE
- 16% have 2 ACEs
- 9.5% have 3 ACEs
- 12.4% have 4+ ACEs
- 64% have at least 1 ACE

Source: Robert Wood Johnson Foundation
ACEs are common

Although the study ended in 1997, some states are collecting information about ACEs in their population through the Behavioral Risk Factor Surveillance System (BRFSS).

Source: Centers for Disease Control and Prevention
http://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html
ACEs are harmful
ACEs are harmful

Source: Centers for Disease Control and Prevention
http://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html
Adverse Childhood Experiences

Sources: Center on the Developing Child, Harvard University
http://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development/
Toxic Stress Derails Healthy Development

Source: Center on the Developing Child, Harvard University
http://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development/
A large portion of many health, safety and prosperity conditions is attributable to Adverse Childhood Experience.

ACE reduction reliably predicts a decrease in all of these conditions simultaneously.

Source: Family Policy Council, 2012
LIFE EXPECTANCY

People with six or more ACEs died nearly 20 years earlier on average than those without ACEs.

0

80 YEARS

6+

60 YEARS

Source: Centers for Disease Control and Prevention
http://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html
Adverse Childhood Experiences

ECONOMIC TOLL

The Centers for Disease Control and Prevention (CDC) estimates that the lifetime costs associated with child maltreatment at $124 billion.

- $83.5 billion Productivity Loss
- $25 billion Health Care
- $4.6 billion Special Education
- $4.4 billion Child Welfare
- $3.9 billion Criminal Justice

Source: Centers for Disease Control and Prevention
http://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html
ACEs are preventable
ACEs are preventable

- Prevent ACEs (primary prevention)
- Strengthen resilience (secondary prevention)
Maternal, Infant, Early Childhood
Home visiting Program
MIECHV Goals

Provide voluntary, evidence-based home visiting services to improve

- Prenatal, maternal, and newborn health
- Child health and development, including the prevention of child injuries and maltreatment
- Parenting skills
- School readiness and child academic achievement
- Family economic self-sufficiency
- Referrals for and provision of other community resources and supports

Priority Populations

- Families in at-risk communities
- Low-income families
- Pregnant women under age 21
- Families with a history of child abuse or neglect
- Families with a history of substance abuse
- Families that have users of tobacco in the home
- Families with children with low student achievement
- Families with children with developmental delays or disabilities
- Families with individuals who are serving or have served in the Armed Forces, including those with multiple deployments

How Does Home Visiting Prevent ACEs?

Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect

Fifteen-Year Follow-up of a Randomized Trial

David L. Oics, PhD; John Eckenrode, PhD; Charles H. Henderson, Jr; Harriet Kranman, RN; PhD; Jane Powers, PhD; Robert Cola, PhD; Kristi Sidorac, MPH; Pamela Morris; Lisa M. Petitt; Dennis Luckey, PhD

Context.—Home-visitation services have been promoted as a means of improving maternal and child health and functioning. However, long-term effects have not been examined.

Objective.—To examine the long-term effects of a program of prenatal and early childhood home visitation by nurses on women’s life course and child abuse and neglect.

Design.—Randomized trial.

Setting.—Seminar community in New York.

Participants.—Of 400 consecutive pregnant women with no previous live births enrolled, 324 participated in a follow-up study when their children were 15 years old.

Intervention.—Families received a mean of 9 home visits during pregnancy and 23 home visits from the child’s birth through the second birthday.

Data Sources and Measures.—Women’s use of welfare and number of subsequent children were based on self-report; their arrests and convictions were based on self-report and archived data from New York State. Verified reports of child abuse and neglect were abstracted from state records.

Main Results.—During the 15-year period after the birth of their first child, in contrast to women in the comparison group, women who were visited by nurses during pregnancy and infancy were identified as perpetrators of child abuse and neglect in 0.20 vs 0.54 verified reports (P <.001). Among women who were unmarried and from households of low socioeconomic status at initial enrollment, in contrast to those in the comparison group, nurse-visited women had 1.2 vs 1.8 subsequent births (P =.02), 65 vs 57 months between the birth of the first and a second child (P =.001), 80 vs 90 months receiving Aid to Families With Dependent Children (P =.005), 0.41 vs 0.73 behavioral impairments due to use of alcohol and other drugs (P =.03), 0.18 vs 0.58 arrests by self-report (P =.001), and 0.16 vs 0.90 arrests disclosed by New York State records (P <.001).

Conclusions.—This program of prenatal and early childhood home visitation by nurses can reduce the number of subsequent pregnancies, the use of welfare, child abuse and neglect, and criminal behavior on the part of low-income, unmarried mothers for up to 15 years after the birth of the first child.

IN RECENT YEARS, home-visitation services have been promoted widely as a means of preventing a range of health and developmental problems in children from vulnerable families. The US Advisory Board on Child Abuse and Neglect, for example, has recommended that home-visitation services be made available to all parents of newborns as a means of preventing child abuse and neglect.1

See also pp 644 and 580.

Many of these recommendations have been based on the results of a randomized trial of a comprehensive program of prenatal and early childhood home visitation by nurses that was conducted in Elmira, NY.2 Findings from this trial indicated that the program reduced the rate of subsequent pregnancy, increased labor force participation, and reduced government spending for low-income unmarried women from the birth

From the University of Colorado; Health Sciences Center, Denver (D.L.O. and D.L.;luckey) Cornell University, New York, N.Y. (G.K. Eckenrode and Powers); M. Festeheitan, and W. Morgan); the University of Rochester, Rochester, NY (D.L. Oics and Rose and M.Sidora); and the Department of Psychology, University of Columbia (L.M. Petitt).

Reprints: David L. Oics, PhD, University of Colorado Health Sciences Center, 1302 E. 17th Ave, Suite 200, Denver, CO 80210 (e-mail: david.oics@uchsc.edu).
How Does Home Visiting Prevent ACEs?

• Screen and support
  • depression
  • domestic violence
  • child abuse and neglect
• Build relationship and resilience
• Connect family to community systems
Adverse Childhood Experiences & Depression

Maternal, Infant, and Childhood Home Visiting Program

Figure 1: Number of Children and Parents Served (2012-2014)

Cumulative Home Visits: 1.41M
Cumulative Home Visits: 663,620

Maternal, Infant, and Childhood Home Visiting Program

Home Visiting Helps At-Risk Families Across the U.S.

HRSA supported Home Visiting Programs in every U.S. State, DC and five territories served 118,500 parents and children (from kindergarten entry) in 787 counties in FY 2014.

The Maternal, Infant, and Early Childhood Home Visiting Program, Partnering with Parents to Help Children Succeed (PDF - 139 KB)

Click a state or use the dropdown menu to see how its Home Visiting Program is working to improve family stability, child health and safety, and school readiness.

http://mchb.hrsa.gov/programs/homevisiting/
ASTHO Position Statement on State Home Visiting Programs

I. ASTHO Supports State Home Visiting Programs

The Association of State and Territorial Health Officials (ASTHO) supports state and territorial health agency leadership and collaboration in state home visiting programs, with the ultimate goal of promoting healthy child development and improving health outcomes for children, women, and families in the United States. Seventy-five percent of Maternal, Infant, and Early Childhood Home Visiting program grants must be used on models of care that are evidence based and cost effective. Decades of scientific research has shown home visiting improves child and family outcomes.

II. ASTHO Recommendations for State and Territorial Health Officials:

- Integrate state and local health agencies into a coordinated state home visiting program to promote family health and early childhood development.
- Create a home visiting system that addresses the full scope of services based on family and child needs.
- Create a comprehensive approach to family needs by integrating and coordinating maternal and child health (MCH) services and social and medical programs such as Special Needs Assistance Programs, Healthy Start, Title V, and others.
ASTHO Position Statement on State Home Visiting Programs: Recommendations for State & Territorial Health Officials

• *Ensure appropriate funding for the sustainability of state home visiting programs*
ASTHO Position Statement on State Home Visiting Programs: Recommendations for State & Territorial Health Officials

- Create a comprehensive approach to family needs by integrating and coordinating maternal and child health (MCH) services and social and medical programs such as Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Title X Family Planning, and services to children with special healthcare needs including early childhood systems activities, trauma-informed systems activities, and early learning agendas.
ADVANCING HEALTH EQUITY: PREVENTING ADVERSE CHILDHOOD EXPERIENCES

Jeanne Ayers
Assistant Commissioner, Minnesota Department of Health
Association of State and Territorial Health Officials
September 30, 2015
Public Health

“Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”

Institute of Medicine (1988), Future of Public Health
Why Do We Do Public Health Work?

Selected Agency Mission Statements

* Saving lives. Protecting people

* Protecting, maintaining and improving the health of all ___

* Protect, preserve, and promote the health and safety of the people

* Promote health and quality of life by preventing and controlling disease, injury, and disability

Institute of Medicine

Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.

How we reconcile these two frames of reference will shape the possibilities for what we can accomplish.
Public Health

“Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”

Institute of Medicine (1988), Future of Public Health
What is Health?
From WHO 1948 and Ottawa Charter for Health 1986

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the objective of living."
What is required for Children to Thrive?
Children Thrive in Thriving Families and Healthy Communities

Safe

Stable

Nurturing Relationships

Environments

Peace
Shelter
Education
Food
Income
Stable eco-system
Sustainable resources
Social justice and equity

World Health Organization
<http://www.who.int/hpr/archive/docs/ottawa.html>
What do Families need to Thrive?

• Job opportunities
• Fair Wages, scheduling, paid leave
• Transportation options
• The quality and affordability of housing and neighborhoods
• Affordable, healthy food supply
• Access to affordable, quality health care
• Quality of child care, public schools and opportunities for higher education
• Freedom from racism and discrimination
• Civic engagement and inclusion
• Availability of networks of social support
• Family Support
“Assuring Conditions” requires Seeing a Wider Set of Relationships

Health

Living Conditions
Social Determinants of Health

• The conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are shaped by a set of forces beyond the control of the individual: economics and the distribution of money, power, social policies, and politics at the global, national, state, and local levels.

• WHO and CDC (adapted)
“Assuring Conditions” requires Seeing a Wider Set of Relationships

- Health
- Capacity to Act
- Living Conditions

Diagram showing the relationship between health, capacity to act, and living conditions.
Structure our work to achieve our overall aim

Our theory of change incorporates an understanding of the importance of strengthening --capacity to act (power)

Strategic Action:
Identification of long-term aims and interests and the means of achieving them

Wikipedia 2014 definition
Essential Practices to Advance Health Equity

Purposefully expand the understanding and conversation of what creates health to include the “opportunity for health” (narrative)

Strengthen the capacity of communities to create their own healthy futures. Use public health tools: partnerships, engagement, convening ability, data, reports, education, policy, resources, legislation, “bully pulpit” (people)

Implement a “health in all policies” approach with health equity as the goal in program and policymaking (resources)
Triple Aim of Health Equity

- Implement Health in All Policies
  - Implement a Health in All Policies Approach With Health Equity as the Goal

- Expand Understanding of Health
  - Expand Our Understanding of What Creates Health

- Strengthen Community Capacity
  - Strengthen the Capacity of Communities to Create Their Own Healthy Future
Expand the Understanding of Health

Common Tools

DATA Collection—Reports—Analysis and Communication--Partners

• Race Ethnicity and Language Data Group
• Healthy MN 2020
  • Statewide Health Assessment
  • Statewide Health Improvement Framework
• Adverse Childhood Experiences—Data, Reports,
• Legislation and Report Advancing Health Equity in Minnesota
• Income and Health
• Paid Leave
• Employment and Diabetes
• Infant Mortality
• .............
'Public sentiment is everything. With public sentiment, nothing can fail; without it nothing can succeed. Consequently he who molds public sentiment, goes deeper than he who enacts statutes or pronounces decisions.

He makes statutes and decisions possible or impossible to be executed.”

Abraham Lincoln
Healthy Minnesota 2020: Statewide Health Assessment and Statewide Health Improvement Framework

Minnesota Department of Health and the Healthy Minnesota Partnership

http://www.health.state.mn.us/healthymnpartnership/hm2020/
Health in all policies with health equity as the goal

Themes
- Capitalize on the opportunity to influence health in early childhood
- Assure that the opportunity to be healthy is available everywhere and for everyone
- Strengthen communities to create their own healthy futures

Indicators
- Prenatal care
- Breastfeeding
- Food security
- On-time high school completion
- Per capita income
- Sense of safety
- Small business development
- Home ownership
- Incarceration justice

Outcomes
- Improved lifetime health
- Reduced health disparities
- More employment success
- Healthier relationships
- Stable, more cohesive communities
- Stronger, more stable families
- Better education outcomes

Social Determinants

Vision
- All people in Minnesota enjoy healthy lives and healthy communities
The MN ACE Report
TABLE 13: RATIO OF SES Indicators AMONG THOSE WITH 5 OR MORE ACES

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than High School Education</td>
<td>2.3</td>
</tr>
<tr>
<td>Never Married</td>
<td>2.2</td>
</tr>
<tr>
<td>Unemployed</td>
<td>2.5</td>
</tr>
<tr>
<td>Rent Not Own</td>
<td>2.7</td>
</tr>
<tr>
<td>Always Worried About Mortgage</td>
<td>4.0</td>
</tr>
<tr>
<td>Always Worried About Buying Food</td>
<td>5.6</td>
</tr>
</tbody>
</table>
## The MN ACE Report

### Table 5: ACEs by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Number of ACEs</th>
<th>5 or more ACEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>52%</td>
<td>4%</td>
</tr>
<tr>
<td>White</td>
<td>46%</td>
<td>7%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>35%</td>
<td>12%</td>
</tr>
<tr>
<td>African American Black</td>
<td>23%</td>
<td>19%</td>
</tr>
<tr>
<td>American Indian</td>
<td>22%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Due to rounding, the numbers may exceed 100%.
ACEs in Minnesota:
Minnesota Student Survey
ACE Score + Bullying Behavior

Experiencing or Exhibiting Bullying Behaviors in Past 30 Days, by ACE Score, 2013

\[\begin{array}{c|c|c|c|c|c|c}
\text{Experienced past 30 day bullying (victim)} & \text{Exhibited past 30 day bulling (bully)} \\
\hline
\text{ACE Score 0} & \text{ACE Score 1} & \text{ACE Score 2} & \text{ACE Score 3} & \text{ACE Score 4+} \\
37.3\% & 53.8\% & 64.7\% & 69.5\% & 77.2\% \\
21.3\% & 34.3\% & 42.5\% & 47.3\% & 55.8\% \\
\end{array}\]
ACEs in Minnesota: College Student Health Survey

2015 College Student Health Survey, Boynton Health Service, University of Minnesota

20 Minnesota Colleges and Universities

12,220 students completed survey
Children Thrive in the context of a Thriving Family and Healthy Community

Children need Safe, Stable, Nurturing Relationships and Environments
Expanding the Understanding
Assuring Conditions for Children to Thrive

• Challenges common mental models
• Short and long term approaches necessary
• Cumulative causes are leading to many effects (Syndemic=Simultaneous epidemics)
• Focus on building agency and partner capacity for system change
• Builds support for investments in prevention
• Necessary to act on multiple levels across many issue and policy arenas
Implement Health In All Policies-Equity

• Health in All Policies (HIAP) is a collaborative approach that integrates and articulates health considerations into policy making and programming across sectors, and at all levels, to improve the health of all communities and people.

• HIAP requires practitioners in all sectors to collaborate to define and achieve mutually beneficial goals.
Tools in Health in All Policies approach

• Data
• Reports
• White Papers
• Health Notes
• Health Impact Assessments
• Community Engagement--partners
• Asking Questions
Health in all Policies:
Questions to ask to advance health equity

✓ What do we know about who will benefit?
✓ What health impacts can we anticipate? Who will experience these impacts?
✓ What and whose values, beliefs and assumptions are guiding or influencing the decision?
✓ What do we know about impact(outcome) versus intent of the policy?
✓ Would the issue/policy benefit from further study or a health impact assessment(HIA)?
Health in All Policies

Work across policy arenas (health, transportation, education, housing, agriculture, safety, etc.)

- Cabinet-level Health in All Policies efforts
- Interagency Council to End Homelessness
- Minnesota Food Charter
- Statewide Health Improvement Program (SHIP)
  - Complete Streets-Safe Routes to School-Smoke-free campuses, housing-Farm to School-Community Gardens....
Policy and System Changes Related to Social Determinants of Health (selected)

• State Agency Policy Changes
  • Grants, RFP’s, hiring, procurement
  • Income-Minimum Wage
  • Paid Leave – Family and Sick
  • REL(D) data
  • Broadband connectivity
  • E-Health Policies
  • Ban the Box
  • Bullying—School Discipline policies

• State and Federal Transportation Policy
• Target Corporation Contracting Policy
• Governor’s Cabinet Council-HiAP
• Minnesota Food Charter
• Others – depending on the opportunities
  • Data
  • Community energy
  • Partnerships
White Paper: Income and Health

Life expectancy by median household income group of ZIP codes, Twin Cities 1998-2002

<table>
<thead>
<tr>
<th>Income Group</th>
<th>Life Expectancy in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $35,000</td>
<td>74.1</td>
</tr>
<tr>
<td>$35,000 to $44,999</td>
<td>77.3</td>
</tr>
<tr>
<td>$45,000 to $59,999</td>
<td>79.6</td>
</tr>
<tr>
<td>$60,000 to $74,999</td>
<td>80.7</td>
</tr>
<tr>
<td>$75,000 or more</td>
<td>82.5</td>
</tr>
</tbody>
</table>

Adults 18-64 reporting "fair" or "poor" health status by income, Minnesota 2011

<table>
<thead>
<tr>
<th>Income Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less $20,000</td>
<td>26.8</td>
</tr>
<tr>
<td>$20 to $34,999</td>
<td>14.9</td>
</tr>
<tr>
<td>$35 to $49,999</td>
<td>10.0</td>
</tr>
<tr>
<td>$50 to $79,999</td>
<td>6.4</td>
</tr>
<tr>
<td>$75,000 or more</td>
<td>3.1</td>
</tr>
<tr>
<td>DK - refused</td>
<td>11.7</td>
</tr>
</tbody>
</table>

Analyses were conducted by Wilder Research using 1998-2002 mortality data from the Minnesota Department of Health and data from the U.S. Census Bureau (population, median household income, and poverty rate by ZIP code).

Source: 2011 Behavioral Risk Factor Surveillance System
Minimum Wage

• “We all benefit from and have a role in creating healthier communities. It’s time for us to come together to implement a minimum wage that further enhances the health benefits of employment…It will be a great investment in the health of individuals, families, communities, and our state.”

• Ehlinger Commentary in MinnPost
Paid Leave Report: Those with lowest incomes least likely to have access to paid sick leave--MN
Strengthen Community Capacity

• Conduct an analysis of our own networks and those of our partners—are these relationships “fit to purpose?” Are they helping advance health equity?

• Clearly assess our skills and intentionally build our internal capacity—race, power, assets, differences, similarities

• Develop a set of guidelines/principles/practices regarding community engagement-convening—to help shift practice-(iterative and with partners)

• Tension and partnership work together.
How we “set the table” matters

Reevaluate roles with eye to building power for change

- (Agreements on roles, Technical Expert panel, Decision-makers, 1 Consultant, Convener/Organizer, physical setting….)

- Healthy Minnesota Partnership (Organize narrative, broaden relationships invest in alignment of partners)
  - Minimum Wage, Income and Health Report, Paid Sick and Family Leave, Pay Day Lending, Incarceration Justice: Ban the Box

- Advancing Health Equity in Minnesota Report (1000 people--Built our capacity to deepen authentic engagement with communities experiencing greatest health inequities
Overall Lessons

• Organic – must be interwoven with all other work-recognize it is iterative

• Must be intentional

• Commitment: Requires commitment to building our organizational and community capacity -- skills

• Leadership – Hold our selves and each other accountable-bring more people into decision-making

• Imperfect-incomplete work--navigating toward health equity -- permission to make course corrections
“Public health is the constant redefinition of the unacceptable”

Geoffrey Vickers

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Links to Referenced Reports

• The Health of Minnesota: Statewide Health Assessment:  
  http://www.health.state.mn.us/healthymnpartnership/sha/

• Healthy Minnesota 2020: Statewide Health Improvement Framework:  
  http://www.health.state.mn.us/healthymnpartnership/hm2020/#fw

• Advancing Health Equity: Report to the Legislature Report:  
  http://www.health.state.mn.us/divs/chs/healthequity/index.htm

• White Paper on Income and Health:  