Working Group on Child Health, Early Childhood, and Adverse Childhood Experiences

Giving Children the Best Opportunity for a Healthy Childhood: A Statement of Principles for Policies to Prevent and Mitigate Adverse Childhood Experiences

Introduction

Children across the U.S. live in poverty at much higher rates than in most other developed countries. They are exposed to poor living conditions, limited access to adequate nutrition and health care, child abuse and neglect, community violence, racism and other forms of discrimination, and other adverse circumstances that have the potential to affect their healthy development.

With over 17 percent of all U.S. children living in poverty (and higher rates for children of color), addressing factors that impact their healthy development is critical.

Adverse childhood experiences (ACEs), broadly defined, are traumatic experiences in childhood that can harm physical, social, cognitive, and emotional development. The original ACE study was conducted in two waves of data collection by Robert Anda and Vincent Felitti from 1995 to 1997. The study surveyed over 17,000 Kaiser Permanente HMO members about childhood exposure to 10 adverse experiences: emotional, physical or sexual abuse, mother treated violently, or living with household members who were substance abusers, depressed, mentally ill, suicidal or ever imprisoned, losing a parent to separation or divorce, exposure to emotional or physical neglect. Since then, the field of ACE research, policy, and practice has advanced considerably. Our understanding of adversity and conceptualization of ACEs has broadened beyond these initial familial indicators to include other adverse experiences such as exposure to racism, gender discrimination, economic hardship, neighborhood or community violence or losing a family member to deportation.

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Nearly half of U.S. children have at least one ACE, and 10 percent have experienced three or more, putting them at extremely high risk for negative health outcomes both in the short term and into adulthood. Data also suggest racial and ethnic disparities in the occurrence and experience of ACEs. Well over half (61 percent) of black children and 51 percent of Latino children experience one or more ACEs compared with 40 percent of white children. Data also suggest that LGBTQ and other marginalized populations may experience disproportionately higher incidence of ACEs and are more likely to lack supports, such as strong schools, that can help mitigate the impact of ACEs.

A focus on equity has brought to light conditions that generate and compound stressors and risk for exposure to early adversity including societal inequities in the allocation of resources, opportunities, and social and economic conditions (i.e., historical, community, and intergenerational processes) and structural inequities (such as race/ethnicity, class, sex, gender identity, and sexual orientation). Unfortunately, existing inequities deprive many children who are exposed to ACEs of access to the services and supports they need. This important area for action can help us identify root causes of trauma, strategies that can support children and families who experience compounding stressors, and promising efforts to improve systems and change community conditions so children and families can thrive.

It is important to recognize that exposure to ACEs does not directly (or necessarily) equate to poor outcomes. In fact, children and families are incredibly resilient and show a tremendous ability to thrive despite adversity. Many factors impact a child's developmental trajectory, health, and well-being, with key protective factors buffering the negative effects of early stress. Supportive early relationships and social connections, as well as access to concrete supports, are among the protective factors that can promote resilience for children and families.

Given this broader conceptualization of ACEs, an effective public policy–focused response requires a strategic, coordinated, multi-sector, and upstream prevention approach. No single system will be able to bend the curve on its own. Policies aimed at both preventing and addressing ACEs are strongest and most effective when they take a multi-systems approach that incentivizes collaboration among the systems that interact with children and families — including health, early childhood, education, child welfare, and judicial systems.

While it is important to work across service delivery systems, health insurance and health care delivery are indispensable tools. The health care system and its financing provide an opportunity to leverage significant resources to advance policies aimed at preventing, diagnosing, and managing ACEs; support families in raising healthy children; and promote child, family, and community resilience. Supporting children and helping families thrive requires policy solutions that focus on ensuring children's access to comprehensive health care coverage and to promising approaches that can prevent or reduce the negative health effects associated with ACEs.

The Working Group on Child Health, Early Childhood, and ACEs

The Working Group on Child Health, Early Childhood and ACEs is composed of cross-sector partners from organizations with deep expertise in child health, health system financing, early childhood, education, child welfare and juvenile justice, among others, who are working together to leverage our collective knowledge and experience to develop and advance a federal health policy agenda around ACEs prevention and mitigation.

While there are multiple pathways to policy change, this Working Group will address ACEs through health and health care financing policies, focusing on ensuring and improving access to health coverage, scaling preventive and early intervention services, and advancing improved provider payment models.

The Working Group on Child Health, Early Childhood, and ACEs represents an ongoing, collaborative effort to develop and advance federal policy solutions that prevent and mitigate ACEs, promote resilience, and support the healthy development of children. We are guided by nine principles:

1. ACEs are social determinants of health that impact children's early development and lifelong health and wellbeing and must be a significant focus of pediatric care. ACEs are widely prevalent, interrelated and intergenerational, and impact multiple domains of health and social functioning. The consequences of ACEs are significant and far reaching for children, families, and communities, including health, social, and economic costs.

2. All children deserve the opportunity to achieve their full potential, yet historic, systemic and structural inequities, including poverty, racism, diminished opportunities for employment, and limited access to nutrition and health care contribute to trauma for children and families of color, children with disabilities, immigrants, and LGBTQ populations, among others, and lead to disparities in the occurrence and experience of ACEs. Policy solutions must be designed to eliminate disparities and achieve equity, and have the ability to measure their impact to ensure all children and families have access to the services and supports they need to achieve optimal health. This is especially important for children of color and other marginalized

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populations who experience higher levels of ACEs and health disparities.

3. The data make clear that investments in preventing early adversity not only improve health outcomes for children and families; they are also cost-effective. Policies to prevent and mitigate ACEs must use a truly preventive upstream approach that explicitly aims to provide the supports children and families need to build on their inherent strengths and reduce the prevalence of ACEs, rather than focusing on deep-end and often costly interventions.

4. Preventing and mitigating ACEs requires a robust public health system response — but that's not enough. All child- and family-serving systems and sectors must be involved, and policy solutions to prevent and mitigate ACEs must use a cross-sector and collaborative approach to ensure children and families have the resources and supports they need to thrive. Families often navigate multiple systems, including health care, education, and child welfare with overlapping, duplicative, or contradictory requirements that can make it difficult to access all necessary supports. Policies must include coordination and integration across all systems that serve children and families to ensure the public programs and systems that children and families encounter are easy to access, well-resourced, aligned, responsive, culturally and linguistically appropriate, and trauma-informed to meet their unique needs.

5. Children, families, and communities are resilient, and policies should build on their inherent strengths. Together with strategies to prevent or mitigate the effects of ACEs and other negative environmental influences, policy solutions must focus on supporting families, fostering resilience, and strengthening the capabilities and resources of parents and caregivers in children's lives. They must also support the role of communities and the workforce in promoting young children's healthy development.

6. Policies and systems often re-traumatize children and families. To effectively prevent and mitigate ACEs, policies and systems must take a trauma-informed approach that fully integrates knowledge about trauma into policies, procedures, and practices and that actively resists re-traumatization. Policies and systems must focus on solutions that are child- and family-centered and that fully integrate knowledge about trauma and effective responses to prevent re-traumatizing children and families.

7. Given the significant impact of ACEs on long-term health outcomes for children, parents, and caregivers, policies must prioritize multi-generational and family-centered strategies that support families and promote a continuum of care.

8. To ensure policies are effective, impactful, and culturally and linguistically responsive, children, families, and communities most affected by childhood adversity -- including groups historically and currently excluded from decision-making processes that impact their health and life opportunities -- must be authentic partners in policy development, program design and implementation, and have the supports needed to engage.

9. Policies must be data-driven, show promise, be evidence-informed or evidence-based, and be culturally responsive. This will ensure they are effective at improving outcomes

for children and families and do not further harm communities that are more severely affected by childhood adversity but not equally reflected in the evidence base. To ensure that policies are data-driven and culturally responsive, data collection should be prioritized by policymakers and any data collected should be stratified by race, ethnicity, language, socioeconomic status, sex, gender identity, sexual orientation, disability, and other demographic factors, and reported and publicly available. Policymakers should focus on building the evidence base and addressing the limitations of existing data for specific populations and communities, to identify concerns and appropriate solutions that work for often overlooked and marginalized populations.

The members of the Child Health, Early Childhood, and ACEs Working Group listed below have signed on to these principles for policies to prevent and mitigate ACEs.

Asian Americans Advancing Justice | Los Angeles
Campaign for Trauma Informed Policy and Practice (CTIPP)
Center for Youth Wellness
Community Catalyst
Families USA
First Focus
Futures Without Violence
Healthy Schools Campaign
The Leadership Conference Education Fund
Mental Health America
National Crittenton
National Health Law Program
National Indian Health Board
National Partnership for Women and Families
The Building Community Resilience Collaborative at the Redstone Center
UnidosUS
Zero to Three

For more information about the Child Health, Early Childhood and ACEs Working Group, please contact Shadi Houshyar, Director of Early Childhood and Child Welfare Initiatives at Families USA at shoushyar@familiesusa.org.