



The Life-Time Health Effects of Adverse Childhood Experiences

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Today's Presentation

A. Review Current Knowledge/ACES Study

B. National and Connecticut Statistics

C. Proposed Solutions



Why is Clifford Beers Clinic interested in this Topic?



Child Traumatic Stress

Adverse Childhood Experiences

What is traumatic stress? The physical and emotional responses of a child to events that threaten the life or physical integrity of the child or of someone critically important to the child.

Acute trauma is a single traumatic event that is limited in time.

Chronic & complex trauma refers to the experience of multiple traumatic events & the impact to the child of these events. The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact;



Adverse Childhood Experience Study (ACES)

Collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Center for Disease Control and Prevention (CDC)

Decade long. 17,000 people involved.

Looked at effects of adverse childhood experiences over the lifespan.

Largest study ever done on this subject.

"The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease"

Lanius & Vermetten. 2009)



**Childhood experiences are
powerful determinants of who
we become as adults**

10 types of adverse childhood experiences:

- Sexual abuse
- Emotional abuse
- Emotional neglect
- Physical abuse
- Physical neglect
- Substance abuse in home
- Mental illness in home
- Incarceration of family member
- Parental separation or divorce
- Witness violence against mother



Individuals with 4 or more of the 10 ACEs are

- Nearly 2 times more likely to smoke cigarettes
- 4 ½ times more likely to engage in drug abuse
- 7 times more likely to suffer from chronic alcoholism
- 11 times more likely to abuse drugs via injection
- 19 times more likely to have attempted suicide
- More likely to have health problems that put them at risk of early mortality.



Findings:

- 1. Intractable public health problems were compensatory behaviors which were put in place as solutions to problems dating back to the earliest years**
- 2. That the original *problem* was hidden by time, by shame, by secrecy, and by social taboos against exploring certain areas of life experience.**
- 3. Traumatic life experiences during childhood and adolescence were far more common than generally recognized**
- 4. The traumatic experiences were complexly interrelated, and associated decades later in a strong and proportionate manner to outcomes important to medical practice, public health, and the social fabric of the nation.**



Adverse Childhood Experiences

- Abuse and Neglect (e.g., psychological, physical, sexual)
- Household Dysfunction (e.g., domestic violence, substance abuse, mental illness)



Impact on Child Development

- Neurobiologic Effects (e.g., brain abnormalities, stress hormone dysregulation)
- Psychosocial Effects (e.g., poor attachment, poor socialization, poor self-efficacy)
- Health Risk Behaviors (e.g., smoking, obesity, substance abuse, promiscuity)



Long-Term Consequences

Disease and Disability

- Major Depression, Suicide, PTSD
- Drug and Alcohol Abuse
- Heart Disease
- Cancer
- Chronic Lung Disease
- Sexually Transmitted Diseases
- Intergenerational transmission of abuse

Social Problems

- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- High utilization of health and social services



“Dose-Effect” Responses for Number of Traumas in Children

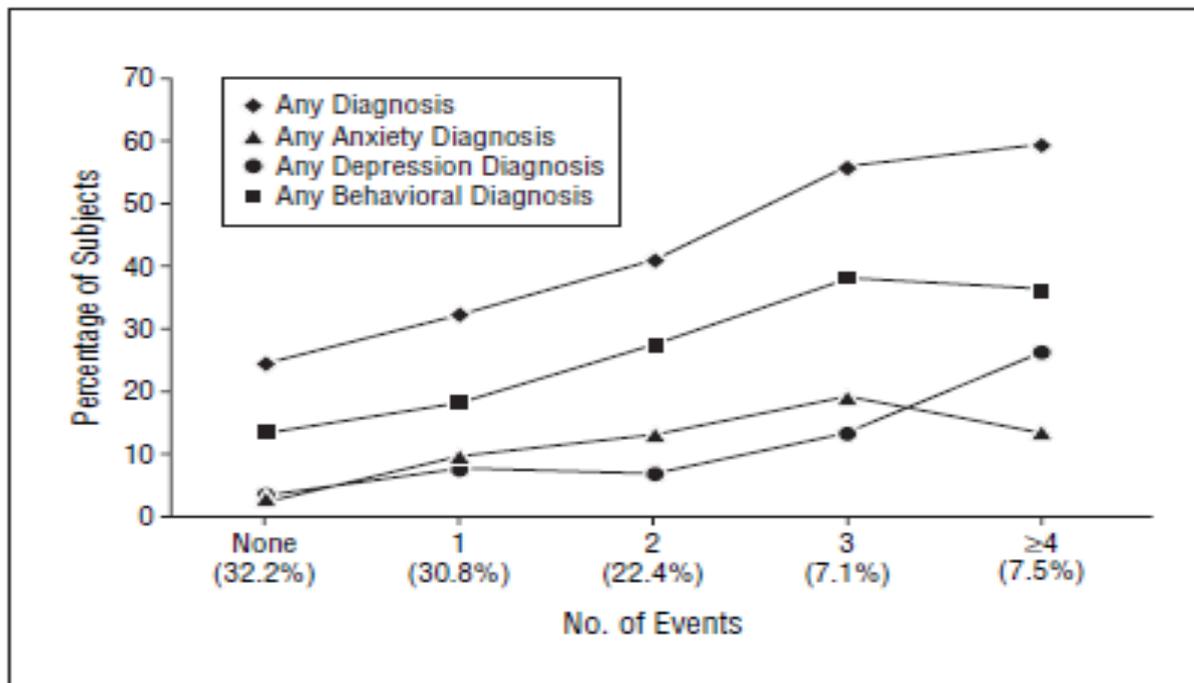
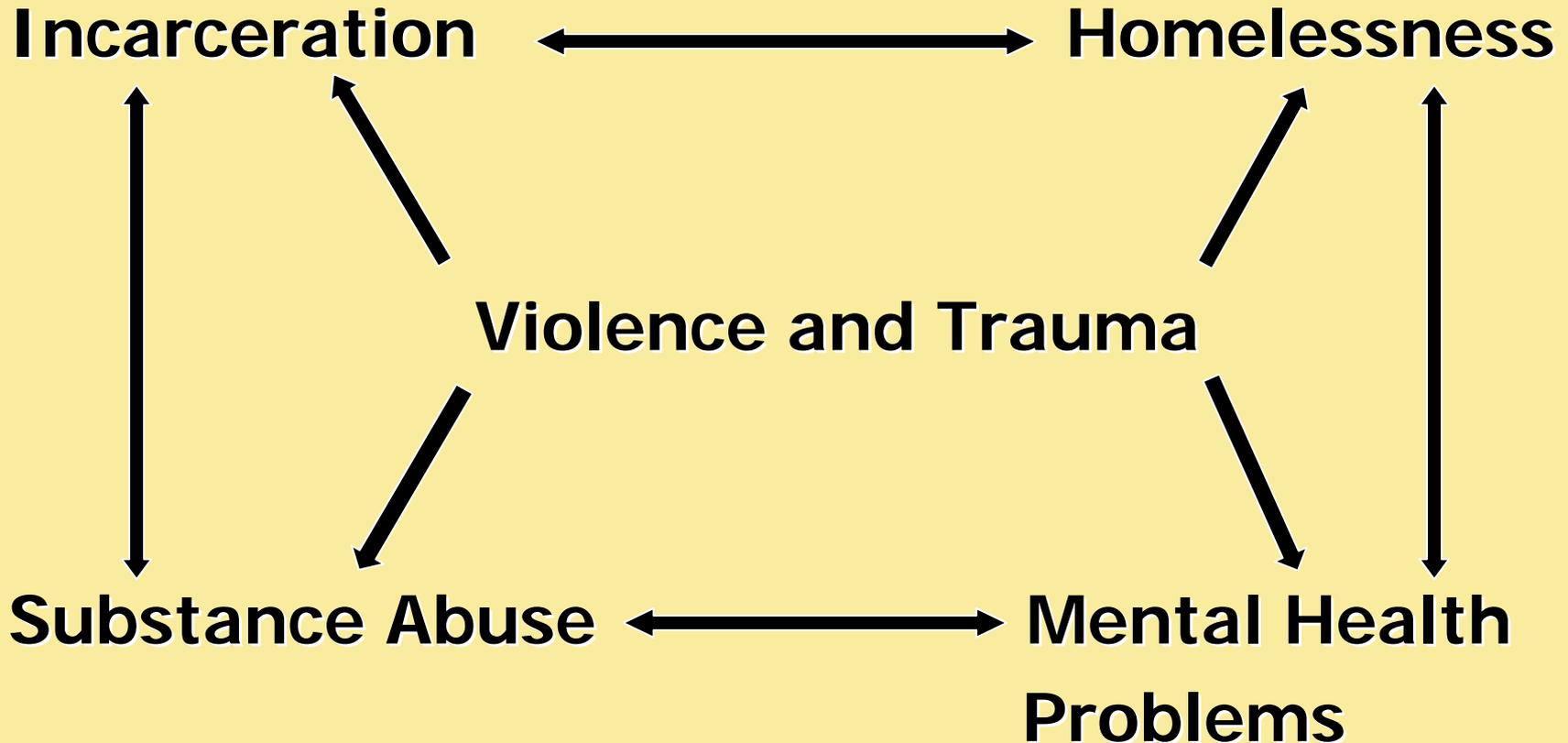


Figure. Effect of increasing trauma exposures on cumulative rates of psychiatric diagnoses by age 16 years.

Copeland et al., Archives of Gen Psychiatry 2007, 64:577-584



A Repetitive Cycle of Risk



National And Connecticut Statistics of Adverse Childhood Experiences



What we know-National Statistics

- A report of child abuse is made every ten seconds.
- 1 in 4 girls and 1 in 6 boys will have experienced an episode of sexual abuse by age 18. (CDC, 2005).
- 90% of public mental health clients have been exposed to trauma (Mueser et. al., 2004)
- 75% of people in drug rehabilitation centers report abuse and trauma histories (SAMHSA/CSAT, 2000)



What we know-National Statistics

- One-third of abused and neglected children may later abuse their own children. (Prevent Child Abuse, New York, 2001)
- About 80% of 21 year old that were abused as children met criteria for at least one psychological disorder. (Al-Qaisy, 2007)
- Estimated cost of child abuse and neglect in the U.S. for 2007 is \$104 billion. (Wang and Holton, 2007)



What we know: CT Statistics

- National rate of victimization is 9.5 victims of 1000 youth; CT has 11.0 victims per 1000 youth (Child Maltreatment 2008)
- CDC Connecticut survey data indicate youth report:
 - physical abuse from boyfriend/girlfriend (9.8%);
 - physically forced to have sexual intercourse (7.4%);
 - verbal or emotional abuse (17.4%) (2009 Youth Risk Behavior Survey)



What we know: CT Statistics

- 60-80% of children being served by Outpatient Clinics screen positive for trauma exposure
(CHDI, TF-CBT Learning Collaborative 2010)
- 70% of Clifford Beers Clinic Outpatient clients report at least 1 trauma, *with an average of 3 traumatic experiences.* (Clifford Beers Statistics)
- Up to 80% of children in juvenile justice system screen positive for trauma exposure
(CHDI, TF-CBT Learning Collaborative 2010)



What we know:

- There is pervasive long term impact of trauma
- A large percentage of adults and children in our human service systems have experienced trauma at some point in their lives.
- Traditional human service systems (mental Health, Education, Justice) largely overlook the ways in which trauma is a central experience of the symptoms that are presented and fail to incorporate trauma knowledge in existing explanations of and responses to these problems.

Suggested Solutions

Value driven, quality healthcare
addressing this
public health epidemic.



Develop a Trauma-Informed Human Service System

- An appreciation for the high prevalence of traumatic experiences in persons who receive services
- A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual
- Designed to minimize re-victimization and validates the survivors' life experiences
- Understands that many problem behaviors originate as understandable attempts to cope with abusive experiences



How is Trauma-informed care Value Driven?

- Prevention and early intervention are the foundation of cost efficiency
- Promotes data collection through assessment and tracking
- Use of evidence-based/best practice models
- Creation of interdisciplinary health teams
- Patient centered, client driven that facilitates choice, control, and participation



Trauma Informed Care Cost Savings

- Estimated Direct costs (social services, health and mental health costs, community costs):
\$17,000 per year (1999 Dollars)
\$850,000 (Over 50 years)
- Estimated Indirect costs (juvenile justice, criminal justice, special education):
\$40,000 per year (1999 dollars)
\$2,007,150 (Over 50 years)
- Opportunity costs (lifetime income lost, lifetime Federal and state tax payments lost):
\$5,998,216
(Conrad, 2006)
- Outpatient trauma evidence based psychotherapy approximately
\$5,000 for 22 sessions (average) (cost of Direct Service and Support/Supervision)



National Activities

■ National Child Traumatic Stress Network

DELAWARE

- Clinicians trained in (TF-CBT).
- Non-clinical staff receive informed training.
- Annual conference on child traumatic stress

OHIO

- Public awareness/education activities
- Cross-system training
- Trauma-informed prevention, screening, early intervention, and treatment strategies.
- Web-based resources.
- Data systems to identify trauma victims.



Trauma Informed Systems Already in place in Connecticut:

To name a few:

- Three National Child Traumatic Stress Sites: Yale, UCONN, Clifford Beers Clinic
- TARGET- NCTSN Northeast collaborative
- Trauma assessment for JJ youth
- DCF Child Welfare Trauma Training Initiative
- Healing the Generations Conference (over 50 presenters from CT a year) sponsored by Clifford Beers Clinic and Mashantucket Pequot Tribal Nation
- Trauma Focused –Cognitive Behavioral Therapy (TF-CBT) Learning Collaborative (LC) sponsored by DCF at the Center for Effective Practice at Children's Health and Development Institute (CHDI)



Learning Collaborative

(based on the Institute of Healthcare Model for Improvement)

Cost Efficient

**Promotes Quality and
Uniformity of Care**

Evidence Based Practice

Data Collection and Analysis

**Creates a collaborative trauma informed
system of care**



Children who complete TF-CBT in LC 2007-2010

- **43%** reduction in child-reported PTSD symptoms
- **52%** reduction in child-reported depression symptoms
- Consistent **high caregiver satisfaction** with treatment

****79%** reduction in PTSD Diagnosis**

Source: Bob Franks, Ph.D., Connecticut Center for Effective Practice, Child Health & Development Institute



Next Steps:

- Understand and communicate the impacts of trauma on health and mental health
- Eliminate Disparities among trauma, mental health, and social services. (linguistic access and cultural competence).
- Make early screening for trauma, assessment of impact of trauma, and referral for integrated trauma services common practice
- School based interventions; Child welfare training and awareness; Juvenile Justice trauma interventions in facilities; Higher Education training: all counseling and MH programs include Trauma Training



Childhood Trauma is a Public Health Epidemic

- Single greatest preventable cause of mental illness and drug and alcohol abuse
- Significant contributor to leading causes of death (heart disease, cancer, stroke, diabetes, suicide, HIV)
- Early Intervention and Evidence Based practices work
- CT has enormous resources and success already; in this time of economic crisis, lets build on success.

(Those researchers who call Trauma a Public Health Epidemic: van der Kolk, 2005; Harris, Putnam, & Fairbank, 2005; Sharfstein, 2006).



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