

# Equity and Adverse Childhood Experience Screenings

*– An ACEs Aware Practice Paper*



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*Prepared by: Children's Cause Orange County on behalf of Early Childhood OC*

*With participating content experts:*

Dr. Miguel Gallardo

Dr. Karen Hill

Dr. Marta M. Shinn

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### **APPENDICES**

- A. Early Childhood Policy Framework
- B. Early Childhood OC Equity Statement

## About ACEs

The term Adverse Childhood Experiences (ACEs) comes from the landmark 1998 study conducted among more than 17,000 adult patients by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente. ACEs are potentially traumatic events that occur in childhood (up to age 18). Though often used colloquially to refer to a variety of adversities in childhood, when capitalized, the term ACEs specifically refers to 10 categories of adversities in three domains – abuse, neglect, and household challenges:

Abuse—physical, emotional, and sexual abuse

Neglect—physical and emotional neglect

Household challenges—growing up in a household with incarceration, mental illness, substance dependence, absence due to parental separation or divorce, or intimate partner violence

ACEs are highly prevalent. In California, 62% of California adults have experienced at least one ACE and 16% have experienced four or more ACEs (CDPH/IVPB, 2017). ACEs affect all communities. They cross ethnic, socioeconomic, gender, and geographic lines. However, some populations are disproportionately affected.

It is now known that one important way in which ACEs increase risk of poor physical, mental, and behavioral health is through prolonged activation of the biological stress response and associated changes to brain development as well as long-term disruptions of immune and hormonal systems and genetic regulatory mechanisms. These long-term changes are known as the toxic stress response.

Repeated or prolonged activation of a child’s stress response, without the buffering of trusted, nurturing caregivers and safe, stable environments, leads to long-term changes in the structure and functioning of the developing brain, metabolic, immune, and neuroendocrine responses, and even the way DNA is read and transcribed. Development of the toxic stress response is influenced by a combination of cumulative adversity, buffering or protective factors, and predisposing vulnerability (Bhushan D, 2020).

ACE-Associated Health Conditions (AAHCs) are supported by empirical evidence showing the connection between ACE exposure and the health outcome. Many physical and mental health conditions have been shown to be AAHCs, including 9 of the 10 leading causes of death in the

United States (heart disease, cancer, unintentional injury, chronic lower respiratory disease, stroke, Alzheimer’s disease or dementia, diabetes, kidney disease, and suicide) (Hughes K., 2017) (Petruccelli K, 2019) (Center for Youth Wellness, 2014) (Merrick MT, 2019) (Waehrer, 2017).

A recent study estimated the total annual cost of ACEs in California to be \$112.5 billion, including \$10.5 billion in personal health care spending and, \$102 billion in years of productive life lost due to early death and disability. These cost estimates include only the ACE-attributable costs associated with eight of the ACE-Associated Health Conditions which are some of the most common and serious conditions associated with ACEs – cardiovascular disease, asthma, arthritis, depression, chronic obstructive pulmonary disease, obesity, smoking, and heavy drinking. The study included only these 8 ACE-Associated Health Conditions – the cost would likely be much greater if all ACE-Associated Health Conditions were included (Miller TR, 2020).

## About ACEs Aware

The Office of the California Surgeon General and the California Department of Health Care Services are leading a first-in-the-nation statewide effort to screen children and adults for ACEs in primary care, and to treat the impacts of toxic stress using evidence-based strategies for mitigating toxic stress. The ACEs Aware initiative is built on the consensus of scientific evidence demonstrating that early detection and evidence-based intervention improve outcomes. The bold goal of this initiative is to reduce ACEs and toxic stress by half in one generation, and to launch a national movement to ensure everyone is ACEs Aware. For more information, visit [www.ACEsAware.org](http://www.ACEsAware.org).

## Practice Paper Summary

Early Childhood OC collaborated with the Multi-Ethnic Collaborative of Community Agencies (MECCA) and Children’s Cause Orange County to develop an understanding of the perspective of community providers who are, and will be, implementing the Adverse Childhood Experience Questionnaire for Adults and Pediatric ACEs and Related Life-events Screener (PEARLS) ACE screening tools. Additional insight was provided by content experts selected by the project with a depth of knowledge related to the intersectionality between ACE screenings and structural racism.

Five provider conversations were implemented by MECCA and five by Early Childhood OC with the intent of receiving direct community provider input on key questions and areas of interest related to addressing equity through the implementation of ACE screenings. These sessions

started on October 16, 2020 and ended on June 18, 2021. For MECCA, advancing antiracism and ending structural racism are key features of its approach to integrated health, mental health, and social service delivery. For Early Childhood OC, its connection to equity is through its mission of advancing the Orange County Early Childhood Policy Framework (see Attachment A).

The MECCA provider conversations included speakers who presented to participants, asked questions, and made comments. Speakers for the community conversations included Dr. Erlanger 'Earl' Turner, Dr. Mario San Bartolome, Ellen Ahn, Dr. Suzie Matsuda, and Dr. Maryam Sayyedi. The speakers and the conversation participants provided extensive information on the challenges faced by providers of color and the needs of Black, Indigenous, People of Color (BIPOC) community members that have experienced ACEs.

Provider conversations implemented by Early Childhood OC focused on early childhood and the implementation of ACE screenings. Participants were asked questions on provider awareness of ACEs and recommendations regarding the implementation of ACE screenings for young children. These conversations confirmed the importance of addressing social determinants of health at the earliest age possible to address racial disparities and begin to change the impact of structural racism.

Interviews of content experts also took place to provide in depth feedback on topics raised through the paper questions and during the provider conversations. The interviewees included Dr. Miguel Gallardo, Dr. Karen Hill, and Dr. Marta M. Shinn. Each had unique observations that contributed to the paper's content and there were also common themes among them.

Based on the information collected from these efforts as well as input from partner organizations, a set of findings and insights was compiled along with a corresponding set of recommendations. The recommendations to ACEs Aware stakeholders are intended to provide opportunities to enhance the existing [ACEs Aware Trauma-Informed Network of Care Roadmap](#), addressing equity and diminishing structural racism through the ACEs Aware screen, treat, and heal process.

## Key Questions and Areas of Interest

This paper examines answers to the following questions to gain a better understanding of the opportunities and challenges for addressing equity through the implementation of ACE screenings:

1. Does stigmatization and re-traumatization of individuals and communities occur when ACE screening results are collected and disseminated? What culturally responsive practices are being used to mitigate this?
2. What unique barriers do professionals of color face in implementing ACE screenings and being able to provide sufficient support for treatment? How is self-care addressed?
3. How well do clinicians that have no experience of discrimination themselves provide appropriate treatment plans for those who have? How can this be improved?
4. Are people of color able to participate in meaningful decision making for ACE health systems and networks of care?
5. Do sufficient mental health support and buffering services exist for young children identified with ACEs?
6. Are there logistical barriers unique to community-based providers, especially those focused on specific racial and ethnic communities?
7. How are young children further impacted by these barriers?
8. Are concerns about stigmatizing and re-traumatization primarily expressed by providers rather than the patients they are treating?



MANY PEDIATRICIANS EXPRESS CONCERNS ABOUT BEING ABLE TO RESPOND TO A “HIGH ACE SCORE”

## Answering the Questions and Informing Areas of Interest

The project collaborative of organizations answering questions and informing areas of interest related to equity and ACEs decided that it was important to hear directly from community providers. This decision was driven primarily based on a previously expressed perception by several providers that there was a potential gap between the expectations of implementing Medi-Cal funded ACE screenings in California and the needs of specific ethnic groups. Additionally, several providers felt that there was a lack of understanding of challenges faced by under resourced providers that are focused on supporting disproportionately underserved communities. The collaborative, having seen the benefits of participatory action approaches in empowering community members, anticipated that this would also be helpful for providers that felt disenfranchised from the decisions that were impacting them. Because of this, various models were explored, including Community-Based Participatory Research (PolicyLink & The University of California, Berkeley School of Public Health, 2012), to identify features in the community input sessions that would encourage community providers to actively participate rather than relying solely on the project's content experts to answer key questions.

In addition to the primary emphasis on community provider input, the project's content experts were selected based on their extensive experience in ACEs as well as their involvement in initiatives that increase equity and address racism. A common element among them was their ability to understand the limitations of the medical model in addressing trauma despite their extensive clinical credentials.

Finally, based on feedback from several providers who expressed fears about stigmatizing or causing harm to children and families through the act of conducting an ACE screen, Children's Cause OC conducted a literature review of research articles for studies that examined the occurrence of traumatic stress or other negative consequences associated with asking ACE questions or administering an ACE screening tool.



## Community Input

### **Multi-Ethnic Collaborative of Community Agencies (MECCA) Provider Conversations**

MECCA facilitated Community Provider Conversations with ethnic community focused providers. These series were designed to be complementary to the ACEs Aware webinars, extending the reach and content for targeted providers. The content developed for the series was focused on ACE screening and treatment challenges related to young children and/or patients with cultural and linguistic barriers. The series was implemented over a period of at least nine months, totaling five sessions on topics including: 1) Racial, Ethnic and Class Implications of ACEs; 2) The Intersection of ACEs, Culture, and Substance Use; 3) Cultural Perspectives on Mental Health and ACEs; 4) Cultural Considerations in Parenting Practices and ACEs; and 5) Cultivating a Culturally Trauma Informed Approach.

Due to the COVID-19 pandemic, sessions were conducted online using the Zoom platform. Outreach activities were targeted to providers, but the sessions were open to all community participants. Discussions helped to inform the practice paper on the racial and ethnic implications and perspectives in the screening and treatment of toxic stress related to ACEs.

The following input was provided by session participants in response to practice paper questions:

#### ***Racial, Ethnic, and Class Implications of ACEs***

It was pointed out that members of marginalized communities lack resources to change their environments or move to other communities. This limits opportunities to “cope with and navigate” ACEs. Therapists indicated a need to be “more intentional about thinking about context,” which includes exploring for individuals and families what other social supports and resources are needed to build resilience in response to the impact of toxic stress. Addressing equity for these populations includes improving social determinants of health such as housing, income, and educational opportunities.

One participant reflected that it’s important to not “make assumptions about a child’s ability to be successful or to pass a test when we really don’t think about the context of what they may be potentially experiencing in their day-to-day lives.”

To fully treat patients and support healing beyond what has traditionally been done, clinicians expressed that it was important to explore how people view their experience through ethnicity and race, but also gender identity, sexual orientation, or other forms of identity “that impact in

terms of systems and how they are functioning.” These forms of identity can either be “a protective factor for them or a factor that might cause...more distress or difficulties.”

It was reflected that as “providers, we are in a position to uplift people and so we should be able to hear their stories and honor their experiences because obviously we weren’t there when the situation happened.”

Finally, the following comments were shared in the session:

*I think it's also important to have these conversations because we do know from research in terms of racial and ethnic socialization when you do prepare children to navigate these experiences, and not just sort of talk about it, but have that awareness about how do you cope with it, how do you respond if someone behaves towards you in this type of way, that does help them to be more resilient and recover from those experiences.*

*It's important for people to keep in mind that assessments are not always welcomed or understood the same way that other communities or backgrounds do.*

*I believe our professional community needs to become more introspective and more sensitive and become more aware of their own humanity, their own experiences, their own traumas and how they managed it and understand that not everybody is able to do that.*

*Understanding ourselves and becoming aware of our own vulnerabilities and how we have managed or how we have been avoiding some of those vulnerabilities, it helps us as professionals to be more responsive to not rush towards labeling, not rush towards pathologizing social problems.*

### ***The Intersection of ACEs, Culture, and Substance Use***

During the one session that was dedicated to the intersection with substance use disorders (SUDs), input was provided that the “language of substance use disorder is different amongst cultures, so you can’t have a cookie cutter approach in the ACEs world.” This is significant because many patients with SUD have an ACE as a main factor in why it developed and addressing this requires cultural understanding and communication.

During this session, it was observed that:

*Those of us that will be implementing ACE screenings and looking at ACEs have to take that critical lens, and, say what are some of the common ACEs that affect communities of color and it has to be teased down between African American, Latinx, and Asian communities to really properly have ACE work.*

The group felt it was important to recognize “that the actual research in communities of color around ACEs is very slim” and that evidence-based practices to treat and heal a patient with ACEs are not evidence-based for all communities.

In general, it was expressed that when “it comes to communities of color, locally, we have a lot of homework to do to expand the infrastructure of services to really start addressing the patients and clients coming through our door.”

Finally:

*We have to be prepared for when we do get four ACEs and they also have a medical condition, and so that's why I'm talking about what we can still do in regard to primary care, when you've identified that and you're looking at those algorithms, it's still part of your intervention.”*

*I think there's also a psychoeducational piece around helping people understand how these life experiences and these childhood experiences can detrimentally affect one's process, one's overall health to a certain degree.*

### **Cultural Perspectives on Mental Health and ACEs**

In response to how race, ethnicity, and class play a role in impacting a person's mental health, a discussion participant responded that:

*I think race, ethnicity, and class are certainly some of those more salient ones depending on our life experiences and what not, so I do think they have an impact. Obviously, that's going to vary from individual to individual and family to family, but I certainly believe those can have a direct correlation and connection.*

Participants indicated an interest in increasing the consideration of social determinants of health such as “housing, their employment issues...their support system” and “the neighborhoods where they live.” Also, that it was important to consider the strengths of the individual but also the resources that they might need.

Finally, one participant observed that:

*In our field, seeing people we need to look at all those things. In an integrated care system with the health information, you can actually see the medications and other physical conditions in addition to mental health conditions. I would love to see other social determinants like housing, their employment issues, their support system, the neighborhoods where they live, it gives us a more diverse picture.*

### ***Cultural Considerations in Parenting Practices and ACEs***

Recent immigration was cited as an important consideration to contextualize the intersection between parenting practices and ACEs. To expand on this further, one participant relayed that:

*Dr. Cruz was mentioning earlier around just sort of acculturation experiences, immigration histories, you know all those kinds of things and then how we make sense of things maybe how we talk about things.*

In working with parents of children with ACEs, one therapist stated that “I tell parents all the time, doesn’t matter how many years or how many degrees I have, you are the expert when it comes to your child, don’t let anybody tell you differently.”

“A lot of time parents, because they sacrificed so much, were forcing what we want. We hear all the time the kids say, “Are you living your dream through me mom?”

“I hope to inspire some folks if there are people in the audience you know really understand what your kids want to do because you’re not living your life through them.”

### ***Cultivating a Culturally Trauma Informed Approach***

The discussion in this session started with the observation that:

*In understanding the culture and the background, and how you need to go about asking these with a great deal of sensitivity, and perhaps before anything else making sure that the person who is participating in this process understands what this is for.*

Regarding ACE screenings, the belief was shared that any “type of questioning...actually creates anxiety” but that “people are quite open to responds to some of these questions.”

It was further expressed that “it’s really important to sort of not limit our understanding of anyone to a number but, especially when it comes to evaluation of people of different backgrounds and culture.”

A mechanism for gaining trust of a patient was contextualized in terms of organizational familiarity: “So after they know about the organization, they know the case manager, they know the therapist, they receive some services so that they know were coming from a good place and we want to help them.”

## Early Childhood OC Provider Conversations

Five pediatric and early childhood provider conversations were implemented by Early Childhood OC on the following dates:

September 18, 2020  
November 20, 2020  
January 15, 2021  
March 19, 2021  
May 21, 2021

These sessions included 193 participants representing the following specialties:

Licensed Medical Professionals	26
Licensed Mental Health Professionals	24
Family Navigator/Family Support	34
Early Care and Education Provider	60
Support Staff	11
Mental Health Consultant	13
Family or Community Member	5
Case Manager/Case Worker	20

To facilitate the discussion, participants were asked to answer the following questions:

1. What physical symptoms of toxic stress/historical trauma have you encountered in the children you serve?
2. What practices do you currently implement in treating children with ACEs?
  - a. Use ACE screening as a Vital Sign
  - b. Trauma Informed Practices
  - c. Patient Education
  - d. Connect to services to build resilient families
3. What barriers do you face, or do you anticipate facing, in screening children/families for Adverse Childhood Experiences?
4. What are your next steps to support children with Adverse Childhood Experiences?

Results were documented and organized under the following topics:

***Common physical symptoms providers are seeing in young children***

GI issues; aggression; challenging behaviors; sleep issues; bed wetting; impulsivity; asthma, eczema, allergies; poor weight gain; obesity; hair loss; withdrawal; inability to focus.

## ***Current Practices in Treating Children with ACEs***

### Use of ACE Screening Tool

- Very few providers using tool (at time of discussions)

### Trauma Informed Practices

- Spending time listening to patient stress load and validating
- Responding to behavior with understanding of their past
- Assess patient readiness to learn about resilience using motivational interviewing
- Connecting to a care manager
- Listening
- All staff trained in TIC
- Building a trusting relationship

### Patient Education on Protective Factors

- Education on toxic stress and the stress response
- Education on resources
- Education on Protective Factors
- Teaching social skills

### Connecting to Services

- Using community services to refer families
- Warm hand-off to Help Me Grow
- Parental mentorship through wraparound program including parent mentoring
- Mentoring
- Use Family Resilience Questionnaire to determine resources and referrals
- Screening questions to determine community resources and referrals

## ***Barriers to Screening, Treatment, and Healing***

- Fear of parents taking blame
- Lack of staff to implement/lack of funding
- Time constraints with patients
- Parents' lack of buy in
- Patients being too scared to talk about what they have been through
- Patient/parent feeling judged
- Lack of training for staff
- Secondary trauma



- Fear of parents seeing this an alarm bell of their child feeling doomed
- Lack of concrete services to refer families to

### ***Next Steps for Providers***

- Train and share information with entire staff
- Have resources available and handy
- Incorporate PEARLS into family practice
- Share learnings of TI practices with support staff
- Train staff on ACE screenings
- Counsel parents and bring awareness
- Parent education on development of the child
- Include more social and emotional work with children
- Serve the 'whole child' by including family in education and training

### ***Overarching Themes***

- Training the entire staff, not just the direct service provider, on ACEs is essential
- Training the person who is giving the PEARLS or Adverse Childhood Experience Questionnaire for Adults on how to approach the parent
- More education on toxic stress and the stress response and its effect on the health and wellbeing in general
- Knowing the why behind giving the PEARLS. Is it always beneficial? Is there a different approach? Do we need to know a specific number or is it ok to know there has been toxic stress?
- Knowing a number does not give you all the information. We need to consider the length of time, the intensity, the age of the child to understand the impact.
- Funding – so providers can adequately train staff on the complexities
- More emphasis on wholistic treatment for young children, rather than clinical treatment

## Content Experts

Interviews were conducted with three content experts on the intersection between ACE screenings and structural racism. From these conversations, common themes emerged, and each also contributed a unique perspective.

### **Dr. Miguel Gallardo**

Dr. Gallardo is a Professor of Psychology and Director of Aliento, The Center for Latina/o Communities at Pepperdine University. He is a licensed clinical psychologist and maintains an independent/consultation practice at the Neurobehavioral Clinical and Counseling Center where he conducts therapy, forensic/legal psychological, and neuropsychological screening assessments, and consults with organizations and universities on developing culturally responsive systems. He teaches courses on multicultural and social justice, advocacy, and professional practice issues.

Dr. Gallardo's areas of scholarship and research interests include understanding the psychotherapy process when working with ethnocultural communities, particularly Latinx communities and in understanding the processes by which individuals develop cultural awareness and humility. Dr. Gallardo has published refereed journal articles, books, and book chapters in the areas of multicultural psychology, Latinx psychology, ethics and evidence-based practices, cultural humility, and racial colorblindness. He is currently a Series Editor for Cognella Academic Press' Advances in Culture, Race, and Ethnicity book series. Dr. Gallardo also regularly discusses issues relevant to understanding how we can develop stronger relationships with one another on his Cultural Humility podcast.

Dr. Gallardo is currently Director of Research and Evaluation for MECCA, a non-profit organization dedicated to serving monolingual Arab, Farsi, Korean, Vietnamese, Cambodian and Spanish speaking communities. He also served a 6-year Governor appointed licensed member of the California Board of Psychology and is currently serving a 5-year appointment on the Clergy Misconduct Oversight Board for the Roman Catholic Archdiocese of Los Angeles. Dr. Gallardo is a Fellow of the American Psychological Association.

### ***Interview Comments (Organized by Topic)***

#### **Preparedness of Providers**

Providers need to conceptualize trauma within the context of societal factors, considering the impact of ethnicity and race, not just clinical factors. This includes deeply understanding the circumstances and identity for each individual.

Are our systems ready to do this work? And I think in all honesty, that the systems weren't ready before so they're still not necessarily ready. I think unconscious implicit biases, that you know, really have a lot to do with types of ways our community members are treated in the system. There's a lot of factual, hard data that supports that.

It's not as simple as saying "here's this tool. You need to implement it". I think there also needs to be this systematic effort to help people get, even assess how they are entering into this effort. They are entering systems that were not made for us, and it's out of the perspective system that wasn't originally designed or created to really cater to our needs.

They are encountering biases and even just through actions, you know, poor access to services, quite often there is absolutely a definite need for some support. Providers have good intentions but that's not sufficient.

I think one of the easiest places to start is by training people on, working with helping diverse communities, working on implicit biases, while were simultaneously talking about ACE and PEARLS screenings that need to happen.

Addressing ACEs can be the starting point for breaking down barriers between people that ultimately, what contributes to trauma is the "otherness" and separation, one group empowered versus another group and that systems respond and build around those differences.

### Diversity, Equity, and Inclusion

We just want to make sure that we're always centered, that the systems need sort of its own DEI assessments. Where are we in terms of this? What do we need to do to make ourselves accessible and sustain that accessibility along the way? I think like all good things, if not done well and not really taking into consideration the voices of community members who are the most affected, there's going to be some mismatch, some casualties, some challenges, some diversions. So, I think we need to really understand that our systems must change. And the people who are being affected need to be a part of the conversation along the way. If there not, it's like looking at health disparities.

They are entering systems that were not made for us, and it's out of the perspective system that wasn't originally designed or created to cater to our needs. And then they are encountering biases and even just through actions, you know, poor access to services, quite often there is absolutely a definite need for some support. It's not about the unconscious biases and the implicit biases that certainly the systems themselves need to be challenged because we know, we've known for a long time, that through well intention providers, whether its medical or mental health.

I do think that we, community members, don't have a sense of feeling safe or trustworthy in entering those systems.

## BIPOC Leadership Development

The culture of the next generation is really, I think bold and really unafraid in so many ways. So, I think all that is necessary, it's needed. So, I would say that boldness, pushing the envelope is good and healthy for us and needs to happen. And simultaneously that scares people. It scares the people who have already been in the system and it makes them nervous. It makes them uneasy.

How can we make them entertain the perspective, the experiences the ideas they have while making, while finding ways, it's not going to change overnight. We are going to have people maintain their integrity in which other people may not be on that same page.

Cultural diversity trainings, CCAT assessments, culturally and inclusively accessible, or there's no ending for center for you or where you want to be and where is your system going to be.

## Societal Context

I think we have this idea of humility but are getting further and further from it. The good of others, it's more about taking the anger and hate and exploiting it for your own acquisition of power and exploiting it, the hatred. And we have technology now, that, the more we're learning about it. You know the algorithms and the social media that instantly put people together of the same people and wrap it up. All kinds of factors that create that classic environment. It does become quite challenging.

What I will say is that today, more than I've seen in a long time, there are people who've been activated to try and do something, to try and do something, different. There are people who feel as if this has nothing to do with him or her, you know or feel connected to it. And because of what's happened over the last four or five years at this point, people aren't motivated enough to want to be so that's a good thing. And so, I try to as much as possible support those folks in this process because we need, we need people. We need people from within, we need allies, to really come together.

I'm hopeful that will continue, I think we'll see them as leaders in the next generation. I have high hopes, and high expectations from them, some change the climate and the culture.

## Participatory Decision Making

Providers need to be more involved in the decisions on how systems are designed.

I think that anytime that we look at participatory community-based research, liberation psychology, community psychology and all these have proven time and time again, when a community has some ownership, some saying over what is going to happen to them, the results are always a lot better.

That process is inherent, the process somehow the community doesn't have the resources or the knowledge base and I would argue that most of those communities that we are talking about are resilient and they have their ways of internal resources.

What I see sometimes now is, that's, it's like people either adjust to what is there or clash, like pushback and fire, fires good, angers good but at the end of the day, it takes a number of actors.

We need the fire for things to change.

## **Dr. Karen Hill**

Dr. Karen Hill is currently a Senior Consultant with Health Management Associates and is based in San Francisco, California. She is a doctoral-prepared, board-certified advance practice registered nurse with a specialty in environmental and occupational health and clinical training in adult, adolescent, and young adult health. An expert in workplace health and safety, Dr. Hill is exceptionally skilled in workforce assessment, engagement, and development. Her clinical capabilities span primary care, acute care, outpatient care, home health care transitions, and trauma-informed systems of care. She is experienced in the social determinates of health and health disparities and community engagement of underserved populations.

Dr. Hill has consulted with non-profit organizations, academic institutions, and community-based organizations including working on several initiatives related to trauma. She is an analytical and growth-minded professional with expertise in cultivating culturally sensitive collaborations. She has a proven track record of leading workplace transformation by enhancing operations and building dynamic, patient-centered, outcome-driven teams by fully engaging patients and staff, improving patient outcomes, and reducing cost.

Prior to HMA, Dr. Hill was vice president of programs for the Center for Youth Wellness, a research center for children and families exposed to Adverse Childhood Experiences. As a member of the senior management team, Dr. Hill directed strategic planning, operations, and compliance. She also facilitated four major strategic partnerships, generating an additional \$4.5 million in annual funding.

Dr. Hill brings both clinical and administrative perspective to client projects. She was clinic manager for Glide Health Services, a nurse-led clinic serving a largely homeless, racially diverse population, in San Francisco. Using data and leveraging partnerships, she expanded community access to primary health services. She also launched a new Wellness Center, which included alternative medicine, and instituted a breast health program with California Pacific Medical Center, which provided screening and treatment for 400 women annually. Dr. Hill also introduced a new social case management program and onsite adult dental health program.

A BlueShield Clinic Leadership Graduate and TeamStepps Master Trainer, Dr. Hill is a nursing adjunct faculty member at University of California-San Francisco (UCSF) and Yale School of Nursing.

Dr. Hill earned her Doctor of Nursing and master's degree in nursing from UCSF and her bachelor's degree in nursing from University of San Francisco.

## ***Interview Comments (Organized by Topic)***

### Preparedness of Providers

I don't think community nor primary care health providers (PCPS) are prepared and one of the reasons the ACEs Aware public Awareness campaigns and education are so important is because PCPs are also under resourced and overburden. I believe, some of the lack of preparedness stems from not wanting look hard at ourselves. People must take responsibility for their behaviors, and for their actions and for their privilege, right? When we talk about social justice and equity for all people, regardless of race, ethnicity, ablebodiness and living up to the ideals of this country, somebody must give up something even if that something is judgement.

One of the things that primary care providers need to understand is that not every single person that we screen needs or wants a formal referral intervention. Everyone needs to understand the preventive and primary education is an "intervention" and for many that may be all that is required.

The most informative thing that we can do for people, is to educate them about how their early life experience can and does impact their life and impact the lives of the people in their environment.

Not every single person really wants you to "do something". Sometimes what patients just want you to do, is to bear witness, they want to tell you, their story. They want somebody to "ask" about their story "what happened to you", They don't need you to fix their life—because people fix themselves. I just want you to understand this in context the ACE screening tool, the PEARLS, trauma.

Healthcare is really entrenched in the "medical" model of service delivery, ...that's why we have so much resistance. With providers, we often think what prescription can I write or where am I going to send them? What can I do since I am not a psychiatrist? I would counter the first thing you do is you do a primary/prevention intervention is to ask and listen? Educate and explain why screening is important. How our life experiences can and does impact the biopsychosocial aspects of our lives. Explaining that negative experiences can change our bodies at the cellular level and can make it harder to control some of the chronic health conditions many people struggle to control. An overactive biological response system or the toxic stress response and high cortisol levels make it so much more difficult to control diabetes, lose weight, stop those maladaptive coping strategies people with high ACEs often adopt to manage feelings. Whether it be food, alcohol, drugs, sex, violence, whatever people are trying to make themselves to feel better even if it hurts them in the long run. I also must acknowledge PCP hesitancy or reluctance to screening is often due to antiquated reimbursement rules. We are still paying for providers with methods that do not work meaning counting the number of patients we see and short 10–15-minute visits.

ACEs and any needed interventions are going to require time and resources and we may not see the returns of those interventions for a while.

Understanding your patient's early life adversity will help you to address those indicators that you as a PCP are struggling with. You're never ever going to make lasting headway on the things that are compromising your patient lives and wellbeing if you can't get your patient to stop maladaptive behaviors. So, what I'm suggesting is that providers understand that they work within a team. A well training empowered team using workflows. Where you have a care manager, a health educator, social worker, psychiatrist, pharmacist and a robust health education program.

I think that you can save a lot of time in your practice. If you do that first, then it makes it easier for you to address all these other things. Now, I'm not going to say all the medical model, or all of my colleagues in primary care do this. But we often reduce individuals down to the medical problems, or the disease processes that they're presenting with, and not as a human.

### Self-Care

We must learn how to take care of ourselves, and organizational leadership must prioritize and allocate the resources. I conduct ACEs trainings across the Country and selfcare is often the last thing that Leadership is interested in including. Truthfully, sometimes you must step away from the work—In the best-case scenario's this work is hard and gets messy. I was right there in the trenches for 15 years. And then at one point, I had to say, "Okay, I need to do this in a different way." I could feel myself burning out. It's hard work. You put a lot out there every day, you hear these stories every day and there's not always a lot of support for those in trenches. Even now, we're hearing from providers who are in this during this pandemic, taking their own lives, they're sick, they're using more substances, they are leaving the profession it can get to be too much if the supports are not in place for patients and the workforce.

### Diversity, Equity, and Inclusion

When we talk about diversity, I like to think of it comprehensively and consider the intersectionality is also a factor. Diversity is gender, age, sexual preference, religion, political affiliations, and fringe and sub-cultures. Still, many pretend as if racism isn't alive and well, and we see the ramifications of that denial played out every single day. We have data to confirm that racism and prejudice contribute to premature morbidity and mortality. For providers who have not had the lived experience of being discriminated against, we can tap into our empathy. I think it's our responsibility as a profession, to teach people about the experiences of others. Ultimately, if you don't give a hoot about the lives or experience of others, then you're in the wrong profession. We've got to be able to understand and accept that for some most of us it is a hard thing to look at yourself and the mess that your life has become due to no fault of your own.

Our jobs and the real work is what we're doing together to break down and end "othering".



## Listening to Patients

Trying to really understand that we're all bricks in the same wall. And it's really, just by the grace, whatever your grace is, right? That the circumstance is not your situation and to do that without judgment. Using our trauma informed skills and the key pillars of the framework. I worked 15 years at Glide Health Services. It's a 50-year organization in downtown San Francisco. We had a Primary Care Behavioral Health Clinic on the fifth and sixth floor and a wellness center of Glide Health Services in downtown San Francisco. And so, here is cocky Karen Hill, just graduating with her master's degree from the University of San Francisco. I had never heard of a community health clinic, and I had been offered a job. And I remember walking down the street, to the clinic for my interview, and I saw all these people on the street. And I was thinking, now why don't these people get a job? I didn't understand it and had never been taught or exposed. I was arrogant and haughty and didn't really understand the lot. I didn't have enough empathy. And it wasn't until I started really listening and hearing. I'm ashamed to admit it now. It wasn't until I started hearing stories, and hearing, you know, what had happened to individuals. There is where I found my humanity. If I thought that I had to spend a night on the street tonight, if I didn't have this beautiful yard that I'm in right now, or could go into my house refrigerator full of food and turn on the heater or air conditioning—all my creature comforts. I would probably have to have some dope or something to survive. Granted, it can be hard to be around people who have lost control of themselves, and to some degree, even their own humanity. But we must tap into our empathy. The broader workforce just needs to suspend judgment and it's not a simple thing. It's not judge people all the time we put a lens on, you know, everybody we see, well, there's that implicit bias. So that's the other thing, I think that we need to really teach people about our biases, and we all have them.

## Participatory Decision Making

Healthcare providers talk about patient-centered care and share or participatory decision and what they often really mean is "Do what I tell you to do." And when they don't, we label them "non-compliant". When we don't include people in their care, we are being disrespectful. People have the right to make informed decisions and have choice about how, when and where they receive services and a mutually agreed upon plan of care.

## **Dr. Marta M. Shinn**

Dr. Shinn is a Senior Consultant for the Child Guidance Center (CGC). In this capacity, she provides support to the leadership team on special projects and assignments. She also assists the Training Department in leading various evidence-based trainings, conducting supervision, and coaching clinical providers.

Dr. Shinn is a Licensed Clinical Child Psychologist, Licensed Educational Psychologist, Nationally Certified School Psychologist, and Research Scientist. She is an experienced psychology professor, clinical supervisor, peer-reviewed author, and Parent-Child Interaction Therapy (PCIT) trainer. She began her work at CGC in 2007 as a bilingual Spanish Registered Psychologist, has led CGC's training department, research team, trained students, and is the co-developer of the Family Mealtime Coaching (FMC) program. Over the years, Dr. Shinn has trained many clinicians and trainers in PCIT and PC-CARE within CGC, and trained various community organizations, including districts and private schools in PCIT and Teacher-Child Interaction Training (TCIT). She also serves as a UC Davis Consultant Trainer and Implementation Specialist.

In her private practice, Variations Psychology, Dr. Shinn and her team specialize in conducting diagnostic assessments. She is also a Volunteer Assistant Clinical Professor of Pediatrics at UCI Medical School. Dr. Shinn is a Psychology Subject Matter Expert for the California Board of Psychology and the Association of State and Provincial Psychology Boards and has worked to develop the national and state licensing exams. Dr. Shinn is a Black Latina and is bilingual English/Spanish speaking. She holds a bachelor's in psychology, a master's in school psychology, and a doctorate in clinical and educational psychology.

### ***Interview Comments (Organized by Topic)***

#### **Preparedness of Providers**

I think the opportunity lies in more than just bringing awareness, I think that having the regular conversations are helpful. And creating a space to have the conversation with safety. So that if you state certain things there is no retaliation, or that you won't be perceived as being disgruntled if you bring things up. One of the things that I'm always cautious of as a Black woman and as a Latina is the stereotype of angry Black woman. In instances where I say something with fervor or am passionate about a particular view among colleagues, in the back of my mind I also remain aware of my tone and other's reaction to avoid eliciting this bias. For this reason, for people with diverse intersectionality, like myself, I do think that it is good to create safe spaces where important discussions involving trauma and race can be had without fear of some type of negative repercussion.

## Diversity, Equity, and Inclusion

It is somewhat problematic that the approach to implementing ACE screenings is coming from the medical model, where you must be an expert, like a physician or a mental health provider assess/screen. I think this model perpetuates barriers and results in inequities. There are other trusted community members that could more easily connect with people, screen, and link to services. We have a lot of people with a willingness and desire to be helpers, and to be a part of the helping fields, but we don't have allocated space for them. I think, for the black and brown community, being a member myself, I know that we as people want to help others even if we don't have a specific position – you are just looking for a way that to contribute. I think if more of those people were invited to engage, then they, their friends, and families and neighbors would also be more interested in accessing services, because it would feel like, “I understand what the service is, and someone that I trust and know is part of the system or part of the care I will receive. I think that in the mental health system, we've created our own ivory towers, which I'm not so proud, because I recognize that I live in the tower too. It's not like a house that I'm not a part of. So, I think that there's space to sort of disrupt that and create change.

I think providers would have more comfort if the recipients had more comfort. I think that when you take for example, a doctor who says, “Well, I don't want to broach these topics about possible trauma(s), I want to address their presenting problem, their chief complaint today. That's my task to help with what they're here for and not to ask, “Hey, can you let me know if you've experienced any of these adverse events in your life?” So, I can understand that may be how a doctor or nurse would feel. But I think that they would have a greater sense of comfort for screening, if they understood that that conversation was normalized, and everyone was having it, and they weren't the only ones. And not that this was just another thing that they alone were tasked to do. I see the potential for ACEs screening to be more like how we've adopted mandated child abuse reporting rules for different types of people that interface with children. We don't say, only doctors are mandated reporters, if you see a bruise, we're all very clear that everyone including teachers, nurses, day care providers etc. are mandated reporters.

## Listening to Patients

I aim to be holistic and want to have those deeper conversations with the people I'm trying to help. It's not going to be like a singular approach of let's get physicians and other mental health providers to screen for us, because that's still creating reliance on the healthcare system to do all the screening. Individuals don't just talk about their prior traumas when they're receiving health care only. They might share it with their health provider, but that's not necessarily so, they may be at the barber shop or hair stylist, their soccer meet, at a book club, or at church. In other words, sharing about traumas naturally comes up in other spaces. Listening to people then also has to happen in other spaces. And these other spaces need to be equally equipped to screen and link to supports. One of the things that the Lighthouse Project at Columbia University did

when they developed the suicide severity scale was develop a measure for clinicians but also various versions for different community members likes fire fighters, teachers, law enforcement, parents, adolescents, neighbors etc. I think if we engage others, then it will make the process less daunting for doctors and other health providers.

### ACE Screening Implementation

The research does not support this notion that we as humans should be afraid of asking people about their histories or that it's dangerous to ask people about their trauma experiences. The research is the opposite. It says that when you ask people about things that are meaningful in their life, and you do it in a respectful way, and in a supportive way, that it's a good thing and it can be the beginning of a helping relationship.

Take for example individuals involved in pastoral counseling and their background is strictly in providing guidance within the structure or beliefs of their religion, they're providing counseling through a very specific spiritual lens and it's helpful. The power in what they do is that they listen and hold space with people through prayer and other forms of presence. Research shows that being a present person and an active listener has a lot of healing power. We're not emphasizing that enough. When it comes to ACEs screening, I often hear, "I would feel incapable of helping them and I don't want to put myself in that position where I don't feel equipped to respond." I think the message needs to shift, it doesn't require advanced training to be a listener, and to be present as a human with a person and to say, "thank you for sharing that, I hear you, I can connect you to someone that can help." In that moment you don't need a TF-CBT therapist, you don't need EMDR, you need a good listener to hold space and start the helping process.

### Participatory Decision Making

Currently, to be part of the stakeholder group, or to be at the table where the decisions are made, you do need to meet these expert or professional criteria. I think the opportunity lies in thinking about how we have seats at the table for other types of people without having special requirements. We've started that conversation for children's mental health and inviting parents and caregivers on committees. That can be applied to ACEs screening and involve other community members, professionals from non-healthcare backgrounds, and including people of diverse ethnic, racial, and linguistic backgrounds.

I'd love to be able to brainstorm who else in the community is part of the work that's not part of the healthcare system, and really think about how we either have other versions of the ACEs screening tool that are more community friendly, that are not solely clinician administered. I believe a community screening approach will engage more people in the work outside of clinicians.

I also think that there's room to include adolescence and transitional age youth more. They're at the stage in their development where they're having an increased awareness of how the things

that have happened in their life affected them. And once you awaken to that, you can begin to have feelings about it as well. For some, there are fond memories of minor stressors, but for many others, there are some really unbearable memories and feelings. I think adolescents and young adults have a lot to contribute to the process both as helpers and recipients of services.

## Literature Review

During the planning and initial implementation of the project, several provider stakeholders expressed concerns about administering ACE screening tools due to what they perceived as a risk of re-traumatization or stigmatization of the patient or client. Because of these concerns, a search for any research showing a risk of harm resulting from the utilization of ACE screening tools or asking related ACE questions was conducted by Children's Cause OC. After a comprehensive review of existing research reports and articles, no research could be found that supported the contention that the use of ACE screening tools cause harm. In fact, just the opposite was found with studies showing no negative impact or initial discomfort by participants that later resulted in positive outcomes resulting from the screening (Koita, 2018) (Mersky, 2019) (Edwards & Anda, 2007).

Because concerns continue to be raised by a number of providers on the potential "harm" of using ACE screenings, it is our view that additional research in this area would be beneficial, especially for specific age groups, ethnicities, and racial identities. Additionally, we view the experience of the project in this area highlighting the need to address apprehension in the workforce regarding ACEs, with fears that might exceed the concerns of the patients and clients themselves. This may be related to a concern about not being prepared professionally or personally to respond effectively to identification of ACEs or existing barriers in referring and linking individuals and families to buffering supports that are not adequately resourced.

## Insights and Recommendations

### ACE Screenings and Breaking Down Barriers to Address Structural Racism

In reviewing the information derived from the provider conversations, speakers, content expert interviews, and input from partners, common threads can begin to be seen that appear to be important. For example, the ongoing need for increased cultural humility for providers and ACEs Aware stakeholders. The input from all these participants was also affirming of what's now included in the ACEs Aware Trauma-Informed Network of Care Roadmap such as the benefit of "Stress Busters" (ACEs Aware, 2021). These seven strategies for mitigating toxic stress include: supportive relationships, quality sleep, balanced nutrition, physical activity, mindfulness practices, experiencing nature, and mental health care as needed (Bhushan D, 2020). Alternatively, there was input that the Roadmap could go much farther to incorporate equity and advancing antiracism in the implementation of trauma-informed networks of care.

Specific questions that the project sought to understand also received answers:

*Does stigmatization and re-traumatization of individuals and communities occur when ACE screening results are collected and disseminated? What culturally responsive practices are being used to mitigate against this?*

Stakeholders who helped designed the project, who are also providers, had expressed initial concerns that the implementation of ACE screenings could cause stigmatization and traumatization. However, when the results of the literature review by project researchers was compiled, it became clear that from the perspective of the health and well being of the patient, there was not research that supported harm being caused by the act of conducting an ACE screening. In fact, related research showed that the opposite was true. For example, one study asked parents to complete an ACE questionnaire for their children. While there was some reported distress, all clients were able to complete the questionnaire and no negative impacts were observed (Koita, 2018). Another study reported that "many service providers report concerns that questions about adverse events may upset clients." However, the results "indicated that most clients in home visiting programs tolerated an adverse childhood experience questionnaire well." Also, "the findings point to clients who may be more likely to report discomfort and highlight an important association between client and provider discomfort" (Mersky, 2019). Another study was:

*...conducted on undergraduate female students which asked about childhood sexual abuse. Three quarters of the participants reported not being bothered by the study. Only 16.7% of participants reported significant distress during the study. (Decker, 2011)*

Finally, in the article "It's okay to ask about past abuse," Dr. Vince Felitti and other researchers mailed 30,000 questionnaires with questions on health and childhood abuse. Over a 24-month

period since they sent out the questionnaires no phone calls were made to the hotline provided in case participants experienced distress due to the questionnaire. The study concluded that the 68% response rate was indicative of acceptability (Edwards & Anda, 2007).

These research findings were consistent with positions maintained by two of the project's content experts—Dr. Hill and Dr. Shinn. For example, Dr. Shinn reflected that the current research shows that asking ACE questions is not shown to lead to harm in and of itself and that there is a misconception that to ask questions that you need to be a highly trained clinician in evidence-based trauma therapies such as EMDR. Dr. Hill similarly expressed those opportunities to extend the identification of trauma to nonclinical settings are being missed. What may cause harm are members of the early childhood, education, and other support workforces that are not prepared to be empathetic, suspend judgement, and work to have awareness of their own implicit biases.

The consistent expression of fears by providers nonetheless raised another concern—that while most patients may be ok with being asked ACE screening questions, their providers may not be ok in asking them. These fears may have a close association with provider's own re-traumatization when there is a lack of sufficient support for selfcare or fears that issues related to the systems that impact the workforce remain unaddressed. In either case, it is likely that additional research in this area would be beneficial to workforce development approaches related to the increased implementation of ACE screenings.

According to The National Child Traumatic Stress Network:

*Enhancing cultural competence and encouraging cultural humility are essential to increasing access and improving the standard of care for traumatized children, families, and communities across the nation. Cultural awareness, responsiveness, and understanding need to be infused throughout every level of an organization to be most effective in addressing the needs of children who have experienced trauma (NCTSN, 2021).*

Regarding cultural responsiveness, Dr. Sayyedi expressed concerns about the ACE screening totals themselves being problematic for defining someone as a number. She indicated that it's important to “not limit someone to a number” to properly assess their resilience. To address these concerns, it may be important to provide increased awareness on how the ACEs Aware toxic stress risk assessment algorithm uses the triad of ACE score, presence/absence of ACE-Associated Health Conditions, and protective factors to create a comprehensive treatment plan.

It was also stated that people of color can react negatively to any form of questioning especially if they've had negative experience with police questioning them or questions from soldiers in a conflict zone they may have immigrated from. She indicated that the acceptability of a screening tool may be fine from a euro-centric point of view, but it can be problematic for some BIPOC community members. The screening needs to be done with a great deal of sensitivity and the



patient needs to fully understand why the screening is being done. Knowing the language is very important because the use of translators may not provide a level of safety needed for patients to feel comfortable discussing their traumatic experiences. Also indicated was being aware of “social ills” and how the patient is impacted by them is important to build the level of trust needed for doing the screening, providing treatment, and supporting healing.

According to Robert Carter:

*Empirical evidence has accumulated over several decades documenting the psychological and emotional effects of racism and racial discrimination. In general, researchers have found that people who are exposed to racism experience stress and have health outcomes such as depression, anxiety, and hypertension (Carter, 2020).*

If a clinician does not accept the existence of racial discrimination, its history, and its impact, then they would not be able to be responsive to those who have experienced this form of toxic stress.

According to Dr. Sayyedi, culturally informed healing practices can take time and cannot be rushed. The pandemic has put BIPOC peoples in crisis, many losing everything. There needs to be help first for basic needs.

Participants in the community discussions also noted that “there is a paucity of research on ACEs for specific ethnic communities” (e.g., AAPI) and that “there needs to be recognition that additional research is needed” as the implementation of ACE screenings move forward.

It was also observed that primary care physicians need to use Motivational Interviewing and doing more trauma-informed care when addressing substance use disorders.

*What unique barriers do professionals of color face in implementing ACE screenings and being able to provide sufficient support for treatment? How is self-care addressed?*

A repeated theme came through in the conversations and interviews that community-based clinicians of color did not have access to the same resources that their white counterparts did. Also, some participants of color expressed that becoming a trained clinician was hard fought and that the reason they now had access to decision-making mechanisms in the community was their level of education, something that might be more accessible to white residents in the community who face a lower bar to entry. Some providers of color expressed difficulty in becoming Medi-Cal providers and being able to access funding for their practices.

There was widespread agreement that self-care was critical in being able to increase ACE screenings and for providers of color there was a need to prepare for their own potential re-traumatization in treating patients with shared lived experience of toxic stress resulting from racism.

*How well do clinicians that have no experience of discrimination themselves, provide appropriate treatment plans for those who have? How can this be improved?*

Participants indicated that all clinicians should be prepared to support those who have experienced discrimination which may not be part of their own lived experience. Dr. Hill suggested that these professionals should all have empathy and an ability suspend their judgment and, if not, being a clinician may not be an appropriate role for them. This conversation opened the possibilities that through ending the “othering” that has traditionally occurred in clinical-patient relationships, new avenues can be created for diminishing structural racism through the ACE screen, treat, and heal process.

It was observed that it’s important that a therapist knows the language of someone who is being assessed for trauma. Using an interpreter creates complications in having the person feel comfortable in sharing their story.

*Are people of color able to participate in meaningful decision making for ACE health systems and networks of care?*

In Orange County, people of color have limited participation in decision making bodies for ACE health systems and networks of care and are disproportionately underrepresented. Despite being a “majority minority” County, most power structures related to healthcare, mental health services, early childhood, and now ACEs Aware network of care implementation are primarily white.

*Do sufficient mental health supports and buffering services exist for young children identified with ACEs?*

The overwhelming consensus from participants in answering this question was “no.” It was also recognized, however, that additional opportunities existed for “stress busters” and work on social determinants of health that could mitigate some need for mental health treatment.

It was stressed on several occasions in the community input sessions that understanding cultural considerations and context is very important, especially when providers interact with the parents of young children. At the same time, providers who do not have life experience with discrimination were still encouraged to not hesitate in providing support, being empathetic as is required in being an effective health care provider. This was seen further as an opportunity to address implicit biases, self-recognizing privilege, and decolonizing the doctor/patient process. For example, questioning the use of language such as “patient” to explore less of a hierarchical relationship and bringing down barriers that can interfere with providing care. One participant reflected that providers can “be mindful, be curious, and be present with their own experiences.”

*Are there logistical barriers unique to community-based providers, especially those focused on the specific racial and ethnic communities?*

There was a time when trauma was not discussed in care professions, but participants acknowledged that this is changing.

Enrolling as a Medi-Cal provider was cited as being unnecessarily difficult. Additionally, most smaller community-based providers had challenges in receiving other forms of funding, supporting IT needs, and had limited or poor quality facilities.

*How are young children further impacted by these barriers?*

It was agreed by participants that young children were particularly vulnerable to toxic stress and are under-identified, under-treated, and can have limited opportunities to heal when their environmental conditions are unable to improve.

The input provided affirmed that protective factors, those known intrinsic or extrinsic conditions or attributes that might mitigate risk for toxic stress, were supported:

Intrinsic factors include:

- Curiosity in learning
- Ability to pay attention
- Ability to regulate emotions
- Neuro, endocrine, metabolic, immune, genetic, and epigenetic factors

Extrinsic factors include:

- Buffering relationships
- Supportive environments
- Community resources

These factors were considered by most participants within a broader perspective based on social determinants of health:

*Conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. According to the World Health Organization, the social determinants of health are education, employment, health systems and services, housing, income and wealth, the physical environment, public safety, the social environment (including structures, institutions, and policies), and transportation (CDC, 2021).*

Beyond this, the conversations focused in on ACE screenings as being a catalyst for addressing structural racism and the opportunities and challenges with ACE screenings to help advance or hinder progress in this area. The ability of ACE screenings to break down barriers between doctor and patient through empathy can lead to a dichotomous choice between racism or antiracism for providers, and even patients and their family members. Ibram X. Kendi presents this choice between the two as (Kendi, 2019, p. 13):

*Racist: One who is supporting a racist policy through their action or interaction or expressing a racist idea.*

*Antiracist: One who is supporting an antiracist policy through their actions or expressing an antiracist idea.*

The interaction between clinicians and patients around ACEs opens the door to new possibilities for human interaction and bringing down barriers between individuals.

### **The Importance of Early Childhood**

Toxic stress (i.e., severe, chronic stress resulting from prolonged exposure to ACEs and lack of buffering support from an adult) is considered the major mechanism by which ACEs affect health (Shonkoff, 2012). This level of stress can disrupt early childhood development, continuing to affect psychological, social, and emotional behavior across the life span (Zannas, 2014).

Repeated or prolonged activation of a child's stress response, without the buffering of trusted, nurturing caregivers and safe, stable environments, leads to long-term changes in the structure and functioning of the developing brain, metabolic, immune, and neuroendocrine responses, and even the way DNA is read and transcribed. Development of the toxic stress response is influenced by a combination of cumulative adversity, buffering or protective factors, and predisposing vulnerability (Bhushan D, 2020).

Also, according to Prevention Institute, community factors reduce—or increase—the likelihood of ACEs (Prevention Institute, 2020). For those communities experiencing a high level of what are referred to as “Adverse Community Experiences,” young children are particularly vulnerable to experiencing toxic stress. Community factors, including the social, economic, and physical environment, shape health, mental wellbeing, safety, and equity outcomes far more than clinical care or personal health behaviors (Prevention Institute, 2019). Adverse Community Experiences can include:

- Concentrated poverty and economic instability
- Housing displacement and homelessness
- Deteriorated community conditions caused by underinvestment and the flight of businesses out of communities
- Failing school systems
- Inequitable access to parks and green spaces
- Residential segregation/segregation from opportunity
- Racism and anti-immigrant bias
- Disproportionate exposures to toxics and pollution
- Poor transportation and food systems

Participants indicated a high degree of need in communities of color that are disproportionately impacted by lack of access to quality childcare and healthy environments promotive of child

development. Efforts are needed that enhance the connection between trauma-informed network of care implementations and early childhood needs in communities of color. These efforts are key to preventing lifelong negative health impacts by addressing social determinants of health at the earliest age possible.

## ACE Screenings as a Catalyst for Systems Change

The conversations, interviews, and partner input confirmed the need for the milestones in the [ACEs Aware Trauma-Informed Network of Care Roadmap](#) (ACEs Aware, 2021). A common reaction from providers and the interviewees were concerns about the challenges created by current system barriers in being able to achieve the full potential to determine the presence of toxic stress in patients. This included the constraints of managed care on physicians and the lack of accessible resources to refer to. If an effective network of care can be established with a provider and CBO friendly closed loop referral system, then some of these barriers can be overcome.

Within this primary prevention, holistic approach, trauma-specific therapies still play a role. Individuals can still benefit from interventions such as Eye Movement Desensitization and Reprocessing (Shapiro, 2018) and reforms for making these therapies without delay after a need is identified should continue.

The experience of both the clinicians, and the patients they interact with, can lead to joint identification of systems change opportunities. For both groups, increased access to participatory decision-making mechanisms within systems of care will advance reforms.

## The Connection to Civic Engagement and Political Determinants of Health

*Health equity is the great unfinished business of our society. It has eluded the United States and other countries, owing in large part to vexing political determinants undergirded by structural racism, misogyny, and other forms of inequality. (Dawes, 2020, p. 143)*

The political determinants of health, according to Daniel Dawes, include: 1) Voting; 2) Government and the Structural, Institutional, Interpersonal, and Intrapersonal Barriers; and 3) Policy. In all three areas, there is an opportunity for increase participation by both providers and their patients. Very importantly, this can be done together rather than separately. Participatory decision-making models offer the possibility of giving patients and their family members a seat at the table, not only to provide input, but to make meaningful decisions for the systems that impact their lives.

## Conclusion

The speakers, providers, partners, and content experts involved as sources of information to answer key questions for this paper revealed a complex interrelationship between individual, interpersonal, systems, social determinants of health, political determinants of health, and societal attitudes that are all influenced by the legacy of historical trauma and current structural racism that exists as a result. What is clear is that ACE screenings and response provide an opportunity to bring down the barriers that cause othering and advance antiracism starting with

an empathetic response by physicians and therapists, regardless of their own life experience, to a patient's physical and emotional reaction to toxic stress.

This perspective allows us to view the organization of recommendations using a spectrum of related levels that begin with the individual and end with all of society. All recommendations are related to ending structural racism but provide tangible options at each level. Also, through equitable participatory democracy it is an expectation that no individual is limited to have agency at anything less than all levels. The additional need for leveling in the clinician-patient relationship requires that there is also not access to mechanisms of change only available to physicians and therapists. In fact, clinicians share with their patients that there are systems and structures that they did not decide themselves.

These levels overlap and are reinforcing of each other. The Prevention Institute, for example, has made the connection between ACEs and what was previously indicated as Adverse Community Experiences (Prevention Institute, 2020).

According to the Prevention Institute, community trauma increases risk factors that make Adverse Childhood Experiences more likely to occur and it reduces resilience factors that protect against the impact of ACEs.

A precursor to this approach is the similar Empower Action Model that:

*...seeks to provide tangible steps to prevent childhood adversity by implementing protective factors to build resilience and health equity across multiple levels and the life span. The model can assist families, those who serve families, communities or coalitions, and policy advocates in developing a plan for action in each of their respective areas of influence (Srivastav, 2020).*

The Empower Action Model includes policy change and recognition of community but does not include action within a social determinants of health and political determinants of health frame.

By taking a crosscutting approach, tying ACE screenings to trauma-informed networks of care to provide response, connecting those networks to changes related to social determinants of health and political determinants of health it is likely that change can occur. It is only then that ACE screenings can be a vehicle to advance antiracism and address equity.

## **Recommendations**

Based on the learnings described in this paper, the following recommendations are provided for consideration by ACEs Aware initiative stakeholders at these levels of opportunity (visualized in Figure 1) for addressing structural racism and ACEs:

### ***Individual***

- Make a commitment to be antiracist rather than “not racist”

### ***Interpersonal***

- Use the ACE screening and the resulting interaction with a patient or client to be empathetic, suspend judgement, and create a space that allows for othering to diminish
- Once an ACE screening is completed, respond first with a resilience assessment, starting with assets instead of deficits or issues

### ***Community Environment and Systems***

- To address inequities in access to resources increase the number of Resource Navigators available to work with clinicians as part of the implementation of the ACEs Aware trauma-informed networks of care. Allow for referrals to buffering supports that include a wide range of options (e.g., support groups, yoga, Tai Chi, marriage classes, activities at community-based or faith-based organizations, body movement classes, nature focused activities, visual arts, and performing arts).
- Include opportunities for cultural creativity in referrals for buffering supports
- Include patients and their family members in decision making in the implementation of trauma-informed networks of care
- Increase buffering supports at the earliest age possible to address racial disparities:
  - All families have help to access preventive, timely, and coordinated services and supports according to their needs, including high-need children and families and special populations
  - Ensure readiness and academic achievement gaps are eliminated for children birth through eight
  - Ensure early childhood professionals are well-trained and well-compensated across programs and settings
  - Ensure all environments for young children are safe, free of toxins, have affordable nutritious foods and other opportunities for physical activity
  - Ensure children with special health, behavioral or developmental needs receive individualized services and supports

### ***Social Determinants of Health***

- Connect trauma informed networks of care planning and implementations to policy change efforts that support education, employment, housing, financial, health and legal supports and policies that contribute to family economic stability and long-term security
- Connect trauma informed networks of care planning and implementations to policy change efforts that ensures health disparities are eliminated through education, employment, housing, financial and legal policies that support child and family health
- Have trauma-informed networks of care be inclusive of early childhood supports for patients in BIPOC communities



### ***Political Determinants of Health***

- Create opportunities for participatory decision making in trauma informed networks of care that is meaningful, allowing BIPOC patients and their family members to make decisions about the design of the system
- Link clinicians and patients participating in trauma-informed networks of care to opportunities for advocacy and policy change through both participatory and representative democracy

### ***Societal Change***

- By encouraging clinician and patient interactions that address ACEs that are grounded in empathy, that suspend judgment, that are supported with training to eliminate implicit bias, and that diminish othering, these can help to model what it means to bridge the gaps between people and provide some of the healing needed to reduce structural racism

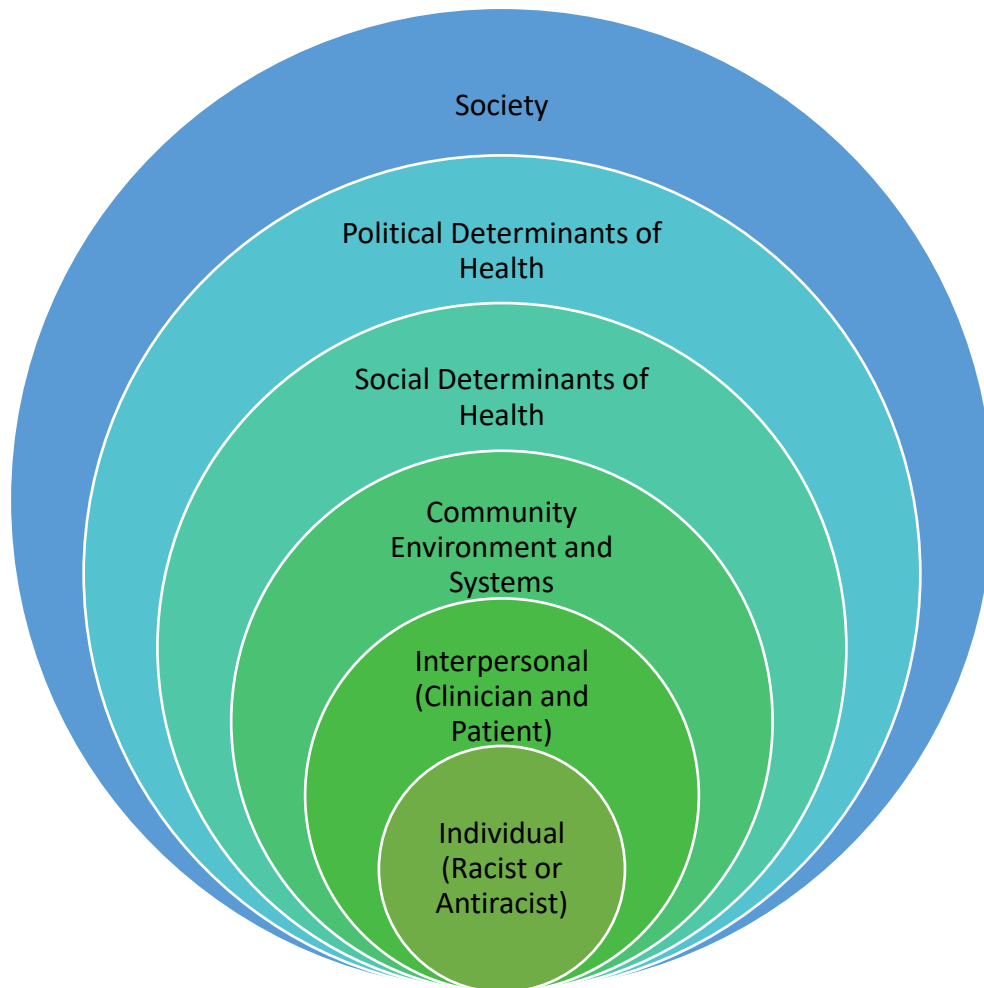


FIGURE 1 – OPPORTUNITY LEVELS FOR ADDRESSING STRUCTURAL RACISM AND ACEs

## Partner Organizations

### MECCA

#### Overview

The Multi-Ethnic Collaborative of Community Agencies (MECCA) is a coalition of community-based service providers working to eliminate racial and ethnic disparities to improve the quality of life for underserved multicultural communities by ensuring the delivery of culturally and linguistically responsive services. MECCA serves all the threshold ethno-linguistic communities within Orange County including Arabic, English, Farsi, Korean, Spanish, Chinese and Vietnamese in addition to subthreshold languages including Khmer and 17 other languages. Together we create a sustainable, integrated health and service delivery system that is culturally and linguistically responsive through advocacy, education, outreach, research, and collaboration in order to increase access, quality and resources to diverse multicultural communities.

MECCA's unique collaborative approach is evidenced in its capacity to strategically reach diverse populations on a scale that has never been done before maximizing impact by leveraging its network of trusted agencies. MECCA advances equity, access, and wellness by being a collective, responsive, and unified voice for diverse communities. MECCA envisions a future where the systems that impact our lives are responsive to all communities.

#### History

The founding members of MECCA, who were Executive Directors leading established local service agencies for decades, saw the power of a collaborative to work with diverse ethnic communities and came together to address the gap in services to multi-ethnic communities facing linguistic, economic and cultural barriers. MECCA was formerly established as a 501(c)(3) non-profit organization in 2010.

#### MECCA's Collaborative Model

MECCA provides a centralized backbone model of program management for member community agencies and is led by skilled professional staff and a team of consultants that provide a catalytic support system in program management, strategic planning, training, and evaluation while MECCA's programs are conducted by its front-line programming staff from each of its member agencies. MECCA's programs are delivered in a culturally responsive way using culturally defined practices at the multiple sites of its member agencies, which are located throughout Orange County within the ethnic communities that they serve. MECCA functions as a collective impact organization which is an evidence-based process based documented by the Stanford Social

Innovation Review. MECCA leads and communicates a shared vision for the collaborative and coordinates the partner agencies activities through a mutually reinforcing plan of action. MECCA centralizes its work on the shared values of equity, social justice, inclusiveness, accountability, innovation and having a community driven approach.

The organizations include Abrazar, Inc., Korean Community Services, Southland Integrated Services, Inc., OMID Institute for Multi-Cultural Education, ACCESS California Services, Orange County Children’s Therapeutic Arts and most recently, The Cambodian Family, the Vietnamese Rainbow of Orange County, VROC serving the LGBTQ communities of color and the Asian American Senior Citizens Service Center which targets the Chinese community and is expanding to all ages.

### **Unique Access to Ethnic Communities**

The impact of MECCA is powerfully unique; as our society has become increasingly diverse, the need for culturally responsive services has dramatically increased. MECCA is most unique in its ability to access hard-to-reach communities with culturally and linguistically responsive services especially in Orange County where 30% of residents are foreign born and 46% speak a language other than English at home. Since its inception, MECCA has amplified the experiences and expertise of its member agencies by creating a broad network of mental health and social service delivery system that is culturally and linguistically responsive. This geographic spread of the collaborative ensures that MECCA serves all eligible residents regardless of culture or language throughout the entire county. Each member agency brings a specific language, culture and service skill set that is then shared with the entire collaborative through an efficient outreach and referral system, increasing the impact of the collaborative as a whole.

This access is crucial in the context of individuals who are vulnerable to mental health conditions and who are most at risk of developing behavioral health conditions due to risk factors or environmental conditions. MECCA’s member agencies are familiar and trusted service providers to the County’s ethnically diverse populations. Ethnic communities combined make up the majority of the County’s population and these diverse populations will only continue to increase. MECCA takes an antiracist approach to our work by focusing on impacting the systems, structures, policies, and practices that have historically marginalized communities. MECCA believes our systems and services need to incorporate meaningful and accessible ways for integrating the community’s needs otherwise ethnic disparities and health issues will be inadequately addressed. MECCA also believes that individuals that are closest to the challenges are also closest to the solutions and are seen as partners and experts that we engage in our work. MECCA serves as an advocate for policy and systems change within the mental health and social service system. Together we must develop innovative approaches to better serving our

communities. MECCA's commitment to the community is evidenced in its efforts to advance health equity, community-based research, community strategic planning and policy and systems change efforts by working with providers, systems leaders and engage community members to have a voice in the systems that impact their lives through a collaborative and community building approach.

Moreover, MECCA not only has experience and access to multicultural communities but also are service providers for ethnic-specific LGBTQ community members, deaf and hard of hearing individuals; social service participants; Medi-Cal populations, veterans; transitional age youth; older adults, and early childhood; court-mandated populations and individuals with disabilities and their families.

### **Early Childhood OC**

Early Childhood OC is a community collaborative that was formed to develop Orange County's Early Childhood Policy Framework in order to ensure that young children reach their developmental potential and are ready to succeed in school and life. The Framework ensures adults are knowledgeable, nurturing, responsive and interact effectively with other adults, children and the family unit and environments that impact children are safe supportive, stable, and healthy. Through implementation of the Framework, Orange County will attain economic and social benefits.

#### **Vision**

All children are valued, nurtured, healthy and thriving.

#### **Mission**

Growing and elevating partnerships and communities to advance the Early Childhood Policy Framework and use our collective strengths for greater impact on early childhood outcomes.

#### **Core Principles**

1. Children and Families thrive regardless of income, language, and culture.
2. Supports and services are coordinated and integrated across settings and sectors.
3. Policies and practices are family centered.

Early Childhood OC has developed an Equity Statement that can be seen in Appendix B.

### **Children's Cause Orange County**

The mission of Children's Cause Orange County is to prevent childhood toxic stress and ensure timely access to quality treatment for all children in Orange County who've experienced trauma.

This is achieved by advancing policy reforms, improving systems, and increasing the capacity of the children’s mental health workforce.

Children’s Cause Orange County, since its inception, has increasingly shifted its focus from tertiary and secondary prevention to primary prevention strategies. This includes projects that advance participatory democracy in Orange County to rebalance power structures to be reflective of those served by health and mental health systems.

### **Aurrera Health Group**

Aurrera Health Group’s mission is to advance access to affordable, comprehensive, high-quality health coverage and care, and we pursue clients that enable our firm to stay true to that mission. Our firm is rooted in a commitment to improving and strengthening the health care delivery system. We pride ourselves on our forward-thinking approach to health policy and strategic communications, our ability to adapt to changing landscapes, and our innovative spirit.

Aurrera Health Group includes nationally recognized experts in Medicaid, Medicare, and behavioral health policy and financing, as well as a seasoned team of strategic communications professionals. Our woman-led firm provides the experience and passion that is essential to navigating a complex and ever-changing health policy landscape. Aurrera Health Group works with clients to design and implement solutions that help achieve their goals. Since 2015, our firm has grown significantly in size, working with more than 80 clients across a dozen states, as well as partnering on several federal government projects.

### **Office of the California Surgeon General**

The role of the Office of the California Surgeon General (CA-OSG) was created in 2019 by Governor Gavin Newsom to advise the Governor, serve as a leading spokesperson on matters of public health, and drive solutions to our most pressing public health challenges. As California’s first Surgeon General, Dr. Nadine Burke Harris has established early childhood, health equity, and Adverse Childhood Experiences and toxic stress as key priorities. Dr. Burke Harris has set a bold goal to reduce ACEs and toxic stress by half in one generation.

### **California Department of Health Care Services**

The mission of the Department of Health Care Services (DHCS) is to provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care. DHCS’ vision is to preserve and improve the overall health and well-being of all Californians. DHCS funds health care services for about 13 million Medi-Cal beneficiaries.

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[INSERT EARLY CHILDHOOD POLICY FRAMEWORK HERE - A]

[INSERT EARLY CHILDHOOD OC EQUITY STATEMENT HERE - B]