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Adverse Childhood Experiences (ACEs):Policies and Practices for Prevention and Intervention

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Adverse Childhood Experiences (ACEs):
Policies and Practices for Prevention and Intervention

Introduction:

Adverse Childhood Experiences (ACEs) Overview:

In 1998, Felitti et al[1] published a seminal study examining the relationship of Adverse Childhood Experiences (ACEs) to health risk behaviors, chronic disease and early death in adults. Conducted by the Centers for Disease Control and Prevention (CDC) at Kaiser Permanente in California, the CDC-Kaiser ACE study examined survey responses from members of the Health Maintenance Organization (HMO) regarding current health status and behaviors. The survey also included questions about childhood physical, emotional, and sexual abuse, and dysfunctional family circumstances (e.g., violence towards mother, household substance abuse, mental illness in the household, parental divorce or separation, and family member incarceration). Questions regarding emotional and physical neglect were added to a second wave of surveys sent to HMO members in the latter part of the study.[2]

The researchers found that ACEs were common,[1] with over half of the respondents experiencing at least one ACE, and a quarter experiencing two or more. They also found a significant dose-response relationship between the number of ACE exposures and health risk factors (e.g., smoking, obesity, depression, sexually transmitted diseases), and with specific health outcomes (e.g., heart disease, cancer, skeletal fractures). The researchers concluded that the impact of ACEs over a lifetime were cumulative and contributed to a multitude of negative physical, mental and behavioral outcomes in adults, including early death.

The CDC-Kaiser ACE Study greatly broadened the understanding among health, public health, social service and other professionals about the widespread impact of ACEs on lifetime health. Researchers conducting the study also recommended further research into effective prevention strategies. These included primary prevention strategies (e.g., infant home visiting programs), secondary prevention strategies (e.g., health risk screenings in primary care settings), and tertiary care (e.g., chronic disease management), to comprehensively address the public health burden of ACEs across the lifespan.[1]

One limitation of the CDC-Kaiser ACE Study was that the study sample was largely White and middle-class.[2] Another was that ACEs were principally framed within a familial context. Extensive research has shown that neighborhood factors and other social circumstances also contribute to traumatic childhood experiences, and are often disproportionately faced by certain populations (e.g., non-White race/ethnicity; people identifying as gay, lesbian, bisexual, transgender, or gender non-conforming; people living with disabilities) and those of low socioeconomic status.[3-8] Current analysis of ACEs from the 2011-2014 Behavioral Risk Factor Surveillance System[9] (Merrick et al, 2018) confirms the continued widespread prevalence of ACEs within the United States (U.S.) and its significantly higher risk among marginalized populations.

Social determinants of health (SDOH)[10] (e.g., poverty, neighborhood violence) are inter-related with ACEs[11] and some researchers propose that expanding the definition of ACEs would provide a more accurate measure of childhood trauma.[12,13] According to Bethell et al (2017),[14] there is no current consensus on a framework for evaluating ACEs measures. Among a sample of ACEs surveys examined in Bethell et al's research (2017), many contain questions regarding various social determinants, including neighborhood violence, discrimination, foster care placement, deportation or immigration separation,

and economic hardship, as well as ACEs identified in the original study. Bethell et al. (2017) provide a Technical Appendix with a detailed comparison of 14 ACEs surveys.[15]

Physical Health, Mental Health, and Psychosocial Outcomes Related to ACEs:

Research into physical, mental and behavioral health outcomes, as well as social outcomes, related to ACEs has been extensive. Many of these outcomes are included below.

Chronic disease and premature death:

- Chronic obstructive pulmonary disease[16]
- Lung and other cancers[17,18]
- Liver disease[19]
- Type 2 diabetes[20]
- Cardiovascular disease[21]
- Allostatic systems and age-related diseases[22,23]
- Medical diagnoses (e.g., asthma, high blood pressure, ulcers)[24]
- Other physical symptoms (e.g., cardiopulmonary, constitutional, musculoskeletal)[24]

Poor mental health status and addiction:

- Adverse mental health outcomes in both adults and adolescents[25-28]
- Suicide ideation and attempts[29]
- Depressive disorders[30]
- Alcohol and illicit drug abuse[31,32]

Violence perpetration and victimization:

- Adolescent violence perpetration[33]
- Teen dating violence[34]
- Sexual victimization in adulthood[35]
- Sexual violence perpetration by males[36]

Behavioral risk factors:

- Smoking in adolescence and adulthood[37]
- Sexually transmitted diseases[38]
- Adolescent pregnancy[39]
- Sexual risk behaviors in women[40]
- Poor school engagement[41]
- Juvenile delinquency[42]

Long-term social and economic impacts:

- Homelessness[43]
- Unemployment[44]
- Low socioeconomic status[45]

Other health impacts:

- Premature mortality and years of potential life lost[46]
- Neurobiological impacts on infant brain development[47-49]
- Physical health, mental health, and socioeconomic disparity in minority populations[50-52]

ACEs in New Mexico:

According to the CDC,[53] results from the Behavioral Risk Factor Surveillance System Survey conducted in 2009 indicate that 61% of adults in New Mexico had a history of at least one category of ACE. The percentage of adults that experienced each type of ACE included:

- 30% lived with a household member who abused substances
- 28% experienced verbal abuse
- 24% lived with a parent who was separated or divorced
- 20% experienced physical abuse
- 19% lived with a mentally ill household member
- 19% witnessed domestic violence in their household
- 13% experienced sexual abuse
- 7% lived with a household member who had been incarcerated

The National Survey of Children's Health[54] (NSCH) conducts periodic mail and web-based surveys of ACE and SDOH experiences among children across the U.S. As stated in the ACEs Overview section of this report, there is no consensus about which experiences make up the traumatic events referred to as ACEs. While the 2016 NSCH survey did not specifically ask about experiences of abuse and neglect, it did ask parents/guardians about other adverse household experiences involving their child, including:

- Parental/guardian divorce or separation
- Death of parent/guardian
- Incarcerated parent/guardian
- Mental illness, suicidality, or severe depression
- Alcohol or drug addiction
- Witnessing violence in the household
- Victimization of or witnessing neighborhood violence
- Economic hardship

According to a recent research brief by Child Trends[51] using data from the 2016 NSCH, the experience of ACEs among children in New Mexico is significant. One quarter of children from birth to age 17 nationally (24%) and in New Mexico (25%) experience at least 1 ACE. However, more than 1 out of every 6 children in New Mexico (18%) have experienced 3 to 8 ACEs. This compares to 1 in 10 children (10%) that have experienced 3 to 8 ACEs nationally.

Additionally, the same research brief shows that many New Mexico children face substantial family disruption. Table 1 shows the prevalence of individual ACEs experienced by children in the U.S. and New Mexico.[51] Four of the 8 types of ACEs described in the table are experienced by New Mexico children at a percentage that is significantly higher compared to children in the U.S. overall.

Table 1: Prevalence of Individual ACEs, U.S. and NM, 2016

	Somewhat or very often hard to cover basics like food or housing	Parent or guardian divorced or separated	Lived with anyone who has a problem with alcohol or drugs	Lived with anyone mentally ill, suicidal or severely depressed	Parent or guardian served time in jail	Saw or heard physical violence by parents or other adults in home	Death of parent of guardian	Victim of or witness to neigh-borhood violence
US	25%	25%	9%	8%	8%	6%	3%	4%
NM	25%	**32%***	**13%***	**12%***	12%	**11%***	5%	6%

Source: Child Trends, based on 2016 National Survey of Children's Health

*Percentage is higher from the national average at a statistically significant level.

Multiple socioeconomic and demographic factors place certain New Mexico children at increased risk for ACEs. In 2017, 27.2% of New Mexico children under 18 years of age lived in poverty,[55] but the burden of poverty is not shared equally among all children. Table 2 compares the percentage of children under 18 in New Mexico with the percentage of children living in poverty in New Mexico in 2017, by race and ethnicity. Children within racial and ethnic minority groups are disproportionately affected by poverty, which may increase parental stress, food insecurity, housing issues and other ACE circumstances.[6,7]

Table 2: Percentage of Children Under Age 18 and Percentage of Children Under Age 18 Living in Poverty, by Race/Ethnicity, NM 2017

Race/Ethnicity	Percent of Total Population that are <18 years*	Percent of Children < 18 living in Poverty (100%)**
White	70.9%	13.1%
Black or African American	2.0%	***
American Indian and Alaska Native alone	11.8%	42.3%
Asian	0.9%	***
Native Hawaiian and Other Pacific Islander	0.1%	***
Some other race	8.2%	Not included in data set
Two or more races	6.1%	***
Hispanic or Latino	60.0%	30.1%

**Source: U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates*
***Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, 2017 American Community Survey*
****: Data suppressed when total confidence interval of the percent estimate is 10 percentage points or greater*

According to the *2018 New Mexico Kids Count Data Book,*[56] a report developed by New Mexico Voices for Children, New Mexico currently ranks 50th in overall child well-being. It also shows New Mexico ranking 49th in the domain of economic well-being (e.g., poverty, employment, housing costs, etc.), 50th in education (e.g., children not in school, high school graduation, etc.), 48th in health (e.g. low-

birthweight, health insurance coverage, etc.), and 49th in the family and community domain (parental education attainment, teen birth rate, etc.). The health and social indicators examined across these domains are indicative of the hardships families in New Mexico often face, and the ripple effect they have on overall child safety and well-being. The *2018 New Mexico Kids Count Data Book*[56] provides an in-depth examination of these domains, as well as recommended policy solutions to address the social determinants and other ACEs risk factors described in the report (See Resources, pg. 14).

Prevention of ACEs

The effects of unaddressed childhood adversity are cumulative and may also be cyclical. Parents raised in abusive and/or neglectful environments are at increased risk for perpetrating abuse against their own children.[57] But not all adults who experience abuse or neglect become perpetrators. Evidence shows that children raised in stable, safe and nurturing relationships can interrupt the cycle of abuse.[58-60] Successful prevention of ACEs requires evidence-based, multigenerational approaches that address protective and risk factors for both children, their parents, and other caregivers.

In addition to strategies aimed at reducing trauma at family- and relationship-levels, community- and policy-level strategies must also be included.[61] These address broader issues that can undermine family security and opportunities. They can also create social and community structures in which children and families are able to thrive. The distribution of risk and opportunity is an important consideration when addressing ACEs, as systemic and structural inequities exacerbate the conditions under which ACEs proliferate.[62,63] Addressing social injustice directly affects the prevalence of ACEs, especially within certain populations and among those of lower socio-economic status. Working within an equity framework is integral to effective ACEs prevention implementation.

Given the economic[64,65] and social burden of ACEs,[45] and the disparate risk for ACEs among children and families, prevention of ACEs requires a comprehensive approach encompassing behavioral, community and structural supports through evidence-based programs, practices and policies. The Centers for Disease Control and Prevention's (CDC) guidance document, *Essentials for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environments*[66] (2017), outlines four goals for developing a comprehensive approach:

1. Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child maltreatment.
2. Use data to inform actions.
3. Create the context for healthy children and families through norms change and programs.
4. Create the context for healthy children and families through policies.

Programs and policies outlined below have been shown to address risk and protective factors for ACEs within family, relationship, community and social environments. They provide examples of cross-sector strategies that can contribute to increased child well-being in New Mexico by supporting stable, safe and nurturing relationships. While an attempt was made to include strategies and policies promoted by organizations like the CDC that have expertise in the field of child maltreatment, the following list is not exhaustive. Please see the Resources section (pages 14-15) for additional examples of programs, policies and prevention frameworks for comprehensively preventing ACEs and addressing social determinants of health.

ACEs Prevention and Intervention through Programs and Practices

Individual- and Relationship-level Strategies:

- **Primary Prevention:** *Home visiting programs*

Evidence-based home visiting (HV) programs, particularly Nurse-Family Partnership,[67-69] improve health and other outcomes for both children and parents (e.g., healthy birth weight; child abuse and neglect; social and emotional behavior; welfare use; foster care placement; etc.), though there are varying levels of effectiveness for specific programs.[70-76] The HV model consists of professionals or paraprofessionals increasing parenting capacity related to child development and healthy attachment through home-based services. They also promote healthier home environments by assisting with family resource development and improved parental physical and mental health. See the U.S. Department of Health and Human Services' Home Visiting Evidence of Effectiveness website[77] for an extensive overview of specific HV programs and outcomes across eight domains: https://homvee.acf.hhs.gov/outcomes.aspx.

- **Primary Prevention:** *Hospital-based abusive head trauma prevention*

Hospital-based abusive head trauma education has been shown to be effective with new parents in hospital settings. Parents are trained on the effects of shaken baby syndrome and alternative strategies for dealing with persistent crying after delivery and prior to discharge.[66,78,79]

- **Primary Prevention:** *High quality, affordable child care*

High quality child care can impact children's socioemotional development and positive behaviors, and is especially important for low-income children. High quality child care has demonstrated a protective effect on child development, even for children raised in homes impacted by poverty, maternal depression, parental stress, and other circumstances that increase risk for child maltreatment.[80-82]

- **Primary Prevention:** *Early Head Start (EHS)*

EHS, which can be center- or home-based, focuses on building parenting skills and promoting healthy parent/child relationships. EHS has been shown to impact parents' use of physical discipline and level of engagement in educational activities with children. It has also been shown that children in EHS had significantly less involvement with child protective services (CPS), and were less likely to have substantiated reports of physical or sexual abuse. Longer-term impacts include increased probability of completing high school among Whites, and decreased likelihood of criminal convictions among African Americans.[66,83-85]

- **Secondary Prevention:** *Parent-Child Interaction Therapy (PCIT)*

PCIT is training for parents and caregivers using interactive coaching methods to teach strategies that strengthen child-parent/caregiver relationships, including positive discipline strategies.[66,86]

- **Secondary Prevention:** *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*

TF-CBT is an individual- and family-based therapeutic intervention that addresses emotional and behavioral issues associated with trauma, especially Post-Traumatic Stress Disorder.[86]

Community-level Strategies:

- **Primary Prevention :** *The Safe Environment for Every Kid (SEEK) Model*

The SEEK Model for pediatric primary care is a clinic-based prevention program for child maltreatment. It consists of three components. The first is training for pediatric residents on how to

address risk factors for child maltreatment (e.g., maternal depression, substance abuse, harsh punishment, etc.), with booster training sessions provided every six months. Residents are also provided with information on local resources and well as user-friendly parent handouts. The second component is implementation of a Parent Screening Questionnaire to screen for child maltreatment risk factors. The third component is an in-house social worker. Based on questionnaire results, residents address risk factors and decide with parents on whether to involve the social worker for additional supports. The SEEK Model has been shown to lower rates of child maltreatment based on child protective service involvement, medical documentation of possible abuse or neglect, and parent report.[87,88]

- **Primary Prevention:** *Triple P-Positive Parenting Program*

Triple P is a population-level, multi-tiered system of parenting and family support aimed at creating stable, safe and nurturing relationships. It includes five levels of intervention, from a universal media-based parenting information campaign, to brief consultations with parents on developmental issues, to intensive parenting interventions. Parents are able to access services through a variety of settings, including primary care, schools, workplaces, and telephone counseling services.[66,89,90]

- **Primary Prevention:** *Community norms change*

Shared community norms around acceptable parenting practices and community responsibility for child well-being can have a protective influence on child maltreatment and ACEs.[91] Steps for changing community norms may include:

  - Raising awareness among the public, organizations, institutions and policymakers about the prevalence of ACEs, their economic and social impacts, and their preventability.[66]
  - Development of cross-sector partnerships, including those with an ability to affect environments, practices and policies related to child maltreatment and the social determinants of health.[66] Including media in cross-sector partnerships is also important for their ability to help raise awareness of ACEs, as well as highlight prevention, intervention and policy efforts to address ACEs.[79,80,92]
  - Use of evidence-based programs, like HV, PCIT and Triple P, to increase stable, safe and nurturing relationships throughout the community, with consideration for program accessibility and sustainability.[66,80]
  - Building leadership capacity and opportunities for women and girls through girl-focused programs, educational opportunities, and community and civic engagement.[93] This can help change gender norms as well as address economic inequities that contribute to risk for ACEs.

- **Primary Prevention:** *Reducing ACEs by building community capacity*

Backed by legislative funding,[94] the Washington State Family Policy Council spearheaded development of community capacity to connect and align prevention resources in 42 community and public health safety networks from 1994-2012.[95] Two evaluations looked at the outcomes of these networks.[96] The first compared 29 funded and 10 unfunded networks and showed that they lowered trends of social and health problems, with funded networks showing greater improvements over time than unfunded networks. The second study used Behavior Risk Factor Surveillance System survey data to examine ACEs rates between respondents living in counties with high community capacity networks and those living in counties with low capacity networks. ACEs prevalence was significantly lower in higher capacity communities.

ACEs Prevention through Policies

Policies that enhance socioeconomic conditions factor substantially in improved family health and stability.[97] Conversely, reductions in economic supports, such as Temporary Assistance for Needy Families (TANF), are associated with increased levels of child maltreatment and out-of-home placements.[98,99] In *Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities* (2016),[80] the CDC describes the role economic policies play in allowing parents to provide basic needs, access quality child care, have a healthy work-life balance, and other conditions that support stable, safe and nurturing relationships. These policies include:

- *Child support payments passed through to custodial parents*

Many states use child support payments to offset welfare costs, but states can choose to pass all or some of the payments directly to custodial parents. This practice has been shown to reduce the likelihood of child abuse or neglect allegations that were investigated by CPS.[80,100]

- *The Earned Income Tax Credit and Child Tax Credit*

The Earned Income Tax Credit (EITC) is a federal tax credit targeted at low- and moderate-wage workers, primarily working parents with children, designed to incentivize work and raise living standards. The Child Tax Credit (CTC) is a tax credit for each dependent child under age 17 to help offset costs associated with child-rearing. These taxes reduce household poverty, a known risk factor for abuse and neglect, as well as improve maternal and child health, school performance, college enrollment and earning potential in the next generation.[80,101-104]

- *The Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)*

Material hardship is linked to child maltreatment. Programs such as SNAP and WIC that lower risk of food insecurity are associated with lower risk of reported child maltreatment and substantiated cases by CPS.[80,105,106]

- *Assisted housing mobility*

Housing vouchers allow families in impoverished neighborhoods to move to areas that are safer, better resourced, and more socially cohesive. They have been shown to reduce rates of conduct disorder among girls, as well as impact school attendance. Other benefits include improved mental and physical health in adults, and overall reductions in homelessness and household overcrowding.[80,107-112]

In 2014, the New Mexico State Legislature enacted the "Keeping Families Together Act."[113] This Act required the New Mexico Children Youth and Families Department (CYFD) to establish a supportive housing pilot project for 60 families in Bernalillo, Doña Ana, and Valencia Counties that had a substantiated case of child maltreatment, substance abuse, or mental health issues, and were unstably housed or homeless. The three-year project (2016-2018) showed promising preliminary results in reducing child maltreatment and homelessness among participating families. According to the *New Mexico Appleseed 2017-2018 Annual Report*, [114] the program has been renewed by the state for another three years, with efforts underway to identify additional funding to expand the pilot to 150 families.

- *Subsidized child care*

Subsidized child care is intended to increase economic well-being through vouchers or cash assistance to off-set the cost of quality child care. Access to subsidized child care can be increased by reducing eligibility limits, addressing waiting lists, reducing the amount of copayment for families

using subsidies, and providing reimbursement rates to child care providers that are sufficient to attract well-trained staff, provide low staff-child ratios, provide a stimulating educational environment, and other aspects associated with high-quality child care. Additionally, providing child care assistance while parents search for work helps maintain a stable home environment.[80,93,115,116]

- *Family-friendly work policies*

Family-friendly work policies contribute to higher job satisfaction, lower levels of stress and depression, and a greater probability that workers will stay in their current position.[117] These policies include:

  - *Livable wages*

    Livable wages allow low-wage workers, disproportionately women of color, to provide their children with basic needs, as well as alleviate stress, mental health issues, and other child maltreatment risk factors associated with poverty.[80,115,118]

  - *Paid work leave*

    Paid work leave includes family leave for parents of newborns, paid sick leave, and paid vacation time. All of these policies contribute to lower parental stress levels and greater economic stability.[80,93]

  - *Flexible and consistent work schedules*

    Job flexibility and dependable work schedules have significant effects on access to quality child care, stable household functioning, and the ability to pursue education or additional employment, particularly among low-wage earners.[80,119,120]

- *Children's Access to Health Insurance*

Both public and private child health care coverage are associated with reductions in child physical abuse. Children with medical coverage are more likely to receive medical care and have better health outcomes. In longer-term studies, children with Medicaid coverage had lower rates of obesity and preventable hospitalizations in adulthood, as well as decreased mental health issues, eating disorders, substance use, and pregnancy in adolescence.[115,121,122]

- *Comparable worth laws*

Comparable worth laws are designed to address long-standing differences in pay structures for jobs that tend to be sex-segregated (e.g., early childhood services traditionally held by women; construction jobs typically held by men). They attempt to eliminate gender-wage disparities by correlating job compensation to equivalent requirements in education and training, level of responsibility, working conditions, etc., across fields of employment. These policies help raise women and their families out of poverty, as well as impact gender inequality, and inequality among women.[93,123-125]

Please see Appendices A-B (pages 15-27) for a state-by-state listing of 2017 ACEs and Trauma-informed policies, statutes and resolutions compiled by ACEs Connection: A Community-of-Practice Social Network (https://www.acesconnection.com/).

Mitigating the Effects of ACEs

Given the prevalence of ACEs, its prevention is paramount for the health and well-being of children and families in New Mexico. Yet it is also important to understand the extensive number of people already affected by ACEs, and the impact of ACEs on life circumstances and opportunities. Trauma-informed

care and restorative justice are two community-level strategies that can transform treatment, education, criminal justice, and other systems in which those effected by ACEs are often involved.

- **Trauma-Informed Care (TIC) in Practice and Policy**

TIC refers to an array of strengths-based interventions designed to mitigate the effects of trauma and promote healing.[78,86,126-128] A trauma-informed system of care requires a fundamental understanding of trauma and its effect on functioning and coping strategies among those working within organizations and across systems. Core components of TIC include: early identification, assessment and screening of exposure to trauma; use of evidence-based, trauma-informed therapeutic interventions such as PCIT and TF-CBT; use of culturally-based strategies; and engagement of those affected by trauma and their families/caregivers in service design, delivery and evaluation.

TIC can be applied at the organizational level (e.g., social service agencies; domestic/sexual violence treatment centers), systems level (e.g., school districts; juvenile justice systems), and policy level (e.g., agency policy requiring TIC training for all staff members; state school policies requiring that disciplinary procedures be aligned with trauma-informed best practices).

Please see *Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma*[86] (Cooper et al, 2007) for an in-depth look at TIC policies and practices, including a list of trauma screening tools, example checklists for ensuring adoption of TIC practices, and a state-by-state table of trauma-informed services in the U.S. (Resources, page 15)

- **Restorative Justice**

A TIC lens can also be applied to systems designed to address criminal or other harmful behavior (e.g., school-based bullying) through the practice of restorative justice (sometimes referred to as indigenous or community justice).[61,129-131] In contrast to a traditional adversarial response to conflict and crime, restorative justice is a system of social justice focused on rebuilding relationships while avoiding re-victimization. It also provides a structure in which perpetrators are held accountable for and recognize the impact of the harms they have caused to victims, others affected by their behaviors, and communities.[132,133] An integrated trauma-informed and restorative justice approach provides a framework for understanding the correlation of ACEs to involvement in the criminal justice system, either as victim or perpetrator, as well as the effects of ACEs on cognitive functioning, attachment, impulse control, and other issues disruptive to healthy personal and community connections.

Recommendations

Prevention of ACEs requires continuous effort and commitment across sectors that are positioned to influence the conditions under which stable, safe and nurturing relationships thrive. State and public health agencies are especially able to address ACEs given their access to funding, data, best practices research, and collaborative partnerships. They can commit leadership and resources that are critical to sustained and coordinated efforts. They also have the ability to implement organizational policies and practices that directly affect ACEs-related services, and ensure trauma-informed service delivery. State agencies also have a role in educating legislators, other decision-makers, and the public about ACEs, including their intersection with SDOH, their public health impact, and the evidence for the types of policies, programs and practices that are effective and protective.

The University of New Mexico Prevention Research Center recommends capitalizing on the strengths of state and public health agencies and other invested partners, to develop a sustained, collaborative, strategic, and coordinated response to ACEs by:

- Developing an ACEs Task Force comprised of decision-makers working in systems poised to prevent and/or mitigate the effects of ACEs including:
    - New Mexico Tribal Communities
    - New Mexico Department of Health (e.g., Epidemiology and Response, Developmental Disabilities, Health Promotion)
    - Children, Youth and Families Department (e.g., Early Childhood, Behavioral Health, Protective Services, Juvenile Justice)
    - Human Services Department (e.g., Behavioral Health Services, Child Support Enforcement, Income Support Division)
    - New Mexico Department of Transportation
    - New Mexico Department of Public Safety
    - New Mexico Public Education Department
    - New Mexico Criminal Justice Department
    - New Mexico Department of Housing and Urban Development
    - Academic Institutions
    - Media
- Collaboratively developing a systemic framework for prevention, including:
    - Reviewing ACEs, SDOH, and equity to ensure shared foundational concepts and language
    - Developing a shared vision and mission
    - Reviewing New Mexico ACEs data, data sources and data collection methodology
    - Assessing systems positioned to affect ACEs (e.g., populations served, geographic locations, services provided, etc.)
- Developing a strategic plan for ACEs, including strategies for:
    - Raising awareness about ACEs among the public, organizations, institutions and policymakers
    - Preventing ACEs across the social ecology through programs, policies and practices
    - Collecting, sharing and disseminating data
    - Conducting process and outcome evaluations
    - Adopting trauma-informed practices at agency- and organizational-levels
    - Identifying mechanisms for sustaining the Task Force
- Implementing the strategic plan, with consideration for:
    - Organizational and community readiness for strategy implementation
    - Potential pilot projects in organizations/communities evidencing readiness
    - Capacity-building strategies to increase readiness for ongoing implementation

Summary

ACEs are common, affecting one quarter of the children in our state. Poverty and other social conditions usual to New Mexico are interrelated with ACEs, and exacerbate experiences of trauma as well as elevate risk. ACEs take a tremendous toll on our families and communities; contributing to intergenerational abuse and neglect, limiting opportunities, raising the risk for chronic mental and physical health issues, and ultimately, resulting in early death.

ACEs are also preventable. There is established and emerging evidence about how to prevent ACEs from occurring in the first place through multi-level strategies that promote stable, safe and nurturing relationships. These strategies are most effective when coordinated across systems that can address inequities, engage decision-makers, contribute to community norms change, and directly prevent ACEs through programs and policies. Development of a sustained, collaborative, strategic, and coordinated ACEs Task Force is important for both elevating the problem of ACEs in New Mexico and solidifying commitment to prevent and address ACEs, making New Mexico a state in which children can be safe, nurtured, and healthy.

Resources

2018 New Mexico Kids Count Data Book (New Mexico Voices for Children)

https://www.nmvoices.org/nm-kids-count

A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organizations (Disability Rights Wisconsin; Wisconsin Coalition Against Domestic Violence; Wisconsin Coalition Against Sexual Assault)

https://www.endabusepwd.org/wp-content/uploads/2015/07/Trauma-Informed-Guide-FINAL.pdf

Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma (Prevention Institute)

https://www.preventioninstitute.org/publications/adverse-community-experiences-and-resilience-framework-addressing-and-preventing

Balancing Adverse Childhood Experiences (ACEs) with HOPE (Health Outcomes of Positive Experiences): New Insights into the Role of Positive Experience on Child and Family Development (Casey Family Programs)

https://www.acesconnection.com/g/alaska-aces-action/blog/balancing-adverse-childhood-experiences-aces-with-hope

Child Traumatic Stress: What Every Policymaker Should Know – A Guide from the National Child Traumatic Stress Network (The National Child Traumatic Stress Network)

https://www.nctsn.org/resources/child-traumatic-stress-what-every-policymaker-should-know

Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention and Prevention Institute)

https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf

Cradle to Community: A Focus on Community Safety and Healthy Child Development (Prevention Institute and Center for the Study of Social Policy)

https://www.preventioninstitute.org/projects/cradle-community-focus-community-safety-and-healthy-child-development

Essentials for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environments (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention)

https://www.cdc.gov/violenceprevention/pdf/essentials_for_childhood_framework.pdf

European Report on Preventing Child Maltreatment (World Health Organization)

http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf

Investing Early: Taking Stock of Outcomes and Economic Returns from Early Childhood Programs (Rand Corporation)
https://www.rand.org/pubs/research_reports/RR1993.html

Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention)
https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf

Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma (National Center for Children in Poverty)
http://www.nccp.org/publications/pdf/text_737.pdf

SAMHSA's National Center for Trauma-Informed Care: Changing Communities, Changing Lives (SAMHSA)
https://www.nasmhpd.org/sites/default/files/NCTIC_Marketing_Brochure_FINAL(2).pdf

STOP SV: A Technical Package to Prevent Sexual Violence (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention)
https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

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