



The Adverse Childhood Experiences Study

**How are the findings
being applied in Oregon?**

David Mandell
with a foreword by Christy Cox

The Ford Family Foundation

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How Are the Findings Being Applied in Oregon?

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A report to The Ford Family Foundation

FOREWORD

By **Christy Cox**
Early Childhood Education
Program Officer
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When I first heard the buzz about the Adverse Childhood Experiences (ACE) Study, I was interested — and concerned. The landmark public health study, the largest of its kind ever conducted, investigated the link between childhood trauma and long-term health and social consequences.

The findings raised a national alarm, as the investigation found incredible correlations between childhood trauma and the increased risks of suffering from health, mental and adverse societal issues.

What struck me most was the evidence on how deep and long lasting the impacts of this trauma can be. The study found that even adults who appeared to have triumphed over difficult childhoods — ones with happy families and good jobs



— were still at higher risk for health conditions such as heart disease.

It's a sobering study with huge implications. Here at The Ford Family Foundation, we also see it as an excellent opportunity — a chance to link together the good work people are doing in health care, early childhood education and social services.

To that end, we commissioned this report to determine how the findings of the ACE Study are related to various efforts going on in Oregon. Our report is not intended as an exhaustive review of programs and initiatives. Instead, we hope to bring attention to the ACE Study and

at the same time spark discussions on how different sectors could work together to prevent the risk factors or at least lessen their impacts.

One way to lessen negative impacts is to focus on the flip side of adversity: resiliency. By striving for early intervention and building protective factors around families, we can help increase children's resiliency.

Collaboration is going to be key, and we hope that by reading what these Oregonians have to say, we will strengthen our resolve to work together on behalf of rural children and families. ■

Add your voice

This report is a first attempt by The Ford Family Foundation to chronicle how Oregon is responding to the findings of the ACE Study. If you'd like to share your experiences for a future report, please send us an email: aces@tfff.org



This report is organized around these
Shared Principles
in applying the findings
of the ACE Study

1. Invest upstream in prevention and resiliency
2. Identify risk early and intervene early
3. Work across the lifespan
4. Build bridges across systems
5. Use data to drive decision-making
6. Develop a skilled workforce
7. Empower self-organizing communities

About the Author

DAVID MANDELL has been active in early childhood policy in Oregon for close to a decade. He spent seven years as the policy and research director of the Children's Institute, where he authored reports on such topics as early childhood professional development, kindergarten assessment and integrating social-emotional development into early childhood services. In addition, he has participated in a number of state policy initiatives. David received his Ph.d. in political science from the University of Chicago and currently serves as the special adviser on early childhood to Oregon Speaker of the House Tina Kotek.



Project Outline

This report was commissioned by The Ford Family Foundation to determine in what ways and to what extent the Adverse Childhood Experiences Study (ACES) is informing work with children and families in Oregon. The report addresses the following questions:

1. To what extent is ACES informing early childhood interventions in Oregon?
2. Who in Oregon (sectors, programs, projects, initiatives) is using ACES?
3. How is ACES being used in Oregon?
4. Is the ACES or ACE scale being used to foster collaboration?
5. What is the role of philanthropy in supporting ACES-informed interventions in Oregon?

The findings from this report are derived from a combination of Internet-based research and 16 open-ended phone interviews conducted September 16 - 27, 2013. This report is intended to give a scan of how ACES is being used in Oregon and is not meant to provide a comprehensive review of all activities. The full list of the interview participants can be found on page 15 of this report.

List of Key Terms

ACES – The Adverse Childhood Experiences Study, the original research by the CDC and Kaiser Permanente (Also referred to as ACE Study)

ACE scale – The questionnaire about Adverse Childhood Experiences used in the original ACE Study. Includes 10 different adverse experiences that could have been experienced during childhood.

ACE score – The total number of Adverse Childhood Experiences reported on an ACE scale questionnaire. The maximum ACE score is 10.

Add your voice

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A landmark study demonstrated strong links between Adverse Childhood Experiences and a host of adult health problems

How are the findings being applied in Oregon?

PREFACE

Between 1995 and 1997 researchers from Kaiser Permanente and the Centers for Disease Control (CDC) conducted research on the link between Adverse Childhood Experiences (ACEs) and adult outcomes in 17,000 patients enrolled in Kaiser’s health insurance program in San Diego. Researchers asked participants if they had ever experienced any of the following as a child: verbal, physical or sexual abuse; physical or emotional neglect; substance abuse in the home; loss of a parent; incarceration of a parent; and mental illness or domestic violence within the household.

The landmark study demonstrated strong links between these

childhood experiences and a host of adult health problems: cardiac disease, obesity, diabetes and depression.

Alcoholism, drug abuse and depression

The study also demonstrated a powerful “dose-response” relationship: the more ACEs experienced as a child, the more likely adults were to suffer from these and other poor health outcomes. Adults who had experienced four or more ACEs as a child were four to 12 times more likely to suffer from alcoholism, drug abuse and depression.

Further research has not only confirmed these relationships but has also shown that high ACE scores are associated with school failure and dropout, interpersonal violence, chronic unemployment and suicide.

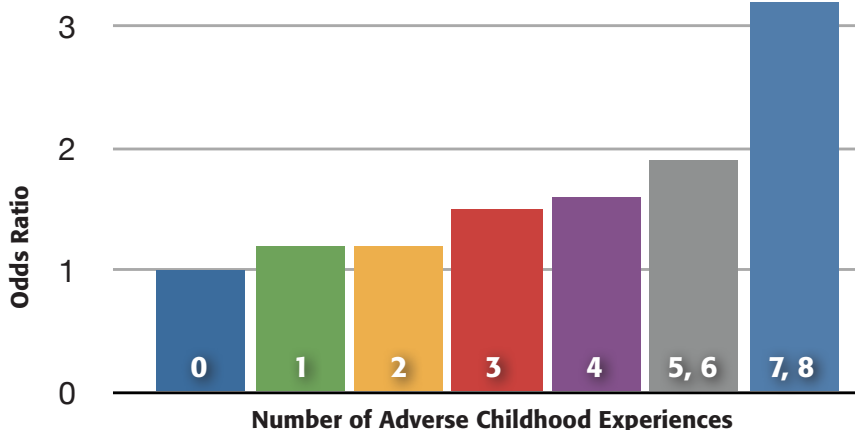
The implications of the ACE Study are at once deeply unsettling and profoundly far reaching: Adverse Childhood Experiences leave a trail of cognitive, behavioral, and health wreckages in their wake, and when untreated, these adverse experiences are often revisited on the next generation.

We will never resolve some of our most pressing social and public health issues without first addressing their origins in these Adverse Childhood Experiences.

Given these implications, it is no surprise that the ACE Study has taken on such national prominence. Its impact is also clearly being felt in Oregon.

“It seems like over the last couple of years,” noted one of the individuals interviewed for this report, “I can’t go to a meeting without someone bringing up the ACE Study.”

Many of the other interviewees reported a similar increase in attention to the ACE Study over the last



The more Adverse Childhood Experiences a person experiences as a child, the more likely he or she will suffer from poor health outcomes as an adult.

Source: Dong et al., 2004

We will never resolve some of our most pressing social and public health issues without first addressing their origins in these Adverse Childhood Experiences.

four years. The ACE Study percolates through almost every conversation about how best to promote the well-being of Oregon's children and families. It is invariably referenced whenever the case is being made for investing early in prevention.

The call to action implicit in the ACE Study is clearly starting to be heard. Across the state and across sectors, individuals, groups and associations have taken inspiration from the ACE Study and are exploring creative ways of using it both to improve their work with children and families, and to increase collaboration within their community.

'just figuring out how to do it'

At the same time, much of the work on how to be effective at embedding the ACE Study in practice, policy and collaboration is still in its early stage. As another interviewee commented, "The ACE Study makes it pretty clear what we need to do; but we are often still just figuring out how to do it."

The impact of the ACE Study in Oregon has been strongest at the conceptual level, providing a framework for articulating, mapping and making sense of the work people are doing, rather than shaping specific practices or interventions.

A number of interviewees commented that the ACE Study is so foundational and so much in the background of everything that they do that it is difficult to point to a

particular action or activity that is driven by it.

As one interviewee put it, "It's the air that we breathe; it's just what we do." Other interviewees pointed out that for people in the field, the ACE Study was, in many ways, not new information, but it did validate what they were doing and gave a new way of explaining it.

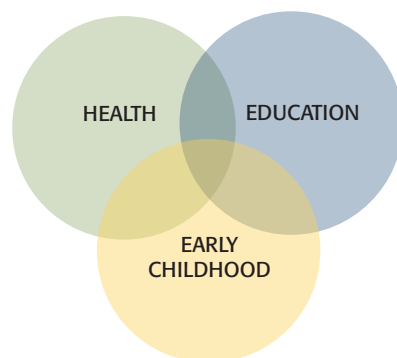
Relief Nurseries

A case in point is Oregon's unique system of Relief Nurseries. The first Relief Nursery was established in Eugene in 1976, well before the release of the ACE Study. The Relief Nurseries, which have now spread across the state, focus on preventing child abuse and neglect by working both with the young children who are at risk for abuse and neglect and their parents.

The idea is twofold: to prevent the accumulation of high ACE scores and to build resiliency that will help both child and parent cope positively with the stresses they have already endured.

While the ACE Study has provided support for the preventive approach to child abuse and neglect and the emphasis on working with both parent and child to build resiliency, it has not necessarily changed what practitioners do on a day-to-day basis. As Heather Murphy, executive director of the Cottage Grove Relief Nursery, put it:

"ACES tells us what we already know, but it puts it in such a great context. It connects the dots. We know at Family Relief Nurseries that the foundations of the children we see are cracked; we are not going to get to school readiness or early literacy unless those cracked foundations are fixed."



Oregon is in the middle of transforming three of its largest service-delivery systems that impact children and families: health, education and early childhood.

ACES and Oregon's Great Transformation

That many of these Oregon efforts are still preliminary should come as no surprise; Oregon is in the middle of transforming three of its largest service-delivery systems that impact children and families: health, education and early childhood.

These transformations are intended not just to change the way government does business, but fundamentally alter the way services are delivered to children, adults, families and communities – be that by a state agency, a health care organization or a community-based non-profit. As a result, this is a moment of unprecedented flux and uncertainty, as well as opportunity.

This great transformation has likely heightened interest within Oregon in the ACE Study. Building bridges between health, education and early childhood is a continual theme of these transformation efforts.

Cross-sector collaboration

Nothing more tangibly demonstrates the linkages between the three systems than the ACE Study,

and the study often serves as an important point of reference within these transformations for the need to build cross-sector collaboration. While these transformations have different foci, different mechanisms and different participants, they are guided by shared principles:

1. Invest upstream in prevention and resiliency
2. Identify risk early and intervene early
3. Work across the lifespan
4. Build bridges across systems
5. Use data to drive decision-making
6. Develop a skilled workforce
7. Empower self-organizing communities

These seven principles also provide a convenient way of describing many of the uses of ACES in Oregon. As a result, there are great opportunities within all early childhood, health and education transformations to make use of ACES.

The ACES framework can also play an additional role in supporting the transformation of these systems.

Many of the most concrete examples of the ACES-informed or -inspired work in Oregon are taking place independent from, outside of or parallel to these systems transformations.

They involve groups of local pediatricians thinking about how to address the needs of their patients more fully; early intervention programs, like Relief Nurseries, explain-

ing to policy-makers how they are contributing to long-term health savings; mentoring programs helping their volunteers understand the impact of trauma on the adolescents with whom they are working; and local communities coming together to determine how they can collectively reduce rates of child abuse and neglect.

The ACE Study is being explicitly and intentionally used in each of these examples.

Shared Principles in applying the findings of the ACE Study

1. Invest upstream in prevention and resiliency

The social and economic benefits of investing upfront in prevention rather than trying to fix costly problems down the road after they occur have been a central motivator for Oregon's three transformations. In health, this concept has been expressed through the notion of the "triple aim"; by redirecting resources, Oregon can serve more people, get better outcomes and spend less. Much of the impetus for focusing on early childhood as a system rests on the intuitive power of "getting it right in the first place," an idea that has gained strength through recent increases

in the understanding of brain and child development.

Advocates, service providers and spokespersons for abuse and neglect prevention have found the ACE Study to be a powerful tool for making this case. Because the ACE Study draws such a strong and clear connection between the experiences of children and some of the most costly chronic adult health conditions, such as cardiac disease and diabetes, it also helps make the economic case.

Janet Arenz, executive director of the Oregon Alliance of Children's Programs (OACP), which represents more than 40 providers working across the continuum of children's services, from residential programs to mentoring, thinks of the ACE Study as:

"[O]ne of the most stunning pieces of data that we've seen. We think this should be a policy foundation for how we make decisions about child well-being. I carry copies of this in my briefcase, and when I'm in a meeting I hand it out. Every legislator has received this more than once."

As powerful and compelling as the ACE Study has been, Janet Arenz still feels that getting it embedded in public policy is an uphill challenge:

"The system is set up to both reward and to penalize you for cost savings. Even in the health deal with the feds, children are just a blip. We still focus on putting resources on the deep end with the most expensive patients and chronically ill adults."

2. Identify risk early and intervene early

A constant refrain through all of the transformations, but especially so in early childhood, is the need to identify at-risk individuals early and intervene before more serious and costly problems develop.

One of the first activities of the Oregon Early Learning Council was to appoint the Screening Tools Workgroup. It was tasked with recommending screening tools that could be used across settings and developmental domains to identify at-risk children. One of the domains the workgroup was asked to address was family well-being. The workgroup delivered its recommendations in September of 2012, but was not able at that time to reach a firm recommendation for a family well-being screening tool.

The ACE Study was landmark for child abuse and neglect prevention and instrumental to our grantmaking. It's what gives us fuel for what we do. We try to intervene and invest as early as we can.

—Susan Lindauer, Executive Director
Children's Trust of Oregon

Use the ACE scale as a screening tool?

Because ACE scores so clearly predict later outcomes, there has been strong interest both nationally and in Oregon in using the ACE scale or some other tool to identify ACEs in children and families who would benefit most from targeted supports. However, this use of the ACE scale remains in its early stages, with many questions still to be answered.

As Beth Gebstadt from the Oregon Health Authority and Director of Project LAUNCH noted, there are two currently prevailing opinions about such a use of ACE scores:

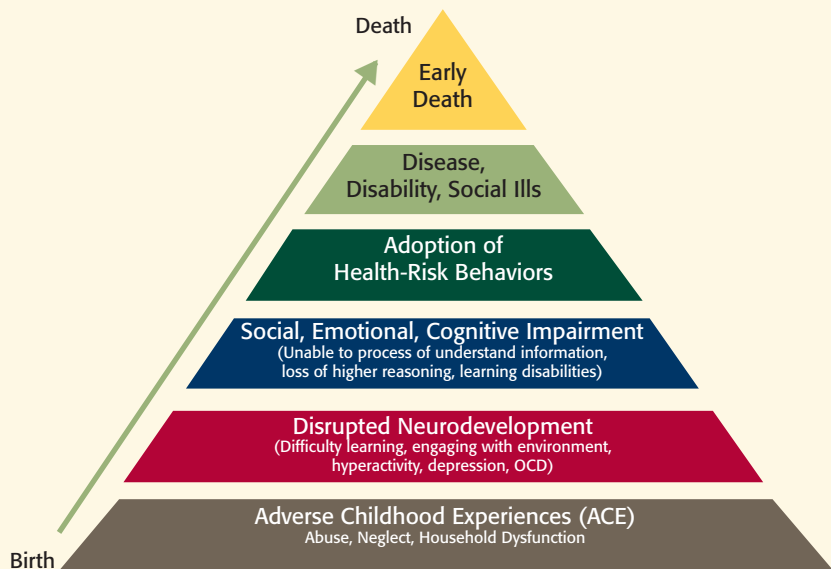
1. If you screen and you stress someone by surfacing the trauma and you don't have resources that support that individual, you may not be helping.
2. Even if resources are unavailable, it's validating to have this conversation if the provider has trauma informed training.

The question of employing the ACE scale as a screening tool has been actively discussed by those involved in developing the Oregon Pediatric Society's START trainings. The goal of START is to teach "pediatric primary care providers how to detect and manage developmental

Achieve outcomes, return on investments and savings:

An investment in children today means they will not become the next chronically ill adults with complex, expensive needs. Together, we can build healthy children, who become educated and working adults and who will raise their own healthy families.

— Oregon Alliance of Children's Programs



Research published in the the American Journal of Preventive Medicine (Vol 14, Issue 4 , May 1998) found "a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults."



and behavioral health issues as well as maternal depression problems.

Identifying problems early and linking families to appropriate services can improve the health of Oregon's children."

(<http://oregonpediatricsociety.org/programs/ops-programs/start/>; accessed 9.26.13)

START currently has five training modules and is exploring the development of a new module focused on the ACE Study and trauma informed care. Whether or not the module should include training on using the ACE scale as a screening tool remains an open question.

Examples of where the ACE scale is being used

Some pediatric practices have already started using the ACE scale as a screening tool. This includes the Children's Clinic, which has locations in Tualatin and near Providence St. Vincent Medical Center in Portland. The two sites have about 29 providers serving close to 60,000 patients, 15%–20% of whom are on Medicaid and about 30% of whom only speak Spanish. They have found that 10% of the parents of the children they serve have ACE scores of 4 or higher. In addition to collecting ACE scores, they are asking them about sources

of strength and resiliency in their families.

They have also put together resource and referral information for families for when the ACE score reveals the need for more in-depth services.

Dr. R. J. Gillespie, a pediatrician at the Children's Clinic as well as the Medical Director of the Oregon Pediatric Improvement Project (OPIP), believes that ACE screening has had an extremely positive impact on his practice.

According to Dr. Gillespie:

"The framing is hugely important: I'm here to support and to help you be the best parent you can be, and that's why I'm asking you these questions. Parents really appreciate that it's not coming from a place of judgment. I tell them about the ACE Study and the impacts it has on long-term health; I'm asking so we can help figure out how to ensure long-term health. I've had some tough-ish conversations when we've had ACE scores of 4 or 5. As a physician, it's hard to move from the idea that my job is to fix problems to ... sometimes it's just to listen. That's not what providers are trained for, but your response can't be to lecture. It needs to be responsive listening."

Impact of ACE scores on academic progress

When the idea of using the ACE scale as a screening tool is discussed, people almost always bring up the work of Dr. Chris Blodgett in Washington state. He has been using an adapted ACE scale with students in Spokane, Wash., and looking at the impact of their ACE scores on academic progress. In addition, he has also been testing intervention programs designed to address impacts of trauma and build resiliency with Head Start and elementary school children with high ACE scores.

Dr. Dana Hargunani, a pediatrician who is also the Child Health Director at the Oregon Health Authority, spoke with Dr. Blodgett while serving on the Screening Tools Workgroup. Her sense was that he was cautious about rushing to adopt the ACE scale as a screener. While he thought the ACE screener he was using showed tremendous promise, he also thought there was more to learn before using it more broadly. Dr. Blodgett confirmed her perception by email.

Three common recommendations regarding screening with the ACE scale:

1. If you are going to ask families about their adverse experiences, you also have to ask them about their sources of resiliency. You are not going to be able to serve families well if the conversation is solely about deficits and doesn't also bring out strengths.
2. Before you start collecting ACE scores, you ought to first figure out what you are going to do with them. What are the resources that families with high ACE scores need? Will you be able to help families access those resources?

3. Those who are collecting ACE scores or asking families about Adverse Childhood Experiences need to have some kind of training in trauma informed care. These are challenging questions and asking about them can bring up traumatic memories. Once you open this conversation, you need to have the training to carry it through.

3. Work across the lifespan

A consistent theme of Oregon's transformation work has been the need not only to think across the sectors, but also across the age continuum and lifespan. This idea is most clearly embedded in the concept of a "P-20" education continuum that starts pre-natal and continues through workforce development.

It is also an idea that is substantiated by the ACE Study and the concrete way that it shows early childhood experiences translating into adult outcomes that are often transmitted to the next generation.

"The ACE Study," according to Amy Johnson, former executive director of Building Healthy Families, "really brought home the need in our organization for a P-20 approach."

Building Healthy Families works collaboratively

Building Healthy Families is a non-profit family support organization serving Wallowa, Union and Baker Counties. It got started in 1999 when the Wallowa Commission on Children and Families led a community needs assessment that identified parent education as a significant missing service in the community.

During their early years, they focused almost exclusively on education for expectant parents and parents of infants and toddlers. While this remains an important part of Building Healthy Families' work, they have also recognized the need to work more holistically across a child's life.

As a result of this approach, Building Healthy Families partnered with the schools around mentoring; it worked with the criminal justice system to help people getting out of prison reintegrate into the community and with their families; it developed career counseling programs for kids in high school to help them transition into the workforce; and it connected with the local medical community so there could be a "warm hand-off" for new parents to home visitors right in the doctor's office.

Working across the lifespan means working collaboratively; no group can do it alone. Amy Johnson thinks that the secret to successful collaboration is that the people they work with are all brought together by the same goal: "Healthy, thriving communities is what we are all trying to achieve."

4. Use data to drive decision-making

One of the most interesting recent applications of ACEs has been to population public health data collection. In recent years, questions about Adverse Childhood Experiences have been included in a number of public health surveys. This data will not only provide richer information about the prevalence of ACEs, but it will also indicate how these frequencies are distributed across geographies and populations. By embedding information about ACEs in public health data, these surveys are also firmly establishing ACEs as a public health matter requiring a public health response.

Behavioral Risk Factor Surveillance System

In 2011, Oregon included the ACE module in its Behavioral Risk Factor Surveillance System (BRFSS) survey. It has also been included in the 2013 and 2014 survey. The module, which uses questions that are somewhat different from the original ACE survey, was first introduced in 2009 and piloted by five states; it is currently used by 22 states.

The Behavioral Risk Factor Surveillance System survey, which is run under the auspices of the CDC, has been conducted in all 50 states since 1993. While there are optional modules, such as the ACE, which

The ACE Study really brought home the need in our organization for a P-20 approach.

—Amy Johnson
Former Executive Director
Building Healthy Families

states can choose from, all states are required to use a basic set of questions about the prevalence of adult behaviors associated with health outcomes, such as diet and exercise, consumption of tobacco and alcohol, sleep patterns and use of seat belts.

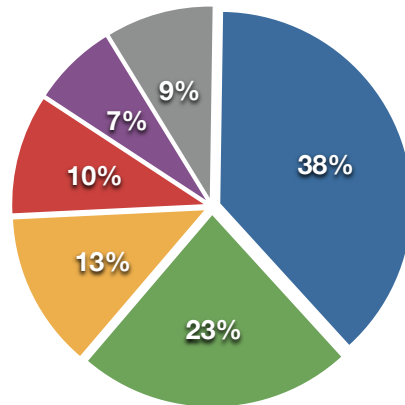
Building Resiliency: Preventing Adverse Childhood Experiences

Earlier this year [2013], the Oregon Health Authority released “Building Resiliency: Preventing Adverse Childhood Experiences (ACEs),” the first report analyzing the 2011 data. Because this is the first cycle of this survey, results should be treated as preliminary. As more cycles of the BRFSS survey are completed, a more robust picture should emerge, and the power of this new tool will only increase. However, because of the nature of BRFSS, it is unlikely that this data will be able to be disaggregated at the level of smaller geographies, such as counties. This first round of data collection does show the extent to which Adverse Childhood Experiences impact the lives of Oregonians: 62% of adults in Oregon have experienced one or more ACEs and 16% have four or more ACEs, an important threshold where the detrimental effects become particularly strong.

Childhood and Adolescent Health Measurement Initiative

The Childhood and Adolescent Health Measurement Initiative (CAHMI) based at Oregon Health & Science University (OHSU) has also been involved in the collection and analysis of national public health data looking at Adverse Childhood Experiences.

Adverse Childhood Experiences are now part of the National Survey of Children’s Health, enabling state-by-state comparisons of prevalence, as well as analysis of how ACEs correlate with a variety of child health and family experiences.



Percentage of ACE scores in Oregon

Number of Adverse Childhood Experiences

- 0
- 1
- 2
- 3
- 4
- 5+

Source: “Building Resiliency: Preventing Adverse Childhood Experiences (ACEs),” Oregon Health Authority.

This public health approach to analyzing ACE data also goes hand in hand with another recent development: a greater attention to community-level Adverse Childhood Experiences. The original ACE Study and ACE scale focused exclusively on adverse experiences within the home — exposure to domestic violence or a parent with a substance abuse problem. There is a growing interest in looking at the impacts of adverse experiences that are experienced by an entire community, such as exposure to racism or violence within a neighborhood.

5. Develop a skilled workforce that can deliver results

The success of Oregon’s three great systems transformations will largely rest on the skills and professionalism of those who work with children and families. The importance of workforce development has been a major focus of both the education and early childhood reforms.

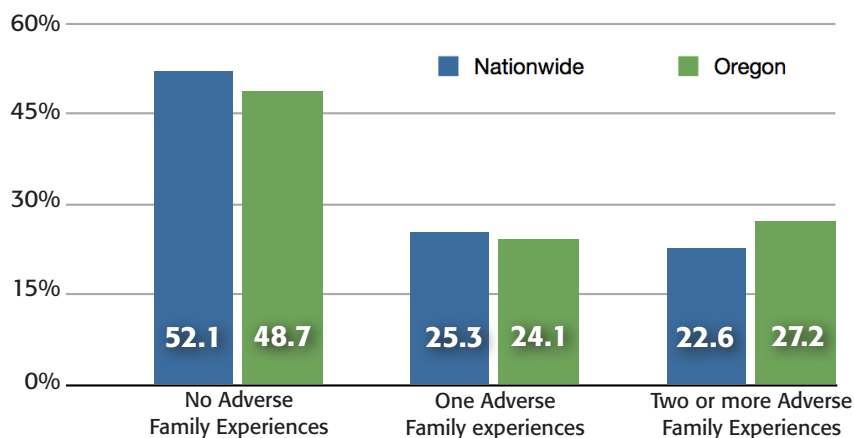
Trauma informed care

The place where the ACE Study has probably had the most impact on practice has been on training and workforce development in trauma informed care. According to Elaine Walters of the Lane County-based Trauma Healing Project, trauma informed care means “that every person who has a point of contact with a patient or client is educated and sensitive to the impact of trauma; that’s from the point of entry until the patient or client walks out the door.” Successfully implementing trauma informed care requires that in addition to developing staff competencies, an organization also looks at policies, procedures and physical space.

Walters’ understanding of trauma informed care has been significantly deepened by research that the Trauma Healing Project has conducted in Lane County. The Survivors Survey, which grew out of a participatory research project with

Trauma informed care: Every person who has a point of contact with a patient or client is educated and sensitive to the impact of trauma; that’s from the point of entry until the patient or client walks out the door.

—Elaine Walters
Trauma Healing Project, Lane County



**Adverse Family Experiences (AFE)
Children age 0-17 years, Nationwide vs. Oregon**

AFE data represent questions that are related, but not identical to the ACE scale. For example, questions are included about socioeconomic hardship and death of a parent.

Source: <http://www.childhealthdata.org/browse/survey/results?q=2614&r=1&r2=39> (accessed: 9.27.13)

survivors of violence and trauma, was a random digit-dial survey of Lane County residents to determine whether they had experienced traumatic violence, and if so, what was its impact. The survey asked about many of the same experiences and outcomes as the ACE Study did.

Like the ACE Study, researchers found that survivors of violence were much more likely to have poor health and life outcomes as adults. Also like the ACE Study, they found that while these experiences greatly increased these likelihoods, there were individuals who seemed to be beating the odds – people who had experienced severe trauma but went on to lead healthy lives.

Common factors in beating the odds

They then asked if there were common factors that these survivors shared that may have contributed to their healing. Project researchers were able to identify three potential contributors:

1. If people felt as if they had been listened to with compassion, they were three times more likely to report being completely or almost completely healed;

2. If someone in their lives understood the impact of trauma on their lives, they were more than twice as likely to report being completely or almost completely healed;
3. If someone with whom they were connected knew how to help them resolve the trauma, they were also more likely to report being completely or almost completely healed.

While the ACE Study is certainly not the only reason for the interest in trauma informed care, it has brought home how the trauma caused by these experiences continues to reverberate across a lifetime.

Professional development focused on trauma informed care is occurring across sectors and involving a wide range of individuals who work with children and families, including judges, medical providers and Head Start teachers, as well as those working directly in the mental health field and in early intervention programs, such as Relief Nurseries.

It includes professionals, paraprofessionals and volunteers, and involves differing degrees of depth and substance. As one interviewee

commented, much of this training involves, “a little smattering here and there.”

Greater Oregon Behavioral Health, Inc.

Greater Oregon Behavioral Health, Inc., better known as GOBHI, is an example of a frontline organization that has invested in this professional development. GOBHI is contracted with the state of Oregon to provide mental health services to Oregon Health Plan patients for a large portion of rural Oregon, including Baker, Clatsop, Columbia, Douglas, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa and Wheeler counties. Every GOBHI provider now has someone who has been trained in child-parent psychotherapy for children ages 0-6 and their caregivers who have experienced trauma.

Professional development for trauma informed care

Trauma informed care is also influencing training outside the behavioral health field. In Multnomah County, a Trauma Informed Care & Professionalism Workgroup has been formed to “increase awareness and implementation of trauma informed care practices in Multnomah County’s child welfare court system (judicial officers, lawyers, DHS workers and management, CASAs and community providers).”

(<http://web.multco.us/ccfc/trauma-informed-care-professionalism-workgroup>; accessed: 9.27.13)

In addition, Multnomah is also infusing the ACE Study and trauma informed care into its training of paraprofessional health promoters, who are trained to work within their community teaching practices that promote good health.

Citizens for Safe Schools

The ACE Study is also an important part of the training that Citizens for Safe Schools provides to its volunteer mentors working with

at-risk school-age children.

Citizens for Safe Schools, based in Klamath Falls, works with 19 schools in two school districts. It supports 86 volunteer mentors working one-on-one with children mostly in fourth through eighth grades. Citizens for Safe Schools Executive Director Debbie Vought has found the ACE Study to be a critical tool for helping volunteers build the empathy they will need mentoring at-risk children:

“My goal is to help adults know how to work effectively with youth, and that’s what leads me to ACEs. When I’m talking to interested volunteers, I start by talking about who are these students that need mentoring. I talk about the outcomes that we can expect them to see with four or more ACEs. I think it significantly heightens their understanding, empathy and tolerance in what they are seeing in kids. Adults will often look at these kids and say, ‘they’re lazy’ or something like that.

“The ACE Study not only provides science but empathy in understanding what these kids are going through and what they are doing. Understanding ACEs helps the adult volunteers have the patience they need to work with these kids.”

6. Build bridges across systems

Because of its ability to translate such things as neglect or growing up with an addicted parent into health and educational outcomes, the ACE Study offers a useful point of departure for cross-systems and cross-agency collaboration. If the frequencies of ACEs are to be reduced and their impacts limited, health, education and human services need to work together.

Children’s Health Policy Team

The Children’s Health Policy Team (CHPT) offers a prime example of how ACEs are being used to focus shared work across state agencies. The CHPT is “charged with providing policy recommendations that contribute to improved health outcomes for children jointly served by [the Oregon Health Authority] and [the Department of Human Services].” Much of its work is being organized around ACEs and addressing the impacts of trauma.

According to a memo from the Children’s Health Policy Team dated April 9, 2013, the group will provide a lead role in convening the following activities:

1. Perform an analysis of existing policy, service and gaps across OHA and DHS regarding ACEs/trauma;
2. Identify needed educational and technical assistance for ACEs/trauma work;
3. Develop a cross-agency strategic plan to address the spectrum of health promotion, prevention, identification and treatment for trauma and ACEs;
4. Identify resources to address this work, including but not limited to federal grants;
5. Provide specific policy recommendations to the Joint Policy Steering Committee that will address the impact of ACEs and trauma on health outcomes in our state.

7. Empower self-organizing communities

Throughout the interviews conducted for this report, Walla Walla, Wash., came up as an example of how the ACE Study can be used by a community to bring people together and galvanize action.

Here in Oregon, both the Coordinated Care Organizations (CCOs) in health and the Early Learning Hubs in early childhood are supposed to be driven by empowered and self-organizing communities.

While the formation of these two entities is in very different stages, both begin with community engagement and self-assessments of needs. Every CCO has a regional council consisting of representatives from local community councils.

These community advisory councils, which are responsible for community needs assessments, include local service providers, dental providers, patients, education and school officials, and representative from Head Start, Early Intervention and Healthy Start.

Organizing for collective action

There is an opportunity to embed ACEs in these community efforts and use it as an organizing principle for collective action. Jeanne McCarty, the Children’s System Coordinator for GOBHI (Greater Oregon Behavioral Health Inc.), notes that this is

If the frequencies of ACEs are to be reduced and their impacts limited, health, education and human services need to work together.

an opportunity that has yet to be fully taken advantage of:

“I wouldn’t say I know of any community or county that has completely taken it on and said, ‘How are we going to change our community to address this, and let’s look at the ACES study to do that.’ Every county is doing something to address all 10 of the ACES even if they aren’t calling it out. They are still finding their feet. Hopefully, they will be able to target the ACES when they are really getting up and running. There is the potential to really develop a community response.”

Collaboration with Walla Walla

As part of an effort to spur such a focused approach, GOBHI has conducted a number of trainings and seminars featuring individuals from the Walla Walla initiative.

“Teri Barila, the coordinator of the Walla Walla County Community Network, came to our annual spring conference,” Jeanne McCarty reported, “and did a four-hour presentation on what they have done in their community and the challenges they have faced.”

The creation of the Early Learning Hubs provides another opportunity for communities to come together around reducing the incidents and impacts of Adverse Childhood Experiences. At the time this report was prepared, Early Learning Hub applicants were in between submitting their Letters of Interest and completing their Request for Applications. As a result, it was premature to determine to what extent the ACE Study is influencing the formation of these hubs.

Lane County’s ‘90by30’

Not all of the efforts to use the ACE Study to bring communities together around common aims are taking place under the auspices of the official systems transformation. Over the last few years, Lane County community members have coalesced around the goal of reducing child abuse and neglect 90% by the year 2030.

This effort — known as “90by30” — is based on the collective impact model: How do you align resources already existing within a community to reach a shared goal? The collective impact model requires that rather than beginning with a list of strategies and plans for implementing them, organizers start with community engagement. In 2011, they held their first community forum, bringing together over 225 participants from Lane County.

According to Jeff Todahl, Director of the Center for the Prevention of Abuse and Neglect at the University of Oregon, which was created to be the back bone organization for this initiative, Lane County will only achieve the 90by30 goal if it succeeds in changing community-wide norms.

One of the questions asked by the Survivors Survey in Lane County (see pages 11-12) was:

During the period of time when you first experienced any of the abuse or violence just mentioned, how often did anyone try to help or protect you?

Nineteen percent of respondents reported rarely and another 48% reported never.

“These are numbers we can change,” Todahl claims, “but only if we change how people in the community think about these things.”

Since the goal of 90by30 is to change community norms, the initiative cannot rely solely on service providers and professionals in the field.

Blackberry Pie Society of Cottage Grove

In order to succeed, it needs to draw on the full civic capacity of the community. Todahl points to the Blackberry Pie Society of Cottage Grove as an example of the kind of group with which they need to engage. The society is a local civic organization dedicated to looking after its community, making sure, for example, that if there is a cracked sidewalk, it gets fixed.

Todahl predicts that it will take another two years of community engagement with groups like this before they are ready to get to specific strategies. The ACE Study has been an important tool in bring people together “because it identifies common denominators; it shows that there is a lot of commonality to this work and that provides natural bridges.”

Supporting diversity

The ACE framework also has another potential use: explaining how these often local and disparate initiatives fit into and support the often rather abstract work of Oregon’s systems transformations such as supporting diversity. A theme that was echoed throughout the interviews — and is also frequently discussed within the three transformations — is the need to be responsive to Oregon’s cultural and regional diversity. If we don’t recognize these differences, our work will fail.

Every county is doing something to address all 10 of the ACEs even if they aren’t calling it out.

Jeanne McCarty
Children’s System Coordinator
Greater Oregon Behavioral Health Inc.



As one interviewee put it when discussing the importance of recognizing the unique needs of rural Oregon:

“In an urban county when a kid comes to school with a knife, he might be considered at-risk for violence, where in Grant County every kid carries a pocket knife. If you don’t understand these cultural differences, you’re going to make big mistakes.”

Conclusion

A number of interviewees noted that while the three transformations, early childhood, health, and education, present a great opportunity to use the ACE framework to shift understanding, focus and practice, we are not there yet. As one interviewee put it, “Right now people are so busy in the weeds getting these things off the ground that they can’t step back and think about the big picture.”

At the same time, these state-investigated transformations seeking to empower local communities can

also distract from the inspired and inventive work in which local communities are already engaged.

One of the potential uses of the ACE Study is as a framework for showing how all of these local pieces are part of the puzzle.

If the ultimate question is how to have healthy, thriving communities and citizens, reducing both the incidents and impacts of Adverse Childhood Experiences must be a central part of the answer.

This work, as the report shows, takes many forms and requires many hands. The ACE framework helps demonstrate how these local projects, even when completely independent from the formal work of the transformations, are critical ingredients for its success. ■

Add your voice

This report is a first attempt by The Ford Family Foundation to chronicle how Oregon is responding to the findings of the ACE Study. If you’d like to share your experiences for a future report, please send us an email: aces@tfff.org

List of Interviewees

Janet Arenz

Executive Director, Alliance of Oregon Children’s Programs

Erin Fairchild,

Defending Childhood Initiative Coordinator, Multnomah County

Beth Gebstadt

Project LAUNCH Director, Oregon Health Authority

Dr. R.J. Gillespie

Pediatrician & Medical Director, Oregon Pediatric Improvement Project

Mary Ellen Glynn

Executive Director, Oregon Association of Relief Nurseries

Dr. Dana Hargunani

Pediatrician and Child Health Director, Oregon Health Authority

Megan Irwin

Early Learning Systems Design Manager, Early Learning Division, Oregon Department of Education

Celeste Janssen

Executive Director, Oregon Mentors

Amy Johnson

Former Director, Building Healthy Families

Peg King

START Program Manager, Oregon Pediatric Society

Susan Lindauer

Executive Director, Children’s Trust Fund of Oregon

Jeanne McCarty

Children’s System Director, Greater Oregon Behavioral Health, Inc.

Heather Murphy

Executive Director, Cottage Grove Relief Nursery

Jeff Todahl

Director for the Center for Prevention of Abuse and Neglect, University of Oregon

Debbie Vought

Executive Director, Citizens for Safe Schools

Elaine Walters

The Trauma Healing Project

