Addressing the Perils Associated with Adverse Childhood Experiences in Washington State

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Justice Policy Journal • Volume 18, Number 1 (Spring 2021)

Abstract

Adverse childhood experiences (ACEs) are traumatic events that can have negative and long-lasting effects on health, welfare, and crime. The experiences cover the spectrum from sexual, physical, and mental abuse to parental incarceration. The state of Washington, realizing the consequences and societal costs associated with ACEs, implemented the Revised Code of Washington RCW 70.190, which allows for the prevention of and intervention in adverse childhood experiences. The policy raises awareness and presents systems that should negate the consequences of ACEs through community networks, partnerships, and training. This paper offers an assessment of how well the law has done since its implementation in 1992.

Introduction

In 2018, an estimated 678,000 children were abused in the United States, and the abusers were the victims' parents about 78% of the time (National Children's Alliance, 2020). Medical and health investigators started an examination of the association between childhood abuse and adult risk behaviors in the mid-1990s (Felitti et al., 1998). Studies found that adverse childhood experiences (ACEs) such

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as abuse or witnessing violence within the household can lead to health issues and negative behavior in adulthood (Brodsky, 1997; Hefferman, 2000; Kendall-Tackett, 1993; Kendler, 2000; Kingree, 1999; Osofsky, 1999; Putnam, 2003; Rohsenow, 1988; van der Kolk, 1991). Research suggests that early childhood experiences with trauma and stress can also lead to various negative health outcomes and behaviors along with illegal behaviors (Dube et al., 2003). Additionally, children from abusive homes are often exposed to devious behaviors such as illegal drug use (Dube et al., 2003). Further, Lee and Hoaken, (2007) hypothesized that childhood physical abuse and neglect can lead to cognitive alterations and perceptions of threat and hostile attribution (Duke et al., 2010).

There are multiple pathways from adverse experiences to delinquency and violence. The initiation of the path begins in adolescence and in families with low supervision and low responsiveness during these years (Borowsky et al., 2008; Duke et al., 2010; Lynch & Cicchetti, 1998). Children in adverse environments may feel hopeless and depressed, further children experiencing ACEs often lack the parental attachment necessary for healthy psychological development. Long-term adult risky behaviors and poor physical health are linked to ACEs (Dube et al., 2001; Duke et al., 2010; Felitti et al., 1998).

ACE outcomes include internalizing symptoms and anger and the seeming need for self-protection (Bergen et al., 2003; Duke et al., 2010; Salzinger et al., 2007). Children sensitive to abuse may sequentially develop abnormal behavior. This development supports a triad of interactions which includes genetic makeup, environmental context, and disordered behavior (Caspi & Moffitt, 2006; Duke et al., 2010). High levels of stress can mean potential maladjustment and poor behavioral functioning. McGowan et al., (2009) associated experiences of childhood abuse with modification of the hypothalamic-pituitary-adrenal stress response and increasing risk for suicide (Duke et al., 2010).

Despite the research and evidence providing information and proof of the relationship between adverse childhood experiences and risky behaviors in adulthood, a sub-sequential initiation of solutions is scarce. Policy responses to ACEs remain deficient. The responses are reactive and "lack intentionality, long-range strategic planning, and system-wide application" (Cooper et al., 2007 p.1). The state of Washington acknowledges and addresses adverse childhood experiences within the state and has implemented systems for prevention. Adverse childhood experiences cause problems for society once the adolescent reaches adulthood. Rather than continue the cycle of ACEs, victims and families should receive appropriate prevention planning and solutions.

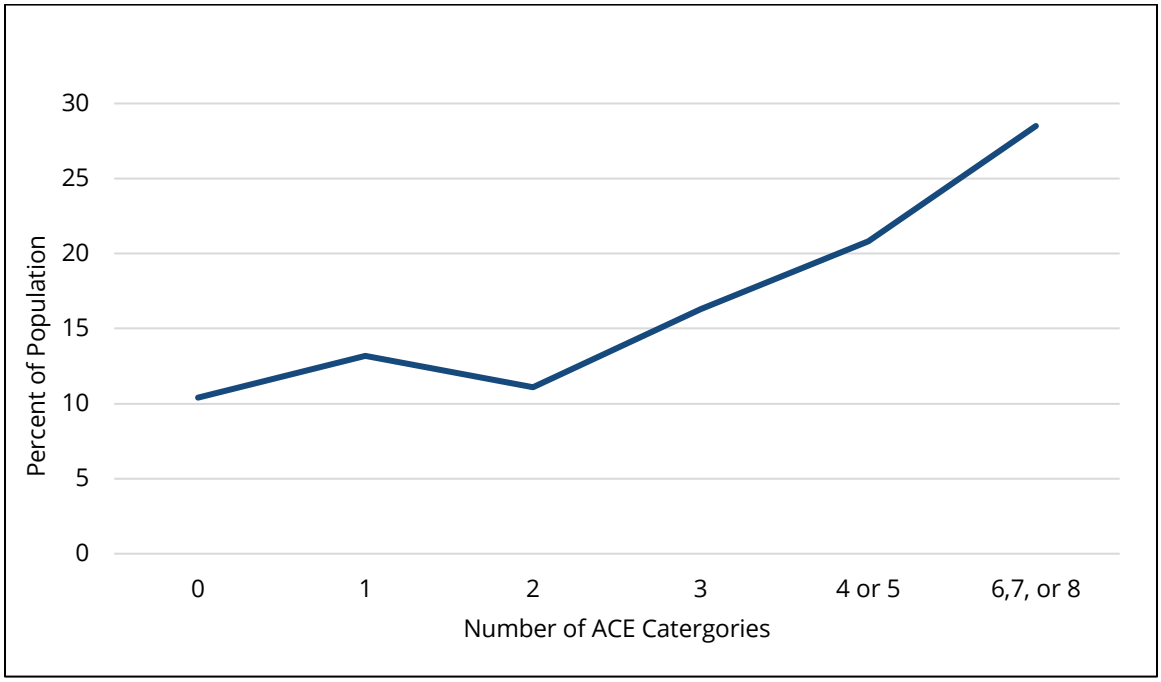
ACEs in Washington and RCW 70.190

Adverse childhood experiences are the most powerful determinates of public health. In the state of Washington, ACEs are common. Based on the Family Policy Council (FPC) data for the year 2011, 62% of the adult population experienced one or more ACE. Of the 62%, 26% report three or more ACEs and 5% report six or more ACEs. Of the proportion of adults exposed to physical abuse, 84% reported at least two or more ACEs. Nearly two-thirds of the adults (72%) exposed to sexual abuse also reported at least two or more ACEs (Carson & Porter, 2019). Washington adults experience high rates of co-occurring and clustered adverse childhood experiences (Carson & Porter, 2019).

After nearly 20 years, the Family Policy Council (FPC) formally ended as a state effort in 2012. The FPC, established in 1989, was formed to address a wide range of problems that contribute to conditions and consequences of ACEs. The Council emphasized ACEs as a field of work. It operated as the state coordinator and a supportive funder of local efforts with the Community Public Health and Safety Networks. The FPC provided an "example of principles of community collaboration and core elements of functions and strategies." Some areas of focus for the Family Policy Council included responding to the increased chances of smoking (see Figure 1) or contracting HIV (see Figure 2) among people who have experiences ACEs. With each added adverse childhood experience, the probability of having mental health problems (see Figure 3) or becoming disabled increased steadily (see Figure 4) (Carson & Porter, 2019).

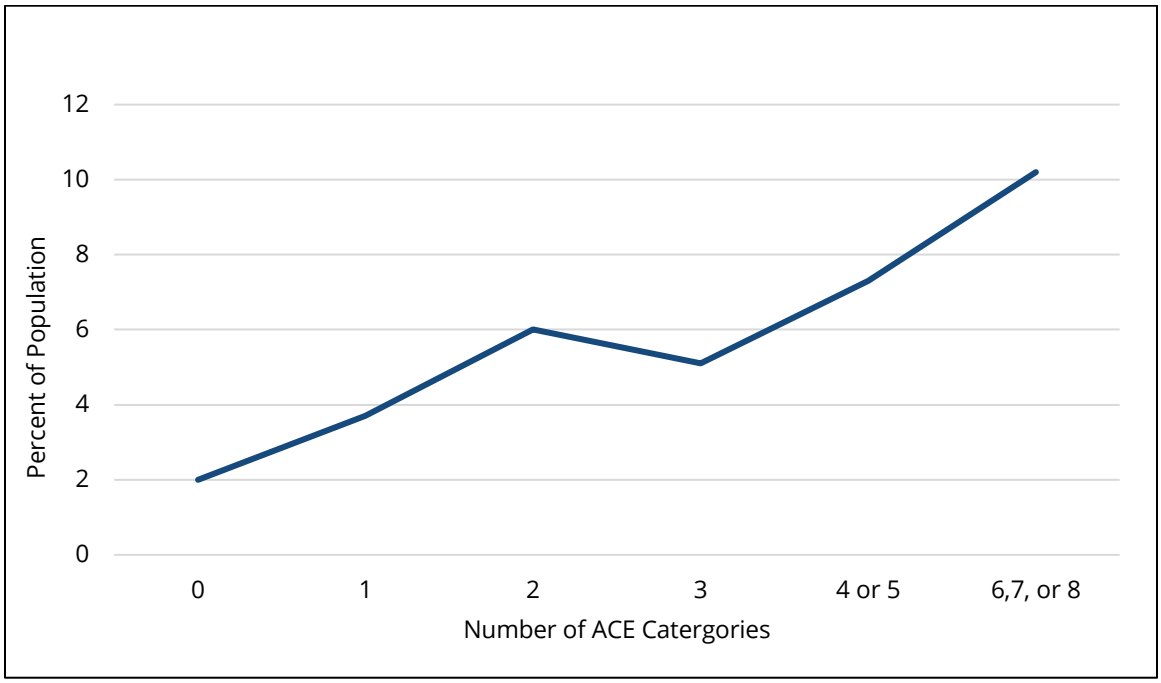
Since the ending of the FPC in 2012, the ACEs Public-Private Partnership Initiative (APPI) was developed to build on the foundational work of the FPC (Blodgett, 2013). An examination of older children in Washington school classrooms (30 high school sophomores and seniors) found that 29% or nine students received exposure to physical abuse or adult-to-adult violence. Of the same respondents, 12% or four students received exposure to physical abuse and adult-on-adult crime. Another Family Policy Council study of 1.2 million found among parenting adults, 26.1% experienced child physical and/or sexual abuse. Of those parenting adults, 78% have 3 or more ACEs, and 29% have experienced six or more ACEs (Carson & Porter, 2019). In 1992, the APPI was enhanced by the provision of RCW 70.190. Washington passed RCW.190 into law in 1992 to mitigate and reduce ACEs throughout the state. Washington acknowledged the importance of community involvement and collaboration with government programs in response to ACEs. This collaboration led to an interagency of 42 local partners creating the Community Public Health and Safety Networks.

Figure 1. Current Smoking



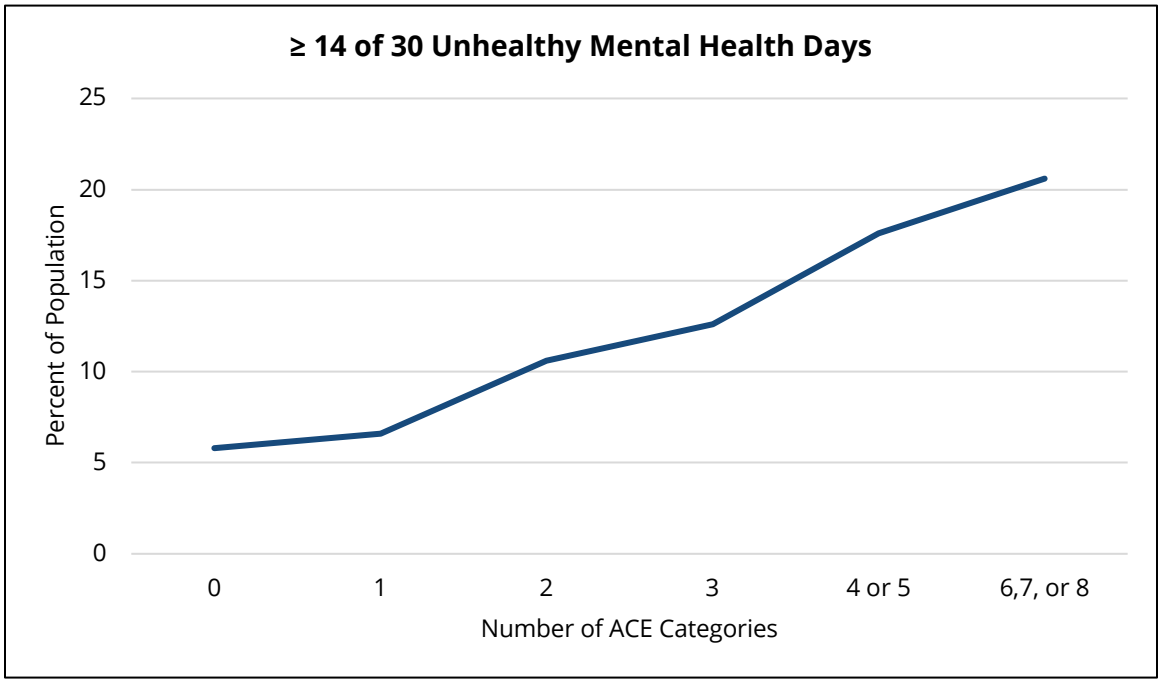
Source: Carson and Porter (2019)

Figure 2. Risk for HIV



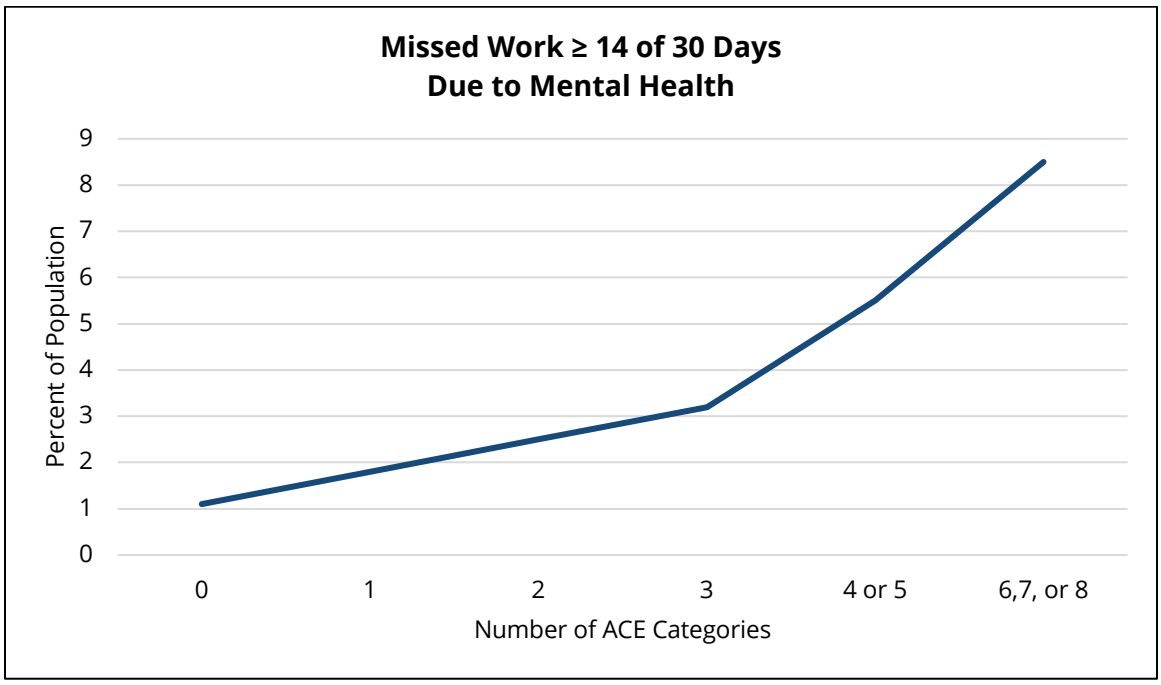
Source: Carson and Porter (2019)

Figure 3. Mental Health



Source: Carson and Porter (2019)

Figure 4. Disability



Source: Carson and Porter (2019)

The RCW 70.190 policy requires a public health approach. The approach must involve defining and measuring the problem, the cause or risk factors, prevention methods, and the implementation of effective schemes, then observing the impact (Satcher & Higginbotham, 2008). Education about health, policy implications, and maximizing funding are a part of the promotion of healthy behaviors and lessening the opportunity for risky behavior (Blodgett, 2013). Interventions promote well-being and assess evidence of disorders and symptoms in high-risk individuals. The Centers for Disease Control and Prevention (CDC) identified 10 services for addressing public health issues such as ACEs (Centers for Disease Control and Prevention, 2020).

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research new insights and innovative solutions to health problems.

Implementation of the 10 services in the FPC and APPI has caused substantial changes in the understanding and reduction of ACEs in Washington. Both programs initiated the use of the APHA steps when they developed trauma interventions, policy and process decisions, and program outcomes for their evaluations.

Another key aspect of the RCW 70.190 law is in-home studies. Nationally, there is an interest in using home visiting as an intervention method for ACEs. Research (Carson & Porter, 2019) shows that families volunteering to receive home-based support from trained professionals have children that are born healthier. The children in these families are less likely to experience abuse and neglect. When the public invests in programs with substance and quality, they create stronger families and fiscal returns of up to $5.70 per dollar spent (Carson & Porter, 2019).

The home visiting program is a federal initiative included in the Health Care Reform legislation. The funding for the program is a mandatory $1.5 billion over a 5-year period that is not subject to annual appropriations process. The program

began in October 2010 and had to be reauthorized by Congress. All the states participating in the program receive an allocation based on the population of children within the state (Carson & Porter, 2019). A major advantage of using the opportunity to engage in the home visiting initiative is the allocation process that requires 75% of funding usage for evaluated and effective programs. The program also allows 25% of the funding to be used for promising programs and practices with strong evaluations in progress or the planning stage. The finding expectancies indicate the federal government is serious about changing the effect of ACEs on its population. The initiative requires that data collection occur to show outcomes (Carson & Porter, 2019).

In 2010, the state of Washington decided to use home visiting services in the communities with greatest ACEs needs. Washington has grown from funding four grantees aiding 120 children to 36 grantees aiding approximately 2,000 children throughout the state. Through a program called NEAR@Home, home visiting professionals found ways to unfold life's complexity by addressing ACE histories in parents and how ACEs may impact their lives and parenting skills. The program is based on the theory of change (Kirkpatrick, 1959) which includes five core elements: preparing, asking, listening, affirming, and remembering. The Pew Center explained that the outcomes of in-home studies are the following: a bright future before birth, stronger bonds indicating a better life, a strong foundation for continuous learning, a safe and healthy home, and benefits that last past the home life. Interventions are more efficient when building upon another intervention. Starting home visits during pregnancy is imperative. It gives the women support and improves health practices. The mothers receive consistent prenatal care, improve their diet and activity, and reduce smoking, alcohol, and drug use. The care ultimately reduces the stress on the mother and the fetus. Using the home visiting program caused a decrease in the mothers' (low-income and unmarried) and their adolescents' (15-year-olds born to low-income and unmarried mothers) risky and unhealthy behaviors (Carson & Porter, 2019).

The strong bond and attachment between a mother and infant must develop while the child is in the womb. This early relationship between the mother and infant develops empathy and the ability to learn. Less stressed mothers become more socially competent, allowing them to learn and make safe choices for their families. Healthy relationship patterns carry on into other relationships for both the mother and the baby (Carson & Porter, 2019). Evidence shows that proactively starting in pregnancy to address family dynamics gives sufficient time to build trust between the mother and the home visitor. The visitor must model a trusting bond and relationship for the mother and baby to see. The bonding occurs when the

home visitor meets the mother where she is, engages her despite her difficulties, celebrates her small changes forward, and develops methods to ease her ACE-related challenges. The participants in these programs tend to identify as wanting to be better parents and desiring new methods of parenting.

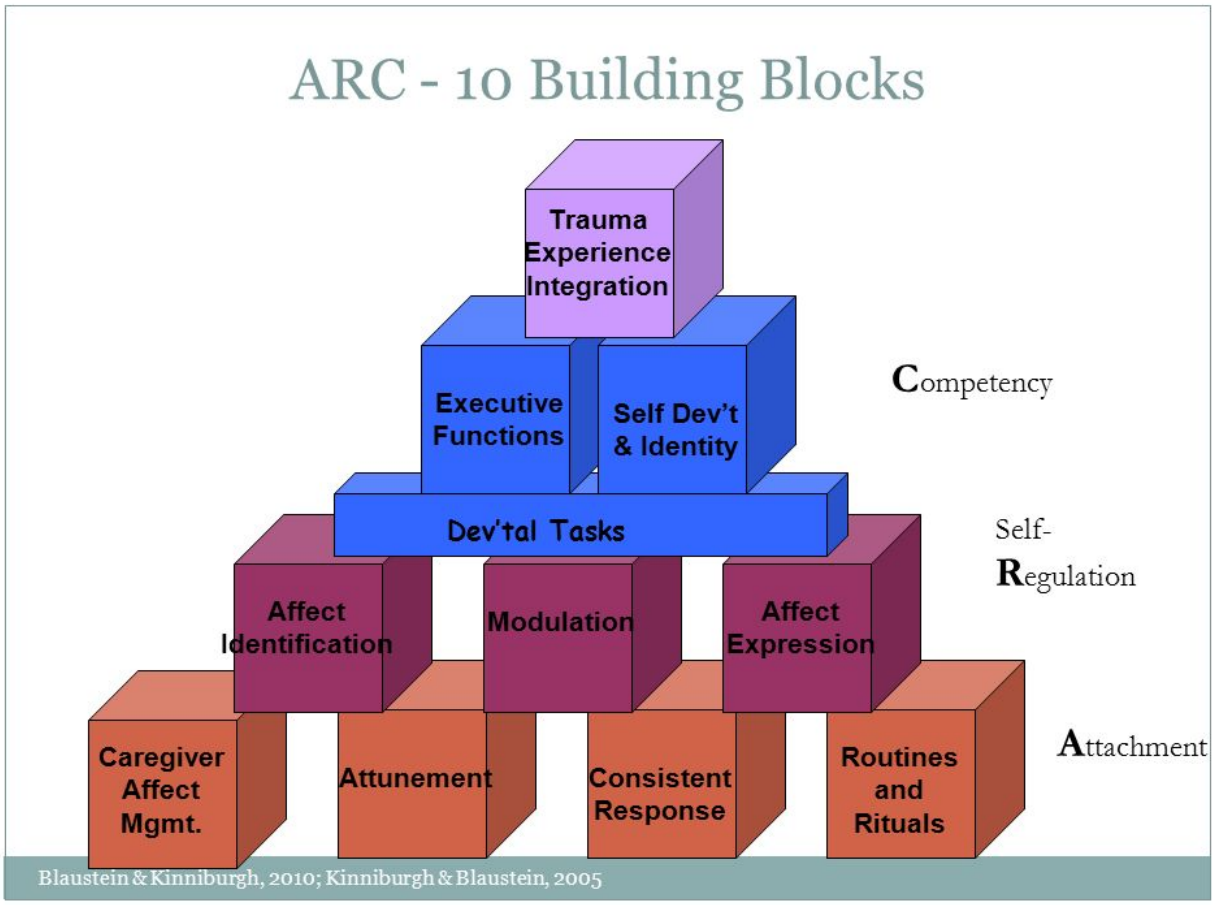
RCW 70.190 also utilizes an Attachment, Self-Regulation, and Competence (ARC) Framework. The first part of the design, attachment, describes the physiological, emotional, and behavioral communications between a child and caregiver. The purpose of this stage is intervention to build or rebuild healthy attachments between the traumatized children and their caregivers. The attachment stage also establishes a support system for a healthy recovery. The target principles for intervention in this step are caregiver affect management (identifying challenging situations), attunement (support caregiver active curiosity), consistent response (identify, experiment with, and enhance response strategies that increase youth felt safety), and routines and rituals (target routines to key identified areas of child/family functioning) (Blaustein & Kinniburgh, 2010; Blodgett, 2013).

The next step is the self-regulation process, which allows an individual to modify affective, physiological, cognitive and behavioral experience through internal control. Self-regulation is influenced by a child's temperament and experiences. Increasing the child's self-regulation ability is identified as the primary target of intervention in this stage (Cook et al., 2005). The three key principles in this step include affect identification (identification in self: a connection of emotions, body sensations, behavior, and cognition); modulation (support and facilitate strategies that successfully lead to state change); and affect expression (exploring goals of expression; building comfort and safety in relationship) as methods to improve self-regulation (Blaustein & Kinniburgh, 2010; Blodgett, 2013).

The final step in the model is competency, which is the process of development. As a child ages, he or she continuously develops, and each developmental stage requires key tasks. Children must use their cognitive functioning and their past successes to grow. This stage addresses the enhancement of normative development and the establishment of external resources. In this stage, there are three key principles: developmental tasks (building interest in exploration), executive functions (emphasizing personal responsibility in decision-making), and self and identity (building a sense of self that integrates past and present experiences and incorporates multiple aspects of self (cohesive self)) (Blaustein & Kinniburgh, 2010; Blodgett, 2013). The framework, originally created by Blaustein and Kinniburgh (2010) is being adapted by the ACEs Public-Private Partnership Initiative (APPI) team to study how complex trauma treatment and intervention can integrate with a public health approach (such as the home visiting initiative).

The ARC model is a components-based model including 10 core targets of treatment with four primary areas of treatment response. The four areas of response are (1) impact of traumatic stress; (2) normative and impactive attachment; (3) normative development; and (4) factors associated with resilience among stress-impacted youth (Blaustein & Kinniburgh, 2010). The principles and techniques of the model are active and adaptive through a cycle of continuous practice. Unlike the home visiting initiative, the ARC is designed for youth in early childhood through adolescence and their caregivers (see Figure 5).

Figure 5. ARC – 10 Building Blocks



Source: Blaustein & Kinniburgh (2010); Kinniburgh & Blaustein (2005)

Research (Arvidson et al., 2011; Blodgett, 2013; Hodgdon et al., 2013; Hodgdon et al., 2016) supports the ARC framework and demonstrates its ability to meet the standards necessary to be a promising evidence-based practice. In Alaska, within a young (0-12) child-welfare-involved population, 92% of children who partook in the

ARC model received permanent placement (adoptive, pre-adoptive, or biological family reunification) in comparison to the 40% rate for the entire state (Arvidson et al., 2011). A study by Hodgdon et al., (2015) using a pre and post analysis of 481 adoptive children (ages 6-17) and their families who completed a 16-week ARC-based treatment found a significant decrease in PTSD symptoms. The study also found increases in child adaptive skills (reported by mothers), significant reduction in bored behavioral symptoms, and reduced parenting stress for both mothers and fathers.

The fact that ARC professionals and ACEs organizations (THRIVE and NEAR@Home) learn about the effects of chronic trauma in children and families seems to be a part of its success (Arvidson et al., 2011; Blodgett, 2013; Hodgdon et al., 2013; Hodgdon et al., 2016). Each step of the ARC Framework builds off the previous step, allowing distinct modifications to behaviors and health. The framework may have usage in both clinical and nonclinical settings; it can also be used in educational settings (Blodgett, 2013).

Recommendations

Clearly, the impact of ACEs demands a response. Practitioners, communities, and policy makers should build an informed response to this public health and justice systems issue. Adverse situations can become intergenerational and the trauma then continues well into the future if unchecked (Carson & Porter, 2019). Trauma is a complex risk because after the initial exposure, the child must often deal with further, unpredictable, and persistent risks (Carson & Porter, 2019).

Evidence shows the home visiting program causes significant changes in the mothers and children of those involved. The program offers the participants a sense of hope by way of resiliency. Resiliency is the ability to recover quickly from difficulties and acts as a buffer to traumatic events. Social support and protective factors from multiple sources can increase resiliency and allow the child to develop effectively. Trained community members, practitioners, and policymakers need to work to build resiliency among ACE-affected persons from early childhood to reduce their despair and vulnerability. If the child believes he or she can overcome a situation, that child will learn how to adapt. In-home visits provide support and resources for the mothers and child. The program increases the knowledge and development for the parents allowing the transition of resiliency across generations (Carson & Porter, 2019). Despite these promising results, the outcomes can improve by incorporating the ARC framework.

Including the ARC framework conveys more focus on the trauma aspect of ACEs. Some individuals need more intensive services than others, and the correct screening can indicate those individuals (Carson & Porter, 2019). The ARC framework and the home visiting initiative focus on educating persons about ACEs. Education about ACE allows the parents to recognize and understand the impact that ACE may have on their life and parenting skills (Carson & Porter, 2019). This allows parents to change their parenting methods and to avoid the transmission of trauma across generations. An integration of the two evidence-based practices, home visiting and the ARC trauma framework, allows the education of communities and opens access to resources and support for the families.

Practitioners, communities, and policymakers should educate themselves about ACEs, how they affect the public, and the necessity of evidence-based interventions. Training practitioners, communities, and policymakers reduces the health and behavior risks in the country. Populations with high-risk factors are most prone to ACEs and should receive additional screening and programs. Fighting ACEs is dependent upon community networks, and therefore the community networks must expand. To end ACEs, comprehensive and collaborative community effort is paramount. This can only occur with help from practitioners and policymakers. Washington realized that and implemented the APPI and THRIVE programs and more states should follow.

Conclusion

The state of Washington made strides in the right direction with the introduction of community networks to identify and to prevent ACEs. The state's focus on training and understanding those dealing with ACEs is acknowledged in the many program networks that have been developed. The use of evidence-based practices improved many systems (i.e., Parent Programs, Early Learning, Law Enforcement, etc.) within the state, by instilling methods of resilience to trauma. By improving the community's ability to partner and help the residents, vital health and behavioral reform occurs. Washington found a method of integrating public, private, and community organizations in an effort to reduce ACEs and the method is promising.

It is vital that nationally, frameworks and evidence-based practices created by states such as Washington are expanded and adjusted as necessary. Data collection has proven the efficiency and effectiveness of including in-home visits and ARC modeled programs (Arvidson et al., 2011; Blodgett, 2013; Carson & Porter, 2019; Hodgdon et al., 2013; Hodgdon et al., 2015; McKinsey, 2008). Trauma is a complex issue, at both the micro and macro levels. A national trauma informed public health

framework is the best proposition for the nation's well-being. Blodgett (2013) proposed this idea for the state of Washington, but after analyzing the information collected in the state, concluded that it is necessary to implement the same plan throughout the country. This proposition advances current practices and policies without the need to recreate approaches.

As more information regarding ACEs develops from the advancement of neurobiology and trauma care, practitioners, communities, and policymakers must absorb the knowledge and alter current practices accordingly. Currently, understanding what works, how it works and why it works is important to mastering the implementation of these programs nationwide. ACEs must not be overlooked if states truly care about the well-being of children and families and their futures.

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