hpio health policy institute of ohio

Health **Policy** Brief

Taking action to prevent Adverse Childhood Experiences (ACEs) in Ohio

Many Ohio children are exposed to adversity and trauma, and the consequences are often harmful and costly to individuals, families and society at large. Trauma can continue across generations; children of parents who experienced adversity are at an increased risk of trauma exposure themselves.[1]

Since 2020, the Health Policy Institute of Ohio (HPIO) has researched and analyzed adverse childhood experiences (ACEs) and what Ohio can do to address them. This analysis found that preventing ACEs can result in substantial health and economic benefits for Ohioans. Achieving the goal of preventing childhood adversity requires getting ahead of potential harms, creating safe, stable and nurturing environments and fostering resilience.

Public and private partners at the state and local level have a collaborative role to play in ACEs prevention. HPIO analysis elevated 12 evidence-informed and cost-effective ACEs prevention strategies for Ohio, as shown in figure 1. These represent a comprehensive and strategic approach to preventing ACEs in Ohio.

3 key findings for policymakers

- **Adverse childhood experiences are pervasive in Ohio** and can have considerable health and cost implications.
- **The 12 evidence-informed strategies** elevated by HPIO can reduce the ACEs with the most significant health and economic impacts in Ohio.
- **Communities can work together to address the root causes of ACEs and foster health and resilience**, by using methods such as the Building Community Resilience (BCR) approach.

This brief is a summary of the information and resources available through HPIO's **Ohio ACEs Impact Project**, and also includes guidance for local and state partners working to elevate ACEs prevention policies or program interventions.

Figure 1. **Key strategies for preventing ACEs in Ohio**

	▼ 12 key strategies
• Ensuring a strong start for children • Strengthening economic supports for families	1. Early childhood education programs 2. Early childhood home visiting 3. Medical-legal partnerships 4. Family income supports
• Enhancing skills so that parents and youth can handle stress, manage emotions and tackle everyday challenges • Connecting youth to caring adults	5. Parent, caregiver and family skills training 6. School-based violence, bullying and intimate partner violence prevention programs 7. School-based social and emotional instruction 8. Mentoring programs
• Promoting social norms that protect against violence and adversity • Intervening to lessen immediate and long-term harms	9. Community-based violence prevention 10. Drug courts 11. Trauma-informed care 12. Behavioral health treatment

Through **collaboration** among a variety of partners, communities can strategically allocate resources, coordinate services and amplify efforts to prevent ACEs.

Adverse childhood experiences

ACEs are potentially traumatic events that occur during childhood. Early research on ACEs grouped them into three categories: abuse, household challenges and neglect, listed in figure 2.[2]

Figure 2. **Adverse childhood experiences, by category**

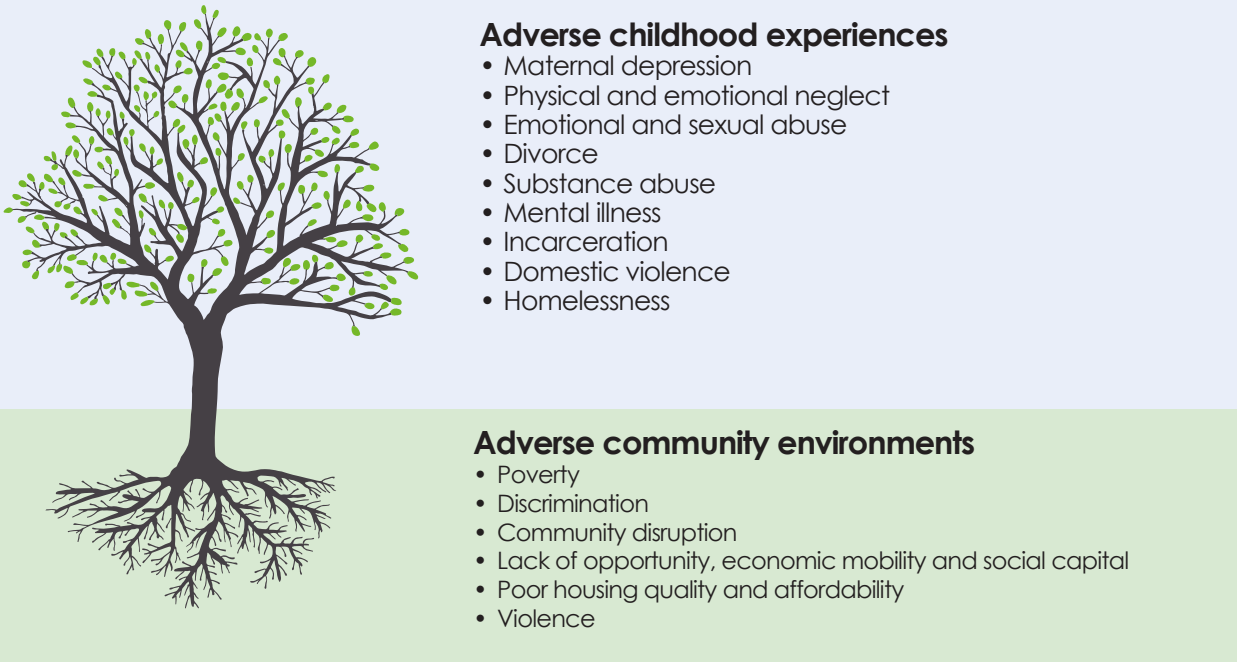
Abuse	Household challenges	Neglect
• Emotional abuse • Physical abuse • Sexual abuse	• Intimate partner violence • Substance use in the household • Mental illness in the household • Parental separation or divorce • Incarcerated member of the household	• Emotional neglect • Physical neglect

Note: These are the categories and ACEs included in the Behavioral Risk Factor Surveillance System (BRFSS), a tool used to collect state data on health-related measures. These ACEs have been used for HPIO's analyses in the Ohio ACEs Impact Project.

More recent research has expanded the list of ACEs to include other forms of childhood adversity and trauma, such as experiencing community violence, homelessness, poverty and racism or other forms of discrimination.[3] The Pair of ACEs framework, introduced in 2017, depicts adverse community environments as the root causes of ACEs, as shown in figure 3.

There is clear **evidence** that ACEs exposure is linked to poorer health and well-being through adulthood. Generally, the more ACEs a person is exposed to, the greater the risk of these poor outcomes.[4]

Figure 3. **Pair of ACEs framework**

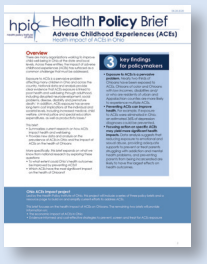


Source: Adapted from Ellis, W., Dietz, W.H., Chen, K.D. (2022). Community Resillience: A Dynamic Model for Public Health 3.0. *Journal of Public Health Managemenet and Practice*, (28)1, S18-S26. doi: 10.1097/PHH.0000000000001413

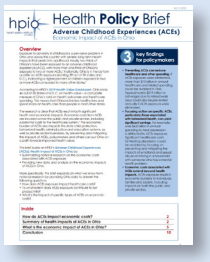
Ohio ACEs Impact Project

PHASE 1

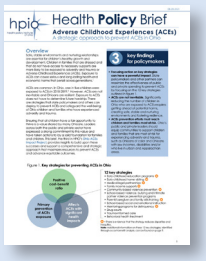
HPIO developed three foundational policy briefs with Ohio-specific analysis:



Health impact of ACEs in Ohio
(August 2020)



Economic impact of ACEs in Ohio
(February 2021)

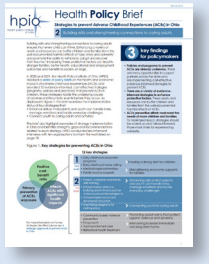


A strategic approach to preventing ACEs in Ohio
(August 2021)

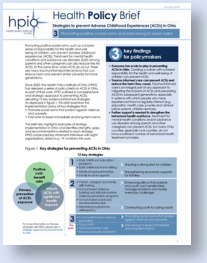
PHASE 2

HPIO took a closer look at the 12 strategies introduced in the third brief of phase 1:

Ensuring a strong start for children and strengthening economic supports for families
(October 2022)



Building skills and strengthening connections to caring adults
(August 2023)



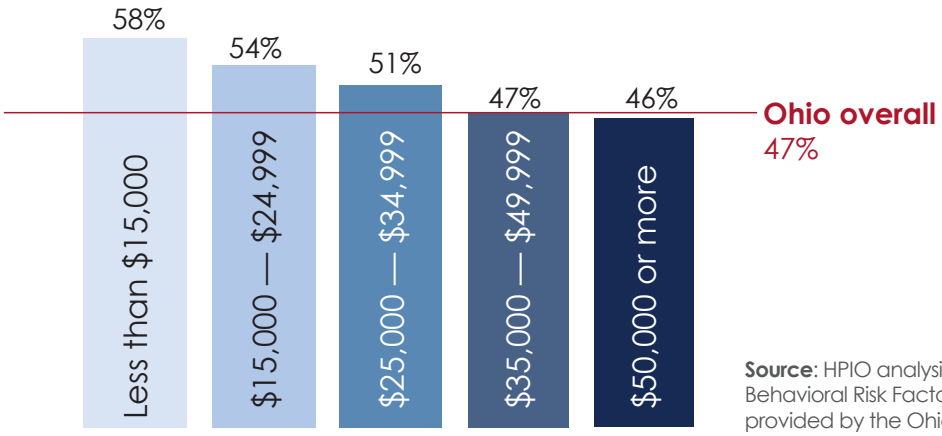
Promoting positive social norms and intervening to lessen harm
(January 2024)

For each strategy, the briefs describe: (1) Research evidence on expected outcomes (2) The extent to which the strategy is being implemented across Ohio, along with examples (3) Implementation considerations (4) Strengths, gaps and recommendations of how to enhance or expand implementation throughout the state

ACEs in Ohio

ACEs are **pervasive** in Ohio. In 2021, 69% of Ohio adults reported exposure to one or more ACEs during childhood, and 47% reported experiencing two or more.[5] Some groups of Ohioans experience ACEs at higher rates than others, including Black Ohioans, Ohioans living in urban and Appalachian counties, Ohioans with disabilities and Ohioans with low incomes.[6] Figure 4 displays ACEs prevalence by income.

Figure 4. **Prevalence of two or more ACES, by income, 2021**



Source: HPIO analysis of data from the 2021 Behavioral Risk Factor Surveillance System provided by the Ohio Department of Health.

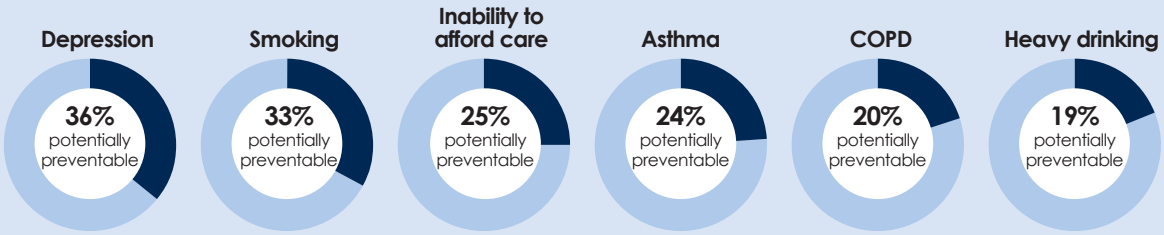
Health and financial impacts of ACEs in Ohio

In 2020 and 2021, HPIO released two publications analyzing the **health** and **economic** impacts of ACEs. The following ACEs were identified as having a significant impact on the health of Ohioans:

- Emotional abuse
- Sexual abuse
- Living in a household with a person with a substance use disorder
- Living in a household with a person with a mental health condition
- Living in a household with someone who is incarcerated[7]

This analysis also included the extent to which several harmful health behaviors and negative health outcomes can be attributed to ACEs exposure, as displayed in figure 5. For example, if exposure to ACEs was eliminated, an estimated 36% of depression diagnoses could be prevented among Ohioans.[8]

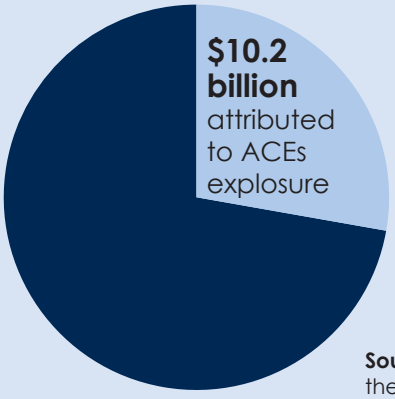
Figure 5. **Population attributable risk (PAR) for outcomes with a significant relationship to ACEs exposure**



Note: In this analysis, PAR provides an estimate of the percentage of negative health-related outcomes in Ohio's entire adult population that can be attributed to Ohioans who have experienced two or more ACEs.
Source: Data from the 2015 BRFSS was provided by the Ohio Department of Health's Division of Health Improvement and Wellness.

ACEs exposure also results in direct and indirect costs to individuals, families and society at large. This includes costs to the healthcare, children services and criminal justice systems, as well as reduced quality of life and lost productivity.[9] For example, more than $10 billion in annual statewide public and private healthcare spending on depression, asthma, COPD, smoking and excessive drinking can be attributed to ACEs exposure, as highlighted in figure 6.[10]

Figure 6. **Annual spending on ACEs-associated conditions and behaviors in Ohio and the portion attributable to ACEs exposure (in 2020 dollars)**



Total: $36.3 billion in spending on depression, asthma, COPD, smoking and excessive drinking

Source: Analysis of data from the Medical Expenditure Panel Survey and the Centers for Disease Control and Prevention

Twelve ACEs prevention strategies

HPIO used the Centers for Disease Control and Prevention (CDC)'s FY2021-FY2024 **Adverse Childhood Experiences Prevention Strategy** framework to guide selection of 12 evidence-informed strategies that:

- Are **primary prevention strategies**, meaning they aim to reach children before they are exposed to ACEs. These interventions have the broadest potential for impact.
- Have a **positive cost-benefit ratio**, meaning the total benefits from implementing the strategy outweigh its cost.
- Have **evidence of affecting the ACEs with the most substantial health and economic costs** to Ohio (listed on page 4).

The 12 elevated strategies, shown in figure 1 on page 1, address a range of ACEs and can be implemented by a variety of sectors. Importantly, these are only examples of ACEs prevention strategies. There are many others, as shown in HPIO's **inventory of 186 evidence-informed strategies**; each strategy has evidence of preventing or mitigating the impacts of at least one ACE.

Risk and protective factors

A strategic approach to preventing and mitigating the harms of ACEs must focus on both promoting protective factors and reducing risk factors for ACEs. Figure 7 provides examples of both protective and risk factors.

Risk factors are circumstances or conditions that increase a child's likelihood of being exposed to an ACE. Risk factors can occur at the individual, family and community levels.

Protective factors are assets and resources that can buffer children and families from the harmful effects of toxic stress and adversity. These factors promote resilience, or the ability to withstand, adapt to and recover from adversity. Studies have shown that people with higher levels of resilience are less likely to experience health problems caused by ACEs.[11]

Figure 7. **Examples of risk and protective factors for ACEs**

	Risk factors	Protective factors
Community	• Communities with limited education and economic opportunities • Communities with high rates of violence and crime • Communities with easy access to drugs and alcohol	• Communities with healthcare providers • Communities with safe and affordable housing • Communities with high-quality childcare and early childhood education providers
Family and peers	• Caregivers who experienced ACEs as children • Families living in poverty • Caregivers with limited understanding of children's needs or development	• Caregivers who provide safe, stable and nurturing relationships • Families who can meet basic needs • Positive friendships and peer networks
Individual	Children who do not feel they can share their feelings with their caregivers	Children who develop healthy social and emotional skills

Source: Modified from: "**Risk and Protective Factors**." Centers for Disease Control and Prevention. Accessed May 17, 2021.

Common strengths, gaps and recommendations for the 12 ACEs prevention strategies

Common themes in the strengths, gaps and recommendations emerged from HPIO's analysis of the 12 strategies, as shown below. Readers should note that the policy environment surrounding some of these strategies may have changed since the corresponding brief was published.

Strengths

Common strengths identified include:

- **Implementation and funding**. All 12 strategies are being implemented to some extent throughout Ohio. Four strategies (early childhood education and home visiting; parent, caregiver and family skills training; and drug courts) are available statewide or programs exist in every county. Many of the strategies are supported by public funding, but supplemental sources of private funding are also commonly needed.
- **Strong foundation.** Ohio has a strong foundation on which to build for several strategies, including the **trauma-informed care regional collaboratives**, **social and emotional learning standards** and the **state requirements for violence prevention education** and **anti-harassment, intimidation and bullying school policies**. Further, Ohio can build on the mission of the newly-created Department of Children and Youth and work with the General Assembly to develop a comprehensive approach to addressing ACEs.
- **School funding**. The state provides **Student Wellness and Success funds** to school districts, which can be used to support five of the 12 strategies (school-based violence prevention, social and emotional instruction, mentoring programs, trauma-informed care and behavioral health treatment)
- **Leadership**. Several strategies are priorities for Gov. DeWine, including early childhood home visiting and behavioral health treatment. In addition, the Ohio General Assembly has taken steps to improve access to behavioral health treatment, such as allocating funding for pediatric behavioral health in the last operating budget.

Gaps

Common gaps identified include:

- **Funding**. While all strategies are being implemented to some extent around the state, almost all lack stable, sufficient funding.
- **Workforce shortages**. Workforce shortages, especially related to early childhood care and education professionals, prevention educators and mental health professionals, are a barrier for full implementation of many of the 12 strategies.
- **Need for community buy in**. A lack of community buy-in has impeded successful implementation of several strategies, including drug courts and school- and community-based violence prevention programs.

Recommendations

Recommendations for all ACEs prevention strategies are compiled **here**. Below are some important considerations to remember when implementing these ACEs prevention strategies:

- **Tailored implementation.** Ensure strategies are tailored and adapted to the community and specifically to those families that are most at risk of ACEs exposure. For example, a specific home visiting model may be more appropriate for one community than another.
- **Authentic engagement of families.** Engage families who have experienced or are at greatest risk of ACEs exposure in a meaningful and authentic way in planning and implementation.
- **Community context.** Understand the current and historical community context that could influence effectiveness.
- **Reduce barriers.** Reduce participation or engagement barriers that may prevent children and families most at risk of ACEs exposure from reaping the full benefits of a strategy (e.g., transportation, cultural/linguistic or accessibility barriers, childcare).
- **Rigorous evaluation.** Evaluate whether a program or policy was successful in reducing ACEs, disparities and inequities. (See HPIO's **Moving toward equity: Equity evaluation toolkit**)

Guidance for elevating ACEs prevention strategies

There are many organizations working to improve children's well-being across Ohio. Public and private partners at the state and local levels can collaborate to elevate and implement the 12 ACEs prevention strategies using the four steps described below. This framework is flexible; the ordering of these steps and the recommendations under them may need to differ from one community to the next.

▶ Engage and explore

- Engage community partners, including Ohioans most at risk of experiencing ACEs, to review and consider prevention strategies. The **Choosing ACEs Prevention Strategies worksheet** includes tips for community engagement.
- Discuss the relevance of the strategies for your community, organization and sector.
- Review data related to strategies of interest, including cost-benefit analyses. HPIO's **Sources of publicly available data** resource may be helpful.
- Review HPIO's **ACEs Impact Project** publications to learn more about the policy environment related to each strategy

▶ Prioritize

Select one or more strategies that are most important to your community or constituents using criteria such as impact on equity, political feasibility, alignment with existing initiatives and partnerships and/or other factors.

The **Choosing ACEs Prevention Strategies worksheet** contains additional guidance.

▶ Align and advocate

- Identify partners with a common interest in addressing ACEs and advancing the prioritized strategies.
- Join or build a coalition with cross-sector partners and community members.
- Develop and implement an advocacy plan to advance implementation, funding and/or support for the ACEs prevention strategies.

The next page contains additional guidance related to building coalitions and advocacy.

Building Community Resilience

Building Community Resilience (BCR) is an approach that facilitates collaboration across organizations and systems to address the root causes of ACEs and build healthier and more resilient communities. BCR utilizes the Pair of ACEs framework (discussed on page 2), which considers both ACEs and Adverse Community Environments, such as poverty, lack of opportunity and violence, and explains how community factors influence individual-level adversity.[12]

BCR's strategic readiness and implementation process enables partners from different sectors to align services and resources to prevent the Pair of ACEs. This process is guided by continuous quality improvement and involves[13]:

1. Creating shared understanding of childhood and community adversity
2. Assessing system readiness
3. Developing cross-sector partnerships
4. Engaging families and residents in a collaborative response to prevent and address the Pair of ACEs

Through this systematic approach, partners can address dimensions of the Pair of ACEs framework based on their expertise, with these efforts coordinated within the community-based network. Teams also collectively develop strategies – from implementing trauma-informed practices to data sharing and advocating for policy change – to build child, family and community resilience.

Coalition Example: Joining Forces for Children

Joining Forces for Children (JFfC) is a BCR initiative in the Greater Cincinnati region. JFfC is led by Cincinnati Children's Hospital and includes over 50 organizations and 600 members from school systems, social service agencies, medical providers and others.[14] JFfC's work focuses on four key areas in which partners raise awareness and develop trauma-informed policies and practices: early childhood, school age, health care and community movement building.

Collaboration and coalitions

Many sectors, including housing, education and criminal justice, have a stake in child health and community well-being. Coordinated, collective efforts can reach children and families where they are, maximize the use of resources and amplify advocacy efforts. Coalitions can also facilitate sharing of knowledge and data to inform ACEs prevention efforts. For additional guidance, review the **coalition-building worksheet**.

Advocacy

Advocacy plays an important role in creating policy change to improve community outcomes. There are many forms of advocacy, including education and building relationships with policymakers, creating and convening a coalition and lobbying. Policymakers need to hear from constituents and experts about the issues that impact their community, and the state as a whole.

HPIO's **advocacy worksheet** and **From Pilot to Policy: Tools for Program Staff, Philanthropy and Other Stakeholders** policy brief contain more guidance.

▶ Monitor implementation

- Monitor and document any policy changes, including implementation of the strategies or lack of progress
- Communicate on a regular basis with stakeholders about implementation status and outcomes
- Continue to engage community partners, including those who have or are at greatest risk of experiencing ACEs, to discuss implementation success stories and challenges

HPIO's **Moving toward equity: Equity evaluation toolkit** contains additional guidance on evaluation, with a focus on incorporating equity into evaluation efforts.

Conclusion

Many of Ohio's public and private leaders have demonstrated a commitment to ensuring the well-being of children and families across the state. However, to become a national leader in child health and well-being, Ohio policymakers and other partners must align on a comprehensive and strategic approach for addressing ACEs. The 12 strategies elevated by HPIO can maximize the effectiveness of public and private spending and provide a roadmap for moving Ohio forward. While all strategies are being utilized throughout Ohio to some extent, there is much more that can be done.

Notes

1. Borja, Sharon et al. "Adverse childhood experiences to adult adversity trends among parents: Socioeconomic, health and developmental implications." *Children and Youth Services Review* 100 (2019): 258-266. doi: 10.1016/j. childyouth.2019.03.007
2. Felitti, Vincent J. et al., "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults," *American Journal of Preventive Medicine* 14, no. 4 (1998): 245-258. https://doi. org/10.1016/s0749-3797(98)00017-8
3. Philadelphia ACE Survey. The Philadelphia ACE Project. Accessed 5.12.24 https://www.philadelphiaaces.org/philadelphia-ace-survey.
4. Anda, Robert. "The Adverse Childhood Experiences Study: Child Abuse and Public Health." *Prevent Child Abuse America, 2011.* https://preventchildabuse.org/wpcontent/uploads/2016/02/anda_wht_ppr.pdf
5. Data from the 2021 Behavioral Risk Factor Surveillance System provided by the Ohio Department of Health
6. HPIO analysis of data from the 2021 Behavioral Risk Factor Surveillance System provided by the Ohio Department of Health.
7. Health Policy Institute of Ohio. Adverse Childhood Experiences: Health Impacts of ACEs in Ohio. Aug. 2020.
8. Ibid.
9. Schickedanz, Adam et al. "Adverse Childhood Experiences and Household Out-of-Pocket Healthcare Costs." *American Journal of Preventative Medicine 56*, no. 5 (2019): 698-707. doi: 10.1016/j.amepre.2018.11.019 See also National Survey of Child and Adolescent Well-Being (NSCAW), No. 20: Adverse Child Experiences in NSCAW. Office of the Administration for Children and Families, U.S. Department of Health and Human Services, 2013; Kimonis, Eva R. et al. "Anger Mediates the Relation Between Violent Exposure and Violence Perpetration in Incarcerated Boys." *Child and Youth Care Forum* 40 (2011): 381-400. https://doi.org/10.1007/s10566-010-9121- 7; Aebi, Marcel et al. "Posttraumatic Stress and Youth Violence Perpetration: A Population-Based Cross-Sectional Study." *European Psychiatry* 40 (2017): 88-95. https://doi.org/10.1016/j.eurpsy.2016.08.007
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11. Ross, Nancy et al. "Adverse childhood experiences: Assessing the impact on physical and psychosocial health in adulthood and the mitigating role of resilience." *Child Abuse & Neglect* 103 (2020): doi: 10.1016/j.chiabu.2020.104440
12. Center for Community Resilience. "The BCR Approach." Center for Community Resilience, Milken Institute School of Public Health. Accessed April 22, 2024. https://ccr.publichealth.gwu.edu/tools-resources/the-BCR-approach.
13. Ellis, Wendy R., and William H. Dietz. "A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience Model." *Academic Pediatrics* 17, no. 7 (September 1, 2017): S86–93. https://doi.org/10.1016/j.acap.2016.12.011.
14. Center for Community Resilience. "Building Community Resilience: Greater Cincinnati." Milken Institute of Public Health, 2023. https://ccr.publichealth.gwu.edu/sites/g/files/zaxdzs4361/files/2023-06/bcr-site-snapshot-cincinnati.pdf.

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