essentials for childhood

kidsdata.org
A Program of Lucile Packard Foundation for Children's Health

# Webinar Q&A: Childhood Adversity—Data to Help Advocate for Change

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**How do we best begin a community dialogue about Adverse Childhood Experiences (ACEs)?**

ACEs provide a valuable frame to highlight how trauma is an intersectional issue. When approaching various stakeholders, you can try to frame your presentations in terms of how ACEs might matter to them in their personal and professional domains. It is also important to stress the idea that addressing adversity is not simply a personal issue but also a broader community responsibility.

There are several different ways to begin a community dialogue about ACEs. One approach is to start by identifying champions who can help you think about how to engage the community in conversations about adversity and trauma. Another important step is to convene and engage these champions and "supporters" around the issue, build baseline awareness about ACEs in the community, and leverage relationships in order to expand and engage your target audiences.

**Can you give us an example of how you integrate values with ACEs facts?**

We are trying to create a "new" public narrative grounded in values and beliefs that support safe, stable, nurturing relationships and environments for all parents and children. In contrast, the current dominant value frame for child maltreatment includes value statements such as: 1) parenting is a family issue–not a government or community problem; and 2) bad parents and children are to blame.

To create a "new" public narrative, we need to propose another set of values that focuses on our shared responsibility for the wellbeing of children and the possibility for pro-active solutions. The ACEs "facts," as seen in the broader set of adversity indicators, support the notion that parenting is not simply an isolated family matter. Instead, the data suggest that the toxic stresses and traumas experienced by children and families are shaped not only by family history and the immediate family dysfunctions, but also by the cumulative past and present environments in which they live, work, grow, and play. Adverse environments include unsafe and violent neighborhoods, poor quality education, persistent poverty, lack of opportunity, and limited job prospects.

The value of shared responsibility can be premised on the notion that we are all responsible for recognizing and addressing these unjust and preventable inequalities. This premise allows us to re-frame the dialogue from simply blaming parents to looking at the potential structural and systemic ways that families are affected. In this frame, government has an important role to play to address these inequalities and provide families and children with the supports they need to prevent, stop, mitigate, and recover from adversity and toxic stress.

**What are some sample messages grounded in values and beliefs that help shift from an individual to a community frame?**

Some of the messages grounded in shared responsibility start with value frames stressing a shared worldview: 1) we all want the best for our children; 2) parenting can be difficult–we all need help at

some time; 3) investing in children is good for all of us/we all benefit when children succeed (e.g., paying into social security); 4) America's "can do" spirit should prevail (we can solve these problems if we work together); and 5) focus on innovative solutions (we can find creative ways to solve problems).

**Are there future plans to incorporate into kidsdata.org additional adversities that are not classified ACEs per se, such as neighborhood violence, housing, or employment discrimination?**

In addition to indicators in the Childhood Adversity and Resilience topic, kidsdata.org has over 550 other indicators of children's health and wellness, and many of them measure the extent of adversity. For example, we have data on poverty, housing instability, food insecurity, and child abuse/neglect. This summer, we expect to add additional community-level indicators related to poverty.

We would also like to add indicators that demonstrate resilience and that measure types of resources that support children's health and wellness. An example of a supportive resource is school-based health centers, for which we currently show counts on our site. Please let us know if you are aware of a data source that measures resilience or quantifies supportive resources for counties in California.

**Does kidsdata.org provide tangible materials for organizations to share with their community?**

Kidsdata.org does not provide tangible materials about childhood adversity and resilience such as screening tools. However, you can generate fact sheets for any county, city, school district, and legislative district for which we have data that include a variety of indicators related to childhood adversity, health, and wellness.

For additional materials specifically related to adversity and resilience, we recommend reviewing the Research and Links section at the bottom of each indicator page and checking the Centers for Disease Control and Prevention (CDC) Essentials for Childhood website.

**How did you identify the different dominant narratives that were presented on the "Dominant Narrative of Child Maltreatment" slide?**

The dominant narratives of child maltreatment (i.e., child abuse is mainly a problem of the poor and other cultural groups, bad parents and children are to blame) were identified through our work on the Essentials for Childhood Initiative but were informed by research conducted by the FrameWorks Institute. We are re-framing this narrative into a "new" public narrative grounded in values and beliefs that support safe, stable, nurturing relationships and environments.

**Are you using other elements of FrameWorks Institute research (origins of toxic stress) to frame messages for multidisciplinary audiences?**

Yes, we use research from several sources including FrameWorks Institute and Davey Strategies. We also received training and technical assistance from the CDC Essentials for Childhood grant project.

**Is the science of ACEs and resilience a concept that is generally familiar to or used by local/county public health departments in California?**

There is a growing awareness across many disciplines and organizations in California, as in many other states, of the body of literature that integrates the science of ACEs. Multiple efforts are underway by local health departments and others to raise awareness and salience for the importance of ACEs and trauma informed policies and practices. The California Department of Public Health (CDPH) Essentials for Childhood Initiative works with several local health departments in California that are addressing childhood adversity and resilience in their work. In communicating their messages they highlight the neurobiology of toxic stress, the health consequences of ACEs, and the historical and generational traumas that are associated with toxic and cumulative negative adverse experiences.

One excellent example to check out is the work going on at the San Francisco Department of Public Health (PDF) in connection with the bay area organization, Trauma Transformed.

**How do we facilitate interagency alignment of ACEs messaging, advocacy, and outreach for collective impact collaboratives? Do you have templates?**

The Essentials for Childhood Initiatives are based on a collective impact approach. We recommend visiting FSG for resources on collective impact. As stressed in the webinar, the ACEs framework crosses multiple domains and provides a unifying platform to create common ground among multiple systems and partners. For more on the process of framing messages, please explore the FrameWorks Institute for information and tools on messaging. Davey Strategies is another resource for information on framing. Unfortunately, we don't have any templates to share at this time.

**Are there resources for getting people to feel comfortable sharing how ACEs have affected them and their communities, to reinforce reframing and engaging policymakers? Any tips on weaving data and personal stories in a persuasive way?**

For tools and resources, please visit ACEs Connection and Trauma Transformed. Screening can be a great tool to help individuals recognize how ACEs have affected them personally and might help to start a conversation about sharing stories. Individual stories can be a powerful part of reaching policymakers, but it is also important to communicate the burden of ACEs at the community level. Prevention Institute has a great report on Adverse Community Experiences that we recommend reading to help tie together individual and community traumas. With regard to weaving the data and individual stories, we would start by using the ACEs science and data to set the stage and to describe the burden of childhood adversity in your community, and then use the individual stories to bring to life what adversity looks like within the community.

Additional resources include:

- Futures without Violence Changing Minds Campaign
- California School-Based Health Alliance (CASBHA) for information on ACEs in schools
    - Trauma-Informed School Models (PDF)
    - CASBHA webinars
- UCSF HEARTs project

- Raising of America, Paper Tigers, and Resilience (films)

**How are you working with the media to change the public narrative? To what degree are you focusing on institutional structures vs. individual stories?**

Essentials for Childhood Initiative of CDPH, Kidsdata of the Lucile Packard Foundation for Children's Health, and ACEs Connection are collaborating with Berkeley Media Studies Group to put on a series of workshops that focus on educating journalists about how to communicate about ACEs. Our partners at the CDC have also put together a wonderful document (PDF) on suggested practices for talking with journalists about child maltreatment.

The majority of our work on ACEs in the Essentials for Childhood Initiative and at Kidsdata focuses on addressing the structural and systemic causes of trauma and changing social norms, but it is also important to highlight individual stories as a part of that narrative. In order to truly address adversity, we need to implement change across all levels of the social-ecological model.

**Do you have information to help explain ACEs to instructors in the college setting? What are tools to help consider equity issues in the classroom?**

Childhood adversity encompasses a wide range of traumas, not simply family dysfunction such as child maltreatment or family alcohol and substance abuse, but also exposure to community violence and concentrated and/or segregated neighborhoods of poverty. Some suggestions include: 1) bring in the social determinants of health literature (e.g., works by Paula Braveman, Howard Pinderhughes with the Prevention Institute, Marilyn Metzler of the CDC); 2) tap into the great health equity work of the Robert Wood Johnson and California Endowment Foundations; 3) look at the California Office of Health Equity within CDPH; 4) explore the ACEs Connection Network which is an essential resource on ACES and how communities are addressing them; and 5) explore the Center for the Developing Child which is a central repository of information on the science of trauma.

**Can you offer more tactics in presenting the ACEs to urban populations?**

The work of the Center for Youth Wellness is a good example of efforts to work in urban communities. We would also suggest exploring local youth models such as Ryse Center. Prevention Institute has a great report on Adverse Community Experiences that we recommend reading to help re-think how to approach urban populations and c of color.

**Have you done any work with the "teen" ACE screening tool?**

We have not done any work with the "teen" ACE screening tool, as we don't directly participate in ACEs screening, but it sounds like it could be a great resource for addressing the issue.

**If we are interested in getting more information about how ACEs was used by the Child Death Review Panel in Baltimore, where would we be able to find it? What is the link/source for more information related to the Baltimore CRDTs screening tool and how that was developed?**

For more information on the screening tool presented, please contact Cathy Costa, Infant Mortality and Child Fatality Review Director at the Baltimore City Health Department: cathy.costa2@baltimorecity.gov. Cathy leads the Fetal and Infant Mortality Review and Child Fatality Review projects.

**Can you make available all screening tools mentioned on PowerPoint?**

For more information, please contact Cathy Costa at the Baltimore City Health Department: cathy.costa2@baltimorecity.gov.

**In addition to Baltimore, which stakeholders are leading the effort to adapt ACEs science and efforts for racial equity in health and human services?**

There are several stakeholders working to address racial equity and ACEs. In California, ACEs Connection, the Center for Youth Wellness California Campaign to Counter Childhood Adversity (4CA), and the CDPH Essentials for Childhood Initiative and Office of Health Equity are just a few additional groups working to integrate conversations about ACEs science and efforts for racial equity.

**Where can I find more information about Parent Leadership Grantees?**

For more information about Lead4Tomorrow Family Hui, please visit the California Department of Social Services, Office of Child Abuse Prevention website or the Lead4Tomorrow website.

**Could we have some examples of some of the trauma-informed activities that Butte County implemented?**

Butte County is in the process of implementing county-wide trauma 101 training with a champion model. The champions then return to their respective organizations and train others on what it means to be trauma-informed in their work. For more information, please contact Anna Bauer, Program Manager at First 5 Butte County: abauer@buttecounty.net.

**Would you be willing to make the resolutions available?**

If you were referring to the Butte County activities, please contact Anna Bauer, Program Manager at First 5 Butte County: abauer@buttecounty.net.

**How do you interpret the ACE score? For example, what is the significance of a score of 2 vs a score of 4 or 5?**

The ACEs score generated from a general self-report screening tool or survey is not a clinical assessment and should not be used as a diagnostic tool. It is often used simply to raise awareness and begin to engage individuals in dialogue about early trauma and how it impacts our lives. In general, people with higher ACE scores are more likely to experience long term negative effects of ACEs. For example, they are more likely to have serious behavioral, emotional, and health issues in adulthood, such as chronic disease, obesity, substance abuse, and depression.

The underlying concept of childhood adversity is that extreme and/or ongoing trauma can lead to "toxic" levels of stress that have substantial negative consequences. It is the toxic and **cumulative** nature of adverse experiences that has the most profound impact on well being (e.g., see Center on the Developing Child). That is why a higher score is generally indicative of more cumulative adversity and thus more likely to be related to more negative consequences.

The original ACEs construct and score were developed for adults and retrospectively refers to their experiences in childhood. More recently, there are many examples of ACEs screening tools being integrated into clinical practices and schools as part of a more comprehensive assessment and trauma informed approach to care for children and families. However, there are now many different versions of ACEs screening tools, for example, with different numbers and types of traumas included. This makes it hard to interpret a score without further information about the specific tool.

**How often is the ACEs assessment given to a parent for their child?**

We are not aware of a central resource that catalogues the extent to which families are given an assessment to assess adversity and needed resources and in what venue the assessment is offered (i.e., pediatrician offices, educational settings). Therefore, we do not know how often the assessment is typically given to a family. If you are aware of such a resource or if you are with an organization that is using a tool to screen for adverse conditions, please let us know.

**How often are data on Kidsdata updated? How often are the NSCH, MIHA, and BRFSS surveys administered?**

In general, data on the site are updated yearly with the most recently available data. However, some survey and administrative data are not available every year, and we update them as soon as possible after they become available to us.

For more information about how often the National Survey of Children's Health (NSCH), Maternal and Infant Health Assessment (MIHA), and Behavioral Risk Factor Surveillance System (BRFSS) surveys are administered and other details about the surveys, please refer to the links in the "Measures of Childhood Adversity and Resilience on Kidsdata.org" section in the narrative portion at the bottom of each indicator page. For example, the NSCH survey was given in 2003, 2007, 2011/12, and 2016. Data from the 2016 administration are not yet available, but we plan to post them when they become available in late fall. The BRFSS is a national system of health-related telephone surveys that collect data in all states regarding health-related risk behaviors, chronic health conditions, and use of preventive

services. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world. MIHA is an annual, statewide-representative survey of women with a recent live birth in California.

**I see you have data broken down by cities and schools. Do you happen to have data broken down by zip code, census block, or census tract? If not, why?**

In general, kidsdata.org provides data for the U.S. and California, along with California counties, cities, school districts, and legislative districts. We do not currently have data by zip code, census blocks, or census tracks. We have not incorporated these levels of data onto the site because of limited resources, and a large portion of the data on the site are not available at these levels. If there are particular data for smaller regions that you are interested in, we might be able to help you find them. Feel free to contact Nathan Porter at nathan.porter@lpfch.org with questions.

**Are there current efforts to obtain data from counties that have missing data? Are there other sources of adversity data?**

We recognize that missing data for small counties and other small geographies is frustrating. The Kidsdata team continuously collects data to the extent that they are available and reliable. Data are missing because they were not collected for the county or because small counts produce unstable estimates or compromise confidentiality. For data that were not collected, typically denoted with N/A on the site, we recommend contacting the data provider identified in the "Data Source" section on the indicator page of interest to show your concern about data availability in your county for future data collections. For small counts, we sometimes combine multiple counties and/or time periods in order to avoid data suppression.

Two resources that have additional data and related materials about childhood adversity are the Center for Youth Wellness Hidden Crisis Report for additional county-level childhood adversity data and the Child and Adolescent Health Measurement Initiative (CAHMI) for national survey data from the NSCH.

**Where can we share the work that we are doing to address childhood adversity and resilience? We are in LA County and we would love to collaborate with others.**

Several suggestions: ACEs Connection Network, the online global social network focused on ACEs, is a great place to share information. Also, you can reach out to your local ACEs Connection Group in LA County or elsewhere or join the California or Essentials groups to share information and connect with others working to address child adversity and resiliency. The California Endowment has offices in LA and has been a leader in this work as well.