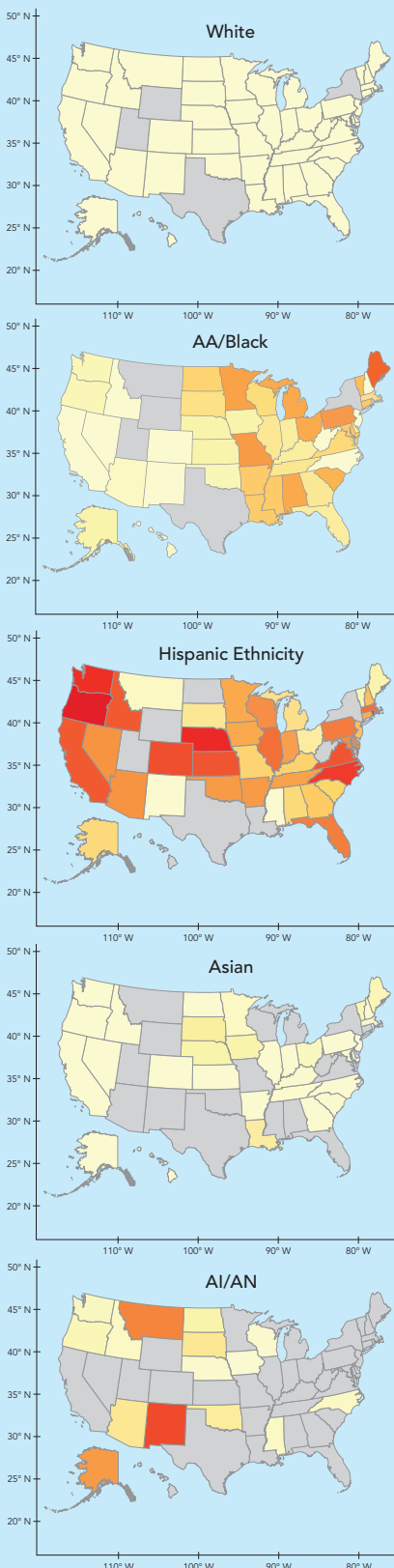


Understanding Adverse Childhood Experiences in the Context of COVID-19

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According to the Centers for Disease Control and Prevention (CDC), **adverse childhood experiences (ACEs)** are potentially traumatic events that occur in childhood (0-17 years). These events include experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide. **ACEs are a major public health concern that are worsening as a result of the health, social, and economic repercussions of the coronavirus disease 2019 (COVID-19) pandemic.¹** Moreover, it is important to highlight that **low-income, Black, Indigenous, and People of Color (BIPOC) communities are disproportionately affected by both ACEs and COVID-19 and its associated disparities as a result of historical and present-day structural racism.**

This policy brief looks at how the health, social, and economic impact of COVID-19 will result in an increase in ACEs, especially in our most vulnerable populations, and discusses the public health responses needed to effectively address ACEs in our communities.

The Impact of COVID-19 on Children and Families

The COVID-19 pandemic negatively impacted the lives of people worldwide by disrupting the social and economic systems that support our well-being and livelihoods. Nonetheless, the effects of the pandemic were not equally felt, as those most vulnerable were disproportionately impacted with higher rates of COVID-19 related infections, hospitalizations, and deaths, and greater economic hardship.

Impact on Healthcare Access and Outcomes

The pandemic has exposed and exacerbated inequities in our healthcare system that disproportionately affected low-income and BIPOC communities. In the U.S., the Hispanic population had a median of 158% higher COVID-19 infection relative to their percentage of the overall population; this was followed by African Americans, with 50% higher COVID-19 infection relative to their percentage of the overall population.² American Indian and Alaska Native (AI/AN) populations were also disproportionately impacted, with 100% excess infections than their percentage of the overall population seen in nine states for AI/AN and seven states for Asian populations.³ Similarly, among AI/ANs, COVID-19 incidents and hospitalization being 3.5 and 5.7 times higher, respectively, than among Whites.⁴

Figure 1. Choropleth map showing crude disparity estimates for COVID-19 infections, computed as absolute percentage point difference between % COVID-19 infection and % population proportion by ethnic/racial groups across U.S. states and the District of Columbia. Source: Xian Z, Saxena A, Javed Z, et al. "COVID-19-related state-wise racial and ethnic disparities across the USA: An observational study based on publicly available data from The COVID Tracking Project." *BMJ open*. 2021;11(6):e048006.

■ Data inconsistency or absence % Difference 0 3 7 10 13 19 27 34 42 50

It is also important to note that there is likely an underreporting of infections, hospitalizations, and deaths, and that the current data do not completely reflect the severity of disparities. Similarly, safety-net health practices (e.g., Federally qualified health centers) which predominantly serve patients from marginalized communities, largely lacked the infrastructure and resources to mobilize and respond to both the immediate needs related to addressing and slowing the spread of COVID, while simultaneously addressing the pre-existing chronic health challenges facing their patient populations.

Social and Economic Impact on Mental Health and Child Abuse

At the beginning of the pandemic, state and local governments introduced safety precaution measures including social isolation, quarantine, and shelter-in-place orders to slow the spread of COVID-19. These federal and state government responses to COVID-19 also resulted in devastating economic consequences such as job insecurity, financial instability, remote work, school/child care closures, business closures, and overall significant social and economic disorder. Consequently, these hardships and related mental distress may result in amplification of some ACEs, especially among BIPOC communities who have been disproportionately impacted by these challenges.

The economic disruptions disproportionately impacted those with a lack of social support and those unable to work from home or who were laid off. BIPOC communities disproportionately occupy low-waged, high-risk occupations (e.g., grocery clerks, public transportation operators, sanitation workers) deemed essential during the pandemic.⁵ Such essential workers often lack basic workplace benefits such as paid sick leave, which puts pressure on them to continue to work in order to survive and provide for their families, even if they develop COVID-related symptoms. School and childcare closures put more burdens on parents and caregivers in taking care of their children, resulting in more stress and anxiety. Similarly, millions of people not being able to work and losing their jobs led to a historic and rapid economic downturn, which exacerbated housing insecurity with over 2 million households have reported being behind on housing mortgage payments in 2020, a 250% increase since the 2010 Great Recession. Moreover, 8 million rental households were behind in their rent.⁶

The conditions discussed above have increased concerns about mental health and substance use, and its effect on children's well-being. Historically, child maltreatment rises with crises and economic downturns.⁷ Studies have found correlation between parental economic hardship with increased substance abuse and mental disorders, and increased living in poor and inadequate housing.⁸ This is also of greater concern given that COVID-19 has created conditions for a rise in child abuse as children are locked in the same home as potential perpetrators.⁹ Similarly, there has been an increase in the number of hospitalizations related to child abuse during the COVID-19 pandemic.¹⁰ However, the impact of COVID-19 pandemic on child maltreatment and child abuse and neglect is not completely understood due to lack of literature around the topic and the ongoing pandemic.¹¹ At the beginning of COVID-19, reports of child abuse and neglect declined across the United States by 20% to 70%. The negative trend in reported cases of child maltreatment is suspected to be a result of limited social connection between children and mandated reporters (e.g., teachers, social workers and health care providers) during the pandemic.¹²

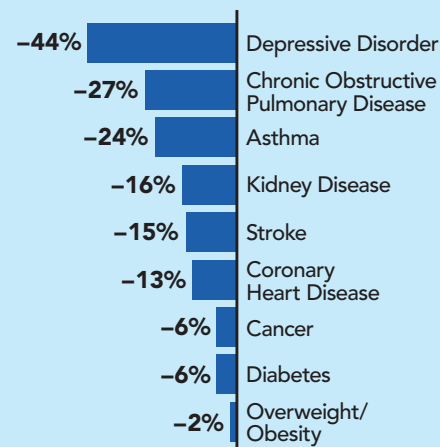
Public Health Response

1. Screen and Address ACEs in Primary Care

Although there is growing recognition of the prevalence of ACEs and the benefit of screening, **only 4% of pediatricians in the U.S. actively screened for ACEs** and 32% did not usually ask about any.¹³ There are multiple factors that could be contributing to the lack of universal screening in the primary care setting, including lack of training, reimbursement challenges, lack of interventions for those exposed to ACEs, and other system-level workflow and capacity barriers.

Given the increased risk for ACEs during the COVID-19 pandemic outlined earlier in this policy brief, it will be essential for pediatric primary care providers to implement ACEs screenings during their visits with patients. Screening children supports the early detection of ACEs and creates opportunities for intervention, including referrals to behavioral health services and education of youth and their families on the negative impact of ACEs on long-term physical and mental health. Through these interventions, we can reduce ACEs, and subsequently, the risk of negative long-term behavioral and physical health outcomes. In fact, the CDC found that ACE prevention could lead to a reduction in the following health conditions and risky health behaviors: smoking (33%); heavy drinking (24%); depressive disorder (44%); Chronic Obstructive Pulmonary Disease (27%), Asthma (24%), Kidney Disease (16%), Stroke (15%), Coronary Heart Disease (13%), Cancer (6%), Diabetes (6%), and Overweight/Obesity (2%).¹⁴

Health Conditions



Health Risk Behaviors

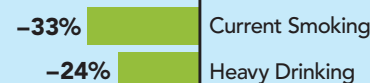


Figure 2. Potential reduction of negative outcomes in adulthood by preventing ACEs. Source: BRFSS 2015-2017, 25 states, CDC Vital Signs, November 2019; <https://www.cdc.gov/vitalsigns/aces/index.html>

Additionally, given the known long-term impact of ACEs, it is vital that healthcare systems begin implementing universal screenings for their patients across the life course; identifying the parameters around screening, including when screening will occur; who will conduct screening, and; what the referral and follow-up workflow will be if there is a positive screen. **Furthermore, screening processes should be trauma-informed and culturally appropriate.** By identifying ACEs and providing clinical and non-clinical interventions, it will not only have long-term health and socioeconomic benefits for our communities, but also improve the lives of those who suffered because of the COVID-19 pandemic.

2. Train Pediatric Care Providers in Trauma-Informed Care

To ensure successful implementation of ACEs screening, health systems and clinics must ensure that providers and clinical staff are equipped to address a positive screen. This includes training providers and clinical staff in trauma-informed care, and that there is a referral process in place to connect patients to follow up care in a timely, accessible, and culturally appropriate manner. Trauma-informed care recognizes and responds to the signs, symptoms, and risks of trauma to better understand the impact of trauma and better support the needs of patients.¹⁵ Providers must implement the trauma-informed framework when providing ACEs screenings to avoid re-traumatizing the patients and know how to best respond to their trauma through care and referrals. The Substance Abuse and Mental Health Services Administration defines the trauma-informed care framework with four main points:¹⁶

1. Realizing that trauma has a widespread impact on individuals, families, groups, organizations, and communities and has an understanding of paths to recovery;
2. Ability to recognize the signs and symptoms of trauma in clients, staff, and others in the system;
3. Integration of trauma knowledge into policies, programs, and practices;
4. Seeks to avoid re-traumatization

In addition to trauma-informed care, health systems must implement a referral system where patients who screen positive for ACEs can receive timely follow up care. For internal referrals, some organizations may be able to conduct “warm handoffs”, or develop interdisciplinary teams comprised of behavioral health, social work, and other internal departments. These internal workflows may support ACEs screening and enable providers to screen for ACEs. For clinics who do not have the internal resources available, there is a need to develop external referral networks and workflows to track follow-up for referred patients. **Furthermore, providers and clinical staff must consider the cost, location, transportation accessibility, and wait time for appointments when referring patients.**

3. Fund School-Based Health Centers (SBHCs)

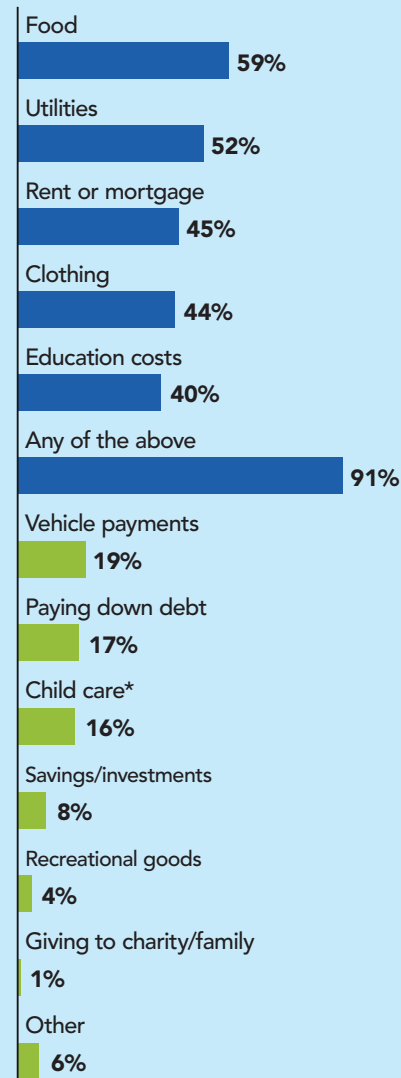
SBHCs can play a critical role in identifying and addressing ACEs in students. SBHCs are on-school site, primary healthcare centers, affiliated with one or more schools that provide medical, and sometimes behavioral, vision, and dental services to students in grades K-12. There are approximately 2,584 SBHCs in 48 states, D.C., and Puerto Rico.¹⁷ SBHCs are often located in areas with high rates of low-income families and in predominantly racial/ethnic minority communities.¹⁸ In addition to screening youth for ACEs, SBHCs can provide care and provide referrals to care that address ACEs. Schools with SBHCs can be a safe place not just away from trauma, but also to access care for the adversity children are facing. SBHCs are well positioned to act both as a medical home, as well as provide referrals to outside organizations, which work to address other social determinants of health affecting students.¹⁹ **Congress must continue investing and funding SBHCs as it did in the Fiscal Year 2022 Omnibus Appropriations package, which included \$30 million for school-based health centers within the Section 330 Health Centers program.**

4. Provide Financial Support for Those Most Impacted by COVID

A significant impact of the COVID-19 pandemic has been the cash assistance available to parents and families across the country. Millions of Americans were eligible for some form of financial assistance from the CARES Act and the American Rescue Plan with many families receiving thousands of dollars in direct cash aid. Additionally, the American

Families with Low Incomes Spend Expanded Child Tax Credit on Most Basic Needs

Percent of households with incomes below \$35,000 who spent their credit payments on:



*Percent of households with child(ren) under age 5.

Note: Education costs include school books and supplies, school tuition, tutoring services, after-school programs, and transportation for school. Household income is in 2020. Figures are for households who reported receiving a Child Tax Credit payment in the last 30 days in data collected July 21–September 27, 2021.

Figure 3. Breakdown of Child Tax Credit Spending. Source: Center on Budget and Policy Priorities analysis of U.S. Census Bureau Household Pulse Survey public use files for survey weeks 34–38.; <https://www.cbpp.org/blog/9-in-10-families-with-low-incomes-are-using-child-tax-credits-to-pay-for-necessities-education>

Rescue Plan provided ongoing monthly support to families with children. This cash assistance helped reduce the child poverty rate by roughly 30%²⁰ and 91% of families reported spending the money on basic necessities such as rent, utilities, food, and educational costs.²¹ Repeated studies have shown the impact of how cash assistance to parents positively impacts child development.²² Furthermore, the cash assistance could relieve some of the financial hardship faced by parents and caregivers, and result in improved mental health and home environments for children. However, these programs are not currently active, including the advanced child tax credit, which ended in December 2021. These economic challenges persist, and with that, youth continue to be at an increased risk for ACEs. **Local, state, and federal governments should develop and implement a cash assistance program targeted to those most impacted by the COVID-19 pandemic. This assistance will help families support their children's development and reduce the risk of ACEs.**

5. Conduct Future Research

Future research is required to assure we are prepared to both understand and address ACEs in the context of the COVID-19 pandemic. Given the unequal impact of COVID-19 on low-income and BIPOC populations, research should examine the link between ACEs and the social and economic environments that contributed to those inequities. Cohort studies present significant opportunities for comparing the impact of ACEs and COVID-19 over time. For example, cohort studies may show us potential increases in ACEs for this generation, as well as ways that the pandemic acts as an adverse childhood experience in its own right.



There is also an unprecedented opportunity for research to examine the results of the natural experiments created by various state and local policies. **Future research can examine potential correlations between pandemic-related policies (e.g., implementation of lockdowns, school closures and re-openings, financial assistance to families and individuals in need), and the extent to which such policies correlate with the prevalence of different types of ACEs.** Such research can inform future policy on various issues from social assistance to pandemic preparedness.

Lastly, research must examine how to address the growing mental health challenges resulting from the pandemic. Prior to the pandemic, there was already a deeply inadequate pool of mental health clinicians and future interventions will need to be at scale. **Models of care should be developed that are large enough to facilitate the healing of individuals and whole communities.**

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