

Lessons From ACEs: Pay Now or Pay (More) Later



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THE INCREDIBLE VALUE to children's mental health of the retrospective research on adverse childhood experiences, or ACEs, pioneered by Felitti and Anda in 1998,¹ as well as the subsequent scholarship it has inspired, cannot be overstated. Following the story backwards, from findings of increased morbidity in adult health outcomes, such as heart disease and early death,² to effects on adult mental health outcomes, such as increased risk of depression and substance use,³ a list of stressors, or "adverse experiences," in childhood have been identified, and ranked. We now know that, unrecognized and untreated, ACEs can negatively affect health and well-being through the life span.

Advocacy on behalf of children has been forever changed by the strength of the basic neuroscience that informed these studies, which, together, draw a bright thread from trauma exposure straight through to each of the harmful sequelae.⁴ In addition to the moral argument for protecting children, we can now add the evidence-based argument regarding the risk of increased lifetime morbidity. This progress is good, akin to moving past the early days of "controversy" about smoking and the link to lung cancer. However, unlike cigarette use, children are not in charge of their exposure to adverse experiences. Instead, the ACE findings serve as an urgent reminder to clinicians and policymakers of the need to prevent child trauma exposure, where possible, and to swiftly intercept the consequences, if protection fails.

There are reasons that the needs of children rarely drive health policy: their numbers are small, representing only approximately 25% of the overall population, they are unlikely to generate income, they do not purchase their own health care, and they cannot vote. However, it has never been more empirically true that the best way to improve our nation's overall health, and health care expense, is to improve the health of its children as quickly as possible. This message arrives as accountable care organization budgets are choosing to target most of their resources toward transforming care delivery for adults. From an insurance perspective, or even a political one, orienting the new delivery system to the largest group of users sounds reasonable. However, it might be prudent to review the cost effectiveness of this approach.

In the past, arguments regarding the economic benefits of improving children's health were mostly theoretical: policymakers and business leaders might allow discussion,

but advocates were quickly reminded that there was no funding for "prevention." Instead, health care expenditures were prioritized toward treating adult "super-spenders," frequently men with multiple chronic conditions, such as heart disease, diabetes, depression, and substance abuse. Spending on health promotion for children was historically located at one end of a long continuum, with funding for intensive treatment of such highly complex adults at the other end.

The ACEs research helps us appreciate that this continuum turns out, instead, to be a circle. There is now a statistical case to be made that the same interventions intended to protect or improve children's mental and physical health, are likely to reduce the numbers of "super-spender" adults. The fact that ACE exposure is predictive for the very conditions that are known to drive health care expense, now offers child advocates a chance to change the argument about resource distribution.

Following-up on the scientific breakthroughs that increased our awareness of the causal chain behind "toxic stress,"⁵ we now need a similar investment in research on interventions that are most likely to be successful in disrupting that chain. Clinicians and policymakers need information about effective ways to mitigate the risk of ACEs,^{6,7} including when and how to intervene, and what system supports are required, for individuals as well as for communities. Child and family trauma treatment programs should be initiated, on the basis of successful, team-based, demonstration projects within integrated care, involving family support, resource identification, and appropriate clinical follow-up.⁸ Such interventions would be expected to not only help children in real time, but to lead to reductions in the numbers of those suffering later in life from the morbidities associated with untreated ACEs.

In the absence of such an integrated support system, teachers, primary care clinicians, child protection workers, etc, might feel at a loss regarding their responsibilities toward children in chronically "simmering" family circumstances where symptoms alternately bubble up and cool down but life at home does not improve. Such delays not only leave a child exposed to repeat trauma; they can convey an unintended message regarding the perceived value of the child, and the legitimacy of their pain, that persists after physical injuries have healed.

However, an accessible, integrated child mental health team can assist the key players as well as the family in

navigating decisions about when and how to get help, reducing delays in recognition and treatment.

If we assume that we have historically overlooked large numbers of children in need, because of unrecognized trauma, and, if we combine that assumption with national data showing that an estimated 2 of every 3 children identified as having mental health needs currently go without treatment,⁹ we can see we are in the midst of a child mental health epidemic. As with other public health crises, this one is occurring in the context of major gaps in treatment capacity, including an absolute deficit of trained clinicians (child psychiatrists, social workers, and child psychologists), along with role and reimbursement restrictions that limit access to those that we do have.

In addition to the importance of screening for ACEs within primary care settings, innovative pediatric delivery systems recognize the equally pressing need to make specialized supports and child mental health consultation accessible for primary care clinicians, children, and families, in the face of trauma, to assist with real-time safety planning, treatment engagement, and the promotion of resilience.

However, even where such highly effective, integrated models exist, and specialty team-based consultations are available, these resources are intended to support earlier recognition of need, clarity of diagnosis, and provide guidance within primary care.¹⁰ Ideally, integrated screening and assessment models facilitate family engagement, but they do not replace the role of child mental health treatment. Until there are policy shifts to address the crisis in mental health treatment capacity for children and families,¹¹ and the need for targeted recruitment of public sector child psychiatrists and other trained child mental health clinicians, we will keep sending children who screened positive, or whose parents come asking for help after trauma, to stand at the end of a very long line and wait for treatment that might remain unattainable.

We owe it to those kids not to let their needs remain unmet. We also bear a responsibility to improve models of care for children that will enhance the overall health of generations to come. The funding of screening, but not treatment, does not save money; letting the chance to reduce lifetime morbidity elude our grasp will, without a doubt, cost us.

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