

Addressing Racial & Ethnic Disparities in Adverse Childhood Experience

Adverse childhood experiences (ACEs) are traumatic experiences that occur during a child's life that can lead to negative health outcomes throughout the life course (Felitti et al., 1998). Exposure to ACEs, including various forms of child abuse and household dysfunction, has been linked to chronic diseases and conditions, mental health challenges, decreased educational attainment, risk-taking behaviors, and intergenerational health impacts (Felitti et al., 1998; Larkin et al., 2012). Beyond harm to individual health, ACEs also cost North America an estimated \$748 billion annually; thus, it is critical that public policy addresses ACE prevention and mitigation (Bellis et al., 2019). However, previous policies about ACE prevention and mitigation have largely focused on the importance of family support in promoting healthy development, without meaningful analysis of the relationships between ACE scores and race/ethnicity (Bruner, 2017). A growing body of research demonstrates that ACE prevalence is disproportionately higher in minority racial/ethnic groups compared to their non-Hispanic white counterparts, and health disparities may be exacerbated due to differential exposure to the stress of racial discrimination (Strompolis et al., 2019). Therefore, it is critical to take race and ethnicity into account when determining future public policy aimed towards prevention and/or mitigation of ACEs. As one of the most racially diverse counties in the U.S., the County of Los Angeles should take steps to reduce racial/ethnic disparities related to ACEs through 1) Screening & Assessments and 2) Institutional Strategies.

Screening & Assessments

We recommend that policymakers address the need for increased equity in child and family health through the implementation of ACE assessments and screenings across all neighborhoods in Los Angeles, including poor neighborhoods which are more likely to consist people of color who are more vulnerable to ACEs and their effects. LA County Department of Public Health can begin by targeting health care systems and primary care providers serving primarily medi-caid patient populations and incentivizing these providers to implement screenings at annual visits. A relatively small financial incentive per visit is likely to provide a significant increase in screenings in aggregate, and a strong argument exists catching these ACE exposures early will result in long-term savings for the public healthcare system that dramatically outweigh the cost to screen. Screening for ACEs during infancy (3-11 months) is an important preventative measure which helps providers reduce chances of ACE exposure and support protective factors that could diminish the negative effects of ACEs by connecting families to community resources and agencies early on. The Adverse Childhood

Experiences (ACE's) Questionnaire has been found to be an effective and feasible screening tool for providers that also facilitates a provider-patient conversation on useful resources (Kia-Keating, 2019). The ACE questionnaire further supports providers by facilitating discussion on protective community resources. In order to ensure that implementation of the ACE Questionnaire across settings is not subject to racial bias, we recommend that the Racial Equity Impact Assessment (REIA) evaluation tool be incorporated by providers as a way to dismantle the structural discrimination that obstructs equal opportunity for health among poorer communities of color (Strompolis et al., 2019; Martin & Connelly, 2015).

Institutional Strategies

In order to establish a more equitable approach to mitigation of the effects of ACEs at the institutional level, we recommend that health centers across Los Angeles incorporate patient navigators and ensure equitable access to trauma-focused cognitive behavioral therapy. One way to address the effects of ACEs more equitably is by shifting the patient-health provider power dynamic so that the patients are more empowered to seek out services (Tawa & Bunts, 2019, Udesky, 2020). One strategy to shift this dynamic includes patient navigators, who serve as healthcare workers that bridge the gap between the community and health care providers (Barnett et al., 2020). Patient navigators often diminish common barriers to healthcare including patient apprehension, language barriers, and cultural misunderstandings. Additionally, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been shown to be an effective treatment across various domains of ACE exposure. The literature supports the use of TF-CBT in diminishing the damaging effects of ACEs, though access to specialized care differs among racial groups (Cohen, Mannarino, & Knudsen, 2005). Noting the racial and economic disparities, policymakers must focus on establishing equitable distribution of services to meet the needs of the community.

Conclusion

At every level of interaction within the health system, Black, Indigenous, and other People of Color (BIPOC) families of children with adverse childhood experiences should encounter providers who are trauma-informed, culturally responsive, and held accountable for their racial biases. While the roots of racial discrimination run deep within health systems and communities, the literature demonstrates policy-level changes related to the universal implementation of preventative measures and increasing ease of access to child- and family-centered evidence-based interventions are a step in the right direction.

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