TRANSFORMING THE CARDS DEALT:
ADVERSITY AND RESILIENCY
FROM THEORY TO PRACTICE

Presented by:
Dr. Allison Sampson-Jackson, LCSW, LICSW, CSOTP
Webinar Tips to Maximize Our Learning Today

• Everyone except the Trainer for today (Allison) will be on mute today given we have more than 500 participants and want to give the best sound quality to all of you listening now and all of you listening to the recording later.

• Please note the toolbar at the upper left hand corner on your Webinar Display:

![Toolbar Image]

• If you are having difficulty hearing or seeing the screen, please raise your hand and we will check in with you or send you a private message to offer you assistance.

• To ask a question about the content today, please click on the Q&A button and type in your question.

• Please note that we will answer questions as soon as possible and any questions we are not able to answer today, we will follow up with a document posting these answers following the webinar.
Magellan Training Site
Course Objectives

Part One

Verbalize 5 of the 10 Adverse Childhood Experience categories and how they relate to risk factors for physical well-being.

Verbalize 3-4 key medical conditions that are more likely to exist among individuals with higher ACE scores.

Part Two

Verbalize how the CYW ACE-Q was developed and can be utilized with caregivers, children and teens.

Reflectively appraise 2 ways they might incorporate ACE understanding into their practices with members utilizing Resiliency Science.
Self-Care Alert!

• Step out and take a break
• Talk to someone you trust
• Do something relaxing
ACEs Primer

https://vimeo.com/139998006
Consequences of a Lifetime Exposure to Violence and Abuse

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
Shift from an ACE Score of 0 to 4 Population Health

- 242% more likely to smoke
- 222% more likely to become obese
- 357% more likely to experience depression
- 443% more likely to use illicit drugs
- 1133% more likely to use injected drugs
- 298% more likely to contract an STD
- 1525% more likely to attempt suicide
- 555% more likely to develop alcoholism
Mechanisms by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
Screening for ACEs
Short Version of the ACEs Tool for adults 18 or older

http://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean
What’s important to know about the ACEs Tool ...

• Important to note that at this time, there are no psychometrically tested and validated ACEs screens for children

• ACEs measure was developed originally as a research tool to gather history from adults 18 years or older

• Dr. Anda and Laura Porter prefer to call it a history gathering tool versus a “screening” tool

• ACEs scores are not predictive at the *individual level* therefore it should not be used to determine eligibility or diagnosis independent of a comprehensive psychosocial assessment with the use of valid and reliable tools that are shown to help in predicting likelihood of mental health challenges in living

Laura Porter (personal communication 10/16/2016)
Center for Youth Wellness
Adverse Childhood Experiences Questionnaire
CYW ACE-Q
So how do we measure children for adversity and use it to predict future physical and behavioral health risks ... 

“Research suggests that individual risk factors in childhood do not determine individual outcomes in adulthood, but that the accumulation of multiple risk factors in childhood greatly increases the odds of a range of poor outcomes” (Marie-Mitchell & O’Connor, 2013, p.14)

So how do we then find a useful clinical tool to screen for ACEs in children so as to better engage in preventative care tailored towards risk factors?
“In a multisite study of children exposed to or at risk for maltreatment, it was found that by age 6 children had an average ACE score of 1.94. Between ages 6 and 12, on average they accumulated an additional 1.53 ACE, and then between ages 12 to 16 another 1.15 24. The gradual accumulation of ACEs suggests that there is an opportunity to identify children at risk for accumulating ACEs and the negative health outcomes associated with them.”

Burke Harris, N. and Renschler, T. (version 7/2015). Center for Youth Wellness ACE-Questionnaire (CYW ACE-Q Child, Teen, Teen SR). Center for Youth Wellness. San Francisco, CA. Pg.8
“In the American Academy of Pediatrics (AAP) policy statement, “Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health,” the AAP explicitly calls on pediatricians to “actively screen for precipitants of toxic stress that are common in their particular practices” 26.”

Burke Harris, N. and Renschler, T. (version 7/2015). Center for Youth Wellness ACE-Questionnaire (CYW ACE-Q Child, Teen, Teen SR). Center for Youth Wellness. San Francisco, CA. Pg.8

Dr. Nadine Harris and the Center for Youth Wellness

http://www.centerforyouthwellness.org/what-we-are-doing/overview/
**CYW ACE-Q VERSIONS**

1. **CYW Adverse Childhood Experiences Questionnaire for Children** *(CYW ACE-Q Child)*  
   *17 item instrument completed by the parent/caregiver for children age 0 to 12*

2. **CYW Adverse Childhood Experiences Questionnaire for Adolescents**  
   *(CYW ACE-Q Teen)*  
   *19 item instrument completed by the parent/caregiver for youth age 13 to 19*

3. **CYW Adverse Childhood Experiences Questionnaire for Adolescents: Self Report**  
   *(CYW ACE-Q Teen SR)*  
   *19 item instrument completed by youth age 13 to 19*

Burke Harris, N. and Renschler, T.  
*(version 7/2015).*  
Center for Youth Wellness ACE-Questionnaire  
*(CYW ACE-Q Child, Teen, Teen SR). Center for Youth Wellness. San Francisco, CA.*  
Pg. 9
CYW-ACE Q

ACE-Q Toolkit
ACE-Q for Children
ACE-Q for Teens

ACE-Q for Teens
ACE-Q Licensing Agreement

* Available in Spanish and English

Burke Harris, N. and Renschler, T.
(version 7/2015).
Center for Youth Wellness ACE-Questionnaire
CYW-ACE Q

SECTION 1 Ten items assessing exposure to the original ten ACEs

* Population level data for disease risk in adults

SECTION 2 Seven or nine items assessing for exposure to additional early life stressors relevant to children/youth served in community clinics

* Hypothesized to lead to disruption in neuro-endocrine-immune axis
* Not yet correlated with population level data about risk of disease

Burke Harris, N. and Renschler, T. (version 7/2015).
Center for Youth Wellness ACE-Questionnaire (CYW ACE-Q Child, Teen, Teen SR). Center for Youth Wellness. San Francisco, CA. Pg. 10
CYW-ACE Q Scoring and Other Considerations

ACE-Q Toolkit

Review of Pages 10 – 18

Burke Harris, N. and Renschler, T. (version 7/2015). Center for Youth Wellness ACE-Questionnaire (CYW ACE-Q Child, Teen, Teen SR). Center for Youth Wellness. San Francisco, CA. Pg. 10
Whole Child Assessment
Child – Adverse Childhood Experiences Only
WCS C-ACEs
Key Points of Measure Development

• Physicians designed this measure to explore ability to distinguish early child outcomes of lower and higher risk children

• Goal was to demonstrate association between ACEs and specific early child outcomes using a brief measure that was feasible to use in clinical practice

• If links between exposure to adversity and childhood onset health conditions and/or behavioral problems arose ... then this could shape their evidence based approaches to well-child care

• They could then look at if practice based interventions are effective in improving health and behavioral outcomes

Population Studied in Pilot

- Cross Sectional Data on 102 children between ages of 4-5
- Presented in a Urban federally Qualified Health Center serving lower income inner-city population
- Medicaid was providing 90% of coverage for the pediatric population in the health center
- 149 selected eligible (female primary caretakers), 102 participated
- 171 children presented for well child visits during 6 month period
- African American (57%)
- Hispanic/Latino (43%)
- 50% male children
- 12% low birth weight (less than 2500 grams)

### Most prevalent ACEs factors in the Study

<table>
<thead>
<tr>
<th>Variable</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maltreatment Suspected</td>
<td>24%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>9%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>11%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>41%</td>
</tr>
<tr>
<td>Criminal Behavior</td>
<td>22%</td>
</tr>
<tr>
<td>Single Parent</td>
<td>76%</td>
</tr>
<tr>
<td>*Maternal Education (no HS diploma or GED)</td>
<td>57%</td>
</tr>
<tr>
<td>At least one of the above 6 risk factors</td>
<td>90%</td>
</tr>
<tr>
<td>At least 1 of the above 7 risk factors</td>
<td>94%</td>
</tr>
</tbody>
</table>

*Important predictor of vulnerability to developmental delay*

Prevalence's of Interest

“... prevalence of behavior problems and developmental delay was 2 to 4 times greater in the higher risk ACE group, and injury visits were 5 times more likely.” p. 16

1) We are having physicians review and counsel in response to the questions. I don't think you need someone with MD expertise, but I would recommend someone with clinical training (psychologist, social worker, or graduate student in same).

2) What I sent you is a work in progress. We are currently collecting data on this tool which will be able to address the question of cut-offs, but at this point I don't have that information. However, in general the literature supports the use of 3 or 4 risk factors as an indicator that the child is at higher risk for chronic diseases, and therefore that child/family may benefit from a higher level of services.

Dr. Ariane Marie Mitchell, Personal Communication October 2016
Whole Child Assessment (C-ACEs Only)  
Supporting Article

WCA C-ACEs Tool
ACEs and Resilience
Treatment Planning Tools
Resilience Trumps ACEs

Children’s Resilience Initiative

Empowering community understanding of the forces that shape us and our children

Website: www.resilencetrumpsaces.org

From Trish Mullen, Chesterfield Community Services Board
Children’s Resilience Initiative

SKILL BUILDING

Think: lack of skill not intentional misbehavior
Think: building missing skills not shaming for lack of skills
Think: nurture not criticize
Think: teach not blame
Think: discipline not punishment
ORIENTATION TO
PHASE ORIENTED TREATMENT
Core areas of focus in Complex Trauma

Courtois, C. & Ford, J. (2009), Introduction (p.2)

**Self-Regulation**
- Affect Regulation
- Disassociation (difficulty in being “present”)
- Somatic Dysregulation

**Positive Self-Identity**
- Impaired Self-Concept
- Impaired Self-Development

**Co-regulation**
- Secure working model of caring relationship
- Disorganized Attachment Patterns
Phase Oriented Treatment
“Gold Standard”

Phase I: Safety and Stabilization
Phase 2: Trauma Reprocessing
Phase 3: Reintegration

Courtois, C., Ford, J., & M. Cloitre (2009), pp.90-100
Phase Oriented Treatment
Courtois, C., Ford, J., & M. Cloitre (2009), pp.90-100

PHASE ONE: Safety and Stabilization

• Personal and Interpersonal Safety Established: Education/Support/Safety Planning
• Enhance Client’s ability to manage extreme arousal (hyper/hypo)
• Active engagement in positive/negative experiences (deal with automatic avoidance behaviors, self awareness of avoidance, increase coping skills and use of coping skills)
• Education (psychotherapy, trauma, skills to be learned)
• Assess and develop relationship capacity (decrease avoidance of relationships or negative thoughts about relationships, build support network, define client’s attachment network)
Contextual Models of Care

Interpersonal Area
• Collaborative approach
• Attachment in the therapeutic relationship

Practical Area
• Skill Development
  – Self-Soothe
  – Being in the Present
  – Cognitive Strategies (problem solving)
  – Release of addiction/maladaptive behaviors
  – Traumatic Stress Reprocessing
  – Engaging in Daily Life

Conceptual Area
• Clinician is a guide through the process
• Client develops the conclusions and outcomes
Psychoeducation: Describe the symptoms of PTSD and explain the treatment rationale. Training in experiencing and identifying feelings, triggers, and thoughts, as well as training in mood regulation strategies.

Learning history: Ask the client the following questions—How did the client deal with traumas past and present? How did the client’s family deal with feelings? How did the client’s family life affect his or her present difficulty experiencing and identifying feeling?

Emotion regulation skills: Identify the cognitive, behavioral, and social support modalities for coping. Use data gathered with self-monitoring forms to identify strengths and weaknesses in each coping modality. Teach skills such as breathing retraining, self-statements to reduce fear, and social skill training to improve social support.

Acceptance and tolerance of negative affect: Motivate clients to face distressing situations related to the trauma that are important to them. Review negative repercussions of avoidance. Discuss tolerating negative affect as a step toward achieving specific goals.

Schema therapy for improved relationships: Identify relevant schemas learned in childhood. Suggest alternative ways of viewing self and others in current relationships. Use role-playing to teach assertiveness, emphasizing response flexibility based on relative power in each relationship.

Once Phase 1 of STAIR is well learned, clients move to Phase 2, which involves exposure therapy.

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Thanks