As the story of COVID-19 unfolds and we see the impact on families and communities across the country, there is a closely woven thread connecting Adverse Childhood Experiences (ACEs) and the effect on physical and emotional health outcomes. ACEs are stressful or traumatic events, including abuse and neglect along with significant challenges in the home such as witnessing domestic violence or growing up with family members who have substance use disorders. While the groundbreaking study on childhood adversity and its powerful effect on adult health outcomes was first published by Vincent Felitti and Robert Anda over 20 years ago, there has been a lag in acting upon the implications of those findings in order to promote individual and community health and well-being. With the current overlay of COVID-19, the urgency to understand ACEs and take action is even more pronounced.

Nationally, there is growing concern that the increased fear and social isolation associated with COVID-19 may exacerbate existing chronic and toxic stress in the home leading to an escalation in interpersonal violence, mental health challenges, and use of drugs and alcohol. With daycare and school closed, children are at home and likely to experience higher rates of trauma exposure. We know that experiencing traumatic events before age 18 can create dangerous levels of stress, which impacts healthy brain development if there is no intervention or support. As youth get older, exposure to trauma can increase the likelihood they will engage in risky behaviors and have more incidents of poor mental and physical health outcomes in later years.

We are uniquely positioned in Monroe County to respond as the Office of Mental Health in partnership with the Department of Public Health and school districts who have worked over the past five years to collect ACEs data through the Youth Risk and Behaviors Survey. Unfortunately, trauma is not the rare event we’d like to believe — 33% of adolescents reported two or more ACEs, which would lead to a conservative estimate of 50,963 children across Monroe County who have had multiple trauma exposures. The outcomes illustrate the clear and unequivocal relationship between the accumulation of ACEs and increased risk for concerning outcomes such as substance use, depression, suicidal ideation, and violence. In addition, we know that not all ACEs are created equal and need to be examined within the context of our society. Children of color will experience higher rates of parental incarceration, untreated substance abuse, unaddressed mental health issues, and poverty due to racism, disparities and discrimination leading to the additional burden of toxic stress.

While defining and understanding ACEs is important, it is not enough. The numbers of children and families impacted by trauma and the associated effect on health solidly confirms that ACEs must be addressed as a public health issue. This leads to important questions we must ask ourselves. As all of us interact every day, knowingly or unknowingly, with someone who has experienced ACEs, what does everyone need to know? Does our current array of community resources match our needs to effectively address ACEs? What are the workforce development needs to ensure professionals have the specialized skills required to address traumatic stress and how do we make sure to care for that same workforce who may experience secondary traumatic stress? Given the disparities associated with ACEs, how do we ensure that solutions are not siloed and explicitly address racism and poverty?

It is equally important to clearly recognize that the challenges presented by ACEs do not solely reside in the domain of health care, social services and education. With two-thirds of adults impacted by at least one ACE, every sector of our community is affected, and therefore needs to understand the impact as well as ways to promote healing and recovery to ensure healthy workplaces and community. As our workforce begins the transition back to the workplace, we must recognize that many people have experienced increased stress and anxiety associated with the pandemic including social isolation, financial concerns, health concerns, and caring for dependents. For those who have continued to work on the frontlines throughout the pandemic, there is the added anxiety associated with the increased risk of exposure for themselves and loved ones. In addition, there has been limited access to natural social supports such as family, friends, neighbors and spiritual community.

While the ACEs data demonstrates the significant level of exposure to trauma in our region, the results also show that the impact of this exposure can be alleviated by concentrating on actions that build resilience. The local findings are in line with research that has consistently shown that assets act as a counterbalance to ACEs. Adolescents who report having at least one non-parental adult, feeling encouraged at school, or feeling a part of the community for all.

Similarly, the science tells us that adult brains are also responsive to positive interventions and supports. The first step is to learn about ACEs and make this information widely available to all. Knowledge is important but not sufficient for change, and we must intentionally apply this information to transform our interactions, practices, and policies to be trauma-responsive throughout the community, including health care, education, human services, government and the business community. The shift to trauma-responsive practices applies not only to those we serve but also to every member of our workforce. Now is a critical moment as we reimagine the workplace to incorporate the key tenets of trauma responsive practices — safety, trustworthiness, choice, control and restoring power — to move towards a physically and emotionally healthier community for all.

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