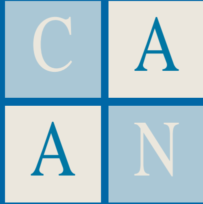

Child Abuse Action Network

Fall 2005 Newsletter

The Maine Child Abuse Action Network (CAAN) is the entity designed by the Governor to receive Children's Justice Act funds which are provided by the Administration for Children and Families of the Department of Health and Human Services

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Cops and Caseworkers Conference

By Vickie Fisher

Department of Health and Human Services caseworkers from across the state joined with local and Maine State Police at the Central Maine Commerce Center in Augusta on October 11th and 12th to look at cooperation in child death and serious injury cases.

On Tuesday, Dr. Robert Reece, Clinical Professor of Pediatrics at Tufts University gave a presentation on accidents, abusive and inflicted injuries. He reviewed the medical literature and pointed out questions that DHHS and police can use to separate accidental from inflicted injuries. He discussed many types of abuse including failure to thrive and neglect.

On Tuesday afternoon and Wednesday morning, the conference continued with Sergeant Timothy Madden of the CT State Police Polygraph unit. Sgt. Madden's topic was Investigative Interview techniques. Many of Sgt. Madden's techniques are reserved only for police staff and this was pointed out to DHHS caseworkers. It was interesting for both disciplines to note the different approaches that are used by each discipline. His knowledge regarding body language and non-verbal techniques, however, was helpful to the caseworkers as well as the police who attended.

Sgt. Timothy Madden

The Child Abuse Action Network hopes to work with Maine State Police next year in developing another quality conference such as this one that encourages caseworkers for the Department and local and state police to work cooperatively on child abuse investigations.

A special thanks to Sgt. Matt Stewart and Dan Despard for helping CAAN put this special project together.

What does the ACE Study Mean for Maine Children?

(Adapted from 2005 CAAN Conference Panel Presentation by Mark Rains, PhD)

The Adverse Childhood Experiences (ACE) Study correlated self-reported presence of seven categories of stressful childhood experiences (psychological, physical, or sexual abuse; violence against mother; living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned) with a variety of measures of adult risk behavior, health status, and disease in over 9,500 adult members of the Kaiser Health Plan in San Diego, CA. (Felitti, et al., 1998). This study found strong relationships between the number of ACE categories experienced in childhood and the presence in adulthood of health risk behaviors and diseases, such as alcoholism, drug abuse, depression, suicide attempt, smoking, promiscuity, obesity, heart disease, cancer, job-related problems, and unwanted pregnancies, etc.

... over 900 children entered foster care in the mid-Maine region over the past six years and received triage pediatric & psychosocial assessment through MaineGeneral

The ACE Study lead to recommendations for primary prevention of adverse childhood experiences, for secondary prevention to ameliorate or heal the bio-pyscho-social impairments associated with ACEs before they lead to adoption of health-risk behaviors, and tertiary intervention with ACE-related health-risk behaviors, disease, and social problems (e.g. before they produce adversities in the next generation of children).

Closer to home, over 900 children entered foster care in the mid-Maine region over the past six years and received triage pediatric and psychosocial assessment through MaineGeneral Medical Center's Pediatric Rapid Evaluation Program. Of that group approximately 29% experienced sexual abuse, 48% were physically abused, 64% had a parent with a substance abuse problem, and over 67% were exposed to domestic violence in their family. About 8% experienced neglect, without any of the preceding adverse childhood experiences. About 23% experienced just one factor, 32% had two factors, and 37% experienced three or more.

The strong dose response relationship identified between the number of ACE categories experienced and the prevalence or percentage of a variety of health behavior problems in adulthood enabled the Study to estimate the odds ratio or risk that a person would develop the negative adult outcomes. When these adult health risk outcome percentages from the retrospective ACE Study are applied to children entering foster care each year in Maine, they predict that unresolved adverse childhood experiences are will lead annually to an additional (above baseline expectations without adversity) 20 children who become obese, 38 who attempt suicide, 42 who have job-related problems, 70 who become involved in illicit drug use, 82 with unwanted pregnancies, and over 100 who develop depression; as adults. Missing in these numbers are the outcomes for children who also experienced adversities, but did not enter foster care.

These behavioral and physical health outcomes may be preventable, if children are provided with opportunities to recover from adversity before they develop unhealthy or risky alternatives for coping with their experience. This will require identifying adverse childhood experiences early, providing safety, supporting families and service providers in helping children to develop healthy emotional and behavioral coping skills and resources, and collaborating among agencies, disciplines, and the State of Maine to coordinate and sustain services, as well as a focus on their outcomes.

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ACE Study .. Maine .....

Not only should such efforts reduce the personal health risks in the children noted above, they should ultimately reduce health care costs and interrupt the transgenerational transfer of adversity to future children. Whereas the ACE Study in California pioneered a retrospective look at the adversities adults experienced as children, Maine has an opportunity to lead the nation in a prospective view of how supporting recovery and resilience in childhood reduces the prevalence of negative health outcomes in adulthood.

Felitti, VJ, Anda, RF, Nordenberg, D, Williamson, DF, Spitz, AM, Edwards, V, Koss, MP, Marks, JS. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine,* 14(4), 245-258.

Maine Department of Health and Human Services Bureau of Health – Division of Family Health

Richard A. Aronson, MD, MPH; Maternal and Child Health
Medical Director

The Maine Center for Disease Control and Prevention, formerly the Bureau of Health, is currently completing the first year of a grant from the March of Dimes to start up a Maternal and Infant Mortality and Resiliency Review Program for our state. During this year, the project has already enriched our capacity as a state to put such a program into place as a core public health activity for Maine.

An average of 68 infant deaths occurred per year in Maine during the five-year period of 1999-2003, giving an average annual infant mortality rate of 5.0 deaths per 1,000 live births, comparable to the national white non-Hispanic rate for 2000-2002 of 5.7 per 1,000. The most common causes of infant death in Maine are birth defects, prematurity, and SIDS, and nearly every year one Maine woman dies from a pregnancy related cause. An average of four women die per year during or just after pregnancy, mostly due to injuries and cancer.

Even when we know 'what' is associated with infant and maternal deaths, we often cannot answer the intensely local 'why', 'how', 'who', and 'when' questions that could lead us to creating stronger and more humane policies, systems, and services for women and infants. The reviews will enable us to recognize emerging patterns that represent opportunities to prevent future maternal and infant deaths and to increase the availability of prevention and genetic services that both reduce risk and increase protective factors.

Brief Summary:
The Adverse Childhood Experiences (ACE) Research

Stephen M. Rose, Ph.D. – University of New England/School of Social Work

The ACE studies are the outcome of a research team co-directed by Vincent J. Felitti, MD, from Kaiser Permanente and Robert F. Anda, MD, from the CDC. The ACE study design, typically, is a retrospective cohort study of one or two waves of Kaiser HMO enrollees (between 8,600-17,300) who completed a survey about their exposure to childhood abuse and household dysfunction as well as a separate instrument eliciting information about their health.

Respondents are asked to self-report on a series of questions derived from various validated instruments (e.g., the Conflict Tactics Scale,) or adapted from them. Currently, there are 10 categories of ACEs (earlier studies used 8): childhood abuse (emotional, physical, and sexual); neglect (emotional and physical); witnessing domestic violence, parental marital discord; and living with substance abusing, mentally ill, or criminal household members. Their data analysis method typically includes analysis of bivariate relationship between each of the 10 ACEs with multivariate linear regression models used to describe the interrelatedness of ACEs, after adjusting for demographic factors. Their very early work established the fact that ACEs rarely occur in isolation: the probability of having more than 1 ACE, given the presence of 1, is very high and increases significantly after that.

Analytically, the ACE group's method attempts to show dose-response relationships to a number of health risk, morbidity, and mortality outcomes. The first published paper (Felitti et al., 1998) established their logic model, purposes, and foundation discoveries. That publication serves as a guide to the more than 35 publications that follow. The ACE Study "is assessing, retrospectively and prospectively, the long-term impact of abuse and household dysfunction during childhood on the following outcomes in adults: disease risk factors and incidence, quality of life, health care utilization, and mortality."

10 risk factors associated with high ACE scores .... linked to the leading causes of morbidity and mortality. They include smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, drug abuse, parental drug abuse, a high lifetime number of sexual partners, and a history of having an STD.

The ACE research team identified 10 risk factors, associated with high ACE scores, that are then empirically linked to the leading causes of morbidity and mortality. They include smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, any drug abuse, parental drug abuse, a high lifetime number of sexual partners (>50), and a history of having an STD. Their first results produced their most basic finding: "We found a strong relationship between the number of childhood exposures and the number of health risk factors for leading causes of death in adults….In logistic regression models (which included age, gender, race, and educational attainment as covariates) we found a strong, dose-response relationship between the number of childhood exposures and each of the 10 risk factors for the leading causes of death that we studied ($p > .001$)." Because they had access to respondents' medical records, they were able to relate medical data to ACE exposure, as ACE outcomes. That association produced the following result: they also found a strong dose-response relationship to ischemic heart disease, cancer, chronic bronchitis or emphysema, history of hepatitis or jaundice, skeletal fractures, and poor self-rated health. These relationships were graded to the level of childhood exposures: "the findings suggest that the impact of these adverse childhood experiences on adult health status is strong and cumulative." The documentation of cumulative impact links the ACE group to other social epidemiologists working in the area of life-course inquiry who describe the effect of cumulative impact.

ACE researchers' conclusions suggest that the risk behaviors identified, such as smoking, alcohol, drugs, overeating or high risk sexual behavior, can be seen as coping mechanisms "in the face of the stress of abuse, DV, or other forms of family and household dysfunction." What remains to be investigated are the social determinants of household dysfunction, child abuse, domestic violence, and the other ACEs. Links developed by other researchers clearly demonstrate that these behaviors, along with health risks identified by the ACE research group, are not equally distributed by class. [References for this article are listed on page 5]

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Division of Family Health.

While our primary focus is on the babies and mothers who die, and their families, our program will ultimately reach and have an impact on all people who live in Maine, especially the roughly 13,500 babies born each year and their families.

During the first 10 months of the current March of Dimes grant, we 1) Established a network of about 100 people from a wide array of public and private, state and local organizations and from all walks of life who are committed to make this program a reality for Maine; 2) Formed four action teams: Technical Review, Community Action, Resiliency, and Steering Group; 3) Identified a Program Coordinator; 4) Introduced legislation (LD 1420) to provide statutory authority for the review panel; 5) Established direct links to the Maine Child Death and Serious Injury Review Panel to ensure that we work in synch with each other, and to the Maine Task Force on Early Childhood of the Governor's Children's Cabinet to ensure a mechanism for the translation of our work into policy and system change; and 6) Set into motion a process that includes family and community involvement from start to finish, honors all cultures, uses simple and non-jargon language, gathers and analyzes accurate and useful data, and respects families for their resiliency.

We have applied to the March of Dimes for a second year of funding. Our hopes for 2006 are: 1) Advocate for the enactment of LD 1420, which the Legislature carried over to the 2006 session; 2) Define the parameters for both clinical and community case reviews and data collection; 3) Finalize the database that will house the case reviews; 4) Engage epidemiologic support for data analysis and linkage; 5) Finalize the unique and innovative resiliency component of the program; 6) Clarify and strengthen community involvement; 7) Seek and obtain long-term funding to sustain this program, including funds to support a full-time Program Coordinator; 8) Develop and start a bereavement educational program; 9) Ensure that the program enriches the creation of the new DHHS; and 10) Start the ongoing case reviews.

MIMRR will consider the entire life 'story' of each of the cases that we review, including medical records, autopsy reports, and family interviews. Rather than try to prove what led to a particular death or assign blame, the team will attempt to find gaps in services and systems that represent an opportunity for prevention, and do so in "real time." Each review provides an opportunity to engage one or more systems, whether health care, the media, education, child welfare, the legislature, community agencies, civic associations, churches, or others. Refining the allocation of a community's social and fiscal resources can result in a wide array of improvements.

References from Richard Aronson's article on page 3

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