Transcript:

Using ACEs Data to Inform Prevention Interventions and Measure Impact: HHS Region 5

Presenter: Dodi Swope
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ANN SCHENSKY: Hello, everyone, and welcome. We're going to give people a minute or so to get settled and we will get started.

All right. We will get started. There are still some people coming in, but want to make sure that we have time for all of this fantastic information. So welcome to our webinar today, using ACEs data to inform prevention interventions and measure the impact. This is the second part of a two-part series. So today, we are going to look at why understanding trauma is important for prevention professionals.

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We have some housekeeping details today. If you are having technical issues, please individually message Kristina Spannbauer or Stephanie Behlman in the chat section at the bottom of your screen, and they will be happy to assist you. We will be using automatic transcription during the webinar today. Please put any questions that you have for the speaker in the Q&A section at the bottom of the screen. We will respond to those questions during the presentation.

Certificates of attendance will be sent out to all who attended the full session and they normally take about two weeks. You will be directed to a very short survey at the end of this presentation. We would really appreciate it if you could fill it out. It takes about three minutes, and it's how we report back to SAMSHA. We are recording this session, and it will be available on our website, again, in a couple of weeks.

If you would like to follow us on social media, please do so. And again, we are thrilled that our presenter today is Dodi Swope. Dodi is a licensed marriage

and family therapist in the state of Massachusetts. Dodi's background includes teaching in regular and special education, and clinical practice serving children and families in the Boston area. Most recently, Dodi has provided training and planning facilitation on a broad scope of community health initiatives. We are excited to have you, and I'm going to turn it over to you, Dodi.

DODI SWOPE: Wonderful. Thanks so much, Ann, and welcome, everyone. It's a pleasure to be with you again this week. I'm thrilled to be back with all of you who joined us last week. And for anyone who's joining us new this week, welcome, welcome. These do kind of stand alone, but they also go really well together. So I hope we have some folks who were with us last week. And if you were, we can continue the great conversation that we had last week. So our purpose is-- today, I'm going to share my screen. I work from a Macintosh. So when I share my screen, I cannot see very much of any of you. So I apologize for that. I will be asking Ann to help me out with the questions when they come up. And we'll pause throughout the session today to ask for questions. So if you do have a question, please do write it in the chat, and we will take pauses throughout today's presentation to answer those questions. So welcome to our session today. We're really focusing in on the ACEs study, and ACEs stands for Adverse Childhood Experiences. So absolutely related to the trauma conversation we had last week, but this is a specific study that really gives us some great data to think about as we think about prevention. So our learning objectives for today are to really understand what the researchers who did the ACE study called the dose response relationship between adverse childhood experiences and poorer outcomes later in life, particularly around chronic disease. And we'll talk in great detail about how they did that study and what that meant.

Then we're going to zero in on what that means for us, working in the field of substance misuse and substance use disorder prevention. So we really zeroed into those parts of the study that are particularly relevant to us as prevention providers or professionals. And then we're going to dive into, what does this mean for us as prevention professionals? And how can we think about the ACEs data as we think about our intervention strategies at the community level?

And then we're going to look at ways that you can use thinking about ACEs to measure the impact of your prevention efforts and get to those outcomes that are so important in all of our communities. So that's what we're up to today. So I don't know if it's possible to do this, Ann, and I don't know if you could see it if people did. But I wonder how many people out there in my virtual universe have heard of the ACEs study. I don't know if it's possible to pop that in the chat. Seeing lots of raised hands. Great. That's how we do it. [LAUGHS] I saw lots of people raising their hands. Great. All right, good. I'm glad folks have a basis of that.

I am going to cover some of the basic information, just as a reminder. And as I said to my colleagues before we get on the call, every time I do it, I kind of go, oh yeah, that's an important point. I forgot about that. So bear with me if you're very familiar with the study. I am going to cover some basic ground here.

So the ACEs study, which stands again for Adverse Childhood Experiences, was done in the mid-'90s by these two lovely gentlemen on your screen, Robert Anda and Vincent Felitti. Robert Anda is still with us. Vincent Felitti is no longer on the planet. They did a study of over 17,000 people through Kaiser Permanente, which is an insurance company out in California. And what's important to say about that is that was a very broad population and pretty much right in the middle of all the demographics that we're used to looking at. So it was very broadly representative. It was very middle class, socioeconomically. And they looked at the impact of adverse childhood experiences on the life course, and particularly as it related to chronic disease. And that's the information that I'm going to share with you today. So let me flip my next slide here. So this is the original ACE pyramid. Many of you may have seen this over time. I start with this, because I think it's important to understand where the ACE study began and then where it has developed to, because we've learned a lot since that mid-'90s, when they first did this study.

So what they were interested in was, up until their study in the early '90s, really our conversation in public health was about the top three layers of this pyramid. So how does risk behavior relate to disease, disability, social problems, and lead to early death? We talked about risk and protective factors. We talked about things like smoking and its relation to heart disease. What we didn't do was look beyond that. And so really, the brilliance of Anda and Felitti was that they said, these things don't happen randomly. I see them concentrated in particular populations. I see them concentrated in parts of the country. They seem to cluster. They don't seem random. So I want to understand what's going on around those risk factors. I want to understand deeper why those risk factors exist.

So they had a sense that it had something to do with development. And so they said, well, this has to do with something that happens in early development. So they wanted to look at what happened in childhood. And they had an inkling that it had to do with the neurodevelopment in people's brains. They were really, really revolutionary in having these concepts back in the early '90s.

I know to us now, this seems like, oh yeah, everybody knows that. But people did not know that back then, and it was a really revolutionary thing that they discovered.

So what they were able to do was identify people who had these adverse childhood experiences. I'm going to talk about exactly what they were in just a

minute. They related those adverse childhood experiences to disrupted neurodevelopment as a child was growing up, that then led to issues around social competence, emotional regulation, and cognitive ability.
And that then led them to say, and that's why those risk factors exist, because of these other three steps of the pyramid. And so we can't just address the risk factors, because these other things are critically important to why those risk factors exist.

So this was the original study. And what they were really looking at was that life course model. What happened to you in childhood has an impact on your overall health. And if you had negative experiences in your childhood, it may lead to chronic disease and early death. And that's what they were-- that was their hypothesis that they were trying to prove.

I did see a couple of raised hands. I don't know if they were raised hands for the ACE study or if they were questions. I'm going to go through another couple of slides, and then I'm going to pause for questions. So do put your questions in the Q&A for us, please.

So what's happened since the early '90s that is critically important is a few additional links were made to that information in the ACE study. And the most important, as you will see, is the base of the triangle-- so the relationship between adverse childhood experience and historical trauma and intergenerational adversity.

So last time, if you were with us, we talked about epigenetics and how trauma is carried right down to the DNA. And oftentimes, folks come into life with some of that already in existence before they've ever even drawn their first breath. And that's critically important when we look at generational well-being. I did notice as folks were coming on, and I hope I can, with utmost respect, call out Choctaw Nation. So I saw that Choctaw Nation was on the call, so welcome, and we're so thrilled that you're with us.

The reality of the genocide of our indigenous populations is a critical historical trauma. And we have to understand that that has an impact over generations. And so if we just think, oh, it's just, you're starting fresh with your family and there's no background burden, that's incorrect. And so it is really critically important that we understand that. We can have some discussion more about that in a little bit. But that base of the triangle is critically important.

So oftentimes, that intergenerational adversity can lead to some of those adverse childhood experiences or increase the likelihood of them. And then what we see is the neurodevelopment doesn't just start in early childhood, it actually starts prenatally. It starts in conception and prenatal development. And then we realize that, as life continues up that continuum along the side of the triangle, from preconception now to death, that adaptations happen, that people adapt.

We talked a lot about this last week when we talked about trauma, and how folks adapt to trauma in different ways, and that those adaptations can often lead specifically to those risks that lead to health issues, social problems, and other kinds of disabilities. So they made these much stronger kind of connections between the layers of the pyramid. And that's been really critical to our understanding.

What is important, I think, to say-- two things. One is this is ongoing science, that we're continuing to learn about this every day. And every day, we learn more and more about how we can understand this neurodevelopment piece better. So the ACE study is a point in time, and I believe we will continue to learn a lot about how this all functions and what we can do to prevent it as we move forward.

A lot of this has been about setting the stage. We haven't gotten as deep into how do we prevent it yet, and that's really where the science needs to go. The second thing I want to say, which is sort of the mantra of Dr. Anda and Dr. Felitti, which is the reason this matters is if we can predict it, we can prevent it. And that's the piece I really want you to carry with you throughout today's webinar, to be thinking about, if I understand that these ACEs exist in my community, that helps me predict what would happen without intervention. But if it helps me predict it, then I can start to think about, what do I need to put in place so that the next generation doesn't have to carry that burden? And I will say, in the work I've done minimally with folks who have experienced historical trauma, that that's the takeaway. It can stop in this generation if we understand how to mitigate and prevent it moving into the next generation. And that's really critically important.

It's also really important to say, we can't blame parents. It's not about that. It's about understanding the cycles of this DNA, oftentimes through multiple generations, and that we have to understand that that has had an impact that is biological, which I think folks have understood it as being emotional or psychological. But it is down into our genetics, where some of this trauma and these adverse childhood experiences live.

So and this is a good place to pause and see if there are any preliminary questions.

ANN SCHENSKY: We do not have any questions right now.

DODI SWOPE: OK, perfect. Great. That's wonderful.

ANN SCHENSKY: Thank you.

DODI SWOPE: Sure, thank you, Ann. So what are ACEs? And I think this is really critically important, because a lot of folks think, oh, adverse childhood experiences-- they are. These the reason that these are the studied adverse childhood experiences that Anda and Felitti settled on to do their research is

because they had data on these. These are not the only adverse childhood experience that exist in the universe. There are plenty of other bad things that can happen to you as a child that aren't encompassed in these 10.

But what's important is to understand that these are the ones they could get enough solid population-based data on to do the study that they wanted to do. So I think that's a misconception that folks have, that these are ACEs and these are the only adverse childhood experiences. These are the ones that were studyable-- if that's a word-- in the mid-'90s. So I want to just review them with you quickly.

So there were five under what we call household dysfunction. None of this language is very user-friendly or very non-stigmatizing. So I just want to own that right away. But this is the language of the study. So substance misuse, substance use disorders. Back then, it was called substance abuse. Parental separation or divorce.

They finally added separation in there. Originally, it was just divorce. And we all know that there are plenty of parents who are separated that maybe never were legally married or never legally divorced. But it's the act of that separation that is the issue that they were measuring.

A history of mental illness in a member of the family or in yourself. Battered mother-- so here you go with stigma again. At the time of this study, there was data on battered mothers. But there wasn't more broad-based data on domestic violence among all different kinds of partners. We now understand that domestic violence is a bigger issue than simply dads battering moms. That's a more complicated area. So I think it's important to understand some of the limitations of the language, as well.

And the final one for household dysfunction was, if there was a member in the household who had been in prison, basically, was the question, but they called it criminal behavior. The problem again-- and I'm just going to call this stuff out, because I think it's important-- is people end up in prison for all different kinds of reasons.

And we know that Black, Indigenous, and people of color end up being larger representations of those populations. Whether or not that's an equitable thing that happened to them is an entirely different conversation and another whole webinar. But it was one of the measures of an adverse childhood experience was, did you have a person who had been in prison?

So it could have been your dad who got picked up for a minor marijuana offense, or it could have been your uncle who lived with you who was in for murder. But there wasn't any distinction about why you were in there. It was just the fact that you were in prison that counted as an ACE score.

So under neglect, they separated neglect into emotional neglect and physical neglect. So whether or not someone bonded with you, took care of your emotional regulation, those kind of things that we talked about last time around, emotional development, or physically harmed you-- or physically neglected you, I'm sorry. Excuse me. Physically neglected you-- didn't feed you, left you in dirty diapers, those kinds of things. And then there were the three abuse categories of emotional abuse, physical abuse, and sexual abuse.

And the ACE survey itself is very simple. It's 10 questions that ask you, have you, in the time under your age of 18, experienced any of these things? They define them very specifically, and it's either a yes or no. So that's what ACEs are. Let's dive a little bit deeper.

What they discovered when they started to pull the data on each of these buckets of what they're calling adverse childhood experiences, this was, in the original study, the way it panned out across a population. So 27% of that population had checked off the box that said, yes, there was substance abuse in my home, or, yes, my parents were separated and divorced, or, yes, there was mental illness in a member of my family that lived with me.

Or yes, my mother was battered by my father, or yes, my brother went to jail. So this is the way those particular adverse childhood experiences panned out across that population of 17,000 people that And and Felitti surveyed at the very beginning of this case study. So it's important to just look at that. I'm going to give you a minute to absorb that. Physical abuse is more common than sexual abuse. Emotional abuse is the least common of that population when they asked them these questions.

Emotional neglect was more common than physical neglect. In the household dysfunction-- I don't think this is a surprise to any of us in prevention-- substance abuse, substance misuse, substance use disorder was the highest in the population that they studied, at 27%, and so on.

And so basically, this was the study. And then I'm going to just give you a sense of, in the next slide, what this looks like across the population. So they asked those 17,000 people to fill out this survey. They asked about what kinds of ACEs those folks had experienced. And that was the slide I just showed you. And then they showed us exactly how that played out across the population.

So they were not as interested in what the specific ACE category was-- the experience itself. What they were interested in was the preponderance of those negative experiences in childhood. So did you have an ACE score of 1? Did you have an ACE score of 0? Did you have an ACE score of 4? And this will become more clear why it matters in just a little bit.

So 33% of the population in the original ACE study had zero aces. So about a third of our population didn't report, or of that population, didn't report having had any of those 10 things happen to them between the ages of 0 and 18. 26% , about a little over a quarter, said, yeah, I have one of those in my family. About 16% said, I have two of those in my childhood experience. About 10% said they had three ACEs. And 16% had four or more ACEs. And so that matters, and I'll get to that in just a minute. But that's how it played out across that population, in terms of ACE scores. So the ACE score becomes the important piece of information in this study.

I want to take a minute to just make a couple of important remarks about that. A lot of folks want to take the ACE study and use it as a screening tool. And here's the reason why I wouldn't recommend that. I think it's fine to use it as a population-based assessment. So if you want to look at your city or town and find out in a large-- it has to be a pretty large population-- what the percentage of ACEs are in your community, you could do that.

But it has to be a population base, not one, by one, by one, by one person. You don't want to scream kids in a classroom. It's too small a population to make this study effective and really give you good information.
So a couple things that are important about that. One is, as I said earlier, this is 10 categories, but they're not all the categories. So if you thought of it as simply a screening tool of an individual, there may be things you would miss. It's much more important to ask people questions like, did you have a hard time when you were a kid, and can you tell me about that? And let them tell you what those adverse childhood experiences were, as opposed to trying to put them into those 10 buckets, because people can have very legitimate trauma in childhood that might not have fit in one of those categories. So that's one important piece about screening.

The other piece that's really critically important is not all ACE scores are equal. So we can't say that everybody who has an ACE score of 2 has the same level of adverse childhood experiences. All that we know is that they answered yes to two of those questions on the survey. So that might have happened to them once or it might have been a chronic situation. And the level of trauma in that person is going to be entirely different based on the exposure to that adverse childhood experience, if that makes sense.
So a person with an ACE score of 2 and a person with an ACE score of 2 may have very different trauma histories, may have very different trauma experiences, may need very different kinds of treatment. So I caution people to understand that this was a population-based study. I think a lot of folks would love to just take the ACE study and go, great. I have a screening tool now. But that's really not the purpose of this study.

So there may be questions that come up about that, and I'd be happy to go in more depth or give you some additional resources. I hope that all made good sense.

So why does the ACE score itself matter? And here is the brilliance of what Anda and Felitti discovered. They discovered what we call this dose response relationship. So the simplest way to think about a dose response relationship is the more gas you have in your car, the farther you're able to go. Or the more food you eat, the more calories you're going to have.

So there's a level to which what you have relates to the strength of what the outcome is. And that's what they're talking about here with dose response relationship.

So they studied a whole bunch of different health problems-- chronic health disease, heart problems, high blood pressure, diabetes, asthma, long-term health consequences. And what they discovered is that folks with more ACEs-- simply the number-- I have 1 ACE. I have 2 ACEs. I have 3 ACEs-- increased the percentage of their likelihood to have that health problem. And so that's why they call it that dose response relationship.

And so what that means is that when we understand that there are populations who have high ACE scores, like large numbers of people who have high ACE scores in a population-- again, not as an individual screening tool, but as a population study-- that those communities need increased interventions to reduce the number of ACE scores in the next generation. And they may need additional trauma treatment and other kinds of mitigating things to help the folks who have those high ACE scores not necessarily have to follow that trajectory into early death, because you can intervene at any time to make that better. And that's an important point, too. So that's the really important piece.

One of my people who has taught me a tremendous amount about trauma is this gentleman named-- I'm sorry. I'm trying to move my bar out of the way, but I'm not going to mess with it, because it'll just distract me. One of my most important teachers of trauma is this gentleman called Bessel Van der Kolk. He works out here in the Massachusetts area, and he's written a lot of books. You may have heard of him. He wrote a book in 2014 called The Body Keeps the Score.

And what I find really useful about Van der Kolk's work is he really makes the body-mind connection. So he talks about the relationship of ACEs, which again, disrupts that emotional and self-regulation, and then that can lead to these lifelong problems. So I'm just going to read the quote, because he says it better than I can.

"Self-regulation depends on having a friendly relationship with your body. Without it, you have to rely on external regulation." Might be medication. It might be drugs-- you know, might be not legal drugs or legal drugs, like alcohol. It might be finding yourself in really codepedent relationships, needing that constant reassurance, not very healthy relationships. Or it might

show up as compliance and being very, very rule-based and having to have everything follow the rules all the time.

What I think is important to say is that internal regulation is way better than having to try to regulate yourself externally. We talked about that a lot last week when we talked about trauma.

Another person has said-- and I can't remember who the quote came from, but I remember it. It hit me strong when they said it. They said, I'm not sure nicotine, or alcohol, or marijuana are the gateway drugs. I actually think trauma is the gateway drug. And I think that's a powerful statement.

I'm not saying that I don't think underage drinking is a bad thing-- I do-- or that starting smoking early doesn't mess up your neurology and make you more likely to have a issue with trying to quit cigarettes later in your life. All of that is true. But what is it that leads to your engaging in that behavior in the first time? Oftentimes, it's just trying to find regulation externally because you don't have it internally.

So I do see a question there, and I will pause now for that.

ANN SCHENSKY: OK. It says, "How do you think COVID will play out as an ACE?" And then the second part of the question is, "Is childhood bullying ever studied in response to the mind-body connection?"

DODI SWOPE: Wonderful. Both great questions. To the first question, I don't have a clue, but I'm fascinated to find out. I'm hoping that they are really brilliant researchers looking at that. I will say, I think it really depends on your COVID experience, because there's such variety in how people have survived this pandemic. It's been much harder, as we know, on Black and Indigenous people of color. It's just taken a much larger toll.

And so that experience is really different from white privilege folks who have been able to go into their bubble and not worry about it too much. Maybe they didn't get to go shopping as often. But other than that, it hasn't had the same impact. So I'm not sure everybody's had the same COVID experience. So I think it would be interesting to think about that. But I think it'll be really interesting to look back at that.

I was talking to my 14-year-old grandson the other day. We were just talking about, what was this year like, and how disrupted his learning has been, and how hard that's been for him. He's right at the point where he's leaving middle school and he's about to enter high school. And I regularly feel very sad that he hasn't had a more traditional experience, because that's an important transition.

But he looked up at me, and he said, but Mimi, I've gotten strong in some other ways that I never would have if it wasn't for this pandemic. And I just

thought that was kind of brilliant coming from a 14-year-old. So I always want to say that trauma really matters. It's important for us to understand it. But healed trauma can be a strength. Once it's healed, that traumatic experience can absolutely be an asset and a strength. But it requires that healing and that intervention. So that's what I have to say about COVID.

And the second half of the book with the question I've now forgotten. Oh, bullying, right. So what we discover is that bullying behavior is very related to early trauma, and that there are real links, and the science is still coming out and very compelling. But that we do see a direct relationship to the kids that engage in that bullying behavior. Not every bully has had childhood trauma, but many, many, many have. And not every child who has had child trauma ends up using bullying as a strategy.

But there does seem to be a strong link between those two things. But the science is still out, to be completely clear about exactly what the details are around that. But there's absolutely a link. Thanks. Great. All right, let's keep going. Thanks so much. Those were great questions.

So I want to look at ACE scores across a lifespan, because I think this will illustrate the point just a little bit more. So if we think about the dysregulation that happens as a result of the trauma of an adverse childhood experience, we see that that neurology is already a little disrupted and kids are looking for external ways to regulate.

Well, guess what happens when you first pick up a cigarette? Not the very first time, because you cough your head off. But later on you might realize, wow. Nicotine actually kind of helps me focus. It kind of helps me calm down. You're not necessarily thinking at that point that you're going to end up having lung cancer when you're 60, or 70, or 80. You're thinking, wow, this is kind of working for me.

So oftentimes, we see that there's higher early smoking initiation with those who have higher ACE scores and have that regulation issue that they're trying to solve. We also see it with people that struggle to quit smoking. So we see it, even with all of our antitobacco efforts and all of our great most smoking cessation, that the stubborn folks that are not giving up smoking, a lot of them have ACE scores of 2, 3, or 4.

And you really see that jump. You're starting to see that jump between 0 ACE scores, 1 ACE score, and then, woo, 2, 3, 4. You start to see a real increase there. And then over time, we see in folks that end up with Chronic Obstructive Pulmonary Disorders, or COPD, that many of them also had higher ACE scores. I can't really explain the graph in the middle there, that it's low. It just was in this population.

But the point of this slide is to really see that there's a consistency of how that impacts people's behavior over a lifetime without intervention. And again, I'm

always going to say that-- without intervention-- because intervention is the key to turning this thing around. So that's it if you think about it over the lifespan when it comes to tobacco use.

We also see that ACEs are very related to early initiation of drinking alcohol, so those who start drinking before the age of 15. What's really striking about this is if you have more than 4 aces, that it shoots right up. That's a really significant jump. So to kids who have experienced a lot of adverse childhood experiences, early initiation of alcohol is a much more common thing than for those who have not.

So that's a critical piece. You're going to start to see some patterns here. You getting the message? The stairsteps-- over, and over, and over again. That's really the message of the ACE study. So ACEs and heavy drinking-- we define heavy drinking, along with the CDC, as being men who have two or more drinks a day and women who have one or more drinks a day.
So again, you see that real stairstep of, in a population, those who report having what we call heavy drinking really start to rise when we see additional ACE scores. And so again, that relationship between ACEs and substance use.

Again, with illicit drugs. Robert Anda said, ACEs have a strong graded relationship to opioid use. He did a little study, post the ACEs study, about when that opioid epidemic was really rolling across the country. There is a piece on the CDC website. If you look up the ACE study on the CDC website, you can see more about his opioid study. But again, very similar kind of stepstool.

So this is illicit drug use before the age of 15. And again, those who have ACE scores of 5 or higher, much more likely to try illicit drugs before the age of 15. And then we see it evens out and becomes much more of a flow along that continuum at ages 15 to 18, when most of that kind of illicit drug use is initiated. So we see that that makes a big difference over time.

And then we see that hangs on and is consistent throughout adulthood. So that's really critical when it comes to looking at ACEs, when we take out the pieces that have to do with actual risk behaviors in regards to substance misuse or substance use disorder in current time.

So finally-- and I'm going to not show you too many more of these. I think you've gotten the point by now. We're going to start to talk about a few other things, but I really wanted to nail this one home, because I think it's really important-- ACEs don't only relate to our own risk behaviors, they also relate to how we interact in relationship.

And I remember when I first saw this slide, I was like, oh, look at that. So people with alcoholism-- we see that that ACE stairstep happens. But they asked folks who were married or in committed relationships with people with

alcoholism, in particular, but I think we could probably assume this was also true for addictive behaviors, that folks get connected to marrying someone who has those behaviors.

So it's interesting that it's not only the ingestion of the substance itself, it's about being in that relationship system around addictive behavior that can also be predicted by ACEs. So folks with an ACE score of 4 or more are almost 35% more likely to be in a relationship with an alcoholic than those who have no ACE scores. So that's pretty powerful stuff.

This slide has a lot going on, so I'm going to talk to you about it a little bit and give you a chance to really look at this. So we affectionately call this slide the oil slick slide. I don't want you to get too involved in the minutia. What I want you to think about is, look at all of the different ways ACEs impact all of the things public health cares about.

So when we look at it all together, what we see is that ACEs have significant impact on all kinds of risk behaviors. So what does that mean for us, as preventionists? It means we have lots of partnerships to build with folks who are working in other areas of risk behavior that can help us, together, think about, how do we mitigate ACEs in the current population so that we can reduce all of these risk behaviors in the next generation?

So some are higher than others, obviously. But the impact is what I really want you to get from this slide. So we call this population attributable risk. So that's a complicated way of simply saying, we understand that the risk for these kinds of issues that our society, and our medical professionals, and our prevention professionals are all trying to mitigate are all, at the core, related to that ACEs have a significant part to play in the amount of that we see in our communities.

And they are controlled for all the other kinds of things we might be thinking about, like gender, age, income, all of that. So there may be a question about this, so let me pause here.

ANN SCHENSKY: Yes. We do have one question. "In addition to counseling, how would you support families or parents who clearly have a high number of ACEs?"

DODI SWOPE: Wonderful question. Great. I'll say a little bit now, but we're going to talk a lot more about that further on in that webinar. So it is really important. Counseling can be very, very helpful. But we also have to address-- any of you who were with me last week remember that picture of the plant. And so I think we have to address the community conditions that surround that family and help to build some of that connectivity to community that is so critical for recovery from trauma.

So when we think about a plant that's not doing well, we don't say, what's wrong with you, plant? We say, is your dirt too dry or is it too wet? Does it have the right nutrients in it? Do you need a sunnier window or a less sunny window? We think about the environment around the plant.

That's critical for addressing ACEs in populations, and in individuals. So it's about, how do we build communities that are trauma-informed and start to build that all around the folks that have been most impacted? So we'll talk more about that as we go forward. Thanks for that great question. I love that people are thinking about that. OK. We're going to keep going.

So I think this is really a really important slide, because I think it brings it home for all of us as prevention folks. So this is a typical classroom, today, in this period of time that we are in. When we measure ACEs in a high school population-- and this is a population of 10th graders-- they discovered that 42% in this high school population had three or more ACEs.

So what does that look like when you look at a classroom? It looks like all of the kids in the end of the third row, the fourth row, and the fifth row are all kids in that high risk part of that ACEs stairstep. So that means that classroom has a significant number of kids who are going to struggle with emotional regulation, who are going to struggle with cognitive issues, who are going to struggle socially.

And we need to understand that we might have built our classrooms for that first row, that 0 ACE row. That's who we built a lot of our traditional classrooms for. And that's why teachers struggle, because they have a curriculum, and a system, and an educational process that works for kids who don't have adverse childhood experiences. What we're learning is more and more kids have had these experiences.

In this study, they compared this high school population to the adult population. And the striking thing about that was that, in this population, it was 42%. In the adult population in the same community, it was 27%. So less adults had higher ACE scores than the children did. So this should raise a sense of urgency for us, that as we roll this out, now that we understand how it functions, we need to understand that there is a growing population that, without intervention, will likely continue to grow over time.

So the kids had more ACEs than the parents did. And we want to make sure that we're mitigating that, because this is a multiplying phenomenon. So but if we can multiply it that way, we can divide it the other way if we understand what interventions are most important to implement. So this is a really powerful slide. And I do see there are a couple of questions, and so I will pause.

ANN SCHENSKY: OK. Sorry, my mouse seems to not want to connect with my unmute. So the first one is, "So to reduce risk factors in addition to counseling-- that's what you're saying?"

DODI SWOPE: Yes, absolutely. And to actually really think about what supports those families, in particular, and how do we talk to those families about what will help them the most. How do we engage them in the healing process? Because they understand that better than, oftentimes, the systems of care around them. And so it's really-- there's a lot about that that I could share, and another whole webinar about how to build resilience and that kind of thing.

But absolutely, it's not enough just to treat people one, by one, by one. We're never going to get there if we do that. We need to look at some of the community-based risk factors and societal, honestly, based risk factors that make this phenomenon happen to begin with. And we need to start turning those around. That's really what I'm saying.

ANN SCHENSKY: Great. Thank you. The next one said, "You said we shouldn't use ACEs for screening. But is it beneficial to use it as a way to screen for the dose effect, meaning to ascertain the number of ACEs and then referring?"

DODI SWOPE: Yeah. And again, I think the most important thing I can say about that is, you can give somebody the ACE study and find out what their ACE score is, and that's a beginning part of the conversation. It's just not the definitive conversation. It can be a very good tool for just going, oh OK, I've got somebody who's got some trauma history. Now I need to take it the next step and really understand the specifics and the details of that, because just having an ACE score of 2 doesn't tell you anything other than, I've had some trauma in my life.

So I hope that's clear. The other thing is that the ACE study, if you use it as a tool in a population base, it can be very helpful in understanding, for example, why a particular part of your state might be experiencing higher percentages of congestive heart failure or smoking-related disease. If there's high ACE scores in that whole population of a particular state, you might go, OK, we got to look at the environment around what's going on at this part of our state. So that's, again, population-based. So I hope that's clear?

ANN SCHENSKY: OK. Yeah, that makes sense.

DODI SWOPE: Great.

ANN SCHENSKY: And someone had a question. "Is the current data-- the classrooms data, is it current or is it from 1990?"

DODI SWOPE: Oh, Thanks so much. It's probably not completely current, but it has been in the last 10 years. I could get a date for you. This was done in Washington state by Laura Porter. I don't know if you know who Laura Porter is, but she's one of the ACE interface master trainers. She does a lot of work up in the state of Washington. And this is her slide and her data that she did up there.

And I would probably-- I don't know the exact date of the study. I could find it. But I would guess it's probably in the 2000s to 2010s. Not completely recent, but also not ancient history, like the '90s feels sort of to us now.

ANN SCHENSKY: OK, great. Thank you. And then the last question is, "Are you familiar with an online tool a school could use to track an ACE questionnaire and compile data that could be utilized by the school?"

DODI SWOPE: Yes, there are those. They do exist. There's a website called ACEs Too High that has sort of a quick ACEs study you can do. There are a number of different tools that folks can use. Basically, they're all built on those 10 questions. But again, it's important to look at those numbers in aggregate, not about individuals. So even when I was doing the master training with ACE Interface, we did a survey of the training group.

And what's important to understand is population-based ACE surveys tend to show those same levels of percentages if they're a big, broad, diverse population. When we get down to, like, gee, why do we have so much cardiovascular health issues in this particular part of the state? That might be a little skewed if there's something really going on in the environment there or in the history there. That might lead us to understand why their ACE scores might be so much higher than other places.

But generally, if you did a large study population of ACE scores, you're going to come up with similar numbers across the board.

ANN SCHENSKY: Great, thank you.

DODI SWOPE: Thank you, ma'am.

ANN SCHENSKY: Those are the questions that we have right now, so we'll turn it back.

DODI SWOPE: Wonderful. Great. OK, let's dive into, so what? Because I think that was a lot of data. So the most important takeaway-- I'm going to just summarize this and then we're going to move to prevention. So the most important thing here is that adverse childhood experiences or high ACE scores relate to all of these lasting impacts that we, as social scientists, as prevention professionals want to mitigate.

And so they go all the way from physical injury, mental health, maternal health, infectious disease, chronic disease, risk behaviors, and even into things like academic opportunities can be diminished by high ACE scores. So they have a big impact. So the most important takeaway is ACEs are common in our population, generally.

They are interrelated. Usually, when one person has an ACE score of 1, it's much more likely that they might also have an ACE score of 2 or something else that wasn't actually measured by the ACE study, but additional traumas there. And that the more of those traumas there are, the higher level of risk for long-time, lifelong impact to health and well-being.

And that they're powerful, that if we really understand them and how to mitigate them, we can make impact that is really, really significant in the social problems that have plagued us, as a country, for a long, long time-- as a world, really. So where there are high ACE scores in a population, you will also likely see concurrent high risk of multiple health and social problems and intergenerational transmission of ACEs.

And that intergenerational transmission of ACEs is really the thing that is so critical for us to understand. When we heal a mother who has a high ACE score, we mitigate the intergenerational transmission of her trauma to her children. It can turn around as quickly as one to two generations. Imagine that. That, to me, is the mind-blower. In one or two generations, if we really took this work on, we could turn around some of our largest social problems. It's really powerful stuff.

So it's also important, however, to remember that ACEs, by themselves, is not enough. We have to think about the whole lifespan, that trauma in human life can happen through historical trauma, through ongoing oppression, folks who are experiencing the retriggering of the trauma after the George Floyd situation. It's in the middle of the trial, so I'm going to be careful with my language.

But a lot of folks that I'm in touch with out here are saying, I can't even watch it because it's getting me so traumatized just to rewatch the footage again. Those are traumatizing. Those events are traumatizing. Obviously, adverse childhood experiences is a part of that. Having a hard time in school can also be an adverse experience that adds trauma to a person's life experience. Or lifetime trauma-- if you've been through a hurricane, or you've been through a tornado, or you've been through a forest fire-- I have a very dear friend who works out in northern California in Butte County, and they experienced the wildfires a couple of years ago, where it was paradise, and just everything burned down to the ground.

They spent three years doing trauma work with their entire community and school population to try to address the trauma so that it didn't continue to fester under the surface and get passed on to the next generation. So all of

those traumatic experiences have impact on mental, physical, relational, and productivity issues for people in work-- in their lives, I mean.
So and then if it's untreated, it can transmit to the next generation. And that's really the part that's so powerful and so important to talk about. And again, I'm going to go back to Anda and Felitti is saying, if we can predict it, that means that we can think carefully about, how do we mitigate it? How do we prevent it?

So I am about to move on to how prevention professionals can help reduce ACEs, but I do see a couple of questions. So before I shift again-- Ann, you've been doing such a great job giving me these questions. Thank you.

ANN SCHENSKY: Thank you. And these are really, really great questions. Someone asked, "Are you familiar with how culture is used as a prevention tool in Indigenous populations?"

DODI SWOPE: Yes. And I would point you to Laura Porter's work in Washington. She's done an amazing amount of work with this. And this is really her passion, is culture is healing. We often say that in prevention, culture is prevention. That when you talk to particularly populations who have experienced generations of historical trauma, and you say, let's work together on what would mitigate it, but I don't know what that is.

You're going to have to tell me. Let's go to your traditional culture and find, where are those gems of healing that have been lost due to that historical trauma? Let's bring them back. Let's revitalize them. Let's give them back to the people. That often is the impetus that then helps a community really turn from being traumatized to being healed.

And it really is important to respect the culture of that population and engage them in the solutions. Like me, as a white lady from Massachusetts, I don't have an idea about how that would work. But I would know if I was walking into a population, that my first job would be, let's talk. I want to hear from you. Where are those things? Let's build those. And facilitate that conversation, but get out of the way of thinking, I know what the answer is. I hope that kind of addressed that. Really important.

ANN SCHENSKY: The other question is, "But what about the trauma in the DNA? How does that heal?"

DODI SWOPE: How does that—

ANN SCHENSKY: How does it heal?

DODI SWOPE: Oh, heal. Well, so what happens is-- so I know this is really complex science. I'm going to point you back to that great resource of the Center for the Developing Child at Harvard University and Jack Shuttlecock's work, because he gets into the myelation of the DNA and how all that works.

So what happens is in the gestation of the infant, there is a process, in unhealed trauma, that disturbs the way that the neurology is built. That's the simplest way I can say it.

In a healed individual, that doesn't exist anymore. It's really amazing. Healing happens at this micro level, not just in our thinking. It happens in every cell of our body. And when that happens, then that disruption to the myelation in the cell generation in a mother who's experienced trauma, been through a healing experience, healed that trauma, then does not have that same issue with the neurology in their newborn child. So that child actually ends up having full capacity, neurologically.

So that's about as far as I can go without being a biological scientist, but I think it's so important to understand that healing happens, even down to the cellular level. And so when healing happens, that's how it doesn't get passed on to the next generation.

ANN SCHENSKY: Fantastic, thank you.

DODI SWOPE: Yeah. But in the meantime, I do need to say this. In the meantime, there's still plenty we can do with the kids that had that negative experience in their gestation. There's still plenty of ways we can help that child succeed and not end up having that negative life course, so that's an important piece, too. We can help them with all those adaptations. We can learn to adapt the environment so that it's more responsive to that child, so that the trauma that they experience is lessened, and then work on healing through multi-generations.

That's why two-family therapies, things that look at multi-generations are so, so powerful, because they're really looking at, how do we manage the parent, help the child develop, and then hope that the child's child won't have to manage that going forward? Thanks so much. Those are great questions-- wonderful.

All right. So how can we help as prevention professionals? So the first thing we can do-- and this is so critically important. And I feel like I'm the girl who walks around and says, hey, have you ever heard of the ACE study? I'm always talking to people about this, because for me, when I first learned this, my experience was, of course. Oh, that now makes perfect sense. Because I was always struggling with why, why, why is this so intractable? Why can't we seem to make a difference here? I've been in social work for almost 40-plus years, and know it seemed like I'd just keep pushing that stone up the hill, and then another trauma would happen, and there we go. We start again. ACEs really helps us understand how all of this fits together.

So the first, most important thing you can do is raise awareness in your communities. Tell people about this. Share the information. Understand that

not just social workers, or teachers, or prevention professionals, or therapists need this information. Everybody needs this information.

And when folks who have had significant early childhood experiences that were traumatic, when they hear this information, they go, it's like you just turned the light on in this room I've been in my whole life and I could never see anything in it. And you just turned the light on. Now it all makes sense. So it can be really, really powerful.

So it also helps to shift that concept that we talked about last time, which is, instead of saying, what's wrong with you, it really shifts the conversation to, what happened to you? And so what can we do to support you since that awful thing happened to you? And it really shifts the stigma in a community around how folks are treated.

And it also means it's on all of us to become a trauma-informed community. I think that was one of the comments I loved from last week. And you mentioned somebody said, so wow. It really is the whole community needs to be involved. And I thought, yes, that's it. That's the message. So it really is important to raise the awareness. It is really important to reduce stigma. We know this, that we put the burden on the people that have the least capacity, energy, time, money, often, to solve their own problems.

And so we really need to shift that and understand that it's our job, as a community, to raise healthy people, and that we all have a responsibility there. And so we really want to open up access to all of the different kinds of therapy, and treatment, and support, cultural interventions, all of those so that we can reduce-- so that we can start the healing process.

And then also, always, you'll hear me say start with the littles. Try to get those littles-- is the best environment that you can. That's going to go a long way to helping them be strong for the next generation. So that's one of the most important things you can do.

In our community out here in Worcester, I just want to share the story. So we have a health foundation, which came as the result of a large community hospital that got sold to a nonprofit. And according to federal law, if you do that, you have to take the proceeds that came from that sale and turn them into public good. So we have this foundation that's called the Health Foundation of Central Massachusetts.

And they started learning about ACEs, and they're like, we're going to take some responsibility and we're going to put a stake in the ground. And they invited out this incredible woman, who you may know or have heard of, Nadine Burke Harris. She's now the surgeon general of California. She did like a 15-minute TED Talk on ACEs years ago. And it's a wonderful piece. If you haven't seen it, I definitely recommend googling it.

They invited, at great cost to themselves-- but there are a health foundation. They brought Nadine Burke Harris, and they invited people from every sector of our community. They rented a big hall, and they had her speak. And that was the first step in our community's awareness. And then we did a lot of different kinds of things with different populations.

We showed the film, The Raising of America. If you haven't seen that, it's an amazing film. It's really about early childhood development and how ACEs impact that, early childhood trauma impacts that. There's another film called Resilience that's very good. So we started doing these movie nights and discussions as a community.

And then, as I spoke about last year-- last year. Last week-- we now have this session called Trauma Training Tuesdays, which we do once or twice a month, where some trauma professional in our community does a two-hour training for free virtually. We now have 200 to 300 people on every call just learning what trauma-informed practice is in a whole bunch of different ways. We just had one on homelessness and housing that was a mind-blower. So that's how you build to a trauma-informed community. Start small. Start with what you've got, but keep building the blocks over time, and it will really help make a huge difference.

So how does that lead to a measurement or an impact outcome? So one of the things you could track is how many community members have been educated in ACEs and trauma and are now available to help you in your prevention efforts, or are now able to help you in other kinds of community coalition efforts that are aimed at prevention. I am going to pause, because I see a couple of questions, before I dive into the next one.

ANN SCHENSKY: Great. Someone says, "Our actual environment-- our air, water, and soil-- is becoming increasingly toxic, and thus, making it more difficult to support our physical body, i.e. gut health, gut-brain connection. And it seems like this is becoming even more difficult on an individual basis when there is no accountability for corporate or societal basis."

DODI SWOPE: Yeah. I agree. I don't know what else to say. I totally agree. I think we are in this-- it feels very stressful. But we're in kind of a race against time. Are we going to save this planet and ourselves or are we not? And so an environmental impact is absolutely a trauma. There's absolutely no doubt about it. If you live next to a toxic waste dump, that has trauma implications. So it's all connected, and I love that you're making the connection. And I think we've just got to band together and decide that we're going to turn it around. I don't know what else to say about that. But thank you for the comment.

ANN SCHENSKY: Yes. And someone asked if you could share the movies or the TED Talks. So we'll try and get a list of those from you and then we can give them out.

DODI SWOPE: Yeah. I'm writing it down this time, Ann.

[LAUGHTER]

I thought about it when I made the remarks. I thought, they're going to want to listen to that. So we can give you the links. Some of them, you do have to rent or you have to make an agreement with the producer to bring it to your community. There's ways to do it, though. And they can be really, really effective. So absolutely, we'll share that. Sure thing.

ANN SCHENSKY: Great. And then there is one more question. "What does this look like globally? Do more ACEs compromise democracy and it can be used as a democratizing tool for peace?"

DODI SWOPE: Wow. I got some deep thinkers on this call. You guys are fabulous. I don't know. This is a US study. I don't know if it's been applied in other places. I do think, though-- and this is the deep thought I have-- I think about places that have been at war for generations. I think about the Israeli-Palestinian conflict. I think about Afghanistan. I think about places where trauma has been the order of the day-- significant trauma, the order of the day. What does that mean about what is available to the next generation? And what's the healing that needs to happen?

I think it's a really big, big hairy question, and I don't have the answer for you. But I love that you're asking the question, and I would ask you to go out there and start having those conversations with other people. Thanks, Ann.

ANN SCHENSKY: Thank you.

DODI SWOPE: Great. Wonderful.

ANN SCHENSKY: Really great questions.

DODI SWOPE: We're going to get back to our local efforts now.

[LAUGHTER]

A little bit of a sphere of influence. They're great, though. They're wonderful questions. And I love that they're sparking these big, philosophical questions, because that's really what this study is meant to do.

So here's one that's comfortable for preventionists when we think about social norms. We think about social norms all the time. We talk about social norms. So promoting social norms that really do support mitigation of ACEs, that help people understand what they are, and then also thinking about, what are those cultural-- big C Cultural-- interventions that will help to turn it around? Even the social norm of saying, I'm going to stop saying, what's the matter

with you, and I'm going to shift that to saying, I want to understand what happened to you.

That's a huge social norm shift. And if all you do is focus on trying to get that through in your community, or in your school system, or even in your little classroom, that can be a huge shift. Some of the bigger ones that we talk about are the shift in the criminal justice system from punitive justice to restorative justice. That can be a really important norm change.

Bullying prevention-- we talked about bullying a little bit earlier, but really thinking about, how do you do some of those bystander approaches so people feel like I'm a member of this community. If that happens in my community, I have some responsibility to do something, and I know what to do. I've been trained. I feel comfortable.

I don't know if I have anybody from Chicago, other than my dear friend, Erin, on the call. But Chicago is the incubator of the Violence Interrupter movement, which is a very powerful movement. That's another movie I'll put on your list, called The Interrupters. Very powerful. They looked at violence transmission as a public health issue, and they really looked at, how do we intervene between one violent acts and the act of revenge that follows it right afterwards? And there's some very powerful work that was done with folks in Chicago around that work.

But thinking about what's the relationship-- especially between those of us who are working in substance use disorder prevention and violence prevention, we have a lot to work on together. We have a lot of common ground. So how would you look at that as a measure of your impact in prevention?

You'd be measuring things like how many community collaborations do I have that are looking at shared risk and protective factors? How are we addressing that oil spill of ACEs so that we're all working in common to reduce the fundamental issue, which is this traumatic childhood impact? And how do we build protection so that we help people who have had that impact have better lives going forward? So those are some of the things that we can measure there.

This is not going to be a surprise to anybody in this group, but start young. I think if you've been around the prevention field for long enough, you've had the conversation, oh, we're doing prevention in high school, but it's not early enough. We have to go to the middle school. Oh, we're at the middle school, but kids are already using in middle school. That's not prevention. How do we get early enough? So I say, really think about, how do you connect to your early childhood community in whatever community you're working in?
One of the most powerful impacts that we have discovered here-- and this is very much the work I'm doing currently-- is that universal home visiting is one of the most powerful things we can do. Helping moms when they get home

with that newborn not feel alone, isolated, scared to death, where's the user manual, but really supporting that first initial couple of months can set a child on a much better trajectory than if we just leave parents to figure it out on their own.

The impact of early education and care is such a mitigating factor for kids who are growing up in difficult situations. It gets kids into those protective environments and helps them learn skills. And then really thinking about, how do we engage families in their child's education from the very beginning, so they feel not franchised from the school, but a part of that community. That's a huge mitigating factor for lifelong problems.

And so many families, so many parents-- I worked many years in the Boston Public Schools as a therapist with kids in the school. And so many parents, I'd call them and say, can you come to the school to meet with me? And they'd say, I'm not coming up to that school. I've come up to that school a million times. I don't want to come up and get yelled at about what a bad parent I am. And I'd say no, no, I'm not doing that. But it took me two or three years to convince the parents that that wasn't what I was up to.

There's a very sweet example I want to share here about how to link some of those middle school, high school efforts to the early childhood piece. So we got a call-- and this is a COVID innovation. We got a call from our local DCF, Department of Children and Families, the child protection agency in my community.

We got a call from their director and said, I'm really worried about what's going in these homes. I can't get my workers into them because of COVID. We're doing drive-bys. We're doing telehealth visits. But I just am really worried that kids are probably not so much being abused, but potentially being neglected. So what could we do to support that?

So we reached out to our local Boys and Girls Club and we have a city Youth Opportunities Office, which does a lot of recreation in the parks in our community. We reached out to those two groups and they said, oh, well, let's train kids in babysitting. Let's just get them the Red Cross babysitting course. And let's make sure that we build it into a really nice intervention for these middle schoolers.

And we're going to teach them basic child development. We're going to teach them basic first aid. We're going to teach them all kinds of great activities to do with your younger siblings or their neighbor's kids. I have to tell you, the program-- and each child who participated in that got a stipend of $80 to $100 for their participation in that program and a basket of activities. So they got books, and Play-Doh, and measuring cups, and a whole bunch of ideas about how to play. And then they had some tools to do it.

We're now in our fifth round of this, and the waiting list is growing. The middle school-age kids can't get enough of it. The families are so thrilled. And we believe-- we're not measuring the young children at home. But we believe we've kind of created this force of young people who are better able to take care of their younger siblings.

And what's been really great is our Youth Opportunities Office director, who's a visionary, has connected it to resume writing and career path exploration. And she said, now you're a babysitter. Next year, you'll be a junior counselor. Next year, you'll be a senior counselor. Then you might decide to go to school for either social work, or education, or youth development, and then you can become a youth development person, and then maybe-- and she's just carved out the path so kids can actually see, yeah, I'm babysitting my little brother. But there's something in it for me in the long haul. It's been really brilliant. OK. So I'm going to pause there for a minute because there's a couple of questions. We're almost out of slides here.

ANN SCHENSKY: Great. I mean, not that we're out of slides, but-- [LAUGHS] can you talk about how public policies and/or racial disparities impact ACEs?

DODI SWOPE: Oh, well that's a huge-- that's another whole webinar. Well, racial injustice is a trauma. I think we have to say it as clearly is that. And racial oppression and systemic racism, institutional oppression-- all of those are traumas visited upon an entire community of people. And often to the point where that community of people feel voiceless.

So one of the most important things is to help elevate and raise-- amplify those voices, help people connect to advocacy, help people to have influence on the policies that impact their lives the most. That's probably the simplest thing I can say in this webinar. But that's a whole area to which there's a tremendous amount of current work happening.

I will say one small little piece. So many, many years ago, I worked in a community close to here, where I live now, that had a big hospital. And a huge maternity-- it was where a lot of families went to give birth. And they had an influx of families from Brazil. And over time, there was just a large wave of immigration that came into that community.

And we did the traditional maternity ward, like the kid went to the nursery. The mom and dad stayed in the room. Anyway, it was like, the whole family wasn't allowed on the ward. There were all kinds of barriers. And the Brazilian community said, wait a minute. This is not how we do birth in our community. This is not culturally competent.

And they literally transformed the maternity ward's policies, procedures. They actually did a whole renovation so the rooms were bigger so whole families could come and visit the family. And then guess what happened? Just what you would expect. The traditional maternity ward went, huh. That looks a lot

better than the way we do it. And so then their entire maternity ward became much more family-friendly, and it really transformed policy. So it's just a simple example of how community voice can raise and really move to change policy.

I'm going to keep going, Ann, just to get through a couple of more slides, and then we'll open it up for questions at the end. Does that sound OK?

ANN SCHENSKY: Absolutely. That's great. Thank you.

DODI SWOPE: Great. So just to say, so one of the things you can think about in outcomes, when you think about starting young, is how are you connecting to that early childhood population? This would just be a outcome that was really related to that particular intervention I was talking about about babysitting. But it also kicks you into thinking about, how am I measuring family bonding as a protective factor? So I just want to spark your thinking about how you can measure some of these things that feel unmeasurable. Skill-building and making sure that kids have access to caring adults. This is prevention's lane. And so how are you building all of these pieces and broadening them to consider where the shared risk and protective factors are around those youth? And then you can use their measures, which are often embedded in the prevention programs that we're doing.

The access to having one to two caring adults is one of the most important protective factors we've found, one of the most potent. So measuring that-- measuring how many kids have at least one, and hopefully two, caring adults they can identify in their lives. So those would point to these particular outcomes. So it might be that the youth are trained in life skills. The parents get positive parenting. And the youth can identify caring adults.
I'm aware of the time here. We are, again, trying to zoom to the end of the webinar. Absolutely, all of us as preventionists understand that the continuum of care really needs to be a continuum, and not a set of buckets lined up next to each other. So how we work across that continuum is a really critical piece. So encouraging the entire continuum to be trauma-informed, not just the therapists and treatment people, and not just the recovery coaches, but everybody, from health promotion all the way through, and really start to work together on changing the culture around help-seeking and reducing stigma. And so those would be the outcomes. Thinking about how are we increasing access to trauma-informed programs across the continuum of care? And how would we measure that we're reducing stigma? And I think that's another whole webinar in and of itself. But I think it's really important to think about how stigma really is another one of those key pieces in thinking about how we become trauma-informed.

So again, that shift-- if I've taught you one thing in these two webinars, the shift that is most critical-- it's not, what's wrong with you? It's, what happened to you and how can I help? That is the most important takeaway.

So now, we're ready for some more questions, Ann. I got through the slides.

ANN SCHENSKY: Fantastic. And they were great slides. So the first question is not really a question, but a statement. But I also feel that would be very helpful if all high school students had brain development information and child development education as a requirement. And it would help tremendously , as they are our next generation of parents.

DODI SWOPE: That is so true. And I think it's interesting. I was on a call last night with our school committee, because we're trying to revamp our health curriculum. I don't know how many of you have survived that. It's not a pretty process, but important. And that was the takeaway-- like, we all need to understand. We need owner's manuals for how these mind-body things work. And our young people need them, too. They need to understand what I've just taught you about ACEs. Everybody should have access to that.

I'll never forget when my daughter, who's now in her mid-30s-- she was an early initiator of tobacco use. I think she started smoking when she was 16 or 17, much to all of our chagrin. We were like, oh, my gosh, how could you do that? We taught you so much about this. Well, anyway, she finally quit at about 25. And I had, over and over and over again, said to her, honey, the sooner you quit, the better off you're going to be. And the easier it's going to be to quit, because your brain's getting used to doing this biology.
And then at one point I said to her-- and I probably had said it 10 other times-- the earlier you start, the harder it is then to quit. And she said, you know, somehow, that just landed on me and I got it. And I realized, oh, I wish somebody had told me that before I started smoking. That, in fact, my neurology was being impacted by this thing I was doing, and it was going to make it harder for me over time.

It was the simplest little thing, but having that bit of information she felt would have made her make different choices. And so I just want to underscore that I think that's absolutely right. Developmental education is critical to us understanding how to be human beings on this planet and how to live together. Absolutely.

ANN SCHENSKY: Thank you. The next one is, "It's very difficult for any Indigenous person to trust the educational process based on forced boarding schools and the current removal of children into non-native foster care. I haven't seen non-native communities organize willingly to take this ACE on and promote healing to connect those communities. Any suggestions?"

DODI SWOPE: Yeah. That's really tough, and I totally validate your concerns. That's real-- totally real. So I think what I would say-- and I don't have a great simple answer for you. It's a complex issue and it's a complex problem.
I would look to where Indigenous communities have been successful in making an impact, either by developing their own schooling process that's significantly separate and figuring out how to do that and show it as a model,

or where they've been able to have real impact into the environment in which they're actually being required to participate, so in their own school systems. But I think the most important thing is to develop that community voice and advocacy, and really get the critical mass of folks elevated so that their voices make a difference, because the reality of how that system perpetuates itself is that people get picked off. Like, ugh, she's just a noisy advocate. He's just a noisy advocate. And the machine continues. It's really that groundswell that can turn that around.

I would point you to some of the work that's being done in Washington state with Laura Porter. Again, she's been my model for that. I think some of the stuff that's happening in Cherokee Nation maybe, also. I don't know if anybody else on the call has any ideas about that. But if you do, please put them in the chat. I wish I had some clearer, simpler solution. But I think it always starts with that loud, coordinated advocacy voice that says, we're not doing this anymore. We want to have a part in the solution. And we understand what the solution should be, because it's our culture and our children.

ANN SCHENSKY: Great. Thank you. Someone asked if it would be possible to get more information about the babysitting program.

DODI SWOPE: Absolutely. Interestingly enough, just last night, our local newspaper did a piece on it. So I could totally send that to Ann, and that'll get you started. And I could just share some background information, as well. Sure. I'm writing it down. [LAUGHS]

ANN SCHENSKY: Thank you. Any recommendations for those with high ACEs who do not want to or are not open to engaging in some of the efforts that we discussed today?

DODI SWOPE: Yeah. I think you have to respect that. Not everybody is ready to take on the healing that's necessary. And so I think what you want to do-- when you do community-level impact, you're impacting the environment around that person and you're softening the edges for them, whether they participate or not. We can't make anybody want to do this. We have to have willing participation. Otherwise, it doesn't work. Otherwise, it can be retraumatizing. We certainly don't want to do that.

So I think you think about the environment around the plant, and don't ask the plant, again, to change, that you think about, how can I soften the situation around that person? And then eventually, maybe they'll join those efforts or maybe they never will. And that's OK, too. Not everybody has to do it. But when you get to a critical mass, that tipping point, I think that's when change can really happen.

ANN SCHENSKY: Great. Thank you. And then Kathleen says, "There is a child welfare law related to Native Americans to help protect their use, that the

tribal Indian Health Service should know about it. So that might be another resource."

DODI SWOPE: We all know, right? We all know that there's policy, and then there's policy enforcement, and that the two don't always go hand in hand. And so sometimes it is just a matter of like, oh, great. Well, there actually is something in place that I can support. And other times, you really have to build the policy. So I just don't feel that I know enough to say more about that, but thank you for that resource. That's great to know. I really appreciate the deep thinking of this group. Really amazing.

ANN SCHENSKY: Right. And then also just a quick-- someone else said that, "I'm doing some work with veterans with breath work workshops, but also with Native Americans." And so her name is in the chat if you wanted some information about that, Kim Blanch.

DODI SWOPE: Wonderful. I think we've learned a lot about post-traumatic stress syndrome from veteran populations. They were the first ones that we studied around this stuff. But then we realized, oh, they're not the only traumatized population. So there's a lot to be learned. And I think some of the veterans mutual aid organizations that are out there-- not the Veterans Administration, not the big, systemic administration, but the little grassroots-- some really innovative things are happening at that level with people.

ANN SCHENSKY: Right. Thank you. We don't have any more questions. I just want to, again, take the time to thank you, thank you, thank you for this amazing webinar. I want to thank everybody for their time. We realize you've put a fair amount of time into this in the last couple weeks, so we appreciate that. And again, we will get the resources and we can post them on the website. The recording and the PowerPoints will also be available on the website.

It takes us about two weeks to get everything pulled together. And you will get certificates of attendance, as well, in a couple weeks. So again, thank you, Dodi, and everyone else, and have a great afternoon.

DODI SWOPE: Thanks so much. And thanks for the opportunity, you guys. I wish I could see all of your faces, because I feel like I'm talking into this void. But I'm watching the chat and the thank yous, and I so appreciate the commitment that all of you made to learn this. Please share this information. We all need to understand it. Thanks so much.