Literature Review:
Best Prevention Practices for Reducing Adverse Childhood Experiences (ACEs)

Introduction. Research supports a strong linkage between adverse childhood experiences (ACEs), such as abuse and neglect, and the development of various behavioral and health-related consequences later in life. For example, research demonstrates that a person's risk for alcoholism, illicit drug use, engaging in risky sexual behaviors, suicide attempts, and smoking all increase proportionally to the number of ACEs experienced during childhood.

Research also indicates that ACEs are very common. Almost two-thirds of 17,000 participants in the foundational CDC-Kaiser Permanente ACEs Study reported having had at least one ACE, and more than 20% reported having three or more ACEs (Felitti et al., 1998).

Adolescent Alcohol and Illicit Drug Use. Research focusing on the impact of ACEs on adolescent health indicates a strong relationship between ACEs and early initiation of alcohol use (Dube et al., 2006; Rothman et al., 2008; SAMSHA 2016). In turn, there is a strong correlation between ACEs and a higher risk of problem drinking behaviors continuing into adulthood (Dube et al., 2002; Rothman et al., 2008; SAMSHA 2015; Strine et al., 2012). Research also implicates the correlation of ACEs with adolescent use of illicit and prescription drugs (Anda et al., 2008; Dube et al., 2003). Dube et al., (2016) additionally found that adolescents with three or more ACEs are more likely to smoke tobacco, drink alcohol, or use illicit drugs than their trauma-free peers *and* their risk of using illicit drugs increases by 2- to 4-fold *for each ACE* they have experienced (Dube et al., 2003). Given the prevalence of ACEs and the strong association between ACEs and substance abuse, researchers conclude that prevention efforts aimed at mitigating underage drinking and drug use may not be effective unless ACEs are addressed as a contributing factor and prevention programs help youth recognize and cope with stressors of abuse, household dysfunction, and other adverse experiences (SAMSHA, 2016).

Risk and Protective Factors. A secondary body of literature has identified many risk and some of the protective factors associated with ACE perpetration (CDC, 2016).[1] **Table 1** below highlights the known risk and protective factors for ACEs that the CDC has identified at the family and community level.

Table 1. CDC-Identified Risk and Protective Factors for ACEs

Family Risk Factors	Family Protective Factors
• Parents' lack of understanding of children's needs, child development, and poor parenting skills • Parents' history of child maltreatment in family of origin • Family history of substance abuse and/or mental health issues including depression • Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income • Nonbiological, transient caregivers in the home • Parental thoughts and emotions that tend to support or justify maltreatment behavior • Social isolation	• Supportive family environment and friends/social networks • Nurturing parenting skills • Stable family relationships • Household rules and child monitoring • Parental employment • Adequate housing • Access to health care and social services • Caring adults outside the family who can serve as role models or mentors

[1] Protective factors have not been studied as extensively or rigorously as risk factors (CDC, 2016).

• Family disorganization, dissolution, and violence, including intimate partner violence • Parenting stress, poor parent-child relationships, and negative interactions	
Community Risk Factors	**Community Protective Factors**
• Community violence • Concentrated environmental disparities and disadvantages in one's neighborhood (e.g., high poverty and residential instability, high unemployment rates, and high density of alcohol outlets), and poor social connections	• Communities that support parents and take responsibility for preventing abuse

Source: CDC (2016).

Evidence-Based Strategies for Reducing ACE Impacts. A more nascent body of research explores evidence-based best practices for preventing, mitigating, or treating ACEs at the primary, secondary, and tertiary levels. Each level includes strategies for improving the lives and health of parents and children so that children grow up with less exposure to adversity and are less likely to experience the health consequences and perpetrate the behaviors associated with ACEs.

Primary Prevention. Primary prevention approaches are implemented at the community and societal level and seek to deter the myriad of ACE-related health consequences by strengthening protective factors (i.e., increasing family and community stability and resilience; teaching positive and effective parenting skills) and reducing the risk factors associated with child abuse and neglect.

Research supports the efficacy of several maternal, infant, and early childhood home visiting programs for reducing ACEs. Home visiting programs incorporate community and public health partnerships in promoting child health and development and preventing child injuries and maltreatment. Some programs additionally teach parenting skills; promote school readiness and child academic achievement; and provide referrals for community resources and additional support (Oral et al., 2016). Effective evidence-based home visiting programs include: The Nurse-Family Partnership; Healthy Steps; Child First; Incredible Years; and the Positive Parenting Program (Triple-P).

At the community level, research also supports the role of coalitions and networks in preventing ACEs through targeted educational and media campaigns, community outreach and engagement, and policy advocacy. **Table 2** below summarizes the key strategies, approaches, and evidence-based programs, policies, and practices for preventing or reducing ACEs.

Table 2. Strategies for Addressing ACEs

Strategy	Approach	Evidenced-Based Program, Policies and Practices
Strengthen economic supports to families	Strengthening household financial security	• Child support passed on to families receiving federal Temporary Assistance for Needy Families (TANF) benefits • Increased tax benefits and credits for children and families • Reducing food insecurity • Assisted housing mobility • Subsidized child care

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Strategy	**Approach**	**Evidenced-Based Program, Policies and Practices**
	Family-friendly work policies	• Livable wages • Paid leave • Flexible and consistent work schedules
Change social norms to support parents and emphasize positive parenting	Public engagement and education campaigns	• *Breaking the Cycle* social marketing campaign
	Legislative approaches to reduce corporal punishment	• Bans on corporal punishment at local (home, school), state and federal levels
Provide quality care and education early in life	Preschool enrichment with family engagement programs	• Child Parent Centers (CPC) program • Early Head Start (EHS) program
	Improved quality of child care	• Licensing and accreditation of child care centers
	Enhanced primary care	• *Safe Environment for Every Kid* (SEEK) program
Enhance parenting skills to promote healthy child development	Early childhood home visitation	• *Nurse Family Partnership* (NFP) program • *Durham Connects* program • Other home visiting programs identified in the *Home Visiting Evidence of Effectiveness Review*
	Parenting skills and programs focused on addressing positive family relationship approaches	• *Adults and Children Together Against Violence: Parents Raising Safe Kids* (ACT) • *The Incredible Years* • *SafeCare* (an in-home parenting program)
	Behavioral parent training programs	• Parent-Child Interaction Therapy (PCIT) • *The Incredible Years* • *SafeCare*
Treatment	Treatment to lessen harms of abuse and neglect exposure	• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
	Treatment to prevent problem behavior and later involvement in violence	• Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Program • Multi-systemic Therapy

Source: Fortson et al., (2016).[2]

[2] The authors note that strength of evidence-based outcomes on preventing child abuse and neglect vary across spheres of influence due to varying levels of evaluation of the effects of community and societal level approaches in preventing child abuse and neglect to date.

Research Gaps. Knowledge gaps hinder research for preventing ACEs, including known local prevalence rates and the role of cultural, regional and demographic differences in responding to ACEs (Larkin et al., 2012; Oral et al., 2016). Addressing such research gaps is critical for informing prevention efforts and deterring the public health consequences associated with ACEs. To move the conversation forward and inform local prevention planning strategies, SAMSHA (2015) recommends the following activities for understanding the scale, scope and prevalence of ACEs:

- Collecting state- and county-level ACE prevalence data to drive local decision making (e.g., by incorporating ACE indicators into Behavioral Risk Factors Surveillance Systems)
- Increasing awareness of ACEs among state- and community-level prevention practitioners, emphasizing the relevance of ACEs to multiple behavioral health disciplines
- Including ACEs among the primary risk and protective factors considered when engaging in prevention planning efforts
- Selecting and implementing programs, policies, and strategies designed to address ACEs, including efforts focusing on reducing intergenerational transmission of ACEs
- Using ACEs research and local ACEs data to identify groups of people who may be at higher risk for substance abuse and related behavioral health problems

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