Mighty Fine, MPH, CHES, moderator: Hello, everyone, my name is Mighty Fine and I'm the director of the Center for Public Health Practice and Professional Development at the American Public Health Association. I'm pleased to be with you all today for our webinar, "Addressing the "C" in ACEs, Combating the Nation's Silent Crisis."

So, I'd just like to say that we have quite the lineup for you all today so hopefully you'll engage with us through the chat feature.

Type in your questions as we move through the day. We will be together for quite some time and we want to make sure that you are a part of this dialogue, so please be sure to type any questions or comments in the chat feature and we will be tracking them.

Today's webinar has been approved for 3.5 continuing education credits and we want to disclose that none of the speakers or the planners have any conflict of interest to disclose.

Again, just some of the accreditation statements for your reference; we will be offering CME, CNE, C PH, CHES, and if you want a certificate of participation, you can get one of those as well.

Please keep in mind, after the close of this webinar you will receive information on a link to claim your credits.

And you must do so before the deadline of June 14, 2021 in order to obtain the credits. Be sure to do that before the system closes otherwise you won't be able to get those 3.5 credits.

So, today I would like to talk a little bit about, before we get into the panelists that we, APHA and CDC, have come together to think about the shared, the intersection of ACEs, overdose, and suicide. And what this does, it really has prompted us to think about the intersections not just of ACEs, overdose, and suicide, but other diseases of despair and other diseases that have point with these issue areas.

And our thinking there is that if we look at these as a collective, then we can be more intentional about how we address them further upstream; recognizing that there may be some of us working in ACEs, overdose, suicide, or any of the allied spaces.

But recognizing that there's so much more synergy and collectiveness if we come together, if we talk about these issues together, and thinking about how to triage and process them as a collective while recognizing the unique contributions to our health and well-being.

As I already mentioned, but I want to reinforce, we have quite the lineup of speakers for you all today. They'll help us to think through effective strategies to address and to prevent ACEs and also challenged us to think more about what is it that we need to do to show up differently in this work. How do we stretch ourselves?

And after your participation, you may find that what you hear today may reinforce what you already know, but it's also our hope that you'll walk away with other thoughts and ideas to help influence your current and future work.

Thinking about not only what we're doing to prevent adverse experiences for children in the current, but what are we doing to create opportunities for self-actualization and ensuring that our communities have the resources to make this a reality. So, not just talking the talk, but really walking the walk and doing our own internal audits to recognize how we show up in these spaces and how committed we really are to improving the health and well-being of our children.

So again, thinking about what are we doing to ensure that our collective environments and systems don't conspire against our well-being as a society.

So it's my pleasure to introduce our first panel where we'll focus on racism as a social determinant of health and how it interfaces with ACEs. First up, we have Dr. Alcalá who studies impact of early life and adversity on health; he also focuses on health disparities, with a strong focus on racial and ethnic disparities, and how that impacts discrimination and other issues at Stony Brook. So, without further ado I'll turn it over you to get us started.

Héctor E. Alcalá, PhD, MPH: So, thank you very much, Mighty for that introduction and thank you all for having me here today. So, I just wanted to state that this is a very interesting opportunity for me because it actually describes two of the intersections of my current work. So, as Mighty said from jump I have nothing to disclose.

So before we actually start, we should define what we're talking about when we're talking about what ACEs are.

We're talking about adverse childhood experiences, so that's what the ACE acronym represents here, and really in terms of defining it, we're talking about three broad categories of experiences; so abuse, we're talking about acts of commission so things that we do to a child under age 18; neglect - so things we fail to do for a child that is needed for their well-being and development; or household dysfunction - so things that exist within the household that are surrounding the child and that can either directly or indirectly involve the child.

So, when we talk about abuse we're talking about physical abuse so kicking punching biting etc. Emotional abuse, telling a kid you do not love them or that they were unwanted, for example. Sexual abuse, so this can include any and all types of sexual activity or being involved in pornography, for example.

Then we move on to neglect, so these are acts of omission so things we fail to do for a child. For example, when we're talking about physical neglect this can be things like, for example, not providing food or shelter for a child when needed. Emotional neglect might be not providing love and support for a child, because it's essential for their development.

When we're talking about household dysfunction this could include things like living with someone who is mentally ill, having a relative who is incarcerated who was formerly a member of the household, a mother treated violently, so we've actually moved away from this terminology but we just more broadly talk about intimate partner violence occurring in the household or domestic violence occurring in the

household; then we have substance abuse , this can include illicit or prescription drugs, and then divorce or parental separation.

So why do we care about ACEs? This really is hopefully not as big of a question as it was 10 years ago. But it's because it's associated with a lot of things that we know that are harmful to health, for example, health behaviors. So it's associated with an increase in lack of physical activity, increased rates of smoking and uses of smokeless tobacco products, increased rates of alcoholism and just alcohol use in general, drug use including use and abuse, and missed days of work.

And when we look at the health outcomes, there's actually a myriad of health outcomes which are associated with ACEs.

So to associate with higher risk of obesity, higher rates of diabetes, higher rates of depression, higher number of suicide attempts, and actually I do want to stop here and highlight it's not just because of what Mighty said at the beginning, but in terms of mental health and suicide, and this is one of the strongest associations we see between ACEs and a specific health outcome.

We also see associations between STDs, heart disease, cancer, stroke, COPD, and broken bones. This evidence comes from a mix of cross sectional, longitudinal, and other types of studies designs.

So I did see a raised hand, so just to say that I believe I will be taking questions at the end.

So how can ACEs impact health?

So first is biological dysregulation. Our biological systems can either become over or under active, and this can put us at a risk of different health conditions later on in life, primarily chronic diseases.

There's also viral exposure. If you think about something like sexual abuse, it can directly expose you to viruses that are known to cause diseases, for example, HIV, HEP C, HPV, that are linked to HIV AIDS and cancers respectively.

There are also deficits in emotional processes that can develop over time.

These can include, for example, being over or under emotionally reactive to stressful situations. These can be seen as maybe adaptive while you're experiencing an ACE, but maladaptive if they occur in the long term.

We see also social and cognitive deficits. So here, maybe individuals learn not to trust the people around them, because this is actually adaptive in context, but in the long term being distrustful of everyone may put you in a situation where you don't turn to people who can actually help you overcome an experience with an ACE.

The big focus of research is often on the adoption of risky behaviors. So, the idea here is that coping with an ACE can involve, for example, drinking, smoking, and using other drugs, in order to alleviate the stress that's associated with ACEs.

And finally, lower SES in adulthood. So, victims of ACEs or survivors of ACEs often have lower levels of SES when compared to the general population or those who don't experience ACES, and we know that socio economic status is associated with a myriad of poor health outcomes.

So, what does this all mean? At their core, ACEs are stressful and potentially traumatic childhood experiences. Their impact is via psychological, biological, and behavioral responses to stress, as I was highlighting in the prior slide.

So what are some typical ACEs?

Well, we're actually measuring ACEs and survey, particularly in the behavior receptor surveillance system, which I hope many members of the audience are familiar with. We're going to include measures of child abuse - physical, sexual, emotional abuse; household dysfunction - violence in the household, living with someone who is mentally ill, etc. But that's kind of it. We actually don't include measures of neglect. So it's really household dis function and abuse. They can include measures of neglect and other adversity, so bullying, neighborhood violence, discrimination, death of a parent, child poverty, etc., although these are seen far less frequently.

And this is really been pointed out in recent work that the conventional notion of adverse childhood experiences includes what you see on the left hand side, which is what I just listed. But there's a push to include a more expanded version of the ACEs which includes discrimination, witnessing violence, living in an unsafe neighborhood, racism and poverty, and it's really this racism that we're going to focus on today and why it should be included in this broader spectrum of ACEs.

So why racism? If you think about the work on racism and its impact on health, racism is a stressful and potentially traumatic childhood experience, much like the remainder of the ACEs that we talked about. It can impact health via psychological, biological, and behavioral responses to stress, so again, like other ACEs.

However, it also impacts health in other ways; so despite racism functioning like the other ACEs, it also has impacts that sort of bake it a little different and maybe in a way that isn't conventionally captured in ACEs scales.

So what do I mean by that. Racism is really operating on multiple levels. So the first level, we can think about internalized racism, or this self-hatred in which We live in a society in which people of color, basically anyone who's not white, receives messages in which they are told or made to believe that they are inferior and they learn to accept these messages about themselves. So this can include things like, for example, modifying ones speech, modifying ones hair color or appearance, hair texture etc., in response to the messages that we receive that tells us that we do not look like a European centric standard of beauty.

Next, and this is probably what most people think about when they think about racism, we have personally mediated experiences. Basically here we're talking about experiences between individuals. This can be prejudice, or these ideas or attitudes that individuals think one group is inferior to another,

or have these assumptions about one group's abilities, knowledge, etc. Discrimination, so these can be actions in which another person is treated unfairly on the basis of their race. Normally when we think about racism, this is pretty much where the lay public tends to focus, on this factor or this level of racism, if you will. This is really what we're measuring oftentimes in our surveys and public health research.

And then there's the institutional level at which racism operates. Here we're talking about a system of white supremacy that denies resources and opportunities to people of color. This can manifest itself as an action in face of need. So, for example, if you look at the current context of vaccine disparities in terms of race, looking specifically at the COVID-19 vaccine, you see that communities of color, particularly Latinx and Black Americans, are less likely to get vaccinated. And you can think about deliberate choices that we, as a government, took to prioritize certain groups to get vaccinated versus others and how that might be an example of institutionalized racism or structural racism, if you will. This level is going to be codified into law, culture, and institutions.

So, now let's bring this together.

So racism is being measured in some scales as an ACE. So here we're talking about the findings that shouldn't be surprising to anyone; that it predicts poor health. This is evident in the racism literature and when you look at racism as an ACE it also predicts poor health. And, most notably, this is being done in the national survey of children's health, and it's been done for quite a few cycles now in its administration in which they are asking parents if their child has experienced racism. However, racism in this context, as I alluded to earlier, only captures the personally mediated facets of racism, so it's not going to capture the internalized self-hatred, or the institutional level factors.

A more comprehensive measures of racism should strive to include these internalized and structural components, including if we want to include those measures within ACEs scales.

So, I wanted to end by saying it's actually a little bit more complicated when we're talking about ACEs and the intersection with racism because ACEs are actually policed because they're criminal activities that can monitored by, for example, child protective services and we have policing involved. So because of this, we actually have unequal enforcement of this and you see patterns like, I'm pointing here on the right hand side, where CPS in California investigates half of all black children in California basically indicating that the system by which ACEs are reacted to or criminalized can also create ACEs by leading to experiences of racism or separation of families ultimately, as well.

So that's the end of my presentation and, here is my contact information.

Mighty Fine, MPH, CHES, moderator: Dr. Alcalá, thank you so much for setting the stage for us for the roundtable today. And with that, I would like to introduce Michele Okoh to come on screen and talk to us about her work relating to ACEs and environmental justice. Coming to us from the Environmental Law and Policy Clinic as a senior lecturing fellow, welcome Michele.

Michele Okoh, JD: Hello. Good afternoon. It is my pleasure to be with you all today to discuss ACEs. First of all, to go a little over my background; as Mighty so graciously brought up, I am a senior lecturing fellow with the Duke Environmental Law and Policy Clinic, and currently I'm also towards the end of earning my Masters of Public Health. What kind of led me down that journey was actually kind of the genesis of my work because I am a practicing attorney, I've been practicing law for over 10 years, and really kind of one of the areas of law that I practice has been in relation to some health and public health in general. So for me, I used to be a prosecutor, focusing on sex crimes. I did have my own practice called Okoh Law Firm, where I focused on representing clients with disabilities and also I did criminal defense work as well. But before all of that, I also was an Associate Attorney General on the North Carolina Department of Justice and I represented the social work board and also the Medicaid program. So, I guess kind of coming through full circle I decided to connect more with the public health aspects of my work, really getting down to wanting to move the clock earlier on my work and really wanting to have a positive effect that way.

I became involved with APHA; I'm currently the section counselor for the environmental section, and I'm the co-Chair of the Environmental Justice Committee and I'm also representing the environments section on the action board.

So…

Mighty Fine, MPH, CHES, moderator: Just to interrupt we're seeing your word document is that what you're intending to share?

Michele Okoh, JD: No, that was not what I intended to share, I apologize.

Mighty Fine, MPH, CHES, moderator: No worries.

Michele Okoh, JD: Thank you. At this point actually I will share my screen, thank you.

I will share my screen and go over where my work currently focuses. Specifically right now, I currently focus my work on environmental justice and one of the things that I wanted to share was the definition of environmental justice. Currently the most prominent definition for environmental justice is from the EPA and, as you can see, it is "environmental justice is the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income, with respect to the development, implementation, and enforcement of environmental laws, regulations and policies. This goal will be achieved when everyone enjoys the same degree of protection from environmental health hazards and equal access to decision making process, to have a healthy environment in which to live, learn, and work".

So those are some of the important aspects of environmental justice, and if you notice, there are a few words that I highlighted in green; *people*, so environmental justice is very much so about people. It's concerned with meaningful involvement of people, and is concerned with the fair treatment of people in this environmental context. If you notice it also details issues of race, color, national origin, and income.

The next slide that I want to show you is a picture from Warren county. This is back in 1982 which is really kind of the birth of the environmental justice movement. It goes with essentially the locating of a PCB landfill in a predominantly black community.

That being said, if you notice race has come up a good bit here when we think about environmental justice. Sometimes environmental justice is also referred to as environmental racism, and that is actually the aspect of environmental justice that we are going to focus on here today.

So a lot of it actually does come out to the health disparities that were discussed earlier in regards to the role ACEs and race play in our society. Another aspect of environmental justice to keep in mind is that it is very much so community driven and it is a collaborative process. We view communities as being experts in their own rights and we recognize that communities have agency. Our role as professionals is to work with those communities to help them find their own agency and then also help them to amplify their voices.

One of the things I wanted to go into is that if we are really focusing on the C in ACEs, in childhood experiences, it connects to a lot of what we were talking about earlier and really expands the view of how we see childhood experiences. We went over earlier how ACEs a lot of time focus on household experiences and household dysfunction and also in relation to abuse and neglect; but another aspect that is also very important in consideration of health and childhood health is the influence of race. When the original 10 ACEs were developed, the focus at that time was really on the main participants of the survey that evolved from ACEs, from participants primarily it was respondents mainly being white college educated adults.

And really, as we move forward and seeing the importance of race as far as impacting an individual's health, there's been a call to expand that view of ACEs; that there is in fact a model that when we're looking at both physical and mental health, is more trauma informed.

What is very important to keep in mind is that whenever were looking at ACEs, we see differences as far as race and also in low income populations; we see that higher adversity exists across those populations. When we really kind of move forward, we also see minority groups are at greater risk of the implications. Were really seeing circumstances where four or more ACEs are going to be more likely in these groups.

The other aspect that I wanted to bring our attention to is the recognition that racism is a public health crisis. As discussed, it works from multiple domains; there is an individual's impact when it comes to racism that deals with more psychosocial stress on the individual level, and we know that racism will increase an individual's allostatic load, and really kind of have more physiological degradation in regards to that chronic stress over time. Which, as we know, we see those differences early on with individuals, even going back towards childhood.

When it comes down to environmental racism, part of the problem that we have is that we're in a circumstance where we keep wanting to move forward with neutral policies. But if we're trying to apply

neutral policies in an unequal society then what we're really doing is perpetuating those same inequalities.

Ever since toxic waste and race in the United States, which is another record that genesis from environmental justice in 1987, it's been recognized that the circumstances, like that picture I showed you from Warren county, is where those hazards are going to be located; incinerators and landfills are more likely to be in communities of color. In fact, race is a larger determinant than income itself.

So, with that being said, we really see a situation where environmental racism is kind of inextricably linked to health outcomes and we see the synergistic effects where really, if we're looking at the child and to look beyond just the household experience of that child and how it will impact their overall lifelong health outcomes.

So, an important aspect of that is also looking at the social determinants of health based on the CDC Healthy People 2030. We're looking at economic stability, education, access and quality, healthcare and quality, and then neighborhood, built environment, and social and community contacts. It's really important to be able to look into that larger context in order to understand childhood experiences.

So, a very well-known circumstance that exists of environmental racism is the high lead levels in the water systems of Flint, Michigan. One of the things that was really significant that came out, because there was a report that came out from the Michigan civil rights commission, one of the things that that report found was that the vestiges of segregation and discrimination found in Flint made it a unique target; the lack of political clout left the residents with nowhere to turn, nowhere to have their voices heard.

One of the undergoing themes here is also the importance of making sure that those voices are heard and, as we know, there's a difference in how those voices are received, based on race.

Even more recently, a report came out that showed that, again, when it comes down to air pollution, communities of color are more significantly impacted by air pollution and will face greater health outcomes in relation to that.

So, with all that being said, the main focus here is that if we are ready to address childhood exposures, childhood experiences, we really have to look at the child in the greater context to address their health needs, and that includes being able to address racism and also specifically environmental racism.

Thank you.

Mighty Fine: Thanks, Michele.

So I'd like to ask both Michelle and Dr. Alcalá to come back on camera and we'll start to take some of the questions that we've been getting from the audience.

So one of the questions that I saw come in earlier, folks are asking about if you could talk a little bit about the interplay between social economic status and ACEs…and thinking about ACEs score in relation

to that. But maybe even just broadening the question a bit and talking about how poverty and those other elements can exacerbate the likelihood for adverse events for children.

Héctor E. Alcalá, PhD, MPH: So absolutely, that's a great question. ACEs are going to be more common in low SES settings unfortunately. If you consider, for example, something like parental separation. One of the consequences of divorce is driving people into poverty. We have to consider that those things are related and they're hard to disentangle. The other thing is we think about parental incarceration; again, another thing that may drag people into poverty but also may put you in a position where you're more likely to be criminalized because you're in a poor neighborhood. So there's a lot of feedback loops within between ACEs and poverty, to such an extent that some scales actually include poverty itself as an ACE. So I think it's important to not look at those as separate things but closely intertwined phenomena.

Michele Okoh, JD: And I would agree in that context as well. The same aspect also plays out in race because racial discrimination will affect economic opportunities, but also the vestiges of racism will affect where that individual starts out. So across the board, we see disparities not only directly in public health, but in areas such as education and our criminal justice system, we see these disparities existing. So really across the board there is a dramatic interplay with income, with educational opportunities, and race itself. And that also shifts towards the environmental racism aspect because it affects where individual can live and what will be in the neighborhoods they live in.

Mighty Fine, MPH, CHES, moderator: To that point, you sort of trickled into another question that came in… thinking about if there are any resources that you can point folks to where racism is included in a scoring rubric, or how folks can integrate that into their practices as they're assessing someone; and not whittling it down to a score, but just for the context of this conversation, if it's incorporated in any detail, or any other tools that you've come across.

Héctor E. Alcalá, PhD, MPH: So, in terms of rubrics themselves, if you look at the National Survey of Children's Health, so they actually include racism as an ACE. So if you want to see what that looks like in a rubric I would point people to that. And it's freely accessible, so you just look up your questionnaires.

Mighty Fine, MPH, CHES, moderator: We also had a question come in from the data regarding California and for black children and the CPS investigations, if you can give any additional context around that.

Héctor E. Alcalá, PhD, MPH: Yeah, so it was a study, I don't recall when, but it was fairly recently done, and they looked at I think survey data to ask whether or not there were investigations done.

Mighty Fine, MPH, CHES, moderator: Someone asked to repeat the previous question, the scale that you reference

Héctor E. Alcalá, PhD, MPH: National Survey of Children's Health, so I will type it into the chat.

Mighty Fine, MPH, CHES, moderator: Awesome, thank you.

So it seems like we have a bunch of questions that are coming in talking about how do we disentangle sort of race, racism, as it relates to adverse experiences and alike.

So, for some of those who are maybe newer to the space, can either you talk about that interplay and thinking about how it can be proxy for something else; so we know that communities of color have concentrated disadvantage, more so than their white counterparts, so if you could talk a little bit about how that interplay of not just focusing on race, but the structural racism that people are subjected to, and how that then reinforces adverse events in childhood that have deleterious impacts into adulthood.

Michele Okoh, JD: So um I mean, I think that is a very good question. It goes into where our focus needs to be if we're going to address race, and the need to recognize that there's systemic and institutional racism and really address the laws; and it's funny that, really like I said, our ticket perspective of being neutral, but in an unequal society you're just going to perpetuate disparities.

So, for example, a big, big, big focus as far as environmental justice concern is what we call E.O. 12 898, and that's the executive order addressing environmental pieces; but part of the problem with that that executive order, being an executive order is it doesn't have any teeth. It doesn't specifically, it doesn't expand anywhere that the Civil Rights Act is and, for example, the arm the Civil Rights Act, how it is interpreted currently it really only addresses those situations of overt racism. It's very limited in application. Part of the things that we have a need to address whenever we're looking at issues of environmental racism is really expanding. The provisions, the legal provisions, that communities and individuals can use in order to protect themselves, in order to advocate for themselves, which are currently not available right now.

Mighty Fine, MPH, CHES, moderator: Héctor, anything you want to add there?

Héctor E. Alcalá, PhD, MPH: Well, I think that what we have to think about is racism is going to condition exposure to all ACEs because it's going to determine what access to resources you have, whether or not you get policed, whether or not you get resources when you've experienced an ACE, so it's all interconnected; like poverty, and because racism and poverty are so closely intertwined, I would say that, again, it's good that we're moving towards adding racism as an ACE, I think that's an important first step.

Mighty Fine, MPH, CHES, moderator: Thank you. Someone put in the chat, sort of tangential to this conversation, but picking up actually something you just mentioned, and it's more applicable to mandatory reporting of sexual abuse by physicians, and so folks want to know if you have any thoughts on the intersection of that work as it relates to ACEs. As I mentioned sort of a tangent but since they pose it I figured I'd ask it. Any thoughts? Probably more so in your realm Héctor, if you have any thoughts there?

Héctor E. Alcalá, PhD, MPH: So we're talking about mandatory reporting by physicians if they think the patient has …

Mighty Fine, MPH, CHES, moderator: No, sorry the mandatory reporting of abuse by physicians.

Héctor E. Alcalá, PhD, MPH: Yeah, I mean I think that it's a good idea that is in place. The problem is that we know that physicians aren't perfect and that they are… one big problem we have is that physicians

actually aren't screening for ACEs in any systematic way. So if this is your mandatory reporting, it's only going to be if it's very overt and if patient is telling you. So I think if we really want to be effective, physicians need to actively screen for ACEs. I know that there's a push in California, in particular, to have this be what standard practice is, but there's a lot of resistance and I understand why there's resistance; because people feel like if we're screening for ACEs we may be re-traumatizing individuals, or that physicians just don't feel comfortable or properly trained to do it. But I think that the field needs to move in that direction of screening every patient.

Mighty Fine, MPH, CHES, moderator: Yeah, so thinking about that and taking it a step further, there's a huge movement in California with the Attorney General; they are really pushing and even incentivizing it and some manners as well. As you all think about the work that you're doing in your respective spaces, how do we, for lack of a better descriptor, incentivize public health or health care to think about ACEs more holistically? How do we move to a person centered, or patient centered, a community centered perspective? Obviously, with an equity focus, what is it that we need to do to move in that direction, so, as you mentioned, we are making note of how adverse events impact our immediate but also our long term health and well-being? Any thoughts of how we can shift that in public health? Or where it has been working and what we can do to elevate somewhere?

Héctor E. Alcalá, PhD, MPH: I think part of the problem is that we're currently very siloed in how we deal with ACEs. So there's a criminal justice response, there's the social work response, and public health has really been late to the game entirely I would say. A lot of the work I do interfaces with social workers and their research but it tends to exist in their spaces. So I think the first thing we really need to do is get on the same page and talk to each other and be using the same language, because often times it feels like we don't view the problem in the same way or the solutions in the same way.

Michele Okoh, JD: I mean that that multi-disciplinary approach is vital, because when we're looking at ACEs when we're looking at childhood health in general it's very complex. The interplay is very significant. It directly relates to the treatment of the patient, for one thing, but it also relates to, I think…Professor Alcalá had brought up a very good point earlier in regards to re-traumatization. So this is… in my previous life when I was a prosecutor, one of the things that I always went over whenever I was dealing with survivors of abuse was to discuss with them that the trial process was traumatizing in itself. Yes, revisiting these issues is traumatizing in itself. However, being able to connect on a wider approach… so one of the things that I felt was very important was to make sure that individuals did have support, and that included mental health support as well, that they could actually be able to sustain that functioning. I think, in addition to public health having a larger voice, we also need to include our mental health community and having a larger role as far as the treatment of individuals.

Mighty Fine, MPH, CHES, moderator: Yeah, very true. Their questions are coming in fast and furious so I'm keeping up, and I have some of my own that I want to ask but I'll defer to those shortly.

So, someone is asking about, which I think is a great question, the intergenerational structure of ACEs in regards to racism, and thinking about how we can impact that. Whether from your perspective Héctor or Michele, thinking about in your work, and thanks for elevating that story, but if we can think about

how you see that in in the work that you're doing and thinking about what more we need to do to interrupt those cycles of poverty of abuse neglect etc., so that way we're not posting it on the community, but recognizing, again, as I mentioned before, that the environments are creating scenarios that make those adverse events more likely to occur. So again, if you could just talk about from your perspective about intergenerational ACEs as it relates to structural racism.

Héctor E. Alcalá, PhD, MPH: Yeah so, if you want to think about… what we talk about frequently is the cycle of abuse that often gets talked about in terms of physical, sexual, emotional abuse. So if your parents were abused they're more likely to have abused you and so on and so forth. If you think about racism, often its abuse by the state, so if that abuse is being perpetrated on your parents or grandparents, they may be reacting in a way, to cope with their trauma, in a way that's unhealthy or neglectful of a child. So I think that is all going to interplay. But I also think that we just need to focus on dealing with racism and poverty at the same time, because a lot of this is driven by the cycle of poverty; that we have individuals dealing with the stress of living with very little money and in constant fear of losing their job, not having enough to eat, and that is going to make them cope with things in an otherwise unhealthy way. Whether it is their own health behavior or treating their kids in a way they should not be treating them.

Michele Okoh, JD: And I think that connects also to a larger problem as far as we like think in the short term. So essentially there was an exposure and that's the end of it, move on. But as Professor Alcalá just brought up, there's that intergenerational aspect. That also exists structurally, and that also exists when we talk about environmental racism, environmental exposures as well because, for example, when there's lead exposure, that doesn't just go away, that's stored in your bones; when we look at other toxins, we have to think about bio accumulation. But, we have a tendency whenever we want to think about health and what an individual has been exposed to, as in the short term, that's the end of it. But we really need to think long term at the overall treatment, not just the when the exposure happens and moving on, but realize that in regards to ACEs, and in regards to environmental exposures as well, that those continue to impact health and those don't just disappear.

Mighty Fine, MPH, CHES, moderator: Yeah, for sure. Another question has come in… I have something I want to say that, but I want to start from the top questions that we have coming in, so I'll come back to that, but thinking about in the immediate… so if a child is subjected to abuse or neglect that's perpetrated by parent or caregiver or someone in an authority role… in your work, is there anything you can speak of that talks about what supports are there? Again, so this kind of harkens back to the intergenerational conversation, so recognizing what supports we have for parents or someone in the caregiving role, and the child to help alleviate what we were seeing happening with abuse and neglect for children. So any thoughts from either of your perspectives?

Michele Okoh, JD: Yeah, I think one of good things about ACEs is it does shift the focus, as far as a focus on support and prevention. Not simply just looking at a place for the finger to be pointed, a place to necessarily blame an individual. And I think, for us, we need to realize that we, as a society, bare responsibility to the environments that exist in regards to supports that are available to an individual, and really need to shift towards thinking about prevention. So does an individual have the resources

that they need in order to… if they are in a circumstance where…let's just say there are economic pressures… where they are able to find the resources they need to support their family. If we're dealing with, for example, a circumstance where there's environmental racism, do they have the information that they need to advocate for themselves. So really to look towards what supports are available to the individual and whether or not they know those are present, and that is the thing that can happen at the treatment phase. Because we have so many tools that we use for screening, to really standardized that and have an eye for…it's not only just getting information from individuals, but giving them resources to be able to address those as well.

Mighty Fine, MPH, CHES, moderator: Thinking about resources, as you mentioned, there's questions coming in regarding how do we think about neighborhood level social economic status versus family socio economic status; and I think we can take that a step further and think about that from the environment lens as well. So thinking about how we disentangle that and if there's anybody that you know of in your spaces that are really exploring how we disentangle what's happening at the neighborhood level but what's also happening within that the nexus of that family.

Héctor E. Alcalá, PhD, MPH: So that really isn't currently being done in the ACEs space, and that really is somewhere we need to move. The problem is that the data collection really isn't there because ACEs tends to flatten neighborhood context into an individual experience; so you are reporting that you've lived in an unsafe neighborhood or your parents are reporting that you live in an unsafe neighborhood. We can, for example, take crime statistics, we can take poverty level from the neighborhood, instead of relying on the individuals report, and plug those in in addition to the individual level reports. I don't know of anyone that's doing that current work, but certainly important work to do.

Michele Okoh, JD: Yeah I agree, I think that is very important work to do. And there is, as you had mentioned early in your presentation, kind of a shift towards looking at ACEs in a broader context as well. On the environmental side there's kind of… there is more and more research, but I do still think that there is the whole issue of that siloed effect.I don't see a lot of talk across different disciplines, as far as connecting that information, connecting that research. And then also thinking beyond the level of work that you're doing, so that, in a sense, is also problematic as far as being able to address ACES and the larger context. I would say yeah, I would say that would be kind of an area where we need to grow and where more research and work is needed. I have seen kind of more, like from an environmental justice aspect, community groups and community organizations coming together. But there's a real resource problem there as well, because a lot of those community groups and organizations that are coming together don't have the resources available to, for example, to do something that is publishable, don't have the resources to really get the word out about the work that they're doing. That's why in environmental justice there's a big emphasis on being collaborative and focusing towards being community driven. And I'll also say that is an issue as a lawyer as well, because now we have a big focus towards human being, actually being a community, lawyering because the legal community, we also have a history of going in and disrupting those networks that already exist, so, whether we are legal professionals, whether we are medical professionals, whatever our profession may be, we have to recognize that there is an existing community and not necessarily go in and work in that Community.

Figure out ways to actually collaborate and partner with those communities; that's how we're going to get better information; that's also how we're going to be able to best help as well.

Mighty Fine, MPH, CHES, moderator: Yeah so Professor Okoh, speaking of that… if the audience is anything like me, we love those anecdotes and those stories, so are there any stories that either of you can uplift that demonstrate how we partner with communities successfully? To your point where we're working in concert, engaging and power building, as opposed to empowerment and really acknowledging that community voice when we talk about adverse events related to racism and not for their stigmatizing or disenfranchising them but also acknowledging what support should be there and how they can be a part of that problem. Just kind of taking a step back and thinking about that health equity perspective. Part of that perspective is acknowledging what's happening, to whom it's happening, and who's involved in the decision making to do some course correction; how are communities involved. So can either of you talk to any experiences that you've had, in regards to ACEs, where you've come in and work with them to address some of these issues? That'd be helpful.

Michele Okoh, JD: Yeah, I would say from the environmental aspect… a group that I work with a good bit, West End Revitalization Association… it's very admirable to me, and they're there in North Carolina, and really they developed, because they're in a situation where they were in a black community in Alamance County and Orange County and didn't have public water services. They were lacking in public health amenities. That was like water, sewer lines, it was related to sidewalks, it was very problematic for that community. But that community came forward and it's really become a partner.

So Omega Wilson, is one of the co-founders, and he is part of the environmental justice committee for APHA. He regularly organizes other professionals around issues that are facing not only his community but he's also taking steps on the national stage. For one thing, there was the Environmental Justice in 2019, he helped to draft that. He and his organization came up with a different model of research - community owned and managed research, which is a type of community based participatory research but actually also focuses on the community owning that research having some ownership in addition. So I think that an example of a community stepping up and really being innovative.

Part of that was also realizing as a professional, that the community had their own expertise, and allowing that community to take the leadership role. Because of that, we've been connected to a lot of issues that perhaps would not have been brought to our attention. So, for example, every other week, we have a COVID- 19 medical waste group that he put together and we meet address those issues. So really I think being humble and taking the time to actually let the community lead; but that's a challenge because communities also distrust people coming from the outside, so that has to be balanced.

Mighty Fine, MPH, CHES, moderator: Thanks for that. Shifting again back to the screening, we're getting a ton of questions about screening and incentivizing that and how do we be more intentional about that. One of the question that's come in, and in thinking about ACEs and about the age of the child, when should screening begin? And how do parents fit into that screening process? Again, we're pushing to screen in schools clinics, etc. Do either of you have any thoughts about where that should happen in

regards to ACEs broadly, but also particularly to what we're speaking about today, the aspect of racism, structural racism. Any thoughts about that?

Héctor E. Alcalá, PhD, MPH: I mean, I think there are two very different conversations; one for pediatric patients and one for adult patients. We should probably be screening all adult patients in terms of asking them if they have experienced ACEs; it's a different question entirely with pediatric patients because you're in the position where you're not going to get an honest response if the parent is the abuser and they are in the room; they're going to be afraid of reprisals.

So that I think needs to be done entirely differently and oftentimes what providers do is look for evidence of ACE experiences. There are some ACEs though you can ask parents about. For example, have you been recently separated? Are you living in poverty? Are you experiencing racism? So we can ask parents about those. It's the abuse and neglect things that we really are not going to be able to collect in the same way as we would with adults.

Michele Okoh, JD: Yeah, I would agree. I would also say as early as possible so that we could intervene as early as possible. But in other aspects, as far as the screening process is concerned, trust has to be built, rapport has to be built, which works against how our medical system is currently organized and structured. This also fits in to our ability to evaluate ACEs as well, because if we're dealing with circumstances where our providers have limited time available to them, that's when we're more likely to see issues in regards to unconscious bias. So we really need to also be in a situation where there's a focus also on building relationship with providers, building rapport with providers, so that there can be that trust. Another thing about ACEs is this is pretty sensitive information, so that rapport, that trust, needs to be there.

Mighty Fine, MPH, CHES, moderator: Thank you. We're coming close to time, I'll take one more question from the audience and then I have a wrap up question for you both, but this question is sort of a unique one; it talks about how we know that there needs to be a shift in how we talk about the historical aspects of structural racism in America; and more recently we're seeing some potential shifts where that can happen within our educational systems both on the collegiate level, but in elementary, high school, etc., but this question is more germane to thinking about ACEs, trauma, and environmental health. Where should we be learning about that, particularly as we are working to increase the capacity of the workforce, to address these issues with intention and conviction? So where are some spaces you think we can potentially elevate that intersection?

Héctor E. Alcalá, PhD, MPH: Honestly, as early as we possibly can, for children, because what you have to realize is that a certain percentage of the children in classrooms will have experienced ACEs or will be currently experiencing cases. And the problem is that they're being conditioned to hide or be ashamed of these experiences because we don't talk about them. Or we talk about them in very hush hush contexts, or very siloed off contexts. So I think the sooner we can talk about that, including racism, the better with them. Obviously there's probably training that needs to occur so educators know how to do this correctly and in a sensitive manner. But, for example, if we're teaching seventh graders about

reproductive health that might be a good point in time to talk about sexual abuse, because it fits naturally into that conversation about consent about not all sex being consensual.

Michele Okoh, JD: Yeah I would agree with that. I mean it has to be a multi-level approach and I agree that the schools need to be collaborated with. I also think that there needs to be some education in regards to law enforcement and our criminal justice system as well. I would say because public health has such a broad outreach and connects with so many different disciplines it seems appropriate for public health to take the lead on that, but definitely with the focus of realizing that we alone cannot do it. This permeates so many different areas, so many different systems and it really needs to have a broad reach, broad outlay; so communication is important and connecting with other disciplines. But also realizing that, as Professor Alcalá brought up, integrating it into normal already established areas of our society in regards to education. Not necessarily looking at it as like an outlier. Like, okay, we're going to have pieces out here, but integrating it into those areas that are related; and that's important also for these the stigma aspect of it. Because if an individual doesn't feel that those experiences are normal or that they'll be judged by it, or that it is something odd, then they're less likely to share that information; and then also less likely to actually be in a situation where they could have more positive responses in regards. So really kind of a focus on prevention across the board, I think is very important.

Mighty Fine, MPH, CHES, moderator: I couldn't agree more, I just quickly I want to mention…through one of the programs that we do … APHA's work…having worked with this work and folks who understood the public health approach and trauma responsive approach, they had a student that was sleeping in the classroom and she was just failing courses and taking that trauma informed approach, they were able to figure out that she was being physically assaulted by her stepfather at home; but she would stay awake while she was home to prevent him from doing that, and then she would come and sleep in school because it was a safe space. But because they didn't assume something was wrong with her, but as what's happening, what's going on, and leading with those questions, they were able to get to the root of the issue. So I think what you're speaking about is how it has to happen at multiple levels and while we're singing …like we can be sopranos, tenors, and altos, and carving out our unique spaces, but we're still singing in harmony to make sure that our messages are aligned and we're understanding the different intricacies of this issue and were entered plays with the work that we're doing.

So thank you both for the great conversation and great presentation. We have like a few minutes left if there's any parting words you want to leave our audience with, with a call to action of what they should be doing a little bit differently in their work, or elevating a little bit more. So let's start with you, Professor Alcalá, and then you'll close us out for this circle.

Héctor E. Alcalá, PhD, MPH: Thank you very much. I think that one thing we can concretely do is advocate for ACEs screening; that's something that needs to be happening nationally in all healthcare contexts, and I think that's an important first step. So thank you all and I'll hand it off to Professor Okoh.

Michele Okoh, JD: And I would advocate for a system wide approach, as opposed to just kind of focusing narrowly; really recognize that this is an issue that crosses multiple disciplines and really focusing on the

childhood experience aspect of ACEs. And to be able to connect individuals with the resources they need to be able to recover from these adversities.

Mighty Fine, MPH, CHES, moderator: Thanks again to you both, this has been great, a great way to kick us off for the day. I want to remind folks that we will be taking a break at 2:05 and coming back promptly at 2:10 and I will engage with a fireside chat with Dr. Avula, who's the Health Director at the Richmond City and Henrico Health Departments. So signing off for five minutes but be sure to join us back at 2:10pm Eastern time, so we can continue with this great dialogue. Thanks again much appreciated.

Welcome back everyone; I hope you all enjoyed that conversation as much as I did. And so it's my pleasure to welcome Dr. Danny Avula who's the director of the Richmond City and Henrico County Health Departments in January of 21 of Governor Northam appointed him to leave the Virginia's unprecedented COVID- 19 vaccination efforts, which is not an easy feat, but you've been doing exceptionally well so kudos to you for that.

My understanding is that you are a public health professional specializing in pediatrics and preventive medicine, and you continue to practice clinically as a pediatric specialist, so Dr. Avula welcome. I'm glad that you can join us today to engage in this fireside chat.

Danny Avula, MD, MPH: Thanks Mighty, so glad to be here.

Mighty Fine, MPH, CHES, moderator: Awesome. So just to set some context, folks we are going to be talking about the COVID-19 pandemic and really how it's interplay with adverse experiences for children and families; more broadly and how, in some instances, it may have amplified or exacerbated some of those experiences. So I just want to open the floor to you, Dr. Avula, if you want to just talk briefly about some of what you've been noticing in that space in regards to COVID- 19 and adverse childhood experiences, excuse me.

Danny Avula, MD, MPH: Yeah thanks. Well, it has been an eventful and super challenging year plus for so many people across the country and across the world, and I think I've seen that kind of from two vantage points; one from the public health lens of trying to respond in real time to the actual disease itself; setting up testing and case investigation and contact tracing, and then now in this most recent phase of really leading up a State level vaccination effort and trying to work out all of the details and nuances of how do we make vaccine accessible to the most vulnerable. But in the background, really along the entirety of the last 15-16 months now, we have seen the toll that COVID has taken on families and on children and both as a parent, I've got five children of my own, and as a pediatrician, I still practice a bit clinically, I've found a little bit of time over the last year and a half to still plug in at the hospital every once in a while and… one specific example back in November, so my clinical roles as a pediatric hospitalist… so I work overnight shifts and one night in November we had eight patients on the floor, eight pediatric patients; two out of the eight patients were adolescents who had attempted their own life and they were in recovery and waiting to be transported to or transferred to a psychiatric facility. That same night, there were six other teenagers, who had all attempted suicide, that we're waiting in the emergency room, and they were waiting because there weren't enough adolescent

psychiatric beds anywhere in the state and they'd been waiting for several days at this point. I think it was just like, one snapshot that so clearly communicated the toll that this is taking on kids; the social isolation they've experienced, the lack of connection to caring adults for many who were not in person in school. I think that the lack of ability to see their friends, and just everything that social distancing put on folks, really has taken its toll. You know, as I think about younger kids particularly, earlier on the pandemic when schools went all virtual, we initially saw that big decrease in child abuse and neglect report. And why did we see that? Because kids were not showing up at school, they weren't being observed by their teachers or their guidance counselors or adults in their life, who typically recognize when something's going on and report it and pursue an intervention and so …you know, I remember seeing many of those larger scale national studies last year from hospitals all over the country that were saying we're seeing fewer abuse and neglect cases, but when they come into the emergency room they're more severe and, and so I think that is one very particular example of where all of this… like the weight of COVID has really exacerbated the frequency and severity of adverse childhood experiences.

Mighty Fine, MPH, CHES, moderator: Absolutely, I can just think of myself and going to school and how… I love my home and I had a good home life, but I loved going to school and interacting with my friends, my teachers and they just added to who I was as a person. I can only imagine what an impact that would have happened to me and certainly seeing some of the deleterious impacts as you've mentioned.

So thinking about that, but maybe taking it a step further and recognizing that some of our low income and communities of color, who were already dealing with structural factors that were impacting their health and wellbeing, what are some ways, taken what we knew, what we've seen demonstrated through the impact of COVID, but moving forward, what is our role to truly recognize and address the structural factors that impacts the health of our most vulnerable communities? And then certainly our communities of color; what more should we be doing there?

Danny Avula, MD, MPH: Yeah, and I think that key term of recognizing structural factors has got to be the bedrock of our move forward. You know, I think what COVID has done is both exacerbate and illuminate those structural underpinnings that really put communities of color at risk, and when we think about the limited family supports, the need for a before and after school care, the childcare needs that so many families who have low income and job instability, I mean it's all played out over the last year. And so I do think yes, there's a health part of this, there's a testing part of this, a vaccination part of this, but just as importantly, in fact, more importantly, for the future is that recognition of structural underlying things that are putting our low income communities of color at a disadvantage; that are not creating the same amount of health opportunity, and so I think we talk all the time about health and all policies so I think our path out of this is…it's in that it's got to be seen in that frame; it's, how do we create more jobs stability for our low income families, how do we really create and in the acute sense… like our school system is still all virtual this year, and they're really wrestling with going back in person next year because there's still so many families who are uncomfortable or scared; and so there's a public health piece of this right, we've got to accurately message to our families' risk. We have to help them understand what is the risk of COVID compared to the risks of all of the other impacts that this pandemic has had on our lives; the risk of that social isolation; the risk of not having that engagement with loving, caring adults and we need to put that in a proper perspective. So there's the kind of acute

way that we've got to think about supporting our families, helping our families understand the need to get back to some sense of normalcy, and perhaps they get vaccinated to help us get there. But then there's the longer term work; how do we support families through income replacement, which we've done a fair amount of locally here in the Richmond area. How do we build employment pathways; how do we build more mentorship in for these kids; and these are all… I mean it's not any different than all of the resilience work that we've been doing for the last few years. I think this pandemic has just shown a huge light on it and, hopefully…. you've seen millions and millions of dollars start to come into the public health infrastructure. How do we start thinking about mobilizing this new infusion of funds to really do that deep long term work of supporting families.

Mighty Fine, MPH, CHES, moderator: Sure, and that's…kind of leads into my next question for you; so do you think there is a shift? So we are seeing some more dollars, so that is indicative of some acknowledgement in a sense, right? Of course we'd like to see some more, but it's a starting place. But to that point, I think we are truly going to take the lessons learned that we've garnered from this pandemic and really re-tool and resource how we do work in public health.

Danny Avula, MD, MPH: it's going to take a lot of intentional work to do that Mighty, because the way that funding is being positioned right now… it's things like hey, we need to build our case investigation infrastructure, our contact tracing, our disease surveillance, and those things are absolutely important. But we can't miss the opportunity to see hundreds of millions of dollars in Virginia that are coming in to support the public health infrastructure. Like that's gotta go towards local health departments building out teams of community health workers that not only acknowledge the expertise that exists in communities, but gives us a bridge, a relationship, to some of those marginalized communities, and help be a voice for them in ways that they haven't always been. So I think it's it goes beyond just communicable disease response and really needs to…like public health needs to be thinking about how do we maneuver those dollars over the long term to help lift up communities, to give them more voice and autonomy in their own journey to health; and I think that's how we're going to be thinking about it as a local health department and the Richmond area.

Mighty Fine, MPH, CHES, moderator: Awesome, well kudos to you for all the great work that you're doing. Thank you for taking time to speak with us today and just the excitement in your voice, in the work that you're doing, certainly has continued to invigorate me to do work differently and better, from our perspective at APHA. So thank you to that and conclude this segment and then move forward with our next, which will be talking about resilience, so you teed us up quite nicely.

Danny Avula, MD, MPH: My pleasure Mighty, great to be here.

Mighty Fine, MPH, CHES, moderator: All right, yeah all right take care.

So welcome, one. As you can see, fast pace, we're moving along quite quickly and we're moving into the next segment of our roundtable; we're going to focus on community resilience, so I think that was a great tee up for this talk. For starters, we have Dr. Josephine Kim who will be presenting and she is a lecturer on education at the Harvard Graduate School of Education. She is a former faculty director of the Office of Diversity and Inclusion at Harvard, the School of Dental Medicine, where she launched her

award winning case 16 pipeline programs, that's pretty impressive Dr. Kim. So without further ado I'll turn it over to you to get us started on a conversation around community resilience and ACEs, thank you.

Josephine Kim, PhD, LMHC, NCC: Awesome. Thank you so much, and thank you for this invitation to be here. I'm taking it a little bit from a different angle, as a mental health clinician as well as an educator. So when we think about ACEs, I know we think about environmental factors and many internal, individual, familial, and community issues. I also want to remind us that mental health is a big part of that, and so I've taken this definition of social determinants from WHO, The World Health Organization, but I've given it my own twist, especially when it concerns childhood mental health. Social determinants are the conditions in which children live, learn, socialize, and grow, and these conditions are shaped by the distribution of power resources, and then of course, access to power and resources, as well as representation, sense of inclusion, belonging ness, and a sense of safety.

And we know that inequities in these conditions are, in essence, responsible for childhood mental health disparities. For me it's really important… when we think about ACEs, we talk a lot about families, of course that's important…we think about the conditions in which students actually live, again, really, really important; I feel like what hasn't been called out yet though is the responsibility of schools and our educators especially when it comes to representing our students well and their cultural identities in ways that really foster's their wellbeing. And so this is my personal call to action for K through 12 institutions specifically. And really thinking about lack of representation as structural racism. As you look at this picture here, you can see how the tree, which in essence, as a system through which our children reside and learn and socialize, is skewed one way. And so, if you were, you know, one of these children, which would you want to be?

There are, as we know, systems are skewed in such a way that certain students are placed at an advantage, not by merit, but simply for being majority and then other students are actually left in the cold and they don't have great access, and so this is where we need to begin thinking about our students, cultural, ethnic, and racial identities.

So I'm using here, this is a different Kim, who really came up with and mirrors the work of Barry who I'm quoting here. When it comes to bi-cultural integration or multicultural integration and, if you look at Barry's work it's really talking about the identification with the heritage culture, combined with participation in the majority culture, and in fact we know this integrated identity has the most positive outcomes when it comes to cultural adjustment, and best outcomes from mental health, especially when it comes to the level of stress our children face. So when it comes to integration, then what is the role of a school and educator?

When students see value, meaning, and respect placed on both cultures, and so, if I'm Korean which I am actually so I'm Korean American, and that means my education really should mirror facets of my identity, and not only invite my cultural identity into the spaces at school, which by the way, our children spend their greater amount of time during the day in schools, not necessarily even with families.

And so, when we think about the role and responsibility of education, institutions and educators… it's about time we brought them to the table. When students see themselves, facets of their identity and they're given these opportunities to practice, they're exposed to their own histories, where they can reclaim what was lost and erased from our history books, all of these opportunities, when it's given in ample amounts, it actually fosters a healthy integrated cultural identity.

But unfortunately what we often see is that schools don't promote healthy cultural identities. In fact, there's a failure to uplift and represent cultures and histories well, and unfortunately what this means is our students become assimilated, and by default, they assimilate to white Western culture and what this basically means is that students cultures are minimized, often erased, simply because it's missing from their education.

How do you go through an entire K through 16 education, I know, for me, I never once read a book written by somebody who looked like me. And so when we think about the messaging this sends to our students, it basically told me people like you don't write books and even if they did, it's not valuable enough to make it into our curriculum. Right, and so again, think about what that does to a student's cultural identity and extended to their wellbeing.

When students don't have ample opportunities to practice and develop their cultural identities they're forced to give up their heritage culture and really adjust for survival. This has huge implications; lack of representation perpetuates things like a culture of stress; this is stress that comes from fitting into a majority culture, in a majority environment, without scaffolding any of their own cultural identities. It fuels things like imposter syndrome, constantly wondering do I belong here, am I good enough, do I deserve to be here, am I going to be found out soon, and then of course, it also perpetuates a low sense of belonging.

This idea that, I am an integral member of the school. No longer, this is a school I go to, but it is my school, that's a sense of belonging. And it perpetuates the lack of sense of belonging, and we know the lack of sense of belonging, is a predictor of depression for many minority student groups. It also fuels minority stress simply because you are in the minority; there’s stress from prejudice, rejection, internalized racism, at every corner, every angle, and we know this to be the root of psychological distress and physical health issues in most people of color.

Not only that, there's also the threat of stereotype. Stereotype threat, the same idea that you may actually disconfirm or confirm the stereotypes that exists about your own people group, and when you are the sole minority, for example, you shoulder the burden because often you’re tokenized and you shoulder the burden of representing your own community really well, and that pressure is enough to actually make you fail. We also know that this leads to lower performance just for those reasons.

We often think about assimilation as this very benign thing but I’m here to say it is cultural genocide. In fact, assimilation involves the eradication of things like language, cultural artifacts; you wouldn't believe how many schools have protocols and practices and policies that actually say English only.

So when the students are not represented in books, artwork, structures, all of that is assimilation and it is cultural erasure; when there is suppression of cultural activities that don't conform to the authorities notion of what is appropriate and sound.

It's also involving this process, taking on the traits of the majority culture to such a degree that the assimilating group becomes socially indistinguishable from majority members of society or their peers. This creates a catch 22 for students of color because, I can tell you, I can be fifth generation Asian American and my phenotype is not going anywhere. And so, I can assimilate behaviorally, linguistically, in any other way to be white American, but I can tell you, because this isn't going anywhere…we live in the land of categorization by phenotype. And so I will still not be considered American. It places students of color in a double catch 22, right, a fail- fail, no win situation.

It's also pointing to policies, regulations, and protocols. Often it's hidden behind, "well, this is how we've always done it for centuries, and it works". If it's not broken, why fix it, right? These rationalizations for the status quo. It also points to practices, things like curriculum as I've already given voice to; pedagogy, how we teach, who's direct or indirect intent is to erase culture at the very least.

Assimilation as cultural genocide was historically used, as we know, to erase any hints of heritage culture, of any cultural group that was deemed as uncivilized and less than, namely nonwhites . And so it's very important for us to realize that assimilation is not so benign. In fact this is an example of what assimilation is; when we tried to remove erase, minimize, diminish, and then denigrate any heritage and cultural identity of our students.

It's important to name that there is no passive stance, educators and schools, in this work. A lack of representation is erasure, it is structural racism. And when environments, including schools, are not actively anti-racist, it is by default entirely racist, because that is how institutions were set up.

You know, representation is extremely important in children and preventing mental illness and self-psychology. Kohut will talk about how children need three things to fully participate in life; one is mirroring - when a child comes to us with certain emotions, they need caring adults who can mirror those emotions back. They also need twinship- likeness when they walk into spaces, like their classroom. They need to be able to see people who reflect back to them what's important to them; there cultural identities, facets of different parts of their identities that feel important. Not being told to check those pieces at the door because there's no space in the classroom. This twinship, being able to be in the sense of likeness with somebody… how is it still possible, that we go through an entire K through 16 system with our students of color never been taught by a teacher of color; never having worked with an administrator of color; never having been supported by a counselor of color?

These are all systemic and structural realities that we have to dismantle and begin to shift. We also need, everyone needs, especially children, the sense of idealization - people that they can aspire to. You know, for me, growing up in the United States, I always wanted to be the next Connie Chung. Because she really was the only Asian face I would see on TV and I thought you know what, if she can do it I must be able to do it, too. And so, because of those reasons, because I needed someone to idealize and aspire

to, that was the reasoning behind wanting to be Connie Chung; all of our children need that as role models.

We could easily say students of color have many mental health issues and lots of vulnerabilities, but that's quite unfair because it becomes… public health is about where do you locate the problem. Is it in students of color? Is it in the minority populations? Or, is it in the systems that they have to reside, learn, grow, and participate in? And so, we need to shift our thinking into not I have mental health problems, but I have problems with oppression and stigma, right, the greater systems that keep vulnerable populations vulnerable and sick. So I'll go ahead and end there. Thank you for listening.

Mighty Fine, MPH, CHES, moderator: Thank you so much, Dr. Kim for getting me again re-energized and reinvigorated. I also agree that culture, identity, representation certainly matters and the need to really focus on the system.

So, I am super pleased to welcome Dr. Wendy Ellis to talk to us about her work in the resilience space; who's an assistant Professor in the Department of Global Health, and the founding director of the Center for Community Resilience at the Milken Institute of Public Health at the George Washington University. Without further ado, Dr. Ellis, please take it away.

Wendy Ellis, DrPH, MPH: Well, thank you good afternoon everyone and I can't think of a better setup than following Dr. Kim on with regard to helping us to start to think about zooming out from rethinking the C in ACEs; it's not just about the childhood adversity, but it's also about the community adversity. And that is really at the center of our work at the Center for Community Resilience at George Washington University. Where it is really helping us to understand that the ACEs science is fundamentally important for us to understand, particularly from public health perspective, the source, the root cause of so many of our chronic conditions that we have, but also recognizing that our environments are chronically ill. So let's talk about that a little bit; when I talk about why the C in ACEs should also include community environment.

This graphic is how we frame our work at the Center for Community Resilience. Thinking about the pair of ACEs, so again adverse childhood experiences in the context of adverse community environments. Earlier you heard from Michele Okoh who was talking about environmental justice and the underpinnings of the disparities, with regard to our policies, that have driven disproportional exposure to environmental hazards, particularly in communities of color.

But it really does point to this systemic inequity that we have that exacerbate, if not oftentimes cause, the adverse childhood experience to begin with. And again, remember, we are talking about multi-generational exposures; not just what's happening to one child in 2021, but what has happened reliably, predictively, and most importantly, intentionally to communities as well as to individuals in our country's history.

So when we look at these outcomes, the branches, the leaves on the trees, as these adverse childhood experiences these are things that we can oftentimes readily assess by perhaps observing a child in a

classroom, or having a conversation to understand that perhaps the reason why this child can't sit still in class is because of parental incarceration.

But that isn't just happening typically, particularly in communities of color, to that one child. That's an adverse community experience as well; that is born of an adverse community environment, particularly of our lower income communities, that have differential policing practices than say some of our upper income communities. So when you begin to think about it and you zoom out from not just what's happening to that child but what's happening within that community then we can begin to see the root cause, or as this graphic shows us, what's in the soil.

And so I know earlier, there was a conversation with regard to community involvement; but oftentimes, you know, this tree is just used as a way to start the conversation. Just as the ACEs, that have been listed as the 10 classic ACEs, should be approached as a way to start a conversation, but they're not definitive because, as you know, in the original ACEs study, racism was not considered an ACE. Well why is that?

Well, largely the population that was being surveyed were white middle-class women who were insured that were part of an obesity clinic study. So no, it's not likely that the experience of racism in itself would have popped up.

But it also begins to help us understand the limitations of using these 10 ACEs as some sort of screening tool; to help us understand what is the experience of the individuals that we work with and of the community that we hope to serve. So I say that to say that the conversation is so much more important than a tool in itself. And this group should be reminded that there is no such thing as a validated ACEs screening tool. What we have as the most powerful opportunity to understand is to be cognizant of the context and ask the questions, have a conversation with regard to understanding the ACEs. But this is also important because this helps us to begin to understand resilience. Resilience, not as a quality of individuals, but resilience as something that can be supported through the community; that what we see in these roots are not just systemic drivers of adversity, there are also opportunities to support, to provide buffers and, as you can see, there isn't just one sector. Healthcare, social services, education, business development, there are multiple sources that have a role and feeding these various nutrients that are in the soil.

So that's why it's not just public health or health care that will address effectively the pair of ACEs. It is an all-in strategy that is necessary to do so. And so, this graphic not only helps us to better understand the context, but also helps us to begin to understand who should be at the table so that we can begin to think about what are those sources that we can use to derive for resilience. So when we talk about resilience it's not just the ability to bounce back from adversity, but, from a public health perspective, it's the prevention of, by putting supports and buffers in place, so that communities can bounce forward.

So we've been talking a little bit about racism and I want you to strap in because I think we need to get a little bit more explicit with regard to why this is so important with regard to ACEs in our communities.

Because equity is at the center of this. If we recognize that it is the inequities, the systematic and intentional inequities that can be measured, and under investment that can be measured, and disproportionate treatment, then we do understand that inequity in itself is a driver of trauma, and that trauma undermines resilience, therefore, the inequity undermines resilience. So therefore, equity is a necessary component to build and in order to get to resilience. So that is absolutely what equity has to do with this work.

So, as that graphic also illustrated, in the soil you can see, there are multiple systems, which means there are multiple policies, that are contributing to not only the environment, but the experiences; what our children and what our families are experiencing, and this was certainly evident in COVID- 19. Where you had on the branches and the leaves, although they are not considered as, because of this traditional ACEs, one would say what many of our children have gone through, and even Dr. Avula alluded to that, the stress of isolation, the stress for parents of having to educate and try to work at the same time. These are adverse experiences, but they also were exacerbated by the community environments.

And so that's where it also helps us to begin to understand it's not just enough to be able to understand what's happening at the individual level. We have to get specific with regard to understanding the policies that are driving, again, reliably, predictably, and intentionally the outcomes that we see, the disproportionate outcomes that we see, in communities.

So let's just get explicit about that. We've talked about structural racism, but we have to really talk about what undergirds structural racism, and that was the belief in white supremacy. So I know there were some of you that might be clutching pearls right now but, hold on. When we talk about white supremacy, quite honestly, and I've said this before, I'm less concerned about individuals in white robes and burning crosses; we all have the right to our beliefs. What we don't have a right to is that our beliefs disproportionately underserve individuals; disproportionately do harm, intentional harm, to others generation after generation. And that is what has happened with white supremacy. That has been empowered by structural racism.

That means that belief that white people should dominate all other races. We are public health professionals, we read the literature; there is a reason why white is always the index, it is at the top. And that's the role of structural racism; that the systems and the policies were designed to empower white supremacist belief. That belief then produced an outcome; that white people dominate in power, health, wealth, and wellbeing. And on every social economic scale in this country, you can see that. Again, reliably, predictably, and intentionally. That is the intentional harm that has been created through structural racism. That produces the disproportionality in experience and creates intergenerational trauma. And this should be really important to us because we understand the science that is showing us the epigenetics of ACEs and of trauma; that this trauma literally gets under the skin and is passed on from generation to generation.

So earlier, you heard Dr. Avula as well as others talk about social determinants of health. But I want to challenge our thinking here with regard to ACEs and social determinants. This is the work that we're doing with non-local health departments across the country; to begin to understand community

resilience as something that is driven by policy. Something that helps us to understand how those policies then result in disproportionate access to the resources necessary for us to both prevent ACEs as well as bounce back, bounce forward, and thrive.

And those things are what we measure in these yellow boxes here, oftentimes we ascribe as social determinants. Whether or not a child is justice-involved; whether or not a child or a family is housed; what is the level of homelessness in a community; what is the matriculation for school to school, and the differences in districts, or even within districts, of graduation rates.

But I challenge our thinking; if we are going to also think about adverse community experiences of which we have embraced as social determinants, but this graphic clearly shows us that these are not things that are necessarily determined by individuals; they become perhaps qualities or outcomes for individuals, but they, more importantly from a community perspective, are characteristics of communities. More specifically, their systems driven.

So instead of worrying about necessarily that an individual is homeless and using that as a predictive measure for how a person, or how many ACEs a person may have or what may be their life course, the question, if we're truly to go upstream and to think about the policies that are driving these outcomes, is to understand why is it that it is, again, reliable, predictable and oftentimes intentional, that we have these disproportionate outcomes, particularly by color, and increasingly by income levels in this country. It is our policies, our practices, that have been driving so much of the trauma that is truly an American public health crisis. Yes, ACEs are a public health crisis and, so follows, is racism. But the solution isn't just in fixing people; it is really looking at the policies that are driving these outcomes. That is inequity by design and that's intentional trauma.

So that is the challenge here; it's not just merely, how do we screen for aces, it is how do we have honest conversations, with public health at the center, to address the true driver of both community trauma as well as childhood trauma. That is the work of building community resilience, and I'm going to turn it back over to Mighty for questions.

Mighty Fine, MPH, CHES, moderator: Thank you very much to you both Dr. Kim and Dr. Ellis. I'm sort of dressed like a poet today and I was snapping my fingers.

As you both were speaking I'm so excited to get into this conversation. So just for jumping off, since she's sort of left off with it Dr. Ellis, if you can just punctuate that point for us about screening, since it came up a lot during the day, as you're steeped in that work. So if you can just punctuate the intersection of what we need to be doing, or thinking about when we talk about screening for ACEs.

Wendy Ellis, DrPH, MPH: Yeah, I really appreciate you giving me an opportunity, and you know I'm not speaking from opinion; I also happen to do work with the American Academy of pediatrics which has taken a long look at this and thoughtful consideration of how do we begin to screen for ACEs. And even the work that Dr. Burke Harris is doing in California, isn't taking the ACEs screener because there is no such thing let's just… I can't say that that…did I mention that there is no such thing as a validated ACEs screener? I just want it to be clear that is not what we're seeing as best practice, a checklist; and yeah I

said was true…I think, Dr. Alcálá mentioned the fact that we have to worry about re- traumatizing people; but more most importantly it is…it's not just the re-traumatization, it's the limitations of what is on that list and also you know, we could get into a whole conversation with regard to child welfare, that it's neither about the child, nor is it about welfare, and reducing individuals down to a single ACEs score while it could be informative, and even Dr. Burke Harris says this it's informative, but it's not necessarily predictive of where a person is going. I myself had an ACEs score of eight. Now, if you just go by what that the field says, or the science says, I shouldn't be able to put two words together, even having lived this long life. Yet it's not just what has happened to an individual, we understand there's, and this is why resilience is so important, it is what supports and buffers are available to individuals. Do they have one adult that can provide support to them? In my own case I had access to a great community, public education with teachers who were able to take extra time with me; there are a lot of other factors that provide those supports for individuals to bounce forward. So, if you're merely screening for the adversity that, and particularly for children of color, that tends to not necessarily be the best route to do.

So here in Washington DC, Children's National, also one of those large child pediatric networks, really grappled hard with we want to be proactive. Obviously, we don't want a child to suffer unnecessary trauma. But entering into, you know, do you abuse your child or have you had this in your past will likely shut down doors because who are you to ask these kinds of questions of me. And, and particularly if we think about people who are at the greatest risk. Do you have that kind of relationship with individuals to ask those kinds of questions, knowing what could be potentially be the outcome if I am truthful about it? So no. You know, after years of going through this and studying patient surveys, they asked one simple question, and that is actually about food security. Have you struggled in the last month to put food on the table? And why did they ask that? Because our science already shows us that individuals that are at higher risk, or families that are a higher risk, for household stressors, let's just say stress because stress in itself could be a number of different sources, but we know that's really what's at the heart of ACEs, is that stress response; so we know that if you're struggling to put food on the table, there probably are a lot of other stressors that are in that household. And if, by asking that one simple question, you begin to open up a dialogue, you build trust, you're building a relationship, perhaps some of the other things will come out.

And so that is really what…you know, not only have they been able to connect families to resources to put food on the table, but they're building trust with these families, they're building an opportunity for dialogue so that if a parent is feeling stressed, they're able to come to and just say I'm probably not managing this the best way I can. And we're seeing that similarly in pediatric practice with our partners in Cincinnati Ohio where they've actually brought in parent coaches, they've trained parent coaches, to be that peer support so that they can have a trusted ally; not only dealing with their own stressors, but ultimately what's best for the wellbeing of that child.

So I just want as a field for us to begin… there's two things here; yes, it's important this ACEs science is important to be deployed and it's certainly should be; we should keep that in mind about the lifelong impact of ACEs. But that doesn't mean you go hauling in like your behind is on fire, with some survey instrument. We have to do our diligence to think through what is really in the best interest of that child,

of that family. But then remember what I said earlier about the C, the other C, in ACEs and that's the community context, and that's where public health really does have a role, and we can talk about that in a moment; about the work that we're doing with local public health departments to bring these partners together, think about those root causes. But I appreciate you letting me have this time to talk about the survey piece of it, because it is… we have to be much more thoughtful than just a screening instrument.

Mighty Fine, MPH, CHES, moderator: Absolutely. As sort of in my work in epi we say to look beyond the numbers. So look beyond; it's not just about the score but it's been… thank you for uplifting that context. One other thing, I'll ask Dr. Kim a question, we did have some requests for your ACEs tree diagram so if there's a website in the chat, folks really want to get a piece of… want to get a copy of that.

Wendy Ellis, DrPH, MPH: Yeah, I actually typed it in, so you should be able to see that.

Josephine Kim, PhD, LMHC, NCC: Yeah, yeah, I just wanted to add…I'm a soft skills person as a clinician and I just want to back up what Dr. Ellis is saying that anytime we use an assessment or inventory it really should be used as a way to open up doors for conversation, and nothing beyond that. Otherwise, it does become very reductionistic and we narrow down people to a number. But not only that, I do think it's missing certain things. For example, we should assess for oppression, and I think that gets to somebody question in the Q and A box, but just as that, you know, we also need to assess for resilience because resilience will cancel out some of these…we know things like spirituality and having a strong cultural identity, all of these things work in our children's favor. And so again, you know, just supporting the fact that we really should use it as a way to open up conversation and further discussion and nothing else.

Mighty Fine, MPH, CHES, moderator: And to that point….

Wendy Ellis, DrPH, MPH: I'd like to make a plug because Dr. Kim is talking about the screening for resilience…I'm going to make a plug for one of your panelists who is coming up later today Dr. Bob Sege and his work that he's doing is really about those positive experiences; how can you balance understanding what's happening to a child that might be negative, but also what are those positive experiences that are available to balance that, and if they're not available, do parents know how to create positive experiences.

Mighty Fine, MPH, CHES, moderator: Back to your point, Dr. Ellis, when you talked about if someone looked at your ACEs score, they'd be like ah, there we go, you know… and it focuses solely on that, as opposed to, like what you're saying, thinking about those protective factors in those buffers and resiliency and how do we be more intentional about that work there? So, you alluded to the question about the oppression, Dr. Kim, is there anything additional you want to add to that or.

Josephine Kim, PhD, LMHC, NCC: Yeah you know, as somebody who trains school counselor specifically because, again they meet such a need and also thinking about student mental health and how to train our educators to do some of this work, because they often are the gatekeepers and often, in my opinion, the under tapped resource in this work when it comes to public health and so, in thinking about that, I do train them like how do you assess for resilience and how do you assess for oppression? And

means we insert some relevant questions that really get at the heart of that right, and I feel right now we're kind of missing that in ACEs, but yeah that's all I'll add.

Mighty Fine, MPH, CHES, moderator: Okay awesome, thank you. There's a question here, a lot of questions are coming… I foresee like a part two with you all in the very near future, but this is a question that doesn't get elevated a lot so I'll pose it to you both; it's really about how do we engage with those folks in our religious spaces? So someone here saying that there are an ordained Minister Chaplin, past counselors, what more work can we do to engage them and what's their role as we're thinking about ACEs?

Wendy Ellis, DrPH, MPH: I'll go ahead and take that first, if you need a moment Kim. You know, it's really interesting because I was just vaccinated so we're back on the road, finally, with some of our partners and was in Cincinnati two weeks ago meeting with a ministry, a small ministry there, where they have translated the ACEs science from scripture. And you know, I don't know how many people here are familiar with various biblical passages, but it was very interesting. You know, the use of our tree, the pair of ACEs tree… trees are a universal symbol, and I can remember from Sunday school oftentimes hearing stories like… there's a passage about the tree…plant it near water and it will thrive. And so that's actually one of the scriptures that this ministry is using to talk about resilience and working with their community using Bible scripture as a way to teach resilience science, to teach ACEs. And so, you know, stay tuned because I'm working with them to lift this up; they're not interested in turning this into something where they make money off of but I really thought one of the hardest audiences that we've been able to work with has been faith based organizations and that's largely because they're not the root of the community as they once were, especially in our larger cities where we were dealing with gentrification and communities are getting busted up; and the church may still be in the community, but the people that are in the Community are really not of the church anymore; we're certainly seeing that in Washington DC. But this idea that this book, and it's not just Christianity, I think that you could also translate this from Talmud, from other faith beliefs, that this idea that we can use a tree, or we can use the lessons that are taught to us, and our various faiths have also very much the alignment with the ACEs science. So, in some ways it's like we studied that… we think we discovered ACEs science in 1999, but it's probably been sitting right in front of us for centuries.

Josephine Kim, PhD, LMHC, NCC: Yeah I would add that, especially in immigrant populations and marginalized communities… while they may not go and seek out your medical doctor or a psychologist or psychiatrist, sometimes they don't even understand what the difference is, the mental literacy may not be there, at least from a Western lens, oftentimes they will go to their community leaders, which often ends up being their religious and spiritual leader, and so they are often the under tapped resource again. And so I think it makes common sense actually to bring them and mobilize them and they might be able to reach populations that we will never be able to from this type of platform.

Mighty Fine, MPH, CHES, moderator: Absolutely. So a lot of questions are coming in around resilience and capital within communities, and in your both of your presentations you touched on this.

And so, someone is asking what more can be done organically, or supporting our communities, for them to develop their own social capital without, I don't want to say interference…but how do we make sure that… not how do we make sure… but what's important to be there to ensure that social capital can happen more organically or naturally within communities without disrupting the networks that they have in those spaces? And I think even back to your point, Dr. Kim, thinking about that if I see it, I can believe it, right. And really helping us to think beyond what we're taught or miss-taught, some learning that we have to do. So, what more needs to happen within community spaces?

Josephine Kim, PhD, LMHC, NCC: I'm borrowing this from youth work and disabilities movement, but nothing for us, about us, without us. And so, if you are a majority white organization and you're trying to, in a positive way, impact communities of color for example, there's no way you can do this without mobilizing the community first; without meeting both community leaders being on the same side, getting them really to be the face of your project, and crediting them where credit is due. I think these are all really sound practices and honestly, what a great time we're living in because you go into any community, and you will find really strong community members who can rise up to the challenge and probably are already doing the work that you envision. So why not create these partnerships and let them take the lead.

Mighty Fine, MPH, CHES, moderator: Absolutely so…

Wendy Ellis, DrPH, MPH: I want to say, Barbara Bloom Alexander, I'm so glad you put this in the chat because I want to clarify when I talk about resilience, I am not talking about expecting people who have had boots on their necks, metaphorically, for centuries to just pull themselves up. And that's why I take the systems perspective on this; why I repeat over and over again, the outcomes that we see are reliable, predictable and, most importantly, intentional. You cannot expect individuals or communities to be resilient if you have these policies, these practices, that have constantly undermined that ability to bounce forward and to thrive. So when I speak of resilience…building community resilience is aspirational at this point. Because we have active policies to undermine that. So it is working with those communities…I don't come in, I mean obviously I'm passionate, but I can't define for Dallas, I can't define for Portland, I can't define for wards seven and eight here in Washington DC, what resilience is, for me, for them, I'm sorry. But having that Community voice sitting, humbling myself, listening, understanding that the expertise that I bring to the table is how do we message this, how do we get this in front of lawmakers, how do we change policy and practice, how do we build these coalition's so that we can be very specific, how do we leverage the data, that's everything I'm describing right now, that's the role of public health. Bringing community together to be able to tell the story of what is the experience of adversity, not just what our public health numbers tell us; but what explicitly, what are the leavers that are driving the outcomes that we see. And then, as public health, what I can do is working with community, bring those sectors together, specifically analyze these data, to get to what are those measures, as you saw my graphic, what are the specific measures, the outcomes, that are being driven in this community, that this community says we need to have addressed, that are being driven by specific systems, practices, and policies. And so that's what resilience looks like is making our systems accountable. Making our systems accountable to each other, but also to the community to provide the support and buffers that actually helped to build resilience not expecting people that have

been beaten down, downtrodden, and held back specifically continually to draw upon their own resilience.

Mighty Fine, MPH, CHES, moderator: Thanks, thanks, thanks again some more snaps, right.

So we have some questions, it looks like some of them have been answered by folks in the Q and A queue… but thinking about, just sort of the historical misgivings and atrocities of America, we talk about racism and against communities of color and what folks in the chat are saying that there's still people who haven't bought into that. So, they haven't bought into that; how do we shift to policies and practices that support what we're just talking about by dismantling the structures of racism that are exacerbating adverse events. So could you talk about how do we disentangle, or how do we move forward… like if you come in you're in, if not you're not; but in all seriousness, just talk about how, how do we garner that level of understanding and appreciation, recognizing all won't come aboard, but what do we do to continue to move forward, so we can inform policies that benefit our children.

Josephine Kim, PhD, LMHC, NCC: I can begin with this one. I mean for me, I think the education pieces are antidote and that has to happen at all times whether you're looking at other things… you know, things can happen concurrently and simultaneously and so education, in my opinion, is kind of the backdrop. And what you're talking about is really the lack of education, or kind of the unlearning, we need to do, and so I'm learning and learning these two have been… I also want to say, though, that I don't know if we can rely and wait for everybody to get on board. People's lives are at stake here and children are dying. Earlier we heard about all the attempts to take their own lives and, I mean students are dying as a result. And so I don't think we can wait for everyone to buy in. What that points to me, then, is accountability; systems need to be held accountable and you need to now insert systems of accountability that really will keep people to certain standards and protocols, whether they believe it or not. And I think that's where I feel is kind of our antidote right now, accountability.

Wendy Ellis, DrPH, MPH: Yeah so I agree 100% with Dr. Kim except that, you know , to be honest with you, you know education will only take us so far. Clearly, I mean the COVID epidemic showed us that when half the country that doesn't want to wear a mask, we got some problems; education will only take us so far. Depending upon what level of government or policy that we're working on, I think we have to be ready for different strategies. Quite frankly, at the federal level, there are only two numbers I care about - 50% or 60%. If it is, you know, we're trying to get something through that's going to require the budget, then that's 50%, we only need a majority. If it's something that is a super majority, it's going to be a little bit more work. So those are the two numbers that quite frankly… I'm not trying to get to 100%, I really could care less about 75%. I do know that it is 100% predictable of what the conditions will be in ward seven and ward eight. So where we can get leverage at the local or the State level. And that's why we're working with local health departments… where we can work with, whether that's a state level education department, you know a lot of things like Dr. Kim was talking about from an education standpoint are our local school districts; our principles have incredible latitude. We're working with the Cincinnati public schools right now, because they've decided to take on themselves how they are going to teach this history of racial oppression in Southwestern Ohio. How they teach social studies, how they incorporate this into not just a social studies or history class; it's not just black history month it is

American history at large. So it's thinking about the multiple levels; where there's opportunity to influence federal legislation, absolutely, we're going to go for that. But there are also things that we can be doing at the state and, at the local level, and certainly organizationally, that's most proximal to those communities and again most proximal to those outcomes that I highlighted, that I'm not going to wait for the Senate to get right before I take action at the local level, and I think that's your answer; that question with regard to what can we do tangibly based upon what is your level of play.

Mighty Fine, MPH, CHES, moderator: Awesome well, this has been my pleasure, certainly, and what I've been asking… we have about a minute left before we take a break and will resume at 3:20pm Eastern time… what's the one call to action or the one nugget or gem that you want to leave our audience within relation to the areas of growth or development, or something we need to do differently as we move this agenda forward? So, I'll leave it pretty open ,any parting words that you have for folks?

Josephine Kim, PhD, LMHC, NCC: I'll just repeat what I kind of ended my presentation with, that we cannot talk about vulnerabilities of marginalized communities without talking about the broader structures that really keep them vulnerable.

Wendy Ellis, DrPH, MPH: I think one of the most important things that I've learned in the six years of doing this is that we all have to come to the table with a level of humility, but we also have to be able to hold space for some very difficult truths. And, you know, for people of color it is sometimes easier to accept those truths, because those truths, or are we that reality. For those individuals, particularly white individuals, it is sometimes very difficult to sit still and listen to this. I just want to say that you know, being an ally means that you will be uncomfortable. That, you know, because living in this skin day to day is always uncomfortable. There's a certain level of comfort that I've learned, it's like having that burn your shoe, finally, you know, you just forget it's there sometimes until it peaks through. So, none of this was meant for us to be comfortable in. It is the courage to move forward, it's to remember that public health, at the center of public health, has always been social justice. You have a right to do this work, just as our communities have a right to have equitable access to support some buffers so that they can thrive.

Mighty Fine, MPH, CHES, moderator: Awesome, I couldn't agree more. And I would just echo that and say as us, in this space doing this work, needs to make sure we're having those internal audits to see how we're showing up and how we're not reinforcing some of those barriers for sure. So again, thanks to you both again, really appreciate it, we will be in touch for part two, I'm certain.

And for the folks online, be sure to come back again at 3:20pm Eastern time, where we're going to actually pick up where we left off and talk a little bit more about health policy, so thanks again.

Mighty Fine, MPH, CHES, moderator: Welcome back everyone. We're excited to get this thing up and started again. As I mentioned at the conclusion of the last panel, now we'll move into talking about policy ACEs and health outcomes. So it's my pleasure to introduce our first speaker Dr. Taryn Morrissey who is an associate professor of public policy at the American University. Her work focuses on examining and improving public policies for vulnerable children, including early care and education, nutrition assistance, and public health policy; so Dr. Morrissey please take it away.

Taryn Morrissey, PhD: Hi, good afternoon, afternoon on the east coast at least. Thank you so much for having me join this really excellent, important, and very timely conversation. It's a real pleasure, and I look forward to the discussion as well. So thank you for sharing my slides.

So next slide please. First I wanted to just start with some research about ACEs, particularly during early childhood and it's what my research study's, so I'm particularly interested in it; but it's also early childhood, as we know, as reams of research show, really forms the foundation for later child and adult outcomes. But today, at least until recently, we haven't had a lot of research on the incidence of adversity in early childhood during these really important years.

So this figure, which… I worked on a report in collaboration with Christina Novo at the Center for American Progress, shows that more than one in four children experienced adversity before their fourth birthday. It's quite common even among those little children. And research shows us that babies and toddlers are acutely sensitive to their environment and early experiences so this suit should be particularly troubling to us.

Early relationship settings and interactions support children's development and stress from adverse experiences, and interrupted relationships can interfere with growth and development. So, we know that adversity, does not mean interfering with growth and development, but it's a risk factor. We know that exposure to toxic stress, so sustained intense forms of stress, particularly during sensitive periods like early childhood, can accelerate the wear and tear on children's developing bodies. And may have lasting effects on adult health and other outcomes. So again, it's certainly… not necessarily that children who have experienced adversity, even during early childhood, have problems and growth and development, but it's a risk factor.

So next slide please.

Now here, from the same report, this slide shows that economic difficulty is the most commonly reported form of adversity. And I want to point out these data are pre pandemic, and we know that economic difficulties have only gotten more widespread and more severe during the pandemic. We see that 20% of young children's parents report that it's hard to cover the basics like food or housing on a family's income; 9% report parent or guardian divorced or separated. So, these are the most common forms of ACEs, so to speak, or adversity.

Our public policies and collective decisions make the experience of ACEs more common. And we should… I know the session focuses on policies and I want to talk about policies that increase the experience of ACEs, but also that we can mitigate it, so end on a high note. But we know that right now, underinvestment in our policies, underinvest in young children and families…our safety net is full of holes, we have time limits on cash welfare like TANA or temporary assistance for needy families, so the first word is temporary, inadequate benefit levels, even among families who received them. We have an inadequate mental health care system that doesn't reach all the individuals who could benefit from it. We know that mass incarceration can lead to separation of a child, sustained separation between parents and children; and then our lack of gun control leads to increased instances of violence, it's the next slide. And we cannot ignore the role that systemic racism plays in all of this. We know that there

are racial and ethnic disparities and exposure to adversity, and these are evident even in the first three years of life. We can see that non-Hispanic black or African American children are more likely to experience at least one form of adversity, or ACE, as well as too… compared to their non-Hispanic white counterparts or Asian American counterparts as well.

Next slide please. I want to emphasize, though, that the absence of adversity does not equal thriving, right. Children need positive ingredients, we all need positive ingredients; positive relationships to grow and learn and thrive.

And next slide please. So we also know that these relationships can both promote children's development to provide children with what they need to learn and grow, and they can mitigate the harms of adversity; but by providing these ingredients, so specifically healthy, consistent, warm relationships, these relationships can buffer the negative effects of ACEs and stress.

You might have heard the term serve and return interactions; this is when a child and typically an adult caregiver engage in this kind of back and forth almost like tennis interaction, where each one is responding to the other in like a conversation; but you know infants and an adult don't necessarily have a traditional conversation, but it is conversive in this interactive way. The emotional wellbeing and social competence that's fostered by these strong relationships provides a strong foundation for emerging cognitive abilities, language development, early literacy and numeracy as well, so that's important for social emotional development but also what we typically think of as cognitive development and self-regulation as well.

Next slide please. So importantly, policies can mitigate the harms of ACEs and reduce their prevalence and support all children's growth and development. So we've made certain decisions in our policy context that have led to potential increases in adversity for some for some children disproportionately, but we can make different decisions to implement policies that both mitigate the harms of ACEs for all children. So this includes increased financial resources, as I mentioned economic difficulties are the most commonly experienced ACE. The expanded refundable child tax credit, that was passed in the American Rescue Plan back in March, as well as increases in the earned income tax credit increased benefit amount would do this in particular; but there are other forms that can put more money essentially in the pockets of parents and others who are caring for young children. This can interrupt the cycle of stress and difficulties. We know that paid family leave is important both for new parents to bond with children, to care for young children, but also to care for ill family members, whether those are older children or older members of families or for personal illness too; it's important to recover from personal illness as we've seen so blatantly on display during our pandemic.

We know that high quality early care and education can support children's development, as well as allow parents to work and earn finances that can reduce financial stress in turn. We also know that adequate worker compensation in those early care education settings, and evidence based curriculum and professional development are key quality ingredients; adequate worker compensation in turn can help can support workers in early care and education, who are disproportionately women and disproportionately women of color, support their own families.

President Biden's Americans Families Plan included many of these elements, so there is… as well as some others like an increased nutrition and health insurance benefits to help with family's expenses, so there's movement in this area. We now have a one year child tax credit that's expanded and refundable that will cut poverty in half. It's only for one year, so that's important to think about and in moving forward to consider what different kinds of policy choices we might take again to support all children and to mitigate the effects of ACEs and to reduce their prevalence in general, so I'll end there. Thank you.

Mighty Fine, MPH, CHES, moderator: Thank you so much, Dr. Morrissey, look forward to engaging in some dialogue with you after Dr. Sege's presentation. So welcome Dr. Sege. Just by way of introduction, he's an attending pediatrician at Tufts Children's Hospital and a professor of pediatrics and medicine at Tufts University School of Medicine, where he directs the Center for Community Engagement Medicine, Dr. Sege.

Robert Sege, MD, PhD: Thank you so much, and thank you Dr. Morrissey for starting us out. I'm going to talk about the other side of the coin with quaint. We've talked about adverse childhood experiences, and now I'm going to talk about hope or healthy outcomes from positive experiences.

By way of introduction, this is a new framework which is rapidly spreading around the country as it provides a simple framework way to think about something that we've actually known in any way for a long time. I get to stand here and talk with you guys, the APHA, I just want to shout out to everyone who's participated. We have a wonderful team based at Tufts Medical Center; we have some of the best consultants in the country and just a phenomenal advisory board who not only don't rubber stamp anything, let me just tell you that they're just great.

So hope exists because we know that positive experiences help children grow into healthy resilient adults, and what we're doing now with hope is exploring how do we evolve our understanding and support of these key experiences for all of us to take care of children and families. Positive experiences are so important; a lot of research, and honestly cultural wisdom, shows the positive experiences promote children's long term health and wellbeing, allow children to form strong relationships, create positive self-image, a sense of belonging, and a sense of mattering, and help children build skills to cope with stress. Because let's face it, all of us during our lives face stress, sometimes severe, and we need to be able to bounce back from that.

However, whatever system you're in, whether it's child welfare, early childhood medical care, or any other system, a lot of the screenings we do focus on the negative, and addressing adverse childhood experiences is vital, but sometimes prioritizing ACEs can overlook the value of positive childhood experiences in preventing, mitigating, and even human childhood trauma. We aim to shift the narrative because you want to consider those positive experiences that impact health outcomes and to recognize, honestly, that each of us, all people, are defined not only by our challenges, but by our strengths. Fundamentally, this is that we treat all people with dignity and we want to make sure that the marginalized families and communities who, honestly, interact with the system more often than other

families are not judged as broken, but are valued, respected, heard; and we believe that finding strengths and things to admire is a key part of that.

So we're developing approaches grounded in science and wisdom that could build from the role of positive experiences in human development. It's… a little bit of data; we published a study that was done in Wisconsin along with the Behavioral Risk Factors Surveillance System. When we added questions about positive childhood experiences to the BRFSS, system questions about mental health, and also to ACEs in that system, what we found was that for all survey respondents, those who had six or seven possible positive experiences had 72% lower odds of depression or mental health than those with zero to two; and those with the middle number, three to five, also had a reduction over a half.

But here's the exciting thing. I wasn't excited enough; among those people who have four or more ACEs, so these people have severely bad childhoods, if you think about it, if they had no, one, or two positive experiences, 60%, had depression or poor mental health, but if they had six or seven positive experiences, that number plummeted to just over 20%; so positive childhood experiences mitigate the effects of ACEs.

There's a bunch of stuff which I can't talk about right now, happy to answer questions about it, about brain changes associated with positive childhood experiences; about actual evidence for healing after trauma from positive experiences, and emerging neuroscience explains the mechanisms for those things. So positive childhood experiences promote flourishing, because it can prevent ACEs, can block toxic stress for children who have experienced adversity, and it can promote healing and in doing so, prevent the health outcomes from toxic stress and ACEs that we all know so well.

So, going back to what does this mean in practice; based on our review of literature, we boiled down the kinds of positive experiences that children need to these four kinds, these building blocks; relationships, environment, engagement, and emotional growth, and these are the key experiences that research shows help children grow into healthy resilience adults.

So, in the couple of minutes I have left, I want to talk about these in a very high level, from a policy point of view. First, there are policies that promote relationships. We know that paid parental leave at the time a child is born or welcomed into a family improves attachment, improves family relationships, reduces stress; I mean actually it doesn't cost very much money at all on a societal level. Paid parental leave is here in many states, and is something that's extremely important to promote the positive childhood experience of safe and secure family relationships.

We also know that relationships involve two people, right. And so you can't have a positive relationship with your parents if they're physically or mentally unwell and, as Medicaid expansion has caught on, we've seen improvements in health outcomes or healthcare access for parents of children.

The next building block is the environment; Dr. Morrissey already talked about the importance of income supports, how things like the new child tax credit will relieve many children from the difficulties of living in poverty. Part of a safe environment in which to live, learn, and play is food in your belly and a roof over your head - basic human needs that require income supports. And then beyond that, there's a

large movement in the schools to provide positive school environments. This grew out of early research on bullying which eventually showed that you need to have an entirely positive school climate. There's tons of evidence that the environment in which children learn is important.

Engagement, the way children learn that they matter is because they're part of a group or part of an effort that's larger than themselves. It could be helping the family at home, it could be helping in the classroom, it could be singing in a choir, playing on a team sport, being involved in politics or a club where others depend on you. A lot of school time activities tend to teach the sense of mattering. In addition, we can provide volunteer or paid opportunities for civic engagement which teenagers in particular find very meaningful. And all of these are under attack, at least the first set, because more and more out of school time activities have fees associated with them, which prevent the young people that need the most from those opportunities to learn that they matter.

Emotional growth most often happens through peer play, and if you watch kids play, they spend a fair amount of time discussing the rules to all those things. This is what emotional growth looks like. As children develop a sense that other people have a perspective, and psychologists call this the theory of mind. But it happens through unstructured play. We need safe playgrounds, safe places to play, access to nature, so the children can have those experiences that are required for emotional growth.

What HOPE does is we work systematically to identify, celebrate, and promote positive childhood experiences. In our trainings for frontline workers, we break up their workflow to initial encounter, what happens when you first meet a family or client interaction, particularly interactions with people who have experienced trauma but also bring experiences of strength and resilience to the picture and, finally, how you fit this all in with cultural norms and promote engagement beyond the program itself and in the community at large. We do this through great collaborations with projects now with the American Academy of Pediatrics, Prevent Child Abuse America, the CDC, our own States Department of Public Health, and we're exploring new partnerships with our National Indian Child Welfare Association. And this is kind of how HOPE works; we work with organizations to help them fulfill their missions by incorporating a viewpoint that includes positive childhood experiences. And we think it's working. I just want to give you a couple of comments three months after a workshop for early childhood educators. What one participant said in an interview, "it is providing an opportunity to have the parents be proud of things they are doing well, instead of focusing on areas that need improvement. I feel that this has increased their willingness to engage and work with me". I'm sorry that was a home visitor. And then, a pediatrician; "parents love hearing the doing something well. I've never had a parent not say something akin to 'Oh my gosh, thank you for saying that!' or, and this makes me sad, 'I'm not used to people saying I'm doing something well'". How important is it to be validated in the most important job that each of us feels we're doing, which is raising our children.

So in five years, we hope that HOPE, PCEs and flourishing are as widely known as ACEs and toxic stress. That they're part of policy agendas at the local, state, and federal level and that they're an integral part of policymaking. Just like there's an environmental impact statement, there should be a child impact statement to make sure that children have access to these positive experiences that they need to grow into healthy, resilient adults, thank you.

Mighty Fine, MPH, CHES, moderator: Awesome, thanks so much Dr. Sege that was… as I mentioned before, I really appreciate elevating the positive childhood experience component to this conversation because unfortunately sometimes it is missing, and I think it builds on some of the resilience that we talked about earlier, and even harkening back to when we set up for the day to talk about how we elevate opportunities and ensure the supports are there to see them actually happen.

So one of the questions that I have for you all is thinking about policy as it relates to this word, so it can be positive I mean, excuse me, can be like big P policy, federal policy, but some of the policies that you talked about can even happen within the workplace. So if you could talk a little bit about what you see as the role of policy across the board, as far as informing some of this work. Either, either of you.

Taryn Morrissey, PhD: Sure I'm happy to take a stab. I think one of the…I don't know if I want to call it a silver lining, but of the pandemic has been to highlight that workers are also caregivers; about one third are parents. And so, in the end, in order to do their jobs and to care for their children, they need childcare or eldercare other kinds of caregiving supports. And so from a federal policy perspective, we could invest more money in supports like subsidies, allowing families to afford childcare, we can improve the quality, the reach; we know that the pandemic has decimated the availability of early care and education and that's going to have lasting effects on women's employment, on family economic security, on children's outcomes, their opportunities, how they arrive to kindergarten, prepared or not; and so I'm thinking through public investments and also workplaces can invest; they can provide more flexibility, they can provide paid family leave, as we talked about several times, that could also be a federal policy or state policy. Many states are on the cutting edge of this; we know that several States just in the past five years have implemented paid family leave; they've expanded childcare programs; but states can't do it alone and employers often can't do it alone and it ends up having that higher income workers disproportionately have access to these benefits that would also benefit lower socioeconomic workers as well. So there's not a shortage of evidence based policy interventions we could do just to help support families and young children.

Robert Sege, MD, PhD: I just want to add one thing to that. You know, one of the things is we're always talking about preventing risks and why that's important, I'm not in favor of any of those things. We also need to do things like say fees for after school programs are wrong, they're jeopardizing the future of children in our country, and we need to fund them the same way we fund math and science, and just because there's not a standardized test for that sense of identity, and that sense of mattering, doesn't mean it's not crucial for child development. And at every local level, we need to make sure that these fees are either abolished or it's everyone who qualifies for school lunch or some other very easy simple program would be able to participate in. It's… that's… one example; if you look at the policies that we have and come by for reasons that don't really involve children, like this involves how do you balance the school budget and stuff, have deep effects by preventing children from having the positive experiences, they need to grow and we need to take that every bit as seriously as we take other problems.

Taryn Morrissey, PhD: I completely agree. Summer, as well. Summer is a really difficult time for lower income families. It's a difficult time for everybody to arrange childcare, I have two little kids too. And

also, I think you know, taking a step back to and thinking about our public education system arbitrarily decided that at age five we're all going to chip in our tax dollars and support education for everybody universal education. But before age five, children are learning and growing as well, just like they are after three o'clock or during July or August, right, but our policies don't match the science.

Mighty Fine, MPH, CHES, moderator: Yeah, I think that's critically important for people to understand how this actually operationalizes, right. Back to your point about creating opportunity, but the support so that they actually can tap into those. So it's cool to say hey, we have an after school program, we know is really beneficial to a child's physical-mental health and then the cost might be a barrier, right, so I'm glad that you brought that up to really help folks online think more critically about the services that are provided; but really asking ourselves well who actually, who has access to them and are the intended benefits actually being reached.

So we have a question somewhat related, but it's more so about the physical or the built environment as it relates to ACEs, and thinking about health outcomes and what more can be done to engage in those spaces. So, thinking about… just neighborhood makeup and derelict buildings and abandoned houses, and the impact that that has on a child just by seeing that and living in a neighborhood that may exacerbate some of those traumatic experiences that they're facing. So I know you all didn't come here to talk about that, but I believe you have perspectives that you can share.

Robert Sege, MD, PhD: Most of my years in primary care practice were spent working with children who live in cities, many whose neighborhoods were frankly dangerous, and the parents protected them by keeping them at home. And what happened is because society didn't provide safe playgrounds, safe places to play and interact with peers, some children really were emotionally…didn't get the social emotional growth that they need to have. And watching TV and playing video games keeps you physically safe and, in some circumstances, it's the right parenting strategy. But it's a failure of society to recognize that children need those things, it's not a luxury.

And, providing that because children need to feel engaged and communities that engaged young people… they just saw the children thrive. In Boston there was a very sad epidemic of teen suicides in one neighborhood and the mayor just poured in money to develop after school programs and teen centers and things like that in the community, and then the energy those children had and what they gave back to our city was phenomenal. So these are kids who had been isolated and depressed, who had all that potential, but just simply wasn't being tapped.

Taryn Morrissey, PhD: Yeah, I agree with that. And I think we can all identify with being isolated and… you're right. If we're young children learning to interact with the world and form relationships and healthy relationships and thinking about peers and sharing and cooperation, all those skills that we know…I mean I hate how they're called social skills or non-cognitive skills. As a psychologist, I kind of, you know, they're important social emotional skills and are key and form the building blocks for everything that comes on top of it. Allow children to regulate their behavior and learn math and learn how these other kinds of critical skills. So I completely agree; children need those, they need to interact with individuals and to manipulate objects and playgrounds and neighborhoods are so important.

Mighty Fine, MPH, CHES, moderator: Yeah, interestingly enough, you talked about the social emotional fees, someone has asked a question, what are your thoughts about integrating those evidence-based practices into curricula for schools, and what could that potentially look like.

Taryn Morrissey, PhD: I'm not an expert in social emotional curricula, but I do know that many schools are talking about that, right now, in particular, as so many students are entering schools for the first time in a long time. And many of them have faced a diverse array of challenges or have been isolated for often… for good physical health reasons. But it's key, it's not segmented from the rest of development, you know. Executive function is a good example of something that we know that high quality early care and education can promote and allow children to focus and devote their attention to certain tasks and that's a cognitive ability that can be fostered; but it's also often, you know, a precursor to social emotional self-regulation and control as well.

Robert Sege, MD, PhD: Mighty I want to just add one thing to that because I thought evidence-based social emotional learning was a great thing and I was schooled in that by a teacher in California, who told me that in some schools, social emotional learning classes, were where children, particularly black boys, were sent to if they responded to racist taunts or other things that were going on, to teach them to behave. So I think that, like everything else, it's the implementation that matters. Everyone needs to learn social emotional learning, but what has to be on guard…that it doesn't become something it's not meant to be, we have to be really careful about that.

Mighty Fine, MPH, CHES, moderator: Yeah no, absolutely. Great point, I think it's sort of tangential; this conversation on another webinar we talked about that and what more schools need to be doing as you're looking at their disciplinary policies and who's actually being disciplined for what, and really doing some internal audits to, like to your point Dr. Sege, to ensure that there's not an over representation of a certain demographic, particularly young boys and girls of color, so I definitely appreciate elevating that point.

Folks are really interested in in schools today, so another question is really about the policy, excuse me, the level of policy interventions at the school district and if, in your estimation, there are things we should be thinking about besides after school activities… are there other places where schools could be more supportive in ensuring the full development of the children that they're serving?

Robert Sege, MD, PhD: Yeah…

Mighty Fine, MPH, CHES, moderator: I was going to say, I feel like I asked it as a closed ended…. It is an open question.

Robert Sege, MD, PhD: So I'm finding with literature around positive school environments, where the principal treats the teachers well and the teachers treat each other well and the children feel as if they have a sense of belonging, and that's something that really is, like a district can foster. But it happens at a school-by-school level. And understanding that children should experience school as a family, not a factory, is a really important concept for school districts. Some of that costs money and some of it is just a culture, a cultural outlook about what is school for; and you know we talked about discipline, but

children are there to learn, including learning how to behave. If a child misbehaves it needs to be an opportunity to teach them what proper behavior is; that they're not, you know, 40-year-old career criminals.

Taryn Morrissey, PhD: I agree with that, I love the family…that schools are a family.

Speaking about early care and education, which is my expertise, that workers are paid abysmally in near poverty wages and have trouble supporting their own families, and that's extremely difficult. We need to make sure that that they're paid commensurate with education and experience.

And we have a range now of growing evidence for professional development interventions like coaching and supportive services that can promote quality in the classroom and children's outcomes. One of the evidence-based interventions that relates to Dr. Sege's good point, is infant early childhood mental health consultation; because we know that preschoolers are being expelled from preschool and they're disproportionately boys of color and a four-year-old is never a problem, right. There are ways to, through infant mental health consultation, provide support to teachers, to parents, to others in that child's classroom to promote healthy relationships, right, the key to development. And so that can really interrupt what's been called this preschool to prison pipeline and promote children's development and supportive relationships.

Mighty Fine, MPH, CHES, moderator: Yeah, it makes me think about that story that came out a few years ago, and it makes me think even more about the ones that we don't hear of. It was a young girl who… she was fingerprinted, she was six I believe, fingerprinted, handcuffed, rode in a squad car, and I just couldn't help but to think about the opportunities for intervention from the teacher to the principal, you know. It just blew my mind, but when you mentioned that school to prison pipeline, excuse me, it made me think about how…how can folks who are entrusted to care for our children, while we're working or whatever, could treat a child in that manner, just blew my mind.

So kind of shifting from that and thinking about the influence of decision makers, and I think this could happen on this school level or have we… thinking about state and federal policy, how do we shift the sense for them to garner a better appreciation of positive childhood experiences, and how that not just benefits the child, it's the families, the community, it's a school environment. So what is it more that we can be doing, or from the perspectives of your work, that is happening that we can tap into to help make that shift from thinking of it as a deficit perspective to something that's added in?

Robert Sege, MD, PhD: Both Dr. Morrissey I talked about paid parental leave, and we know that those first relationships that infants make with their parents, and honestly parents make with each other and other caregivers, are so crucial. The paid family leave in my state is paid for by I think as a 0.1% tax that goes in the unemployment pool; it is remarkably cheap. Employers love it because it also allows people… it's even more likely to return to work after parenting leave and are even more likely to be seen when they do, so just from a business point of view, it's important. And so we need to be constantly looking for policy angles; where there's something that perhaps they do in other countries, like paid parental leave, that we can bring in, that we know has important benefits for families. And this is a benefit for all families. And I think to keep track of that it is also, you know, really, really important to do

that. So that's an example where I don't how they've managed to do that, but somehow paid parental leave is taking off around the country.

Taryn Morrissey, PhD: I agree with that. And I also I think it's really important that paid family leave benefits all kinds of families and can bridge this kind of false divide about policies that benefit young children and policies that might benefit older individuals. I mean, I think the reason that these policies haven't gotten a lot of attention is, you know, historically it has a lot to do with… a colleague of this, said by Miriam Calderon from Oregon, was saying that classism, sexism, racism, and ageism are reasons why young children's policies, and family policies in general, haven't gotten the investment that they warrant. And I think that's slowly changing. Again, the pandemic has been devastating to so many people, and disproportionately to so many groups of people, but it's highlighted the importance of the whole worker, and that workers have caregiving responsibilities, whether it's for children are older people. And people are at their breaking point and there's more women with these responsibilities in political office and I think there's growing attention, and I think that's encouraging.

Robert Sege, MD, PhD: I'm always optimistic. There's a potential for broad agreement on these policies for two reasons; people whose politics disagree with mine also have children and in the scheme of budgets, this is like… it's tiny. Like compare the cost of universal pre K, to the cost of bridge repairs or office infrastructure, I will say…

Taryn Morrissey, PhD: …we allow people to get to work and just stay at work…

Robert Sege, MD, PhD: I think, President Biden is exactly right about that.

Mighty Fine, MPH, CHES, moderator: Yeah, for sure I totally agree. So one of the questions that has come in, and it's an interesting one, wondering if there is any research around the role of grandparents as the primary caregiver and if that has any additional benefits or protective measures for the development of a child. So, any comments on the role of grandparents, or absence, in support of child rearing?

Robert Sege, MD, PhD: Taryn and I are both looking at each other…. You go ahead.

Taryn Morrissey, PhD: I will say, I know that grandparents have served in an increasing role as primary caregivers of children during the opioid epidemic, recently and historically, and have been a huge source of non-parental childcare for parents to work as well. In addition to just a supportive family member influence, they play a huge role, and again the pandemic often interrupted those relationships and the formation of those relationships among young children and their grandparents, which was really unfortunate. I mean hopefully now with vaccines and as we get lower case numbers, that's changing, but they serve a really, really vital role. And I don't know specifically about grandparents and ACEs, I must say.

Robert Sege, MD, PhD: I just want to just add two things; one is that what grandparents need is access to healthcare. Often grandparents are older than parents, so they may have more health problems. And the second is they need support. Just like a family with, you know, with a mom or a dad, or mom and

dad, or two moms or two dads, if they're socially isolated it's hard. Often their grandparents can be isolated with their children as well. And so increasingly programs need to pay attention to kinship care, and to providing social outlets, places where and encouragement for people to get together. And playgrounds and do all those things that we talked about and include grandparents, or whoever it is just caring for the child, in the group of caregivers who need those social connections and supports to do the work.

Mighty Fine, MPH, CHES, moderator: Thanks. It's interesting, more questions coming in regarding after school or out of school hours; and this question is about what can be done, maybe during the day, to create that social capital and collectiveness amongst students and those supports that they need, because there may be some places in rural spaces, or even urban spaces, where they just don't have the capacity for out of school or after school programs. And then another component to that question is that after school… we know that there are benefits there, but is it a deterrent from the capital that students have a chance to build with their family during that time there? So, a few questions there, and let me know if I need to repeat it, but the first is what are, and you touched on this earlier but maybe to reiterate it, what are some other things that schools can do during the day to facilitate support for students; and then the other part of it is for those places that do have after school programs and after school services, how do you disentangle that with the time away from family, building supports there.

Robert Sege, MD, PhD: I think the question kind of answers itself; yes, schools need to do that. You know, one of the trends in schools, has been the ever vanishing recess.

Mighty Fine, MPH, CHES, moderator: Yeah, I used to love recess, you know. Kickball, ultimate frisbee… I I'm aging myself a little here, but we did some type of… well not recess, you know? That's high school… same sentiment, you know, but sorry.

Robert Sege, MD, PhD: I know as a parent, we always knew when one of my kids had indoor recess because the weather was bad, just take me to that. But in one school district that I visited they had a psychologist who came by the third-grade classrooms, maybe once a month right after recess, and talked with the kids about what happened during recess and really helped them make those connections about sort of the…. Metalevel connections about what's going on. I thought that was a brilliant concept. Now I think that's one area, and the other is when more school have group learning where kids need to do group projects together, and you…

Mighty Fine, MPH, CHES, moderator: Can you say the same is going to…. sorry to interrupt, would you say the same as for some of those other allied programs that I think are disappearing from schools? Like they would have music and library and others; so would the sentiment be the same you say for those too?

Robert Sege, MD, PhD: Yeah, I think honestly music has been around longer than math which suggests that it's probably a basic human need. It certainly touches a different part of the brain and is very effective emotional control and pleasure, and I think that there's a role for that and I know you're right.

Taryn Morrissey, PhD: I would echo all of that and, and especially the recess. I have a four-year-old and a six-year-old and when they finally returned to some school in person, the thing they were most excited about was the playground and recess. And it's where children form relationships, it's where they learn to navigate those social skills and those relationships, and it has been disappearing. It's also for physical activity, which we know is so important to teach children too, and to release those very high energy… little kids too so that's really, really important. And I think too, I should say, you know, I mentioned evidence-based curriculum my remarks for early care and education and many people have images of kids sitting in desks, you know, three-year-old sitting in a desk with a piece of paper and a pencil and that's not what the evidence says, you know, evidence-based. Play based learning is really key, and group interactions and projects and manipulating objects, those are all really, really important. So math and art, you know, those incorporate math concepts as well, music and art incorporate math concepts too, not just a strict math class, and so I think we're really… it's really problematic when we cut those things from children's curriculum.

Mighty Fine, MPH, CHES, moderator: Sure, absolutely. I appreciate those points. So I've been asking the panelists… in your closing remarks are there sort of words of wisdom, or opportunities for growth and development, when we think about the conversation we've had in this segment. But, you know, thinking about what we've talked about all day today and where it is that you feel it needs to be going. How do we build upon what we know has been working, and I know we talked about the parental leave and those policies, but if there's any other sort of gems that you want to leave folks with before closing this panel out?

Taryn Morrissey, PhD: I would say on, you know, on a positive note, I think the evidence is really clear; that public policies can promote children's development across a range of context, right. We can mitigate the harms of ACEs and we can also provide children with these really important positive experiences that Dr. Sege described. And so we can make different policy investments and different choices that are evidence-based, and I think we'll set future generations up in important ways.

Robert Sege, MD, PhD: I also just want to echo what we just heard, and the way to think about spending on schools and spending on these programs, as an investment. That this is how we invest in the future, and if you go out and you buy something it's gone. But the children are really literally are our future, and families are, and I think that what we need to do is really understand how important two generational or three generational approaches to child development are. All the research shows that we can incorporate that in the work we do, and my argument is that positive childhood experiences need to receive as much attention as adverse childhood experiences are. And they both need attention and it's just something that we can't afford not to do. And I just want to mention, I saw Cindy Riker, I hope I'm pronouncing your name right, mentioned that this should be school personnel, in the panel, if we're going to talk about schools, and I couldn't agree more. The things, many of the things I said that were correct, I've learned from teachers as I talked to them. So I want to point that out, and as you talking… I'm talking really more about the child's experience; I hope I didn't offend those educators.

Mighty Fine, MPH, CHES, moderator: Yeah absolutely. The intention is never to it to offend but we pose the question so that we can collectively stimulate our minds to come up with the answers from our

perspective; but recognizing that there are appreciations from all corners of the public health system and ally system and so obviously the intention was not to offend.

Robert Sege, MD, PhD: Just the final thing I want to say is we all notice that APHA prevention is always a hard sell because you don't see it happen. And it's like really easy to fund an ambulance; it's a little harder to fund that fence on the top of the hill. And I think that hearing from us, and I hope that one other silver lining from the pandemic, is an appreciation that public health has something to say about, for example, public health and this is really part of it and very important for us to present that over and over again, to understand that even though you can't see prevention, that it's the best.

Mighty Fine, MPH, CHES, moderator: Absolutely, and that's a way to punctuate this segment, prevention; we're punctuating with prevention.

So again, thanks to you both very much. We're going to take a short five-minute break and then resume at 4:15 eastern time to talk about building the workforce capacity and how do we elevate what everyone has talked about thus far and really get the public health field moving and shaking. So thanks again, see you all back at 4:15 Eastern time.

Dana Rice, DrPH: We good? I'm here.

Marleen Wong, PhD, MSW: Me too.

Mighty Fine, MPH, CHES, moderator: We'll be starting in one minute.

Welcome back everyone, we are in the homestretch. So this is our closing panel where we're going to focus on building the public health workforce to address that C in ACEs. We have two dynamic speakers to help close this out today. First, we have Dr. Dana Rice, who is the assistant Dean for the master's degree and assistant professor of Public Health Leadership at the University of North Carolina at Chapel Hill Gillings School of Global Public Health, now that's enough… Doctors Rice's work examines the best practices in public health leadership and community engagement within the health equity, social justice, and human rights lens, and the impact of mass criminalization and mass incarceration on public health. So Dr. Rice, I'll turn it over to you to get us started.

Dana Rice, DrPH: Thank you so much, I appreciate it. I agree that it's a lot to say. I'm going to share my screen so we can get started. I've been asked to join you are here today to talk a bit about building the workforce capacity to address ACEs.

And I'm hoping you all can see my screen… Let me let me try that one more time… My screen… It looks like… okay, there we go. Sorry about that.

So, I'm here to talk about addressing the C in ACEs and building workforce capacity to address ACEs. And sort of to highlight what we're doing at UNC to think about what the future workforce should be prepared to do. We've gone through quite a bit of change in this last several years, and so I thought that would be important for me to highlight for everyone; sort of where we've been and where we're going. And so I think to start off I wanted to share the experience of some of the key features of the Gillings

MPH core program and then offer an example of a course that I've been teaching at Gillings, of one of the courses that I've been teaching at Gillings, on mass incarceration and public health, to sort of unpack one of the ways that we are integrating understanding ACEs and how the work we can do, can shift from this narrow focus on identifying individual level solutions to more of a systems based approach.

So our school has been… has had a long history of training public health practitioners through a 42 credit competency based program. And in the last several years we've really focused on not only thinking about offering a breadth and depth of public health principles and practice through didactic preparation, but also coupling that with learning experiences and a culminating experience. And in 2016, we took an examination of our guiding principles and began to think about planning what we called a new core, and this would be what we're calling the integrated core experience, which was really motivated by the recognition that we had five discrete foundational courses in our five different departments, and they have been in place for at least three decades, and there was very little interaction between the instructors of those courses. So, for example, there were some foundational courses in epi that mirrored some aspects of foundational courses in health behavior, but rarely did the students have the opportunity to engage in sort of that cross-collaborative learning.

There was also a lot of student feedback that came through that focused around the desire to have more interaction with students in other concentrations. And we felt like we should be able to have more of an integrated approach to be able to better address emerging public health problems of the 21st century.

Simultaneously CEPH, our accrediting body, was scheduled to release new competencies for completing an MPH degree, and so it was really the prime opportunity for us to think deeply about redeveloping our core courses. And so what this resulted in was that we ended up with what we are now… what we've launched in 2018 is what's called the integrated MPH core experience where we have a continuous quality improvement process where students are required to take foundational courses within all of the concentrations, so they're able to sort of share and learn from one another, really gaining diverse perspectives on the foundational learning within public health.

We also launched thirteen MPH concentrations, and what that meant was that learning that was traditionally focused maybe in one of our concentrations, and if we're talking about ACEs that could be in particularly thinking about maternal and child health, this afforded us the opportunity to ensure that students in all concentrations were introduced to theoretical concepts and foundational learning that informed all public health work. And so what that means is that our students in their first year are being exposed to courses that are foundational, theoretically foundational concepts that build on all the rest of their learning within their particular concentrations. And students are asked, through their courses, to draw on this knowledge and how they not only think about framing what public health problems are, but also in how they think about the solutions that they develop.

And so with that, one of the classes, that was developed once I came to Gillings was a class on mass incarceration in public health. I am a self-professed practicademic, and so most of my work has been as a public health practitioner working in local jails. And so bringing this perspective into an academic

space was one that I thought was necessary because it is one of the largest systems that impacts health that I've seen discussed throughout this day, that has had very little influence over public health training in traditional academic settings. So we've talked about mass incarceration or incarceration as an outcome, we are getting to the point where we're understanding its influences on health; but there are very few courses that focus on an understanding of how interaction with this system impacts health outcomes for children and adults all throughout the life course. And so I'd like to sort of draw attention to this one quote, that really captures the essence of how important this system is, and understanding the system, for public health work. And so it's really from David Cloud and others that just speaks to the over reliance on the criminal justice system, or criminal legal system, to respond to all of the problems of poverty and homelessness, mental illness, and that really is resulting in an epidemic of mass incarceration.

So one of the questions that I ask in this course is really to first understand the system before we can think about how it has influenced health across an individual's life course. And when we recognize the scope of the problem, we see that the justice system, or the legal system, has grown by a scale unmatched in any other country in the world; we see that we currently have 2.3 million people locked up in more than 6000 correctional facilities, and I want to just note that this this really captures just a moment in time; this really doesn't represent the full scale of the problem, because what we're seeing here is sort of a day in the life, and not necessarily the churn of the criminal legal system. Because, as we see here, right, we have about 2.3 million people locked up on any day; there are actually over 600,000 people who enter prisons, but there are 10.6 million people who enter jails, right. There are 77 million people in this country with a criminal record, and 113 million adults with an immediate family member that has ever been to jail or prison.

And so it's important for our students and future practitioners to be knowledgeable about the system that touches so many people, that has had such influence over the health outcomes of these people and sort of contributes to ACEs as we understand.

And so the course walks through taking a public health approach to understanding who's incarcerated and why; what their experiences are. And then directly thinking about what the health implications are of that interaction with that system and then what we can and should do about it. And so, some guiding questions that are asked are really around if this system represents a symptom of foundational and social conditions that influence health, and can we, and should we, fix the system without addressing the structural forces that shape population health. And so the course is structured around what I would like to call… thinking about using the prevention model of public health, we start by understanding the system, and so we unpack some of the historical analysis and thinking about what a health oriented system of justice could look like. Which really pushes us to a space of trying to be innovative.

There's a focus on understanding some of the primary prevention, so thinking about reducing the number of people entering the system. The secondary prevention approach is really around improving conditions of confinement and reducing the size of the incarcerated population. And the tertiary prevention is really focusing on the communities experiences of both reentry, as well as their

experiences of the social upheaval that's caused in communities by having family members or themselves with experiences of incarceration.

We also talk a bit about the role of health reform and helping to address many of these issues. But at the foundation of the course are really some primary principles, primarily the social ecological framework the public health critical race praxis, which is really foundational to understanding how the system came to be and what we can do to imagine a different, more health oriented response; but also the life course theory, because as folks have said throughout this this fabulous day, is that really ACEs helps to think about how we respond and the impact the system has on communities at large. I would say that there's been lots of talk about moving to trauma informed care and I really like to think about folks who are talking about more of healing centered engagement, which is less deficit oriented, and I think having conversations in these courses by framing understanding… this system with these theoretical models helps us to really get at what healing centered engagement could look like when you address the impacts of this system. It really allows us to shift our thinking between what happened to you, to sort of what's right with you. How do we move from centering experiences, based on the worst moment in time, and think about adjusting and addressing the systems that have created the environment for us to for the system to have such great impact.

So, several of the course topics that we go through within the foundational within those three or four arcs of the course are listed here and I won't touch on them, but it really gets to unpacking the system and its multiple levels and then thinking about innovative solutions and alternatives to addressing that.

I want to, you know, touch briefly on the fact that, you know, social justice… public health is at its foundation is really thinking about pushing forward social justice principles, human rights principles, and equity principles, and this system has direct implications on addressing and affecting health equity. And so our failure to collectively think about that in academic settings our failure to prepare our students and our next generation of practitioners to think about the largest some of the largest and most significant systems will be our failure to address the challenge that the system has presented on our communities, and specifically on communities of color who have been disproportionately impacted by their relationship to the system.

And so, in closing, what I'll say is, I think that the theoretical frameworks that are presented from thinking about life course theory, taking a public health critical race praxis, focus on that and training our future practitioners in understanding these frameworks, allows us to ask better questions which ultimately helps us land in a place where we think about developing better solutions. It helps to guide the conceptual framework, and it really provides us with a more holistic approach to addressing the problems. I think there's been lots of conversation today where we've talked about the focus of identifying you know, following up on an ACEs scale to measure the amount of ACEs and I really think, while it's important to measure ACEs, I think we have to move beyond a space where we're measuring and counting things to actually taking actionable steps towards addressing systems that aren't creating healthy and well supportive environments, so with that I will stop.

Mighty Fine, MPH, CHES, moderator: Thanks Dr. Rice. I definitely look forward to engaging in some dialogue to talk a little bit more about that shift and how your training practitioners, particularly around that healing centered engagement. I'm looking forward to talking a little bit more about that.

So next up I'd like to welcome Dr. Marleen Wong who's a former partner, excuse me, a founding partner and CEO of the Center for Safer Resilience Schools and Workplaces. Since 2018 she has served in various roles, excuse me, since 2008 serving in the various roles, such as the former Executive Director of the USC Telehealth clinic, the Director of the Fields, Education, and Clinical Advisor for the Cohen Military Clinic. She also previously was the Director of Mental Health Crisis team and Suicide Prevention Program at the Los Angeles Unified school district. You bring a wealth of expertise and perspectives to the conversation today so without further ado I'll turn it over to Dr. Wong.

Marleen Wong, PhD, MSW: Well, good morning Mighty, and to all of you who are on this webinar. I bring you greetings from Hawaii, aloha, and it's still morning here so looking forward to a great day and spending some time with you.

And if we could start my slides please. Thank you so much. I'm going to talk a little bit about schools and childhood trauma, especially in these times of crisis. And my whole in… I guess most of my professional life has been in K 12 schools and I'm really speaking from using that hat as the former Director of Mental Health and Crisis Teams for LA Unified school district, which at the time that I was there, had 750,000 children K 12, and about 120,000 employees. Next slide please.

And what I want to acknowledge is that I'm going to talk about the community-based research partnership that I've been in since 1997, so I guess this slide is one year old because it's now 2021. And if you look here, here are all the partners; we've been together since 1997, speak every week, and it's been a wonderful, wonderful working relationship as you can see, with also the National Child Traumatic Stress Network and, next slide please. So, we define a crisis as something sudden, unexpected, and unanticipated critical incident, and this is how we describe it. How we define it for our over a thousand schools in LA Unified school district, and the reason why I start with this is because we have been in a crisis that is truly unprecedented for the schools that has lasted over a year, and has waxed and waned and had, you know, different phases and also different waves of increased rates of infection and death, and next please.

So the objective of crisis teams, of course, is to reestablish emotional safety, bring children back to the classroom and return the school and the classroom to calm routines so that teachers can teach and children can learn, and next please. Now this is very different, because what existed prior to this, and there's a great deal of funding that's coming in from the Biden administration, to address the negative effects of COVID, the loss, grief, trauma, etc., anxiety, and other mental health disorders that have arisen and been exacerbated by the pandemic, as well as by the racial tensions that have been brought about by the murder of African American men and women across the country, the most current wave of attacks on Asian Americans and Pacific islanders.

But we have to remember that trauma was a public health issue before this. And what our research showed was that children in specific neighborhoods and zip codes with high rates of crime poverty

families of color, gang activity, those were the neighborhoods that were exposed to very high rates of violence and these children were exposed at early ages.

So that, unlike the ACEs study, which was conducted in La Jolla California, and you can look that up, Google La Jolla if you want, it was a very wealthy and upper middle class to upper class community of very high social economic standing. And next, please.

So I believe that child trauma is, this is my opinion, that it's probably the number one public health issue of our time, and it is a civil rights issue of our time because… I want to go on then to our research which shows that it has really a very negative impact early on, on school performance, on academic progress and, on school attendance, and next please.

So our research that has spanned over 20 years has shown that, you know, as the head of the crisis team, I would go out with folks, and I have to tell you that because there are 1000 schools in LA Unified is the city of Los Angeles and, at the time I worked there, 26 other cities that within a year, we could have 2500 to 3000 crisis incidence per year; 2500 to 3000 crisis incidents per year. And I have to say, they were in those same zip codes of crime and poverty. So knowing what we do about PTSD, especially childhood PTSD, the first requirement for that diagnosis is exposure to a situation in which the child was hit, kicked, punched, or threatened with a gun or a knife and might have been a victim of gun or a knife violence. And what we showed is that 11 year olds in South Los Angeles and East Los Angeles had rates of exposure to violence that they could endorse - that they had been hit, kicked, punched, or threatened with a gun or a knife within the last 12 months - 88 to 92% of those 11 year old said yes. That was alarming. So we wanted to know, they've been exposed at this rate, what are the rates, the prevalence of PTSD?

A follow up study showed that in those same zip codes, 27% of those 11-year-olds had PTSD at high levels, and 16% had childhood depression solidly within the clinical level of depression. And what was really tragic for us as we discovered that they had never been identified, they had never been referred to a someone in the school, either a social worker or a school psychologist, a nurse they had not been referred to any community agency.

What we also discovered in our early wave of research was that parents did not realize what their children were experiencing. They were dealing with the symptoms, such as you know, increased anger, hostility, getting into fights unable to sleep at night, sleeping during the day, refusing to go to school, both teachers and parents were identifying this as disciplinary issues. And when the parents were given a couple of sessions of parent education on PTSD, especially those parents that had children with that diagnosis, they realized what it was and 76% of them said there's another person in my family who has the same problem. In 2003, we published in the journal of the American Medical Association the intervention that we created, which is an evidence-based intervention called Cognitive Behavioral Intervention for Trauma in Schools, shortened to C BITS. And on that same day when it was released in JAMA, our effectiveness article was the highlight of the lead LA Times editorial, indicating that in South LA they were higher rates of PTSD among 11-year-olds than all the military personnel returning from the Middle East. And next, please.

So, here it is, I always feel like diagrams are very powerful in and of themselves, that support the words; and this was published in the LA Times and it really reflects the research that we did, our research finding. This is a certain number of miles of in the West San Fernando valley, and those of you who have visited Los Angeles, we know, it's a suburb and it's 30 miles away from South LA. And what you're seeing here, in these monopoly houses that are numbered, are elementary schools located within this grid. And the black dots represent unsolved homicides; not all the homicides but the unsolved homicides. Now, this is the suburb at that particular time, mostly Caucasian, very few African Americans, very low rate of African Americans and other people of color in this particular segment of town.

Now, imagine what South LA must look like. If you think of unsolved homicides, again, those of you who have visited Los Angeles it's south, way south of the freeway; it's east of the harbor freeway, and it represents the area in which there was the highest rate of crime gang violence, deaths, etc. From a public health point of view, I think this map demonstrates where children might be more at risk for adverse childhood experiences, and next slide please.

Here's south LA. This was gathered over an eight-year period and it shows all the unsolved homicides. And this is why we, we have couched it in the language of social justice, and that the protection that these children and families deserve is clearly not the same as in the suburbs; and the rates of death were extremely high; they were 10, 15 times higher than what it was in the previous map, and next slide please.

So this is from a while ago, but I think that these findings, if you could click again they'll come up individually, that over the years… and this has been established very early on, and that is that children who live in these neighborhoods have lower grade point averages, they have decreased rates of high school graduation, they have decreased reading ability, and their suspensions and expulsions in those neighborhoods are off the charts; and, in fact, they were the subject of a civil rights office from the Department of Education.

It was a parent, complaints that were filed against LA Unified and what they discovered back in 2008 and earlier, was that in one given year there were over 47,000 children Black and Latino, and primarily African American, who were suspended and expelled from schools at rates that were far beyond what they represented within the school population, and next, please.

So I want to end there. I think that every community has its areas that, in which some of these populations exist, primarily, and these are the students who are highest risk, if not almost 100% of the children in the Department of Children and Family Services in protective services, possibly in the juvenile justice system but certainly among commercially sexually exploited children, those exposed to community violence, etc., etc. And most recently I think students separated from their parents, due to the mass incarceration of immigrants who crossed over from the border at Mexico. And next, please.

So here's some resources. We certainly now have a large number of interventions that we have created since 1997; the Cognitive Behavioral Intervention for Trauma in Schools is but one, it's called C BITS, and the Support for Students Exposed to Violence, as well as Bounced Back, which is for early elementary to… C BITS is for children 11 and older up through high school. And of course, Psychological First Aid/

Listen Protect Connect Model and Teach. But you can go to these two websites and learn more about these particular interventions, as well as our research.

So I think that is last slide, I thank you so much. I think I finished on time, I hope so, so that we can move on, because I feel like there's so much to discuss. I really want to hear from the people who are still on the webinar and I would love to hear you know, Dr. Rice's thoughts and share some thoughts together, so Mighty I'm turning it over to you.

Mighty Fine, MPH, CHES, moderator: Awesome, thanks so much Dr. Wong. I appreciate that; appreciate you both being here with us and helping us to close out with which, in my estimation, has been a pretty...

...fulfilling day; lots of great information and dialogue throughout. But what I'd like to do is turn over to either view first to see if you have any questions for one another, based on way you each have presented, and then I'll go into some questions from the audience so.

Dr. Rice, do you have any questions for Dr. Wong or vice versa.?

Well, can I just jump in first, because I was listening to Dr. Rice and juvenile justice, and you know the intersection between juvenile justice and education is so important. We still have children from juvenile justice that are in schools and we just need to learn more. So, one question that was raised in my mind is in education, there is sort of a research that has shown that children who haven't learned to read by third grade are just at high risk for never learning how to read. Like it becomes increasingly difficult and, if you look at just the statistics, almost miraculous if anyone you know beyond third grade learns to read on their own, or catches up. Is there an equivalent age for risk in criminal juvenile justice interactions and the end the prison pipeline?

Thanks for asking that question, I would say that I'm not sure that I could identify a specific age. What I can say is that I think what we know is that young people who are not able to read by the third grade are not experiencing their lives in a silo right, so they have other lived experience that put them at risk for coming into greater contact with the criminal legal system. And so those children typically come from certain environments, certain types of environments, they typically tend to come, or fit within, certain demographic categories that experience or have experiences of greater exposure to poverty, greater exposure to lack of transportation, so all of those things that we define as the social determinants of health that impact health outcomes throughout the life course, when we see a deficit we acknowledge that there's increased risk for interaction with a criminal legal system. And the earlier someone interacts with that system, the more deleterious it becomes throughout their entire life, right, and so it's much harder for them to remove themselves from that system and from the trauma caused by interacting with that system.

And so it creates sort of a vicious cycle because the cycle continues sort of intergenerationally, right, because those children are raised in environments where communities are exposed to greater interactions to systems that are not there to provide health and restoration. And so that's sort of the issue that we have to grapple with is that these children don't exist in sort of in a vacuum.

Thanks for that question.

Absolutely. Dr. Wong I have a question for you, it's come from based on your experience and your involvement with schools, someone wants to know if they're outside of that space, what can they still do within a public health realm to support students and their families if they don't have the opportunity to interact with them within the school setting; what are some other spaces they can engage in?

Well there's certainly many, many more.

Important institutions, institutions of faith for example. And for me, it underscores the importance of those churches, temples, synagogues that do a great deal of outreach because that's what's needed here, and they are certainly important partners. I think of other supervised sort of family children activities and organizations , boys and girls clubs, these are also community based places where the protective factors can come into play. And I really go back to the resilience literature about the importance of having early on, and even through our whole lifetime one person outside the family, and it could be different people as we grow and develop, who is on our side, who understands what's going on with us, who's that champion. And those of us who work professionally, that's true for all of us as well. I mean there's no group of folks who can't benefit from someone who is on your side whenever you are stuck in a place in your life. And so everyone on this webinar is a protective factor, and the question is where can you I love the question because that is it, where can you as a protective factor really weigh in and do great things.

I like that, really helping us to think, as we've discussed before, thinking about those spaces that are not traditionally services for children or connected to ACEs, or they may not be prescribed in that way, but we certainly know that there are opportunities to support outside of school outside of the home, etc., so I like that thinking to put it back on us as practitioners and those in these spaces to think about how we be those buffers and supports outside of those traditional.

And just one other thing, I feel that we're under identifying parents and other family members. I mean sometimes it happens, naturally, and my grandmother was a protective factor for me.

But maybe we educated them a bit more to say if you live in these kinds of neighborhoods you play such an important role, here’s the ways that you can do that. You know, I feel like public health education I think the public health approaches, including mental health, excuse me education is a place that they can expand in the ways that they currently interact.

Absolutely. So someone linking to that, Dr. Rice my question for you as a pracademic and maybe speaking to the pracademics on the webinar today, how do we make those shifts? Because words do matter, and I really liked how you lifted up this idea of thinking about how healing centered engagement and helping us to rethink about how we maybe engage in these spaces, but how we classify it and the intention behind it, so if you could talk a little bit about the shift that you've helped to orchestrate within your institution of moving us to this more healing centered engagement and approach to address some of these traumas because I think that speaks to the workforce and some of the shifts that they can make.

No that's a great question. I think one of the things that I try to do in my classroom and just from years of working in such a challenging environment is primarily to start by thinking about how we talk about each other and how we talk about human beings, right. So, part of the first class that I have is really about reframing how we define each other and ensuring that we use human centered language, because the importance language is so important, when we think about how it informs our policies and our practices. So if we use dehumanizing terms, you know as it relates to the subject that I'm talking about, if we use terms like inmate or convict or detainee we are dehumanizing the individual and we are categorizing them based on their experience, right, based on something that they've done.

Rather than reframing the conversation around a person who is incarcerated, right. And that that translates to other areas when we think about talking about people who have experienced homelessness versus a homeless person, right.

And so we really need to start thinking about shifting our language, because, again, as I said, that really informs the decisions that we make, it informs how we frame problems, it informs how we think about solutions. And so I think from that it's important we think about what our solutions are, right. And so when we start talking about I think trauma informed care and trauma informed practices

..have…those are not new concepts, right, but they're coming from this work of building resilience in communities to be able to respond to all of the challenges that they've experienced across their lifetime. What it does is it still centers the solutions from that deficit oriented framing. And so people need to understand that people respond to feeling like a whole person, right. You are more than just the worst thing that's ever happened to you.

And if you reframe that, you allow individuals to redefine themselves and redefine their role in creating health and wellbeing for themselves, for each other, for communities.

And so I think as leaders in public health, we really have to take that orientation into the work, into the spaces, into the communities that we serve if we want to see sort of long term structural change.

Absolutely, and I like the idea, which you are alluding to is having that own pulse check on ourselves, because as people are populating in the chat, words really matter language really matters. And it even resonates differently, like if you say convict there's certainly a whole list of attributes that someone will assign but if you say someone who was incarcerated just resonates differently so I agree, I think, words are critically important. Dr. Wong, a question for you regarding some of the work that you spoke about with the interventions that you mentioned, and someone wanted to know if you can just give us one example of a component of that intervention and how it was received.

Well it's based in cognitive behavioral therapy, which is, I mean I'm not saying that there aren't other forms of therapies that are effective, but they have been the ones that most of researchers have used to determine the effectiveness, and there are 10 parts of that. I mean it's so let me just go over cognitive behavioral, the triangle that it's based on the cognitive triangle, which is what you think...

...maybe this relates with Dr. Rice is saying; what someone calls you affects your behavior and you're feeling of yourself.

And I was really thinking about this and you were saying I almost feel like there needs to be public health education of law enforcement because I think about these young kids that get into trouble. You know, I mean, their brains aren't developed; if we look at his brain research, they make dumb decisions, they do things that are just totally against their their interests; they get into groups of kids and they, you know maybe individually they went and do it, but together they do these things and what happens is that they are arrested and they start their quote unquote criminal history. Why would we call kids criminals. And I feel like there's got to be something that intervenes where there's a far more diversion.

…to you need social skills, you know, you need let's talk about how you get in with …what do you need, how do you get that, how do you get your needs met. What about job training, what about just conflict mediation. What about you know, all these other things that should be the intervention, rather than where they automatically go into the criminal justice system. And to me they just can't be that many not that many bad kids in this world, and yet we have this inordinate number of people in prisons who have these histories because nobody, no other system intervened, no other institution. So I feel like language counts

yeah

Can I jump in here because I just so amazing you've touched on some really brilliant points. I think I would it would be remiss if we didn't highlight that we actually do practice different policies in different communities. And so this is where we have to acknowledge where the role of institutional and systemic racism have played a role in the creation of the criminal legal system in this country.

And then think about ways that we can use the skills of public health, like bringing evidence based practice into identifying what some of those alternative approaches are that you've just highlighted, because we actually do practice those things we just don't practice those things in very specific communities. And so I think we have to ask ourselves not only why that is, but what's the solution to doing that; it's not necessarily developing more programs for you know, addressing one child's one child's, you know, poor decisions, right. It's really about coupling that individual level intervention with system wide approaches that are rooted in evidence. So, you know, your example around we know that ensuring that kids stay in school longer is protective to them, you know, not becoming involved and entrenched in the in the legal system. We know that when children someone mentioned earlier around having access to food and access to some of those really primary things helps keep them healthy and safe right, and so, if we start practicing those things and requiring that more people understand that connection, that we get out of our silos we stop talking to one another and we start talking to everyone else and bring them into the conversation, they can really understand sort of the serious implications that follow from our policy choices that have been developed to differentially impact different communities. Because we can do it differently, we do we currently do it differently so.

Absolutely, yeah. We have a minute left, and I could talk to you both for a large amount of time, so Dr. Rice this is kind of like a combo question for you so first I'll say I would love for you all again just to give

folks who are listening one thought, I was going to say senior and thought, but a thought of how we can work a little bit differently as we're thinking about developing, building the workforce. So that's my question, but if there's something else you want to impart to folks please do that.

But this one question, I think I'd be remiss if oh I'm old we have 10 minutes, I thought we were done at five so forget what I just said.

And so, this question is for you, Dr. Rice; if thinking about reimagining what shared safety looks like, recognizing that what looks safe in my community may look safe in another Community, I may fear that, right.

So thinking about that and thinking about how we currently police in America and, what they're posing here is if we redirected those funds and put them in some more social services and social agencies, how do you think that would impact mass incarceration and then the related deleterious health incomes, excuse me health outcomes from folks being warehoused in that manner.

So is this a question about the defund the police….

Yeah, very nice that was the way to get there.

yeah

I'm happy to have that conversation of which, I think it should be a conversation because I think we have gotten to a place where we ended up with a very

sort of narrow approach to a conversation that is really complex about a system that is really complex. And that's part of the reason that I orient sort of how I talk about the system I think it's helpful to sort of break down the system to understand all of the ways in which we could implement different approaches. And so I think we also have to take into consideration that we actually have always excuse me, in public health have always operated like we're always operating in a system where we have limited resources, so we always have to make those decisions around what we are putting our resources towards and what we are by default neglecting, because we have to make those decisions. We hope that those decisions are based on evidence.

Coming from the scientific discipline, we hope that those decisions are based on the evidence around what makes communities safe, what makes communities healthy, what makes communities well; and so at the local level, I would hope that local public health leaders are in conversation with city councilmen and county commissioners and whoever's leading and responsible for delegating resources to one, understand the importance of the fact that health is in all policies, right. And so we have if we make decisions based on health, it's in all policies we would start to allocate our resources towards our values and to ensure that we create those communities that are healthy and well.

In and of itself, that would initially have us think differently about where we want to put most of our resources and I do think that it's important to engage in a conversation with putting our resources,

where our values lie , right. That's what a budget is essentially when you're thinking about work at the local level right, and so I think it's important to engage in that conversation.

Also because we're hoping that the needs and desires of the local community will be uplifted in that practice, right.

So, for acting in an approach that allows us to truly engage with community, with community seen as partners, right because we don't want to do public health on people right, we want to do with and in service to, so if that's part of the conversation, then we will be creative about how we think about resourcing our policing, how we think about resourcing our public health funding, how we think about resourcing all of those things, transportation the food economy, education, and then make different decisions. So I think it's a worthwhile conversation to engage in that I think the tagline has gotten politicized in a way that's unproductive to creating really systemic change that we want to see.

So I hope that gives you that

yeah, thanks. I think that gets to that and I agree; I feel like back to your earlier point, words matter right.

So let's talk about what we're actually talking about in the appropriate context, totally agree. Dr. Wong, we have a question for you from a parent actually thinking about if you're not a teacher, if you're not a practitioner, what questions or how can parents and other allies hold school boards accountable to ensure that the environment is conducive to the mental wellbeing of the students that they serve, any thoughts there?

Yeah I do have thoughts and it really leads me into a discussion of culture, because I think the culture of the school or district is really important, and if they're looking at children's behavior as either being bad or good and it's either that they're entirely, you know, they're the good students and the bad students get expelled and suspended. And that is part of the, you know the labels that are put on kids, and so early in their development…we need to hold a school boards accountable for how they deal with children who don't follow the rules. And to look at it through the lens of a trauma informed lens. If someone comes to school during the day let's say and starts a fight. Well parents might need to know, maybe that child got in a fight on the way from home to school and got knocked down or, God, as you know a backpack stolen. I mean these are very common kinds of things and I think that a child is on the verge of suspension, there needs to be a group of folks who look at this, practitioners who say tell us what happened, you know .And to really encourage restorative justice programs, to really bolster counseling programs because again it's about labels . Is this a good kid or is this a bad kid. Years ago, oh my goodness, there's so I have two kids. There are so many different shades between good and bad and on any given day, you know, you could travel that path. But I want to go back also to link it to juvenile justice to the criminal justice and that, within the police, there are cultural groups. I mean I'm going to say in the LA Times there was an article that said there's a gang within the LA Sheriffs program. So I'm not I don't know anything about this myself, but it was in the LA Times that they had tattoos, that they had drinking practices that they got points for knocking heads, cracking heads open, it was a gang within the sheriff's department.

And, you know, what is the culture within law enforcement. If it's command and control, guess what every kid who does something that crosses the line if your object is to command and control that is not looking at it from a developmental you know ,viewpoint. And rather than talk about defunding the police, it's like why would the police be the only have only law enforcement folks have a gun and tasers when they confront the most pernicious social problems of our time.

You know, that's not a law enforcement issue. That's a human being issue that, you know, our own vulnerabilities get us into trouble all the time. So you know, and I thought of this more from a cultural perspective, like please have to look at their culture and I'm sure it varies for every department across this country.

But if the focus is on command and control and showing that you're in charge, and you know, breaking heads, that's just a continuation of the prison pipeline to me.

Yeah so, kind of picking up on that and we are actually in reality coming closer to the end unlike what I said before, but thinking about that, how do we keep building this momentum, because we know that there's a shift happening and more that we want to happen in the space, as we talked about before, as we renamed, retool and just reimagine, so to speak, how we engage in this work, recognizing that there are some folks who are engaged in this work, there's still some unlearning and learning that needs to happen.

When we talk about the structural factors that impact the health and wellbeing of our children. So thinking about that, how do we continue to engage and move this work forward while holding ourselves accountable as well, to learn again and unlearn some of the things that we thought were most effective but we're realizing that they're not beneficial to a child's health or wellbeing.

I just going to say one thing before I turn it over to Dr. Rice, and that is it's time limited we're in a very critical period now. I'm considered as a subject matter expert in crises and crisis intervention and there's a window open because so many terrible things have happened, we need to really use this momentum to keep talking about it, to really push on change because that window will close, and it doesn't mean that we won't be able to do anything, but it's going to take a lot more effort and energy in order to keep it open and keep that conversation going, so that's just kind of my perspective on this. I feel like so many crises are we're just coming out of one now so all these great ideas that you brought forth in your conference, this is the time to make change.

Thank you. Dr. Rice, do you want to closes us out with your thoughts.

Sure, I mean, I think, from my perspective, being in a school of public health, that that thinks about these issues and is focused on training, the next generation of practitioners I think it's going to be critically important for us to engage our students in understanding the systems that have such great impact on health outcomes. And traditionally we have not looked at the system, the criminal legal system, we've not looked at even we've not done the deep dive that we need to do to really think about the work that we do as interdisciplinary, right. Andso really engaging our students in understanding what it means to be a true partner, which means that we bring our expertise to other fields and we

share the health outcomes that follow from the decisions made by those systems, and we ensure that our students understand the role that policy change can play in addressing these systemic issues, and that we have to couple that with what we've traditionally done around thinking about sort of the individual behavioral level interventions that we've traditionally focused on. And so I think when we get to a place where we get really good at understanding all of those individual level interventions and couple that with best practices from community best practices and partner with community to integrate and develop those systems wide solutions, we will start to see the true change that we need in creating healthy and well communities.

Awesome thanks to you both for the conversation today. Thanks to everyone at home listening. We have a special treat that we want to share with everyone.

As we've been talking throughout the day we've had an artist on hand, who has been drawing to capture the certain aspects and different sentiments of the conversation today.

So if that can be shared as we close, it would be awesome for folks to get a chance to see a visual depiction of what was discussed today.

We will be sharing this with all of the participants. For your reference it will be available, excuse me, on our web page, along with the recording of the presentation within about two weeks and for those of you who are seeking continuing education credits, please be sure to be on the lookout for our email that will provide you with instructions on how to claim your credits.

It was pretty obvious to me today that health equity was woven throughout every aspect of the conversation today, so my charge to everyone is to think about the work with a critical lens, you know, with conviction and intention and ensure that you recognize that social justice is a major component of public health, and we should be thinking about that in every step of the work that we do.

Again, doing an audit on ourselves, our organizations, and making sure that we really are doing what we need to be doing so that our communities have the opportunity, and we provide the support to make sure those opportunities are in place so that we are living life to the fullest potential, not just by namesake, but actually doing the word to make it happen.

So again, thanks to everyone, and this concludes our ACEs roundtable for the day. Bye bye.