Subcommittee on Human Resources, Committee on Ways and Means: Hearing on The Opioid Crisis: Implementation of the Family First Prevention Services Act (FFPSA)

Statement for the Record of Matthew E. Melmed, Executive Director, ZERO TO THREE

ZERO TO THREE
Early connections last a lifetime

Thank you, Mr. Chairman, Ranking Member Davis, and Members of the Subcommittee, for holding this hearing looking at the intersection of the great challenges many families face, particularly from substance abuse, and one of the most promising opportunities for changing their lives. The Family First Prevention Services Act (FFPSA) represents a chance to achieve something we strive for in our own work: transforming the child welfare system into a child wellbeing system. At ZERO TO THREE, we focus on families with infants and toddlers, the age group most likely to experience maltreatment and placement in foster care. My remarks are based on our experience in developing and implementing the Safe Babies Court Team™ (SBCT) approach, which works in courts and communities from Alaska to Florida to use the science of early childhood development and the impact of trauma to transform how they work with infants, toddlers, and families in the child welfare system.

Based on this experience, as you look at the implementation of FFPSA and the prevalence of substance abuse this new funding authority will help address*, my principal recommendation is this: ensure that comprehensive approaches encompassing the three service areas identified in FFPSA are included in evidence-based programs approved for funding.* Substance abuse is only one aspect in a range of complex family needs. All these needs must be considered in a comprehensive way for any effort to be successful, whether its preventing maltreatment or foster care placement, reunifying families, or reaching some other form of permanency. Transforming child welfare is not an easy task. It means more than simply increasing the availability of a few services. It means a cultural shift in working with families and requires a comprehensive approach with an organizing principle grounded in science that guides how each family is considered individually.

Founded more than 40 years ago, ZERO TO THREE is a national nonprofit organization whose mission is to ensure that all babies and toddlers have a strong start in life. We translate the science of early childhood development into useful knowledge and strategies for parents, practitioners, and policymakers. We work to ensure that babies and toddlers benefit from the family and community connections critical to their wellbeing and healthy development. Nowhere are these connections that are so essential to early brain development more important than for babies in the child welfare system. Over the last decade, we have worked around the country to bring the science of early brain development to local child welfare agencies, courts and the communities that surround them.

The Safe Babies Court Team (SBCT) approach is an evidence-based practice that uses this science to drive change at both the systems and practice levels for infants, toddlers, and families in the child welfare system. From the judge who leads the team, to every caseworker, attorney, and service provider, the teams transform the culture of working with families, the community systems that must come together to meet families' needs, and the lives of the children and families themselves.

What does this mean in real terms? Culture is changed as all professionals as well as the families themselves learn to make decisions within a framework of early childhood development and the impacts of trauma. A central tenet is valuing birth parents as individuals and in their important relationships with their children. Systems are changed as stakeholders come together to identify needed services, and particularly, to select appropriate evidence-based practices and make them more widely available and integrated within the community. At the family level, it means their needs are approached in a holistic way, starting with assessments of children *and* parents, and ensuring they receive evidence-based mental health, substance

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abuse treatment, and parenting services as part of an array of supports and services that includes support to keep the child's early development on track. Although both parents and babies carry a heavy trauma burden as measured by Adverse Childhood Experiences (ACEs), SBCT's two-generation approach is showing great success in keeping families together. Auguring well for the feasibility of working with many families within the 12-month FFPSA limit, 84 percent of closed SBCT cases reach permanency within a year.[i] SBCT has reduced further maltreatment to levels surpassing what is acceptable under national standards: 0.7 percent of SBCT cases experience a recurrence of maltreatment compared with the national standard of 9.1 percent.[ii]

As the Subcommittee works with the Administration to implement FFPSA, I urge you to ensure that comprehensive approaches such as SBCT, which provide a science-based framework for changing child welfare policy and practice as well as evidence-based interventions, are included in the Clearinghouse in the programs and practices approved for states as they develop their plans. Funding for services such as substance abuse and mental health treatment as well as parenting support will greatly enhance the ability to work with families, many of whom are currently offered very few services. But using this funding authority effectively means having a coherent overall approach that ensures the structure is in place for assessing and addressing individual families' needs; providing guidance to communities that need assistance in selecting which evidence-based interventions to use; and avoiding situations where services are prescribed simply because funding is available, or where a less intensive service is provided because the overall framework is not in place to determine that a more intensive intervention is needed. FFPSA requires states to address some of these steps, such as assessing needs and developing case plans. But it would help to enable states and communities to easily access approaches that can provide those steps as part of a comprehensive and integrated whole.

Several other recommendations flow from SBCT and our experience in identifying evidence-based practices for our Court Teams and communities to draw on.[iii] First, while the Department of Health and Human Services (HHS) is contemplating a fairly short list of pre-approved interventions, addressing the needs of individual families calls for a broader range of interventions as well as the flexibility to add new ones as warranted by family needs, as I discuss later. The fact that states will be able to define their population "at imminent risk" also argues for a longer list to accommodate different levels of family complexity. The Clearinghouse also needs to ensure that interventions appropriate for different age groups and populations are included on the approved list, so that states do not exclude groups based on a lack of approved interventions. In addition, we encourage HHS in concert with the Clearinghouse, once established, to develop a research agenda to fill gaps in evidence-based interventions for particular groups and work with states to implement that agenda.

Infants and Toddlers are Particularly Vulnerable to Impacts of Maltreatment

We emphasize the inclusion of services for distinct age groups, because science tells us that infants and toddlers are the age group most vulnerable to maltreatment, and their rapid development requires responses tailored to their unique needs. They make up the largest age group entering foster care, accounting for a third of all placements. Infants (children under one year of age) alone now account for 18 percent of all foster care entries.[iv] Some part of this increase may be due to the explosion of opioid use in some areas of the country, although drugs such as meth are found in other areas, and alcohol—a known teratogen with well-documented detrimental impacts on development—is ever-present. From news reports, we know that some communities are overwhelmed by parental opioid use, and their reflexive response is to remove children from their parents' care. Such a separation is not necessarily the best way to help either young children or families. Separation from parents can be wrenching for babies who cannot understand what is happening to them. It may also be detrimental to the parents' ability to get their lives back on track. However, communities often lack capacity for an alternative response.

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These encounters with the child welfare system occur during the most rapid period of human brain development. Babies' brains create more than one million new neural connections a second, laying the foundation for all learning that life will bring them. The architecture of the developing brain is shaped by a baby's experiences, whether positive or negative. These experiences occur in the context of close relationships with trusted adults, without which babies cannot thrive. So, it is not surprising that maltreatment can harm the development of vulnerable young brains or that building strong, trusting relationships may be a particular need if the cycle of stress, trauma, and unhealthy behaviors is to be broken. More than half of children under age two who come to the attention of the child welfare system are at high risk for neurological or development impairment.[v] Studies have found extremely high rates of attachment disturbances.[vi] [vii] Other longer-term effects include poor self-esteem and behavior control, deficits in language development and school success, and later in life, delinquency, substance abuse, and depression.[viii]

ZERO TO THREE's child welfare work began out of concern that infants and toddlers entering the child welfare system rarely receive care based on their developmental needs. Child welfare practices, such as multiple foster care placements, a lack of parental contact, and little attention to supporting early development can compound effects of maltreatment.[ix] A survey of state child welfare policies found that few states had policies or practices differentiated to address the unique needs and rapid development of infants and toddlers.[x] Moreover, states have a long way to go in understanding and meeting parents' needs to help them address their own issues and become successful parents to their infants and toddlers. Fewer than half of states had policies requiring that birth parents be offered services and supports to overcome their own past trauma, as well as mental health, substance abuse, and domestic violence issues.[xi] So, the child welfare system seems particularly ill-equipped to respond supportively to either the child's development or the parent's substance abuse and other problems.

Community Responses Must Address Families' Complex Trauma Histories

Our work around the country has built a picture of the complex needs of families with very young children who enter the child welfare system. Substance abuse is indeed prevalent in the families we serve—90 percent have some substance abuse involvement, and it is a reason for removal in 69 percent of foster care placements.[xii] However, I want to underscore that **the central issue for these families is *trauma*.** And I speak not only of the trauma that abuse or neglect, exposure to substance abuse, etc., brings to the children, but of the wrenching experiences many of their parents have carried with them since childhood. It is this trauma burden that is associated with their child's ultimate permanency outcome—remaining together as a birth family, placement with relatives, or adoption.[xiii] Congress was right to insist that the *interventions* funded under FFPSA be trauma-informed. I would go further and suggest that *the whole system of child welfare and court professionals, as well as other stakeholders*, must understand both the basics of early childhood development, the effects of trauma on that development, and the central role of recognizing and healing parents' past trauma in keeping families together or guiding them toward another outcome for the child.

To measure the trauma burden of SBCT birth parents, we looked at the number of Adverse Childhood Experiences (ACE)[xiv] in their backgrounds. Out of the ten experiences identified in the original ACE study, a score of four is the tipping point at which the likelihood of poor adult outcomes, such as heart disease, cancer, diabetes, mental health problems, or substance abuse, dramatically increase and continue to climb with each additional ACE. *With that scale in mind, a staggering 63 percent of parents in our study had four or more ACEs, and one in six parents had from eight to all ten ACEs.*[xv] Thus, it is not astonishing that so many parents had substance use problems. It would have been more astounding if they did not. The most common type of ACEs experienced by these parents in their own pasts were parental separation or divorce (80%), household substance abuse (64%), physical abuse (52%), and emotional neglect (51%).

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Children who have not yet reached their third birthday may seem too young to have accumulated a trauma history, but that is not the case for infants and toddlers with whom the Court Teams work. *59 percent had an ACE score of 4 or higher.* Even at a very young age, the majority of babies had already reached the "tipping point" at which the odds of poor health and behavioral outcomes in adulthood had vastly increased. In addition to maltreatment, the most common adverse experiences fell under the "Household Dysfunction" category: parental separation or divorce (89%), household substance abuse (79%), and household mental illness (64%). 47 percent had a household member who was or had been incarcerated.

Safe Babies Court Teams: How a Comprehensive Approach Changes Communities and Changes Lives

Much as Congress enacted FFPSA to change the conditions that lead to foster care placement, the Safe Babies Court Team movement began in 2005 in response to family court judges' frustration with the cycle of abuse and neglect that played out in their court rooms and their determination to find a way to break it. ZERO TO THREE worked with a core group of judges and communities to bring the science of early childhood development to bear on both decision-making and interventions with families, growing an approach that could be tailored to community needs and meet communities where they are, whether resource-rich or lacking in evidence-based approaches and other services. I want to emphasize that SBCT is not a "specialty court," but rather an approach that can be applied in any court and community serving children and families in the child welfare system. SBCT is now being implemented or developed in more than 70 sites around the country. The approach has garnered widespread attention and support from the judges and communities that have adopted it. Interest in bringing the approach to more locations has grown significantly over the past four years. For example, Tennessee passed legislation establishing 10 Court Teams. The State of Maryland recently began a Court Team with IV-E waiver funding. Court Teams in Florida's statewide program have expanded from 5 original teams supported by the ZERO TO THREE Court Teams staff to 21 sites.

Each SBCT is led by a judge and/or a child welfare agency leader who recognizes both the impact of trauma on families and the importance of a child's first three years in avoiding the next generation of maltreatment. A key figure in program success is the community coordinator, who works with the judge to coordinate services and resources for the babies and families overseen by the court. Along with the families, the team is composed of key community stakeholders, all committed to restructuring the way the community responds to the needs of the babies and families. In addition to courts, attorneys, and child welfare professionals, stakeholders include providers of health care/Medicaid, mental health treatment, early care and education (particularly Early Head Start), early intervention, substance abuse treatment, domestic violence treatment, parenting education, housing and energy assistance, and more. SBCT originally focused on promoting stability, permanency and positive child development for infants and toddlers in foster care, but increasingly its powerful structure is being used for addressing needs as soon as children come to the attention of the child welfare system and helping support them in their own homes. We firmly believe that this approach, built on community collaboration among service providers outside of the child welfare system, has profound implications for supporting families before they reach that system.[xvi]

FFPSA Requirements: Administrative processes

Built into the SBCT approach are elements required under FFPSA for case management and state planning that include (1) case plans detailing a prevention plan with services to be provided and a description of how the state will monitor the children: *SBCT provides detailed case plans coupled with monthly court and staff oversight to ensure progress*; (2) assessments of parents' and children's needs, described below; (3) plans to implement and monitor services selected and use information from monitoring to refine and improve practices: *SBCT uses a data collection system across sites that allows all levels of management to monitor in*

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real time and promotes Continuous Quality Improvement at the caseworker, site, and national program levels while also providing multisite evaluation data; (4) consultation with other agencies and coordination of services: *SBCT includes all service providers in the team, so consultation occurs frequently and all services are coordinated*; and (5) steps to support a child welfare workforce to deliver trauma-informed and evidence-based services: *SBCT provide training and support for professionals in the child welfare agency, court, and community stakeholders in early childhood development and trauma impacts*. The holistic SBCT approach means all services regardless of funding source are automatically coordinated, as FFPSA requires.

While I discuss some of the systems-level impacts below, I want to point out how the court team functions for *families*. In traditional child welfare practice, services are usually provided to families in isolation of each other in a kind of hub-and-spoke configuration where the caseworker is the hub and the service providers are the spokes, connected only to the hub, not each other. Now, think of the court team as the wheel rim, where everyone touching the family meets frequently, through monthly court hearings, family team meetings, stakeholder meetings, as well as regular e-mails and phone calls. One team member noted, "One thing I always notice—all the providers, our team, know each other really well and know our cases. It almost creates less work because we are always communicating with each other."[xvii]

FFPSA Emphasis: Addressing Trauma within SBCT

FFPSA requires services and programs to be "provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma." SBCT is built around an understanding of trauma infused within the entire team and approach. Parents receive comprehensive medical and mental health assessments, including evaluation for their own childhood trauma, prenatal alcohol exposure, substance abuse, and domestic violence. Sites are required to have a Continuum of Behavioral Services, enabling the development of service plans that include supporting the parent-child relationship and increasing a parent's ability to provide emotional support, create structure, set limits, and help the child learn. Based on the assessment, clinicians provide recommendations to the team and the court on the types of evidence-based interventions needed by the family, including visit coaching, psychoeducational parent education, and Child-Parent Psychotherapy (CPP). In CPP, one of the few dyadic mental health interventions validated for infants and toddlers with their caregivers, the therapist helps the parent understand how their own early experiences may affect how they feel about and interact with their child.[xviii]

Parents also need mental health and substance abuse treatment services to help them address their underlying mental or emotional concerns, which the SBCT works effectively to obtain. Almost three quarters of parents who are screened and referred for substance abuse treatment begin services within a week of referral. (See Figure 1.)

Figure 1: SBCT Parents Experience Prompt Screening and Receipt

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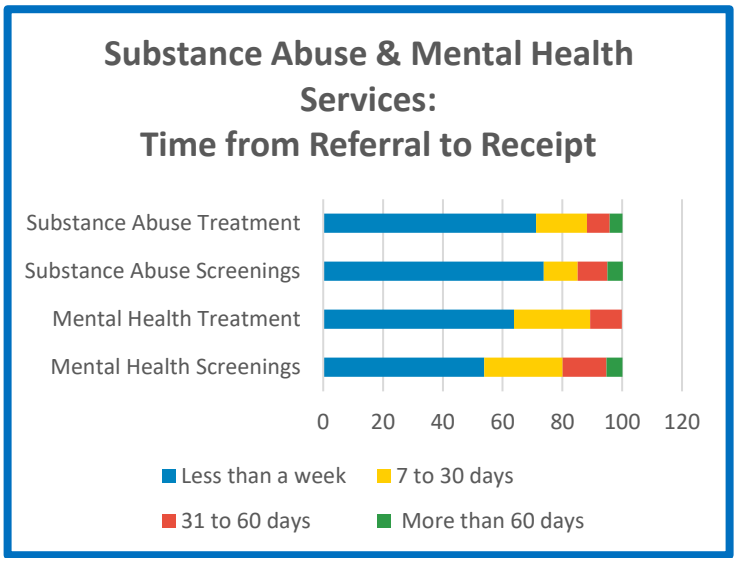
Of Substance Abuse and Mental Health Services[xix]



FFPSA Requirement, Coordination with other services: SBCT Assesses and Addresses Children's Needs
For young children who, because of experiences of adversity in their homes and communities, have dysregulated behaviors and emotions, we may think that these experiences have set these children on a negative lifelong path. Yet, research shows us that these experiences do not have to dictate a child's future; when negative early experiences occur concurrently with protective factors, there is an opportunity to promote resilience.[xx] Though involvement in the SBCT will not undo ACE experiences for young children, the SBCT approach provides concrete strategies that support resilience in young children and their families. An infant-Toddler court team uses their unique knowledge of their community to find local solutions and interventions that meet the developmental needs of infants and toddlers in foster care. While infant-early childhood mental health services are a key need for the children, so are services to support overall development. *As states and communities implement FFPSA, it is critical that their approaches to children's and families' needs begin with, but are not limited by, the services that can be funded through FFPSA.*

Based on the Ages & Stages Questionnaires (ASQ-3) completed with parents/caregivers of children aged 1 month to 5.5 years, about 70% of children have one or more developmental areas that need to be monitored or were below normal development. SBCT guidelines include ensuring that all children are screened within the first 3 months of becoming involved with the court team. Developmental screening was identified as a service need among more than 95% of children. After screening, early intervention (including occupational therapy, physical therapy, speech therapy, and early intervention education services) was identified among needed services for more than 40 percent of children. Other services needed by children included CPP (51%), dental care (25%), and Early Head Start (12%).[xxi]

SBCT is effective in obtaining needed services for these developmentally vulnerable babies. 97 percent of children identified for services such as developmental screening and early intervention receive them, while 94 percent of children needing Child Parent Psychotherapy (evidence-based mental health therapy for parents and children together) receive services—limited mostly by the lack of infant-early childhood mental health clinicians.[xxii] (See Figure 2.)

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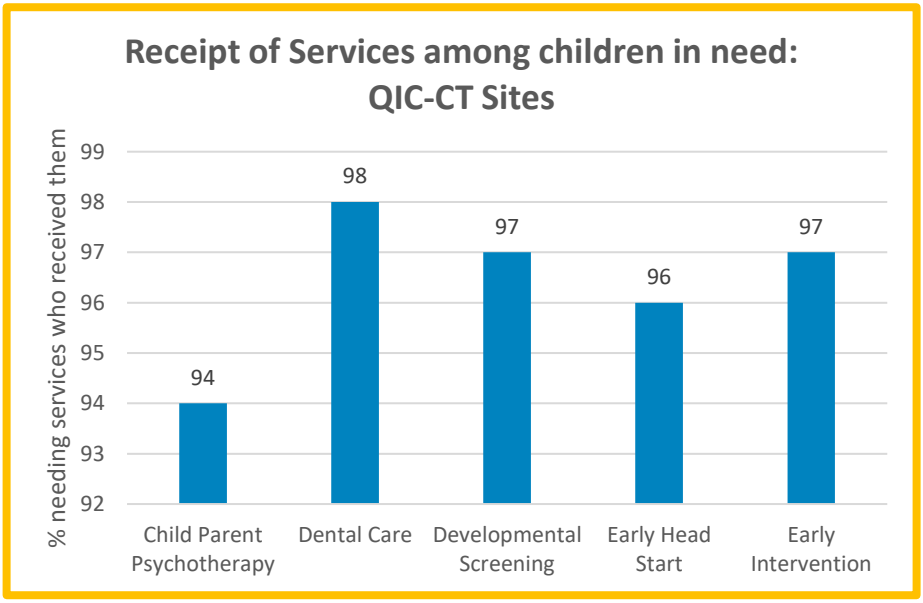
Figure 2: Services Support SBCT Children's Development[xxiii]



Systems Change: Ensuring Communities are Trauma-Informed and Focused on Evidence-Based Practice
A major reason for SBCT's effectiveness in obtaining needed services is the team's role at the community systems level. The team of large and diverse stakeholder groups meet monthly to discuss various topics at hand: early childhood court policies and procedures, case and system issues, and community resources. Some sites have workgroups to target specific issues. Stakeholders report being more informed on the needs of infants and toddlers; attachment and infant mental health; the impact of child maltreatment, trauma, and foster care placements; parents' individual trauma; and historical trauma influencing the community.

Two outcomes help promote FFPSA goals on trauma and evidence: (1) The increased focus on trauma has led the court teams to respond to the needs of birth parents in the context of traumatic stressors and their past histories of trauma; and (2) the court teams have worked to improve the availability of evidence-based practices (EBP) within the community. Judges are part of this focus on implementing EBPs, often inquiring about progress through such interventions during hearings. One example is their work to make Child-Parent Psychotherapy (CPP), the EBP of choice for many teams, more widely available. Several sites found the need for additional EBP providers, including the training of clinicians certified to provide CPP, was necessary to implement and sustain EBPs. The SBCT national staff offered certified training to expand capacity. Still, the lack of certified CPP clinicians continues to be a barrier to use of this practice that is a particularly effective intervention for babies and parents. As FFPSA is implemented, we urge consideration of allowing funds to be used to expand the presence of EBPs as with training clinical providers, rather than only paying for what is readily available. The ability of FFPSA funds to pay for mental health and other services will help communities sustain evidence-based practices, but this may depend on how reimbursement is structured. Some states do not cover dyadic treatment for families under Medicaid, and in many states, the reimbursement rate is so low that the Court Team cannot sustain the evidence-based practice.

Regarding the total number of evidence-based practices included in the FFPSA Clearinghouse, we recommend a strategy that gives states and communities a wide enough choice to ensure they can provide the most appropriate services for the families they serve. These choices will not always be obvious as a state is writing its state plan, but may become apparent as actual practice proceeds. For example, ZERO TO THREE identified

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several evidence-based parenting skills curricula recommended for sites to use. However, when the sites found that many parents had intellectual disabilities hampering their ability to absorb parenting information in traditional formats, we identified and worked with them to implement Step-by-Step Parenting, an evidence-based approach developed for parents with this type of challenge. Such an experience makes a strong case for more flexibility for states and communities, rather than a short-list of options.

Another example of the court teams working at the systems level occurred in Iowa, where a parent overdosing on heroin in court brought the SBCT judge face to face with the opioid crisis. In seeking a solution to opioid-involved families—cases which the family drug court judge indicated he did not take—the SBCT judge discovered there was only one accessible MAT program in the area, a provider who was at odds with the human services agency. The SBCT community coordinator was able to bring the parties together and heal this breach, opening the door to treatment. But the work went further. As the only available MAT provider, this provider could not take all cases needing MAT and also provide behavioral therapy. An agreement was worked out so other providers did the behavioral therapy, freeing up the only MAT clinic in the area to work with more patients. This cooperation opened up more treatment services for all courts. As the judge noted, who would have thought that a court focusing on babies could have such a broad effect? *While HHS indicated in its request for comment on implementing the Clearinghouse that it would not consider access to services as an outcome, we note that outcomes cannot be achieved without systemic efforts to ensure access.*

Evidence of Effectiveness

The SBCT approach has undergone multiple evaluations. One evaluation was a quasi-experimental design using a subsample of infants and toddlers from the National Survey of Child and Adolescent Wellbeing (NSCAW) database for a mixed-method analysis of length of time to permanency and type of permanency outcome. In a current evaluation, the American Institutes for Research (AIR) is conducting a natural experiment that relies on the random assignment of families to judges that naturally occurs in three sites currently implementing SBCT. This study will compare cases in courts implementing SBCT to cases in regular dependency courts. It will answer questions about length of time in foster care, rate of exposure to reoccurring abuse or neglect, and level of family and child well-being.

Major outcomes identified in the first study:[xxiv]

- Court Teams children exit foster care faster regardless of the type of exit: the median exit for Court Teams children was about a year faster than the median in the control group.
- Court Teams cases experience a different pattern of exits from the foster care system: Reunification is the most common type of exit for Court Teams cases (38%) while adoption is the most prevalent for the comparison group (41%). Overall, Court Teams children were more likely to experience reunification, placement with a relative, or non-relative guardianship.
- Court Teams children reach permanency sooner, regardless of the type of exit, meaning that the difference in rates of adoption do not account for the overall difference in time to permanency.

Based on the first evaluation, the California Evidence-Based Clearinghouse for Child Welfare rated SBCT as Promising Research Evidence whose Child Welfare System Relevance Level is High.

Comparison of SBCT Outcomes with Federal Standards:

Safety outcomes—Recurrence of Maltreatment: The most recent evaluation of infants and toddlers in SBCT found that maltreatment recurrence within 12 months (CFSR 3, Safety outcome 2) among 251 children across sites using the SBCT approach was just 1.2 percent.[xxv] Since that evaluation, updated analysis of 430 cases at

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SBCT sites between April 2015 (or date of site initiation up to 2016) to July 2018 ***have reduced the maltreatment recurrence within 12 months to 0.7 percent.***[xxvi] These findings compare to:

- National standard of the Children's Bureau for Safety Performance Area 2, recurrence of maltreatment during a 12-month period: **9.1**%[xxvii]
- Analysis of data that combined the second National Survey of Child and Adolescent Well-Being (NSCAW) and the National Child Abuse and Neglect Data System of cases with a median time of 12 months of children regardless of age, substantiation status, and placement out of home, found that 6.9% of all children had maltreatment recurrence, but among a subsample of caseworkers who were interviewed at follow up (because the case was still open or there had been contact with the CWS since closing the investigation), maltreatment recurrence was 24.1%.[xxviii]
- The latest data on child welfare outcomes based on 2014 reported a national median of 4.9% for recurrence of maltreatment among children of any age within a 6-month period.[xxix]

Permanency and Stability: Implications for FFPSA 12 Month Limit

The recent study found permanency outcomes that echoed the earlier evaluation and by far exceeded the federal standard. ***84 percent of children with closed cases reached permanency within a year, double the national standard expectations established by the Children's Bureau of 41 percent.*** Reaching success with such a caseload suggests that **a comprehensive approach can reach successful outcomes with families whose children might otherwise be placed in foster care within the 12-month limit established by FFPSA**. Moreover, this impressive outcome occurred in a caseload where parents had more risk factors than a nationally representative sample (NSCAW II) of children investigated for maltreatment: 90% of SBCT children with closed cases had one or both parents with substance use disorders, compared with 10% of primary caregivers in the national sample; close to two-thirds of the SBCT children had parents with mental health problems, compared with 15% in the national sample. Over half of the children had a parent who had been incarcerated. As with the earlier evaluation, reunification was the permanency outcome in a large proportion of cases, 49 percent. Adoption was more prevalent where parents had extremely high ACE scores (7-10 ACEs), but reunification was possible in 30 percent of those cases with high risk factors.[xxx]

Conclusion

We at ZERO TO THREE are heartened by the possibilities opened up by the enactment of FFPSA. At the same time, we urge that the implementation of this important new funding stream consider how best to maximize the effectiveness of services provided, the ability to transform culture and practice, and above all, to meet families' needs in a comprehensive manner that in the long run truly leads to healthier lives and thriving children. The experience of SBCT illustrates how comprehensive approaches provide a framework within which the needs of individual families are appropriately considered, services are integrated, and the community's ability to respond with the most appropriate evidence-based interventions is enhanced. We hope that in implementing FFPSA, the Congress and the Administration will work together in considering the myriad needs of families, what drives their long-term outcomes, and enable states and communities to build thoughtful systems of services to support family and child wellbeing.

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[xiii] Casanueva, C., et al. *Adverse childhood experiences, family risk factors, and child permanency outcomes of very young children involved in Safe Babies Court Team™ sites.*

[xiv] In a major retrospective study of adults conducted at Kaiser Permanente in San Diego, investigators surveyed 17,000 members of the health maintenance organization on their exposure to ten adverse childhood experiences (ACE). Each factor was separately tallied and each study participant was given an ACE score of the number of separate ACE they reported experiencing as children. When the investigators correlated the number of ACEs with the patients' current medical status their findings confirmed that the more troubling the childhood, the greater the number and severity of medical and psychological conditions in adulthood. Four or more ACEs predicted significant adult health issues and early death.

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