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Geri Amori, PhD, DFASHRM: Before we begin, because this podcast is discussing pediatric mental health, including suicide, it might be disturbing to some listeners. Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I'm joined by Dr. Cara Pratt, a psychologist who works with all age groups and specializes in clinical anxiety disorders; Dr. Neil Bruce, a psychiatrist who specializes in child and adolescent affective disorders; and Mary Kisting, a clinical nurse specialist who works primarily with the inpatient pediatric population at a Level 1 trauma teaching hospital. Welcome. Today, we're talking about the effect of adverse childhood experiences, including trauma, and the social determinants of health, including the impact of COVID-19 on the mental health of our current youth, from infants to those entering young adulthood.

Let me take a minute here to set up. The population we're talking about is those people who are age 0 to 17, as well as those who were during those ages during the height of the COVID pandemic, from about 2020 to 2023. I'd like to start by talking about what is called adverse childhood experiences that are sometimes referred to as ACEs. These experiences can include a broad range of things, everything from emotional or physical neglect to parental separation or divorce, to parental substance abuse, mental illness, or incarceration, to direct physical, sexual, or emotional abuse. There's a lot there. And the level of experience can run the gamut from externally appearing mild to very traumatic and direct. Experiences before the age of 3 are particularly critical for brain development.

A Kaiser and CDC study showed that 4 or more of these events contributed to a 4 times greater chance of physical health conditions, as well as mental health conditions, and were twice as likely to develop diabetes, believe it or not. So it's very important stuff. The Surgeon General's report called *Protecting Youth Mental Health*, said that socioeconomically disadvantaged children and adolescents are 2 to 3 times more likely to develop mental health condition than peers with higher socioeconomic status. And in 2017, the Substance Abuse and Mental Health Administration reported that American Indian and Alaska Native youth, as well as youth of more than one race, reported the highest rates of both suicidal ideation and suicide attempts. And the Surgeon General's report stated that Black youth experienced a greater number of suicide attempts and injury by suicide attempt; they were, in fact, 2 times as likely to die by suicide.

So, given this recognition of social determinants of health through the US Department of Health and Human Services and the Office of Disease Prevention and Health Promotion, the Healthy People 2030 also report some states are starting to mandate screening for ACEs. California was the first in 2020, and by now, about 43 states have introduced various levels of legislation. So here's the question for our audience and for our panelists: Is this problem bigger than the system? What can healthcare providers do to detect adverse childhood experiences and ensure the proper trauma-based care? And is it even doable? So Cara, I'd like to start with you today. Given the vast array of potential adverse

childhood experiences and the limited access to behavioral healthcare, does the system even have a shot at counteracting some of these social determinants of health?

Cara Pratt, PsyD, HSPP: Well, that's a really, really big question, Geri. It's a huge picture, right? So if we're thinking about social determinants of health, what that means is to change this, we need to change society. So this is huge stuff. We're talking racial inequality, access to care, cost of care, trauma, generational trauma. Really huge, system-wide things. So that can start to feel hopeless when we're talking about that level. And when I start feeling hopeless, then I narrow in on the little areas where individual clinicians or families or parents might have some role or option in shifting some of this. So I do think there is hope, but it can feel a little overwhelming.

The first part, the awareness part, is important, and that's part of what we're doing here today, just talking about the fact that all of these factors do impact health outcomes in really meaningful ways. Assessing ACEs is an easy way to do it. There are free measures that just ask about potential adverse childhood experiences. That's something we use regularly at our practice. We can also teach other providers about assessing for these things, taking a trauma-informed approach. If possible, if—we're busy as clinicians—but if we have time to be involved in any advocacy groups or community outreach, those are some ways that we, as individuals, can play some sort of a role. But it is a really big scope of a problem.

Amori: It sounds big. Mary, do you ever see kids that are resilient despite having all these ACEs? And what do you think makes them different?

Mary Kisting, MS, RN, CCNS, CCRN-K: The great answer to that is, yes, we do see children that seem to be able to navigate the world with limited resources, even to the point where some children seem to be parenting the parent. It's truly amazing how kids will be able to see that and step up. But the children that seem to be able to do that the best have some sort of support. They have some nurturing relationship somewhere in their life, or they've got other protective factors, like a family or community support system. And they are also kids that seem to be able to talk about feelings, and they can name feelings and discuss those. Those kids just seem to be able to do better in dealing with issues. But there are children that truly seem to navigate that, to everybody's amazement.

Amori: That makes me feel very hopeful. We got to figure out what it is that makes them more resilient and bottle it so we can give it to all the kids, right? So, Neil, we know from the reports that kids become suicidal, and when they're suicidal, you see them in the hospital. Is it too late to change how these formative experiences affect them, or do we still have a shot?

Neil Bruce, MD: Yeah, I would say it's not too late to change how these experiences affect them. Obviously, when they're suicidal, you want to focus on that first. You want to make sure they're safe. You want to make sure they don't have the means. If they are having active suicidal thoughts with a plan, you want to either make sure they're safe in

the hospital or have a very clear safety plan leaving the hospital. And then once you have those immediate safety concerns, that's kind of when you start to work on things like past trauma and how that's affecting them. Like how this didn't start to affect them overnight, this won't change overnight, either.

So, I think the big things are to find a good therapist who the kid relates to and seems to be open with. Initially, you'll probably start to establish rapport, just kind of build that treatment connection. But as you do, you also have the kid opening more and more up about these traumatic experiences that they might have had, how they view them, and then you start to work, kind of peel back the layers, start to realize although this one terrible thing happened, that's not how the world is, that's not how people are, that's not how all your future experiences will be.

Amori: Well, that must be a real awakening for kids. It'd be hard to believe if you've had that other experience. What do you think about that, Cara? Do you feel a child could come back brink of a bleak future to become resilient and healthy psychologically and physically, maybe even?

Pratt: Yeah, absolutely. And I've seen it myself. Resilience is really complicated, and I don't think we yet understand, fully, kind of the different aspects of that. But one thing I do is try to not only assess for those traumatic childhood experiences but also assess for the resiliency factors. So, like, assess for those people they do feel really comfortable with, like Mary was saying. And we never…my outlook, at least, is never like, oh, they've had lots of really difficult experiences, and that means they're kind of doomed. Instead, it means, okay, all of that needs to be addressed, and it might impact how I plan treatment with them or what we work on.

An important thing is that we know that resilience can be learned, and there are specific things that you can do for children and even for adults to learn and build on resilience. And if anybody is really dorky and wants to learn more about that, Martin Seligman specializes in that stuff, and he has some models, specifically on resilience. And it truly is something that you can teach kids over time and their parents, as well, so not hopeless.

Amori: Seligman is not dorky. I like his work. I think it's good. So Mary, what about the trauma the kids experienced during COVID? How do we counteract that? Because you can't take back COVID. Do we have a whole generation of emotionally traumatized young adults, in your mind?

Kisting: I don't think so because I think that we had issues with depression, suicide, stress before COVID even came along. These numbers have been increasing over the years. I think COVID significantly added to that. But I think that these issues have been there, and so I think that we are dealing with something that perhaps we wouldn't have dealt with in such a targeted way because now the numbers are higher, the kids are younger, and so the stress that we got from COVID is counteracted by things that Cara just said.

Whether it was COVID or not COVID, we need to build children's resilience, and they need to have the counteracting of that stress and anxiety is meeting basic needs. Kids have to have good nutrition, and this speaks a little bit to what we were saying about this being such a large problem and a socioeconomic issue, but you need to have good omega-3 fatty acids, and children need to have quality sleep. It's really hard to cope or control mood swings if you're exhausted and fatigued. And so I think the strategies that we have, if we're able to implement them, can counteract things that we had that were exacerbated by COVID.

Amori: That's pretty positive. Neil, do you agree with that, or what are you seeing?

Bruce: Yeah, I do think COVID has had an impact on kids. I do think there was a loss of some socialization during COVID. I think kids are still relearning that, but thanks to resilience, I do think they are bouncing back. I think some kids are still having a hard time kind of adjusting to schooling with COVID. Online schools have become more and more prevalent and common, too, and I do think…and a lot of my colleagues have a similar opinion…but I do think in-school, in-person schooling is kind of the best because then you get socialization, you get teachers right there, firsthand, easy access to help you if you do have questions. You have a very regimented setup, similar to kind of having to go to work in the real world. So there are still some things people need to catch up on, but I think just given the resilience of kids, I'm hopeful that people will.

Amori: Cara, do you agree with that, too, or are you seeing something different? I mean, all of us have talked about how bad COVID was for the kids. We all want to know if our kids are going to get back to normal, right?

Pratt: I'm seeing a lot getting back to normal. I'm definitely seeing a lot of what Neil is talking about with the socialization, attention problems, transitioning back to school, and some are still having a hard time making that transition back. A lot of kids and families are opting to do online schools or kind of like alternative schooling methods. I don't know if that's always the best, but I see that as a response to some of the stressors and issues that arose during attempting to continue with schooling during COVID. So that's one of the main things that I see.

Amori: Well, I'm glad to get those optimistic reports from all of you because I was just sitting here wondering, really, are the kids going to get back to normal? So, I'd like to ask you, Mary, how do you feel the system can improve screening for these adverse childhood experiences and shift the care to trauma-focused care, both for medical and mental issues?

Kisting: I think there needs to be widespread training for people that interact with children on general screening tools and trauma-informed care. I think we really need to create a culture that prevents any additional harm. These kids have already been through a lot, and I think the concepts and approaches in trauma-informed care really ameliorate that. And so I think that's truly a golden opportunity.

Amori: And, Neil, what do you see as the barrier to addressing the social determinants of health among your population that you see?

Bruce: I think one of the barriers is just how complex and multifaceted social determinants of health are. So like Cara was saying, I think access can be a big issue, thinking about like insurance and coverage and payment, also thinking about how to address different socioeconomic classes. I think disparities in school and education, particularly public education, can also affect mental health and resilience. And I think given the complexity, some people kind of just stop there and say, okay, we can't do anything. But I think if you break it into smaller parts, it becomes a lot more manageable and doable. So I think trying to take a step back, see what we can work on, what we can fix, take it piece by piece, and go from there.

Amori: Well, that's optimistic, as well. So we've talked about a lot of stuff today, and I'd like to ask my traditional question: if you want our audience to take away one point from what you've talked about today, what would that be? So Mary, let's start with you.

Kisting: I think the one takeaway that I would have would be that people look into trauma-informed care. It's really easy to see children acting out in a certain way and jump to the conclusion that they are poorly behaved, they're misbehaving, when truly they have a burden. They're carrying a burden that we don't even understand. And I think if people would have some background in that and that perspective, it changes your focus entirely.

Amori: Okay, thank you. Cara, what about you?

Pratt: I think, to kind of summarize everything, just as much as you can, implement trauma assessment when you're working with kids, and even assessment of family traumas because there's some generational trauma that maybe didn't happen to the kid directly, but their parents' trauma can impact them. And just asking a few questions, it only takes a couple seconds. The one form we use at our office maybe takes 30 seconds for parents to fill out. So it's an easy way to assess. And you can also look, while you're doing that, to assess for the areas of resilience as well. It's not hard to do, and it can really help guide treatment.

Amori: Good. Thank you. The areas of resilience, as well. That's a good point. Neil, what's your one point for today?

Bruce: I think kind of piggybacking on what Cara was saying, the ACEs—obviously, these are things that have already happened, but a lot of it does have to do with intergenerational trauma and the parents' own mental health problems. Although the patient might be the kid, I think it's important to think about families as systems and making sure parents have the support they need. So, if you have a parent who's struggling, I think still being there for them and offering them referrals for the help that they need, as well, I think that can be very important and helpful.

Amori: Wow. Thank you. Well, this has been a very rich conversation, and I want to thank our panelists and our listening audience. I hope our discussion has provided you all with some new insights. Thank you, again, for joining us. See you next time when we explore another aspect of this issue from a *Healthcare Perspective 360*.

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