Addressing ACES in Early Childhood to Mitigate Future Police Contact

Kathleen A. Kemp, PhD,[a,b] Kaitlin M. Sheerin, PhD[a,b]

Adverse childhood experiences (ACEs; eg, abuse or neglect, household dysfunction) are highly prevalent among youth with juvenile justice (JJ) involvement, such that these youth are 4 times more likely to endorse 4 or more ACEs and 13 times less likely to report zero ACEs than the original Kaiser Permanente ACEs study participants.[1] Despite this work, a recent scoping review identified few studies focused on the prevalence of ACEs among youth with early justice system contact (eg, youth making contact with police).[2] Moreover, given the retrospective nature of the original ACEs study,[3] prospective longitudinal designs are needed to identify both whether and how ACEs are linked with justice system contact.

In the current issue of *Pediatrics*, Jackson et al begin to address this critical gap by evaluating cumulative ACEs in early childhood, mental health symptoms in early adolescence, and police stops in midadolescence using data from the United Kingdom's Millennium Cohort Study.[4] The authors leveraged a large sample and multiple data collection timepoints to yield 2 highly important findings. First, ACEs that accumulated in early childhood were associated with an increased risk for police contact at age 14. Second, the link between ACEs and police contact is mediated by mental health concerns, particularly externalizing behaviors (eg, physical assault, stealing, substance use). Concerningly, even in a sample outside of the United States, Black youth were still more likely to make police contact, suggesting the cross-cultural persistence of systemic racism.

The authors' findings make an important contribution to the literature on early risk factors for JJ involvement. The predominant JJ risk model, the Risk-Needs-Responsivity model,[5,6] has described ACES and trauma sequelae as a destabilizing factor rather than a risk factor for JJ involvement. However, this view largely ignores the role of ACEs as likely the first important link in the causal chain to justice involvement, and, therefore, risk factors that need critical intervention. ACEs likely continue accumulating for youth during and after initial system contact including police and early court involvement, which potentially could exacerbate their mental health concerns and further system contact.

The work of Jackson et al and others on ACEs, mental health symptoms, and JJ involvement suggest the need for major policy changes at several levels. At the international level, it is recommended that international health bodies (eg, the World Health Organization) continue to expand their efforts to provide concrete frameworks and recommendations for countries to implement early childhood screening of ACEs. At the national level, nations must focus on how and in which settings (eg, schools, pediatricians' offices) should they concretely implement ACEs and mental health symptom screening in early childhood in a way that best fits each nation's culture. Furthermore, certain types of ACEs may be especially important in certain nations. For example, rates of youth gun violence exposure are particularly high

[a]*Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Providence, Rhode Island; and* [b]*Rhode Island Hospital, Providence, Rhode Island*

Drs Kemp and Sheerin contributed equally to the conceptualization and writing of this commentary.

DOI: https://doi.org/10.1542/peds.2022-057568

Accepted for publication Jul 22, 2022

Address correspondence to Kathleen Kemp, PhD, Bradley-Hasbro Children's Research Center, 1 Hoppin St, Suite 204, Providence RI 02903. E-mail: kathleen_kemp@brown.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2022 by the American Academy of Pediatrics

FUNDING: This work was supported by the National Institute of Mental Health [R01MH129770; T32MH078788].

CONFLICT OF INTEREST DISCLOSURES: The authors have no conflicts of interest relevant to this article to disclose.

To cite: Kemp KA, Sheerin KM. Addressing ACES in Early Childhood to Mitigate Future Police Contact. *Pediatrics*. 2022;150(4):e2022057568

Downloaded from http://publications.aap.org/pediatrics/article-pdf/150/4/e2022057568/1374178/peds_2022057568.pdf
by UT Rio Grande Valley, Stanley Fisch

in the United States versus rates of physical violence in Malawi.[7] At the regional government level (eg, states, provinces), there is a need for intervention for reduction of ACEs and punitive policing. Given that local areas may yield differential exposure to ACEs (eg, high rates of domestic violence, parental incarceration), it is important for regions to target ACEs prevalent in their area. In addition, as Jackson et al suggested, police contact may pose its own unique ACE, and many of the youths arrested had high rates of externalizing mental health concerns. Therefore, it seems reasonable to suggest the reduction of punitive police contact for mental health and substance use emergencies by using alternative models, such as coresponder models that pair law enforcement and clinical staff together when responding to a behavioral health crisis.[8] At the community level, the availability for evidenced-based programs for services (eg, Gun Violence Initiative[9]) and positive experiences (eg, mobility mentoring[10]) sensitive to the local culture are important as well as useful for referrals from police and police alternatives (eg, coresponders). In addition, communities may wish to reconsider efforts that increase police contact but do not increase public safety (eg, school resource officers[11]). Finally, at the individual provider level (eg, pediatric primary care), providers may wish to conduct enhanced screening of mental health concerns (with a particular focus on externalizing concerns), given the mediating role of mental health concerns between ACEs and police contact.

The authors' findings have implications for several lines of future inquiries. Indeed, the authors clarified whether and how ACEs are linked to justice involvement; yet, further work is needed to determine for whom ACEs may play an important role in first system contact. For example, mental health symptoms may be a stronger mechanism linking ACEs and justice contact for White youth, given that Black and Hispanic youth face additional systems-level factors (eg, systemic racism) underlying their police and justice contact.[12] Given that the authors highlight that mental health can mediate the association between ACEs and police contact, it seems important to also understand which protective factors may help youth who have experienced ACEs to avoid such contact. To better assist in prevention and intervention efforts, future research should focus on how the frequency and intensity of ACEs and mental health symptoms may accumulate during adolescence as youth begin interacting with police. Finally, the expanded ACEs framework,[13] which seeks to measure ACEs that are particularly relevant to racially and ethnically minoritized youth, should be used in future research to evaluate the effect of other ACEs (eg, community violence) on youth police contact. In sum, Jackson et al's work serves as an important springboard for further research, as well as a call to action spanning from government bodies to primary care offices.

ABBREVIATIONS

ACEs: adverse childhood experiences
JJ: juvenile justice

REFERENCES

1. Baglivio MT, Epps N, Swartz K, Huq MS, Sheer A, Hardt NS. The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *J Juv Justice*. 2014;3(2)
2. Folk JB, Kemp K, Yurasek A, Barr-Walker J, Tolou-Shams M. *Adverse childhood experiences among justice-involved youth: data-driven recommendations for action using the sequential intercept model*. *Am Psychol*. 2021 Feb-Mar;76(2):268–283
3. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245–258
4. Jackson D, Jindal M, Testa A, Ganson K, Fix R, Nagata J. Adverse childhood experiences and adolescent-police contact in the UK. *Pediatrics*. 2022, In press.
5. Brogan L, Haney-Caron E, NeMoyer A, DeMatteo D. Applying the risk-needs-responsivity (RNR) model to juvenile justice. *Crim Justice Rev*. 2015;40(3): 277–302
6. Bonta J, Andrews DA. Risk-need-responsivity model for offender assessment and rehabilitation. *Rehabilitation (Stuttg)*. 2007;6(1):1–22
7. VanderEnde K, Chiang L, Mercy J, et al. Adverse childhood experiences and HIV sexual risk-taking behaviors among young adults in Malawi. *J Interpers Violence*. 2018;33(11): 1710–1730
8. Puntis S, Perfect D, Kirubarajan A, et al. A systematic review of co-responder models of police mental health 'street'triage. *BMC Psychiatry*. 2018;18(1):1–11
9. Webster DW. Public health approaches to reducing community gun violence. *Daedalus*. 2022;151(1):38–48
10. Homer CJ, Winning A, Cummings K. A coaching model to promote economic mobility and child developmental outcomes. *Pediatrics*. 2022;149(1): e2020018473
11. Fisher BW, Hennessy EA. School resource officers and exclusionary discipline in US high schools: A systematic review and meta-analysis. *Adolesc Res Rev*. 2016; 1(3):217–233
12. Nordberg A, Twis MK, Stevens MA, Hatcher SS. Precarity and structural racism in Black youth encounters with police. *Child Adolesc Social Work J*. 2018;35(5):511–518
13. Cronholm PF, Forke CM, Wade R, et al. Adverse childhood experiences: Expanding the concept of adversity. *Am J Prev Med*. 2015;49(3):354–361

Downloaded from http://publications.aap.org/pediatrics/article-pdf/150/4/e2022057568/1374178/peds_2022057568.pdf
by UT Rio Grande Valley, Stanley Fisch