

# WHAT IF WE COULD PREVENT MOST MENTAL HEALTH PROBLEMS?

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**The Adverse Childhood Experiences Study (ACEs Study) may turn out to be the most important scientific finding of the late 20<sup>th</sup> century**, opening up windows of opportunity that could vastly improve mental health care, physical health care, and virtually all of our current major social problems. The ACEs study, along with other major epidemiological studies, show that we have a Major Public Health Epidemic that is actually getting relatively little attention in public discourse and has yet to seriously impact policy.

**In two recent bills focused on mental health care (sponsored by Representatives Tim Murphy and Eddie Bernice Johnson in the House and Senators Chris Murphy and Bill Cassidy in the Senate), there is scant attention paid to the issue of trauma, much less to childhood adversity and developmental trauma.** Such inattention cannot lead to good policy. It would be like trying to eliminate an infectious disease while denying that germs and viruses even exist!

By 1998 when the ACEs Study was first published, the groundwork for the study had already been laid by scientific research on traumatic stress that accelerated after the Holocaust and the Vietnam War. What began to emerge - with ever-increasing importance - was a clearer picture of cause and effect relationships between what happens to us, particularly when we are young and still so actively developing, and the predictable emergence later of a wide variety of health, mental health, and social problems.

**There is now such an extensive body of knowledge, research, and evidence that we can no longer rightfully speak about this as “trauma theory” because there is relatively little that remains theoretical about it. It is time for us to take a lifespan approach to all of our major problems with a focus on treatment, yes, but with a simultaneous focus on *prevention*.** Now we can say with surety what it is we need to prevent. Put simply, the greater a person’s exposure to adverse experiences – and all traumatic experiences are considered to be forms of adversity – the greater is the person’s risk for health problems, a shorter lifespan, a wide variety of mental health disorders, involvement in the criminal justice system, substance abuse disorders, homelessness, workplace difficulties. It is important to emphasize here, however, that the research is pointing to RISK, not inevitability. We can say with surety, given a level of exposure that X% of people will develop problems, but we cannot say which individual person will develop which kind of problem. The ACEs Study and all of the major epidemiological studies to which I am referring, are population studies and this is what makes exposure to adversity a Public Health problem, not just a medical, psychiatric, child welfare, or criminal justice problem.

In public health, we loosely describe three levels of intervention and prevention: primary, secondary and tertiary. Primary interventions are aimed at everyone – universal precautions like washing your hands after using the toilet. Secondary interventions are aimed at people who are at risk for a problem. So

children who are not big enough to use seat belts in a car are at risk for serious injury even in relatively minor collisions and therefore we create policies that mandate car seats for young children. Seat belts are a primary intervention while special car seats for children are a secondary intervention. Tertiary interventions focus on trying to help the people who already have whatever problem it is we are defining. In the car example, tertiary interventions could be thought of as airbags – they are only deployed when the crash has occurred and are designed to minimize damage while having emergency medical technicians who come to remove injured or trapped people from car crashes can also be thought of as a tertiary strategy.

If we use such a framework around policy initiatives and trauma, then it is useful to think about primary, secondary, and tertiary initiatives. There is a great deal of talk throughout our service delivery systems about “trauma-informed” care or services. This can be thought of as a primary intervention. Everyone should be trauma-informed. A basic understanding of risk factors for – among other things, the ten most common causes of death – should be public knowledge, just as the general public knows that smoking is not good for your health. “Trauma-responsive” is a useful term for secondary initiatives. To the extent that we can assess who is at risk for problems, our systems of service delivery at every level – healthcare, mental healthcare, child welfare, juvenile and adult justice systems, education at all levels, and all of our social service sectors – need to respond through a trauma-informed lens and to develop specific procedures and policies based on those needs. “Trauma-centered” as recently defined by trauma therapists David Read Johnson and Hadar Lubin, is a term that can be applied to tertiary approaches that are trauma-specific in that they are used to help traumatized people heal.

**Based on the knowledge we have now, it is time for all of our sectors to take a lifespan approach. For every person, childhood determines the adults we will become in body, mind, and soul. But change can occur at any time along the lifespan and those changes can make things worse or make them better.** Making things better without making them worse requires wise, creative, and long-sighted policy decisions made by people who are motivated toward the future, not just the present or the past. As we learn more about the epigenetics of human experience, we are discovering that the challenges and the responses to those challenges in one generation may get passed down to future generations through our own genetic coding. Such knowledge brings with it a whole new level of responsibility, knowledge that is actually at least as old as the Bible when in Exodus, the writer declares that “He will by no means leave the guilty unpunished, visiting the iniquity of fathers on the children and on the grandchildren to the third and fourth generations.” We no longer need to be believers to see how this truism carries forth, even if we deplore the punitive and even unjust premises.

**As a society, we have a moral responsibility to do something with the knowledge we now have that most of the suffering brought about in the world today is preventable.** In the last century, during World War II, we launched the Manhattan Project to create and detonate the first atomic bombs. Surely we have the ability, though not yet the will, to launch a similar project, only this time not about creating weapons of mass destruction, but instead creating a future worth surviving.

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