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ABSTRACT

The Role of Policy in Preventing Adverse Childhood Experiences (ACEs) and Childhood Trauma in Georgia

By

Hallie Elizabeth Andrews

April 23rd, 2020

Abstract:

Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur during childhood including experiencing abuse, household dysfunction, and neglect. ACEs are exacerbated by social inequities and have an intergenerational impact. Conversations around ACEs are shifting from data collection to prevention strategies. This capstone will focus on policy strategies for preventing ACEs using the World Health Organization's "Conceptual Framework for Action on the Social Determinants of Health" and the Center for Disease Control's "Essentials for Childhood" framework. Policy strategies for preventing ACEs in Georgia include (1) ensuring housing stability for families and (2) expanding healthcare access.

The Role of Policy in Preventing Adverse Childhood Experiences (ACEs) and Childhood Trauma in Georgia

by

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MSW, Georgia State University
BS, Marshall University

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of Georgia State University in Partial Fulfillment
of the
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MASTER OF PUBLIC HEALTH

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APPROVAL PAGE

The Role of Policy in Preventing Adverse Childhood Experiences (ACEs) and Childhood Trauma in Georgia.

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Author's Statement Page

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Hallie Elizabeth Andrews

Signature of Author

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Introduction

Public health and medical research has shifted toward prevention of disease through a social determinants of health lens to promote life-long and intergenerational wellness. Some of the most impactful intergenerational public health research has focused on childhood traumatic experiences (often called adverse childhood experiences, ACEs) and their effects on long-term health. Data shows the impact of childhood trauma and adversity on adult health outcomes and behaviors (Felitti et al., 1998). Interventions to address ACEs can take many angles.

The Social-Ecological Model describes the complex relationship between an individual and their interpersonal relationships, community, and society. The individual, described to be at the center of the model, is

influenced by their age, gender, genetic makeup, and personal experiences. The individual is influenced by their



Figure 1: (Centers for Disease Control and Prevention: Division of Violence Prevention, 2002)

interpersonal relationships, their

community (both organizational and their external community), and society, including cultural norms and policy (Centers for Disease Control and Prevention: Division of Violence Prevention, 2002). While change occurs at every level through public health interventions, greater influence is achieved with each broader level. The societal level of the Social-Ecological Model impacts communities, relationships, and individuals from the highest level. Policy changes and cultural shifts at the cultural level have the greatest level of influence, whether positively or negatively (Centers for Disease Control and Prevention: Division of Violence Prevention, 2002).

Health promotion/programmatic strategies for preventing childhood trauma and ACEs include preventing family violence, improving the health of parents and family members, and improving primary education access. These programs have shown various levels of efficacy in preventing ACEs with many improving coping skills and preventing future trauma (Dagenais, Bégin, Bouchard, & Fortin, 2004; Rolfsnes & Idsoe, 2011).

However, policy interventions have greater impact on preventing ACEs through broader influence on shifting cultural norms, institutions, relationships, and individual health beliefs. Policy strategies discussed in this capstone are guided by the World Health Organization's "Conceptual Framework for Action on the Social Determinants of Health" and the Center for Disease Control and Prevention's "Essentials for Childhood Framework." Two main strategies that will be discussed in this capstone are improving housing security and access to health care. The two topics are interrelated in their impact on health but have unique opportunities and challenges. The state of Georgia is among the states with the highest level of income inequality (Center on Budget and Policy Priorities, 2012) In addition, Georgia is one of only 14 states to have not implemented Medicaid expansion under the Affordable Care Act (Kaiser Family Foundation, 2019). The population of children under 18 years has grown by 23.8% since 2010 (U.S. Census Bureau, 2018). Thus, Georgia has a unique opportunity to prevent ACEs and support families through policy change.

Adverse Childhood Experiences (ACEs)

Childhood trauma has a major impact on lifelong health, violence, and overall life achievement. ACEs are defined as traumatic experiences that occur during childhood that have an effect on stress levels and brain development in children. ACEs are Social Determinants of

Health (SDOH), which are social/cultural factors that impact health outcomes. According to The Office of Disease Prevention and Health Promotion (Healthy People 2020, 2020), the five main SDOH of health are:

- Economic Stability
- Education
- Social and Community Context
- Health and Health Care
- Neighborhood and Built Environment

Each determinant has underlying factors that are used to collect data and set objectives for public health action for reducing health inequities. Examples of factors and objectives for public health action include accurately measuring “SDOH-3.2: Proportion of children aged 0-17 years living in poverty” and “AH-11.4: Reduce the rate of adolescent and young adult victimization from crimes of violence” (Healthy People 2020, 2020). Social stratification exacerbates inequities caused by SDOH, as resources and policies are allocated differently based on power in communities. The World Health Organization’s Commission on Social Determinants of Health makes a clear distinction between social determinants of health and social determinants of health inequities, which are a result of power imbalances (World Health Organization, 2010).

A 1998 Kaiser Permanente study on obesity was the first to study the link between ACEs and health outcomes (Felitti et al., 1998). Specifically, the researchers in this study used a standardized questionnaire to gather data on participants’ exposures to the following Adverse Childhood Experiences:

- Physical and emotional abuse
- Physical and emotional neglect
- Sexual abuse
- Witnessing domestic violence
- Substance abuse within the household
- Death or serious illness of a family member

- Mental illness of a family member
- Parent divorce or separation
- Incarceration of a family member

Results from this study indicated that the more ACEs an individual experienced, the more likely he/she was to adopt risky behaviors, experience disease, disability, and an early death. The groundbreaking 1998 study by Felitti, et al. shifted the application of public health, medicine, and social work/mental health to understanding the role of childhood trauma and lifelong health outcomes. Many subsequent studies have been published on the link between ACEs and health outcomes and behaviors including heart disease (Dong et al., 2004), alcohol abuse (Dube, Anda, Felitti, Edwards, & Croft, 2002; Robert F. Anda et al., 2002; Strine et al., 2012), sexual risk behavior (Hillis, Anda, Felitti, & Marchbanks, 2001; Hillis, Anda, Felitti, Nordenberg, & Marchbanks, 2000), suicide (Dube et al., 2001) (Enns et al., 2006), and educational attainment and lifespan (Brown et al., 2009; Metzler, Merrick, Klevens, Ports, & Ford, 2017).

The Behavior Risk Factor Surveillance System (BRFSS) included questions on ACEs in data collection from 2009-2018 to determine the prevalence of ACEs across the U.S. population. The BRFSS study found that 61% of respondents experienced one or more ACE and nearly 16% experienced four or more ACEs (Centers for Disease Control and Prevention, 2020). The data continue to show that ACEs are not exclusive to one population or one region (Centers for Disease Control and Prevention, 2020). However, evidence does suggest that ACEs are disproportionately experienced by racial/ethnic minority populations. For example, Maguire-Jack, Lanier, and Lombardi (2020) found in their study using the nationally representative 2016 National Survey of Children's Health data that 59% of White children experienced zero ACEs; by contrast, fewer Latinx children (49%) and Black children (36%) experienced zero ACEs (Maguire-Jack, Lanier, & Lombardi, 2020). More than 34% of Black children in this survey

experienced two or more ACEs (compared to 22% of Latinx and 14% of White children). Black children had higher risk for all ACEs compared to White children in all but two categories (living with someone with mental illness and drug and alcohol abuse by a family member). Notably, 36.6% of parents of Black children said that it was “hard to get by on family’s income,” compared to 21.6% of White children and 28.7% of Latinx children (Maguire-Jack et al., 2020). Data on prevalence of ACEs and health outcomes draw greater attention to the health disparities and systemic racism in the United States.

Black and Latinx populations experience disproportionately higher ACEs in the U.S. in part due to systemic racism in education (Gandara, 2005; National Education Association, 2008), healthcare (National Center for Health Statistics, 2016), and criminal justice systems (Clair & Winter, 2016), wealth disparities, and the physical and emotional impact of racism. These systems of oppression cause unequal distribution of resources in a Capitalist economy that has growing wealth inequality. Recent studies show intergenerational impact of ACEs through stress and inadequate healthcare access during pregnancies (McDonnell & Valentino, 2016). Child maltreatment is also an intergenerational ACE relating to homelessness, mental health, and poverty (Narayan et al., 2017). Systems where there is unequal access to basic essentials including health, housing, and education will inherently cause trauma. As more health and health-allied professionals have become aware of ACEs, the conversation has shifted toward understanding protective factors and prevention.

Recent national surveys have collected new data on the prevalence of other childhood adverse experiences. The 2016 National Survey of Children’s Health included questions on witnessing neighborhood violence and experiencing racial and ethnic discrimination in its section focused on other ACEs. The 2019 and 2020 National Health Interview Surveys include

questions regarding childhood poverty, housing insecurity, and food insecurity. Studying childhood trauma and adversity has expanded as researchers and clinicians understand the connections between brain development, stress, and behavior.

Children who are under chronic stress or experience an extreme traumatic event have irregular brain development compared to children who do not experience this same adversity. At any stage of development, children who are neglected or experience prolonged poverty develop cognitively and emotionally differently. A child who experiences one extreme traumatic event, such as a parent's death, might not have the coping skills to process their trauma and might experience prolonged stress as a result. This prolonged stress, called "toxic stress," has biological impacts on the development of hormones such as cortisol, as well as on the body through heightened stress responses, heart rate, and blood pressure (Center on the Developing Child, 2007). Toxic stress has a cumulative impact on an individual's physical and mental health, and they are more likely to develop physical and mental health issues, as previously discussed. However, children who experience adversity and grow up with supportive and nurturing relationships learn healthy coping skills and resiliency during times of stress (Center on the Developing Child, 2007).

Protective factors are relationships, genetics, or learned behaviors that can decrease risks for long-term effects of childhood trauma and toxic stress. Protective caregiver relationships promote resilience among children who experience high numbers of ACEs. Factors of resiliency that help individuals overcome adversity include courage, a positive outlook, internal locus of control, internal motivation, social skills, and self-worth. These internal messages are learned and shaped during childhood and are directly influenced by children's access to positive and consistent support from a parent or influential adult figure. However, parents who experienced

multiple ACEs are less likely to be able to foster resilient attitudes in children (Panisch et al., 2020). Specifically, parents who lack health insurance or who are insured through Medicaid and Medicare were less able to support resiliency in their children due to less economic stability, concrete support, and social connections (Panisch et al., 2020).

While the original study on ACEs was groundbreaking over 20 years ago, it is essential that conversations continue to shift toward solving social determinants of health inequities. Policies and programs have the capacity to perpetuate or mitigate health disparities in poverty, education, housing, employment, health care, and violence. They are being studied with a greater interest for their role in addressing and preventing ACEs.

Policy Interventions for Preventing ACEs

Interventions for preventing and coping with ACEs have been implemented at all levels of the Social-Ecological Model. For example, school-based mental health programs have proven to be effective for children experiencing post-traumatic stress disorder (Rolfesnes & Idsoe, 2011). Other programs designed to prevent foster care placement through intensive parent skills trainings were also effective at teaching coping skills and resiliency (Dagenais et al., 2004). However, a focus on policy interventions would be more effective in preventing ACEs and intergenerational trauma by promoting cultural shifts, breaking down economic barriers that cause inequities, and preventing violence. Health-focused policies to address SDOH are more effective at preventing intergenerational trauma and promoting health equity.

Policy interventions discussed in this capstone will use a SDOH lens for improving family stability, preventing childhood trauma, and promoting intergenerational health equity. Both the World Health Organization (WHO) and Centers for Disease Control and Prevention

(CDC) have developed frameworks to outline these strategies. Applying these frameworks to formulation of policy in Georgia will have a positive and expansive impact on health in the state.

“A Conceptual Framework for Action on the Social Determinants of Health” by the World Health Organization, Commission on Social Determinants of Health

This framework, published in 2010 by the Commission on Social Determinants of Health (CSDH), was designed to “show how social, economic and political mechanisms give rise to a set of social economic positions, whereby populations are stratified according to income, education, occupation, gender, race/ethnicity and other factors” (World Health Organization, 2010). The most important stratifiers and indicators defined in the framework are Income, Education, Occupation, Social Class, Gender, and Race/Ethnicity. The framework distinguishes between “structural determinants of health” and “intermediary determinants of health” to underscore the causal relationship. Intermediary determinants of health include material circumstances, behaviors and biological factors, and psychological factors. Psychological factors include stressors, relationships, social support, and coping styles (or lack thereof). These indicators illuminate the “social determinants of health inequities” as they operate within political and socioeconomic context. Rather than defining health as an endpoint, this framework defines the health system as a determinant of health, accounting for the unequitable access to healthcare.

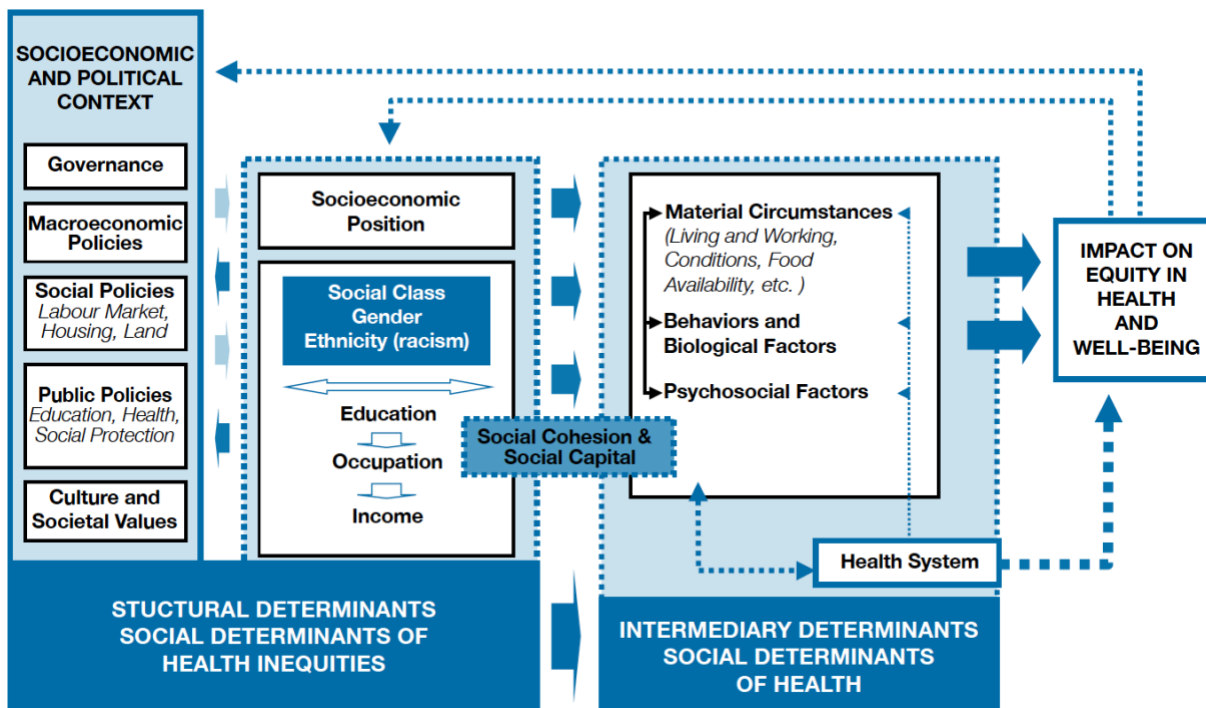


Figure 2: (World Health Organization, 2010)

Policy action that should be taken to address social determinants of health inequities include targeted programs for disadvantaged populations, closing health gaps, and addressing the social health gradient among the whole population. Policies that aim to reduce health inequities should not be focused only on intermediary determinants such as material circumstances or behaviors. Rather, they should aim to dismantle underlying structural determinants that create health gaps (World Health Organization, 2010).

“Essentials for Childhood: Creating Safe, Stable, Nurturing Relationships and Environments for Children” by the Center for Disease Control and Prevention, Division of Violence Prevention

The Essentials for Childhood framework was developed to guide communities to enact policies and practices that will create environments to ensure children grow up to be healthy and productive members of their community (Alexander, 2014; Centers for Disease Control and Prevention, 2014). The framework is designed to prevent child abuse and neglect and other

ACEs through promoting safe, stable, and nurturing environments in which these children can develop skills and reach their full potential. In the event of children experiencing traumatic or stressful events, a safe, stable, and nurturing environment is intended to be able to mitigate the negative effects of ACEs and reduce overall health inequities (Alexander, 2014).

Strategies for creating safe, stable, and nurturing environments include strengthening economic support for families, changing social norms, providing quality care and early learning, enhancing parenting skills, and intervening to mitigate harm and prevent future risks. This policy analysis will focus on the first strategy, strengthening economic supports to families.

First and foremost, public health professionals and community partners should collect complete and accurate data on child abuse and neglect as well as health, violence, education, economic outcomes. Without complete and accurate data, decision-makers are unable to implement evidence-based strategies that will equitably address the goals of this framework. Policies that are enacted to achieve such goals should have data to show effectiveness and should engage in continued evaluation to ensure ongoing positive results (Alexander, 2014).

Policy interventions have the greatest impact in changing health at all levels of the Social-Ecological Model from society, including changing cultural norms and economic and educational outcomes, down to an individual's attitudes, behaviors, and health status. Enacting goals of the Essentials for Childhood Framework requires that communities form partnerships to ensure that decision-makers are provided with all of the information they need to enact policies that support relationships and environments for children and their caregivers. Policy interventions should be made with the goal of ensuring that healthy decisions being made by caregivers, such as choosing healthier food options or choosing to allow a child to play outdoors, are made without compromising other essential needs. Promoting these healthy decisions

through policy are often achieved through improving the socioeconomic conditions for families (Alexander, 2014).

Policy changes to promote safe, stable, and nurturing environments for children are achieved at organizational, regulatory (governmental agency), and legislative levels. According to the Centers for Disease Control and Prevention (2014), these include:

- Organizational policies include enacting family-friendly work policies and removing barriers to participating in household security programs such as food stamps, tax credits, and other supports such as subsidized childcare.
- Regulatory policies that strengthen the socioeconomic conditions of families include changing to a more progressive tax policy and reducing interest rates for low-income individuals and families. Doing so increases available funds and reduces stress levels for maintaining family stability.
- State and local legislative policies such as raising the minimum wage, increasing budgets for high-quality child care, providing paid family leave, and increasing access to affordable substance abuse and mental health treatment can increase parents' ability to provide safe, stable, and nurturing environments by removing barriers to essential care and promoting family stability.

Application of the Frameworks to Policy Intervention Strategies

Public health messaging can often be overburdened with statistics and can be ineffective when discussing policy with decision-makers and the public. Housing and healthcare policy changes are two interventions that can be addressed at the state-level. Public health strategies and data should be incorporated into bills' language and into advocacy efforts. Both policy domains have established data from economics and business sides, and policymakers often have moral or

emotional responses to housing and healthcare policies. However, housing and healthcare have wide-reaching public health impact, as discussed previously. Policy proposals risk being depersonalized by focusing on the data on housing instability or un-insurance/under-insurance and attempting to appeal to solely business or economic reasoning. Housing and healthcare issues can be reframed to educate decision-makers on the impact of ACEs and make the connections between childhood trauma, family stability, economic security, and overall public health.

Housing Security as a Policy Intervention

A key strategy for preventing childhood trauma is enacting housing policies that ensure family stability. Housing and social policy initiatives like Housing First provide housing to homeless individuals as a first step to health promotion interventions. Stable housing improves mental health (Suglia, Duarte, & Sandel, 2011) and medication adherence (Harris, Xue, & Selwyn, 2017; Rezansoff et al., 2016) in adults. In children, housing insecurity and moving often is associated with fair or poor child health, developmental risks, lower weight, and poorer educational outcomes (Cutts et al., 2011; Evans, Wells, & Moch, 2003). Economic and social barriers exist that prevent families from providing safe, stable, and nurturing environments for children. Housing security positively impacts physical and mental health of parents and children. Interventions to prevent ACEs and childhood trauma may focus on ensuring secure housing as a strategy.

Housing security is defined as “the extent to which an individual’s customary access to housing of reasonable quality is secure” (Frederick, Chwalek, Hughes, Karabanow, & Kidd, 2014). Housing security is a continuum and focuses on the threat of instability and eviction.

Homeless populations are transient and the stressors associated with instability are broad. Core factors related to stable housing include the type of housing agreement, recent housing history, current housing tenure, financial status, education and employment status, drug abuse, legal status, and housing satisfaction. Changes in these factors can shift individuals in secure housing toward instability due to insufficient social support, wealth, or access to welfare programs (Frederick et al., 2014). Another key factor is whether there are children present in the home. Homes with children face higher levels of eviction than those without children (Desmond, An, Winkler, & Ferriss, 2013). Desmond et al. (2013) found that neighborhoods with a higher population of children face six times higher rates of eviction. Further, 62% of households who do face evictions have children, with over one third of households being led by single parents (Desmond et al., 2013). These disparities in evictions may be related to discrimination, unregulated rental markets, or added financial stress for single parent households. Housing security is not detached from other societal inequities. However, for families who are already on the verge of crisis, these inequities are exacerbated along with other traumas.

Unstable housing has many negative consequences for healthcare access and outcomes. Those who are housing insecure are more likely to delay their doctors' visits, report poor health, and have more than 14 days in the past 30 where their physical or mental health has limited their daily activity (Stahre, VanEenwyk, Siegel, & Njai, 2015). Among those experiencing housing insecurity, 33.3% also reported delaying doctor visits because of cost, 26.9% were current smokers, and 26.3% had poor or fair health. The groups with the highest frequency for being worried or stressed about paying their rent were individuals who have an income below \$25,000, individuals without health insurance, and individuals with more than three self-reported ACEs (Stahre et al., 2015).

A lack of housing security can also have a negative impact on parents' mental health. For example, evidence suggests that housing quality (such as structure deterioration, pests and mold, and overcrowding) have a direct relationship to maternal mental health, even when controlling for intimate partner violence (IPV) and economic strain (Suglia et al., 2011). Parents living in supported housing also experience higher than average anxiety, depression, and somatization (Gewirtz, DeGarmo, Plowman, August, & Realmuto, 2009). Their children score low on measures of resiliency on the Behavioral and Emotional Rating Scale (Gewirtz et al., 2009). Housing security for parents and their children may impact children's ACEs and exposure to stress. As shown, insecure housing may lead to children living in households where domestic violence is present, where someone in their household is experiencing severe mental illness, addiction, or physical illness, which all may cause severe childhood stress and trauma.

One study using the National Health Interview Survey 1999-2012 data and Housing and Urban Development (HUD) 1999-2014 data found that receiving housing assistance through various HUD programs was associated with better than average health for low-income adults. Benefits included lower psychological distress and improved overall health status, mainly for those living in supported housing, rather than for those receiving housing vouchers (Fenelon et al., 2017). Using the same data source, another study found that a smaller share of adults currently receiving HUD housing assistance were uninsured (31.8% to 37.2%) and were less likely to have unmet healthcare needs, especially among those in public housing (Simon, Fenelon, Helms, Lloyd, & Rossen, 2017). By supporting individuals and families in meeting basic needs (housing, food, etc.), housing assistance programs have a "stability effect" in which recipients are able to focus on other competing priorities such as healthcare treatment, education, job security (Simon et al., 2017). More stability for families provides opportunities for parents to

provide safe and nurturing environments for children and build resiliency. Housing policies aimed at providing safe and stable housing for families are likely to positively impact parent mental health and eliminate many of the stressors that cause ACEs in children (Rollins et al., 2012).

Expanding Healthcare Coverage as a Policy Intervention

Parents' mental and physical health can greatly impact the health outcomes and presence of ACEs in their children. Parents' poor mental and physical health has been shown to be associated with adverse child health outcomes including asthma (Khashan et al., 2012), depression (Ashman, Dawson, Panagiotides, Yamada, & Wilkinson, 2002; Essex, Klein, Cho, & Kalin, 2002) behavioral difficulties and conduct disorders (Davé, Sherr, Senior, & Nazareth, 2008; Glover, 2014; Weitzman, Rosenthal, & Liu, 2011) impaired cognitive development (Glover, 2014; Laplante et al., 2004), attention-deficit/hyperactivity disorder (ADHD) (Glover, 2014), and anxiety disorder (Rice et al., 2010). Parents who are uninsured are at higher risk of worse health outcomes, stress, and instability (Finkelstein et al., 2012). Regardless of children's own health insurance coverage, their parents' health insurance status plays a major role in the overall wellness and stability of families.

Individuals who live in states that chose to expand Medicaid under the Affordable Care Act (ACA) experienced lower levels of severe food insecurity, showing a "spillover" effect in other indicators of poverty (Himmelstein, 2019). Himmelstein found that individuals who live in states that did not expand Medicaid access, including Georgia, saw a slight increase of severe food insecurity among low-income, nonelderly childless adults. Conversely, states who did expand healthcare access for the same populations saw a 2.2% reduction in food insecurity. Food

security is a newly defined adverse childhood experience on which data is still being collected through the National Health Interview Survey in collaboration with the U.S. Department of Agriculture (National Center for Health Statistics, 2019). Food security is essential to children's academics, cognitive, and psychosocial development (Alaimo, Olson, & Frongillo, 2001; Jyoti, Frongillo, & Jones, 2005). Availability of free or low-cost healthcare has additional benefit of reducing stressors to securing other essential needs (Himmelstein, 2019). Similar to HUD programs' impact on health of parents, health insurance expansion helps parents ensure that one more basic need is met for their children and may have the potential to reduce childhood stress and trauma.

Reid, Vittinghoff, and Kushel (2008) found that housing instability and health insurance are distinctly intertwined more so than other indicators directly impacting health. Being uninsured or underinsured (e.g. having inadequate or expensive health insurance in a way that discourages use) was positively correlated with increasing levels of housing insecurity and homelessness. Housing insecurity may create more barriers to obtaining health insurance such as regularly following up on necessary paperwork (Reid, Vittinghoff, & Kushel, 2008). These same barriers exist to securing housing and other essentials for families. Barriers to health insurance and housing prevent parents from providing safe, stable, and nurturing environments for their children to the best of their ability.

Parents who are uninsured experience poorer health outcomes, but it is also notable that their children are also impacted by their parents' health and healthcare access. Children whose parents are uninsured experience poorer health outcomes than children whose parents have health insurance (Akobirshoev, Bowser, Parish, Thomas, & Bachman, 2017). Children, who themselves have health insurance, have higher rates of asthma, ADHD, developmental delays,

learning disabilities, and mental disabilities when their parents are uninsured. This is correlated with physical and emotional stress, poor housing and environmental conditions, and poor education access. Further, poor parental health exacerbated these health outcomes in children (Akobirshoev et al., 2017).

The Policy Landscape for Preventing ACEs in Georgia

Successful policy interventions for promoting public health should use social determinants of health objectives to effectively set intentions and utilize data. Policy changes at the organizational, regulatory, and legislative levels can all have positive impacts on preventing childhood trauma. A top priority for the state of Georgia should be supporting parents so that they can instill resiliency and provide opportunity for their children. Policies should be focused on removing barriers to participating in safety net programs and protecting families from dire instability. Three key policy changes include preventing unjust evictions at municipal levels through “Just Cause” ordinances, expanding Medicaid in Georgia, and expanding Medicaid programs specifically for pregnant women.

Protecting Housing for Families

In 2016, 4.71% of all renters in Georgia faced evictions, more than double the national average. Relatedly, 16.82% of Georgians faced eviction filings, which causes household stress regardless of the eviction ruling (Eviction Lab, 2016). Strategies for addressing eviction crises include building and maintaining affordable housing in communities, ensuring that evicted people have safe living alternatives, and more clearly defining “eviction” in order to collect accurate data (Brennan, 2018). In Georgia, there are almost no legal recourses or protections available to renters, which has led to higher than the national average eviction rates. Taking civil

action against a wrongful eviction requires time, money, and knowledge of the civil justice system that are unavailable to many parents due to societal inequities previously discussed.

Each city has their own court system, eviction filings system, and vary widely in their protections for renters. The state of New Jersey, along with a handful of cities in the United States, defined specific reasons for which a landlord can evict a tenant (Legal Services of New Jersey, 2017). Tenants living in jurisdictions with “Just Cause” orders have more legal ground to appeal evictions notices and protect themselves against abusive landlords (Giwargis, 2017; Legal Services of New Jersey, 2017). Tenants’ Rights laws such as these help preserve family stability and reduce chronic stress for families living in poverty. They prevent landlords from taking retaliatory action or discriminating against households with children (Legal Services of New Jersey, 2017). These laws might have significant impacts on children’s education, as well, as they would likely result in fewer school transitions (Cutts et al., 2011). Just Cause laws disrupt current systems that perpetuate inequities by stabilizing living and working conditions and minimizing negative psychological factors brought on by stress and housing instability.

Expanding Access to Health Insurance

Despite years of decreasing rates of uninsurance in the United States, Georgia’s rates have dropped more slowly and are still higher than average in every metric. In a survey released by Georgia’s Department of Community Health in July 2019, 14.8% of the state’s population lacked health insurance coverage compared to 10.5% in the United States (Fowler, 2019). As of January 2020, 14 states have not expanded their Medicaid programs to increase healthcare coverage for more low-income residents and receive federal matching funds (healthinsurance.org, April 3, 2020). This includes Georgia, but recent legislation has passed that will soon cover more Georgians, but will not cover all of those who are uninsured.

To qualify for Medicaid in Georgia, parents must make less than 35% of the Federal Poverty Level, or \$21,330 for a family of three. Pregnant mothers who are below 225% of the Federal Poverty Level qualify for specific Medicaid plans during their pregnancy that extend 60 days post-partum. Adults who are not the primary caregivers of their children do not qualify under current state law (Kaiser Family Foundation, 2019). Individuals making more than 100% the Federal Poverty Level qualify for federally subsidized health insurance through the Affordable Care Act Marketplace. However, subsidized plans are often still not affordable for those earning just over poverty levels.

In 2019, the Georgia legislature voted and Gov. Brian Kemp signed Senate Bill 106 to allow the Department of Community Health to expand Medicaid in the state under federal waivers to cover adults earning up to 100% the federal poverty level ("Patients First Act," 2019). Under federal waivers, the state will receive partial matching funds from the federal government, but will still not cover all Georgians. This partial expansion leaves 267,000 individuals in the "Medicaid Gap" (Kaiser Family Foundation, 2019). The "Medicaid Gap" refers to individuals who do not qualify for healthcare coverage under their states' guidelines by (1) earning too much in income to be deemed poor enough, (2) not receiving employer-sponsored health insurance, and (3) not earning enough to reasonably afford health insurance through the ACA Marketplace based on their monthly income.

To address this gap in healthcare coverage for Georgians, multiple bills have been proposed at the state level. All of these plans could have a positive impact on the health status, stability, and resiliency for Georgia's parents and children.

Prior to Senate Bill 106 being introduced and passed in 2019, representatives in the Georgia House of Representatives introduced the "Expand Medicaid Now Act," which proposed

expanding Medicaid in the state to 138% FPL ("Expand Medicaid Now Act," 2019). This bill would close the Medicaid Gap and the state would receive higher federal matching dollars. More parents who are earning just over poverty levels would have improved access to mental health services, preventative medicine, and catastrophic healthcare coverage ("Expand Medicaid Now Act," 2019).

Sen. Sally Harrell proposed the PeachCare for Adults bill during the 2020 legislative session, which would create a state-wide public option for any adult who does not otherwise qualify for coverage by Medicaid or Medicare ("Senate Bill 330," 2020). State spending on health insurance programs like Medicaid rise more slowly than costs for private health insurance. A PeachCare for Adults program would allow adults to buy into state-run health insurance programs that consistently receive high reviews from participants. Under this bill, the program would provide the same coverage to individuals as is provided by Medicaid, but without dental insurance. The bill would also cover all essential health benefits as defined by the Affordable Care Act ("Senate Bill 330," 2020). A similar program in Delaware has been proposed that leverages additional federal dollars in an attempt to replicate the reduced medical spending by Medicaid versus individual spending on private health insurance ("Senate Concurrent Resolution No. 70," 2019). Enacting a statewide health insurance buy-in program would greatly improve healthcare access in the state for adults to cover basic health needs and cover individuals in times of emergency so that they can recover more quickly without pushing off care.

Other Medicaid expansion efforts specifically targeted lowering the state's high maternal mortality rate. Chairman Sharon Cooper introduced House Bill 1114, which would extend Medicaid coverage for mothers' lactation and postpartum care for six months following giving birth ("House Bill 1114," 2020). The bill would encourage mothers to utilize healthcare services

and prevent postpartum injury and death during a highly stressful time. However, this bill does not cover all pregnant people who earn up to 225% FPL and are covered under Medicaid in Georgia. A more effective addition to the bill would be to expand coverage for new mothers to one full year postpartum to ensure that more new mothers are able to access healthcare and have one more source of social support.

Policy Recommendations

Legislators in Georgia should consider passing and funding two policies that will support families and prevent intergenerational trauma and ACEs. These policies are as follows:

1. Georgia should adopt a state-wide “Just-Cause” Eviction Ordinance to clearly outline eviction justification. This could protect families from experiencing undue stress, preserve housing security, and enable parents to provide safe, stable and nurturing environments for their children.
2. Georgia should expand Medicaid in the state to cover those earning up to 138% of the Federal Poverty Level to close the Medicaid Gap and maximize federal matching dollars. Fully expanding the Medicaid program in the state would insure an additional 267,000 adults, regardless of their status as parents or not. This would promote community-wide health and support rural hospitals in the state.
3. Georgia should fully expand Medicaid programs for postpartum mothers earning up to 225% of the Federal Poverty Level for a full year after giving birth. This expansion will provide access to mental health treatment, preventative healthcare, and contraception to prevent closely-timed pregnancies. This will also help lower Georgia’s high maternal mortality rate by providing more avenues for preventative healthcare in low-resource areas.

Conclusions

Adverse Childhood Experiences are a major public health research interest. The topic has changed the way healthcare professionals and researchers regard health disparities. ACEs are felt by the majority of the American population, but impact low-income and racial/ethnic minority populations at a higher rate because they are exacerbated by systemic racism and inequities. Efforts to prevent ACEs through teaching children resilience are important. However, to make the greatest impact on populations, public health lenses must be used to craft policy in states that will deconstruct the systems that cause trauma and build up safety nets for families. Healthy, capable, and stable parents are the greatest resource for children. Policy changes in Georgia aimed at preventing ACEs should not solely focus on children, but on supporting families as a whole.

Expanding access to affordable health insurance and reducing eviction rates are not a cure to preventing ACEs in Georgia. However, these policy interventions are major tools in the state's toolbox. Policy changes to increase health insurance access and improve housing stability for families should address the structural determinants of health inequities by dismantling existing barriers to education and stable income. Using WHO and CDC frameworks for preventing childhood trauma and violence are valuable for also improving the overall health and wellness of Georgia's population.

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