Congress asked to support public-health prevention approach

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How will the US realize the goal of the Affordable Care Act to shift the balance of medical expenditures from today’s imbalance of 97% treatment/3% prevention, to a 70%/30% balance by the end of this decade? And, where might such a major effort begin?

These questions—and their answers—were at the core of a December 5 public policy forum, “Harnessing Community Support for Health and Well-being,” hosted by ACMHA—The College of Behavioral Health Leadership. The forum was unusual because, after decades of functioning as a kind of industry think tank, ACMHA members took their discussion straight to a Senate briefing room on Capitol Hill. The goals of their three-hour briefing, whose audience included many Congresional staff, were 1) demonstrating that the research base for a sustained prevention effort is in place; 2) highlighting of the enormous role of family and community factors in long-term individual and population health; 3) arguing for active engagement of families and children in community educational and prevention programs, and 4) calling on Congress for greater latitude in using available resources for disease prevention work.

Tom Bornemann, PhD, the director of mental health programs at the Carter Center (Atlanta, Ga.) launched the briefing by suggesting that “health is about more than health care,” and that in order to understand public health challenges, it is vital to recognize that “people don’t live in a bubble,” and that basic behavioral, environmental, and social determinants play an enormous and unappreciated role in long-term health.

Thanks to advances in knowledge, Bornemann asserted that it is now essential—for the US to “get past the point of playing catch-up” with public health problems. “We need to work upstream,” he said, suggesting that Congress help lead a new conversation about prevention that recognized the value of delivering research-based knowledge and prevention practices through innovative, engaging, and sustained community-based programs.

Public health problems rooted in childhood trauma

Vincent Felitti, MD, a clinical professor of Medicine at the University of California, continued the briefing by outlining the implications of the Adverse Childhood Experiences (ACE) study, which he co-authored. He began by juxtaposing a series of images. “What is it,” he asked, “that in a space of just 20 years, can transform the remarkable potential of a newborn like this into the
reality of a homeless man lying in the street, like this?” Then, with images showing an obese woman at 408 lbs and the same woman, a year later, at 132 pounds following a medically-supervised fast, he asked what problem would cause this woman, after successfully losing more than 270 lbs, to regain 37 pounds in just three weeks, then go on to regain more than 400 pounds and disappear for 12 years before returning?”

The answer to both questions, he learned, was found in the detailed life histories of the individuals, specifically in After her sudden weight gain, the woman revealed a history of incest as a child. Subsequent detailed histories from 300 other individuals undergoing obesity treatment revealed a high prevalence of childhood abuse, neglect, or major family dysfunction. After sharing the findings with CDC researchers at an obesity treatment conference, Felitti joined with pediatrician Robert Anda, MD, to pursue a large-scale epidemiologic study to determine the prevalence of abusive or “adverse” experiences in childhood and their long-term impacts on life and health. The study would come to include over 17,000 mostly white, middle and upper-middle class, college educated people in enrolled in a Kaiser-Permanente Health plan.

In 1995, the release of the ACE study results—which focused on 10 ACEs that were prevalent among the original group of obese patients (figure 1)—demonstrated a “startling” prevalence of ACEs among the general population (Figure 2). Felitti added that subsequent analysis showed that two of three individuals report at least one ACE and that when one is reported, there is an 87% likelihood that one more is present and a 50% likelihood that two more are present but unreported. Felitti noted that, regardless of category, the ACEs were found to be “essentially co-equal” in terms of their long-term health implications.

Overall, he said that ACEs drive health risks to individuals in two ways:

· by increasing individual’s likelihood of engaging in risky health behaviors (overeating, smoking, drinking, drug use, risky sex) and

· by contributing to chronic stress that affects neurological and physical development by causing dysregulation of the body’s stress response and, over time, disruption of the molecular controls that modulate the expression of an individual’s genes.

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