

The Role of Prevention in a Trauma-Informed Approach to Wellness

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INTRODUCTION

More prevention (Pv) practitioners are adopting a **trauma-informed approach (TIA)** to effectively address physical and mental problem behaviors people develop as a result of experiencing past or current trauma. These problem behaviors can lead to serious illness and disease such as substance use disorders (SUDs).

The movement to address problem behaviors by implementing a TIA is requiring the SUD Pv field to learn about adverse childhood experiences (ACEs), historical or generational trauma, and other types of trauma that impact individuals and communities. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as *the results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening, with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

Trauma is an important concept for the Pv field because it is a risk factor for SUDs and other behavioral health challenges. Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation, although communities and populations experience different levels of risk for some traumas. Many people who suffer from mental health and SUDs experience or have experienced trauma.¹



Using a TIA within the behavioral health delivery system includes: 1) understanding both individual and community trauma; 2) being aware of how Pv practitioners can implement a TIA across settings, services, and populations; 3) recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic;² and 4) viewing trauma through a cultural and ecological lens. According to the Centers for Disease Control and Prevention, a social-ecological model is one that considers the complex interplay between individual, relationship, community, and societal life domains.³

A strong understanding of trauma can enhance both direct and indirect Pv services. Implementing a TIA to assess risk can increase the efficacy of indicated SUD Pv interventions.¹ The TIA acknowledges **“something wrong has happened to an individual that challenged their resilience.”** This approach considers the individual's socio-economic and cultural conditions, and views individuals' problematic behaviors and emotions as adaptations that enabled them to survive past trauma.² A TIA can also help ensure that environmental Pv approaches effectively address community-level needs and SUD risk factors.

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Tactics (Tak'tiks) n. 1. a plan for promoting a desired end. 2. the art of the possible.

¹ Indicated interventions are designed to prevent substance abuse among people who are experiencing early signs of use and associated problem behaviors.

This Prevention Tactic will:

1. Describe the impact of trauma on individuals and communities, focusing on how trauma impacts risk for SUDs;
2. Define and introduce the key components of a TIA, and how this approach is different from current Pv efforts; and
3. Provide examples and strategies from communities that are implementing a TIA.

Three E's of Trauma

SAMHSA advanced the definition of trauma with the three "E's" of trauma: **Event(s)**, **Experience** of the event(s), and **Effect**.¹

Event(s)

An **event**, or a series of events, is a situation or circumstance that occurred and caused a person to feel very threatened.⁴ The event(s) may occur once or may continue over a period of time, and may happen at the individual, community, or generational level.

Experience of the Event(s)

The individual's **experience** of these events or circumstances help determine whether the events are traumatic.¹ It is important to understand what may be a traumatizing experience for one person may not be to another. Individuals experience events influenced by cultural beliefs, social supports, or developmental stage.⁵

Protective factors increase an individual's or community's resiliency to build coping skills, reduce the negative internalization of a traumatic event, and help prevent later consequences or effects of trauma. For example, a caregiver may recognize the impact of potentially traumatic events on a young child and intervene on the



For more information about types of trauma, visit SAMHSA's webpage, Trauma and Violence: <https://www.samhsa.gov/trauma-violence>

child's behalf by providing emotional support, advice, and advocacy that may reduce the impact of trauma.

Interrelated threatening events can build on one another, compound the experience of trauma, and result in greater risk for developing behavioral health challenges. For instance, a parent who uses substances to self-medicate may create traumatic experiences for a young child. The child may be further traumatized if the substance abuse causes other family devastations such as child maltreatment, divorce, and financial problems.

As another example, a community may be impacted by a natural disaster or high-profile incident of violence, such as a school shooting. If the community does not have the resources and services it needs to recover from the incident, or if there is unequal access to support resources, this may result in further trauma to the community.

Effects

The **effects** of trauma can be long term. The initial effect of an event may occur immediately while others occur later. Trauma is a significant risk factor for SUDs. Many times, an individual will not correlate the connection between adult behaviors and negative health outcomes with childhood trauma. Although research has shown a strong link between childhood trauma and SUDs, this correlation is not always apparent to the people who experience them or to a practitioner who is not competent in TIA.

Types and Causes of Trauma

Traumatic events come in many forms, impacting both individuals and communities. Examples of **traumatic abuse experienced by individuals** include sexual abuse or assault; physical abuse or assault; military trauma; traumatic grief or separation; and psychological maltreatment, such as verbal abuse, emotional abuse, excessive demands or expectations, or intentional social deprivation. **Maltreatment** and **neglect** is the most

Toxic stress experienced early in life can have a cumulative toll on an individual's physical and mental health.¹¹

common form of abuse reported to child welfare authorities. Maltreatment is the cruel or violent treatment (physical and/or psychological) of an individual. Neglect is the failure to provide an individual with basic needs, and also includes exposure to dangerous and/or unhealthy environments, abandonment, or expulsion from home.⁷ Additionally, system-induced trauma can be experienced by individuals and families involved in child welfare, mental health, and other systems of care.⁸

Community or collective trauma is the result of a group of people experiencing or witnessing a traumatic event or conflict. Examples of these include natural disasters, war, displacement, genocide, state violence, or school shootings, among other trauma.⁸ This kind of trauma can be harmful or promote risk even among individuals who do not appear to be directly impacted by the event.

Racial or race-based trauma describes the harmful impacts of racism and discrimination at both individual and community levels. For example, recent research has found that police killings of unarmed African Americans have a negative, cumulative effect on the mental health of African American adults in the general population, not just for individuals who knew a person who was killed.⁹

Historical or generational trauma is a form of collective trauma. It is the cumulative emotional and psychological wounds transmitted across generations, often involving unresolved grief and anger. In many cases, it is associated with racial and ethnic groups who experienced intergenerational trauma caused by systemic assaults on their culture, livelihood, and well-being.⁸ It is also important to understand that the term “historical” trauma does not mean that the traumatic events have ended or took place only in the past.

Influence of Trauma

Cognitive and Executive Functioning and Disruptions of the Body's Stress Response

Over the past twenty-five years, neuroscience provides us with an understanding of how genetics, early childhood

experiences with caregivers, and the environment can have a long-lasting impact, for better or worse, on a child's developing brain. These advances in neuroscience have begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental health and SUDs across the life-span.^{9,10}

Part of childhood is coping with stressful events. When we are threatened, our bodies activate a variety of physiological responses, including increases in heart rate, blood pressure, and stress hormones such as cortisol.¹¹ These survival responses (sometimes referred to as fight, flight, and freeze) protect or buffer us from the threat. When children have connections with caring adults, the child's response systems can return to normal. This form of resiliency helps children cope with trauma.

Traumatized children tend to respond to the world as a dangerous place by activating the neurobiological systems geared for survival even when they are safe.¹² These traumatized children have experienced strong, frequent, or prolonged adverse experiences such as extreme poverty or repeated abuse. The stress from these experiences becomes toxic as excessive cortisol disrupts developing brain circuits. Toxic stress experienced early in life can have a cumulative toll on an individual's physical and mental health.¹¹

Trauma's Influence on the Developing Brain and Child Response Systems

Health consequences from trauma are significant as we consider the nature, scope, harm, and influence on risk behaviors, including substance use, abuse, and dependence. Substantial documentation in scientific literature supports the link between early childhood traumas, health behaviors, and health. In the case of child maltreatment trauma, there is an association with a broad range of emotional, behavioral, and physical health problems.¹⁰ Prevalence estimates vary, but as many as 68 percent of children and youth in the United States may be exposed to a traumatic event by age sixteen.

Childhood trauma is a risk factor for substance use and SUDs. Consequences of childhood trauma depend on various factors: child's age when victimized; duration and severity of the abuse or neglect; the child's innate resiliency; and co-occurrence with other maltreatment or adverse exposures, such as the mental health or substance abuse of the parents or family violence.^{13,14}

Aggression, conduct disorder, delinquency, antisocial behavior, substance abuse, intimate partner violence, teenage pregnancy, post-traumatic stress disorder, anxiety, depression, and suicide are among the emotional and behavioral problems associated with child maltreatment.¹⁵⁻¹⁸ Maltreatment and other adverse exposures are also associated with poor adult health, including diabetes; ischemic heart disease; sexually transmitted diseases; and a variety of health risk behaviors, including smoking and obesity.¹⁹⁻²² In addition, exposure to child maltreatment can have negative repercussions for cognitive development, including language deficits and reduced cognitive functioning.¹²

ADVERSE CHILDHOOD EXPERIENCES (ACEs)

The Adverse Childhood Experiences Study

The following section describes the Adverse Childhood Experiences (ACE) Study. The study assessed ten categories of traumatic childhood experiences (see Appendix).²³ The key concept underlying the ACE Study was that stressful or traumatic childhood experiences are a common pathway to social, emotional, and cognitive impairments. The study was critical for showing that an accumulation of ACEs can lead to increased risk of poor health outcomes, including SUDs, violence or re-victimization, disease, disability, and premature death (Figure 1).²⁴

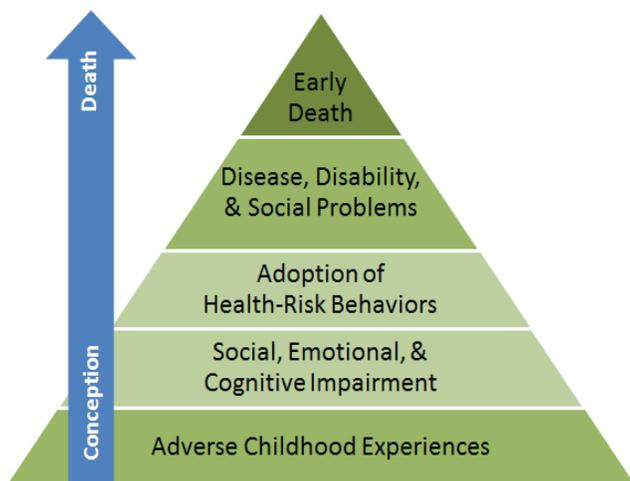


Figure 1. Conceptual Framework for Understanding the Public Health Impact of ACEs²⁵

Kaiser Permanente’s Health Appraisal Clinic in San Diego and the Centers for Disease Control and Prevention conducted the ACE Study in the late 1990s. The study was one of the largest studies to assess the correlation of

family dysfunction and child maltreatment to health behaviors and outcomes later in life. The study’s population included 17,337 people (54 percent women, 46 percent men) with a mean age of 56 years; 75 percent were white. Of the participants’ educational backgrounds, 39 percent had college degrees, 36 percent had some college education, 18 percent had a high school education, and 7 percent did not graduate from high school.

The study claimed two major findings. The first finding is that **ACEs are much more common than anticipated or recognized**. Even in the middle-class population that participated in the study, nearly two-thirds of the participants reported at least one ACE.²⁵ Additionally, the data demonstrate that ACEs are highly interrelated. If a person has one ACE, more than likely they have others.

The second major finding is that **ACEs have a powerful correlation to health outcomes later in life**. Therefore, the short- and long-term outcomes of these childhood exposures include a multitude of health and social problems.²⁶ The study indicated that as the number of ACEs increase, there is a strong gradient response to the number of participants that demonstrated adverse behaviors and health outcomes. Examples of some adverse behaviors include early initiation of alcohol, alcoholism and alcohol abuse, early initiation of smoking, illicit drug use, domestic violence, depression, and early initiation of sexual activity. Examples of adverse health outcomes include fetal death, liver disease, chronic obstructive pulmonary disease, and ischemic heart disease.²⁷

One of the strongest relationships was between the ACE score and alcohol use and abuse (Figure 2).^{28,29} Early initiation of alcohol use is related to higher ACE scores.³⁰

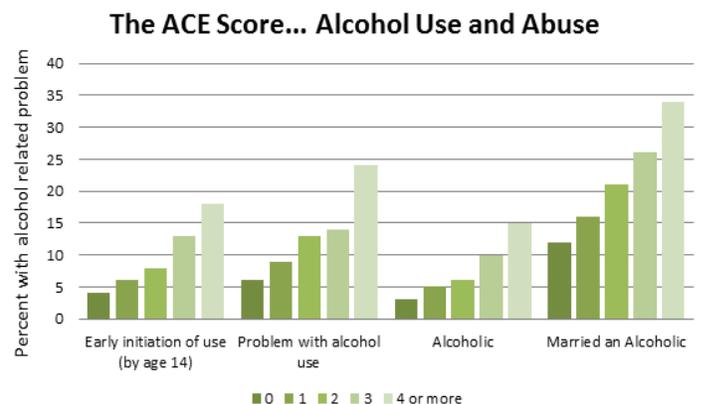


Figure 2. The ACE Score – Alcohol Use and Abuse

The cycle of alcohol use and dependence, including marriage to a person with alcoholism, appears to be closely related to higher ACE scores.²⁶

ACEs Across Populations

Although the prevalence of ACEs is generally consistent across race and ethnicity, high numbers of ACEs correlate with a person's socioeconomic status, including poverty, education, and employment.²⁴ Recently, the Center for Youth Wellness published *A Hidden Crisis*, a report that highlights empirical data on ACEs in California. The report used data that the annual California Behavioral Risk Factor Surveillance System collected data in 2008, 2009, 2011, and 2013. The study found that ACEs affect Californians regardless of geography, race, income, or education. However, a person with four or more ACEs is:

- 21% more likely to be below 250% of the Federal Poverty Level
- 27% more likely to have less than a college degree
- 39% more likely to be unemployed

Given the pervasiveness and broad societal influences of trauma, efforts must begin to recognize and address trauma as a public health problem. A public health approach to trauma focuses on preventing trauma from occurring and intervening early to mitigate its effect when it does occur.³¹

Understanding ACEs as a public health concern requires us to think about the “causes behind the causes,” also referred to as the social determinants of health (SDOH). SDOH are the conditions in which we live, work, learn, and play that heavily influence the health we can achieve (Figure 3).³² The SDOH influence early childhood experiences that either protect and nurture childhood development or incite the emergence of ACEs.²⁴ Studies have shown that social determinants such as economic distress, housing insecurity, low family income, low parental education, and lack of social support are associated with child maltreatment and dysfunctional households, which result in ACEs.^{33,34} For more information about SDOH, read *Social Determinants of Health: A Common Language Across Sectors* (CPI).

PRINCIPLES, ASSUMPTIONS, AND STRATEGIES OF A TRAUMA-INFORMED APPROACH

Key Principles of a TIA Approach

Trauma-specific interventions are specific programs or practices that are designed to address or prevent the

long-term consequences of trauma and address trauma as a risk factor. Seeking Safety, the Sanctuary Model, and Addiction and Trauma Recovery Integration Model (ATRIUM) are examples of trauma-specific interventions.³⁵ A TIA reflects a commitment to SAMHSA's six principles (Figure 3).

Key Principles to Support a Trauma-Informed Approach³⁵

SAMSHA developed six key principles to support a TIA. These principles should provide guidance to an organization or community working towards creating trauma-informed systems of health and social services. The six key principles consist of the following:

1. **Safety:** The organization providing services ensures clients feel both physically and emotionally safe. The organization makes sure that the physical setting is safe and interpersonal interactions promote a sense of safety.
2. **Trustworthiness and Transparency:** The organization ensures transparency in organizational decision-making in order to build trust with clients, family members, and staff.
3. **Peer Support:** The organization employs peer support and mutual self-help as key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing client stories and lived experiences to promote recovery and healing.
4. **Collaboration and Mutuality:** The organization recognizes that everyone has a role to play in a TIA. Importance is placed on partnering and the leveling of power differences among staff as well as between staff and clients.
5. **Empowerment:** The organization recognizes and builds upon individuals' strengths and experiences throughout the organization and among the clients served.
6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases; offers access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served; and recognizes and addresses historical trauma.

Figure 3. SAMHSA's Six Key Principles

The 4 Rs: Key Assumptions for a Trauma-Informed Approach

SAMHSA's concept of a TIA is grounded in four key assumptions.¹ A trauma-informed program, organization, system, or community should:

- **Realize** the widespread impact of trauma and understand potential paths to overcome trauma and prevent behavioral and mental health challenges.
- **Recognize** the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
- **Respond** by fully integrating knowledge about trauma into policies, procedures, practices, and settings.
- **Resist** re-traumatization of clients and staff.

Strategies to Preventing Trauma

Research and practice produced effective strategies to promote trauma-informed environments, prevent ACEs and re-traumatization, and intervene in traumatic circumstances. This section outlines some strategies that are based on trauma-informed principles.

Enhance Protective Factors

Enhancing protective factors is a core strategy in a TIA. Protective factors are circumstances in a child's life that protect the child from harm and promote stability and resilience. Examples include supportive family and social relationships, exercise, sleep, nutrition, positive

A Trauma-Informed Approach in Human Services?

"When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization."

—National Center for Trauma-Informed Care

environment, listening to music, and meditation. Protective community factors include adequate housing, access to health care, available support systems, and caring adults outside the family.³⁶ For example, the Arizona ACE Consortium implements the evidenced-based Pv program Triple P Parenting to increase caregivers' knowledge, skills, and confidence, with the goal of reducing the rates of behavioral and emotional problems in children.³⁷

Build Capacity to Prevent ACEs

Agencies, service providers, and local organizations and leaders can foster a community infrastructure that identifies trauma as a risk factor; reduces violence; and links youth and adults to support services, people, and environments. Providing capacity building opportunities around trauma-informed, culturally competent, and developmentally appropriate services and systems can help to foster this infrastructure.³⁸ For example, two school systems in Maine are piloting screening for trauma as part of their in-home visits to all pre-kindergarten children. Pediatric and family practices statewide are incorporating trauma screening in their work.²⁷ Screening helps to identify children who are experiencing trauma or who are experiencing high-risk situations. Early identification and interventions can prevent adverse health outcomes in later life.

Promote Resilience

Inherent to a TIA is the concept of resiliency. Resilience refers to the ability to bounce back or rise above adversity as an individual, family, community, or provider. From SAMHSA's perspective, it is **critical to promote resilience** for those individuals and families affected by trauma.⁴⁰ Well beyond individual characteristics of self-assurance, resilience includes the process of using available resources to navigate hardship and/or the consequences of adverse events.² For example, Alberta, Canada implemented a TIA with its Alberta Family Wellness Initiative (AFWI). The AFWI implemented a corrections system model, a website, and podcasts that explicitly link toxic stress, resilience, and prevention.³⁹

TAKING ACTION ON A TRAUMA-INFORMED APPROACH

Transitioning to a Trauma-Informed Approach

There are a growing number of initiatives to implement a TIA. For example, the state of Washington implemented a framework for a TIA that includes neurobiology, ACEs, resiliency, and systems change. Many communities already have an existing coalition whose mission is SUD Pv. Most of these coalitions already include community mobilization efforts, cross-sector membership, a planning process (the Strategic Prevention Framework), and resources to support their efforts. The challenge and opportunity is infusing the TIA as a strategy within the coalition's strategic plan.

The strategies and examples in this section are adapted from The [Community Resilience Cookbook](#) and from SAMHSA's Building Resilient and Trauma-Informed Communities series.⁴⁰ The Cookbook identifies the following elements for moving Pv upstream in their Recipe for Resilience: Collaboration and Leadership, Community Education, Resources, Communication, Research, and Mindset. Communities nationwide and abroad are referencing this successful framework to implement a TIA to community building.

Collaboration and Leadership

Anyone from the community can be the catalyst for beginning to build a community's understanding of trauma and resilience. Collaboration allows small or siloed groups to assess what, if any, trauma-specific interventions exist in their community. If services do not implement a TIA, the group can develop a plan to improve the current TIA in place, develop a TIA, or implement trauma-specific interventions.

Contacting other cities and states that have trauma-informed systems of care is a great start. For example, when the Vice Mayor of Tarpon Springs, Florida, learned about the ACEs study, she launched an effort to become a trauma-informed community that grew into an initiative (Peace4Tarpon) that engages thousands of community members. One community member spearheaded an effort to extend the work of *Peace4Tarpon* into the county ex-offender reentry coalition's substance abuse program by incorporating the Seeking Safety curriculum.⁴¹



Cross-Sector and Community Education

This element involves educating all relevant sectors about trauma and the TIA, including both professionals and community stakeholders, such as direct prevention service providers, local government, school administrators, law enforcement, youth and families, etc. For the Pv field, this is an opportunity to promote understanding of the TIA as an upstream approach to preventing SUDs and other behavioral health challenges. The education can begin at a foundational level and then progress to subsequent forums that address more complex issues. For example, under its Trauma-Informed Systems initiative, the San Francisco Department of Public Health launched an effort to train its 9,000 employees across agencies on a trauma-informed framework and addressing trauma in the workforce.⁴² Consider developing a curriculum that integrates TIA competencies, such as promoting resilience and coping skills. Explicitly link the TIA to Pv by explaining how trauma is a risk factor for SUDs. Include a discussion of the relationship between ACEs and trauma, trauma-informed best practices, and successful community-driven TIA strategies.

Resources

Fostering community development strategies to link individuals to opportunities encourages community stability.³⁴ Community efforts to implement a TIA should include an assessment of current resources to support the future planning, data-gathering, and other activities of the group or coalition. For example, Dalles, Oregon's

city education was the only recipient to receive a five-year Safe Schools/Healthy Students grant. However, the core multi-agency team used this opportunity to conduct a needs assessment to identify problems, trauma-informed solutions, and partners with whom to share resources and implement the project.⁴³

Communication

Trauma-informed community communication efforts involve internal and external engagement. Formal memoranda of understanding, mission and vision development, and documentation of efforts are internal communications. External communications include presentations about trauma and ACEs, media outreach, websites, and newsletters. For example, the Central Massachusetts Recovery Learning Community (CMRLC) developed a documentary on trauma, *What Happened to You?* This film is a tool that supports trauma-related screenings, discussions, and outreach.⁴⁴

Data/Research

ACEs data collection creates a baseline to measure change and gauge the effects of ACEs in the selected community or area. In order to measure short-term success, the Pv specialist will have to identify intermediary indicators to encourage and maintain a community's decision to invest in a TIA. Success along the way, as captured by data-driven intermediary indicators, will help a community persevere long term in order to see the positive individual and community health outcomes that result from a TIA. The strategic plan may be updated to include implementation of policies, practices, and programs that address ACEs through the lens of resiliency. For example, before launching the Children's Resilience Initiative in Walla Walla, Washington, implementers spent nine months gathering information on ACEs-related community needs, resources, and possible partnerships. They continue to monitor progress through a collective impact model in which multiple agencies evaluate change using common measurement techniques.⁴⁵

Mindset

Developing a trauma-informed mindset involves recognizing the community's attitudinal barriers to understanding the role of ACEs, following the interests of the community, letting local conditions guide the work, and preparing for long-term engagement. Focusing on hope, resilience, and change can help to sustain these efforts. For example, the Porch Light Program in

Philadelphia, Pennsylvania, is a collaboration to co-create public art across the city to build trust, morale, and communities of healing. This highly visible creative project has led to community conferences, trauma-informed public tours, and more opportunities for advancing the work.⁴⁶

CONCLUSION

As shared in this Tactic, a comprehensive TIA can effectively support those who experience trauma. A TIA instills individual coping skills, enhances community resources for dealing with collective trauma, and may ultimately help prevent future traumatic events. The examples throughout the tactic demonstrate how a small group of people can initiate community education and mobilization through a TIA approach.

The Pv workforce can play a critical role in addressing SUD risk by implementing a TIA that includes promoting resilience, enhancing protective factors, collaborating with other agencies and with the community, being responsive to historical and cultural trauma, and educating others about trauma and resilience.

Behavioral and mental health challenges do not emerge in a vacuum. They are rooted in the lives and histories of individuals and communities. Adopting a TIA helps us understand how traumatic experiences can contribute to the development of SUDs. Using a TIA, Pv professionals can implement programs and services that more effectively address underlying risk factors for SUDs.



Appendix: ACEs Questionnaire

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
No ___ If Yes, enter 1 ___
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
No ___ If Yes, enter 1 ___
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
No ___ If Yes, enter 1 ___
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
No ___ If Yes, enter 1 ___
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
No ___ If Yes, enter 1 ___
6. Was a biological parent ever lost to you through divorce, abandonment, or other reason? No ___ If Yes, enter 1 ___
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
No ___ If Yes, enter 1 ___
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
No ___ If Yes, enter 1 ___
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
No ___ If Yes, enter 1 ___
10. Did a household member go to prison? No ___ If Yes, enter 1 ___

Now add up your "Yes" answers: This is your ACE Score _____

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