

May 2024

California Adults With Adverse Childhood Experiences (ACEs) Are at Greater Risk for Serious Psychological Distress and Report Perceived and Unmet Need for Mental Health Care Services

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SUMMARY

KEY TAKEAWAYS

- > 1 in 5 California adults overall reported four or more adverse childhood experiences (ACEs), although larger proportions of young adults had four or more ACEs.
- > Among adults with four or more ACEs, the percentage experiencing serious psychological distress (SPD) in the past year was 28.6%, about four times the figure for adults who reported zero ACEs (7.3%).
- > 1 in 3 adults with one to three ACEs had an unmet need for mental health care services, and almost 2 in 5 with four or more ACEs had unmet need. Young adults had greater unmet need for mental health care services compared with other age groups.

Summary: This policy brief uses data from the 2022 California Health Interview Survey to analyze the distribution of adverse childhood experiences (ACEs) and positive childhood experiences (PCEs) and their relationship to mental health issues such as serious psychological distress (SPD) and to perceived need and unmet need for mental health care among California adults.

Adverse childhood experiences (ACEs) refer to particularly stressful or traumatic events that children experience before the age of 18.

INTRODUCTION

Research shows that childhood experiences shape health trajectories across a person's lifespan.¹ Adverse childhood experiences (ACEs) refer to particularly stressful or traumatic events that children experience before the age of 18. These include physical or emotional neglect; physical, sexual, and emotional abuse; and household challenges, including intimate partner violence, divorce or parental separation, or living with anyone involved in the criminal justice system or struggling with mental illness and/or substance use disorder.²

ACEs can contribute to repeated or prolonged activation of the body's stress response, or toxic stress, which can disrupt healthy brain development and alter how the body responds to future stressful experiences.^{3,4} ACEs can negatively impact mental and physical health into adulthood, even when environmental conditions have improved.^{5,6} Accordingly, preventing ACEs can reduce a broad range

of serious health conditions (e.g., depression and cardiovascular disease), socioeconomic challenges (e.g., unemployment), and health risk behaviors (e.g., heavy drinking and smoking) in adulthood, as well as the economic burden associated with these conditions.^{3,7}

California is implementing several state-level efforts to increase public awareness and prevention of ACEs. For instance, the Office of the California Surgeon General (OSG) is developing a \$24 million public awareness campaign centered on ACEs and toxic stress.⁸ Specifically, the ACEs Aware Initiative aims to increase awareness about the profound impacts of ACEs and toxic stress on long-term health outcomes and to identify ways to address them early in life. Also, insurance providers in California have begun reimbursing hospitals for ACEs screenings of both children and adults.

2 in 3

California adults reported having had at least one ACE, with

1 in 5

experiencing four or more ACEs before the age of 18.

By integrating ACEs screenings into routine health care practice, providers are able to identify individuals at risk for toxic stress and initiate timely interventions to prevent or mitigate the adverse effects of childhood trauma.⁸

In addition to the prevention of ACEs and their harmful health effects, research has also recognized the protective role of positive childhood experiences (PCEs). PCEs refer to seven benevolent or advantageous experiences an individual may have before the age of 18, including feeling safe and protected at home, feeling that their family stood by them during difficult times, and feeling a sense of belonging in high school.⁹ Some studies have found evidence that PCEs can preserve health later in life even for adults who were exposed to many ACEs. A national longitudinal study found evidence that PCEs are protective against several adult health conditions, and that some of these associations (e.g., childhood peer support, healthy school climate, and

neighborhood safety domains) persisted, even when accounting for ACEs.¹ A regional study found that adults with higher numbers of PCEs had lower odds of depression in adulthood, adjusting for ACEs.¹⁰

The life course theory provides a framework for understanding how early life events, especially during sensitive developmental periods, shape health later in life.^{11, 12} Thus, investigating how both adverse and positive early life experiences shape mental health across phases of adulthood can shed light on what periods of adulthood are most affected.

Using the 2022 California Health Interview Survey (CHIS), this policy brief documents trends in ACEs and PCEs across the adult life course and examines their association with severe psychological distress (SPD) and with perceived and unmet need for mental health care across several demographic characteristics. Research has documented positive associations between ACEs and unmet health care needs among children in the U.S.^{13, 14} This policy brief examines differences in perceived and unmet need for mental health services among California adults who have experienced ACEs, across racial and ethnic groups and self-reported gender, with the goal of providing tailored mental health care policy recommendations and interventions.

Adverse and Positive Childhood Experiences Among California Adults

2022 CHIS data show that 2 in 3 California adults reported having had at least one ACE, with 1 in 5 experiencing four or more ACEs before the age of 18. In addition, about 9 in 10 adults reported having had at least one PCE (data not shown). (See Appendix Exhibits A1 and A2 for breakdown of ACEs and PCEs categories.)

Exhibit 1 shows that exposure to ACEs varies across the California adult population. Examining each age group, the proportions of

1 in 4 (24.5%)

adults ages 18–35 reported four or more adverse childhood experiences, higher than for adults overall.

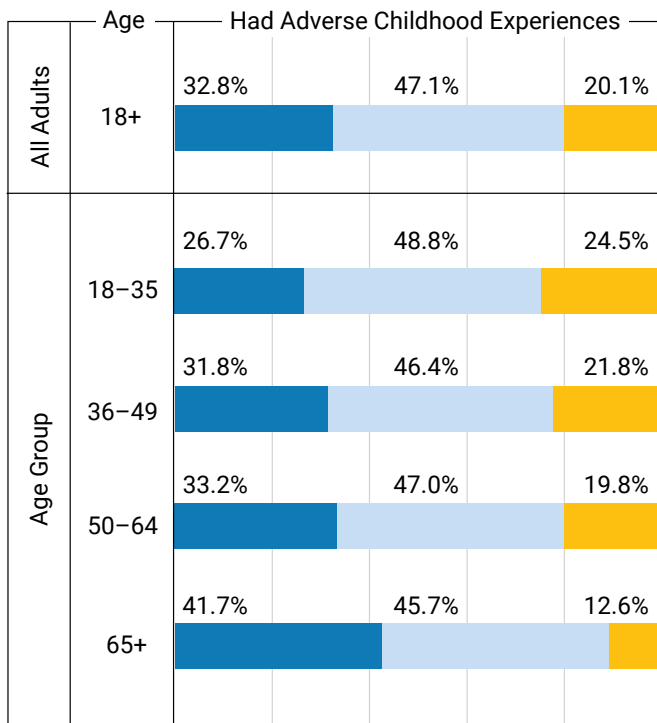
young adults (ages 18 to 35) and middle-aged adults (ages 36 to 49) who reported having had four or more ACEs were about twice as large as the proportion of older adults (ages 65 and over) (24.5% and 21.8% vs. 12.6%, respectively).

Data segmented by race and ethnicity show that more than 7 in 10 Native Hawaiian or Pacific Islander (NHPI) adults reported having one to three ACEs – the greatest proportion among all racial or ethnic groups (Appendix, Exhibit A3). Greater proportions of adults who identified as American Indian or Alaska Native, as belonging to two or more racial or ethnic categories, as Black or African American, or as Latinx reported having had four or more ACEs when compared to all adults (36.8%, 27.3%, 25.9%, and 24.2%, respectively). Furthermore, about half (50.8%) of Asian adults reported not having had any ACEs.

Although there were no significant differences when comparing ACEs exposure by self-reported gender, almost half of men and women (46.9% and 47.4%, respectively) had one to three ACEs, and about 1 in 5 had four or more ACEs (Appendix, Exhibit A3).

Exhibit 1 / Percentages of Adults Reporting Adverse Childhood Experiences (ACEs) by Age Category, California, 2022

■ 0 ACEs ■ 1 to 3 ACEs ■ 4 or More ACEs

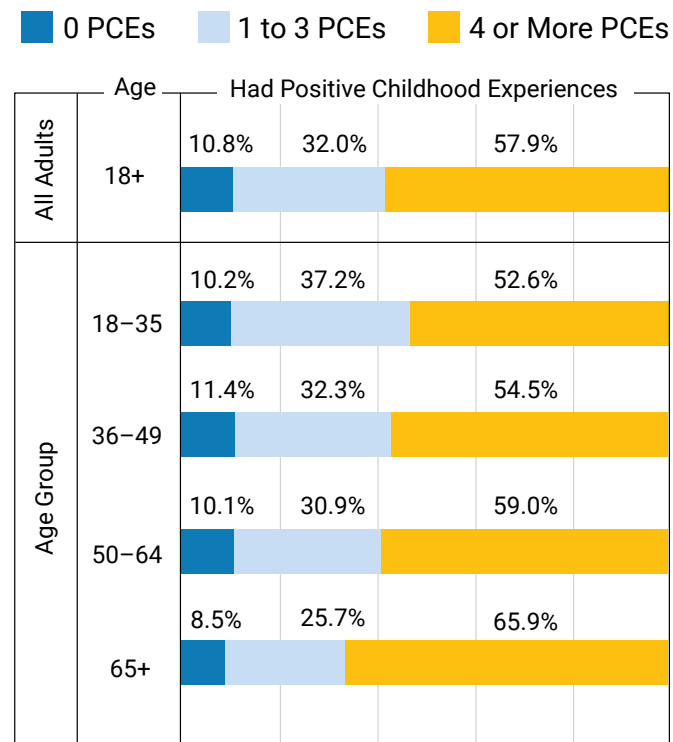


Source: 2022 California Health Interview Survey

Exhibit 2 shows that 1 in 10 adults reported not having had any PCEs, while about one-third had one to three PCEs, and a majority reported having had four or more PCEs.

Data also show that slightly larger proportions of young and middle-aged adults reported not having had any PCEs compared to older adults (10.2% and 11.4% vs. 8.5%, respectively). At the same time, larger proportions of young and middle-aged adults reported having had one to three PCEs compared to older adults. However, a larger proportion of older adults reported having had four or more PCEs compared to young and middle-aged adults (65.9% vs. 52.6% and 54.5%, respectively).

Exhibit 2 / Percentages of Adults Reporting Positive Childhood Experiences (PCEs) by Age Category, California, 2022



Source: 2022 California Health Interview Survey

DEFINITIONS

PERCEIVED NEED FOR MENTAL HEALTH CARE

Based on self-reported need to see a professional for problems with mental health and use of alcohol and/or drugs in the past year.

UNMET NEED FOR MENTAL HEALTH SERVICES

Based on self-reports of not seeing a mental health or medical provider in the past year for mental or behavioral health problems among adults with a perceived need for mental health services or with moderate or serious psychological distress.

Greater proportions of adults who identified as Latinx, as belonging to two or more racial or ethnic categories, and as Black or African American reported not having had any PCEs (12.0%, 11.8% and 10.9%, respectively) compared to all other racial and ethnic categories. Greater proportions of white, Black or African American, and Asian adults reported having had four or more PCEs (62.7%, 62.3%, and 61.7%) compared to all adults (Appendix, Exhibit A4).

Women were more likely than men to report not having had any PCEs (11.6% vs. 8.5%), and a smaller proportion of women than men reported four or more PCEs (56.3% vs. 59.6%) (Appendix, Exhibit A4).

ACEs, PCEs, and Serious Psychological Distress

Exhibit 3 shows that among adults who reported zero ACEs, 7.3% reported experiencing serious psychological distress in the past year. In comparison, the proportion of adults with one to three ACEs who reported serious psychological distress in the past year was more than twice that (17.5%), and the proportion of adults with four or more ACEs who reported experiencing serious psychological distress in the past year (28.6%) was four times that of adults with no ACEs.

In comparison, adults who had no PCEs had the greatest proportion who reported experiencing serious psychological distress in the past year (29.2%), while adults with four or more PCEs had the smallest proportion who reported experiencing serious psychological distress in the past year (9.8%).

ACEs, PCEs, and Perceived Need for Mental Health Care

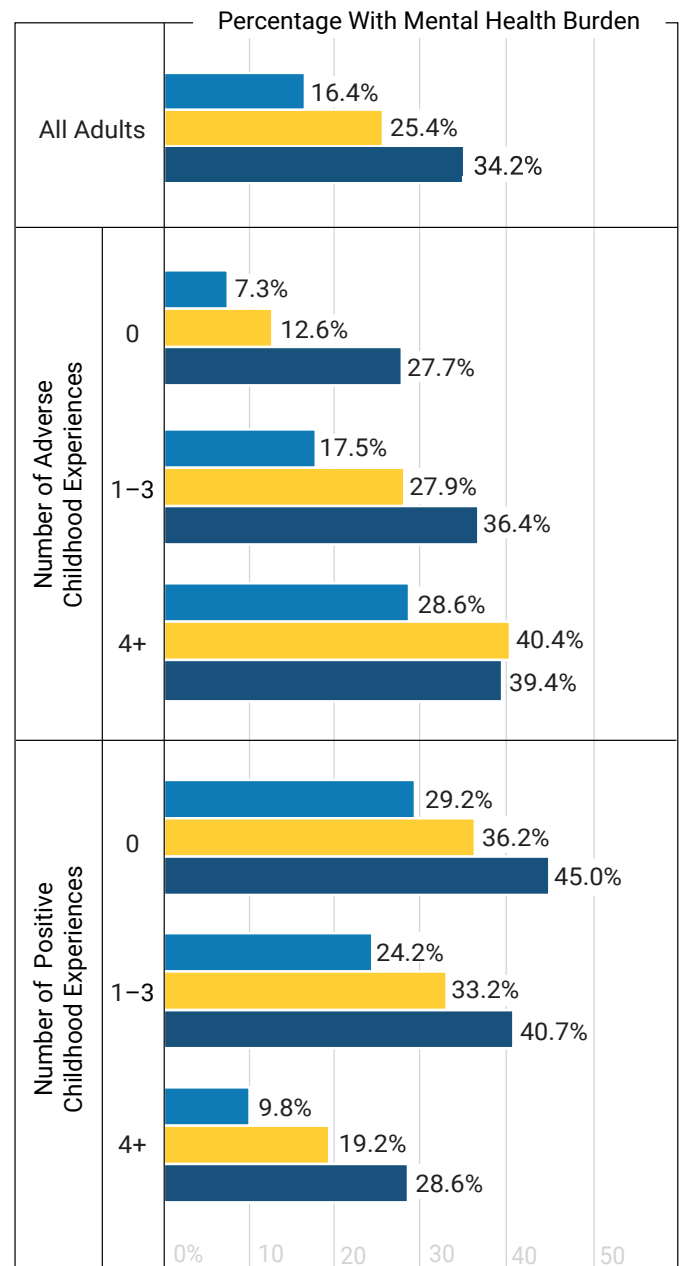
Exhibit 3 shows that adults with more ACEs also report greater proportions of perceived need for mental health care.

Two in 5 adults with four or more ACEs reported a perceived need, which is more than three times the proportion of adults who did not have any ACEs (40.4% vs. 12.6%).

Adults who reported zero PCEs and those who reported one to three PCEs had similar proportions of perceived need for mental health services (36.2% vs. 33.2%), while among adults with four or more PCEs the figure was 19.2%.

Exhibit 3 / Percentages of Adults by ACEs and PCEs Exposure, Past Year Serious Psychological Distress, Perceived Need for Mental Health Care, and Unmet Need for Mental Health Services in the Past Year, California, 2022

- Serious psychological distress in the past year
- Perceived need for mental health care in the past year
- Unmet need for mental health services in the past year



Source: 2022 California Health Interview Survey

ACEs, PCEs, and Unmet Need for Mental Health Services

Exhibit 3 further shows that about one-third of adults with one to three ACEs had an unmet need for mental health care, and close to 2 in 5 adults with four or more ACEs also had unmet need.

Similar proportions of adults who reported zero or one to three PCEs reported having unmet need for mental health care (45.0% and 40.7%). In contrast, less than one-third (28.6%) of adults with four or more PCEs reported having unmet need.

Exhibit 4 shows that among young adults who had at least one ACE, 37.7% reported experiencing serious psychological distress in the past year, which is about twice the proportion of middle-aged adults (18.7%), almost four times as large as that of adults ages 50 to 64 (10.5%), and six times as large as that of older adults (6.5%).

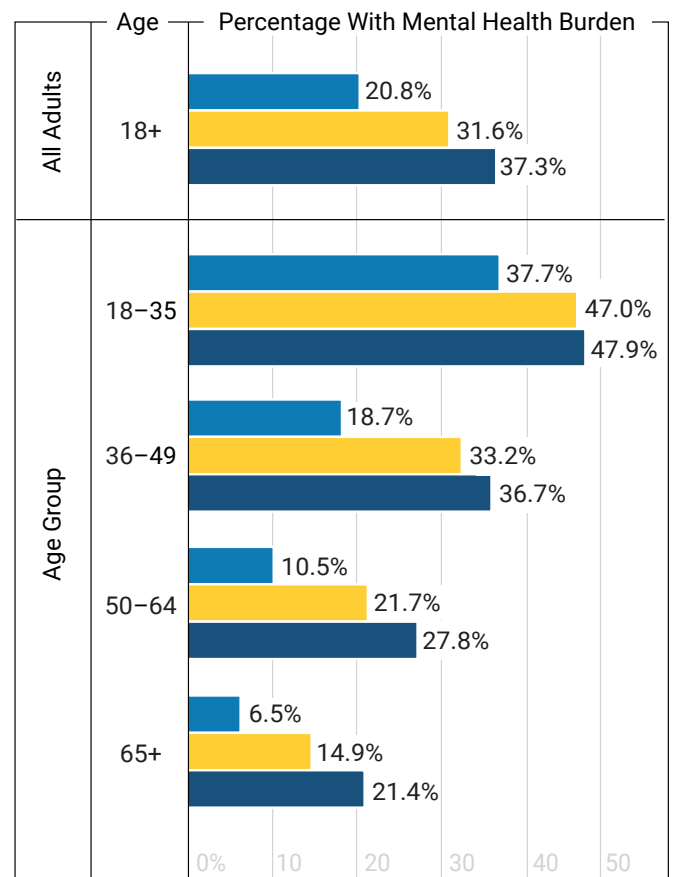
Among adults who identified as two or more racial or ethnic categories, 44.3% reported having a perceived need for mental health services, which was the largest proportion across all racial or ethnic categories. Latinx adults, adults who belong to two or more race categories, and Asian adults had the largest proportions reporting having an unmet need for mental health care (36.0%, 38.4%, and 39.5%, respectively) (Appendix, Exhibit A5).

Although men and women had similar proportions of ACE exposure, a larger proportion of women than men reported

experiencing SPD (24.7% vs. 16.5%) and having perceived need for mental health care (37.2% vs. 25.6%). Women and men had similar proportions of unmet need (33.0% vs. 33.0%) (Appendix, Exhibit A5).

Exhibit 4 / Percentages of Adults With at Least One ACE Who Reported Past Year Serious Psychological Distress, Perceived Need for Mental Health Care, and Unmet Need for Mental Health Services by Age, California, 2022

- Serious psychological distress in the past year
- Perceived need for mental health services in the past year
- Unmet need for mental health services in the past year



Source: 2022 California Health Interview Survey

1 in 3

adults with one to three ACEs had an unmet need for mental health care, and almost

2 in 5

with four or more ACEs had unmet need.

DISCUSSION

This brief demonstrates the high burden of ACEs that adults in California reported in 2022. The findings also suggest that the prevalence of having at least one ACE as well as of having four or more ACEs was higher among California adults compared to the national average (67.2% vs. 63.9% and 20.1% vs. 17.0%, respectively).¹⁵ Moreover, the findings also bolster prior research documenting the adverse mental health implications associated with ACEs.

The brief also indicates the protective role of PCEs in relation to adult mental health. However, about 1 in 5 adults with four or more PCEs still reported a perceived need for mental health care, and almost one-third reported unmet need for mental health services. These data further emphasize the need for greater investments in mental health services, access to toxic stress-responsive care, and other forms of mental health care.

Recommendations

Below are recommendations for bolstering current efforts to identify and prevent ACEs, as well as to mitigate its negative effects on health:

- **Increase health care providers' confirmed ACEs trainings (attestations).** While CHIS data indicate high exposure to ACEs across adult age groups in 2022, there remains a critical gap in the prevalence of ACEs screenings. In California, health care providers who wish to receive Medi-Cal reimbursement payments for conducting ACEs screenings must attest to (or confirm) completion of the ACEs Aware trainings. However, data from the California Department of Health Care Services (DHCS) show that confirmed training among Medi-Cal health care providers varied drastically, with many California counties reporting low attestations.¹⁶

Data also show that the percentages of Medi-Cal recipients who were screened for ACEs varied greatly by county. For example, the percentage of Medi-Cal recipients who had an ACEs screening ranged from 0.2% (Colusa County) to 39.6% (Orange County) among children and young adults ages 0 to 20, and from 0.1% (Lake, Butte, and San Mateo counties) to 8.4% (Tulare County) among adults ages 21 to 64.¹⁷ Given that Medi-Cal serves low-income California households, the state should consider developing new awareness campaigns targeted at increasing provider attestations to ensure equitable ACEs screenings and treatments.



- **Expand ACEs training requirements to all insurance payers.** In 2021, the state also enacted a new law mandating that all commercial insurance plans provide coverage for ACEs screenings of children.¹⁸ There is a need to expand training requirements across all payers to ensure widespread adoption and sustained implementation of ACEs screenings and intervention protocols for both adults and children. This could also help ensure that (1) ACEs screenings continue to identify the risk of toxic stress across the California population, and (2) informed, toxic stress-responsive care, including “stress busters” (e.g., balanced nutrition, mindfulness activities, and quality sleep), become core components of treating any health condition associated with ACEs or toxic stress as a standard practice in health care delivery.⁸ Furthermore, ensuring training requirements across all payers will promote equitable access to ACEs screenings and

toxic stress interventions, particularly among populations disproportionately affected by ACEs, as identified in this policy brief.

- **Strengthen community networks and build resilience.** Findings from this brief underscore the urgent need for targeted interventions to address and improve mental health outcomes for adults who have experienced childhood adversity.

Integrated care models – such as the Collaborative Care Model (CoCM) and the Primary Care Behavioral Health (PCBH) model – can be developed in areas where community-based mental health services are integrated with primary care clinics. Doing so may increase access to mental health care following positive detection of ACEs during routine screenings in primary care settings, especially for populations who do not often seek out mental health care.¹⁹

Implementation of trauma-informed care across sectors is another option. Building strong relationships within communities by engaging community members in the development and implementation of trauma-informed initiatives can ensure that the voices and experiences of those directly impacted by ACEs and toxic stress shape policies and intervention programs aimed at promoting resilience and healing.²⁰

Data Sources and Methods

This policy brief presents data from the 2022 California Health Interview Survey (CHIS), conducted by the UCLA Center for Health Policy Research. Beginning in 2021, CHIS added a questionnaire module regarding positive and adverse childhood experiences, based on the following:

- **Adverse Childhood Experiences (ACEs):** Utilizes the 11-question set of ACEs (AQ1–AQ11), but uses an 8-point scale combining the two alcohol/drug-related questions into one item and the three sexual abuse questions into one item. (See Appendix for ACEs categories.)
- **Positive Childhood Experiences (PCEs):** Utilizes the AQ16–AQ22 set of questions regarding positive childhood experiences. (See Appendix for PCEs categories.)
- **Serious Psychological Distress:** Measures psychological distress for worst month in past year using responses from two sets of questionnaire items, AJ29–AJ34 and AF63–AF68.

- **Perceived Need:** Perceived need for mental health care was measured with one question: “Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health, emotions, or nerves or your use of alcohol or drugs?” A “yes” response was coded as a perceived need for mental health care.
- **Unmet Need for Mental Health Services:** This was based on self-reports of not seeing a mental health or medical provider in the past year for mental or behavioral health problems among adults with a perceived need for mental health care or with moderate or serious psychological distress. Using the Kessler-6 (K6) score measure, moderate psychological distress is defined as having a K6 score between 5 to 12 and serious psychological distress as a score between 13 to 24.

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Funder Information

This policy brief was funded by the California Department of Health Care Services – Community Services Division. The content is solely the responsibility of the authors and does not necessarily represent the official views or position of the funder.

Acknowledgments

The authors would like to thank Todd Hughes of the UCLA Center for Health Policy Research; Daniel Eisenberg, PhD, of the UCLA Fielding School of Public Health; Bonnie Zima of the UCLA Semel Institute for Neuroscience and Human Behavior; and Simarjot Vinayak of the California Department of Health Care Services. The authors also thank Wendy Barrera, MPH; Devika Bhushan, MD; Jeffrey Gassen, PhD; Rachel Gilgoff, MD; George Slavich, PhD; and Cheryl Wold, MPH, of the UCLA-UCSF ACEs Aware Family Resilience Network (UCANN) for their thorough and thoughtful reviews of the brief. A special thank you to Julian Aviles of the CHIS Statistical Unit for statistical analysis and support.

Suggested Citation

Tan S, Thomas Tobin CS, Gutiérrez A, Pereira N, and Oh L. 2024. *California Adults With Adverse Childhood Experiences Are at Greater Risk for Serious Psychological Distress and Report Perceived and Unmet Need for Mental Health Care Services*. Los Angeles, Calif.: UCLA Center for Health Policy Research.



The California Health Interview Survey covers a wide array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. It is based on interviews conducted continuously throughout the year with respondents from more than 20,000 California households. CHIS interviews were offered in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese, Korean, and Tagalog. CHIS is designed with complex survey methods requiring analysts to use complex survey weights in order to provide accurate variance estimates and statistical testing. CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Public Health, the California Department of Health Care Services, and the Public Health Institute. For other information about CHIS, visit chis.ucla.edu.

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ISSN 2691-7475

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