

## Adverse childhood experiences and homelessness: advances and aspirations



Adverse childhood experiences (ACEs)—ie, potentially traumatic events, such as abuse, neglect, and household dysfunction, that occur before a child reaches 17 years old—predict a range of negative outcomes throughout the lifespan.<sup>1</sup> A large body of evidence has shown strong links between ACEs and poor physical, behavioral, educational, and employment outcomes.<sup>1</sup> Although studies have found increased odds of homelessness among adults reporting ACEs,<sup>2</sup> previous reviews have often excluded people experiencing homelessness, limiting knowledge about ACEs in this vulnerable population.<sup>3</sup>

In this issue of *The Lancet Public Health*, Liu and colleagues advance the scientific literature by conducting the first systematic review and meta-analysis synthesising prevalence of ACEs and their associations with health-related and functioning-related outcomes among adults experiencing homelessness.<sup>4</sup> The findings—based on 29 studies in the systematic review and 20 studies in the meta-analysis—emphasise the near universality of ACEs in the homeless population, as well as their association with poor outcomes in adulthood. Specifically, lifetime prevalence was 89.8% for one or more ACEs and 53.9% for four or more ACEs among people experiencing homelessness. These numbers are substantially higher than those reported for the general population globally (ie, in the general population, it is estimated that 38–39% have one ACE exposure and 3–5% have four or more).<sup>5</sup> ACEs were consistently positively associated with suicidal risk, suicide attempts, major depressive disorder, problematic substance use, and adult victimisation among people experiencing homelessness.

A key question for the future is the extent to which ACEs cause—rather than are associated with—homelessness. This Article examined cross-sectional or retrospective studies where the population was exclusively adults experiencing homelessness, showing the strong association between ACEs and homelessness. However, these studies did not explore causation, as they did not prospectively follow a population from exposure or non-exposure to ACEs to the outcome of homeless or non-homeless. Given that homelessness is

a particularly rare and dynamic experience (ie, affecting less than 0.2% of the US population at one point in time), the sample size in such a prospective study would need to be large, with data collected over the lifespan rather than cross-sectionally. Additionally, all studies included in this Article used self-report of ACEs; evidence suggests that report of adversity during childhood can differ from reports collected later in life.<sup>6</sup>

Liu and colleagues' Article also raises important questions about which ACEs in particular matter in understanding the link between early life adversity and homelessness. There are different types of ACEs and different ways to measure them; however, they generally include abuse (ie, emotional, sexual, and physical), neglect (ie, emotional and physical), and household dysfunction (eg, parental divorce or incarcerated household member). The absence of standardisation for defining and measuring ACEs is a challenge; for example, early adversity thought to be associated with homelessness—eg, poverty and housing problems—were each measured in only one study in this Article. The widely used Centers for Disease Control and Prevention-Kaiser Scale does not include measures such as poverty, community violence, or racism, which are considered adversities at the community level.<sup>7</sup> This exclusion is notable, as it suggests that ACEs as they are commonly defined could in fact be a symptom of wider upstream structural inequities that are not being measured or addressed.

A compelling strength of this Article is that it calls to attention the need for clinicians and policy makers to be aware of ACEs in the homeless population and the imperative to design clinical and policy efforts to mitigate their effects. Clinically, providers should apply the principles of trauma-informed care, which appreciates the complete picture of a patient's life—ie, past and present—to provide a healing orientation.<sup>8</sup> Providers should realise the widespread effects of trauma, recognise its signs and symptoms, actively avoid re-traumatisation, and integrate these themes into policies. Shelter settings, case management services, and housing interventions should also be built on these trauma-informed principles.

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These findings emphasise the need for interventions across all three levels of prevention. Primary prevention, or prevention of initial ACEs from occurring, is ideal. Early life and parenting interventions (eg, Family Nurse Partnership, Triple-P, and Incredible Years Programs) have been shown to prevent ACEs and their later sequelae.<sup>9</sup> However, despite their cost-effectiveness, policy makers have not yet made these programmes widespread. Secondary prevention can include preventing children with a history of childhood adversity from having further ACEs. Finally, tertiary prevention would include interventions for homeless adults with a previous history of ACEs who have poor outcomes. Evidence suggests that interventions to promote resilience and social support might reduce poor mental health outcomes that are associated with ACEs among adults experiencing homelessness.<sup>10</sup>

Liu and colleagues have established a clear link between ACEs, homelessness, and poor behavioural health outcomes. Although causation is yet to be established, this Article brings forth the importance of elucidating this pathway through rigorous study designs, measurements, and interventions. Reducing ACEs and the associated effects among the homeless population is an aspiration that necessitates comprehensive efforts from researchers, clinicians, and policy makers.

We declare no competing interests.

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