

# Leaving the past behind: Exploring and expanding the ACE framework within a secure deaf mental health population

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## Abstract

**Background:** Adverse childhood experiences (ACEs) are elevated in secure settings, and linked to poor health outcomes. Deaf people experience a range of adversities, often specific to communication. We explore the prevalence of ACEs, including deaf-specific ACEs (ACE-Ds), in a secure deaf mental health population. **Methods:** A file review was conducted on existing electronic clinical records for 27 deaf patients detained to a secure mental health service. **Results:** Complete data pertaining to ACEs and ACE-Ds was missing for 22.2% and 70.4% of participants, respectively. Nevertheless, 92.9% had experienced at least one ACE, and 60.7% had experienced at least one ACE-D. Those who experienced ACEs tended to experience both direct child maltreatment and indirect household adversities. **Discussion:** The prevalence of ACEs were high, exceeding rates reported in other secure populations. The lower prevalence of ACE-Ds is likely an artefact of the omission of such information within clinical documents. Challenges in data collection were recorded, to inform how we adapt psychiatric care. We provide recommendations for psychiatric inpatient services for deaf people to improve information collection on admission.

## Introduction

Adverse childhood experiences (ACEs) are strongly associated with poor physical and mental health outcomes in adulthood (Kvam & Loebe, 2010), are prevalent in users of secure services. In parallel, Deaf people more frequently experience trauma, when compared with the hearing population (Archer & Zoller, 2018; Kushalnagar et al., 2020) and are proportionally more likely to access secure care. Øhre et al. (2015) reported that Deaf and Hard-of-Hearing Psychiatric outpatients reported a mean of 6.2 different types of traumatic events, the most frequent being emotional neglect, family problems and emotional abuse.

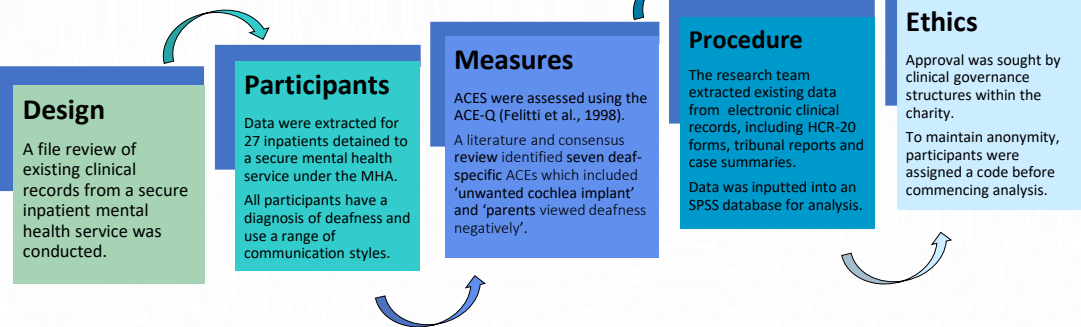
Clinical observation suggests that a deaf person's traumatic experiences are often connected with communication difficulties and may be considered an ACE specific to Deaf people (ACE-D). These negative communication experiences may promote and complicate experiences of abuse and neglect for Deaf people.

A brief survey of the literature suggested that there may be at least seven ACEs specific to Deaf people. We identified these as: (1) being deprived of information; (2) experiencing language deprivation; (3) having an unwanted cochlea implant; (4) experiencing punishment for using sign language to promote spoken language; (5) repeatedly experiencing lack of access to an interpreter at important meetings and events; (6) having parents who viewed deafness negatively; and (7) being sent to a residential school for deaf children at an early age.

## Study aims

Little is known about whether the ACE framework is relevant to the secure Deaf inpatient population. To aid our understanding of the utility of both ACEs and ACE-Ds we aimed to review clinical records for Deaf people detained to a secure mental health service.

## Methodology



## Results

### I. Missing data

The collation of data from available clinical reports revealed that a complete ACE history could not be determined for six (22.2%) participants. Data was particularly limited for direct experiences of emotional abuse and neglect, and parental substance use (all 11.1% missing).

Based upon the ACE-Ds identified through the literature review, there was insufficient data to determine a complete profile for 19 (70.4%) participants. Data was particularly limited for 'repeated lack of access to interpreter at important meetings' (48.1% missing) and 'information deprivation trauma' (33.3% missing), which describes being the last to know, or being unable to access information that is critical to understanding an event.

### II. Prevalence of ACEs

Based on the data, findings showed that 25 of the 27 participants (92.9%) had experienced at least one ACE. The most common ACEs reported were 'parental separation' (64.3%), 'sexual abuse' (42.9%), 'parental mental illness' and 'physical abuse' (both 39.3%).

Figure 1 shows the prevalence of ACE exposure, across the whole sample. However, of the 25 participants who had experienced an ACE, most (n=14, 56%) had experienced both 'direct' experiences of child maltreatment and witnessed 'household' adversities. Of those who had experienced just one type of ACE (n=11, 44%), this was more commonly witnessed 'household' ACEs (n=8, 72.7%) than 'direct' child maltreatment ACEs (n=3, 27.3%).

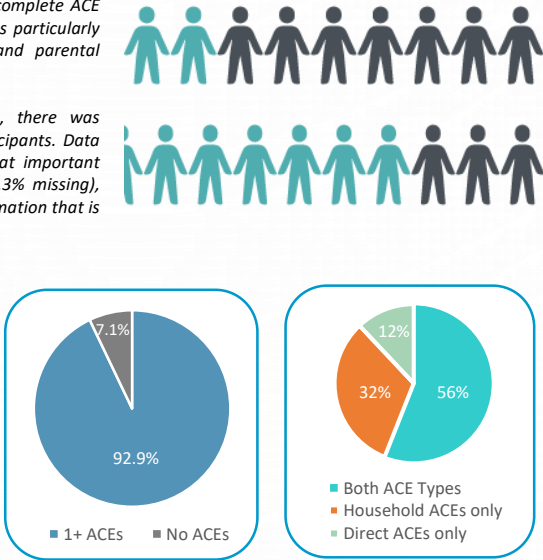


Figure 1. Prevalence of ACE exposure

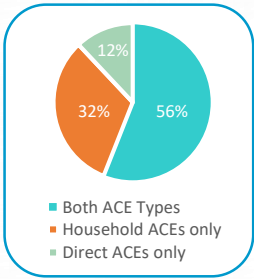


Figure 2. ACE exposure by type

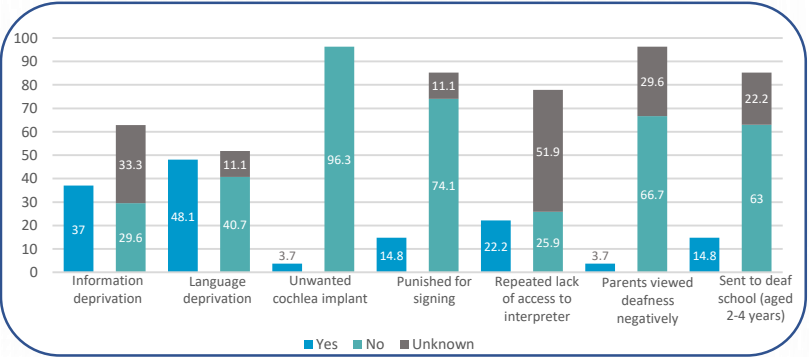


Figure 2. Prevalence of ACE-Ds

## Discussion

The file review proved challenging due to a high level of data which was missing, or difficult to align with the ACEs framework. Despite the utilisation of records from a specialised deaf mental health service, the collation of accurate data pertaining to ACE-Ds was a particular challenge. Many records provided no clear evidence that an ACE or ACE-D was absent, but indicated that "absence of evidence is not evidence of absence". There are at least three possible explanations for these difficulties:

- 1) Deaf people's adverse experiences may be 'normalised' or neglected, and so are not considered relevant during admission to inpatient services;
- 2) Communication difficulties apparent in a clinical interview with a Deaf person raise significant difficulties in taking a clear history;
- 3) Deaf adults may not have had the language, at the time of the adverse experience, to recognise them as unusual or relevant.

Given that traumatic experiences manifest, and are processed differently for people from diverse cultures (Buse et al., 2013), an ACE framework may not offer much to improve secure inpatient care for deaf people. Additionally, while ACEs may be of use within a public health or policy context, they may not offer much to psychological interventions or psychiatric care (Edwards et al., 2017).

Communication and language are consistently identified as important aspects of adverse experiences for most, if not all, deaf people, and often appear within deaf people's trauma histories (Øhre et al., 2015). However, collecting information about ACEs may not be as useful as considering the Deaf specific adverse experiences as current and continuing beyond childhood. Each ACE-D can be interpreted as a micro-aggression which continues to impact on a Deaf person's mental health throughout their lifetime.

The current study identified seven adverse experiences for Deaf people, based on a brief review of the literature. Going forward, expansion and validation of a 'deaf-specific' ACEs framework is warranted.

## References

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