Early Identification and Promising Interventions in Early Childhood

Moderator:
Moira Kenney

Presenters:
Christina Bethell, Kadija Johnston, Dayna Long
Getting Ahead of the Curve by Addressing ACEs for Young Children and Families

*The case for “through any door” family-centered strategies*

Christina Bethell, PhD, MBA, MPH
Johns Hopkins Bloomberg School of Public Health
Child and Adolescent Health Measurement Initiative
The Issue: Adverse Childhood Experiences, Flourishing and Developmental Status Among Young Children in the US

Findings from the National Survey of Children’s Health
Prevalence of Adverse Childhood Experiences among US Children Age 0-5

Percent of children Ages 0-5 Years Who Experienced Two or More of Nine Adverse Childhood Experiences Evaluated in the 2011-12 National Survey of Children's Health, By State

Prevalence of 2+ (of 9 items) ACEs
State Range: 7.3% (CA) – 20.1% (KY)
Nearly half (45.7%) of all US children age 4 months – 5 years at HIGH or MODERATE risk for developmental, behavioral or social problems have had ACEs—a risk for trauma and high persistent stress (and neuro-endocrine-immune effect threatening resilience and positive health).
Nearly half (46.3%) of all young children age 0-5 with emotional, mental or behavioral problems have had ACEs—a risk for trauma and high persistent stress (and neuro-endocrine-immune effect threatening resilience and positive health).

EMB conditions include: 8 conditions: learning disability, depression, anxiety, behavioral problems, ADD/ADHD, autism, developmental delay, Tourette syndrome, OR qualify for CSHCN Screener: ongoing emotions, developmental, or behavioral problem OR high/moderate risk for developmental, behavioral or social delay.

<table>
<thead>
<tr>
<th>Event</th>
<th>Adjusted Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child lived in families very/somewhat often hard to get by on family's income</td>
<td>1.32</td>
</tr>
<tr>
<td>Child lived with parent who got divorced/separated</td>
<td>1.63</td>
</tr>
<tr>
<td>Child lived with parent who died</td>
<td>1.90</td>
</tr>
<tr>
<td>Child lived with parent who served time in jail</td>
<td>1.54</td>
</tr>
<tr>
<td>Child saw parents hit, kip, slap, punch or beat each other up</td>
<td>1.91</td>
</tr>
<tr>
<td>Child was a victim of violence or witness violence in neighborhood</td>
<td>2.02</td>
</tr>
<tr>
<td>Child lived with anyone who was mentally ill/suicidal/severity depressed</td>
<td>1.84</td>
</tr>
<tr>
<td>Child lived with anyone who had a problem with alcohol or drugs</td>
<td>1.65</td>
</tr>
<tr>
<td>Child was ever treated or judged unfairly because of race/ethnic group</td>
<td>1.82</td>
</tr>
<tr>
<td>No adverse childhood experience</td>
<td>1.21</td>
</tr>
<tr>
<td>1 adverse childhood experience</td>
<td>1.21</td>
</tr>
<tr>
<td>2-3 adverse childhood experiences</td>
<td>1.79</td>
</tr>
<tr>
<td>4 or more adverse childhood experiences</td>
<td>2.84</td>
</tr>
</tbody>
</table>

Adjusted odds ratios are significant after adjusting sex, race/ethnicity, income and insurance.
Prevention goal #1 and we can teach children to be resilient even with ACEs!

Prevalence of emotional, mental or behavioral problems or being at high or moderate risk for developmental, behavioral or social delay lower when learn basic resilience abilities (all US children ages 0-5) Data: 2011-12 NSCH

- Usually/always stays calm/in control with challenges (has this aspect of resilience)**
- Never/sometimes calm/in control with challenges (no resilience)
Proportion of Children Age 0-5 Years With Mother’s In Excellent or Very Good Physical and Mental Health: By Number of ACEs

- None of 9 ACEs: 70.8%
- 1 ACE: 47.2%
- 2-3 ACEs: 37.8%
- 4 or more ACEs: 29.6%
Unique Characteristics of, and Challenges in, Identifying Trauma in Very Young Children

Kadija Johnston
Infant-Parent Program, UCSF
San Francisco General Hospital
Time of Great Vulnerability

• 75% of the children who died as a result of child abuse and neglect were younger than 4 years old

• The first year of life is the most dangerous one in a child’s life.

• More than a third of the children who enter foster care do so in the first 5 years of life (U.S. Department of Health and Human Services, 2013)

• Nearly two-thirds of children attending a Head Start program had either witnessed or been victimized by community violence (Shahinfar, Fox, & Leavitt, 2000).

• One in 10 children had witnessed a knifing or shooting, half of these occurred in their home (Taylor, Zuckerman, Harik, & Groves, 1992).

• Some groups suffer more than others - children of color and children of lower socioeconomic status had greater lifetime exposure to physical abuse, sexual abuse, and witnessing family violence (Turner et al. 2006).
Impact is Evidenced and the Effect of Adversities Accumulate

- Risk of difficulty increases significantly as adversities accumulate (Rutter, 1999; Pynoos et al., 1999; Sameroff, 1993)
- Early childhood trauma has been associated with reduced size of the brain cortex, causing difficulty in memory, language, thinking and regulation
- Less able to anticipate or avoid danger.
- May blame themselves or caregivers
- Pediatric Clinic study found 17.4% of 2 to 5 year olds with diagnosable disorder (Egger & Angold 2004)
Evidence of the Impact is Discounted

• Despite evidence of the negative impact of trauma, efforts to address the repercussions remain limited.

• Difficult to acknowledge severe suffering in anyone, especially small children

• Wish to rely on the belief that children can’t remember

• Symptoms are hard to decipher as they may mimic other types of developmental concern
Behavioral Indicators of Trauma

• Hypervigilance

• Panic Attack

• “Unprovoked Aggression”

• Re-experiencing

• Restricted and/or repetitive play
The Interpersonal Origins of Early Trauma

• The core sense of self and beliefs about others and the world are shaped by early relational experience.

• Children come to expect the world to be dangerous, start to view the adults on whose survival they depend as the sources of danger. Have to fend for themselves in a scary world.

• These unresolvable contradictions get expressed in behaviors, ways of relating
Structural Origins of Adversity

• Historical Trauma and Racism Impacts the Parent-Child Relationship
  ◊ Disproportionate incarceration
  ◊ Fear of deportation
  ◊ Police Violence

● Racism Impacts Perception and Treatment of children
  ◊ preschool age boys of color seen as older, more threatening
  ◊ disproportionalities in discipline practices and expulsion from child care.
  ◊ parents of color are less like to be asked if they have concerns about their child’s development
How Does Addressing ACES Occur in Clinical Primary Care Practice?

Dayna Long, MD
Medical Director of Center for Community Health And Engagement
10/20/2016
UCSF Benioff Children’s Hospital Oakland
Center for Community Health and Engagement

Mission Statement:
To achieve health equity for all children
UCSF Benioff Children’s Hospital Oakland

- Private nonprofit
- Affiliated with UCSF since 2014
- Over 100 years old
- Primary to quaternary care; 41 specialties
- FQHC: Highest Volume Pediatric Primary Care Clinic
• 4 in 5 physicians surveyed (85%) say unmet social needs are directly leading to worse health

• 4 in 5 physicians surveyed (85%) say patients’ social needs are as important to address as their medical conditions.
  -This is especially true for physicians (more than 9 in 10, or 95%) serving patients in low-income, urban communities.

• 4 in 5 physicians surveyed (80%) are not confident in their capacity to address their patients’ social needs
The iScreen Study

- 57% are concerned about running out of food before they have money to buy more food
- 52% are concerned about their child’s safety at a school and/or in their neighborhood
- 45% are concerned about the mental health of the primary caregiver
- 44% are concerned about their housing

Laura Gottlieb, Danielle Hessler, Dayna Long, Analí Amaya and Nancy Adler. A Randomized Trial on Screening for Social Determinants of Health: the iScreen Study Pediatrics; originally published online November 3, 2014
Bay Area Help Desk Screening and Intervention

Primary research goal
- Examine the comparative effectiveness of two social needs interventions intended to decrease social needs and improve health

Results
- Less than 20% of families reported being asked about unmet needs in the last year
- In the intervention group, we resolved at least one unmet social need and improved child health outcomes

## FIT: Feasibility of Implementing an ACE Screening Tool: Pilot

<table>
<thead>
<tr>
<th>Area / Domain</th>
<th>Source for Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Sexual Abuse</td>
<td>ACE / CYW ACE-Q / WHO ACE-1Q</td>
</tr>
<tr>
<td>Child Verbal Abuse</td>
<td>CYW ACE-Q</td>
</tr>
<tr>
<td>Child Emotional Neglect</td>
<td>CYW ACE-Q</td>
</tr>
<tr>
<td>Child Physical Neglect</td>
<td>ACE</td>
</tr>
<tr>
<td>Child Physical Abuse</td>
<td>ACE / CYW ACE-Q</td>
</tr>
<tr>
<td>Family Medical Illness</td>
<td>FIT work group</td>
</tr>
<tr>
<td>Discrimination</td>
<td>CYW ACE-Q</td>
</tr>
<tr>
<td>Housing Insecurity</td>
<td>FIND</td>
</tr>
<tr>
<td>Low family cohesion</td>
<td>FIT work group</td>
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<tr>
<td>Separation from Caregiver</td>
<td>CYW ACE-Q</td>
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<tr>
<td>Food insecurity</td>
<td>FIND</td>
</tr>
<tr>
<td>Family Substance Use</td>
<td>CYW ACE-Q</td>
</tr>
<tr>
<td>Family/Domestic Violence</td>
<td>ACE</td>
</tr>
<tr>
<td>Family Mental Illness</td>
<td>CYW ACE-Q</td>
</tr>
<tr>
<td>Community Violence</td>
<td>CYW ACE-Q</td>
</tr>
</tbody>
</table>
Intervening Effectively in Early Trauma

Kadija Johnston
Infant-Parent Program, UCSF
San Francisco General Hospital
Interventions Are Aimed at the Relationship

- Acknowledge and address the contribution of the caregivers’ history of trauma – listen for negative attributions and ghosts in the nursery (Selma Fraiberg)
- Resurrect or create angels (Alicia Lieberman) – benevolent bringer of hope
- Provide containment, consistency and coherence
- Help partners accurately read cues and respond to the meaning in the others message
- If possible help caregiver reclaim position as protector
- Legitimize the response to trauma
Acknowledge and Address Structural Determinants of ACEs

• Commit to a Practice of Self Reflection on bias, privilege and oppression

• Watch for and address structural inequities in our practice and work place

• Acknowledge historical and structural contributors to trauma with our clients

• Claim our Work in Early Childhood as a Social Justice Activity
Paying Attention to the Impact of Trauma on You

- Watch for and guard against vicarious traumatization
- Cultivate practices of self care and compassion
- Seek supervision or consultation
- Remember that small moments matter and incremental changes accrue
- We need to work together to heal trauma – our own, others’ and our community’s
Effective Interventions in Early Childhood

- Attachment and Biobehavioral Catch-up (Bernard et al., in press; Dozier et al., 2009; Dozier et al., 2008; Dozier et al., 2006)
- Infant-Parent Psychotherapy (Fraiberg, 1980; Lieberman, Silverman & Pawl, 2000; St. John and Pawl, 2000)
- Promoting First Relationships
<table>
<thead>
<tr>
<th>ACE Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Violence</td>
<td>60.7</td>
</tr>
<tr>
<td>Family Mental Illness</td>
<td>42.9</td>
</tr>
<tr>
<td>Family/Domestic Violence</td>
<td>39.3</td>
</tr>
<tr>
<td>Family Substance Use</td>
<td>35.7</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>32.1</td>
</tr>
<tr>
<td>Separation from Caregiver</td>
<td>28.6</td>
</tr>
<tr>
<td>Low family cohesion</td>
<td>28.6</td>
</tr>
<tr>
<td>Housing Insecurity</td>
<td>28.6</td>
</tr>
<tr>
<td>Discrimination</td>
<td>21.4</td>
</tr>
<tr>
<td>Family Medical Illness</td>
<td>21.4</td>
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<tr>
<td>Child Physical Abuse</td>
<td>14.3</td>
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<tr>
<td>Child Physical Neglect</td>
<td>10.7</td>
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<tr>
<td>Child Emotional Neglect</td>
<td>7.1</td>
</tr>
<tr>
<td>Child Verbal Abuse</td>
<td>7.1</td>
</tr>
<tr>
<td>Child Sexual Abuse</td>
<td>3.6</td>
</tr>
</tbody>
</table>
Frequency of Adult ACEs

- 92.2% of Caregivers endorsed 1 or more (from list of 10)
- 46.3% endorsed 4 or more (from list of 10)

- Substance Abuse: 60.70%
- Verbal Abuse: 50%
- Caregiver Separation: 50%
- Sexual Abuse: 39.30%
- Physical Abuse: 39.30%
- Emotional Neglect: 32.10%
- Domestic Violence: 25%
- Caregiver incarcerated: 25%
- Physical Neglect: 17.90%
- Mental illness: 17.90%
Original ACE Study Vs. FIT Caregivers: ACEs Frequency

<table>
<thead>
<tr>
<th>Types of ACEs</th>
<th>ACEs Study</th>
<th>FIT Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological abuse</td>
<td>11.10%</td>
<td>50%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>10.80%</td>
<td>39.28%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>22%</td>
<td>39.28%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>25.60%</td>
<td>60.71%</td>
</tr>
<tr>
<td>Mental illness</td>
<td>18.80%</td>
<td>17.85%</td>
</tr>
<tr>
<td>Mother treated violently</td>
<td>12.50%</td>
<td>25%</td>
</tr>
<tr>
<td>Criminal behavior in the household</td>
<td>3.40%</td>
<td>25%</td>
</tr>
</tbody>
</table>
Through Any Door
Family Centered Approaches
• Assess & Reflect
• Engage & Identify
• Connect & Select
• Improve & Advocate
Christie Bethell
Developmental Screening by ACEs, 10 months-5 Years
Data: 2011-12 NSCH

- 4 or more ACEs: 24.6%
- 2-3 ACEs: 25.7%
- 1 ACE: 29.9%
- None of 9 ACEs: 32.4%
Shining a light on ACEs is more than a “Courtesy Alert”

“In my beginning is my end.” (?)
T.S. Eliot, Four Quartets

“Where you stumble, there your treasure lies” Joseph Campbell

Source: Bethell, C 2016
Developmental Trauma Disorder (DTD):
National Traumatic Stress Network suggests that DTD is indicated with:

(1) dysregulation of a child’s stress response, as exhibited by symptoms, behaviors and, potentially, biologic measurements; (often categorized as mental health diagnoses now)
(2) internalized negative attributions and diminished hope and expectations for life;
(3) difficulty with self-esteem regulation; and
(4) functional impairments in key areas such as making social connections, participating in school, etc.

Source: Bethell, C 2016
Biology of Adversity Points Toward a “We Are the Medicine” Approach

If we really want to achieve breakthrough outcomes for children experiencing toxic stress, then we have to transform the lives of the adults who care for them.
Early Childhood Health and Wellness

The Well-Visit Planner for Families

The Well-Visit Planner is an Internet-based tool developed to improve well-child care for children 4 months to 6 years of age. Information in this tool is based on recommendations established by the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition. The tool helps parents and caregivers to customize the well-child visit to their family's needs by helping them identify and prioritize their health risks and concerns before the well-child appointment. This means that parents and health care professionals are better able to communicate and address the family's needs during the well-child visit.

The Well-Visit Planner and Head Start

The Child and Adolescent Health Measurement Initiative (CAHMI) has worked with the Office of Head Start National Center on Health to expand the Well-Visit Planner to children 4 months to 6 years and has prepared materials to help Head Start and Early Head Start programs use this tool with the families they serve. Knowing that school readiness begins with health, Head Start and Early Head Start programs are committed to supporting the health and well-being of every child enrolled in a program. The Well-Visit Planner has been tested in several programs, and staff have found it helpful for encouraging parents to complete well-child visits and become familiar with what is expected at each visit. The tool also reinforces the role of parents as the experts for their child's needs—considering those related to health.

Using the Well-Visit Planner in Head Start and Early Head Start Programs

In partnership with the National Center on Health, CAHMI has prepared a number of tools and resources to help programs assess their readiness to begin using the Well-Visit Planner as a standard part of their work with parents and children. There is also an implementation toolkit that helps programs with step-by-step implementation of the Well-Visit Planner within the program, including materials to help promote the use of the tool among parents. Materials are also there to help reach out to local health care professionals to help prepare them for the use of the Well-Visit Planner by their patient families.

These materials will be shared on the Early Childhood Learning & Knowledge Center but are currently available at http://www.caohmii.org/projects/wvp/13, the implementation portal.

Your privacy is important to us. Please review our terms and conditions, check each box and click the Get Started button below:

- I am 18 years old or older, I agree to the Terms and Conditions of the Well-Visit Planner
- I voluntarily consent to the Well-Visit Planner.

Get Started! [Click here]
**Priorities:** Most common priorities reported by parents during their children’s 6 years routine visit

<table>
<thead>
<tr>
<th>All children</th>
<th>CSHCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Helping your child express feelings and control behaviors (39.9%)</td>
<td>1. Helping your child express feelings and control behaviors (40.0%)</td>
</tr>
<tr>
<td>2. Teaching your child to make healthy food choices (29.8%)</td>
<td>2. Succeeding in social situations (25.0%)</td>
</tr>
<tr>
<td>3. Succeeding in social situations (28.6%)</td>
<td>3. Healthy weight for your child (25.0%)</td>
</tr>
<tr>
<td>4. Helping your child make good decisions and gain independence (26.2%)</td>
<td>4. Helping your child make good decisions and gain independence (25.0%)</td>
</tr>
<tr>
<td>5. Continuing to improve in listening, reading, and math (23.8%)</td>
<td>5. Deciding if your child needs more help (22.5%)</td>
</tr>
</tbody>
</table>
In order for children to meet all of the criteria on the Minimum Quality of Care Summary Measure, the following conditions must be met: 1) Children are currently insured and that insurance is usually/always adequate to meet child's health needs; 2) Child meets criteria for receiving coordinate, comprehensive, culturally effective care within a medical home; and 3) Child had a least one preventive medical care visit in the past 12 months.