Addressing ACEs and PCEs in Pediatric Primary Care: "Building the Buffering"

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Objectives

- Share the importance of Positive Childhood Experiences, their connection to early relational health, and their impacts on health and wellness.

- Review practical approaches to addressing PCEs in practice, including one clinic's model for integrating PCEs into well care.

Social-Emotional / Early Relational Health

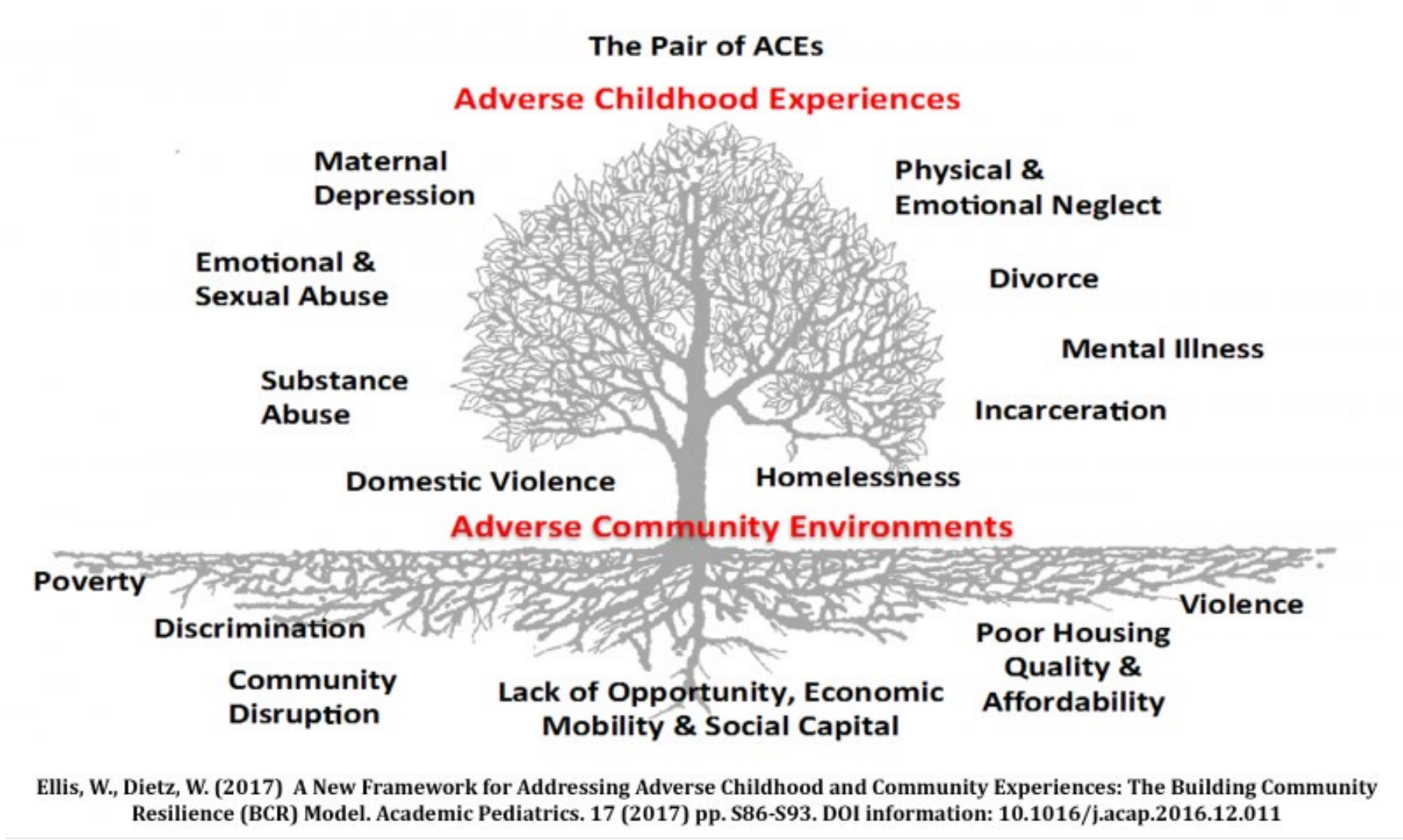
- Social-emotional health refers to a child's ability to:
  - Form secure relationships
  - Experience and regulate emotions
  - Explore and learn
- Early relational health establishes the centrality of relationships between caregivers and children for future health, development, and social-emotional well-being.

Why Focus on Early Relational Health?

- A child's developmental trajectory – both positive and negative – is dependent on their early relationships.
- Problems in early social, emotional, and behavioral development will predict early school failure… which predicts later school failure.
- Intervening early helps to prevent the need for later, and more expensive interventions – both in the educational system and the mental health system.
- According to parents, social-emotional health significantly contributes to Kindergarten success, but is also the area where parents need the most support.

SSNRs and ERH

- Early relational health is dependent on safe, stable, nurturing relationships (SSNRs).
- Anything that gets in the way of SSNRs can disrupt ERH… “It’s hard to be in relational mode when you’re in survival mode.”
- Conversely, Positive Childhood Experiences are all about supporting and promoting SSNRs and therefore ERH.



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

How can we, as a profession

prevent ACEs

promote PCEs

if parents don't first know what these things are?

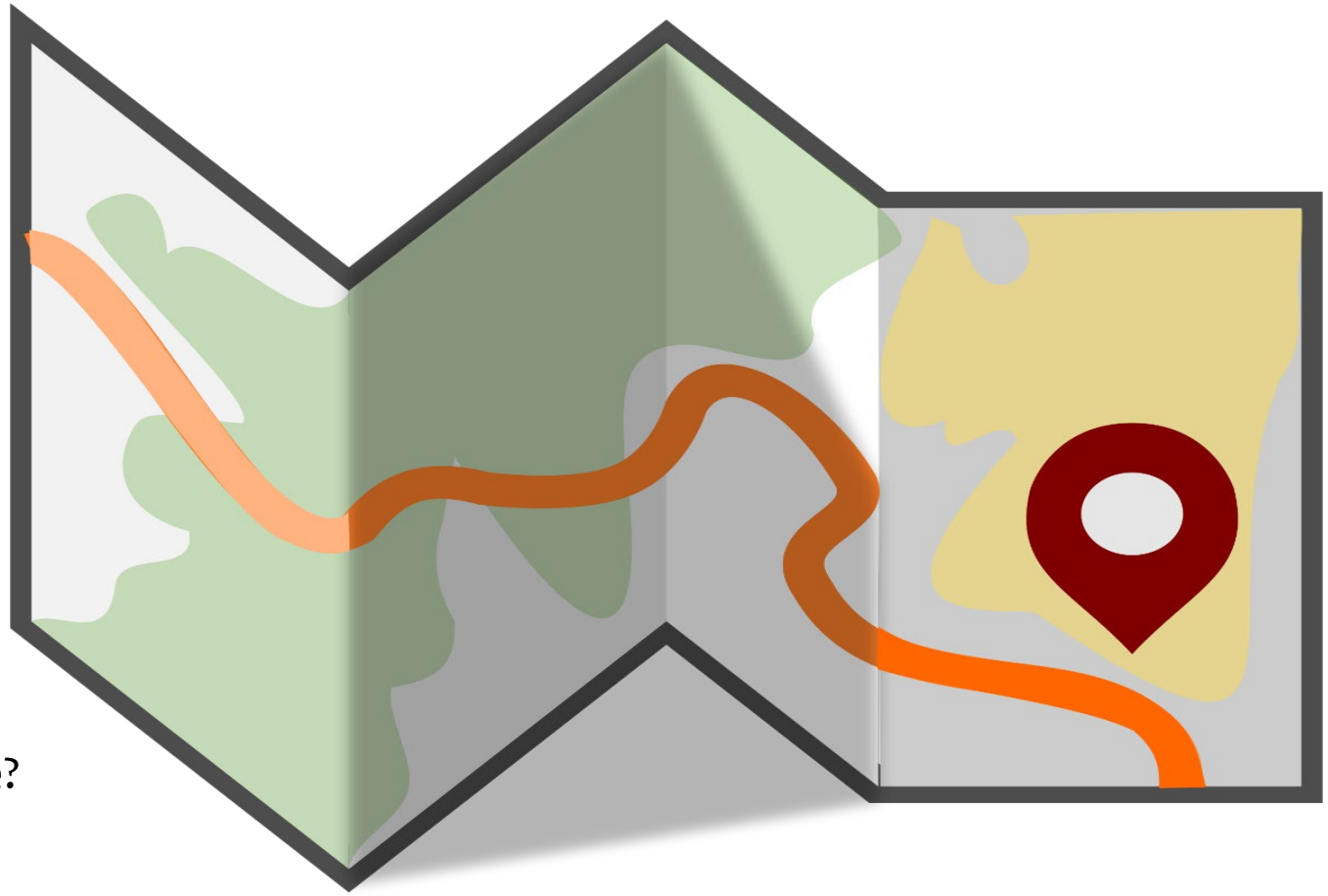
A Word from the American Academy of Pediatrics…

- Pediatric medical homes should:
    1. strengthen their provision of anticipatory guidance to support children's emerging social-emotional-linguistic skills and to encourage the adoption of positive parenting techniques;
    2. actively screen for precipitants of toxic stress that are common in their particular practices;
    3. develop, help secure funding, and participate in innovative service-delivery adaptations that expand the ability of the medical home to support children at risk; and
    4. identify (or advocate for the development of) local resources that address those risks for toxic stress that are prevalent in their communities.

What was missing…

Who do we screen?

Do we screen once, or multiple times?



When do we screen?

What tool do we use?

WHAT DO WE DO IF WE FIND IT???

Stories from the literature – why parent trauma matters….

1. Correlations exist between parent ACE scores and child's ACE score… the more ACEs a parent experiences, the more ACEs the child is likely to experience.
2. Parenting styles are at least in part inherited: if a parent experienced harsh parenting, they are more likely to engage in harsh parenting styles themselves.
3. Parents have new brain growth in the first six months after their child's birth – in both the amygdala (emotional center) and frontal cortex (logical center) UNLESS they are experiencing stress, which impairs frontal cortex development.
4. Children who have experienced three or more ACEs before entering Kindergarten have lower readiness scores: literacy, language and math skills are lower – and rates of behavioral problems are higher.

Background – Where We've Been

- Working on assessing parental ACEs since 2013.
- Started with a small pilot driven by two providers who felt it was urgent to "do something".
- At the time, little guidance as to what to actually do in practice…
- (and a lot of debate since then)

The assumption

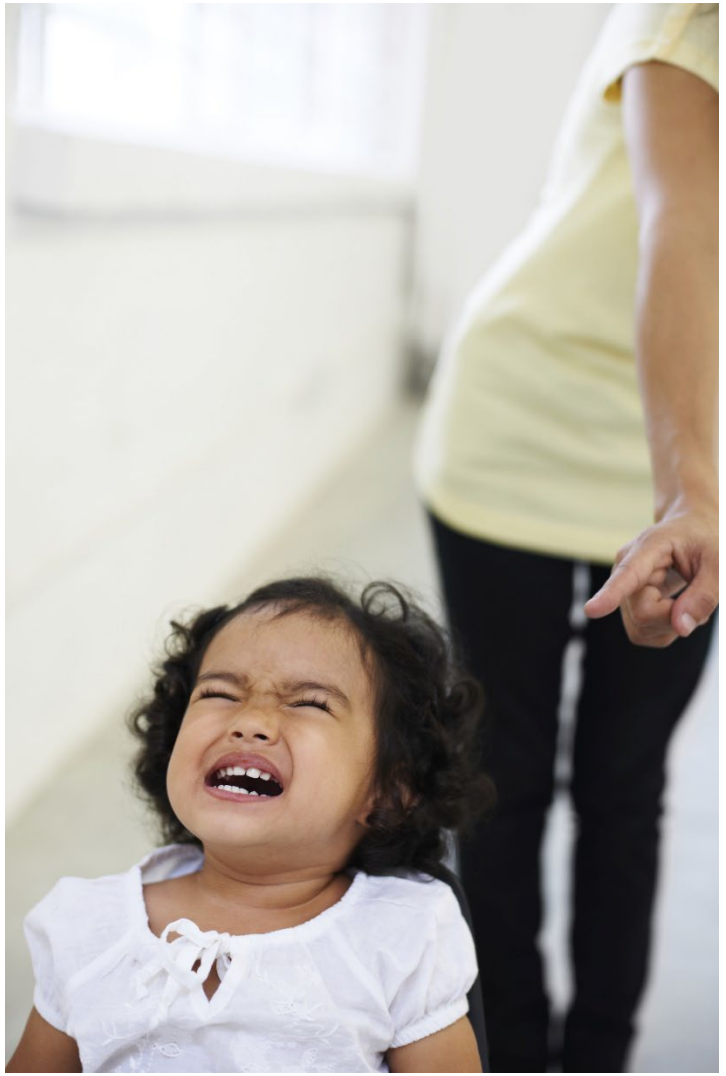
If…

- we can identify parents who are at greatest risk
- bring their trauma histories out of the closet
- agree to support them when they feel most challenged in a non-judgmental way

…we will be able to create a new cycle of healthier parenting.

The Theory…

- Certain moments in the life of an infant or toddler will be stressful
  - Tantrums, colic, toilet training, hitting / biting, sleep problems are examples
- What happens to a parent who has experienced trauma? Will their response be:
  - Fight?
  - Flight?
  - Freeze?
  - Can it be something else?
- How can we better prepare at-risk parents for these inevitable moments?



And thinking further…

- If a parent experienced trauma, do they have appropriate skills / ideas for:
  - Taking care of themselves?
  - Identifying when they need help?
  - Modeling appropriate conflict resolution?
  - Discipline that is developmentally appropriate?
  - Playing with their child?
- In other words, can we teach parents and children to be more resilient?

Case Study: The Children's Clinic

- 28 providers in three practice sites
- Strong interest in early childhood development / developmental promotion
- Since 2008 have implemented multiple standardized universal screening protocols
  - Developmental delay
  - Autism
  - Maternal Depression
  - Adolescent Depression
  - Adolescent Substance Abuse
- Adolescent questionnaire has always included questions about dating violence; many providers ask about bullying in their history for school aged children.

The Children's Clinic
welcoming families since 1911

How do I Find it? Our First Step

- Eight providers piloted screening
- At the four month visit, parents are given the ACE screener, along with a questionnaire about resilience and a list of potential resources.
    - Cover letter explaining the rationale for the screening tool, and what we plan to do with the information
- Created a confidential field in the EMR that does not print into notes, but perpetuates into visits to document results while minimizing risk to families.
- Added questions about community violence, bullying, racism / prejudice and foster care exposure.

Initial Goals

- How do we best assess parental ACEs in primary care?
- (Is it feasible to assess parental ACEs in the course of a primary care visit?)

Adjusted risk for suspected developmental delay

	Relative Risk (95% CI)	
	[a]Maternal (n=311)	[b]Paternal (n=122)
[c]ACE		
≥ 1	1.25 (0.77, 2.00)	2.47 (1.09, 5.57)**
< 1 (Ref)	-	-
≥ 2	1.78 (1.11, 2.91)**	3.96 (1.45, 10.83)***
< 2 (Ref)	-	-
≥ 3	2.23 (1.37, 3.63)***	0.82 (0.12, 5.72)
< 3 (Ref)	-	-
Payer source		
Public	1.67 (1.05, 2.67)**	0.87 (0.37, 2.03)
Private (Ref)	-	-
Gestational age at birth		
< 37 weeks	1.70 (0.89, 3.24)	7.76 (3.12, 19.33)***
≥ 37 weeks (Ref)	-	-

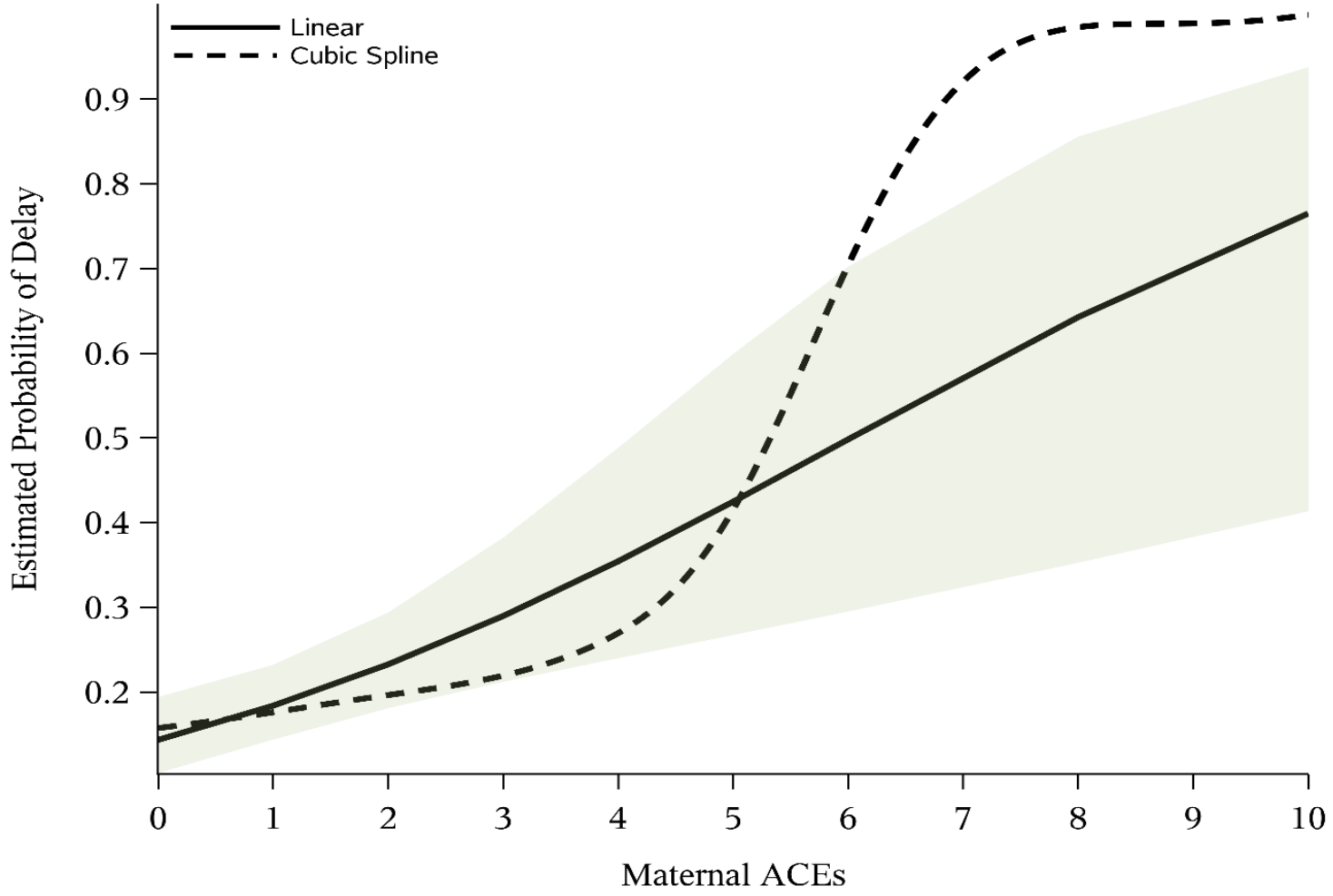
* = p <0.1, ** = p <0.05, *** = p <0.01

Domain-specific developmental risk by Maternal ACE exposure

	Maternal ACEs		Relative Risk (95% CI)
	≥ 1 (*n*=149)	<1 (*n*=162)	
Communication, *n* (%)	24 (16.3)	18 (11.1)	1.47 (0.83, 2.60)
Gross Motor, *n* (%)	20 (13.5)	17 (10.6)	1.28 (0.70, 2.35)
Fine Motor, *n* (%)	18 (12.1)	16 (9.9)	1.22 (0.65, 2.31)
Problem Solving, *n* (%)	17 (11.6)	8 (5.0)	2.31 (1.03, 5.20)**
Personal-Social, *n* (%)	19 (12.9)	17 (10.6)	1.22 (0.66, 2.26)
	≥ 2 (*n*=60)	<2 (*n*=251)	
Communication, *n* (%)	12 (20.3)	30 (12.0)	1.69 (0.92, 3.11)*
Gross Motor, *n* (%)	12 (20.0)	25 (10.0)	1.99 (1.06, 3.73)**
Fine Motor, *n* (%)	9 (15.0)	25 (10.0)	1.51 (0.74, 3.06)
Problem Solving, *n* (%)	11 (18.3)	14 (5.7)	3.23 (1.55, 6.76)***
Personal-Social, *n* (%)	9 (15.0)	27 (10.9)	1.38 (0.68, 2.77)
	≥ 3 (*n*=39)	<3 (*n*=272)	
Communication, *n* (%)	10 (26.3)	32 (11.8)	2.23 (1.19, 4.16)**
Gross Motor, *n* (%)	9 (23.1)	28 (10.4)	2.23 (1.14, 4.36)**
Fine Motor, *n* (%)	8 (20.5)	26 (9.6)	2.15 (1.05, 4.40)**
Problem Solving, *n* (%)	6 (15.4)	19 (7.1)	2.17 (0.92, 5.10)*
Personal-Social, *n* (%)	8 (20.5)	28 (10.4)	1.97 (0.97, 4.01)*

* = p <0.1, ** = p <0.05, *** = p <0.01

Dose response relationship between Maternal ACE and risk for suspected developmental delay



Parental ACEs and Behavioral Outcomes

- Compared to children whose parents have no ACEs, a child whose parent has 4+ ACEs has:
  - 2.3 point higher score on the Behavior Problems Index (BPI)
  - 2.1x higher odds of hyperactivity
  - 4.2x higher odds of emotional disturbances
- Correlations were stronger for maternal ACEs than paternal ACEs.

Schickedanz et al., *Pediatrics*. 2018;142(2).

Parental ACEs and Health Outcomes

- For each additional parental ACE:
  - Worsening overall health status (aOR 1.19)
  - Increase rates of asthma (aOR 1.19)
  - Increase in excessive media use (aOR 1.16)

- Since these effects are cumulative, if a parent has 6+ ACEs, their child has 6.38x the risk of asthma.

Lê-Scherban et al., *Pediatrics*. 2018;141(6).

Parental ACEs and Utilization Patterns

- For each additional maternal ACE, there is a 12% increased risk of missing well visits in the first two years.
- This did not result in missing immunizations.

- However, given the risk of developmental delays, it is likely that:
  - Parents are not receiving anticipatory guidance on developmental promotion.
  - There may be an increased risk of missing on-time administration of standardized developmental screens, meaning a potential delay in referral to services.

Eismann EA et al.(… Gillespie RJ), J Pediatr 2019;211:146-51.

Stories from the literature – why parent trauma matters…

5

There is a correlation between parental ACEs and their child's developmental, behavioral and overall health risks.

So what?

- We believe the correlations between parental trauma and their child's developmental and behavioral outcomes are due to disruptions in ERH.
- Therefore, in order to promote SE health, primary care providers must promote early relational health by assessing barriers experienced by the family.
  - Parents who have experienced ACEs (particularly in the absence of PCEs), may not have experienced appropriate modeling in positive parenting, self care, and an understanding of normal child development.
  - Parents who experience SDoH may be physically and / or emotionally unavailable to build relational health with their children.
  - Parents who experience peripartum depression or anxiety may have challenges observing and responding to infant's cues, and may not have the energy to actively promote their child's development.

“It’s hard to be in relational mode when you’re in survival mode.”

Promoting SSNRs in caregiver-child dyads requires careful support of caregiver health and wellness.

The Sticking Points

- Sitting with data about developmental outcomes was a bit like holding a hot potato…
- The assumption is that developmental outcomes in the context of parental trauma is due to disruptions in the attachment relationship…how do we build that?
- The resilience questionnaire (CD-RISC) wasn't really leading to questions from patients or conversations from providers.
- How do we better balance the conversations with parents (is "balancing ACEs with hope" trademarked yet)?
  - "Summing the suffering" versus "building the buffering"…

What we're working on now

- Broadening definition of adversity
  - Included bullying, discrimination, community violence and foster care in previous iterations
  - "Did anything else scary or upsetting happen to you as a child? Please describe that, if you feel comfortable."
- Switched from resilience questionnaire to Positive Childhood Experiences
- Implementing universal resilience interventions

Switching to Positive Childhood Experiences

- Before the age of 18, I…
  - Was able to talk with the family about my feelings
  - Felt that my family stood by me during difficult times
  - Enjoyed participating in community traditions
  - Felt a sense of belonging in high school
  - Felt supported by friends
  - Had at least two non-parent adults who took a genuine interest in me
  - Felt safe and protected by an adult in my home

From Bethell C, et al (2019). JAMA Pediatrics 173(11), e193007

Rounding Out the Conversation

- Which of these positive childhood experiences are you most excited to have happen for your child?
- How are you doing with making that experience happen?
  - I'm doing great
  - I need some help with this
  - I don't need to discuss this right now
- Is there anything that you think would be helpful for your pediatrician to provide right now?

Which of these PCEs are you most excited to have happen with your child?

- “All of them.”
- “For him to create friendships with his cousins”
- “I would love it if my kids talked about feelings early and also always feel protected.”
- “Having the support of friends.”
- “Traditions and being supported by family and friends.”
- “I’m excited for her to grow older and have us to talk to about anything. And for her to know we are there for her no matter what.”

Creating a Culture of Safety…and a Space to Heal

- **Positive relationships with providers matter for building resilience.**
  - Children with 2+ ACEs whose parents report that their child's health care providers "always" listen, spend needed time, and give needed information are over 1.5x more likely to live in families that practice four basic resilience skills.
  - Children whose parents report "always" having positive communication with their child's health care providers are over 1.5x more likely to practice 3 or more (of 5) recommended protective family routines and habits.

    - National Survey of Children's Health, www.cahmi.org

Altering our view of screening tools

- In order to move forward, we have to change how we think about screening protocols in primary care.
- Adding new screening or assessment protocols has often been seen as “one more thing” for providers to do.
- Sensemaking of our data changes the perception of how assessment tools relate to each other.
- Assessment tools are also an opportunity to educate parents and families…and help them understand about development, trauma, and the importance of PCEs and relational health.

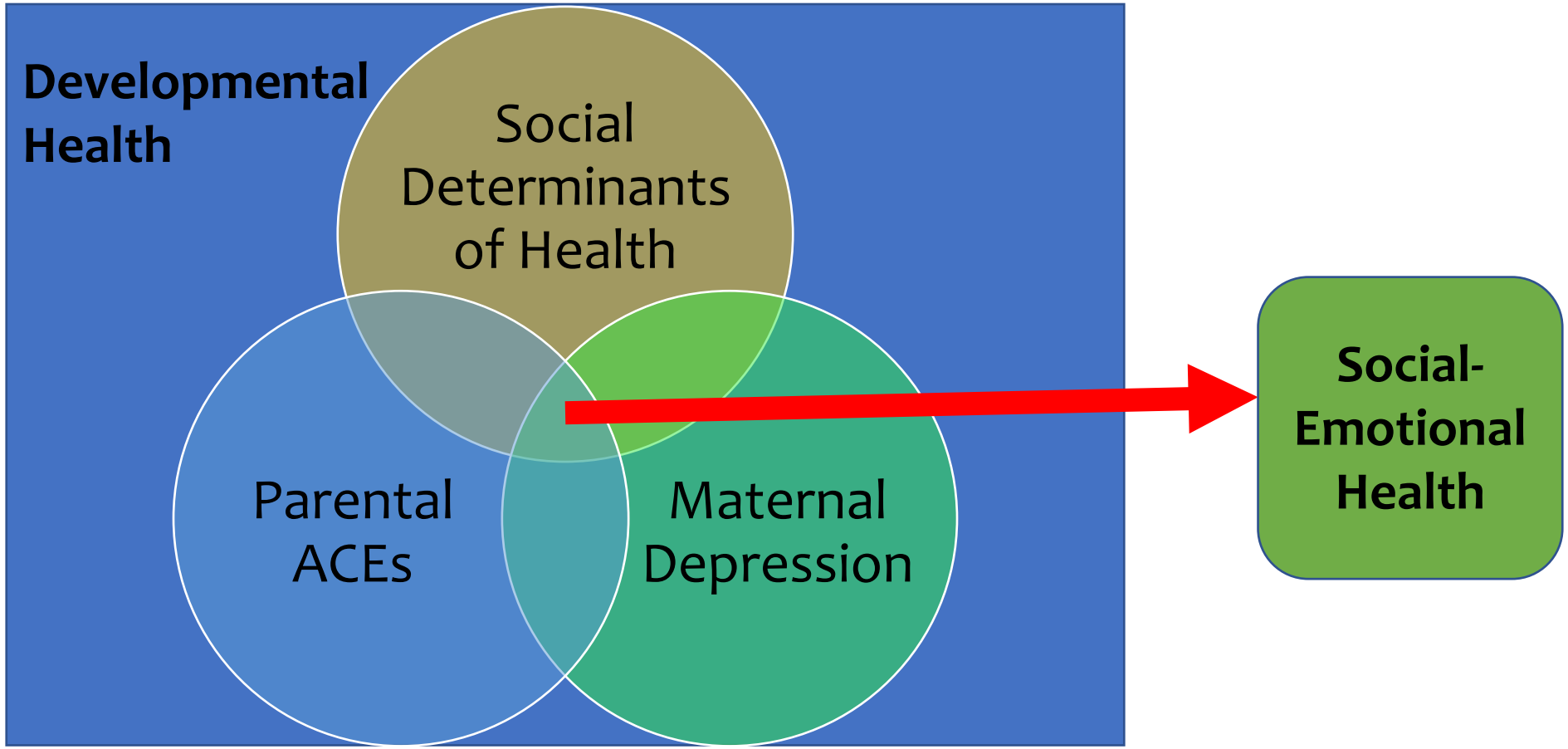
Screening Tools and Recommendations

Current State:

Maternal Depression at 2 weeks, 2 months, 4 months, 6 months	✓
Developmen	✓
Autism at 18 a	✓
Social-Emotio rvals	✓
Toxic stress / trauma history (patient or parent), Social Determinants of Health at undefined intervals	✓

Pass / Fail?
Refer or observe?
Move on…

Future State: An Integrated Screening Model



Beyond Screening

- That said, screening is necessary but not sufficient for promoting SSNRs between caregivers and their children.
- In order to effectively promote SSNRs, we have to actively work on enhancing them, or building and supporting them when they are threatened.

Public Health Level	Types of Prevention	Approaches to Toxic Stress	Examples	Approaches to Relational Health
3	Tertiary	Indicated Treatments for toxic stress related symptoms and diagnoses (e.g., anxiety, PTSD)	ABC PCIT CPP TF-CBT	Repair strained or compromised relationships
2	Secondary	Targeted Interventions for those at higher risk of toxic stress responses	Parent/Child ACEs SDoH	Identify / Address potential barriers to SSNRs
1	Primary	Universal Preventions (anticipatory guidance, consistent messaging)	Positive Parenting ROR Play	Promote SSNRs by building 2-Gen relational skills

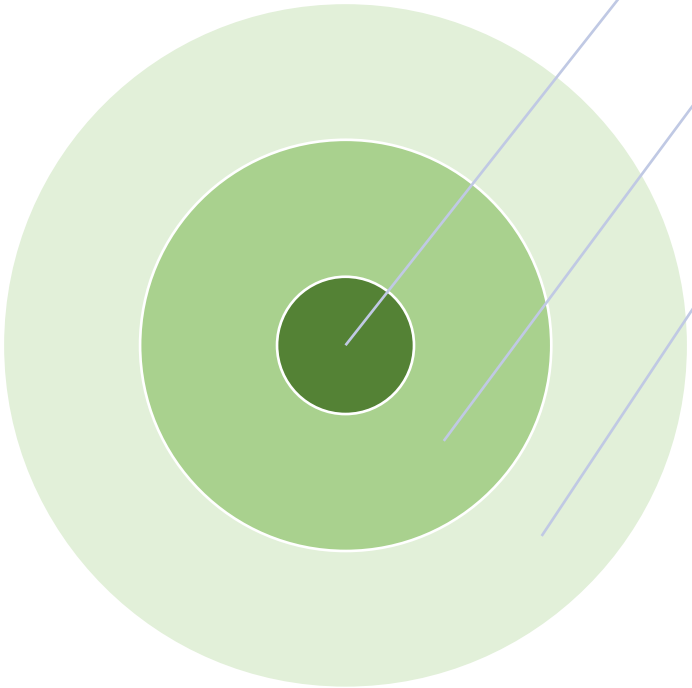
Slide adapted from *Thinking Developmentally: Nurturing Wellness in Childhood to Promote Lifelong Health*, Garner and Saul, 2018. Used with permission.

Resilience-based Interventions

- At each well visit in the first year, using specific brief interventions to promote resilience, attachment / attunement, and positive parenting.
- Partnership with Amy King, PhD
  - 2 weeks – Parent Self-Care
  - 2 months – Mirror time
  - 4 months – Focusing on attachment
  - 6 months – Time ins
  - 9 months – Review mirror time and time-ins
  - 12 months – Beginning discipline
  - A variety of other tools in our belt to address problems as they arise…

Self-Care Intervention

Circle of Support Intervention



Primary Circle - the people you can call day or night for help

Secondary Circle - the people you might reach out to after things get better

Tertiary Circle - the people who are here to support you when you can't find anyone else

Supporting Families Requires:

- Screening for risks
- Identifying strengths and supporting resilience
- Referring when needed

- But more importantly… **changing the culture of practice**.
  - Radical acceptance… suspending judgment, blame and stigma.
  - Recognize that children develop in the context of a healthy family.
  - Remember that resilience is learned and improved upon in relationships… it can't be done alone.

The Road Ahead

- How do we ensure social-emotional PROMOTION in our support of families, rather than just responding to a screen that identifies a patient or family as “at-risk”?
- How do we help parents and families understand social emotional health – and the concept of SSNRs – and their roles in wellness?
- How do we create a culture where parent trauma, social determinants of health, and other barriers to SSNRs are just part of the way we do business in primary care?
- How do we collectively – primary care providers and CBOs – respond appropriately to family needs?

The Ultimate Outcomes

- How do we use our knowledge of ACEs / PCEs in children and in parents to
  a) Prevent ACEs and promote PCEs in the next generation?
  b) Support and promote Kindergarten Readiness?

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