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September 17, 2020





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Parental ACEs and Pediatrics: Transforming Well Care

Dr R.J. Gillespie

September 17, 2020



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- Is a supplemental training to enhance healthcare professionals' and others' knowledge of ACEs, trauma informed care, and of strengths, protective factors, and resilience in their patients, families and communities. If you're seeking Medi-Cal certification, please visit acesaware.org
- National + local experts + small group learning collaboratives = more connected and caring communities
- Online communities of care provide a place to discuss challenges, share resources, and celebrate successes
- CAA, with funding from ACEs Aware, is a collaboration of the American Professional Society on the Abuse of Children (APSAC), the Academy on Violence and Abuse (AVA), the California Professional Society on the Abuse of Children (CAPSAC) and the Center for Innovation and Resources (CIR).



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Parental ACEs and Pediatrics: Transforming Well Care

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California ACEs Academy

September 17, 2020

Disclosures

I have no personal financial relationships in any commercial interest related to this presentation.

I do not plan to reference off label/unapproved uses of drugs or devices.

Objectives

- Discuss one pediatric practice's approach to integrating parental ACE assessments into clinical care.
- Stimulate some thinking on next steps... and how primary care / community-based organizations / mental health partnerships may be able to repair patients and families



Background

What we're doing... and why we decided to do it this way...

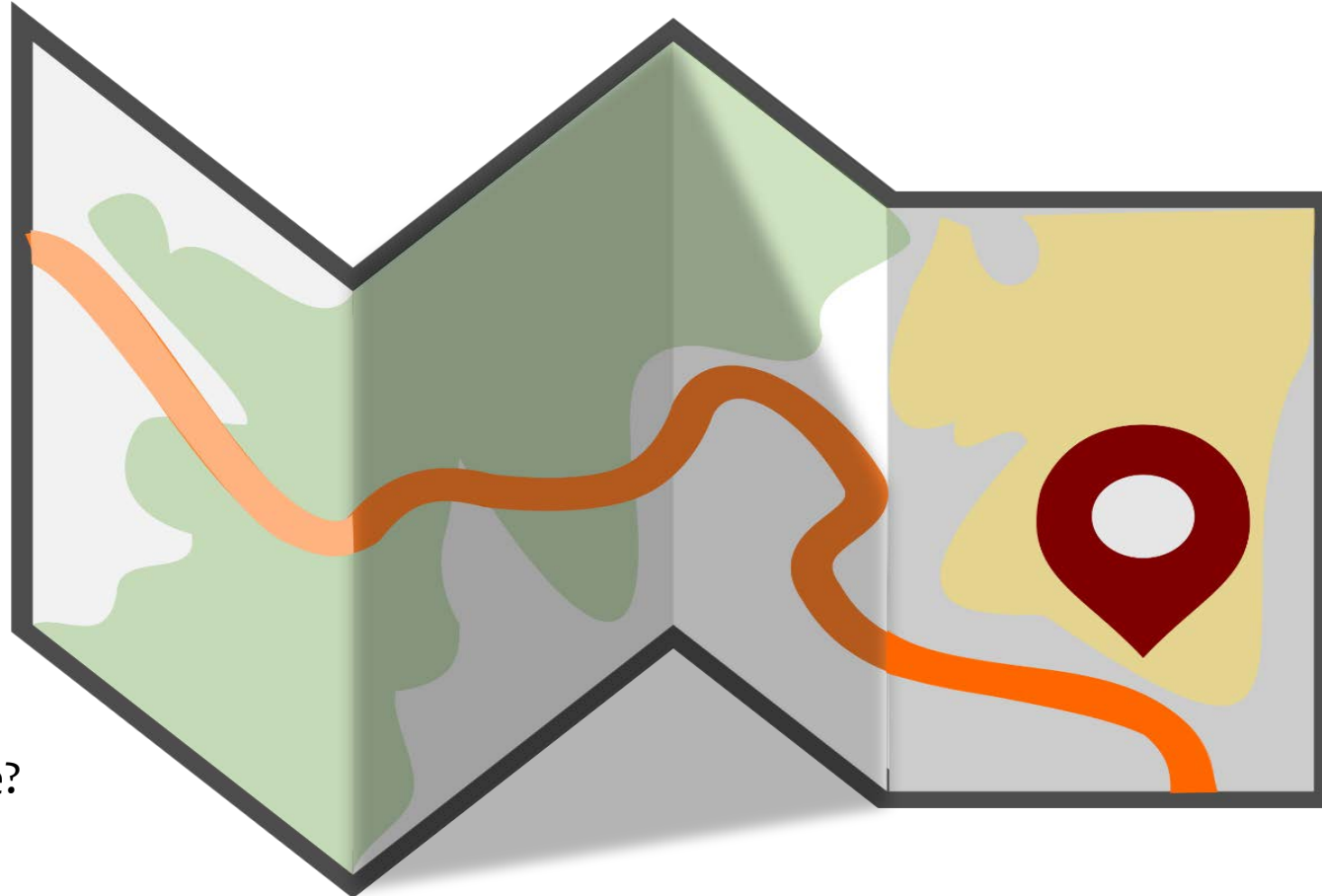
A Word from the American Academy of Pediatrics...

- 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.

Lessons from the Field... What Pioneering Practices Have Taught Us

- Screening in practice is feasible.
 - Doesn't take as long as you would think.
 - Usually doesn't change the immediate plan when a patient discloses trauma.
- Patients and parents appreciate being asked.
 - They see the importance to their health.
 - They appreciate the conversation... and don't mind the results being recorded in their records.
- Parents look to pediatricians for guidance.
 - Parents see pediatricians as trusted change agents.
 - We are viewed as a bridge to needed resources.



Our Process

What we did... and what we've found. (And some key lessons we've learned along the way)

The assumption

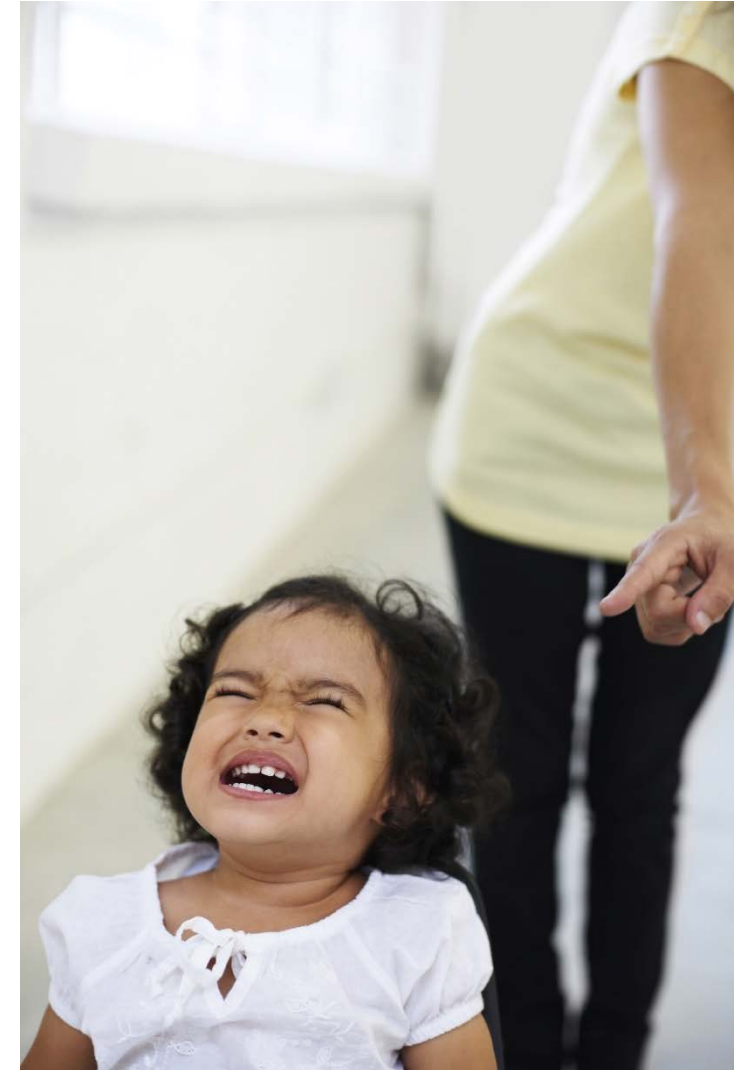
If...

- 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

- 30 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.



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.

Pro tip: Be intentional with spread... use a pilot of people willing to get their hands dirty.



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)	-	-

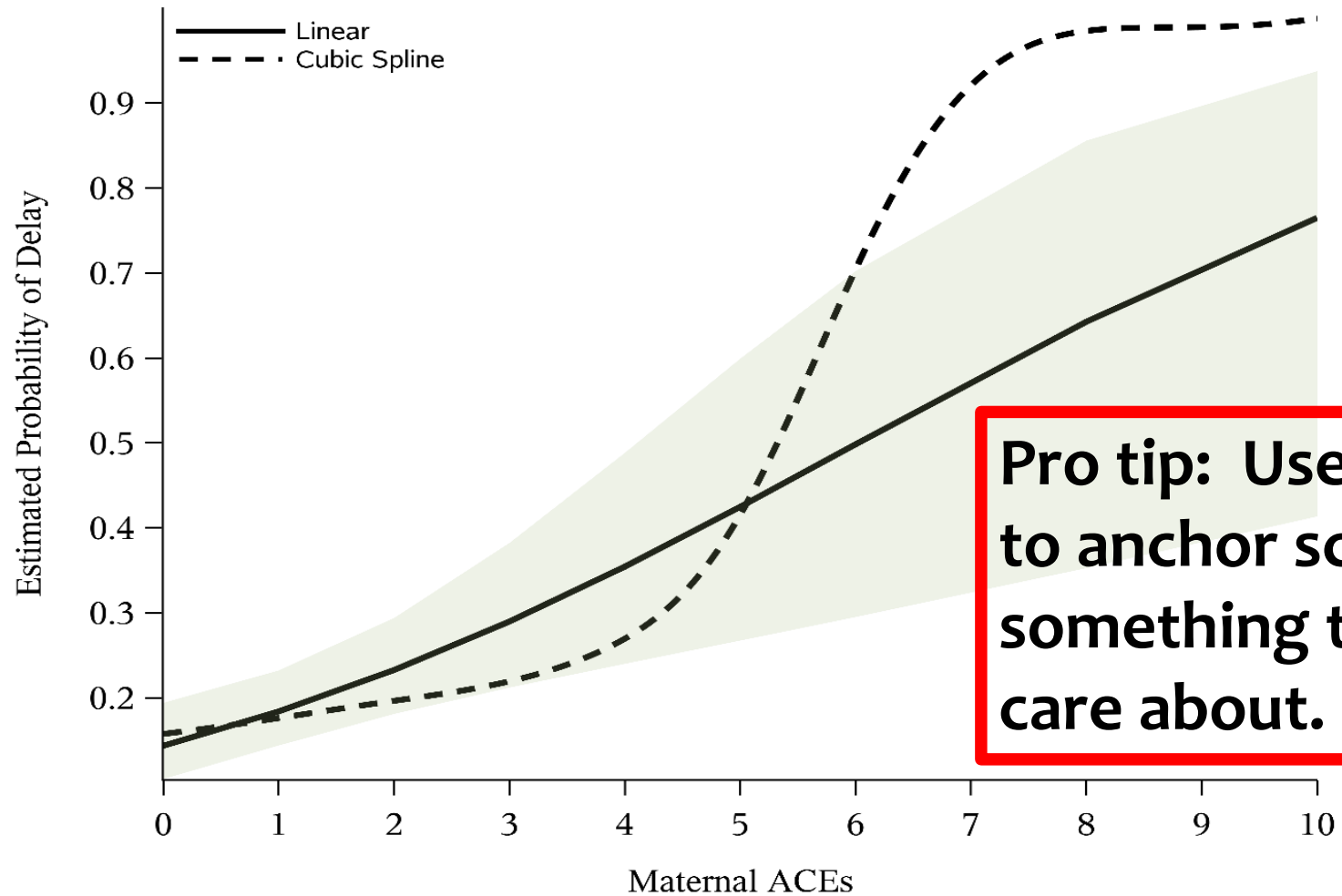
* = p < 0.1, ** = p < 0.05, *** = p < 0.01

Domain-specific developmental risk by Maternal ACE exposure

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



Pro tip: Use your own data to anchor screening to something that providers care about.

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.



What it's been like

Some cases to illustrate common conversations that I've had

Disclaimer...

- None of these cases came from our routine screening protocol.
- But... once you start thinking about ACEs in one context, you become more sensitive to them in other contexts.

The Angry Mom

- Mom of a four year old boy... her main concerns are about behavior.
- Whenever mom disciplines her son, he laughs at her.
- As mom describes how frustrating she thinks this behavior is, you can see the veins popping out of her neck...



Understanding Developmental Stages

- I asked mom why she thought he was laughing.
 - Mom has a history of verbal abuse... she interpreted her son's laughing as humiliation.
 - After a minute or two, the boy would always apologize and say "sorry, mommy."
- I asked if maybe she thought he laughed because he was embarrassed... her shoulders immediately dropped.
- We then talked about ways to center herself when needing to correct his behavior... take a deep breath, remind yourself why you're doing the correction, and focus on your goal.

Punchlines

- Understanding your kid's development keeps people from misinterpreting their reactions.
 - Toddlers aren't mean, stubborn, selfish, etc.
- Help parents understand that “kids do well when they can.”
- Since then...mom has spontaneously brought up food insecurity, family losses, financial hardships...and how those things might be affecting her older kid's behaviors...

The worst clinical visit I've ever had...

- 15 year old who is doing “everything wrong” comes in for a well visit
 - Truancy – being kicked out of the “last ditch” high school
 - Violent fights with mom
 - Unprotected sex with her “boyfriend” who is 26
 - Meth, marijuana, cocaine
- After figuring out this history, I ask her if she has any goals
- Her response: “you think I’m having unprotected sex because I don’t have any goals? You’re an a\$\$@*&!”

After the shock wore off...

- My initial instinct?
- She reported her ACE score as 5.
 - Father is out of the picture after going to jail for drug abuse.
 - Verbal abuse, emotional neglect were part of her experiences.
- My instinct now?
- Discussion about coping strategies, and boosting her sense of competence.





“It's hard to get enough of something that *almost* works.”

- V. Fellitti

And the next visit?

- She had transferred to a Gateway program at our community college.
- She had stopped all drugs except marijuana.
- She ditched her much-older boyfriend.
- When I asked her what had changed...

“The kids at that last school were losers... they didn’t have any goals.”

The Quietly Failing Teen

- 12 year old male in for a well visit... first time with this office.
- Mom concerned that his grades are slipping: he used to be a B student, now C-D student.
- In a new school this year, patient cries when talking about how he has made no friends.
- Not disruptive in the classroom.
- Past history of anxiety.
- No thoughts of self-harm.



What if...

- Father is in jail?
- Both parents have a history of substance abuse?
- Parents are divorced?
- Mother has a history of anxiety and depression and “can’t get on the right medications”?
- Used to live with his grandmother, but now that mom “has her act together” he has moved across town and not only is in a new school but also is no longer allowed to talk with his grandmother?
- **ACE score: at least 4...**

Factors in Resiliency: The 7 C's

- Connection
- Confidence
- Competence
- Character
- Coping
- Control
- Contribution



From www.fosteringresilience.com (Ken Ginsburg, MD)

Addressing Some of the 7 C's

- **Connection:** Big Brother, school counselor, other mentoring programs.
- Asking about his strengths, interests and passions assesses **Competence** and **Confidence:**
 - Really likes skateboarding... Boys & Girls Club has competitions...
- **Coping:** exercise, meditation, Youth Contact for counseling.

Punchlines

- Screening for ACEs in ANY context in our practice has made us aware of ACEs in ALL contexts.
- This fundamental culture shift towards Trauma-Informed Care changes how we view patients and their problems.
- Our needs as health care providers are extending beyond what our clinic can provide on its own...



So now what?

Transforming well care... one step at a time.

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.

Screening Tools and Recommendations

Current
State:

Maternal Depression at 2 weeks, 2 months, 4 months, 6 months



Developmental

Pass / Fail?



Autism at 18 a

Refer or observe?



Social-Emotio

Move on...

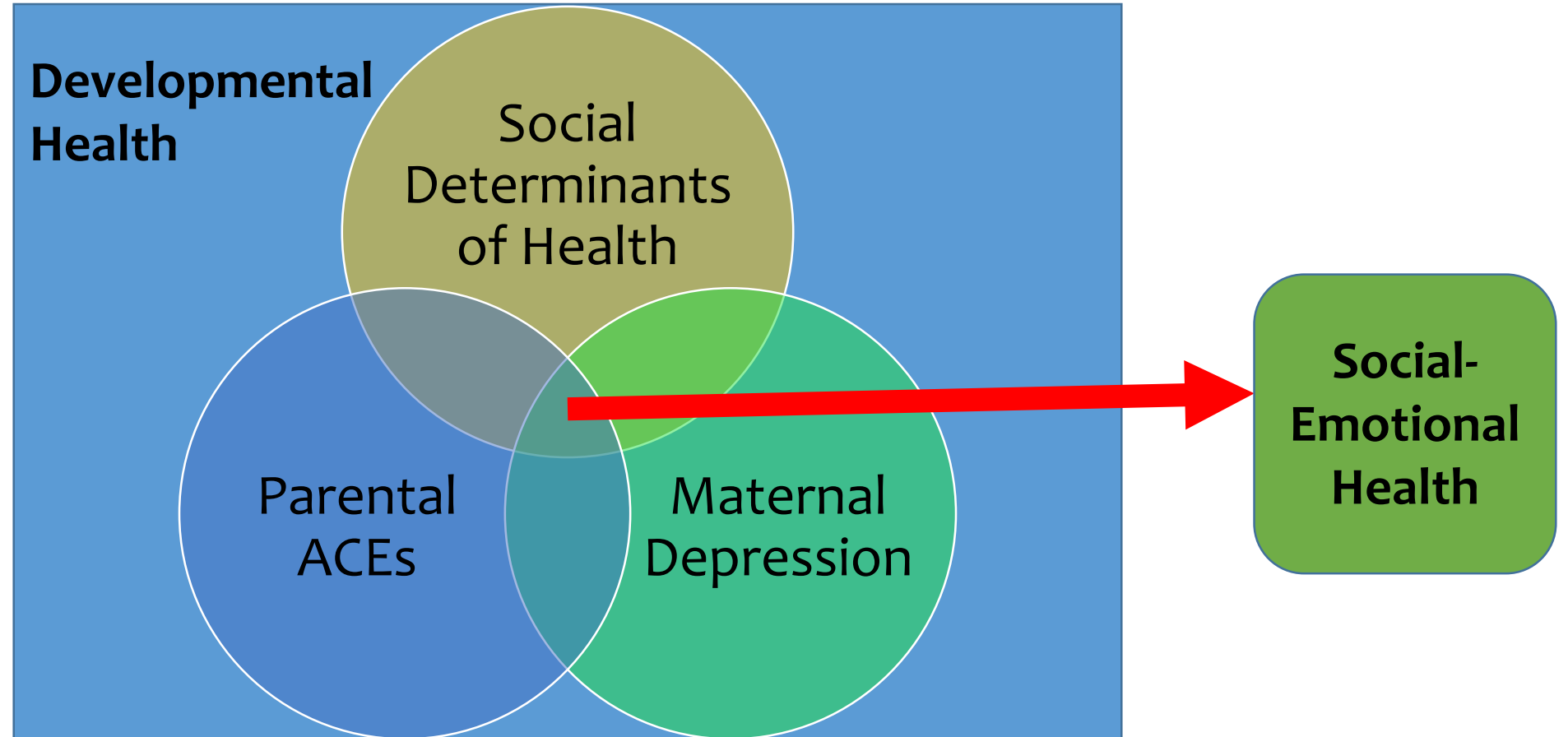
ervals



ACEs (patient or parent), Social Determinants of Health at
undefined intervals



Integrated Screening Model



Expanding on the purpose of screening tools

- Previously, screening tools were all about assessing risk, and connecting to resources as needed.
- Now, using screening tools as teachable moments and opportunities for education.

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

Public Health Approach to ACE Assessments

- Primary Prevention:
 - ACE assessment tools become an opportunity to provide UNIVERSAL education about trauma and resilience
- Secondary Prevention:
 - ACE assessment tools help to identify families that MAY BE AT RISK and therefore get extra help in positive parenting, relational / attachment repair, or other interventions
- Tertiary Prevention:
 - ACE assessments give an opportunity to identify TRAUMA SYMPTOMS and therefore which patients / families need further evidence-based treatments

Figuring out who's on our side...



Public Health / Community Interventions

- Nurse Family Partnerships and other home visiting programs
 - 2 home visits in the first year shown to reduce child abuse by 50%
- Community Referral Agencies
 - 211 Info
 - Help Me Grow
- Early Intervention / Early Childhood Special Education
 - Parent coaching model to improve interactions between parent and child
 - Some states include family risks as qualifying diagnoses – Illinois uses maternal depression as a qualifying diagnosis for EI
- Mother-Baby Dyad Interventions
- Mentoring programs (Big Brother / Big Sister Programs, Boys & Girls Clubs, etc.)
- Trauma-Informed Schools: major work being done in implementing trauma-informed discipline, resilience programs within school systems with great success.

Parenting Interventions with Good Evidence

- Triple P
- Parent-Child Interaction Therapy (PCIT)
- Attachment and Biobehavioral Catch-up (ABC)
- Child-Parent Psychotherapy (CPP)
- Child First
- Promoting First Relationships (PFR)
- Family Check-up
- Safe Care
- The Incredible Years
- Circle of Security

From David Willis, MD (used with permission)



Our Integrated Response

Redefining Our Role & Goal: Understanding the “Righting Reflex”

- “Success” in our conversations about ACEs and trauma is relational.
 - Goal is not about “forcing” a disclosure.
 - Is the door open to further conversation?
- Conversation should be validating, safe and non-threatening.
- If we’re leaning on our training to “fix everything” we may not be present to hear the stories.
- Parents’ behaviors make more sense if you understand their story.
 - Instead of “what’s wrong with this person?”, think “what happened to this person?”

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

Initiating the Conversation to Help Patients Understand their own Experiences

- Thank patient / parent for opening up about their experiences, validate the importance of the conversation.
- Are there any of these experiences that still bother you now?
- Of those that no longer bother you, how did you get to the point that they don't bother you?
- How do you think these experiences affect you now?

Universal Resilience Interventions

- Complements of Amy Stoeber, PhD – all providers are trained in a series of interventions that will be implemented universally at well visits
- Assuming that ACEs interfere with parent-child attachment...
 - Interventions relate to parent self-care, promoting attachment / attunement, and building resilience in parents
- Building in data collection to measure outcomes for kids based on whether interventions were delivered (and which ones)

Expanding our Assessment for Kids at Risk

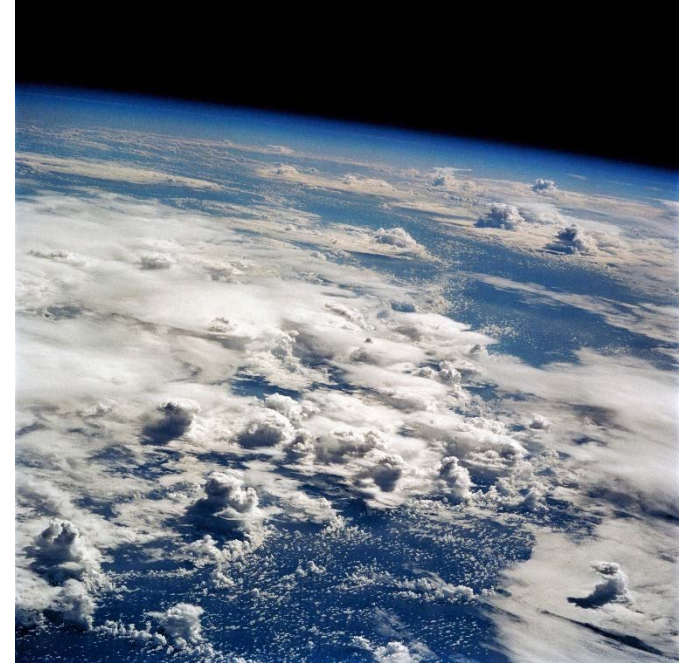
- Currently the AAP guidelines for maternal depression recommend specific social emotional screening for kids whose parents experience depression
- Given the effects of ACEs on a parent's attachment and attunement with their child, makes sense to create an analogous workflow for positive ACEs
- TCC has added integrated Behavioral Health Consultants into practice
 - BHCs will be engaged with families to conduct screening and give more in-depth interventions for families at risk
 - Planning co-visits with pediatrician and BHC at 6 month visits as needed

Pro tip: Use an expanded care team to offer more tailored services to families in need.

Expanded workflow / clinical response

- **Parent ACE score 0**
 - Resilience interventions
 - Universal education about trauma and resilience
- **Parent ACE score 1-3**
 - Resilience interventions
 - Universal education about trauma and resilience
 - Safety assessment and resource needs assessment
 - Refer to Care Coordinator or Help Me Grow as needed
- **Parent ACE score 4+, or 1-3 with symptoms / safety concerns**
 - Resilience interventions
 - Universal education about trauma and resilience
 - Safety assessment and resource needs assessment
 - Refer to Care Coordinator or Help Me Grow as needed
 - Schedule joint 6 month visit with BHC
 - Social emotional development screening
 - Video interaction intervention
 - If concerns - schedule joint 9 month visit, consider referral to PCIT or other therapy

Pro tip: Adapt your model of care based on patient and family needs.



Looking to the future...

The 50,000 foot view

How else can we apply these learnings to prevention?

- Given what we know about risks to development and mental / behavioral health:
 - How does primary care, with the support of our mental health colleagues, approach mental health prevention?
 - What is the role of mental health in promoting and supporting social emotional development?
 - Can we transform primary care enough to be able to promote Kindergarten readiness as a cross-sector, multidisciplinary effort?

The Ultimate Outcomes

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

On being a snowflake...





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