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Supporting Children & Families Post Sandy

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NJAAP wishes to acknowledge the invaluable contributions of the medical experts listed below for their role in developing the Pediatric Partnership Initiative training curriculum and thank them for their ongoing efforts, guidance and support of this important program.

- Elizabeth Hodgson, MD, FAAP
- Robert Like, MD, MS, AAP, Illinois Chapter
- Manuel Jimenez, MD, MS
- Gary Rosenberg, MD
- Steven Kairys, MD, MPH, FAAP
- Suzanne Sawyer, MSN
- Colleen Kraft, MD, FAAP
- David J Schonfeld, MD, FAAP

Cover Picture Courtesy of Amanda’s Easel Creative Arts Therapy Program
Dear Friends,

To support children and families challenged by post-Superstorm Sandy stress, the New Jersey Department of Children and Families and the American Academy of Pediatrics – New Jersey Chapter partnered to create the Pediatric Partnership Initiative (PPI). This partnership provides special training for New Jersey pediatricians and family practice physicians.

Thanks to the Christie Administration’s allocation of more than $1 million in Social Services Block Grant funds to the PPI effort, physicians are being taught how to help patients manage post-storm stress, provide psychological first aid, recognize and intervene with families in distress, and access and refer families to community resources.

The stress many families are facing in the aftermath of Superstorm Sandy can be especially toxic to children, increasing the likelihood of disease and cognitive impairment. To prevent this, it’s important that physicians identify signs of stress in patients before families suffer further and healthy childhoods are compromised.

Our department is proud to partner with NJ AAP to help protect children and families from harmful and destructive stress. For us, the work of dedicated partner organizations like NJ AAP is critical to our mission to ensure a better today and an even greater tomorrow for every individual we serve.

Warm Regards,

Allison Blake
Commissioner
New Jersey Department of Children and Families
“I loved the Learning Collaborative, loved the materials, and was very impressed by the curriculum. I loved the Survey of Wellbeing of Young Children [screening tool] and have already printed it out and given it to the practice’s lead doctor. I’m planning to use it myself with all of my well child visits, which include children whose families were affected by Superstorm Sandy.”

Southern Ocean Medical Center, Ocean County

About the Pediatric Partnership Initiative (PPI)

The Pediatric Partnership Initiative is comprised of several learning opportunities for pediatric and family practice providers who serve children and families in communities that were hardest hit by Superstorm Sandy (i.e., those in Atlantic, Bergen, Cape May, Cumberland, Essex, Hudson, Middlesex, Monmouth, Ocean, and Union Counties in New Jersey). Featured clinical content experts include physicians Steven Kairys, MD, MPH, FAAP; David J. Schonfeld, MD, FAAP; Manuel Jimenez, MD, MS; Elizabeth Susan Hodgson, MD; and Colleen A. Kraft, MD, FAAP among others.

Through hospital Grand Rounds and Business Meetings, Office-Based Sessions, and Learning Collaboratives, providers participate in educational opportunities designed to support children and families dealing with toxic stress from adverse childhood experiences. With funding through the Social Services Block Grant – Disaster Recovery (SSBG-DR) provided by the Administration for Children and Families, New Jersey Department of Children and Families and New Jersey Chapter, American Academy of Pediatrics have partnered to support pediatricians, family physicians and other health care providers as they care for patients and families recovering from the impact of Sandy. PPI offers participants, at no cost to them, information on how to:

- manage Post-Sandy stress;
- provide psychological first aid;
- recognize and intervene with children and families in distress; and
- access community resources to which they can refer children and families in their care.

These educational opportunities have been phased in across the ten most impacted counties.

Please refer to the back cover of this publication to learn about opportunities in your county.
Contact any PPI Team member at (609)842-0014.

Southern Ocean Medical Center, Ocean County
# Pediatric Partnership Initiative

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Pediatrician-in-Chief, St. Christopher’s Hospital for Children; Chair, Department of Pediatrics, Drexel University College of Medicine; Director, National Center for School Crisis & Bereavement | October 29, 2014  
8AM - 9AM                                         |
| Helping Children Cope after a Disaster             | David J Schonfeld, MD, FAAP                                                                                                                                                                          | November 12, 2014  
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| Implementing Developmental Screening Tools         | Manuel Jimenez, MD, MS  
Rutgers Robert Wood Johnson Medical School Children's Health Institute of NJ                                                                                                                                  | December 3, 2014  
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| Positive Parenting and its Effect on Resiliency    | Steven Kairys, MD, MPH  
Chairman of Pediatrics at Jersey Shore University MC                                                                                                                                                  | January 14, 2015  
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| How Children Come to Understand Illness and How We Can Learn to Explain It Better | David J Schonfeld, MD, FAAP                                                                                                                                                                          | February 11, 2015  
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| Payment: Coding and Documentation                 | Sherry Barron-Seabrook, MD, Child Psychiatrist NeuroBehavioral Associates, LLC  
and  
Chuck Scott, MD, FAAP  
Advocare Medford and Mansfield Pediatrics           | Date / Time TBD                     |

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| Children’s System of Care (CSOC)                   | Elizabeth Manley, Director  
New Jersey Children’s System of Care                                                                                                                                                                     |                                    |
| Cultural Competence: Addressing Cultural Diversity Issues in Clinical Care | Robert C. Like, MD, MS  
Professor and Director, Center for Healthy Families and Cultural Diversity Department of Family Medicine & Community Health; Rutgers Robert Wood Johnson Medical School                          |                                    |
| Quality Improvement Fundamentals                   | Ruth S. Gubernick, MPH, PCMH, CCE  
Quality Improvement Advisor                                                                                                                                         |                                    |
| Overview and Use of AAP Mental Health Toolkit      | Marian Earls, MD  
Director of Pediatric Programs, Community Care of NC                                                                                                                                                  |                                    |


Colleagues,

Pediatricians pride themselves on the specialized healthcare they provide to children, but unfortunately, too few have objective ways for documenting the quality and effectiveness of that care. And while a growing body of new guidelines and evidence unequivocally demonstrates the benefits to organized screening, surveillance and care management, the gap between the new knowledge and the current practice approach continues to widen. Health care researchers refer to this as the Implementation Gap.

Myriad solutions have been put forth to address this growing implementation gap. The most basic to mentor and support individual child health care providers to become more reflective and evidence-based in key parts of their work. This is the basic concept behind quality improvement: to step back from the day to day frenetic pace of work and to focus on one or two parts of the work for a specific period of time.

Early in 2014, NJAAP and the Department of Children and Families, partnered to launch the Pediatric Partnership Initiative (PPI), a far-reaching quality improvement project designed to support and enhance pediatricians’ efforts to care and support children and families coping with toxic stress from adverse childhood experiences. PPI provides pediatric offices with a wide range of screening and care management tools that support efforts to improve the quality of care AND ability to document the benefits of that enhanced care.

Numerous pediatric practices from across New Jersey have already participated in a PPI Learning Collaborative and many more have registered for a future Learning Collaborative. However, due to scheduling conflicts and other time constraints, some practices have been unable to avail themselves of this uniquely rich training opportunity. Therefore, NJAAP decided to compile a collection of key resources from the PPI and make them available to all practices through this special issue of New Jersey Pediatrics.

You will find an abundance of tools and resources throughout this issue, many of which are provided to Learning Collaborative participants only. We hope you will find these tools valuable in increasing the quality and effectiveness of the care you provide to all the children and families you serve, most especially to those who continue dealing with adverse effects associated with post-Sandy recovery.

Sincerely,

Steven Kairys, MD, MPH, FAAP

New Jersey Chapter, American Academy of Pediatrics
3836 Quakerbridge Road, Suite 108 | Hamilton, NJ 08619
TEL 609.842.0014 | FAX 609.842.0015 | www.aapnj.org
## Disaster Planning, Response, and Recovery Considerations for Children and Families

### Resource List: Tools for Planning for Children and Families

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Visit [http://bit.ly/1wrHaVe](http://bit.ly/1wrHaVe) or scan QR Code to access an interactive version of this document, including links to all cited resources.

**SOURCE:** Content derived from Appendix F of the IOM workshop summary Preparedness, Response, and Recovery Considerations for Children and Families. This list is not comprehensive, but is meant to be a compilation of tools and resources highlighted by speakers during the workshop and mentioned throughout the summary.

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What happens in early childhood can matter for a lifetime. To successfully manage our society’s future, we must recognize problems and address them before they get worse. In early childhood, research on the biology of stress shows how major adversity, such as extreme poverty, abuse, or neglect can weaken developing brain architecture and permanently set the body’s stress response system on high alert. Science also shows that providing stable, responsive, nurturing relationships in the earliest years of life can prevent or even reverse the damaging effects of early life stress, with lifelong benefits for learning, behavior, and health.

1 Early experiences influence the developing brain. From the prenatal period through the first years of life, the brain undergoes its most rapid development, and early experiences determine whether its architecture is sturdy or fragile. During early sensitive periods of development, the brain’s circuitry is most open to the influence of external experiences, for better or for worse. During these sensitive periods, healthy emotional and cognitive development is shaped by responsive, dependable interaction with adults, while chronic or extreme adversity can interrupt normal brain development. For example, children who were placed shortly after birth into orphanages with conditions of severe neglect show dramatically decreased brain activity compared to children who were never institutionalized.

2 Chronic stress can be toxic to developing brains. Learning how to cope with adversity is an important part of healthy child development. When we are threatened, our bodies activate a variety of physiological responses, including increases in heart rate, blood pressure, and stress hormones such as cortisol. When a young child is protected by supportive relationships with adults, he learns to cope with everyday challenges and his stress response system returns to baseline. Scientists call this positive stress. Tolerable stress occurs when more serious difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury, are buffered by caring adults who help the child adapt, which mitigates the potentially damaging effects of extreme stress.

The brain’s activity can be measured in electrical impulses—here, "hot" colors like red or orange indicate more activity, and each column shows a different kind of brain activity. Young children institutionalized in poor conditions show much less than the expected activity.

POLICY IMPLICATIONS

- The basic principles of neuroscience indicate that providing supportive and positive conditions for early childhood development is more effective and less costly than attempting to address the consequences of early adversity later. Policies and programs that identify and support children and families who are most at risk for experiencing toxic stress as early as possible will reduce or avoid the need for more costly and less effective remediation and support programs down the road.

- From pregnancy through early childhood, all of the environments in which children live and learn, and the quality of their relationships with adults and caregivers, have a significant impact on their cognitive, emotional, and social development. A wide range of policies, including those directed toward early care and education, child protective services, adult mental health, family economic supports, and many other areas, can promote the safe, supportive environments and stable, caring relationships that children need.
abnormal levels of stress hormones. When strong, frequent, or prolonged adverse experiences such as extreme poverty or repeated abuse are experienced without adult support, stress becomes toxic, as excessive cortisol disrupts developing brain circuits.

3 Significant early adversity can lead to lifelong problems. Toxic stress experienced early in life and common precipitants of toxic stress—such as poverty, abuse or neglect, parental substance abuse or mental illness, and exposure to violence—can have a cumulative toll on an individual’s physical and mental health. The more adverse experiences in childhood, the greater the likelihood of developmental delays and other problems. Adults with more adverse experiences in early childhood are also more likely to have health problems, including alcoholism, depression, heart disease, and diabetes.

4 Early intervention can prevent the consequences of early adversity. Research shows that later interventions are likely to be less successful—and in some cases are ineffective. For example, when the same children who experienced extreme neglect were placed in responsive foster care families before age two, their IQs increased more substantially and their brain activity and attachment relationships were more likely to become normal than if they were placed after the age of two. While there is no “magic age” for intervention, it is clear that, in most cases, intervening as early as possible is significantly more effective than waiting.

5 Stable, caring relationships are essential for healthy development. Children develop in an environment of relationships that begin in the home and include extended family members, early care and education providers, and members of the community. Studies show that toddlers who have secure, trusting relationships with parents or non-parent caregivers experience minimal stress hormone activation when frightened by a strange event, and those who have insecure relationships experience a significant activation of the stress response system. Numerous scientific studies support these conclusions: providing supportive, responsive relationships as early in life as possible can prevent or reverse the damaging effects of toxic stress.

As the number of adverse early childhood experiences mounts, so does the risk of developmental delays (top). Similarly, adult reports of cumulative, adverse experiences in early childhood correlate to a range of lifelong problems in physical and mental health—in this case, heart disease (bottom).


THE INBRIEF SERIES:
INBRIEF: The Science of Early Childhood Development
INBRIEF: The Impact of Early Adversity on Children’s Development
INBRIEF: Early Childhood Program Effectiveness
INBRIEF: The Foundations of Lifelong Health

www.developingchild.harvard.edu
Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH

Background: The relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household dysfunction during childhood has not previously been described.

Methods: A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or even imprisoned. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. Logistic regression was used to adjust for effects of demographic factors on the association between the cumulative number of categories of childhood exposures (range: 0-7) and risk factors for the leading causes of death in adult life.

Results: More than half of respondents reported at least one, and one-fourth reported ≥2 categories of childhood exposures. We found a graded relationship between the number of categories if childhood exposure and each of the adult health risk behaviors and diseases that were studied (P < .001). Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

Conclusions: We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.


We will address a more effective way of implementing our screening questionnaires to our patients.

Research Article

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When parents take their four-month-old for a well-baby checkup at the Children’s Clinic in Portland, OR, Drs. Teri Petersen, R.J. Gillespie and their 15 other partners ask the parents about their adverse childhood experiences (ACEs).

When parents bring a child who’s bouncing off the walls and having nightmares to the Bayview Child Health Center in San Francisco, Dr. Nadine Burke Harris doesn’t ask: “What’s wrong with this child?” Instead, she asks, “What happened to this child?” and calculates the child’s ACE score.

What’s an ACE score? Think of it as a cholesterol score for childhood trauma.

Why is it important? Because childhood trauma can cause the adult onset of chronic disease (including cancer, heart disease and diabetes), mental illness, violence, becoming a victim of violence, divorce, broken bones, obesity, teen and unwanted pregnancies, and work absences.

The CDC’s Adverse Childhood Experiences Study (ACE Study) measured 10 types of childhood adversity: sexual, physical and verbal abuse, and physical and emotional neglect; and five types of family dysfunction – witnessing a mother who was abused, a household member who’s an alcoholic or drug user, who’s been imprisoned, or diagnosed with mental illness, or loss of a parent through separation or divorce. (There are, of course, other types of trauma, but those were not measured in this study. Other ACE surveys are beginning to include other types of trauma.)

The ACE Study found that childhood trauma was very common -- two-thirds of the 17,000 mostly white, middle-class, college-educated participants (all had jobs and great health care because they were members of Kaiser Permanene) experienced at least one type of severe childhood trauma. Most had suffered two or more.

The more types of childhood trauma a person has, the higher the risk of medical, mental and social problems as an adult (Got Your ACE Score?).

Compared with people who have zero ACEs, people with an ACEs score of 4 are twice as likely to be smokers, 12 times more likely to attempt suicide, seven times more likely to be alcoholic, and 10 times more likely to inject street drugs.

The life expectancy of people with an ACE score of 6 is 20 years shorter than those with zero ACEs.

Twenty-two states and Washington, D.C., have done their own ACE surveys, with similar results.

The ACE Study is part of a perfect storm of research emerging over the last 20 years that is revolutionizing our understanding of human development. Brain research shows how the toxic stress of trauma damages the structure and function of children's brains, which can explain their hyperactivity, inattentiveness, angry outbursts and other behavior. This affects their ability to learn in school, and leads them to use drugs, alcohol, thrill sports, food and/or work as coping mechanisms.

Biomedical researchers discovered that toxic stress experienced as a child can linger in the body to cause chronic inflammation as an adult, resulting in heart and auto-immune diseases, such as arthritis. And epigenetic research shows that the social and emotional environment can turn genes on and off, and childhood trauma can be passed from parent to child to grandchild.

Let’s put this another way: A huge chunk of the billions upon billions of dollars that Americans spend on health care, emergency services, social services and criminal justice boils down to what happens – or doesn’t happen -- to children in their families and communities.

Pediatricians across the U.S. are beginning to integrate ACEs research into their practices. For the last several years, the American Academy of Pediatrics has been helping pediatricians create medical homes where all needs of children and their families are met, including “specialty care, educational services, out-of-home care, family support, and other public and private community services that are important for the overall health of the child and family.”

Two years ago, the AAP encouraged pediatricians to also address adverse childhood experiences and toxic
stress in early childhood. In July, AAP President Dr. James Perrin launched a new initiative, the Center on Healthy Resilient Children, to “coordinate the academy’s response to the issue of adverse childhood experiences, the promotion of healthy development, and the prevention of toxic stress.”

Pediatricians aren’t just about sore throats and ear infections anymore, says Gillespie. “This is a culture shift. We’re here to support families.

When Tabitha Lawson brought her four-month-old son in to the Children’s Clinic in Portland, OR, they both were having a hard time. Unlike her 6-year-old daughter, he wasn’t an easy baby. He had colic, and Tabitha and her husband were under stress from his long bouts of crying.

“I was feeling overwhelmed,” she recalls. “I had no breaks. I work full time. From my job to my house is five minutes, where I’d go into my other life mode, and every evening, the scream-outs.”

She filled out a survey with 10 questions about her adverse childhood experiences (ACEs) and another 15 questions about protective factors. The 10 ACEs include physical, sexual and verbal abuse, and physical and emotional neglect; and five types of family dysfunction – a family member addicted to alcohol or other drug, a family member in prison or diagnosed with a mental illness, witnessing a mother being abused, and loss of a parent through separation or divorce.

Her pediatrician, Dr. R.J. Gillespie, went over the survey with her. He said it was helpful for him to know what she experienced while growing up, so that he could think about how to support her own parenting skills through what might be challenging times or experiences.

Lawson had suffered through her parents’ acrimonious divorce, her father had been an alcoholic, and had retained custody of Lawson and her sister in a poisonous dispute. Her mother withdrew, neglecting Lawson, and her father was emotionally abusive. That’s an ACE score of 4, which can be a red flag. In Lawson’s case, she was already aware of how harmful those experiences were.

“I had decided to rise above the cycle of dysfunction and divorce,” says Lawson, and she and her husband were very clear about the loving environment they wanted to create for their children. She believes in the mantra, “It takes a village to raise a child,” so welcomed the support and involvement of her husband’s parents and aunt.

Nevertheless, Gillespie knew that the addition of a colicky baby was putting stress on Lawson and her family. “He gave me a worksheet to fill out, so that I knew in advance who I could call when I was under extreme stress,” she says. He also gave her tips on how to reduce her stress level by doing breathing exercises, yoga, and stopping for 10 minutes on her way home to give herself some alone time. He told her to call him anytime she needed to talk with him.

“Just knowing that he was taking the time to listen to me, and validating that I was doing everything right, and that I was doing a great job, meant a lot to me,” she says. “I have no idea how I got through it, but I did. Having the support of my pediatrician who genuinely cared about me definitely helped. By the six-month appointment, things were much better.”

A child’s behavior can reveal a parent’s ACE score

Perhaps the first pediatrician to do anything with the ACE Study was Dr. David Willis, who was medical director at the Artz Center for Developmental Health in Portland. The center received referrals from pediatricians for children who had behavioral or developmental problems. Willis had learned about the ACE Study in 2005, and its implications had hit him like a thunderbolt.

“I knew that trauma in previous generations could play a big part in parenting,” he says. “The ACE data could clearly help us move upstream, targeting how to begin to work with families, to understand how the trauma endured by parents in their childhood impacted attachment with their own children. That’s what got me going.”

Willis, who is now director of the Division of Home Visiting and Early Childhood Systems in the U.S. Department of Health and Human Services’ Health Resources and Services Administration, began using the ACE questionnaire with all families who came to him. “It got to the point where I could predict the parents’ ACE score after they described the child’s behavioral pattern,” he says.

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Having the parents fill out the ACE survey enabled him to have frank discussions with them.

“We could now freely talk about when they were in conflict with the child,” he says. This enabled him to help the parents help their child regulate, instead of dissociating or avoiding the child when the child was angry with them. He taught them the importance of being firm, fair and friendly in an atmosphere of struggle and conflict, while listening and acknowledging the child’s frustrations and fears.

“After three or four visits in which I counseled them to go home and try these approaches, if they returned unsuccessful, I knew that they probably needed their own psychological care, because it was difficult for them to do the work they wanted to do,” he continues. “So I would ask: ‘Have you considered why this is so hard?’ Then we would have 90 to 100 percent of the parents agree to see a counselor.

The hook was their desire to improve their child’s space, so it made them willing to confront when they were afraid to seek their own mental health counselor.”

The Children’s Clinic pediatricians began screening for ACEs after Dr. Teri Pettersen took a sabbatical to work with Willis in 2011. In March 2013, she and eight of her partners started a pilot to screen the parents of four-month-old babies because, generally speaking, “four-month-olds are the happiest critters on the planet,” she says. “They smile at everything their parents do. As a result, parents feel more confident. They’re not as exhausted as they were at the beginning. It’s a positive time to ask them about these topics.”

Pettersen knows that parents who’ve experienced chronic trauma in their childhoods have a good chance of passing that on to their children.

“I wanted to create the relationship so that when parents are struggling, they’ll come to us and say they’re struggling and ask for help,” she says. Otherwise, she worries that parents may abuse or neglect their children until there’s “necessity for a punitive approach.”

Screening for ACES wasn’t a huge leap, explains Gillespie, because the clinic began screening for developmental disability and autism in 2008, and for peripartum mood disorders in 2009.

But none of those screening tools helped them understand what was going on in the family, or to help parents understand why childhood trauma is such a critical issue.

This is how the screening works, says Petersen: The parents fill out the questionnaire in the waiting room. Pettersen quickly reviews the results, and, on meeting with the parents, says one of two things:

- “It looks like you had pretty supportive family, so you’re going to be a pretty good parent without even having to think about it. And most parents’ response has been: ‘I’m so glad you’re asking. I think this is important stuff.’”

- “Or, if they do have higher ACEs, I say: It looks like you had some very difficult experiences during your childhood. Most parents I talk to with similar experiences feel they have worked through some of these experiences but still get tripped up by others. I am wondering if that is the case for you?”

The responses, says Petersen, have ranged from, “This one’s kind of hard for me still,” or “I’ve gone back into counseling for this one”, or “I plan to go back into counseling.”

The pediatricians don't ask the parents how their ACEs are affecting their parenting, because the clinic does not yet have a therapist on site, although it's planning on adding one. They just focus on how their childhood trauma is affecting them at this point in their lives. If it’s an issue, they advise talking with a counselor. Petersen says that the overwhelming response from parents has been: “Thank you so much for asking about these things. It’s really a load off my mind. I feel like I can come to you if I need help.”

When asked what kinds of support they needed, most parents said parenting classes, support groups, or more information on the web. “Only three said a respite nursery (where stressed parents can bring their children),” says Pettersen. “That’s very telling, because it says that they want to do it themselves. They want to have the support so they can do the best job they can.”

cont. next page
The pediatricians also emphasize the resilience questions, to point out resources the parents had or have, so that they can build on them.

How this new knowledge works in practice, says Gillespie, can be subtle and “impacts a lot of the little things we do on a day-to-day basis,” he says. Take the example of a mother whose ACE score revealed that when she was two years old, she’d been abandoned by her mother. When Gillespie coached her on how to help her baby learn to go to sleep by itself, and said it was okay to let her baby cry a little, that “triggered a lot of fear,” he says. “She couldn’t and didn’t do it. We’d talked about sleep problems many, many times, and I never got to why she wasn’t following my advice until she filled out the ACE survey. I don’t think she thought about how her experience interfered with letting her baby cry for 10 minutes to settle down and get to sleep.”

“The real take-home message,” of screening parents for ACEs, says Pettersen, “is that my partners who are doing this say they cannot imagine going back to the way things were. The amount of intimacy they have with their patients has increased. Their comfort level with this was much easier to come to than they expected.” All of the clinic’s pediatricians now do ACEs screening.

This approach — screening parents of infants — “more closely approaches prevention than screening for kids for ACEs when they’ve already happened,” says Gillespie. Parents are screened while they’re young, they’re receiving reinforcement, and they haven’t slipped into bad habits yet. They can be prepared for the time when their toddler hits them, “because it will happen,” he says, “and they can respond better if they’ve thought about it ahead of time.”

The pediatricians provide parents resources, such as brochures and web sites, and programs such as Connected Kids, which is recommended by the American Academy of Pediatrics, or age-specific activities recommended by Zero to Three.

One of the side effects of screening for ACEs and peripartum mood disorders, says Gillespie, is that mothers have felt more comfortable asking the pediatricians to help them with domestic violence. In turn, the clinic developed responses, including arranging immediate entry for a woman and her children to an emergency shelter, providing referrals to attorneys, and/or support groups.

The next steps for the clinic, says Gillespie, include:

— Adding other types of childhood trauma to the ACE questions, including bullying, involvement in the foster care system, witnessing community violence, or discrimination based on race, ethnicity or sexual orientation.

— Working closely with their Spanish-speaking populations to understand cultural differences that may require different questions. “We find that one-third of our Spanish-speaking patients never attest to more than one ACE,” says Gillespie.

— Expanding the ACEs and resilience questionnaires to different age groups. Research has shown that ACEs is a significant factor in elementary students failing in school. “We need different screening for the kids for their experiences than the screening that asks parents what’s going on in household,” says Gillespie. “Asking parents if kids are being abused….we haven't figured out best way to do that yet.”

One of the issues that Gillespie believes will emerge is to identify how to build resiliency in families and communities. “We don't know how to build resiliency in the family yet,” he explains. “If certain aspects of resilience were stronger, that would protect people from ACEs.

We want to take a strength-based approach. ACEs is not strength-based.”

A medical home that addresses ACEs and toxic stress

A strength-based approach is what Dr. Nadine Burke Harris and her team are taking at the Center for Youth Wellness in San Francisco, which provides wrap-around services for children and families at Bayview Child Health Center. The two organizations are in the same building; to the families they serve, there’s no distinction.

Dr. Nadine Burke Harris founded the Bayview clinic in 2007 to serve families in the long-marginalized neighborhood of Bayview-Hunters Point in San cont. next page

“To understand the mechanism,” says Burke Harris, “is to know what to target.” If children's exposure to trauma was causing illness, then it was important to target the trauma.

To understand how trauma was affecting her clinic's patients, she and Dr. Victor Carrion, a psychiatrist at Stanford School of Medicine's Early Life Stress and Pediatric Anxiety Program, did a study of 701 children who had come through Bayview’s doors between 2007 and 2009.

The study, published in the Journal of Child Abuse and Neglect in 2011, found that 67% of the children had experienced at least one type of trauma. Twelve percent had experienced four or more. The average age of the children was seven — which showed that the kids in this neighborhood were accumulating adverse childhood experiences (ACEs) at a fast clip.

The outcomes were striking: Of the kids with zero ACEs, 97% had no learning problems. But half the kids with an ACE score of 4 or higher had learning problems. Kids with an ACE score of 4 or more also had higher rates of obesity.

“These exposures are critically important,” says Burke Harris. “That informed our system.”

Now Bayview’s pediatricians screen every child for ACEs at a well-child check. For children who have 1-3 ACEs with symptoms, or 4 or more ACEs with or without symptoms, they and their families are referred to services provided by CYW, which include mental health practitioners, case managers who connect families with social services and do home visits, and people who work with the children's schools. CYW is also exploring solutions ranging from teaching kids how to regulate their stress levels through mindfulness and biofeedback, to working with the local district attorney, police, and schools to develop community resilience.

One of the reasons Burke Harris decided to do the study in 2009 was because so many parents who showed up at the clinic were asking for ADHD medication for their kids; they'd been told by their children's school teachers that their children had ADHD.

Out of 100 cases of kids with behavioral issues, she says, on average 50 will reveal a history of trauma. Another 47 show up at the clinic with an ADHD diagnosis and are already on medication. “Part of my work is to help the parent understand that there may be something more going on and that we also need to get to the root cause of their child's behavior problems,” says Burke Harris.

Only three children out of 100 will have true ADHD, she says. In these cases, there's no history of trauma, the child lives in a supportive household and there are no major stressors. Nevertheless, if Burke Harris writes a prescription, she also prescribes therapy and provides parents with guidance to change their behavior so that they can bond more closely with their child.

The pediatricians at The Children's Clinic in Oregon and those at the Center for Youth Wellness in San Francisco are among a few hundred across the U.S. who are implementing practices based on ACEs research. With about 58,000 general pediatricians in the U.S., and another 30,000 in pediatric subspecialties, there's a long way to go before this becomes common practice. But Dr. David Willis believes there's no turning back.

His experience of integrating an awareness of how adversity affects a child's development and behavior “sensitized me to figure out ways for this to become a natural part of the health system,” says Willis. “We ask our patients about their family medical histories, we tell them to undress, we do intimate exams. Bringing this unspoken history of life experiences into doctor-patient communication is the first step in the beginning of the healing process.”

JANE ELLEN STEVENS is founder and editor of ACEsTooHigh.com, a news site for the general public, and its accompanying community of practice social network, ACEsConnection.com. The sites focus on research on adverse childhood experiences, and practices based on that research. The sites are supported by funding from the Robert Wood Johnson Foundation and The California Endowment. A long-time health, science and technology journalist, Stevens has written for the Boston Globe, the New York Times, the Washington Post, the Los Angeles Times and National Geographic.
Find Your ACE Score

Answers questions below with a “Yes” or “No” response. For each “Yes” response enter a “1” on the line to the right side of the questions. For each “No” response, enter a “0.” Add up the points for a total score of 0 to 10. The higher the score, the greater the exposure, and therefore the greater the risk of negative consequences. Consequences are discussed and available for download from http://acestudy.org/

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes   No
   If yes enter 1 ________

2. Did a parent or other adult in the household often or very often…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes   No
   If yes enter 1 ________

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes   No
   If yes enter 1 ________

4. Did you often or very often feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn’t look out for each other, feel close to each other, or support each other?
   Yes   No
   If yes enter 1 ________

5. Did you often or very often feel that …
   You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes   No
   If yes enter 1 ________

6. Were your parents ever separated or divorced?
   Yes   No
   If yes enter 1 ________

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes   No
   If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes   No
   If yes enter 1 ________

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes   No
   If yes enter 1 ________

10. Did a household member go to prison?
    Yes   No
    If yes enter 1 ________

Now add up your “Yes” answers: ________ This is your ACE Score.
**DEVELOPMENTAL AND BEHAVIORAL SCREENING FOR CHILDREN AND YOUTH**

by The PPI Team

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**Importance of Standardized Screening**

Screening for developmental problems is an essential role for child health providers, yet according to AAP Periodic Survey #53 in 2002, only 23% of pediatricians used a standardized instrument to screen young children for developmental problems.

Most clinicians eyeball the child and ask a couple of questions. This may be fine for physical delays, but is not a good way to identify children with mild cognitive/developmental disabilities, communication problems, emotional problems, or delays in social development.

If a standardized approach is not applied, developmental problems in 70-80% in children will be missed. Alternatively, if a structured, standardized instrument is used, 70-80% of the issues will be identified.

Using standardized screening is also important because parents often underestimate symptoms, either because a child may withhold complaints because of concerns they are abnormal, or to protect parents who are upset. Also, parents may not think professionals are interested or assume “normal reactions to abnormal event,” and there is a stigma related to mental illness.

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**Strengths of Tools Using Parent Report & Relying on Parent Concerns**

Having parents complete a screening tool gives parents and providers information on children's actual skills. It helps parents learn important developmental milestones, and illustrates a child's strengths and weaknesses in development. It also frees up professional time for more important things – like helping families, and gives providers confidence in decision-making.

Parents are the experts on their child. Using a tool that relies on their concerns helps focus the clinical encounter on issues of importance to families. It enhances a parent's sense of a true collaboration with professionals, increases attendance at well-visits, makes it easier to give difficult news, and reduces “doorknob/oh by the way” concerns. It also creates a “teachable moment” and increases positive parenting practices.

Citation: Setting the Stage for Success. Presentation by Marian Earls, MD, FAAP, Guildford Child Health, Inc., Greensboro, NC, 2007

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**Examples of Validated Tools for Developmental Screening**

**Survey of Wellbeing of Young Children**

The SWYC is designed to be a comprehensive surveillance or first-level screening instrument for routine use in regular well child care, for each age on the pediatric periodicity schedule from ages 2 months – 5 years.

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It is freely-available, takes 15 minutes or less to complete, and is currently available in English and Spanish. It combines what is traditionally “developmental” with traditionally “behavioral” screening, and features sections on developmental milestones, social/emotional development and family risk factors, including parental depression. At certain ages a section for Autism-specific screening is also included.

SWYC development was led by Ellen C. Perrin, M.D., who serves as the Director of Research for the Center for Children with Special Needs, and is a professor at Tufts University School of Medicine. She is board certified in both Developmental-Behavioral Pediatrics and Pediatrics. SWYC developers anticipate that an electronic version of the SWYC that can be used on a tablet or via the internet will soon be available. Because the SWYC is available at no cost, they also hope that it will be incorporated as a standard option in Electronic Health Records.

http://www.theswyc.org/

**Ages & Stages Questionnaire (ASQ) and Ages & Stages Questionnaire Social-Emotional (ASQ-SE)**

The Ages & Stages Questionnaire (ASQ) and ASQ-SE have been in use for over 15 years. They are valid, reliable, and accurate, and available in English, Spanish, and French. They include questionnaires for ages 2-60 months of age.

There is a cost associated with implementing ASQ in your practice, but once you purchase the questionnaires, you have free use to photocopy them.

The ASQ is a strictly developmental screen of 5 domains of development including communication, gross motor, fine motor, problem solving, and personal-social. It also includes a brief questionnaire for parents that asks about concerns of child's vision, hearing, and behavior.

The ASQ-SE screens for temperament, behavior, regulations, attention, etc., and is available for children 1-66 months. It is a parent-completed tool and identifies children in need of further assessment.

http://agesandstages.com/

**Pediatric Symptom Checklist**

The Pediatric Symptom Checklist (PSC) is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. There are two versions: the parent-completed version (PSC) and the youth self-report (Y-PSC). The PSC is available for parents to complete for young children ages 6-11, and the Y-PSC can be completed by adolescents ages 11 and up. The PSC is available in multiple languages as well as a pictorial version. The PSC is available at: http://www.massgeneral.org/psychiatry/services/psc_about.aspx
Caregiver checks in/registers
Demographics updates, insurance collected

Encounter Form sent to nurses station

Nurse pulls chart, encounter form, anticipatory development guideline sheet, ASQ

Who will ensure copies are available to parents?
Who will provide the tool to the parent?
Who scores the tool?

Who is going to provide the parent with educational material?

Nurse takes child’s vitals

Who makes sure the materials and tools are restocked?

Nurse shares ASQ with caregiver in exam room and assists if necessary

Child examined by pediatrician
MD scores ASQ and discusses results with caregiver

Who scores the tool?

When are the results discussed?

Nurse reviews immunization record, prepares vaccines, provides education info on vaccinations

What happens with the tool after the results are discussed?

Child examined by pediatrician
MD scores ASQ and discusses results with caregiver

Who will ensure copies are available to parents?
Who will provide the tool to the parent?
Who scores the tool?

Nurse administers vaccines - children who are “identified at risk” should be referred/presented to community resources & services and obtain feedback

How will referrals be handled?

Caregiver checks out
Staff coordinates follow up on referrals

*Adapted with the permission of Marian Earls, MD, FAAP - Guilford Child Health, Inc., Greensboro, North Carolina
The Survey of Wellbeing of Young Children (SWYC) is a freely-available, comprehensive screening instrument for children under 5 years of age. The SWYC was written to be simple to answer, short, and easy to read.

### DEVELOPMENTAL MILESTONES

These questions are about your child’s development. Please tell us how much your child is doing each of these things. If your child doesn’t do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not Yet</th>
<th>Somewhat</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holds up arms to be picked up</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Gets to a sitting position by him or herself</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Picks up food and eats it</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Pulls up to standing</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Plays games like &quot;peek-a-boo&quot; or &quot;pat-a-cake&quot;</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Calls you &quot;mama&quot; or &quot;dada&quot; or similar name</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Looks around when you say things like &quot;Where's your bottle?&quot; or &quot;Where's your blanket?&quot;</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Copies sounds that you make</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Walks across a room without help</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Follows directions - like &quot;Come here&quot; or &quot;Give me the ball&quot;</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

### BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child’s behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child have a hard time being with new people?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Does your child have a hard time in new places?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Does your child have a hard time with change?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Does your child mind being held by other people?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Does your child cry a lot?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Does your child have a hard time calming down?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Is your child fussy or irritable?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Is it hard to comfort your child?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Is it hard to keep your child on a schedule or routine?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Is it hard to put your child to sleep?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Is it hard to get enough sleep because of your child?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Does your child have trouble staying asleep?</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
**PARENT'S CONCERNS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any concerns about your child's learning or development?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any concerns about your child's behavior?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY QUESTIONS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Does anyone smoke tobacco at home?</td>
<td>y</td>
<td>n</td>
</tr>
<tr>
<td>2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?</td>
<td>y</td>
<td>n</td>
</tr>
<tr>
<td>3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?</td>
<td>y</td>
<td>n</td>
</tr>
<tr>
<td>4 Has a family member's drinking or drug use ever had a bad effect on your child?</td>
<td>y</td>
<td>n</td>
</tr>
<tr>
<td>5 In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?</td>
<td>y</td>
<td>n</td>
</tr>
</tbody>
</table>

**Over the past two weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Having little interest or pleasure in doing things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Feeling down, depressed, or hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Not applicable</th>
<th>No tension</th>
<th>Some tension</th>
<th>A lot of tension</th>
<th>Not applicable</th>
<th>No difficulty</th>
<th>Some difficulty</th>
<th>Great difficulty</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 In general, how would you describe your relationship with your spouse/partner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Do you and your partner work out arguments with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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“Through our involvement in the NJ AAP Pediatric Partnership Initiative, our busy practice of nine pediatricians working across 5 office locations, recently integrated the “Pediatric Symptom Checklist – Youth” at well visits of patients 11 years and up. I find it to be an efficient way to find out my patient’s general wellbeing and mental health. Most of the work is done by the patient, the receptionist, and the nurse. I simply look at the score and intervene if it is high. And the patients love to fill it out themselves.”

Diana Mayer, MD, Pediatric Health, P.A.

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Visit [http://www.theswyc.org/](http://www.theswyc.org/) to download free SWYC age-specific forms
Pediatric Symptom Checklist

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Included are two versions, the parent-completed version (PSC) and the youth self-report (Y-PSC). The Y-PSC can be administered to adolescents ages 11 and up.

The PSC consists of 35 items that are rated as “Never,” “Sometimes,” or “Often” present and scored 0, 1, and 2, respectively. The total score is calculated by adding together the score for each of the 35 items. For children and adolescents ages 6 through 16, a cutoff score of 28 or higher indicates psychosocial impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher (Little et al., 1994; Pagano et al., 1996). The cutoff score for the Y-PSC is 30 or higher. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.C.S.W.) professional. Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC or Y-PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC and Y-PSC indicate that two out of three children and adolescents who screen positive on the PSC or Y-PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child or adolescent “incorrectly” identified usually has at least mild impairment, although a small percentage of children and adolescents turn out to have very little or no impairment (e.g., an adequately functioning child or adolescent of an overly anxious parent). Data on PSC and Y-PSC negative screens indicate 95 percent accuracy, which, although statistically adequate, still means that 1 out of 20 children and adolescents rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other laypeople who administer the form to consult with a licensed professional if their child receives a PSC or Y-PSC positive score.

For more information, visit the Web site: http://psc.partners.org.

REFERENCES


Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child’s behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Complains of aches and pains</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Spends more time alone</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Tires easily, has little energy</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Fidgety, unable to sit still</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Has trouble with teacher</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Less interested in school</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Acts as if driven by a motor</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Daydreams too much</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Distracted easily</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Is afraid of new situations</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Feels sad, unhappy</td>
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<td>Has trouble sleeping</td>
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<td>Wants to be with you more than before</td>
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<td>Refuses to share</td>
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Total score ____________________________________________

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N  ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N  ( ) Y

If yes, what services? __________________________________

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cont. next page
## Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

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<th>Never</th>
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<tr>
<td>1. Complain of aches or pains</td>
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<td>2. Spend more time alone</td>
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<td>3. Tire easily, little energy</td>
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<td>4. Fidgety, unable to sit still</td>
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<td>5. Have trouble with teacher</td>
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<td>7. Act as if driven by motor</td>
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<td>8. Daydream too much</td>
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<td>9. Distract easily</td>
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<td>10. Are afraid of new situations</td>
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FOR PROVIDERS:  PRACTICE READINESS

Setting the Stage: Rapport, Active Listening and Empathy

Make every effort to create a safe, non-judgmental, and supportive environment so that your adolescent patients will be open to discussing their feelings and behaviors.

**ESTABLISH RAPPORT**
- Design your office to be welcoming to teens.
- Spend time alone with the teen during each visit. Start when the teen is 11 years old. Explain this to parents ahead of time.
- Explain your confidentiality practices to parents and teens at the start of each visit.
- Wash your hands within view of the adolescent.
- Shake hands with the adolescent and begin the visit with informal conversation. Explain what she/he can expect during the visit.
- Help teens recognize and appreciate their assets and strengths.
- Use terminology and expressions that the teen will understand.
- Ask the teen if he/she wants a parent or chaperone present during physical exams.
- Ask for the teen’s input into treatment plans.
- Summarize findings, treatment plans, and next steps to the teen and, when appropriate, to parents.
- Allow time for questions and provide information on community resources.
- Provide teen patients with your office or clinic contact information, including the names of people to call for questions or follow-up, office hours, and daytime and after hours phone numbers.
- Pay attention to teen’s concerns. Try to understand the teen’s perspective and keep an open mind.
- Use gender-neutral terms when conversing with the teen. Example: “Are you going out with someone?” Rather than, “Do you have a girlfriend?”
- Avoid interrupting.
- Minimize note-taking, particularly during sensitive questioning.
- Notice teen’s non-verbal cues such as eye contact, facial expressions, affect, posture, and physical movements.

**LISTEN ACTIVELY**
- Pay attention to teen’s concerns. Try to understand the teen’s perspective and keep an open mind.
- Use gender-neutral terms when conversing with the teen. Example: “Are you going out with someone?” Rather than, “Do you have a girlfriend?”
- Avoid interrupting.
- Minimize note-taking, particularly during sensitive questioning.
- Notice teen’s non-verbal cues such as eye contact, facial expressions, affect, posture, and physical movements.
- Ask open-ended questions in a non-threatening and judgment free manner.
  - DO NOT ask: “Do you use drugs or alcohol?”
  - DO ask: “I know drugs and alcohol are common at a lot of schools. What drugs are popular at your school? What do you think about your peers using drugs or alcohol? How do you deal with that? What have you tried?”

**EXPRESS EMPATHY**
- Sense the emotion the teen is feeling then state it back to him/her. Wait for the teen to respond before continuing. Example: “You seem tense. Do you feel stressed or worried?”
- Validate the teen’s feelings by letting her/him know you understand the reason for the emotions. Example: “Breaking up with a boy/girl friend is very hard. I can understand why you feel sad.”
- Educate the teen about mental health and substance use. Refer him/her to additional resources and give out emergency and hotline contact information. Education helps to reduce stigma.
- Focus on the teen’s strengths such as caring friends, supportive family, or coping abilities.
- Construct a plan of action with the teen. Set realistic short-term goals and then follow up by phone and/or in person.
- Reassure the teen that she/he is not alone.
- Honor the teen’s emotions and honesty. Example: “It took a lot of courage to talk about your feelings. Thanks for your honesty. I am impressed with how well you are doing under these circumstances.”

**SOURCES**
Primary care clinicians are accustomed to a certain level of diagnostic uncertainty. Children presenting with fever are typically triaged based on the child’s clinical appearance—the very toxic-appearing child may require further diagnostic assessment and admission to the hospital for observation and presumptive treatment; the child with clinical findings suggesting a specific diagnosis may be treated as an outpatient, returning for further attention if recovery does not progress as expected; the child with mild symptoms may simply require parental reassurance, symptomatic care, and monitoring. Clearly, in many instances the clinician can relieve parental distress and decrease the child’s discomfort without knowing exactly what is causing the child’s symptoms.

Similarly, in the absence of an emergent need, clinicians presented with a child’s mental health problem can often take steps to address parents’ distress and children’s symptoms without knowing the specific diagnosis. They may offer parenting strategies to cope with common behavioral problems. They may offer advice about lifestyle issues affecting mental health, such as sleep, exercise, sunlight, diet, and one-on-one time for the parent and child. They can employ effective family-centered techniques known as common factors, so-called because they are common factors in a number of evidence-based interventions. These can be represented by the mnemonic HELP.

**H** Hope  
Increase the family’s hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the child and family.

**E** Empathy  
Communicate empathy by listening attentively.

**L** Language  
Use the child or family’s own language to reflect your understanding of the problem as they see it and to give the child and family an opportunity to correct any misperceptions.

**L** Loyalty  
Communicate loyalty to the family by expressing your support and your commitment to help.

**P** Permission  
Ask the family’s permission for you to ask more in-depth questions or make suggestions for further evaluation or management.

**Partnership**  
Partner with the child and family to identify any barriers or resistance to addressing the problem, find strategies to bypass or overcome barriers, and find agreement on achievable steps aligned with the family’s motivation.

**Plan**  
Establish a plan (or incremental first step) through which the child and family will take some action(s), work toward greater readiness to take action, or monitor the problem, then follow up with you, based on the child and family’s preferences and sense of urgency. (The plan might include, for example, gathering information from other sources such as the child’s school, making lifestyle changes, applying parenting strategies or self-management techniques, reviewing educational resources about the problem or condition, initiating specific treatment, seeking referral for further assessment or treatment, or returning for further family discussion.)

Considerable evidence suggests that medical generalists can readily learn and retain these techniques.  

> “I now have a valid and brief set of assessments that I can use with my patients and their families. This was very good information and I am looking forward to the next webinar.”

Castillo & Castillo, Hudson County

“Dealing with trauma, such as those inflicted by Superstorm Sandy, can seem like an overwhelming task within the realm of a typical office visit. The Common Factors framework reminds us how much can be accomplished through the doctor/patient relationship. The premise behind the Common Factors is that evidence-based therapies have common attributes that can be used by front line clinicians while they connect families to other diagnostic and therapeutic resources in non-emergent situations. When you review the Common Factors you may find that you already incorporate some or many of these strategies into your daily practice. Using the Common Factors framework can be a way to fine tune these skills and may help you to be part of the healing process for families who are suffering.”

Manny Jimenez, MD
Notes
Use of multiple, brief visits (in contrast with the 45- to 60-minute visits common in mental health specialty practice) will often be necessary to address a child’s mental health concerns in a busy primary care practice. Experienced primary care clinicians can readily acquire skills in bringing a visit to an efficient close and increasing the likelihood that youth and families will continue in care.

Studies in adult primary care suggest that applying common factors skills such as those represented by the HELP mnemonic can improve patient outcomes without increasing the length of visits.

References

2. Bickman L. A common factors approach to improving mental health services. Ment Health Serv Res. 2005;7(1):1–4


Online Course
An online course on communication skills is available through Northwest AHEC (http://tinyurl.com/EnhancingMentalHealth).

“It was nice to network with community agencies – I was able to call a mom of a child in my practice and gave her the number for Catholic Charities this week for her to call regarding issues she has with her two children . . . the residents from my hospital were really positive about the things they learned . . . great resources were given out . . . it made me think about budgeting my time differently to better address patient concerns – even if it ends up that there is less time devoted to the “real” purpose of visit, rather than pushing aside parent’s stated main concern to another date or visit.”

Pediatric Health, P.A., Monmouth County
COMPETENCE

Competence is the ability or know-how to handle situations effectively. It’s not a vague feeling or hunch that “I can do this.” Competence is acquired through actual experience. Children can’t become competent without first developing a set of skills that allows them to trust their judgments, make responsible choices, and face difficult situations.

In thinking about your child’s competence and how to fortify it, ask yourself:

- Do I help my child focus on his strengths and build on them?
- Do I notice what he does well or do I focus on his mistakes?
- When I need to point out a mistake, am I clear and focused or do I communicate that I believe he always messes up?
- Do I help him recognize what he has going for himself?
- Am I helping him build the educational, social, and stress-reduction skills necessary to make him competent in the real world?
- Do I communicate in a way that empowers my child to make his own decisions or do I undermine his sense of competence by giving him information in ways he can’t grasp? In other words, do I lecture him or do I facilitate his thinking?
- Do I let him make safe mistakes so he has the opportunity to right himself or do I try to protect him from every trip and fall?
- As I try to protect him, does my interference mistakenly send the message, “I don’t think you can handle this?”
- If I have more than one child, do I recognize the competencies of each without comparison to siblings?

CONFIDENCE

True confidence, the solid belief in one’s own abilities, is rooted in competence. Children gain confidence by demonstrating their competence in real situations. Confidence is not warm-and-fuzzy self-esteem that supposedly results from telling kids they’re special or precious. Children who experience their own competence and know they are safe and protected develop a deep-seated security that promotes the confidence to face and cope with challenges. When parents support children in finding their own islands of competence and building on them, they prepare kids to gain enough confidence to try new ventures and trust their abilities to make sound choices.

In thinking about your child’s degree of confidence, consider the following questions:

- Do I see the best in my child so that he can see the best in himself?
- Do I clearly express that I expect the best qualities (not achievements, but personal qualities such as fairness, integrity, persistence, and kindness) in him?
- Do I help him recognize what he has done right or well?
- Do I treat him as an incapable child or as a youngster who is learning to navigate his world?
- Do I praise him often enough? Do I praise him honestly about specific achievements or do I give such diffuse praise that it doesn’t seem authentic? (More information about praising effectively is in Chapter 6.)
- Do I catch him being good when he is generous, helpful, and kind or when he does something without being asked or cajoled?
- Do I encourage him to strive just a little bit farther because I believe he can succeed?
- Do I hold realistically high expectations?
- Do I unintentionally push him to take on more than he can realistically handle, causing him to stumble and lose confidence?
- When I need to criticize or correct him, do I focus only on what he’s doing wrong or do I remind him that he is capable of doing well?
- Do I avoid instilling shame in my child?
CONNECTION

Children with close ties to family, friends, school, and community are more likely to have a solid sense of security that produces strong values and prevents them from seeking destructive alternatives. Family is the central force in any child’s life, but connections to civic, educational, religious, and athletic groups can also increase a young person’s sense of belonging to a wider world and being safe within it.

*Some questions to ponder when considering how connected your child is to family and the broader world include:*

- Do we build a sense of physical safety and emotional security within our home?
- Does my child know that I am absolutely crazy in love with him?
- Do I understand that the challenges my child will put me through on his path towards independence are normal developmental phases or will I take them so personally that our relationship will be harmed?
- Do I allow my child to have and express all types of emotions or do I suppress unpleasant feelings?
- Is he learning that going to other people for emotional support during difficult times is productive or shameful?
- Do we do everything to address conflict within our family and work to resolve problems rather than let them fester?
- Do we have a television and entertainment center in almost every room or do we create a common space where our family shares time together?
- Do I encourage my child to take pride in the various ethnic, religious, or cultural groups to which we belong?
- Do I jealously guard my child from developing close relationships with others or do I foster healthy relationships that I know will reinforce my positive messages?
- Do I protect my friends’ and neighbors’ children, just as I hope they will protect mine?

CHARACTER

Children need a fundamental sense of right and wrong to ensure they are prepared to make wise choices, contribute to the world, and become stable adults. Children with character enjoy a strong sense of self-worth and confidence. They are more comfortable sticking to their own values and demonstrating a caring attitude toward others.

*Some basic questions to ask yourself include:*

- Do I help my child understand how his behaviors affect other people in good and bad ways?
- Am I helping my child recognize himself as a caring person?
- Do I allow him to clarify his own values?
- Do I allow him to consider right versus wrong and look beyond immediate satisfaction or selfish needs?
- Do I value him so clearly that I model the importance of caring for others?
- Do I demonstrate the importance of community?
- Do I help him develop a sense of spirituality?
- Am I careful to avoid racist, ethnic, or hateful statements or stereotypes? Am I clear how I regard these thoughts and statements whenever and wherever my child is exposed to them?
- Do I express how I think of others’ needs when I make decisions or take actions?

CONTRIBUTION

It is a powerful lesson when children realize that the world is a better place because they are in it. Children who understand the importance of personal contribution gain a sense of purpose that can motivate them. They will not only take actions and make choices that improve the world, but they will also enhance their own competence, character, and sense of connection. Teens who contribute to their communities will be surrounded by reinforcing thank yous instead of the low expectations and condemnation so many teens endure.

*Before we can foster this sense of contribution, here are some things to consider:*

- Do I communicate to my child (at appropriate age levels, of course) that many people in the world do not have as much human contact, money, freedom, and security as they need?
- Do I teach the important value of serving others?
- Do I model generosity with my time and money?
• Do I make clear to my child that I believe he can improve the world?

• Do I create opportunities for each child to contribute in some specific way?

• Do I search my child’s circle for other adults who might serve as role models who contribute to their communities and the world? Do I use these adults as examples to encourage my child to be the best he can be?

COPING

Children who learn to cope effectively with stress are better prepared to overcome life’s challenges. The best protection against unsafe, worrisome behaviors may be a wide repertoire of positive, adaptive coping strategies.

Before we begin teaching children this repertoire of coping and stress-reduction skills, here are some basic questions to ask ourselves:

• Do I help him understand the difference between a real crisis and something that just feels like an emergency?

• Do I model positive coping strategies on a consistent basis?

• Do I allow my child enough time to use imaginative play? Do I recognize that fantasy and play are childhood’s tools to solve problems?

• Do I guide my child to develop positive, effective coping strategies?

• Do I believe that telling him to “just stop” the negative behaviors will do any good?

• Do I recognize that for many young people, risk behaviors are attempts to alleviate their stress and pain?

• If my child participates in negative behaviors, do I condemn him for it? Do I recognize that I may only increase his sense of shame and therefore drive him toward more negativity?

• Do I model problem-solving step by step or do I just react emotionally when I’m overwhelmed?

• Do I model the response that sometimes the best thing to do is conserve energy and let go of the belief that I can tackle all problems?

• Do I model the importance of caring for our bodies through exercise, good nutrition, and adequate sleep? Do I model relaxation techniques?

• Do I encourage creative expression?

• As I struggle to compose myself so I can make fair, wise decisions under pressure, do I model how I take control rather than respond impulsively or rashly to stressful situations?

• Do I create a family environment in which talking, listening, and sharing is safe, comfortable, and productive?

CONTROL

When children realize that they can control the outcomes of their decisions and actions, they’re more likely to know that they have the ability to do what it takes to bounce back. On the other hand, if parents make all the decisions, children are denied opportunities to learn control. A child who feels “everything always happens to me” tends to become passive, pessimistic, or even depressed. He sees control as external—whatever he does really doesn’t matter because he has no control of the outcome. But a resilient child knows that he has internal control. By his choices and actions, he determines the results. He knows that he can make a difference, which further promotes his competence and confidence.

Some questions about control:

• Do I help my child understand that life’s events are not purely random and most things happen as a direct result of someone’s actions and choices?

• On the other hand, do I help my child understand that he isn’t responsible for many of the bad circumstances in his life (such as parents’ separation or divorce)?

• Do I help him think about the future, but take it one step at a time?

• Do I help him recognize even his small successes so he can experience the knowledge that he can succeed?

• Do I help him understand that no one can control all circumstances, but everyone can shift the odds by choosing positive or protective behaviors?

cont. next page
• Do I understand that discipline is about teaching, not punishing or controlling? Do I use discipline as a means to help my child understand that his actions produce certain consequences?

• Do I reward demonstrated responsibility with increased privileges?

Dr. Ginsburg is a pediatrician specializing in Adolescent Medicine at The Children’s Hospital of Philadelphia and a Professor of Pediatrics at the University of Pennsylvania School of Medicine. He also serves Philadelphia’s homeless youth as Director of Health Services at Covenant House Pennsylvania. The theme that ties together his clinical practice, teaching, research and advocacy efforts is that of building on the strength of teenagers by fostering their internal resilience. His goal is to translate the best of what is known from research and practice into practical approaches parents, professionals and communities can use to prepare children and teens to thrive.

Building Resilience in Children and Teens offers strategies to help kids from 18 months to 18 years build seven crucial “Cs” — competence, confidence, connection, character, contribution, coping, and control — so they can bounce back from challenges and excel in life. The book describes how to raise authentically successful children who will be happy, hardworking, compassionate, creative, and innovative. Dr. Ginsburg reminds parents that our goal is to think in the present and prepare for the future, to remember that our real goal is to raise children to be successful 35-year-olds. It’s about more than immediate smiles or even good grades; it’s about raising kids to be emotionally and socially intelligent, to be able to recover from disappointment and forge ahead throughout their lives. The stable connection between caring adults and children is the key to the security that allows kids to creatively master challenges and reach their highest potential. This book offers concrete strategies to solidify those vital family connections.

Resilience is also about confronting the overwhelming stress that kids face today. This invaluable guide offers coping strategies for facing the stresses of academic performance, high achievement standards, media messages, peer pressure, and family tension. Young people too commonly survive stress by indulging in unhealthy behaviors or by giving up completely. The strategies offered here are aimed at building a repertoire of positive coping skills. Kids who have these healthy strategies in place may be less likely to turn to those quick, easy, but dangerous fixes that adults fear. The book includes a guide for teens to create their own customized positive coping strategies.

The second edition of this already acclaimed book continues to focus on parents, but now also offers wisdom about how schools and communities can best support families. It is updated throughout and entirely new chapters offer strategies on how best to: support military families, confront the negative portrayal of teens, prevent perfectionism and support authentic success. Finally, the book now guides parents on how to recharge and rebound when their own resilience reaches its limits.


This handout is used with permission from Kenneth R. Ginsburg, MD, MS Ed. Ginsburg KR, Jablow MM. Building Resilience in Children and Teens: Giving Kids Roots and Wings. 2nd ed. Elk Grove Village, IL: American Academy

“PPI staff conducted a TA visit at my office recently and brought a representative from the local Children’s Inter-Agency Coordinating Council (CIACC). The CIACC representative gave me in-depth information about the NJ Children’s System of Care and how PerformCare works. I had never referred a patient there before and was not aware of all the services they had to offer. I was so excited that I interrupted the visit and requested that my office manager immediately contact a parent of a child who was suffering extreme anxiety due to bullying, and refer that parent to call PerformCare.

Shore Care Pediatrics, LLC, Monmouth County
PerformCare New Jersey

PerformCare partners with the state of New Jersey’s Division of Children’s System of Care (CSOC) as the single point of entry for all children, adolescents and young adults (up to age 21) who are in need of behavioral health, or developmental and intellectual disability, or certain substance abuse treatment services.

PerformCare is focused on prevention and early intervention by connecting a young person with the care they need in the most appropriate setting—the right care in the right place at the right time. Our goal is to help families and caregivers create a more stable and healing environment for children, address barriers to well-being, and maximize youth and family strengths.

How we help

Starting with just one phone call, PerformCare can help a parent or guardian connect their child to the behavioral health, substance abuse and developmental disability services they need to be well and thrive.

We are available 24 hours a day, 7 days a week.

PerformCare staff are available 24 hours a day, 7 days a week to provide individualized care to eligible children. Depending on the child’s unique needs, support may include:

<table>
<thead>
<tr>
<th>✓ In-home therapy</th>
<th>✓ Family support services</th>
<th>✓ Behavioral supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Mobile crisis response</td>
<td>✓ Care management</td>
<td>✓ Out-of-home treatment</td>
</tr>
<tr>
<td>✓ Respite services</td>
<td>✓ Assistive technology devices</td>
<td>✓ Outpatient services</td>
</tr>
<tr>
<td>✓ Summer camp assistance</td>
<td>✓ Substance abuse treatment/referral (under 18 only)</td>
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When to call

If you have never called PerformCare before, you may not be sure if you should reach out to us. We want to assist families as early as possible. Families should call if their child’s behavior has changed from normal or if they are overwhelmed by challenges at home or in the community. Contact us, for example, if:

- You are struggling to meet the needs of your developmentally delayed child or adolescent.
- Your child refuses to attend school, or has repeated lateness or skipping, or if you have other concerns about his or her school performance.
- Your child shows physical and/or verbal aggression, bullies others, or is being bullied.
- You observe family conflict, including youth substance abuse or refusal to comply with rules.
- Your child seems to experience grief that is beyond “normal,” such as from the loss of a family member or friend through divorce, death or relocation.
- Your child experiences a traumatic event, such as a house fire or witnessing violence.
- A trusted friend, teacher or other adult in your child’s life has expressed concerns.
- You’d like to know more about the types of services available.

“PerformCare was there in my time in of need. They were able to link me to care management and they took the time to set up services. Setting me up with services lifted such a burden and it also allowed me to be able to really work on being a family again.”

—Glenn M, parent
Keys to Success

Early response and prevention

New Jersey Children’s System of Care has achieved tremendous results. The system is reaching more children at a younger age than ever before. By engaging children in support services at an earlier age, NJ Children’s System of Care can often prevent a more serious and difficult behavioral problem from developing. This early intervention means children have a better chance of positive outcomes and being healthy and happy.

Child-centered care in the right place

No matter what the challenge, PerformCare can direct a child’s family to the NJ Children’s System of Care program that will put him or her on the path to healing. These services include in-home, in-community and out-of-home programs.

NJ Children’s System of Care is accessible whenever and wherever the challenge arises.

Mobile Response is provided to youth who experience challenges that threaten their current living arrangements. They provide face-to-face crisis response within one hour of notification. The goal is to stabilize behavior and preserve the child’s ability to remain in the home. Mobile Response is available 24 hours a day, 7 days a week, and can offer up to an additional 8 weeks of stabilization services in certain situations. Mobile Response has demonstrated great success with this rapid-response system: 96 percent of children served by this program in 2012 remained in their homes instead of needing out-of-home placement.

NJ Children’s System of Care ensures that children and young adults receive care in the setting best suited to their needs. The goal is to keep children at home whenever possible, where they can remain in a familiar environment with their family support system. When out-of-home treatment is needed, PerformCare works with the family to identify the best program available and helps monitor the service to ensure treatment goals are being met so the child can return home.
Child Abuse and Neglect (CAN)
Child Abuse and Neglect (CAN) - In partnership with the New Jersey Department of Children and Families (DCF), NJAAP provides child abuse and neglect prevention trainings to pediatric practices, emergency departments and emergency medical services statewide. The Chapter also offers a Maintenance of Certification (MOC) project entitled Strengthening Pediatric Partners. This project is ABP-approved for 25 part four Points.
For additional information, contact the CAN team, at CAN@aapnj.org

Critical Congenital Heart Disease (CCHD)
New Jersey is the Nation's first state to pass legislation requiring pulse oximetry screening for all newborns in birthing facilities. In partnering with the New Jersey Department of Health (NJDOH), NJAAP is supporting the development of enhanced statewide surveillance, training and education programs for healthcare professionals to increase the number of newborns identified with CCHD prior to discharge.
For additional information, contact Harriet Lazarus, MBA at hlazarus@aapnj.org

Healthy Homes
The NJ Chapter of the American Academy of Pediatrics has received funding from the NJDOH to create an outreach program to educate primary care practices in the nine Superstorm Sandy affected counties on strategies to address exposure to lead and other housing-based hazards that may impact the health of children and pregnant women. The program will be delivered via webinar and in office-based settings.
For additional information or to schedule an office based session, please contact Harriet Lazarus, MBA at hlazarus@aapnj.org

Immunization Initiative
Working in concert with NJDOH, NJAAP provides technical assistance to primary care practices to assess current immunization rates and to define and implement strategies and best practices such as utilization of the NJ Immunization Registry and patient education to improve immunization service delivery.
For additional information, contact Judie Grandjean at jgrandjean@aapnj.org

Medical Home / Practice Transformation
In partnership with the NJDOH, NJAAP provides primary care practices with training and technical support necessary to work toward attainment of NCQA Recognition as a Patient-Centered Medical Home.
For additional information, contact Judie Grandjean, at jgrandjean@aapnj.org

New Jersey Immunization Network (NJIN)
A statewide coalition, comprised of over 380 members from more than 150 public and private organizations, is dedicated to educating healthcare professionals, legislators, and the public about the vital role timely and age-appropriate immunizations play in shielding infants, children, adolescents, adults and the elderly against the ever-present threat of vaccine preventable diseases. New members are encouraged to join.
For additional information, contact Diane Carroll at dcarroll@aapnj.org

New Jersey Oral Health 2014
NJAAP, in partnership with the New Jersey Dental Association, NJDOH and other public and private health organizations is strongly committed to improving children's oral health care, especially in underserved areas of the state. With funding from DeltaQuest Foundation's Oral Health 2014 and Delta Dental, this initiative will increase access to preventative care and oral health services for children birth to three years of age.
For additional information, contact Juliana David, MEd at jdavid@aapnj.org

NJAAP Resources for Pediatricians to Help Families
Pediatric Partnership Initiative (PPI)
Supporting Children and Families: Dealing with Adverse Childhood Experiences and Recovery Post-Sandy

Joining the Collaborative

The Pediatric Partnership Initiative (PPI) offers several educational opportunities for pediatric and family practice providers who serve children and families in the counties that were hardest hit by Superstorm Sandy (Atlantic, Bergen, Cape May, Cumberland, Essex, Hudson, Middlesex, Monmouth, Ocean and Union). Through hospital Grand Rounds, Business Meetings and Learning Collaboratives, providers participate in training opportunities designed to enhance their efforts to support children and families trying to deal with the toxic stress of adverse childhood experiences. With funding through the Social Service Block Grant - Disaster Recovery (SSBG-DR) provided by the administration for Children and Families, the New Jersey Department of Children and Families and New Jersey Chapter, American Academy of Pediatrics have partnered to support primary care providers as they care for the families continuing to recover from the physical and emotional devastation of Superstorm Sandy. PPI offers providers with guidance and information on how best to:

- recognize and intervene with families in distress;
- provide psychological first aid;
- manage post Sandy stress;
- access and connect children with families with locally-based community resources

To learn more on how your practice can become part of a PPI Collaborative, please call (609) 842-0014 and ask to speak with any PPI team member.