

RESEARCH TO PRACTICE SUMMARY

Engaging Families and Addressing Adverse Childhood Experiences in Early Head Start

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Supporting parenting and home environments for children through collaborations with families is a critical function of Early Head Start (EHS)/Head Start (HS) providers. Building a strong partnership with caregivers allows educators to identify family strengths and identifying areas of concern in parenting and home environments, such as those linked to adverse childhood experiences (ACEs). Family Map Inventory (FMI) is a tool used to screen for ACEs among children birth to 5 years-of-age while respecting the family needs. The effectiveness of FMI in its original paper format (p-FMI) has been validated. This study examined the validity of a new, web-based Family Map Inventory (e-FMI) by (1) comparing the distribution of ACEs risks captured in e-FMI with the traditional p-FMI, and (2) investigating the association of ACEs captured through e-FMI and parental warmth. Further, this study documented decreases in ACEs risks after center-based EHS services.

Keywords: early childhood education, adverse childhood experiences (ACEs), screening

SUMMARY OF LITERATURE

Adverse childhood experiences (ACEs) have been shown to have long-term negative consequences on children's development as early as in infancy and early childhood; including developmental delays (Bethell et al., 2014; McKelvey, Connors Edge, et al., 2017), and social-emotional behaviors (Hunt et al., 2017; Jimenez et al., 2016; Kerker et al., 2015; McKelvey, Selig, et al., 2017). Further, the impact on educational experiences begins very early. Using data from the National Survey of Children's Health, Zeng and colleagues found that among 6,100 preschool age children, for each additional ACE reported, there was an incremental increase in odds of suspension and expulsion from early childhood care and education programs (Zeng et al., 2019).

While care must be taken in the approach, best practice guidance on creating trauma-informed educational systems suggests that the ability to identify children and families with a history of trauma is important to support appropriate response (National Child Traumatic Stress Network & Schools Committee, 2017). As a result, there have been significant efforts to develop tools to screen for ACEs in families with young children and support interventions to reduce ACEs. To optimize the benefit of screening, instrument selection should be appropriate for the context in which they are used and for the expected intervention efforts that will be implemented based of the information gained (Bethell et al., 2017).

This study focused on a tool developed for programs working with families of children from birth of age 5, the Family Map Inventory (FMI). The FMI allows early childcare educators and family support professionals to identify family needs and customize supportive services in partnership with parents (Whiteside-Mansell et al., 2007, 2013). The FMI includes items that measure ACEs (FMI-ACE) that are appropriate for families with young children. For example, the FMI asks questions to determine if the parent engages in harsh parenting, rather than asking directly about whether the child has been physically abused. In response to the widespread acknowledgment of the importance of reducing ACEs, the FMI-ACEs was examined and validated for one-on-one interviews, using a paper format, with parents enrolled in Arkansas home visiting programs (McKelvey et al., 2016). Further, because the FMI was developed specifically to collaborate with parents, the interview is family-friendly and evidenced to enhance the parent-provider partnership (Whiteside-Mansell et al., 2013).

THE CURRENT STUDY

This study examined the use of the FMI with center-based Early Head Start families when administered in one-on-one interviews using the electronic version. The electronic version offers several benefits over the paper version; it provides helpful prompts for actions that support identified concerns, including calculating the number of ACEs experienced by the child (ACE score). However, it is unknown whether the electronic delivery of the FMI might disrupt the interaction between the provider and parent or the responses provided. For example, findings from studies of implementation of electronic health records suggest that when physicians spend more time facing the computer, their communication suffers and they are rated as being less patient-centered (Street et al., 2014). Thus, it cannot be assumed that paper and electronic systems function similarly.

We had two goals for this study. First, we aimed to confirm the similar functioning of the FMI-ACE captured through the electric system (eFMI-ACE) to the paper delivery (pFMI-ACE) and validate the use of eFMI-ACE in the EHS context. Our second goal was to produce evidence that EHS programs are using the FMI effectively as an intervention tool by examining whether EHS enrolled children whose educators use eFMI-ACE experience a reduction in the number of ACEs.

We extracted FMI interview data from the online portal system used by EHS programs. This included nine agencies providing EHS services from seven states and resulted in a sample of 1,591 interviews of parents of children from birth to age 3 years. Of these, 301 families had been interviewed twice at least nine months apart.

KEY FINDINGS

We found that the distribution of the ACE score for EHS children assessed through eFMI-ACE was similar to the distribution found in the previous study of families enrolled in home visiting interviewed using the pFMI-ACE. In addition, the association between the ACE scores and parental warmth was observed, which is also compatible to findings from the previous study. The association confirmed that the risk of the caregiver exhibiting emotional distance in interaction increased as the ACE score increased. Both findings supported the use of the FMI in electric format to assess ACEs.

Finally, families reported reduced ACE scores after their child attended at least 3 months of EHS, compared to their initial ACE scores. While this does not exclude the possibility that other factors such as the maturing of the child or the increased comfort of parenting as factors in the reduction of ACEs, it suggests that EHS experiences may have contributed to the reduction of these stressful experiences for children.

IMPLICATIONS FOR PROFESSIONAL DEVELOPMENT

Early childhood education, like home visiting, have a mission to promote child development. Developing a meaningful and productive partnership with families is a critical step in supporting optimal parenting and home environments. In this study, we examined one tool that supports programs in this effort, the FMI, in its new electric format. The FMI provides early childhood and family support professionals the opportunity to assess young children's exposure to ACEs and to initiate interventions that either reduce the risk exposure or promote resilience.

There are factors that programs should consider while addressing ACEs for children and families. ACEs include traumatic events in childhood, but it does not cover all of what we know negatively influences development (McEwen & Gregerson, 2019). The FMI allows programs to measure not only ACEs but other potentially traumatic experiences such as deprivation related to poverty and homelessness. Still, it is important to not overlook other experiences for which children and families may need additional support, such as experiences of racial injustice, discrimination, natural disasters, and other violence exposures.

It is also important for the programs to be trauma-informed and sensitive to the needs of children and their families (Zorrah, 2015). As such, all staff members should be trained to understand how trauma affects children and their families, recognize and respond to signs of trauma, and actively resist re-traumatization (Substance Abuse and Mental Health Services Administration, 2014). Steps to building a trauma-informed approach typically involve staff education, supporting a culture of staff wellness, enhancing partnerships with families, ensuring that program policies and procedures (e.g. crisis response, discipline) consider the needs of children with experiences of trauma, and ensuring that cross system collaborations and community partnerships are in place to support children, staff and families (Loomis & Felt, 2020; Menschner & Maul, 2016; National Child Traumatic Stress Network & Schools Committee, 2017; Substance Abuse and Mental Health Services Administration, 2014). Our data suggest that there is a benefit of EHS for reducing ACEs, still, identifying children with trauma should benefit the child and family by leading to more

appropriate direct and indirect supports and referrals. In terms of indirect supports, Infant and Early Childhood Mental Health Consultation has shown to be effective in supporting teachers in working with children impacted by childhood trauma (Perry & Conners-Burrow, 2016). Other families may benefit from more direct support, such as a referral to a mental health treatment provider trained to support children and families impacted by trauma. It is also important to support the parents and family without judgment and to provide other appropriate educational and resource referrals (Administration for Children and Families, 2020).

Additionally, in a trauma-informed approach, early childhood professionals are equipped to actively build resilience in children by providing the supportive and nurturing relationships essential for healthy child development and by focusing on teaching skills in children that will support their resilience. It is important for early childhood professionals to understand that behaviors that can result from early childhood trauma, like difficulties in learning and behavioral regulation, are behavioral symptoms and not intentional on the part of the child. In a trauma-informed learning environment, educators teach and model social-emotional skills in the classroom to strengthen resilience (National Child Traumatic Stress Network & Schools Committee, 2017). They also take intentional steps to support self-regulation (e.g., building emotional literacy, teaching calm down methods). The development of these skills should also take place in environments designed to enhance children's sense of physical and emotional safety so that they are able to relax and learn (e.g., ensuring safe physical environments, creating predictable routines, supporting children through transitions, ensuring adults are calm and composed).

Finally, many early childhood educators and family support professionals have experienced adversities and trauma in their lives (Hubel et al., 2020), and some data would suggest at higher levels than the general population (Phillips, 1997). Just as we consider supports to children and their families, we must consider the well-being of the workforce to provide stable and nurturing services. The Head Start Early Childhood Learning & Knowledge Center has additional resources to support staff well-being (*Promoting Staff Well-Being* | ECLKC, n.d.).

Given the known long-term consequences of ACEs, the value of early intervention is apparent. Early childhood educators are uniquely positioned to observe and assess both children and parents. Head Start and Early Head Start program staff are perceived by parents with credibility as a key part of the community. This provides an ideal environment for conducting a family-friendly, interview-based ACEs screening to promote the provision of additional caregiver and child supports.

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