2017
Sonoma County

Early Childhood Mental Health Summit

Building Relationships to Support Families in Times of Stress

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We owe a great deal of thanks to the following people who have given innumerable hours of their time, resources and expertise to help plan the 2017 Summit:

- **Carla Denner**, First 5 Sonoma County
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- **Michele Rogers**, Early Learning Institute
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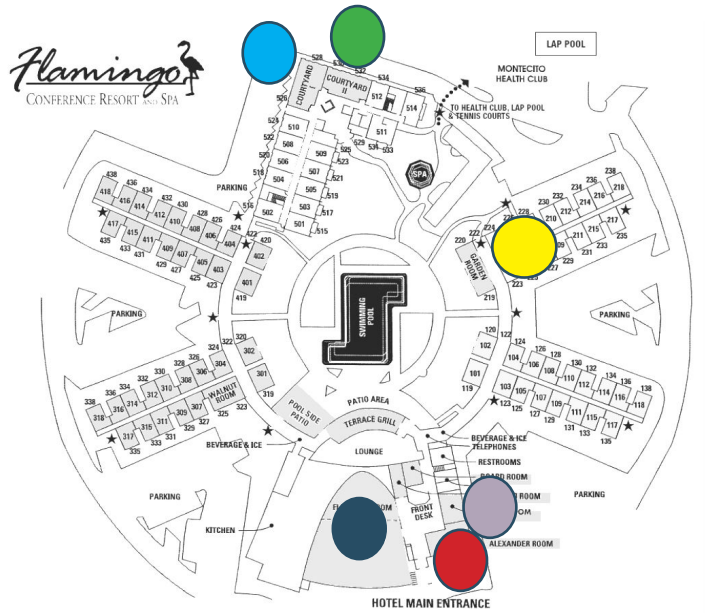
- **Jenni Silverstein**, Infant Family Mental Health Specialist Private Practice
- **JulieAnn Steinberger**, Santa Rosa Community Health

Agenda



8:30-9:00 AM **CHECK-IN & CONTINENTAL BREAKFAST ..... EMPIRE**

9:00-10:30 AM **WELCOME & KEYNOTE PRESENTATION ..... EMPIRE**

Welcome: Barbie Robinson, MPP, JD, Director of Health Services, Sonoma County Department of Health Services

Keynote - "Buidling Relationships to Support Families in Times of Stress," Page 14-22: Barbara Stroud, Ph. D., Infant Mental Health Training Consultant, Barbara Stroud Training and Consultation

10:40-12:10 PM **MORNING BREAKOUT SESSIONS**

- How to Meaure a Relationship, Page 23-32 ..... **ALEXANDER**
- Afraid you are opening Pandora's box? How to Successfully integrate Early Childhood Mental Health Concepts into Home Visits, Page 33-36 ..... **GARDEN**
- Adverse Childhood Experiences (ACEs) in the Perinatal Period: Implications for Bonding and Attachment, Page 37-49 ..... **COURTYARD I**
- Sensory Implications of Early Childhood Trauma: Using Sensory Strategies to Support Relationships, Page 50-59 ..... **COURTYARD II**
- Desorden de animo perinatal (Perinatal Mood Disorders), Page 60-62 ..... **OAK**

12:15-1:15 PM **LUNCH & PRESENTATION ..... EMPIRE**

- Supervisor Shirlee Zane, Chairwoman, Sonoma County Board of Supervisors
- Christina Amarant, LMFT, Youth & Family Section Manager, Sonoma County Behavioral Health Division

1:20-2:50 PM **AFTERNOON BREAKOUT SESSIONS**

- Families as Complex Cultural Systems, Page 63-66 ..... **ALEXANDER**
- Practical Strategies to Promote Positive Behavior in Childcare Settings, Page 67-74 . **GARDEN**
- Perinatal Substance Use: Mitigating the Risks Through Timely Assessment and Comprehensive Treatment, Page 75-83 ..... **COURTYARD II**
- How Music, Rhythem and Movement Help Heal Trauma and Develop Self-Regulation (children ages 0-5), Page 84 ..... **COURTYARD I**
- Efectos de abuso de substancias durante y despues de el embrazo y como afecta en la paternidad (Perinatal substance abuse), Page 85-88 ..... **OAK**

3:00-4:30 PM **BRAIN ARCHITECTURE GAME, RESOURCE TABLES, NETWORKING, PAGE 89 ..... EMPIRE**

The Basics of Infant and Early Childhood Mental Health: A Briefing Paper

ZERO TO THREE
Early connections last a lifetime

Early experiences matter—a lot. In the first years of life, more than 1 million new neural connections are formed every second.[1] Babies' earliest relationships and experiences shape the architecture of their brain, creating a foundation on which future development and learning unfolds. Babies who engage with responsive, consistent, nurturing caregivers and who are living in safe and economically secure environments are more likely to have strong emotional health—also referred to as infant and early childhood mental health (IECMH; see the box on p. 2 for definitions of this and other key terms). As they mature, their emotional health supports growth and well-being in other essential areas including physical development and health, cognitive skills, language and literacy, social skills, and even their approach to learning and readiness for school. When emotional health is compromised, so too is development across these other areas, leaving children more susceptible to poor health, poor educational performance, and even criminal justice involvement over the course of their lives.[2] Promoting the emotional health of infants and young children should be underscored as an essential ingredient for a bright future for all infants and young children.

During the infant and toddler years, there are many opportunities to promote emotional health, to prevent emotional disturbances from taking root, and to treat mental health problems before they can manifest into more severe problems later in life. Policymakers need to support a continuum of services delivered by trained professionals with a financing mechanism that covers the cost of services. Investing early in supporting the mental health of infants and young children will yield benefits later and will allow states to forgo much more costly interventions that all too often result when mental health challenges go unaddressed.

This briefing paper will introduce IECMH, discuss why it is important, and provide policy recommendations.

What Is Infant and Early Childhood Mental Health?

IECMH is the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture. Experts from a range of disciplines consider IECMH to be the foundation of healthy, lifelong development.

IECMH is also a term used to describe the full continuum of services and supports (i.e., promotion, prevention, and treatment) necessary to promote healthy development, prevent mental health problems, and treat mental health disorders.

Why Is IECMH Important?

While positive early childhood experiences promote strong emotional health, negative experiences can adversely impact brain development, with serious lifelong consequences. When an infant or young child's emotional health deteriorates significantly, they can, and do, experience mental health problems. Approximately 9.5%–14.2% of children birth to 5 years old experience emotional, relational, or behavioral disturbance.[3] Young children who live in families dealing with parental loss, substance abuse, mental illness, or exposure to trauma are at heightened risk of developing IECMH disorders.[4] And the stressors of poverty can multiply these risks. If untreated, IECMH disorders can have detrimental effects on every aspect of a child's development (i.e., physical, cognitive, communication, sensory, emotional, social, and motor skills) and the child's ability to succeed in school and in life. In fact, young children who do not achieve early social and emotional milestones perform poorly in the early school years and are at higher risk for school problems and juvenile delinquency later in life.[5] However, when mental health concerns are identified early, there are services that can redirect the course and place children who are at risk on a pathway for healthy development. Early and accurate identification of mental health disorders requires a developmentally specific diagnostic classification system such as *DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0–5). Research demonstrates that early prevention and treatment is more beneficial and cost-effective than attempting to treat emotional difficulties and their effects on learning and health after they become more serious.[6] For example, evidence-based child trauma treatments such as Parent-Child Interaction Therapy (PCIT) return $3.64 per dollar of cost.[7]

Policymakers can and should take an active role in promoting the kinds of services and supports that prevent and, if necessary, treat mental health issues. Because of the early onset of emotional and behavioral disorders, the Institute of Medicine estimates that their ensuing indirect and direct costs total $247 billion annually,[8] impacting federal and state spending on health care, education, child welfare, criminal justice, child welfare, and economic productivity.[9] A full continuum of services—from promotion to prevention to treatment—is needed to best support babies, young children, and the significant adults in their lives.

Recommendations for Policymakers

While there is no single remedy to prevent or treat IECMH disorders, policymakers can use evidence-based strategies and explore promising approaches to improve outcomes for infants, young children, and their families. The following recommendations, examples of actions policymakers can take to improve and advance IECMH, first appeared in *Planting Seeds in*

Policy Recommendations in Brief

1. Establish cross-agency leadership for IECMH.
2. Ensure Medicaid payment for IECMH services.
3. Invest in prevention through mental health consultation.
4. Train the workforce on IECMH.
5. Raise public awareness of IECMH.

Key Terms

Infant and Early Childhood Mental Health: Infant and early childhood mental health (IECMH) is the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture.

Promotion: Promotion of healthy emotional development focuses on supporting the well-being of all children. It might involve programs to educate parents and other caregivers about the role they play in creating responsive and nurturing environments for young children.

Prevention: Prevention approaches, such as IECMH consultation, can help identify and support children who are at risk of developing mental health problems. Child care settings, pediatric offices, home visiting programs, and other early childhood programs can provide screening and support aimed at addressing the situations that cause children to be at risk.

Treatment: Treatment focuses on specialized interventions for infants, toddlers, and families who are already exhibiting symptoms of mental health challenges. Treatment is provided by staff who have advanced training in IECMH

Selected Behaviors That Warrant Concern

Infants and Toddlers (Birth to 3 Years Old)[10]

- Chronic eating or sleeping difficulties
- Inconsolable "fussiness" or irritability
- Incessant crying with little ability to be consoled
- Extreme upset when left with another adult
- Inability to adapt to new situations
- Easily startled or alarmed by routine events
- Inability to establish relationships with other children or adults
- Excessive hitting, biting, and pushing of other children or very withdrawn behavior
- Flat affect (shows little to no emotion at all)

Preschoolers (3 to 5 Years Old)

- Engages in compulsive activities (e.g., play enacted in a specific order, hand washing, repeating words silently)
- Throws wild, despairing tantrums
- Withdrawn; shows little interest in social interaction
- Displays repeated aggressive or impulsive behavior
- Difficulty playing with others
- Little or no communication; lack of language
- Loss of earlier developmental achievements
- Anxious and fearful in most situations

Fertile Ground: Actions Every Policymaker Should Take to Advance Infant and Early Childhood Mental Health. For a more detailed discussion of these strategies, please visit www.zerotothree.org/resources/1221-planting-seeds-in-fertile-ground-steps-every-policymaker-should-take-to-advance-infant-and-early-childhood-mental-health

- **Establish cross-agency leadership for IECMH.** Improving IECMH outcomes requires leadership. To ensure coordination and accountability and to drive a statewide IECMH strategy, the state should designate an accountable person (or team) to develop IECMH policies, make programmatic and funding recommendations, manage implementation, and monitor the state's progress. It is helpful to have an identified IECMH lead person within each early childhood delivery system such as child care, home visiting, early intervention, child welfare, and health. Cross-agency collaboration is critical to integrate and prioritize IECMH policies across otherwise siloed state entities and funding streams.
- **Ensure Medicaid payment for IECMH services.** Nearly 50% of children under 6 years old receive health care coverage through Medicaid or CHIP.[11] States should leverage Medicaid payment to support IECMH prevention, assessment, diagnosis, and treatment services for children and their families. In many states, contracts with Medicaid Managed Care Organizations or accountable provider-led organizations can serve as a lever. The contracts with these providers can include specific promotion and prevention strategies to support emotional health.
- **Invest in prevention through mental health consultation.** An early childhood mental health consultation system involves a consultant with mental health expertise working collaboratively with programs, their staff, and families to improve their ability to prevent and identify mental health issues among children in their care.[12] Mental health consultation helps reduce problem behaviors in young children and, more broadly, promotes positive emotional development.[13]
- **Train the workforce on IECMH.** Embedding IECMH education and competency standards in mental health, social work, health care, and early childhood education professionals' training, coursework, and on-going professional development provide opportunities to build a workforce that understands IECMH and is prepared to identify situations that threaten children's healthy emotional development.

- **Raise public awareness of IECMH.** Developing public health campaigns, educational materials, and other efforts aimed both at parents of young children and at providers can help build public awareness of the importance of promoting emotional health and of preventing and treating IECMH disorders.

For more information, and to see other briefing papers in the series, please visit www.zerotothree.org/policy-and-advocacy/social-and-emotional-health

Acknowledgments

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About Us

For more information, and to see other briefing papers in the series, please visit www.zerotothree.org/policy-and-advocacy/social-and-emotional-health

Endnotes

1 Center on the Developing Child. (2009). *Five numbers to remember about early childhood development* (Brief). Retrieved from www.developingchild.harvard.edu

2 ZERO TO THREE. (2016). *Planting seeds in fertile ground: Actions every policymaker should take to advance infant and early childhood mental health.* Retrieved from www.zerotothree.org/resources/1221-planting-seeds-in-fertile-ground-steps-every-policymaker-should-take-to-advance-infant-and-early-childhood-mental-health

2 Brauner, C. B., & Stephens, C. B. (2006). Estimating the prevalence of early childhood serious emotional/behavioral disorders: Challenges and recommendations. *Public Health Reports, 121*(3), 303–310. Available from www.ncbi.nlm.nih.gov/pmc/articles/PMC1525276/

4 Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ...Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.

5 Raver, C. (2002). Emotions matter: Making the case for the role of young children's emotional development for early school readiness. *Social Policy Report of the Society for Research in Child Development, 16*(1) 3–23.

6 National Scientific Council on the Developing Child. (2010). *Persistent fear and anxiety can affect young children's learning and development, Working Paper No. 9.* from http://developingchild.harvard.edu/resources/persistent-fear-and-anxiety-can-affect-young-childrens-learning-and-development

7 Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). *Benefits and costs of prevention and early intervention programs for youth: Technical appendix*. Retrieved from www.wsipp.wa.gov/rptfiles/04-07-3901a.pdf

8 American Academy of Child and Adolescent Psychiatry, American School Counselor Association, The Balanced Mind Foundation, Children and Adults with Attention-Deficit/Hyperactivity Disorder, Mental Health America, and National Alliance on Mental Illness (2013). *Improving Lives, Avoiding Tragedies* (Fact Sheet). Retrieved from www.aacap.org/App_Themes/AACAP/docs/Advocacy/policy_resources/Children%27s_Mental_Health_Fact_Sheet_FINAL.pdf

9 ZERO TO THREE. (2016). *Planting seeds in fertile ground: Actions every policymaker should take to advance infant and early childhood mental health.* Retrieved from www.zerotothree.org/resources/1221-planting-seeds-in-fertile-ground-steps-every-policymaker-should-take-to-advance-infant-and-early-childhood-mental-health

10 ZERO TO THREE. (2016). *DC:0–5™: Diagnostic classification of mental health and developmental disorders of infancy and early childhood* (DC:0–5). Washington, DC: Author.

11 Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ...Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.

12 Cohen, E., and Kaufmann, R. *Early Childhood Mental Health Consultation.* DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005. Retrieved from http://store.samhsa.gov/shin/content/SVP05-0151/SVP05-0151.pdf

13 Cohen, E., and Kaufmann, R. *Early Childhood Mental Health Consultation.* DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005. Retrieved from http://store.samhsa.gov/shin/content/SVP05-0151/SVP05-0151.pdf

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Keynote Speaker

2017
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Early Childhood Mental Health Summit

Building Relationships to Support Families in Times of Stress

Barbara Stroud, Ph.D.

Building Relationships to Support Families in Times of Stress

Barbara Stroud, Ph.D., is a licensed psychologist, trainer, and consultant with over two decades worth of culturally informed clinical practice and training in the early childhood development and mental health arenas. She is a national ZERO TO THREE Graduate Fellow and holds prestigious endorsements as an Infant and Family Mental Health Specialist/Reflective Practice Facilitator Mentor with the California Center for Infant-Family and Early Childhood Mental Health. Embedded in all of her trainings, clinical service models, and consultations are the practices of reflective supervision and sensitivity to cultural uniqueness. In 2012, Dr. Stroud published the book "How to Measure a Relationship", which is improving infant mental health practices around the country. Her newest text "Intentional Living: finding the inner peace to create successful relationships" walks the reader through a deeper understanding of how their brain influences relationships. Both volumes are currently available on Amazon. Additionally, Dr Stroud is a contributing author to the text "Infant and early childhood mental health: Core concepts and clinical practice" edited by Kristie Brandt, Bruce Perry, Steve Seligman, & Ed Tronick.

Dr. Stroud received her Ph.D. in Applied Developmental Psychology from Nova Southeastern University, and she has worked largely with severely emotional disturbed children in urban communities. Dr. Stroud's professional career path spans classroom based, community oriented, and legislative systems of care. She is highly regarded and has been a key player in the inception and implementation of cutting edge service delivery to children 0-5 and their families; her innovative approaches have won national awards. More specifically, Dr. Stroud is a former preschool director at Northridge Preschool, a non-public school administrator, and director of early intervention services at the Los Angeles Child Guidance Clinic in South Central Los Angeles. In addition, Dr. Stroud was the community training program manager for The Child Development Institute in Woodland Hills, CA and held faculty ranking at the graduate level with California State University Long Beach. Presently, Dr. Stroud is among the distinguished faculty at the University of California Davis Extension Infant-Parent Mental Health Fellowship.

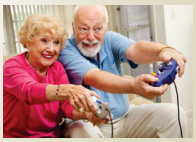
Dr. Stroud works closely with professionals across multiple disciplines and, annually, she trains up to 2,000 providers that touch the lives of children and families. She regularly conducts training for those in mental health, early intervention (Part C), Head Start and Early Head Start, Child Protective Services (CPS), and dependency court, primary care, as well as individual caregivers. As Dr. Stroud is particularly passionate about the unique needs of children of color in the mental health and foster care systems, she has continually worked to infuse reflective and culturally mindful course of action in developing service programs that support the goals of a relationship-based framework within the context of a government contracted organization.

2



Relationships Fuel All Development BUT . . .





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3

Regulation is Required for Relationship

Regulation is required for relationships

Parent & child must be regulated

Regulation is required for reasoning

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4

The Role of Relationships

Neuroception Attachment

Social-emotional Dev. Self-Regulation

Self-Understanding

Cultural Individual & Community

Community Survival

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5

Culture as a Source of Strength

- Culture is part of our identity and to devalue culture is to devalue the individual
- We are each culturally unique and worthy of cultural respect
- Historical trauma, oppression, and social injustice produce similar neurological outcomes as toxic stress
- Cultural connections, validation, and communities can enhance resilience

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Relationships Should

- Protect from harm
- Demonstrate sensitivity to the other's needs
- Teach emotional understanding
- Co-regulate in times of distress
  - to build a healthy stress response system
- Infuse cultural identity via the relationship
- Delight in the other's successes – share joy

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7

Nurturing Relationships Will

- Support all development
- Build the brain
- Heal trauma
- Teach cultural understanding
- Shape emotional development
- Maintain safety to explore and learn
- Celebrate curiosity in learning

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8

Sensitivity of Response

- When we feel heard and seen, we feel safe
- When we feel safe, we can actively engage in relationships of learning
- When others notice our needs, do not judge but make us feel valued, we thrive

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9

Ruptures to Development

- Caregivers that are too emotionally overwhelmed to nurture
- Environments of toxic stress or custodial care
- Adversity that is not regulated, organized, or comforted
  - Rupture without Repair
- Persistent lack of emotional and/or physical safety

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Fear is not healthy for development

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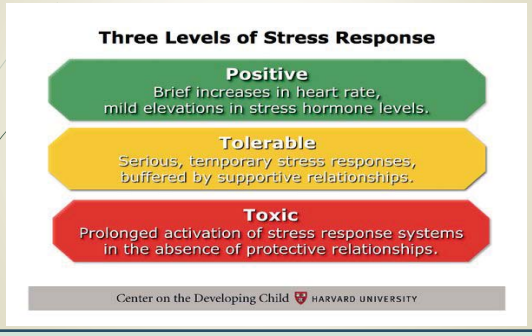
Not all Stress is Bad



12

Relationships Heal

- Relationships provide emotional and physical safety
- Relationships co-regulate and calm emotions
- Relationship live in the mind/memory and hold psychological meaning of safety or fear
- Supportive & sensitive relationships serve as a protective factor

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Relationships of healing require that adults have the capacity

1. to manage their emotional responses,
2. calm any internalized fears, &
3. maintain a foundation in resilience (*hope*)

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What is Resilience?

- The capacity to bounce back from difficulty
  - Resilience is not physical strength
- Resilience requires emotional balance
  - Resilience is not perfection
- Resilient people can see an opportunity in a negative event
  - Using hardship to build inner strength
- ***Resilient people are open to learning, have a hopeful outlook, and know how to find necessary resources in times of need***

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Resilient Traits

- A positive attitude and the ability to see hope in the situation
- The ability to manage highly charged emotions and return to a calm state when stressed
- Using problems as a place to learn and grow
- Seeking others for support when life feels overwhelming
- Faith in your internal abilities and external supports

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Activities of Healing

- Nurturing relationships
  - Caregivers that can notice and respond to their child's needs in a developmentally appropriate manner
- Environments and relationships that are stable and predictable
  - All children need to be able to count on some stable elements in their daily lives
- Emotional support in the management of overwhelming affect, hostile relationships, and toxic stress

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Activities of Healing

- Strong internal understanding of myself as a cultural being, rich in my capacity to seek and maintain emotional connection
- Adults that can hear, accept, and mirror back the child's needs and experiences
  - Narration of the emotional world of the child
  - Assisting the child in organizing and internalizing their story – a healthy narrative

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Parallel Process

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Your Relationships With Families

- You must demonstrate in your professional role
  - Sensitivity of response
  - Stability in your emotions and availability
  - Co-regulation of the family system
  - Connection to and articulation of your agency mission or professional role
  - Reflection of the needs of the other

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Holding the Emotional Pain of Another

LISTEN **HOLD** **ACCEPT**

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Finding Hope in Challenging Times

- Where do you have control
- Where can you make an impact
- How do you stay safe
- How can you support others to maintain safety
- Hear and hold the emotional stress/ trauma of another
- Who supports you emotionally and holds your story
- How can you establish stability in your life
- How can you encourage predictability for others

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We are the hope for our clients, the children, & families we serve

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23

Adversity vs. Trauma Responses

- Adversity = a negative event
- Trauma Responses = negative reactions to an adverse event arising out of unorganized, unprocessed internal state or experiences
- Prevent Trauma Responses by:
  - Supporting the developmental needs of the child
  - Listening to the emotions of the child
  - Offering consistency in your relationship
  - Setting realistic goals and helping the child achieve them

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Trauma Repair & Social Injustice

- My pain is the worst I have ever experienced
- You do not have to agree to convey empathy
- Never minimize another's inequity
- Do not seek to fix injustice, it is not fair by definition
- Some challenges can not be changed but only lived through
- Ensure you have resources for your emotional needs when dealing with families that regularly face injustice

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Ordinary Moments –Life Long Outcomes

- When caregivers respond to their child's emotional needs
  - a child learns safety and comfort in relationship
- When caregivers comfort a child that is in pain
  - the child learns that others are dependable, available, and they develop self calming skills over time
- When the tantruming child is effectively calmed by a caring adult
  - the child's brain develops strong pathways for stress recovery

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A series of brief summaries of essential findings from recent scientific publications and presentations by the Center on the Developing Child at Harvard University.

Thriving communities depend on the successful development of the people who live in them, and building the foundations of successful development in childhood requires responsive relationships and supportive environments. Beginning shortly after birth, the typical "serve and return" interactions that occur between young children and the adults who care for them actually affect the formation of neural connections and the circuitry of the developing brain. Over the next few months, as babies reach out for greater engagement through cooing, crying, and facial expressions–and adults "return the serve" by responding with similar vocalizing and expressiveness–these reciprocal and dynamic exchanges literally shape the architecture of the developing brain. In contrast, if adult responses are unreliable, inappropriate, or simply absent, developing brain circuits can be disrupted, and subsequent learning, behavior, and health can be impaired.

1 Because responsive relationships are both expected and essential, their absence is a serious threat to a child's development and well-being. Sensing threat activates biological stress response systems, and excessive activation of those systems can have a toxic effect on developing brain circuitry. When the lack of responsiveness persists, the adverse effects of toxic stress can compound the lost opportunities for development associated with limited or ineffective interaction. This multifaceted impact of neglect on the developing brain underscores why it is so harmful in the earliest years of life and why effective early interventions are likely to pay significant dividends in better, long-term outcomes in educational achievement, lifelong health, and successful parenting of the next generation.

2 Chronic neglect is associated with a wider range of damage than active abuse, but it receives less attention in policy and practice. Science tells us that young children who experience significantly limited caregiver responsiveness may sustain a range of adverse physical and mental health consequences that actually produce more widespread developmental impairments than overt physical abuse. These can include cognitive delays, stunting of physical growth, impairments in executive function and self-regulation skills, and disruptions of the body's stress response.

Science Helps to Differentiate Four Types of Unresponsive Care

	OCCASIONAL INATTENTION	CHRONIC UNDER-STIMULATION	SEVERE NEGLECT IN A FAMILY CONTEXT	SEVERE NEGLECT IN AN INSTITUTIONAL SETTING
Features	Intermittent, diminished attention in an otherwise responsive environment	Ongoing, diminished level of child-focused responsiveness and developmental enrichment	Significant, ongoing absence of serve and return interaction, often associated with failure to provide for basic needs	"Warehouse-like" conditions with many children, few caregivers, and no individualized adult-child relationships that are reliably responsive
Effects	Can be growth-promoting under caring conditions	Often leads to developmental delays and may be caused by a variety of factors	Wide range of adverse impacts, from significant developmental impairments to immediate threat to health or survival	Basic survival needs may be met, but lack of individualized adult responsiveness can lead to severe impairments in cognitive, physical, and psychosocial development
Action	No intervention needed	Interventions that address the needs of caregivers combined with access to high-quality early care and education for children can be effective	Intervention to assure caregiver responsiveness and address the developmental needs of the child required as soon as possible	Intervention and removal to a stable, caring, and socially responsive environment required as soon as possible

With more than a half million documented cases in the U.S. in 2010 alone, neglect accounts for 78% of all child maltreatment cases nationwide, far more than physical abuse (17%), sexual abuse (9%), and psychological abuse (8%) *combined*. Despite these compelling findings, child neglect receives far less public attention than either physical abuse or sexual exploitation and a lower proportion of mental health services.

3 Studies on children in a variety of settings show conclusively that severe deprivation or neglect:

- **disrupts the ways in which children's brains develop and process information,** thereby increasing the risk for attentional, emotional, cognitive, and behavioral disorders.
- **alters the development of biological stress-response systems,** leading to greater risk for anxiety, depression, cardiovascular problems, and other chronic health impairments later in life.
- **is associated with significant risk for emotional and interpersonal difficulties,** including high levels of negativity, poor impulse control, and personality disorders, as well as low levels of enthusiasm, confidence, and assertiveness.
- **is associated with significant risk for learning difficulties and poor school achievement,** including deficits in executive function and attention regulation, low IQ scores, poor reading skills, and low rates of high school graduation.

4 The negative consequences of deprivation and neglect can be reversed or reduced through appropriate and timely interventions, but merely removing a young child from an insufficiently responsive environment does not guarantee positive outcomes. Children who experience severe deprivation typically need therapeutic intervention and highly supportive care to mitigate the adverse effects and facilitate recovery.

For more information, see "The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain" and the Working Paper series from the Center on the Developing Child at Harvard University. *www.developingchild.harvard.edu/resources/*

IMPLICATIONS FOR POLICY AND PROGRAMS

Science tells us that repeated and persistent periods of prolonged unresponsiveness from primary caregivers can produce toxic stress, which disrupts brain architecture and stress response systems that, in turn, can lead to long-term problems in learning, behavior, and both physical and mental health. These advances in science should inform a fundamental re-examination of our approaches to the identification, prevention, reduction, and mitigation of neglect and its consequences, particularly in the early years of life.

- **Address the distinctive needs of children who are experiencing significant neglect.** The immediate circumstances and long-term prospects of neglected children could be enhanced significantly by: (1) disseminating new scientific findings to child welfare professionals and focusing on the implications of this evidence for practice; (2) supporting collaboration between child development researchers and service providers to develop more effective prevention and intervention strategies; (3) coordinating across policy and service sectors to identify vulnerable children and families as early as possible; and (4) creating contexts for cooperation among policymakers, family court judges, and practitioners to improve access to non-stigmatizing, community-based services.
- **Invest in prevention programs that intervene as early as possible.** The earlier in life that neglected children receive appropriate intervention, the more likely they are to achieve long-term, positive outcomes and contribute productively to their communities. Key personnel in the primary health care, child welfare, mental health, and legal systems can work together to assure the earliest possible identification of families that require preventive assistance as well as children who need therapeutic intervention. Because child neglect often co-occurs with other family problems (particularly parental mental health disorders and addictions), specialized services that address a variety of medical, economic, and social needs in adults present important opportunities to identify and address neglectful circumstances for young children. Policies and programs that provide preventive interventions in high-risk situations before the onset of neglect present a particularly compelling goal.

The authors gratefully acknowledge the contributions of the National Governors Association Center for Best Practices and the National Conference of State Legislatures.

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At Intersection of Trauma and Disabilities: A New Toolkit for Providers

Sponsored by the Culture Consortium

Patty Shure, Director of Child and Family Services at Las Cumbres Community Services in Española, NM, recently recalled her work three years ago with a young toddler receiving care at the Conjunto Therapeutic Preschool at Las Cumbres. The treatment team believed that the child's developmental and speech delays were due to severe facial injuries she sustained in a car accident before she was a year old. Shure, a social worker who has worked for more than 22 years with children with disabilities and trauma, suspected that the girl's delays might also be related to unresolved traumatic grief over the loss of her mother, who had died in the accident. The family and the teaching staff were not convinced that her behaviors were a trauma reaction – until the grandmother, out driving with the child, had a minor fender-bender. When she jumped out of the car to inspect the damage, her granddaughter, though unhurt, started screaming and was "inconsolable" for more than an hour.

"That [event] was the clue for the family and the treatment team that, for her, the trauma was still very present," Shure said. "It wasn't solely her injuries that caused her inability to communicate and articulate words." The preschooler's situation illustrates some of the complexities of working with clients at the intersection of disability and trauma.

"Many clinicians say they would be willing to work with children who have developmental disabilities, if only they knew how," said Diane M. Jacobstein, PhD, Clinical Psychologist/ Senior Policy Associate, Georgetown University Center for Child and Human Development, Washington, DC. But until this year, no tools existed to help clinicians disentangle what might be symptoms of trauma from behaviors related to intellectual and developmental disabilities (IDD).

With the release of the toolkit, The Road to Recovery: Supporting Children with IDD Who Have Experienced Trauma, providers well-versed in trauma now have the tools to factor in a new understanding of IDD in their assessment and treatment. And, providers who work with children with IDD can widen their therapeutic lens to "think trauma."

"This toolkit and its training materials fill an important need in the face of our current workforce crisis," said Jacobstein, who was a member of the expert panel that developed the toolkit. "They will help therapists gain skills and confidence to serve children with disabilities who experience trauma."

Developed by the NCTSN, the toolkit was funded by the Hogg Foundation for Mental Health in Austin, TX. The development panel was chaired by Susan Ko, PhD, UCLA/Duke NCCTS, and comprised f a wide range of nationally known trauma and IDD experts, including NCTSN members The Family Center at Kennedy Krieger Institute and DePelchin Children's Center. Following two initial rounds of pilot trainings, a train-the-trainer session took place in August 2015 in Redondo Beach, CA. Feedback from all trainings was then incorporated into the toolkit.

Daniel Hoover, PhD, ABPP, a Senior Clinical Psychologist at the Kennedy Krieger Institute's Center for Child and Family Traumatic Stress, Baltimore, MD, was one of the participants at the Redondo Beach session. "This is a very innovative toolkit," he said. "There are so many myths out there about working with children and families who have IDD. You can talk about trauma and you can get some resources on IDD, but until now there has been nothing in the field that combines the two in such a comprehensive way."

High Risk and Challenges

According to the Hogg Foundation, children with developmental disabilities are twice as likely as those without IDD to experience emotional neglect and physical or sexual abuse; twice as likely to be bullied; and three times as likely to be in families where domestic violence is present. Because these children and youth are at such high risk of trauma, any behavior that a teacher, pediatrician, or child welfare worker observes "could be an expression of trauma versus just something that comes along with their disability," Hoover pointed out.

Christopher Beegle, LCSW-C, a Clinical Field Instructor at the Family Connections program, University of Maryland School of Social Work, noted that even trained clinicians may not realize that some of the children with whom they work have an intellectual or developmental disability. He said his participation in the Redondo Beach train-the-trainer session strengthened his understanding about tying in the developmental piece. "The toolkit raises awareness about keeping both frameworks – trauma and IDD – in mind when working with families."

NCTSN The National Child Traumatic Stress Network

For example, in the toolkit's Module 2 on development and trauma, providers are reminded of the developmental complexities they must consider in addition to assessing for trauma. A child may have co-occurring medical, genetic, or developmental issues, communication challenges, or attention deficit issues. "This module brought up questions about how to structure sessions to best attend to the presenting developmental issues for the families and children we serve, to promote healing," Beegle said.

'A Culture Shift'

Colleen Horton, MPAff, MA, Program Officer for the Hogg Foundation, observed that, "One of the biggest challenges in working with children with IDD is the added time it takes to talk with caregivers, and then finding a way an individual child communicates best." Horton has been a prime mover in the IDD toolkit project. Her involvement stemmed from a congruence of factors. As the parent of a daughter with autism, she could not find appropriate services to help her daughter after a traumatic event. At about the same time, she was asked to join the NCTSN Advisory Board, and she became familiar with trauma toolkits for other populations. "I recognized that children with IDD comprised a population for which this information was missing, but very much needed," she recalled.

Too often, children and youth with IDD do not receive state-of-the-art mental health treatment, Horton noted. Reflecting the combined expertise of the trauma and IDD communities, the toolkit encourages a culture shift in a provider's own perception. "We want to get away from a focus on managing behaviors with compliance as the primary goal; and to look at the history and cause of behaviors, to determine if trauma has occurred, and if what we're doing is creating an environment that continues to produce trauma reminders," Horton emphasized.

Caregivers, Parents Are Pivotal Team Members

Hoover recently initiated the Horizons Program, a therapeutic clinic dedicated to treating traumatized children with developmental disabilities. He will be participating in a panel on the toolkit at the 2016 All-Network Conference. He praised the toolkit's incorporation of family members and caregivers, which underlines the message to clinicians to honor the family's expertise and to approach the family's perception and knowledge of their child from their point of view.

Anne Fogg, MA, LPC, who works at the Aurora Mental Health Center in Aurora, CO, concurred with Hoover, adding, "The parents of our clients are experts with their child's disability, but not necessarily with trauma. Having the resources and vignettes in this toolkit really helps people who don't have as much experience working with this population." Fogg has begun to use materials from the toolkit in individual sessions with families. She pointed to the board game adapted from the Life Course Game as an excellent tool for underscoring risk factors and protective factors to help families build on their own resilience.

"I cannot say enough good things about this toolkit," said Mayra Mendez, PhD, LMFT, Certified Group Psychotherapist, CAMFT Certified Supervisor at Saint John's Child and Family Development Center in Santa Monica, CA, who also participated in the Redondo Beach training. "The developers gave great thought to using understandable concepts in the PowerPoint slides." Mendez has already begun training clinicians at her agency, and last November she launched a training group for parents. The group was so successful that the parents requested she offer an ongoing series on coping with trauma – "not just the trauma of abuse or bullying," she said, "but the trauma of dealing with the world, because having a child with a disability is traumatic for the parents, too." Part of their traumatic stress arises from the need to negotiate resources for their children; and changing developmental phases also introduce new challenges. Mendez praised the structure of the IDD toolkit, which requires a skilled facilitator to help ensure that parents, when their emotions are triggered, do not "spin out of control." Parents need to keep coping, she emphasized: "That's the trick with trauma."

Changing the Lens

The toolkit also underscores the need to dispel common myths surrounding work with children with IDD – mainly, that these children cannot engage in mental health treatment. At Las Cumbres, Shure has begun training clinicians and school staff together and has observed that each group has pushed the other to expand their ability to perceive clues about possible trauma. "The most important thing is taking both trauma and IDD into consideration," Shure noted, "and not seeing kids through a lens of behavior alone."

Once the treatment team at Conjunto Therapeutic Preschool realized that trauma was affecting the young toddler's ability to speak, the team and the family began to work through that piece of the treatment process. The girl was able to make progress with the help of clinical services and speech therapy. When clinicians understand that they are not just seeing "willful behaviors," and design ways to support the child to work through his or her trauma, "you get to see change and you get to see hope," Shure said. "And that makes a huge difference."

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AM Breakout Session #1

How to Measure a Relationship

Barbara Stroud, Ph.D.
Barbara Stroud Training and Consultation

Barbara Stroud, Ph.D., is a licensed psychologist, trainer, and consultant with over two decades worth of culturally informed clinical practice and training in the early childhood development and mental health arenas. She is a national ZERO TO THREE Graduate Fellow and holds prestigious endorsements as an Infant and Family Mental Health Specialist/Reflective Practice Facilitator Mentor with the California Center for Infant-Family and Early Childhood Mental Health. Embedded in all of her trainings, clinical service models, and consultations are the practices of reflective supervision and sensitivity to cultural uniqueness. In 2012, Dr. Stroud published the book "How to Measure a Relationship", which is improving infant mental health practices around the country. Her newest text "Intentional Living: finding the inner peace to create successful relationships" walks the reader through a deeper understanding of how their brain influences relationships. Both volumes are currently available on Amazon. Additionally, Dr Stroud is a contributing author to the text "Infant and early childhood mental health: Core concepts and clinical practice" edited by Kristie Brandt, Bruce Perry, Steve Seligman, & Ed Tronick.

Dr. Stroud received her Ph.D. in Applied Developmental Psychology from Nova Southeastern University, and she has worked largely with severely emotional disturbed children in urban communities. Dr. Stroud's professional career path spans classroom based, community oriented, and legislative systems of care. She is highly regarded and has been a key player in the inception and implementation of cutting edge service delivery to children 0-5 and their families; her innovative approaches have won national awards. More specifically, Dr. Stroud is a former preschool director at Northridge Preschool, a non-public school administrator, and director of early intervention services at the Los Angeles Child Guidance Clinic in South Central Los Angeles.

2

Infant Mental Health

- Capacity to experience, regulate, and express emotion
- Form close and secure interpersonal relationships
- Explore the environment and learn, **within the cultural context of the family**
- Synonymous with healthy social and emotional development

ZERO TO THREE, Infant Mental Health Task Force, 2001

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3

Social Emotional Development

- To **experience and express** emotions in an adaptive manner
- To accurately **read and respond** to the emotions of other in a culturally appropriate manner
- To **manage** your feeling states such that they do not interfere with social relationships and with learning
- Social emotional success is necessary for all learning to occur

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4

Influences on Social Ways of Being

- **Child's Inner Self**
  - Developmental skills
  - Physical health or constitutional limitations
  - Ego or self esteem
- **Environmental Conditions**
  - Stress in the system – poverty – substance recovery
  - Trauma or emotional chaos
- **Available Caregiver Supports**
  - Attachment experiences
  - Emotional resources available to the caregiver
  - Sensitive and responsive caregiving

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5

Assessing Infants and Toddlers

- **Optimal Development**
  - Sensitivity of response, safety in relationship, validation of lived experience, narration of their world to build meaning making
- **Risks to Development**
  - Constitutional, Relational, and/or Environmental
- **Trauma** –Resulting in disorder or delays in development
  - Assaults to psychological integrity, alienation of the self, continuous rupture without repair

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6

Risks to Relationship Success

- When the quality of the caregiver-infant interaction is less than optimal
  - Lead by the emotional needs of the caregiver
  - Infants cues go unmet
- When preschoolers are unable to regulate or demonstrate developmentally appropriate social emotional skills
  - Child is often functioning at brain stem level
  - Poor peer interactions
  - Socially unacceptable expression of emotions

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7

Risks to Relationship Success

- When school age children cannot maintain emotional regulation such that they can hear and understand the emotional needs of another
  - Listening without defensiveness
  - Accepting differences and not losing your sense of self
- Relationship-based intervention is needed when:
  - Caregiving relationships do not adequately nurture
  - Emotional regulation is off line
  - Social emotional skills are age inappropriate

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8 Psychological Tasks of Childhood

- To develop a strong secure attachment bond
- To learn to modulate external sensory input
- To learn to manage my internal affective states
- To effectively communicate and get my needs met
- To effectively adapt to my changing world

9 The Meaning of Behavior

Behavior as Communication

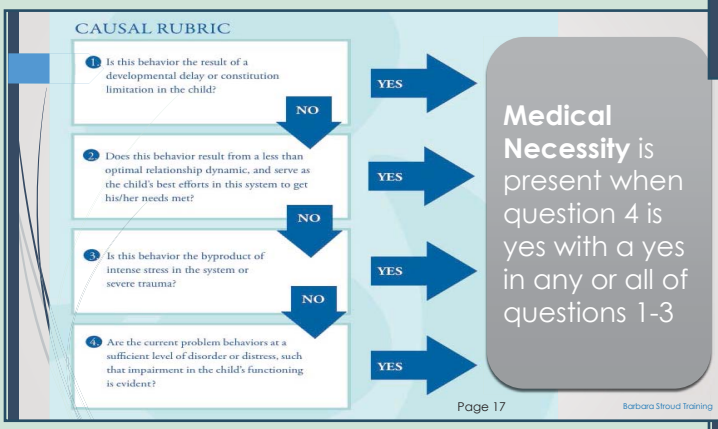
1. Behavior as a method of emotional regulation
2. Behavior as a means to seek connection
3. Behavior as a method to push others away – safety

Concerning Caregiver Responses

1. Ignoring the need for co-regulation
2. Punishment for misbehavior or responding to the wrong need
3. Failure to provide safety and offer meaning making

10 When Behaviors Become Symptoms

- Behavior creates a safety risk to the child & those around him/her
- Behavior impedes the success of the relationship
- Frequency or intensity of behavior is too challenging for the caregiver to manage
- Behavior disrupts or delays developmental trajectory
- Behavior isolates child and/or family from cultural communities of support



12 Linking Symptom to Cause

- **Development**
  - How might a constitutional issue lead to symptoms of disruptive behavior or mood instability
- **Relationship**
  - What might be lacking in the caregiving relationship to produce symptoms of disruptive behavior or mood instability
- **Environmental stress or trauma**
  - How does environmental trauma impair the development of self-regulation

13 Relationships as the Intervention Tool

- Your interventions should enhance the emerging psychological tasks of childhood
- Your interventions target relationships of support and co-regulation
- Interventions should build skills that diminish the problem behavior
- Effective interventions should be able to be enacted by the caregiver after the session and in every day moments
- Your intervention target is the relationship as the process which alters behavior

- **The Name of the Game is Delight**: Babies are "hard-wired" to experience joy with their caregivers in the early months of life. Researchers are finding that mutual joy is the basis for increased brain growth. A baby feels more secure knowing that "Life is good, because my parent enjoys life when s/he is with me."
- **Every Baby Needs a Holding Environment**: Babies soak up affection and love through their skin. Gentle touch shares the tenderness that every infant requires. Playful touch encourages joy. Holding your baby not only provides pleasure and reassurance, it is essential in helping to soothe and organize difficult feelings.
- **"The Eyes Have It:"** Gaze into your baby's eyes from the first day of life, and pay close attention to when your child wants to look back. At about six weeks, your child will regularly focus in on your eyes and read what they are "saying." Lots of pleasurable eye contact will translate into a feeling of reassurance and connection for your baby.
- **Whenever Possible, Follow Your Child's Lead**: Security of attachment requires a caregiver who is sensitive and responsive to her/his child's needs. Your willingness to answer subtle requests for attention, comfort, holding, exploration, and discovery (with you nearby) will provide an increased sense of security for your child.
- **You Can't Spoil a Baby**: Contrary to those who may be saying that you will harm your child if you are "too responsive" to her/his needs, it isn't possible to spoil a baby in the first 9-10 months of life. Researchers are finding that the most responsive parents actually have children who are less demanding and more self-reliant as they grow older.
- **Stay With Your Child During Difficult Feelings**: Young children often have upset feelings (anger, hurt, sadness, fear) that are too difficult to manage on their own. When your child has an intense feeling, stay with her/him until the feeling has been worked through. Your child will be learning basic trust: "Someone is here with me when I am in difficulty and pain," and "I can count on a good outcome to follow a difficult experience."
- **Talk Out Loud about Feelings**: From your child's earliest days, talking out loud about feelings (your child's and your own) will begin to help your child to eventually label feelings and realize that they can be shared. As your child gets older, s/he will realize that intense feelings can be named (mad, sad, glad, and afraid) and discussed with another, thus ending a need to act them out.
- **"Mistakes Happen (You Only Need To Be "Good Enough"):"** Perfection is impossible in parenting. In fact, it isn't even recommended. A child who knows that everyone in the family makes mistakes, and that they will eventually be worked out, will feel more secure than a child who thinks everything has to be right the first time.
- **Be Bigger, Stronger, Wiser, and Kind**: At the heart of secure attachment is a child's recognition that s/he has a parent who can be counted on to lovingly provide tenderness, comfort, firm guidance and protection during the inevitable difficulties of life. If the truth be told, all of us have this need some of the time, no matter what our age.

Make the Most of Playtime

Does This Sound Familiar?

Eight-month-old Jamia loves the game of peek-a- boo she and her father play. Jamia's father, Tomas, hides his face behind the couch then pops up and with a big smile says, "Here's Daddy!" Tomas and Jamia repeat the interaction over and over. Each time Tomas pops up from behind the couch, Jamia expresses sheer glee. After a number of repetitions, Tomas becomes tired of the game and is ready to move on to things he needs to do. Once Tomas stops playing and starts to fold laundry, Jamia screams and shrieks, stretching and waving her arms out to her dad as if to say, "Don't stop!" or "More! More!"

Jackson (age 14 months) throws his sippy cup in the trash. His mother, Danette, gently picks it out, washes it off, and hands it back to him. Only seconds later, Jackson throws his sippy cup in the trash again, giving his mother a wide smile. Danette, a bit distracted and frustrated, takes the sippy cup out again, washes it off, and gives it back to him. This time, she scolds Jackson. She tells him the sippy cup doesn't go in the trash and to stop playing in the trash. Before Danette can distract Jackson with another game or remove the trash can to another location, he throws the sippy cup in the trash again. He looks to his mother with another wide smile, appearing proud and eager for her reaction.

The Focus

Babies and toddlers love to play. As a parent, it can feel overwhelming at times. You might feel like your young child thinks everything is a game. Often young children want to repeat their games over and over. They also want to test the boundaries to learn what is appropriate and what is not. For busy parents, this can test your patience. Sometimes it might seem as though your child wants to "play" exactly at the time when you have other things that must be done.

Development of Play Skills for Infants and Toddlers

Babies Birth to 4 Months	• Smile (usually around 6 weeks of age) and begin to coo (make sounds like "oooooo" or "aaaaaa") (usually around 4 months) • Prefer human faces over objects or toys • Turn toward familiar voices and faces • Follow objects with their eyes and recognize familiar faces and objects • Begin to explore their hands by bringing them to their face or putting them in their mouth
Babies 4-7 Months	• Enjoy social games with a caregiver such as peek-a-boo and patty cake • Bring toys to their mouth • Can use their fingers and thumb to pick up objects • Enjoy looking at themselves in a baby-safe mirror • Laugh and babble (saying things like "ba-ba-ba-ba") • Distinguish feelings by listening to the tone of your voice and the voices of other loved ones. (Babies can tell when you are sad, upset, or happy just by the tone of your voice.)
Babies 8-12 Months	• Might begin to make recognizable sounds (like "Ma" or "Da") and repeat or copy sounds/word they hear you say, like "Hi!" or "Bye bye!" • Communicate nonverbally by pointing, gesturing, pulling up, or crawling • Play games such as peek-a-boo and patty cake • Use some objects correctly to imitate actions, like holding a toy phone to their ear or holding a cup to their mouth • Explore objects by shaking or banging them • Might become shy around strangers • Might cry when Mom or Dad or a primary caregiver leaves
Toddlers 13-24 Months	• Enjoy playing with objects such as wooden spoons, cardboard boxes, and empty plastic food containers. Toddlers also enjoy toys like board books, balls, stackable cups or blocks, dolls, simple puzzles, etc. • Have fun filling containers up with water, sand, or toys and then dumping them out • Enjoy watching other children play. Your child might carefully look on or smile as other children play, but might not want to join the group • Usually plays alone or next to other children • Might offer toys to caregivers or other children, but might want them right back • Might choose to play close to other children using the same kind of toy or materials, but not necessarily interact with them • Will struggle with sharing and turn taking
Toddlers 25-36 Months	• Might play with other children but in an occasional, brief, or limited way. For example, a child might play "monsters" or run around chasing other children for a brief period • Older toddlers might begin to cooperate with other toddlers in a shared play activity. For example, children might work together to build a block tower. Or, they might work together to paint a picture together, complete a puzzle, or take on roles and act out a story. One child might pretend to be the "baby," while another is a "mom." • Begin to use their imaginations in their play. For example, toddlers might pretend to give a doll a bottle, pretend to do household chores like cooking or cleaning, or pretend that the shoebox is a garage for toy cars. • Still play alone frequently. • Will struggle with sharing and turn taking.

Playing with your child in the first three years of life helps the two of you build a warm and loving relationship. Playing together also supports the development of essential social skills (like sharing and turn taking), language skills (like labeling objects, making requests, commenting), and thinking skills (like problem-solving).

For babies and toddlers, play is their "work." It is through play and repetition that babies and toddlers try out and master new skills. Through play, they learn what can happen as a result of an action, explore their imagination and creativity, learn to communicate, and learn about relationships with other people. Any activity can be playful to young children, whether it's a game of peek-a-boo or helping you wipe the table with a sponge. And all types of play help children learn and practice new skills.

As a parent, you are your child's very first and favorite playmate. From the very beginning of his/her life, he/she is playing with you, whether watching your face at meal time or listening to your voice as you sing during a diaper change. Your baby needs you to help him/her learn to play and develop social skills to connect and build friendships with others. As your child grows, he/she will use the skills learned with you and other caregivers to have fun, enjoy, and play with other children. Your child will also learn what is appropriate to play with and what is not. For example, he/she might learn that it is okay to play with a sippy cup but it is not okay to put it in the trash.

Playtime is special. Playing together with your child is not only fun, but a critical time to support your baby or toddler's healthy development. Making time to play with your child each day is not always easy. However, setting aside a brief period every day to play together goes a long way in building a loving relationship between you and your child. Making time for play, especially active play, can also help in reducing your child's challenging behavior.

So what can you do to make the most of your child's playtime? Check out the tips below.

Follow Your Child's Lead

Provide an object, toy, or activity for your baby or toddler and then see what he/she does with it. When your child plays, it's okay if it's not the "right" way...let him/her show you a "new way." For example, when you hand your child a plastic cup, instead of pretending to drink from it, he/she might put it on his/her head as a "party hat". Support your child's creativity and join in the birthday play.

Go Slowly

It's great to show your child how a toy works, but try to hold off on "doing it for him/her" every time. You can begin something, such as stacking one block on another, and then encourage your child to give it a try. Providing just enough help to keep frustration at bay motivates your child to learn new skills.

Read Your Child's Signals

Your little one might not be able to tell you with words when he/she's had enough or when he/she's frustrated. But your child has other ways—like using sounds, facial expressions, and gestures. Reading these signals can also tell you what activities your child prefers. Reading the signals that come before a tantrum help you know when to jump in or change to a new activity.

Look at Your Play Space

Is the area where you play child-friendly and child-safe? Is there too much noise or other distractions? Is the area safe to explore? Is this a good place for the activity you've chosen, such as running, throwing balls, or painting? Checking out your space beforehand can prevent a tantrum, an accident, or a broken lamp.

Play It Again, Sam

While doing things over and over again is not necessarily thrilling for Mom and Dad, it is for young children. They are practicing in order to master a challenge. And when your child can do it "all by myself!" he/she is rewarded with a powerful sense of his/her own skills and abilities—the confidence that he/she is a smart and successful being. The more children have a chance to practice and master new skills, the more likely they are to take on new challenges and learn new things. So when you're tempted to hide that toy because you don't think you can stand playing with it one more time, remember how important repetition is to your child's development.

Look For Ways to Adapt Play Activities to Meet Your Child's Needs

All children learn through play, and any play activity can be adapted to meet a child's unique needs. The suggestions below can help parents of children with special needs as well as other parents think about how to make playtime enjoyable and appropriate to their child's skills, preferences, and abilities.

- **Think about the environment.** How do variables like sound or light affect your child? What is the background noise like in your play area? Is there a television or radio on? Are there many other kids around? If your child seems distressed during playtime, and you've tried everything else, move to a quieter, less stimulating area to play.
- **How does your child respond to new things**? Some infants and toddlers, particularly if they have a special need, are easily overstimulated, while others enjoy a lot of activity. Try starting playtime slowly, with one toy or object, and gradually add others. See what kind of reactions you get. Are there smiles when a stuffed bear is touched and hugged? Does your child seem startled by the loud noises coming from the toy fire engine?
- **How does your child react to different textures, smells, and tastes?** For example, some objects might be particularly enjoyable for your little one to touch and hold. Others might "feel funny" to them. Read your child's signals and change the materials you are using accordingly.
- **Involve peers.** It is important for children to establish relationships with other children their age. Encourage siblings to play together. Arrange times to play with other children or family members. Check out opportunities to play with other kids at the park or during free public library story hours. Having fun with peers is an important way for children to learn social skills like sharing, problem solving, and understanding others' feelings—and also helps prepare children for the school setting later on.

Ideas for How to Play With Your Child

Sometimes it is difficult to figure out how to play with a very young child, especially if he/she is too young to play with toys or other children. Remember that your smile and attention are your baby's favorite "toys." Watch for your child's cues that he/she is ready to play. Play when he/she is calm, alert and content. Let him/her cuddle and rest when he/she is tired, fussy, or hungry. Below are just a few ideas to spark your own playtime adventures.

For Babies Under 6 Months

- Imitate the sounds your baby makes and try to have a "conversation" with your baby as you coo or babble back and forth to each other.
- Sing your favorite songs or lullabies to your baby.
- Talk to your baby about what you are doing. You might say, "I'm starting to cook dinner. First I wash my hands, etc." or "I'm going to change your diaper now. First we take off your pants."
- Talk to your baby about his/her surroundings, for example, "Look at your brother—he is laughing and having so much fun!" or "Look at those bright lights."
- Read to your baby. Point out bright colored pictures with contrasting bright colors.
- Let your baby touch objects with different textures. Hold a toy within reach so he/she can swat it with his/her hands or feet.

For Babies 6 to 12 Months

- Start a bedtime routine that includes time to interact with your baby and read or describe pictures from books.
- Use bath time as a time to gently splash, pour, and explore the water.
- Play peek-a-boo by covering your face and then removing your hands while you say, "Surprise!" or "Peek-a-boo!" and make a surprised facial expression.
- Hide your child's favorite toy under a blanket and ask him/her where the toy went. Encourage your child to look for it and/or help him/her find it. You can ask, "Where did your bear go? Is it on the couch? Is it behind the pillow? Oh, here it is under the blanket!"
- Play hide and seek. "Hide" yourself (leave lots of you showing!), and if your child is crawling, encourage him/her to come and find you.

- Imitate your child's sounds. Encourage a dialogue by taking turns listening and copying each other's sounds.
- Use containers to fill with objects like toys or sand, and dump them out. You might use a shoebox with soft foam blocks or other baby-safe small toys.

For Toddlers 12-24 Months

- Sing special songs while changing a diaper or getting ready for bed.
- Keep reading and talking together. When looking at a book, ask your child questions about the pictures like, "Where is the doggy?" Show your excitement by acknowledging when your child points to the object: "Yes, you know where the doggy is!"
- Hide behind a door, the couch, or the high chair, then pop up and say, "Surprise!" If your child enjoys this game, change the location where you pop up. For example, if you usually pop up from under the high chair, try popping up from under the table. This switch will delight him/her!
- Use play objects to act out pretend actions. For example, use a toy phone to say, "Ring ring ring. It's the phone. Hello. Oh, you are calling for Teddy. Teddy, the phone is for you." Use a toy car to move across the floor saying, "Vroom, vroom, go car go!"
- Help your child stack blocks and then share his/her excitement when he/she knocks it down.
- Explore the outdoors by taking walks, visiting a park, or helping your child run up or down grassy hills.

For Toddlers 24-36 Months

- Continue to read and talk often to your child. When looking at books together, give your child time to look at the pictures before reading the words. Begin to ask questions about the book such as, "Why did he do that?", "What happens next?", and "Where did she go?"
- Dance and jump around to music and encourage your child to join you.
- Support your child's imagination by providing dress-up clothes like scarves, hats, pocketbooks, or your old shoes; and props such as plastic kitchen bowls and plates, or toy musical instruments.
- Encourage your child's creativity by playing with crayons, markers, play dough, finger paint, paints, etc.
- Use play objects that look like the "real" thing: child-sized brooms and dust pans, pots and pans, toy cash registers, etc.

What can you do when your child's play is inappropriate or dangerous (e.g., throwing the sippy cup in the trash, pulling at the lamp, etc.)?

- Try to give your child an acceptable way to meet his/her goal. For example, show him/her how to throw the ball into a laundry basket instead of into the trash.
- Use words to validate your child's desires: "You want to pull that lamp. You want to see what will happen. You are playing a game. You want me to come close and play with you."
- Show your child what he/she can do: "You can put it in this basket"; "You can put the socks in the hamper"; "You can push this block tower down."
- Distract or redirect your child to another toy or game with you: "Look at this toy." "Do you see how this toy moves?"

- When you tell your child, "No" or "No touch, it is dangerous," direct him/her to what he/she can do: "No touch, look with your eyes."
- Remove the object, if possible, to make the play area more child-friendly.
- Remove the child from the area or activity: "Let's play over here instead."
- Use humor and join the game: "You just want me to come chase you. Now I'm going to tickle you."

What happens when my baby or toddler has difficulty moving on from play time? What if, like Jamia, she doesn't want to stop?

- Tell your child when a transition is coming: "one more time," "last time."
- Give your child a visual reminder of the transition. Set a kitchen timer or egg timer for "two more minutes" or "five more minutes."
- Explain what is happening: "I have to stop playing now. I have to make dinner."
- Provide an alternative activity: "I can't play anymore, but you can sit at the table while I cook and color with crayons."
- Provide a choice: "You can do a puzzle or play with cars."
- Use words to validate your child's feelings: "You want to play longer." "Again? You want to do it again." "You feel sad that it is time to leave the park."
- If your child becomes upset, validate his/her feelings and try to provide words of comfort: "I know you are mad because I have to change your diaper now. You want to keep playing. We'll play again after your diaper change."

Adapted with permission from: "ZERO TO THREE. (n.d.) Make the most of play time." Retrieved May 22, 2008, from www.zerotothree.org/site/PageServer?pagename=ter_key_play_tips&AddInterest=1154

The Center on the Social and Emotional Foundations for Early Learning

Child Care Bureau

Office of Head Start

AM Breakout Session #2

Afraid you are opening Pandora's box? How to Successfully Integrate Early Childhood Mental Health Concepts into Home Visits.

Michele Rogers, Ph.D.
Executive Director, Early Learning Institute

Michele Rogers, Ph.D. is the Executive Director and Co-founder of the Early Learning Institute. Ms. Rogers has her PhD in psychology with an emphasis in early childhood mental health/neurobiology from the University of Colorado, Denver. She worked for several years on Sonoma County's Early Childhood Mental Health task force, focusing primarily on creating a system of care for children 0-5 that includes social-emotional supports. Ms. Rogers is a certified childbirth educator and lactation specialist; has been NCAST certified at the research level and completed a Fellowship in the UMass Boston/Harvard Infant-Parent Mental Health Post-Graduate Certificate Program (Napa site).

Afraid you're opening Pandora's Box?

How to successfully integrate ECMH concepts into home visits

Workshop Outline

I. Why is this Important? Is this even MY Job?!

II. Core ECMH Concepts for Home Visitors

1) Learning Happens within the Context of Relationships (Attachment matters)
2) Play *is* an intervention – for children and adults! (Positive experiences matter)
3) Words well-spoken can make all the difference (Words matter)
4) Environments matter
5) Routines matter
6) Responses matter

III. Best ECMH Support Strategies for ANY type of Home Visitor –

1) Use Teachable Moments
2) Reframing and Rephrasing (Rinse and Repeat…)
3) Listening *is* doing something

IV. Unexpected Disclosures

1) Your initial response is REALLY important
2) Relevance
3) Timing

V. Necessary Conversations

1) Revisiting a Disclosure
2) Sharing an Observation
3) Answering a Hard Question

VI. Self-Care

What do you do AFTER a tough visit?

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Afraid you're opening Pandora's Box?

How to successfully integrate ECMH concepts into home visits

WORKSHOP NOTES

Why is this Important? Is this even MY Job?!

Define "Early Childhood Mental Health"

Influences on ECMH

Reality Check – Might not be in your job description but it is in your job!

Core ECMH Concepts for Home Visitors

Learning Happens within the Context of Relationships (Attachment matters)
What exactly *is* Attachment?

Attachment Myths

Home Visiting Relationships – The Triangle

Play *is* an intervention – for children and adults! (Positive experiences matter)
Build humor and fun into every home visit if at all possible

Words well-spoken can make all the difference (Words matter)
It's not just what you say but when to say it

Use Questions wisely

Let's talk about being --
Sad/Angry/Judgemental/Condescending/enabling/excusing/normalizing/minimizing

Environments matter
What does is "feel" like when you visit? For you? For Parent? For Child?

Toxic Stress tolerance – both for families and Home Visitors

Novelty in small doses is good for the brain

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Routines matter
Children need consistent care, smooth transitions, and predictable patterns of behavior

So do their parents…
Responses matter
Engagement cues/Disengagement cues

Respectful parenting

Communication loops

Discipline and impulse control

Best ECMH Support Strategies for ANY type of Home Visitor –
Use Teachable Moments

Reframing and Rephrasing (Rinse and Repeat…)

Listening *is* doing something

Unexpected Disclosures
Has this ever happened to you? What prompted the disclosure?

Your initial response is REALLY important

Relevance – What does the disclosure have to do with what is happening

Timing – Why Now? (Consider age of child/relationship between HV & Parent/Hidden agenda of disclosure)

Necessary Conversations
Revisiting a Disclosure

Sharing an Observation

Answering a Hard Question

Self-Care

What do you do AFTER a tough visit?

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AM Breakout Session #3

Adverse Childhood Experiences (ACEs) in the Perinatal Period: Implications for Bonding and Attachment

Allison Murphy, LMFT, Mother & Care

Jennifer Silverstein, LCSW, IFMHS, Private Practive

Allison Murphy MFT, is the Founder and Executive Director of Mothers Care, an innovative evidence-based perinatal mood and anxiety disorder screening and treatment program located in Sonoma County, CA. Allison is an ACE Interface Master Trainer and the Co-chair of the Mental Health and Substance Abuse workgroup for Community Health Initiative for the Petaluma Area. Allison's experience includes an instructor at Sonoma State University, a consultant/trainer on the topic of perinatal mood and anxiety disorders to state and local organizations and a radio co-host.

Jenni Silverstein, LCSW is an Infant-Family Mental Health Specialist with over 17 years experience in supporting families during the transition into parenthood, and fostering early childhood mental health. Jenni is a Napa Infant-Parent Mental Health Fellow, and she is currently completing the Child Trauma Academy Neurosequential Model of Therapeutics training. She works in private practice Santa Rosa and Sebastopol, as a staff therapist for Mothers Care, and as a consultant for the Early Learning Institute.

- Perinatal Mood and Anxiety Disorders (PMADs)
- Adverse Childhood Experiences (ACEs)
- Neurodevelopment
- Implications of trauma on attachment and Neurodevelopment

Allison Murphy, MFT

Dance me to your beauty with a burning violin
Dance me through the panic till I'm gathered safely in
Lift me like an olive branch and be my homeward dove
Dance me to the end of love
Dance me to the end of love

Allison Murphy, MFT

Relational Tasks of a Family with a New Baby

Restructure
Define and redefine:
- Roles
- Routines
- Functioning
- Connection

These are impacted by untreated Perinatal Mood and Anxiety Disorders (PMADs) and Adverse Childhood Experiences(ACEs)

Perinatal Mood and Anxiety Disorders (PMADs)

Perinatal: Pregnancy to one year PP

Mood and Anxiety Disorders includes the following mental health diagnoses
- Depression
- Anxiety: Panic Disorders, Agoraphobia, OCD
- PTSD
- Bipolar Disorder
- Psychosis

Adverse Childhood Experiences Study

Before the age of 18
Interpersonal:
- family, household member and/or friends*

Indicators measured:
- Household dysfunction
- Neglect
- Abuse

10 items questionnaire w/ max score of 10

Allison Murphy, MFT

ACEs and PMADs

Dose response
Toxic stress- increased stress response
Impacts brain development
ACEs are common, inter-related, and powerful

ACEs impacts PMADs
Not all PMADs are associated with ACEs

Rates of PMADs

2017, California Task Force on the Status of Maternal Mental Health Report

MMH Disorder	During Pregnancy	Postpartum
Major Depressive Disorder	5.6%	7.1%
Minor Depressive Disorder	7.3%	12.1%
Gen Anxiety Disorder	0-11%	6-10%
Panic Disorder	0.2-5.7%	1.4-10.9%
OCD	0-5.2%	2.7-3.9%
Perinatal Post traumatic Stress	n/a	3.1%
Bi-polar Disorder	2.8%	2.8%
Postpartum Psychosis	n/a	0.1-0.2%

In Sonoma County:

- Nearly 1/3 women, reported they needed help for emotional/mental health problems or use of alcohol/drugs.[1]
- Pregnant women with a mental health diagnosis were hospitalized nearly 2.5X the California average.[2]
- From 2005-2013, the number of emergency department visits of women with a mood disorders has increase by 4X.[2]

1/7 women experience postpartum depression in the United States.[3]

"I felt completely consumed by a dark fog. I lost interest in everything and pulled away from my children and husband. I stopped calling friends. I just wanted to disappear. I believed I was the worst mother and wife in the world. The guilt I felt was overwhelming."

Allison Murphy, MFT

Postpartum Depression

- #1 most common postpartum complication
- Most under-diagnosed ob complication
- More common than PP anemia
- Not routinely or uniformly screened: United States Preventive Services Task Force, American Colleges of OB/GYN
- Can be fatal

Sonoma County Perinatal Depression Rates

2013-14 CA Department of Public Health Maternal Infant Health Assessment (MIHA)

Sonoma County

- Prenatal depression: 14.8 %
- Postpartum depression: 13.3%

These statistics do not account for perinatal anxiety, perinatal OCD, perinatal bi-polar disorder, or postpartum PTSD or psychosis

- Experienced 2 or more hardships during childhood: 26.8%

ACEs Rates

CA:
4 or more: 15.9%
1-3 ACEs: 45.1%
0 ACEs: 39%

Sonoma County:
4 or more: 21.6%
1-3:ACEs: 40%
0 ACEs: 37.5%

Mothers Care:
4 or more: 33%

PMAD screening:
58% with Edinburgh Postnatal Depression Screening of >10 received services
14% of total screened that services

Baby Blues

- Mild sadness
- Tearfulness
- Anxiety
- Irritability-no clear reason
- Fluctuating moods
- Increased sensitivity
- Fatigue
- Symptoms subside in 10-14 days postpartum
- Duration and severity*

Anxiety

- Agitated and/or Angry
- Trouble concentrating and remembering things: misdiagnosed as "nursing brain, baby brain"
- Difficulties finishing everyday tasks/making decisions
- Difficulty relaxing
- Insomnia-Exhaustion
- Feelings of extreme uneasiness for prolonged periods of time
- Loss of appetite/lack of hydration
- Possible suicidal thoughts
- Panic Disorder -Agoraphobia

Allison Murphy, MFT

Bipolar Disorder I and II

- Mania/Depression
- Rapid and severe mood swings (mixed state)
- Bipolar Disorder II is less severe
- Periods of severely depressed mood and irritability
- Mood much better than normal
- Rapid speech
- Little need for sleep
- Racing thoughts, trouble concentrating
- Continuous high energy
- Overconfidence
- Delusions (often grandiose, but including paranoid)
- Impulsiveness, poor judgment, distractibility
- Grandiose thoughts, inflated sense of self-importance
- In the most severe cases, delusions and hallucinations

Postpartum Depression

- 2 to 4 weeks postpartum, more days than not
- Symptoms range from mild to severe
- Sleeping disturbances:
  - insomnia or hypersomnia
- Persistent low mood
- Suicidal ideation
- Lack of feeling towards baby: "feeling flat"
  - Projected feeling on to baby*
- No appetite: weight loss and weight gain
- Feeling overwhelmed
- Feeling of worthlessness and inappropriate guilt

Obsessive Compulsive Disorder

- Obsession usually involving the baby-intrusive thought is that the mother will hurt the baby
- Mother knows that the thought is abnormal: is often horrified and ashamed.
- Is scared to tell someone for fear her child will be removed by authorities
- Avoidance behavior
- Repetitive behavior: counting
- Obsessive Cleaning: fear of germs, focus on hygiene
- Unrelenting perfectionism
- Hoarding
- 70 % of women with postpartum OCD have had some history or previous symptoms of OCD.

Considerations Bipolar I and II

- Working with a team: Ob/Gyn, Psychiatrist, Social Workers at hospital
- Preconception counseling and treatment planning is critical
- Medication management during preg/postpartum
- Possible precursor to psychotic episode
- AOD
- mothertobaby.org

PMADs Underreported and Underestimated

Under-reported by patients
- Patient minimizes symptoms:
- Due to lack of awareness
- Unstable symptomology
- Stigma/embarrassment/fear

Underestimated by Providers
- Not comfortable "driving the conversation"
- Lacks awareness, subtle symptoms
- If the patient does not seem to have a problem, there is no problem
- Result is an undetected PMAD

Rates of Underestimation
- 6.3% to 35.4% (Evins et.al, 2000)
- 3.7% to 10.7% with routine screening. (Georgiopoulous et. al. 2001)

Predictors for PP Depression

- Not having a partner
- Financial stress
- Mental health history-associated with ACEs
- Unwanted pregnancy
- Unplanned pregnancy-associated with ACEs

- Barson R. 2006. ***Considering Interventions for Depression in Reproductive Age Women in Family Planning Programs***. Baltimore, MD. Women' and Children' s Health Policy Center. Johns Hopkins Bloomberg School of Public Health.

Adverse Effects of Untreated Depression

- Diminished quality of life and personal suffering
- Increased health care services: anxiety/depression manifest somatically
- Poor self care, decreased use and compliance with prenatal care
- Lower than expected weight gain during pregnancy
- Higher risk use of AOD
- Negative implication for bonding and attachment

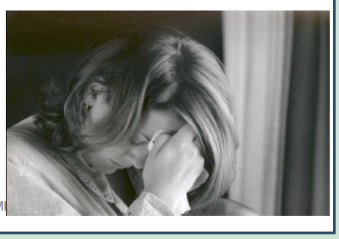
Psychosis

- The earliest signs are restlessness, irritability, and insomnia-resembles a manic episode
- Rapidly shifting depressed or elated mood, disorientation or confusion, and erratic or disorganized behavior.
- Hallucinations: Auditory hallucinations that instruct the mother to harm herself or her infant may also occur.
- Delusions: center on the infant
- Illogical thoughts: losing touch with reality
- Insomnia
- Refusing to eat
- Overwhelming guilt that they done something wrong
- Suicidal or homicidal thoughts
- Typically within 3-5 days of delivery-not always

Always an emergency: Hospitalize immediately

Etiology

- No consensus: multi-factorial
- Biological vulnerability
- Dramatic hormonal shift
- Hypothyroidism/Hyperthyroidism



Allison Murphy, M

Contributing Factors

- Lack of sleep
- Labor and Delivery
- Infant Care/Feeding
- Fertility Treatments and Miscarriages
- History of Psych diagnosis
- Social-Relational

Adverse effects of untreated PMAD on mother and family

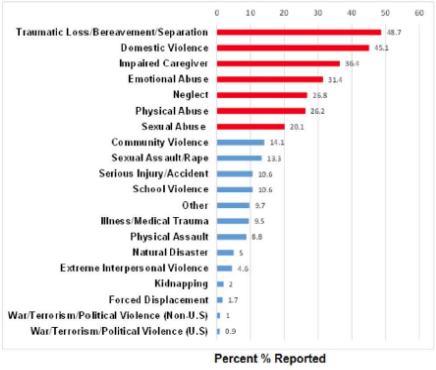
- Poor maternal-child attachment
- Developmental delays: language delays
- Behavioral difficulties
- Lower cognitive performance
- Mental health disorders
- Attention problems
- Comorbid depression w/ partner and baby

There is No Single "Best" Term

- Child trauma and adversity come in many forms and no term covers all of them.
- In this Narrative we use ACES (Adverse Childhood Experiences) because it is one of the better known terms among the many audiences this Narrative seeks to reach.
- The basic findings of the original ACES research[1] have been independently replicated by many different studies.

The ACES are Among Many Childhood Traumas and Adversities Measured by the National Child Traumatic Stress Network N=10,991[1]

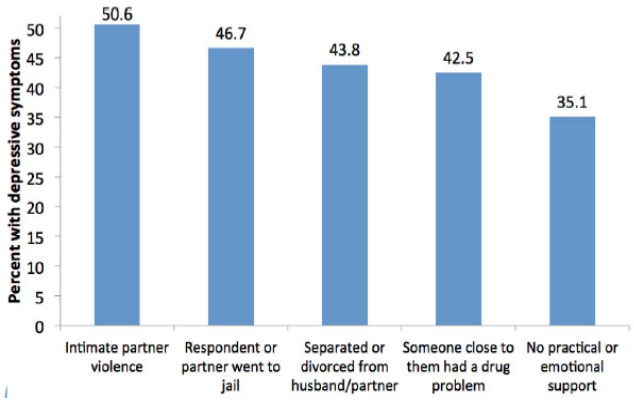
- The original ACES (**in red**) are among the most commonly reported traumas in studies that look at additional traumas.
- Over 40% of the children and adolescents served by the NCTSN experienced 4 or more different types of trauma and adversity.



[1]Pynoos et. al (2014). Psychological Trauma: Theory, Research, Practice and Policy. 6:S9-S13.

CANarratives.org

Depressive symptoms by interpersonal stressors during pregnancy



How the ACES Work

Adverse Childhood Experiences
- Abuse and Neglect (e.g., psychological, physical, sexual)
- Household Dysfunction (e.g., domestic violence, substance abuse, mental illness)

Impact on Child Development
- Neurobiologic Effects (e.g., brain abnormalities, stress hormone dysregulation)
- Psychosocial Effects (e.g., poor attachment, poor socialization, poor self-efficacy)
- Health Risk Behaviors (e.g., smoking, obesity, substance abuse, promiscuity)

Long-Term Consequences

Disease and Disability
- Major Depression, Suicide, PTSD
- Drug and Alcohol Abuse
- Heart Disease
- Cancer
- Chronic Lung Disease
- Sexually Transmitted Diseases
- Intergenerational transmission of abuse

Social Problems
- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- High utilization of health and social services
- Shortened Lifespan

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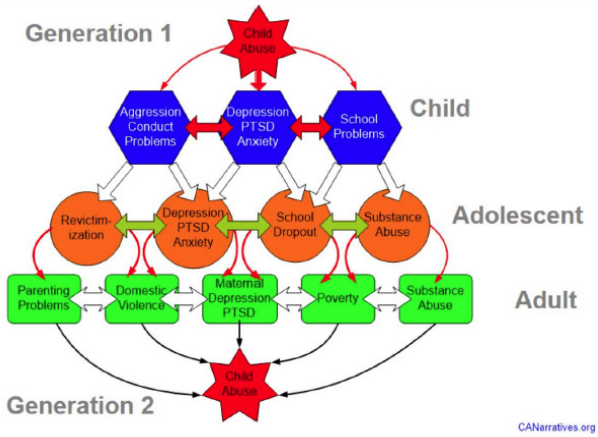
How ACES Cross Generations



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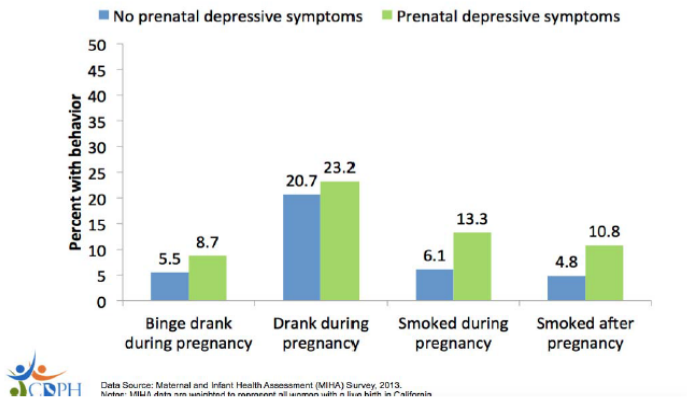
Impact on Attachment

Toxic Stress
Emotional Regulation
Intergenerational attachment
Untreated Trauma

Impact on Pregnancy

Increase	4 or More ACEs	Untreated PMAD
Preterm Birth/Short Gestation	X	X
Low Birth Weight	X	X
Miscarriage	X	X
Preeclampsia	X	X
Gestational Diabetes	X	

Substance use is greater among women with prenatal depressive symptoms



Data Source: Maternal and Infant Health Assessment (MIHA) Survey, 2013.

Allison Murphy, MFT

Impact on Family Life

ACEs associated with:

- Depression
- Teen Pregnancy
- Marital Discord
- Risky behavior during pregnancy
  - Tobacco smoking
  - THC use

Hope and Change

- Neuroplasticity
- Resilience
- Preventable
- Protective Factors
  - Family and social relationships
  - Self care
  - Protective and Healthy community

Sexual Abuse and Birth Trauma

PTSD
Impact during:

- Pregnancy
- Birth
- Postpartum

- Birth Trauma

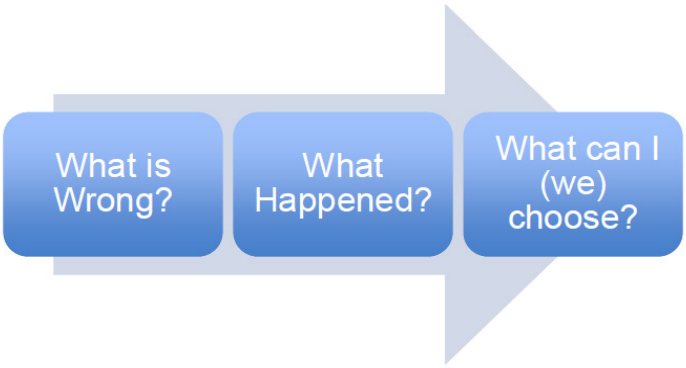
Barriers to Treatment

- Stigma of PMADs (i.e. Andrea Yeats)
- Fear children will be removed
- **Expectations**
- Self and culturally imposed isolation
- Culturally imposed stigma to MH--better to have a physical illness
- Can feel different than a "regular" depression- lack of education
- Shame

Systemic Barriers to Treatment

- Lack of universal and interval screening
- Lack of proper professional assessment – symptoms are minimized by patient, family and professional
- Inadequate insurance coverage; especially for mental health services, concerns about $$
- Lack of transportation
- Communication barriers
- Lack of Mental Health Provider trained in Maternal Mental Health and PMADs

Call to Action



Allison Murphy, MFT

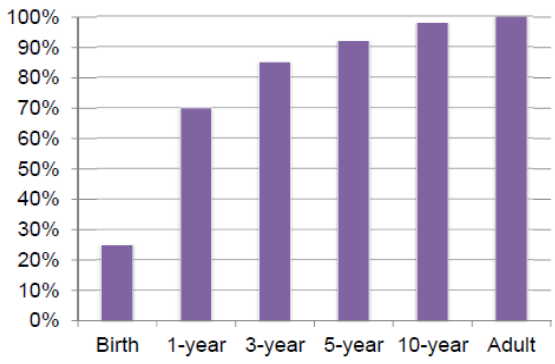
Call to Action

- Education prior to pregnancy
- Universal and interval screening during pregnancy and postpartum PMADs
- Become a trauma-informed organization- ACEs Interface Training
- Ob-Gyn, Pediatricians and mental health professional coordinated care
- Effective and evidenced-based maternal mental health programs/treatment- includes ACEs screening

Human Brain Complexity

- 84 billion neurons
- Each has 10,000 synaptic connections
- Electrical impulses through synapses: 10 to the 1-million possible on/off combinations
- Human brain is the most complex thing in the known universe

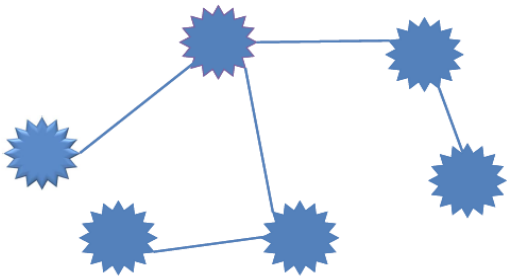
Brain Development



Brain Size Relative to Adult Brain

Neurons that Fire Together Wire Together

"CAT"



Experiences Shape the Brain

- Humans are born with very underdeveloped brains: relatively few interconnections among neurons
- Adaptive feature given complexity of human experiences – especially social network
- Plasticity: Capacity to adapt to environment and change over time

Sequential Neurodevelopment

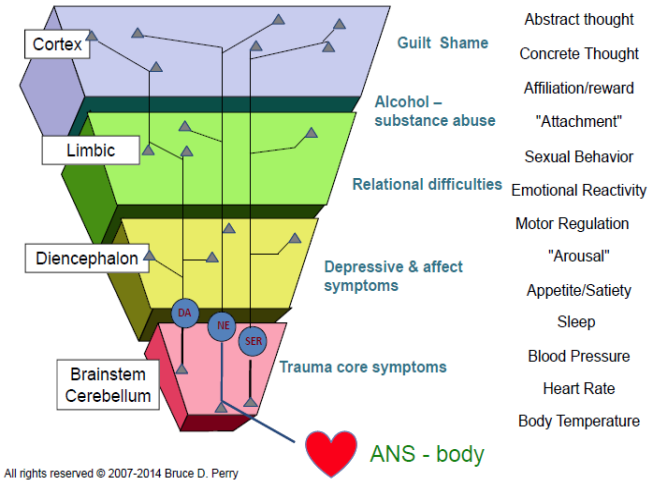
- Brain organizes from the bottom up and inside out
- Evolutionary sequence: the most complex (human) areas of the brain develop last
- Lower areas of brain must be well organized for complex areas of brain to function optimally
- Brain is most malleable in early childhood = great opportunity and great vulnerability.

Use Dependent Development

- Patterned, repetitive activity reinforces formation of brain circuits
- The most used areas of the brain are the most developed
  - When children live with fear, the areas of their brains controlling the fear response can become overdeveloped.
  - When children lack relational interaction, the areas of the brain controlling empathy and social bonding can be under-developed

Memory

Changes in connections among neurons that lead to associations between co-occurring sensory signals



Implicit Memory

- Nonverbal: emotions, behavior, perception, sensation
- Present at or before birth
- Encoded without conscious attention required
- Unaware of recall
- Important social and emotional lessons from first years are experienced as "givens"
- Channels our perceptions and expectations
- Unconscious influence on present

"For the infant and young child, attachment relationships are the major environmental factors that shape brain development during its period of maximal growth… Human connections create neuronal connections." Dan Siegel

Attachment

- Infant attachment behaviors promote proximity to caregivers for protection from danger
- Caregiver's attuned response to attachment behaviors leads to greater autonomy
- Secure base: trust that world is safe and needs will be met, explore world in healthy way
- Attachment to primary caregiver is generalized: will become internal working model of relationships

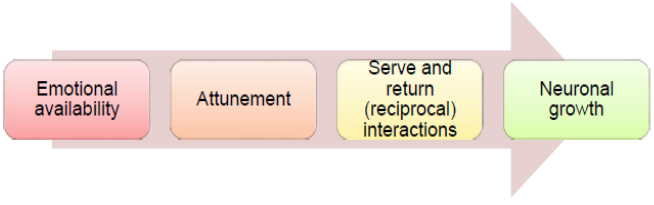
4 S's of Attachment

- Safe: protect from harm
- Seen: seeing baby's subjective experience enables us to meet their needs
- Soothed: mutual regulation – immature brain depends on adult to help ease distress
- Secure: over-all feeling of security

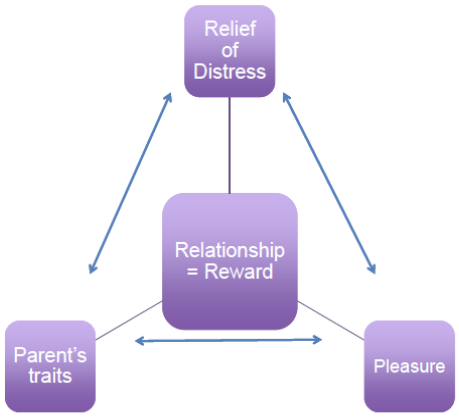
Relationships & Brain Development

- Early relationships are the fundamental organizing experiences for neural networks
- Human brain is "shaped by evolution to be exquisitely sensitive to the people who surrounded it."

Secure Attachment Creates Brain Structure



Relationship and Reward



Sensitive Periods

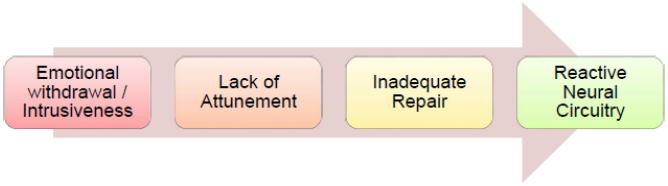
- Adverse events impact children differently at different times of life
- The part of the brain most rapidly developing (with the most moving parts) will be most affected
- Disruption to lower brain development will impact future development of higher brain functioning
  - Disruption of neurochemical pathways
  - Disorganized states
- Once a part of the brain reaches functional maturity, it is very difficult to change

Internalized Parent

- Primary caregivers are the stress regulation system for infants and young children
- To develop healthy self-regulation and sense of self, infant must internalize
  - Soothing touch
  - Secure holding
  - Comforting warmth
  - Homeostatic balance
  - Emotional regulation
  - Sustained positive emotion
  - Rupture and repair

Relationships & Brain Development

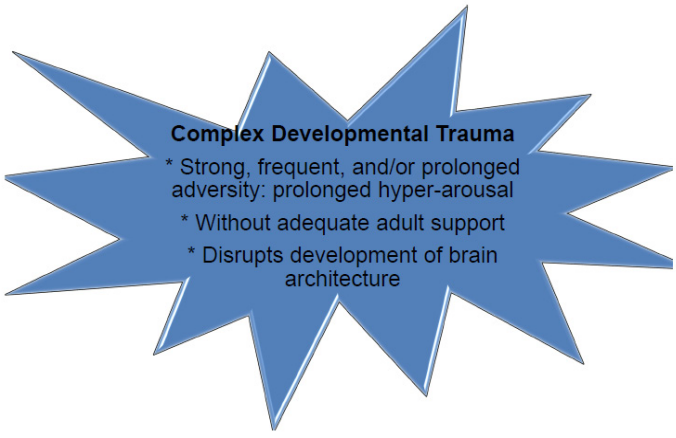
- Early relationships are the fundamental organizing experiences for neural networks
- **Small, frequent negative interactions / failures to repair have a cumulative effect as patterns of interaction shape brain structure**



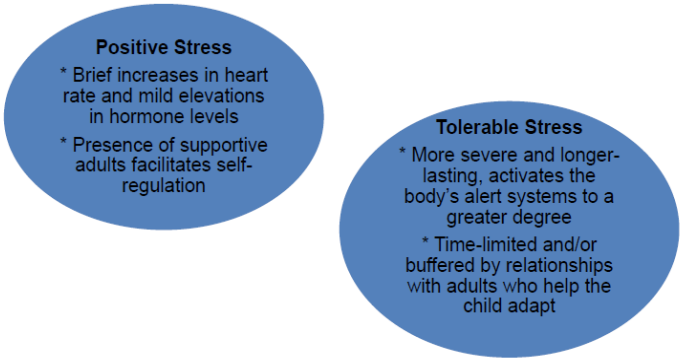
PMADs & Attachment Disruption

- Decrease in maternal sensitivity and responsiveness
- Decreased engagement in face to face play
- Increase in negative affect of infant
- Decreased interactive coordination / mutual regulation
- Decreased capacity to repair
- Increase in negative meaning making

Toxic Stress



Manageable Stress



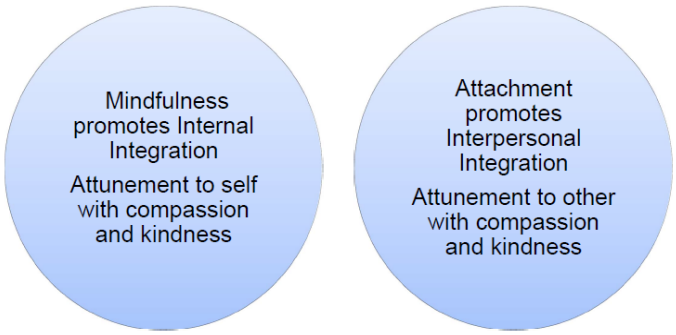
Neglect

- Global
  - Severe and chronic lack of nurturing / interaction
  - Global developmental delays
  - Reactive Attachment Disorder
- Episodic
  - Lack of nurturing of one or more developmental areas
  - Developmental delays
- Chaotic
  - Inconsistent interaction, inconsistent attunement
  - Social / Emotional delays
  - Hyperarousal: distrust in environment

Complex Developmental Trauma

- Ambient, cumulative relational trauma
  - Toxic stress
  - Chaotic neglect
- Inhibits opportunity for growth promoting interactions
- Disrupts development of brain architecture
- Mislabeled as a variety of childhood diagnoses (ADHD, ODD, Sensory Processing, Learning Differences, etc.)

Mindfulness & Attachment



Mindfulness & Attachment

- Mindfulness develops the same areas of brain as secure attachment
  - Indices of well-being are identical
- Secure attachment correlates to mindfulness traits in adults
- Mindfulness-based interventions provide opportunity to simultaneously promote maternal wellbeing while enhancing attachment status

Promote Maternal Self-Regulation

- Respite
- Social Support
- Exercise
- Deep breathing
- Mindfulness tools
- CBT tools
- IPP tools

Promote Dyadic Mutual Regulation

- Utilize rhythm
- Provide gentle developmental guidance
- Speak for baby / Wonder for mother
- Observe baby cues with mother
- Model and support repair
- Define and access unique protective factors

Rhythm

- Swinging
- Rocking
- Drumming
- Music / Dance
- Equestrian therapy / Animal assisted therapy
- Swimming
- Exercise

Promote Shared Positive Experiences

- Routine quality time
- Face to face interactions
- Follow baby's lead
- Promote attuned, contingent communication
- Mirroring / Imitating
- "I Love You Rituals" (Bailey)

Relationships and Resilience

- We are fundamentally social creatures
- Primary caregivers are the stress regulation system for infants and young children
- Communities with strong social networks exhibit less trauma following catastrophic events
- Access to: support groups, partner and family support, warm line

Rhythm

- Lower brain must be regulated before we can access higher brain : bottom-up modulation
- Brainstem regulates through patterned, rhythmic activity because it developed in-utero.
- We instinctively rock babies at 80bpm
- When highly aroused, we unconsciously self-soothe with rhythm

Somatosensory Regulation

- Massage
- Yoga
- Martial Arts
- Occupational Therapy
- Breathing Exercises
- Gardening
- Creative Arts
- Stress balls, etc.

Promote Maternal Efficacy

- Create space for mothering
- Focus on what is working in dyad
- Focus on positive trajectory
- Focus on positive efforts
- Be conscious of your misattunement
  - Ex: Mother's shame-based negative filter
  - Ex: Therapist triggers

AM Breakout Session #4

Sensory Implications of Early Childhood Trauma: Using Sensory Strategies to Support Relationships

Julia Bantimba, MS, OTR/L
Seneca Family of Agencies

Julia earned her MS in occupational therapy at Boston University's Sargent College, and has been practicing as a licensed occupational therapist since 2013. Currently, Julia works for Seneca Family of Agencies as a full-time trauma focused OT consultant to non-public schools. There, she provides consultation through modeling strategies with students, clinical meetings, and trainings to their multidisciplinary team of staff. Prior to Seneca, Julia worked for A Better Way, Inc. in Oakland, CA providing direct therapy for children birth through adolescence, who have extensive trauma and/or are involved in the child welfare system, and who have difficulty with sensory and emotional regulation. Julia also provides consultation services to colleagues of various disciplines and provides trainings on the role of occupational therapy in mental health and the ways in which trauma can impact occupational and sensory function in children and families.

Julia is a faculty member and graduate of the UC Davis-Napa Infant Parent Mental Health Fellowship and trained in multiple models. She has completed certification in: Neurosequential Model of Therapeutics (NMT Phase I), Attachment, Regulation and Competency Model (ARC), the Newborn Behavior Observation, Fussy Baby Level 1, NCAST Feeding Scale, and various Cultural Humility trainings including train-the-trainer. Julia is currently working toward certification as an NMT trainer.

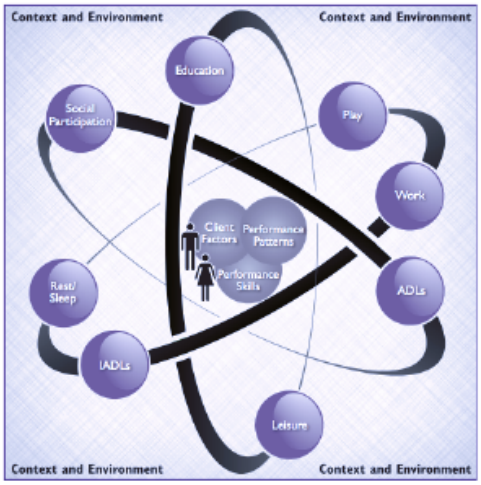
"For optimal parent-child development, the dyad must achieve the milestone of mutual delight"
-Lou Sander

Occupational Therapy

"In its simplest terms, occupational therapists and occupational therapy assistants help people across the lifespan participate in the things they want and need to do through the therapeutic use of every day activities (occupations)." –AOTA, 2015

OT Domain & Process

- Areas of occupation
- Client factors
  - Sensory integration
- Performance skills
- Performance patterns
- Context & Environment
- Activity demands



What is Trauma?

- "Stress is any challenge or condition which forces our regulating physiological and neurophysiologic systems to move outside of their normal dynamic activity. Stress occurs when homeostasis is disrupted. Traumatic stress is an extreme form of stress." (Perry, 2007)
- Children who have had a high level of adverse experience and low relational health are at risk for trauma related delays

Developmental Trauma

Between conception and the 3rd birthday, brain development is occurring more rapidly and extensively than at any other point in life making children highly vulnerable to adverse experience

The parts of the brain developing at this young age are those largely responsible for the organization of sensory material

What we are really talking about today is the lasting impact on the sensory system that early childhood trauma leaves…

In order for you to do your work, children must be in relationship with you and in order for them to be in relationship they must be regulated

Relationships are the agents of change and the most powerful therapy is human love"-Dr. Bruce Perry

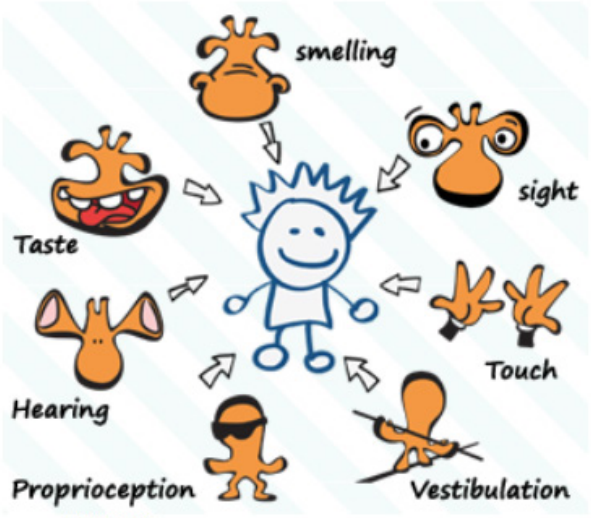
Overview of the Senses & Sensory Integration

Understanding what each part of "sensory" is can be helpful in picking up subtle cues from your clients…and yourself!

EIGHT senses

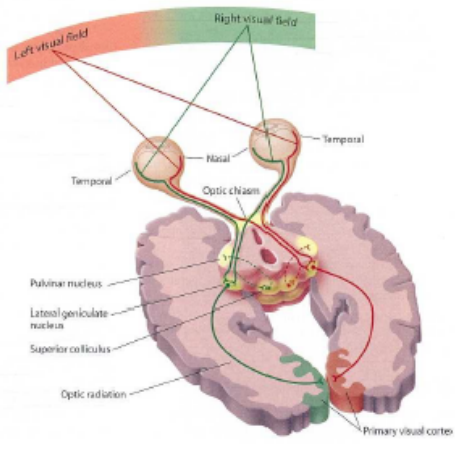
Senses function to protect us from harm. When working correctly they let us know when we may be in danger.

\+ Interoception



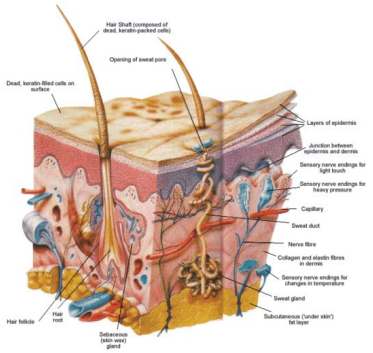
Vision

Visual input enters through the retina and travels through the optic tracts and nerves, through the thalamus and to the visual cortex in the occipital lobe



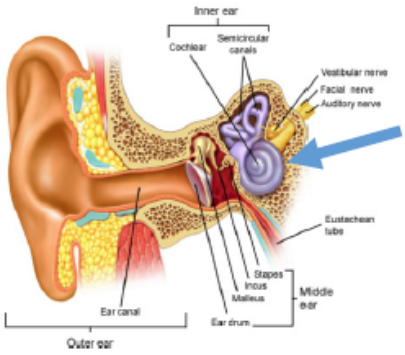
Touch

We have receptors all over our bodies & skin to sense pressure, light touch, vibration & temperature



Vestibulation

The organs that sense balance are located in the inner ear. A series of small tubes filled with fluid allow us to locate the rate of movement and the position of the head.



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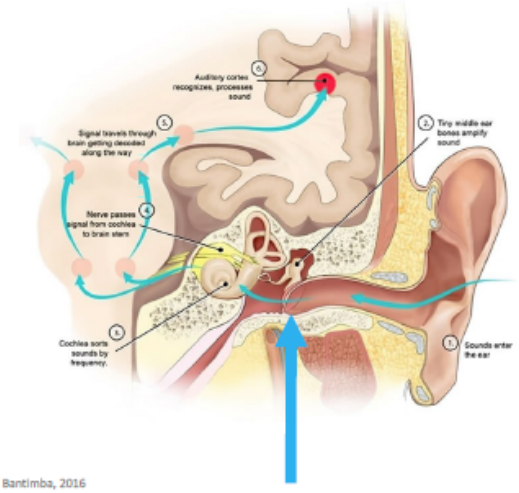
Proprioception

There are receptors located in our muscles, tendons, ligaments and joints that allow us to determine the location of our body parts (without looking)

Hearing (Auditory)

- Sound enters the ear and causes vibration in the small bones in the middle ear. The vibrations are sorted by frequency and are interpreted in multiple brain areas.
- Fast acting- general warning
- Higher up- slow acting and allow for more detailed interpretation (e.g. where sound is located)



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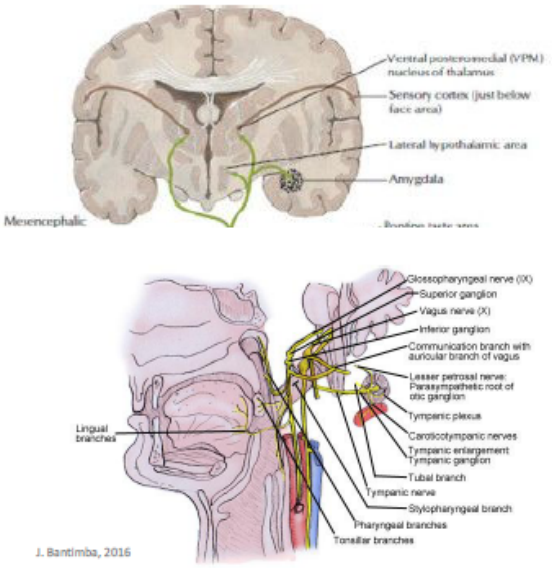
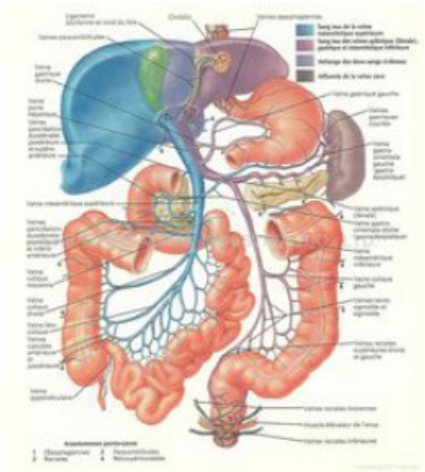
Taste

Taste receptors are located on the tongue, soft palate, pharynx, and in the top of the esophagus. This sense, along with olfaction, allows us to determine whether food is safe to ingest and then also facilitates the beginning stages of digestion.



Interoception

- The sense we have of the inside of the body
  - Hunger/thirst
  - Bladder/bowel filling
  - Pain
  - Temperature
  - Sensual touch



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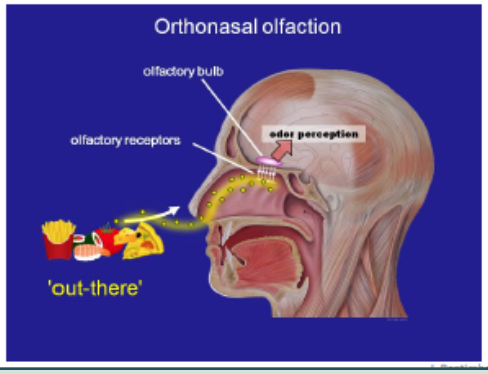
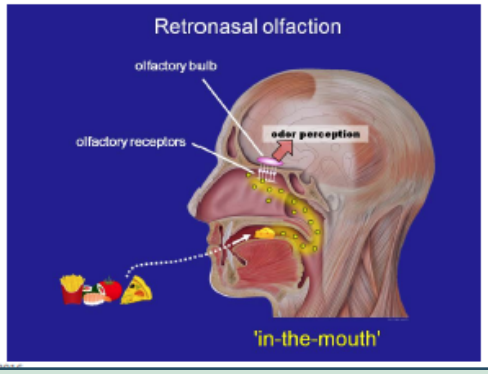
Smell (Olfaction)

- Smell receptors in the nose and mouth sense smells in the external and internal environment
- Smell is thought to be the most primal of the senses
- The majority of smell data goes "directly" to the olefactory cortex and is physiologically closely tied to the areas of emotion
- Smell can be a highly evocative cue for memory and emotion

Smell (Olfaction)

Smell receptors in the nose and mouth sense smells in the external and internal



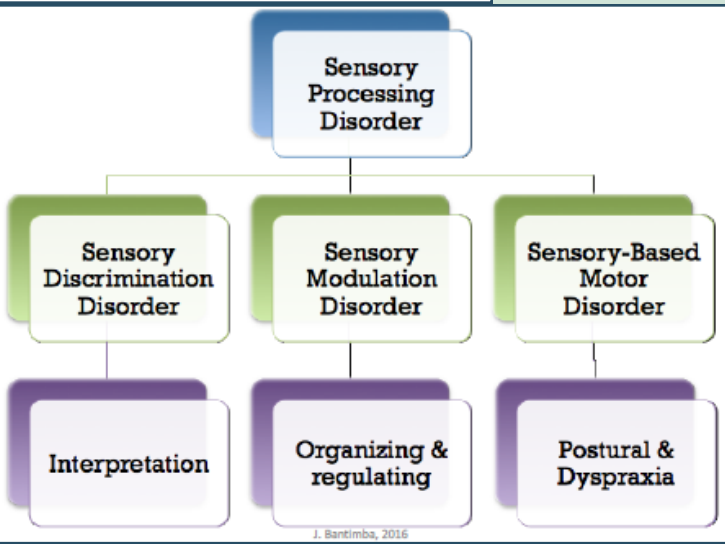


Sensory Integration Process

Sensory Integration is the interpretation and organization of sensation FOR USE

SI Differences are associated with:

- Trauma
- Environmental deprivation
- Autism spectrum and other developmental disorders
- ADHD
- Prematurity
- Cerebral Palsy
- Traumatic brain injury
- Various mental health conditions
- Fetal alcohol spectrum disorder
- Learning disability



Modulation

- Regulating and organizing
- Magnitude of responses to input do not match magnitude of stimuli

Discrimination

- Interpreting types and qualities of stimuli
- Difficulty identifying similarities and differences between stimuli

Sensory-Based Motor Disorder

- Postural: Poor postural stability, balance, and low muscle tone
- Dyspraxia: Difficulty conceptualizing, planning, sequencing, and executing movement tasks

Modulation Difficulty: Threshold

- Under-responsivity
  - "A lack of response or insufficient response to the sensory environment"
    - Not responding to loud noises, like the fire alarm
    - Not hearing or responding to name being called
    - Not responding to what you think should be painful
- Over-responsivity
  - "An exaggerated response of the nervous system to sensory input"
    - Takes multiple hours to recover from fire alarm
    - "he's yelling at me!"
    - Thinking that others are hitting/punching more than others
    - Noticing and commenting on small environmental changes. E.g. people walking by the window, your new perfume

Modulation Difficulty: Regulation Style

- Sensory Seeking
  - "The nervous system of the sensory seeker needs intense input in order for the sensation to be registered properly in the brain. Therefore the sensory seeker craves intense sensations constantly"
    - Jumping off high places
    - Crashing/bumping more than others
    - Holding objects or bright lights close to eyes
    - Choosing spicy/bold flavors
- Sensory Avoiding
  - The nervous system is easily overwhelmed by intense or even normal levels of input. The sensory avoider will shy away from intense environments or situations
    - Not liking crowds or being around others
    - Avoiding otherwise pleasurable activities like messy play
    - Wanting hat or hood over face
    - Covering ears

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Modulation: Response Style

- Active Regulation Style
  - People who are likely to try to control their sensory environment
- Passive Regulation Style
  - Style of letting things happen and then respond

Red Flags

- Child has a dx that is associated with sensory processing issues
- Behaviors don't seem to be explained by psych diagnosis
- Pediatrician does not explain behaviors through physiological disease/concern
- Behaviors are somewhat consistent across settings and time***
  - But remember that all function is state-dependent!

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Assessment/Screening

- Sensory Profile
- Sensory Processing Measure
- Observation
- Parent/caregiver/teacher report
- Sensational Brain checklists
- **The child's report and behavior!**

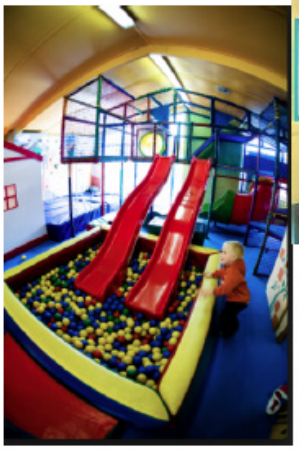
Why Use Sensory Approaches?

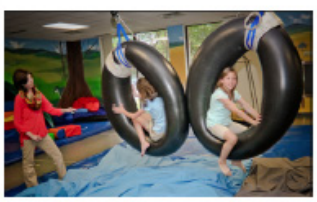
- Sensory experiences can lead to
  - A sense of safety & stability
  - Support, build relationships
  - Support development
  - Regulate emotions and behaviors
  - Contribute to overall health & well being

There's Plenty You Can Do

While Occupational Therapists are often the providers who use and consult about sensory-based regulation strategies, there is PLENTY that psychotherapists, teachers, administrators, and other professionals can do to acknowledge the sensory worlds of children (and themselves)

Not (only) this





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Think this!

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Two Basic Classifications of Sensation

Calming

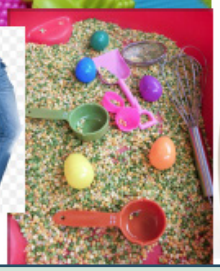
- Familiar
- Slow
- Soothing/relaxing
- Rhythmic
- Holds positive associations
- Continuous & predictable
- Mild intensity
- Simple
- Low demand
- Consistent

Alerting

- Novel
- Fast
- Irritating
- Dyssynchronous
- Holds negative associations
- Unpredictable
- Moderate/high intensity
- Complex
- High demand

Tactile Stimulation

- Body lotions/powders
- Swaddling in blankets
- Water play (hot/cold)
- Hand/foot massage (deep pressure)
- Getting hair done
- Tactile manipulatives
- Vibrating pillows/chairs
- Others?



Proprioceptive Stimulation

- Hugs
- Carrying a heavy backpack
- Moving heavy furniture
- Swaddling
- Sitting or lying on the floor (as opposed to in bed or a squishy chair)
- Massage
- Gum! Hard snacks
- Straws/water bottles
- Trampoline
- Other?

Proprioceptive Stimulation

Deep Touch/Pressure

Deep pressure is sensed by proprioceptive receptors and is often associated with a feelings of grounded-ness and calmness as well as a greater sense of the body's boundaries

Vestibular Stimulation

- Swings
- Jumping games
- Running games
- Moving up and down the stairs
- Wagons, scooters, etc.
- Rocking chairs (either for the child/person or while holding a baby)
- Other?

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Sensory Dissonance & Sensory Scaffolding

- "A State that occurs when expectations for sensory experiences during occupational performance are incongruent with the sensation encountered" (Bailliard, 2015)
- "The strategic use of sensory stimuli that appeal to clients' sensory habits to support therapeutic intervention…"

"To the man with the hammer, everything looks like a nail"

-Mark Twain

AM Breakout Session #5

2017
Sonoma County
Early Childhood
Mental Health Summit
Building Relationships to Support
Families in Times of Stress

Desorden de animo perinatal
(Perinatal Mood Disorders)

Kembly Mahiri, MSW, LCSW, Dept. of Public Health
Paola Escobedo, MSW, Child Parent Institute

Kem Mahiri serves as the Supervising Social Worker for the Teen Parent Connections program through the Dept. of Public Health. Kem has also worked for 18 years as a bilingual therapist for women experiencing perinatal mood at the Petaluma Health Center.

Paola Escobedo is a Bilingual Parent Educator for the Child Parent Institute and provides in-home parenting support to families. She is also an MSW intern and provides in-home peer support for perinatal mood and anxiety disorders to new mothers of low socioeconomic and a variety of cultural backgrounds.

RUEDA DE AUTOCUIDADO

Tipo	Comienzo	Frecuencia	Síntomas
Depresión prenatal	Durante el embarazo	10% - 20% de mujeres embarazadas Alrededor de 50% de probabilidad de que una mujer experimenta la depresión en el embarazo si tiene un historial de depresión	• Llorar • Problemas para dormir • Cansancio • Cambio en apetito • Incapacidad de sentir placer • Ansiedad • Apego fetal disminuido • Irritabilidad

Tipo	Comienzo	Frecuencia	Síntomas
Baby Blues	Empieza durante las primeras semanas después del parto (generalmente en la primera semana alcanzando un máximo a los 3-5 días). Síntomas suelen desparecer dos semanas después del embarazo	Hasta el 80% de madres nuevas.	• Llorar • Tristeza • Irritabilidad • Sentido exagerado de empatía • Ansiedad • Estados de animo altos y bajos • Sentirse abrumado • Insomnio, problemas para caer o permanecer dormido • Cansancio/agotamiento • frustración

Tipo	Comienzo	Frecuencia	Síntomas
Depresión post-parto	Por lo general, dentro de los primeros dos a tres meses después del parto, aunque el inicio puede ser inmediato después del parto (se puede distinguir de "baby blues," ya que dura mas de dos semanas después del parto)	10%-20% de madres nuevas	• Tristeza persistente • Llanto frecuente, incluso sobre cosas pequeñas • Concentración pobre • Dificultad para recordar cosas • Sentimientos de inutilidad, inadecuación o culpabilidad • Irritabilidad • Perdida de interés en el cuidado de uno mismo • No sentirse dispuesto a hacer tareas diarias • Agitación psicomotora o retraso • Cansancio, perdida de energía • Insomnio • Disminución o aumento significativo del apetito • Ansiedad manifestada como pensamientos y miedos extraños, tales como pensamientos obsesivos de lastimar al bebe • Sentirse abrumado • Síntomas somáticos (dolor de cabeza, en el pecho, palpitaciones cardiacas) • Falta de apego con el bebe, falta de interés en el bebe, la familia o las actividades • Perdida de placer o interés en hacer cosas que uno solía disfrutar • Pensamientos recurrentes de muerte o suicidio

PM Breakout Session #1

Families as Complex Cultural Systems

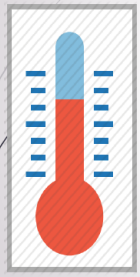
Barbara Stroud, Ph.D.
Barbara Stroud Training and Consultation

Barbara Stroud, Ph.D., is a licensed psychologist, trainer, and consultant with over two decades worth of culturally informed clinical practice and training in the early childhood development and mental health arenas. She is a national ZERO TO THREE Graduate Fellow and holds prestigious endorsements as an Infant and Family Mental Health Specialist/Reflective Practice Facilitator Mentor with the California Center for Infant-Family and Early Childhood Mental Health. Embedded in all of her trainings, clinical service models, and consultations are the practices of reflective supervision and sensitivity to cultural uniqueness. In 2012, Dr. Stroud published the book "How to Measure a Relationship", which is improving infant mental health practices around the country. Her newest text "Intentional Living: finding the inner peace to create successful relationships" walks the reader through a deeper understanding of how their brain influences relationships. Both volumes are currently available on Amazon. Additionally, Dr Stroud is a contributing author to the text "Infant and early childhood mental health: Core concepts and clinical practice" edited by Kristie Brandt, Bruce Perry, Steve Seligman, & Ed Tronick.

Dr. Stroud received her Ph.D. in Applied Developmental Psychology from Nova Southeastern University, and she has worked largely with severely emotional disturbed children in urban communities. Dr. Stroud's professional career path spans classroom based, community oriented, and legislative systems of care. She is highly regarded and has been a key player in the inception and implementation of cutting edge service delivery to children 0-5 and their families; her innovative approaches have won national awards. More specifically, Dr. Stroud is a former preschool director at Northridge Preschool, a non-public school administrator, and director of early intervention services at the Los Angeles Child Guidance Clinic in South Central Los Angeles.

2

Readiness to Investigate Culture



- **Acceptance**
  - Inequity exist and I am ready to be in the place of repair not blame
- **Tolerance**
  - It is not fair that other's voice receive greater weight than mine. I am aware of privilege but I often feel de-valued in these discussions
- **Anger & Fear**
  - I feel overwhelmed by this issues, and cannot look beyond my own pain to see the larger systemic experience

Barbara Stroud Training & Consultation

3

Cultural Humility

"**Intrapersonally**, cultural humility involves a willingness and openness to **reflect on one's own self as an embedded cultural being**, having self **awareness of personal limitations** in understanding the cultural background and viewpoints of others: **interpersonally**, cultural humility involves an other-orientation stance (or **openness to the other**) with regard to aspects of an individual's or group's cultural background and identity."

Hook, J. N. 2015

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4

Understanding Labels

- **Race** – a social construct defined by a government or other organizing groups to classify individuals with similar physical traits
- **Ethnicity** -Classification of people based upon common ancestry (real or assumed); the group holds a collective understanding of customs (religious, linguistic, tribal, behavioral or cultural)
- **Culture** –behaviors and rituals that have shared meaning or a set of values that guide behavior (family culture, professional culture, special needs community, etc.)

-Culture is the enactment of Ethnicity

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Ethnicity vs. Race

Ethnicity	Race
• Italian, German, French, Russian	• White
• Chinese, Korean, Japanese, Taiwanese	• Asian
• Guatemalan, El Salvadorian, Mexican	• Latino/Latina
• Jewish	• White- Asian- Latino- Black
• Strong Ethnicity without a race category- Middle Eastern, From India, Born in Africa (of every race), Native American/ Native Alaskan, and more	• Race labels do not clearly describe these groups
• Race without Ethnicity –Black Americans	• Black is a race not an ethnicity

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Leaves = Expressed Culture

Trunk = Personal Morality & Opinions

Roots = Values & Beliefs

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Culture Is . . .

- Culture defines not only ***who*** we are but ***how*** we are
- Culture is defined by how we see ourselves – **'inside-out culture*'** (*within the context of sub-cultures –race, gender, faith, region, orientation, class, profession, ability/disability*)
- Culture is defined by the labels others give us – '**outside-in culture***' (*stereotypes, biases, pre-judgments*)
- Culture is multifaceted and expressed in every social interaction

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Cultural Informs Relationships

- How did relationships in your family system teach you about culture? – *the rules in our house*
- What was your home culture expectations for social behavior? – *how you behave with others*
- How does your family culture define emotional wellness?

As providers we must remember:

- Your services are provided through a relational model
- All relationships are culturally informed

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What Does the Research Tell Us

- The 2001 Surgeon General Supplement Report on Mental Health indicates that "**racism and discrimination adversely affect** the **health and mental health** of racial minorities and likely place them at risk for mental disorders."

U.S. Dept of Health and Human Services as cited in Okazaki (2009)

- Research among African Americans indicates that **perceived experiences of racial bias** ignite the stress response system resulting in negative psychological and physiological reactions that **adversely impact health outcomes**

Carter, R.T. (2007)

- White Americans when evaluated by African American interviewers showed **higher level of stress responses** as related to **higher levels of implicit racial biases**

Okazaki, S. (2009)

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What Does the Research Tell Us

- Participants is a qualitative study of experienced racism, reported harmful and helpful responses to stories of racial discrimination. Harmful responses included: '*resistance*, *denial*, *blame*, and *minimizing*'. Helpful responses included: '**active listening**, **conveying empathy and understanding**, **advocating for their rights**, **intervening on their behalf**, and **validating their experience**.'

Lowe, et al (2012)

- "Multicultural competence ensures that all clients will be respected and **their unique cultural identities** will find a fitting place in clinical understanding."

Falender, C. A., Shafranske, E. P., & Falcov, C. J. (2014)

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Culture in a Social Context

- We are social by nature and cultural by condition – different conditions require a different response
- Social behavior seeks to bring connection, personal understanding, and approval from others
- Your professional role determines a set of acceptable social behaviors (culture in action) for that role
- Social behavior can be specific to environment or relationship (*how I behave at work or home vs. how I behave with a client or my family*)
- Rules of social behavior are implicitly taught, yet explicitly required
- **Personal Success** is a culturally specific term – your life's goals and mine can be different

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12

Culture can best be defined as the unspoken social rules that guide behavior

(© 2015)

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13

Who Defines the Agenda

What I think Families Need

- Agency Mission
- Funding Mandates
- Evidence Based Practices
- Dominant Culture Values
- My Professional Lens
- My Personal Values

Family Defined Cultural Agenda

- Legacy – Family History
- Allegiance to a National Identity
- Ethnicity Issues
- Faith Values
- Longevity of the idea or belief

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What is Dominant Culture

14

A continuum of behaviors & attitudes that reflect dominant values - the holder of power in the relationship

Dominant Culture	Non-Dominant Culture
Financial Access	Limited Economic Resource
Educational Advancement	Failure to Succeed Academically
Heterosexual	LGBTQ
Caucasian	Persons of Color (non-whites)
Urban	Rural
Christian	Non Christian
30 to 55 years of age	Older Adults, Children and Youth
In Good Health (BMI –within normal limits)	Health Challenges, Physical & Mental Illness

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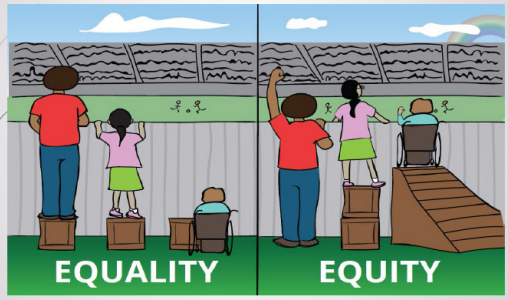
Equity is our Goal

15



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Immigration Trauma

16

1. How did your family arrive to the US?
2. Who is the holder of the immigration story and how is it shared to next generations?
3. How do you see healing being created within your own story?

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Oppression & Our Internal Story

17

- Oppression Definition -prolonged cruel or unjust treatment or control
- Oppression is present in social injustice, historical trauma, issues of equity and access, stereotyping and internal provider biases
- Internal Story –how do we learn to define ourselves when the external world sees us as flawed or less than
- What does the world say about us and how does this influence what we internalize

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Tool Kit of Acceptance

18

- Start from the belief that all families have strengths – then go find them
- Know where your values begin and end
- Remember the difference between disagreeable and unacceptable
- How can you incorporate the families culture into your service agenda
- Be kinder then necessary and always thank families for allowing you into their cultural world

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19

People may not remember what you say

People may not remember what you do

People will remember
how you make them feel

Maya Angelou

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PM Breakout Session #2

2017
Sonoma County
Early Childhood
Mental Health Summit
Building Relationships to Support
Families in Times of Stress

Practical Strategies to Promote Positive Behavior in Early Childcare Settings

Heather Harshbarger, LMFT
Mental Health Specialist, Community Action Partnership of Sonoma County Head Start and Early Head Start Programs

Heather Harshbarger is a Licensed Marriage and Family Therapist who has been serving the mental health needs of children and families for over a decade. She is currently working as the Mental Health Specialist for the Head Start and Early Head Start programs of Sonoma County where she provides early childhood mental health consultation and trainings for parents and educators. Heather is also a recent graduate of the UC Davis Napa Infant-Parent Mental Health Fellowship and is pursuing endorsement as an Early Childhood Mental Health Specialist.

What is emotional literacy?

"Emotional literacy is the ability to identify, understand, and respond to emotions in oneself and others in a healthy manner. Children who have a strong foundation in emotional literacy tolerate frustration better, get into fewer fights, and engage in less self-destructive behavior than children who do not have a strong foundation. These children are also healthier, less lonely, less impulsive, more focused, and they have greater academic achievement."

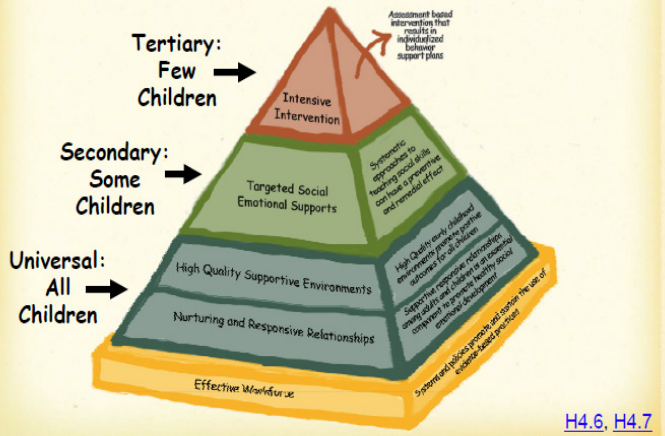
— CSEFEL

School Readiness

Social emotional learning is pervasive throughout the school day and enables other learning by giving the child a sense of safety, connection, and empowerment.

The Pyramid Model:

Promoting Social and Emotional Competence and Addressing Challenging Behavior



H4.6, H4.7

What skills are we targeting?

Emotional Literacy Skills:

Awareness of one's own feelings
Ability to regulate emotions/use healthy coping skills
Ability to understand the feelings of others/demonstrate empathy
Ability to feel safe and confident enough to explore and learn
Ability to be flexible and resilient

Social Skills:

Forming and maintaining positive relationships
Communicating needs effectively
Taking turns, Sharing
Problem solving and conflict resolution skills

Where does emotional learning occur?

- No man is an island. We all need relationships to survive. When we have supportive relationships we are more able to manage stress, learn new things, and thrive. This is especially true for children. We know that a child's earliest brain development, including emotional learning, takes place within the context of responsive and nurturing relationships.

Relationships are the Foundation for Growth

- We nurture ourselves, each other, and our children so we all may thrive.
- The Pyramid Model focuses on relationships as the foundation for social emotional growth and school success.

Targeted Social Emotional Supports

- There are specific strategies that help teach children the skills needed to promote social emotional development and learning.
- These skills are best developed within the context of a trusting relationship.

Stages of Teaching

There are three stages of teaching a new skill:

1. Introduction of the skill
2. Practice of the skill
3. Positive recognition and reinforcement of the skill

I Can Be a SUPER FRIEND!

Social Emotional Themed Books

- *How Are You Peeling: Foods with Moods* by Saxton Freymann
- *My Many Colored Days* by Dr. Seuss
- *Owl Babies* by Martin Waddell
- *It's Okay to Be Different* by Todd Parr
- *Pete the Cat* by Eric Litwin

Practice Strategies

- Set up centers to target practice of the skill you introduced.
- Identify and utilize "teachable moments"
- Sample resources include:
  - Feelings Poster
  - Solution Cards
  - Turtle Technique

Introduction Strategies

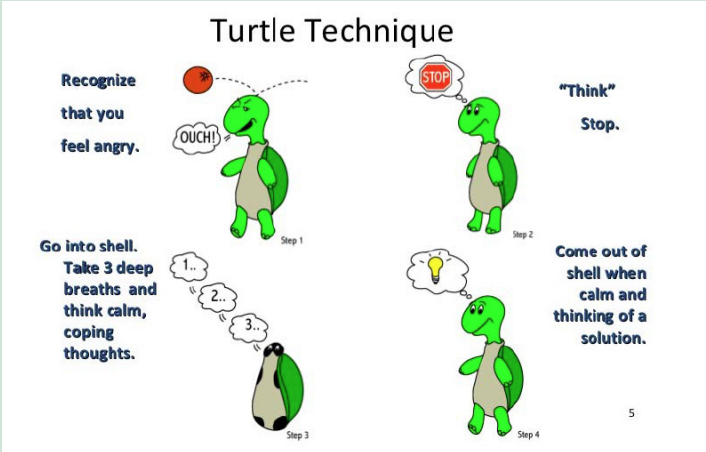
- Scripted Stories
- Songs/Role Plays/Puppet Theatre
- Books with social emotional themes built into narrative
- Building social emotional learning opportunities into your curriculum

Clear Blue Sky Song

My mind is a clear blue sky (x2)
I breathe in, I breathe out
My mind is a clear blue sky (x2)
Feelings come and feelings go
And my mind is a clear blue sky (x2)

Curriculum Planning

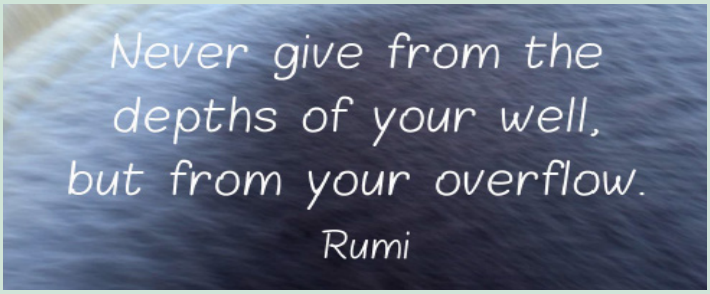
- Build skill instruction/introduction into your curriculum
- Examples include: introducing the theme of working with a buddy to investigate a question, teach turn taking when sharing back ideas, identify feelings that arise during lesson, teach coping skills and work with frustration tolerance as part of learning process, engage in reflection on learning experience, encourage children to work together to solve problems, etc.



Reinforcement Strategies

Positive Recognition Examples:

- "You have really learned how to..."
- "You must feel proud of yourself for..."
- "Excellent idea for..."
- "You've done a wonderful job at..."
- "See how _____ has improved in..."
- "You have worked so hard..."
- "WOW!! What a fabulous job you've done of..."
- "That's a cool way to ..."
- "I'm so appreciative that you..."
- "You are being a Super Friend because..."
- "Give me an EXTRA HUGE high five for..."
- "Class, I have an announcement! Let's all give a hip, hip hooray to _____ for _____"
- "I really appreciate the way all of you have your eye on the story and are listening so carefully. "



Nurture from Overflow

As teachers and caregivers, it is important to keep your own needs in mind when most of your time is focused on giving to others.

Self-care and having your own cup filled by others are critical components of being able to effectively nurture others.

Self-Care Practices

How do you take care of yourself?

How do you let others take care of you?

Turn to a partner and take turns sharing. Be prepared to share back to the large group.

Takeaways

- Emotional literacy is key for development and learning.
- Social emotional development takes place in the context of nurturing relationships.
- Teaching social emotional skills is a three-stage process.
- Do not forget yourself and your own needs. Good self-care practices will make you an effective role model for others and provide you with lasting health and well being.

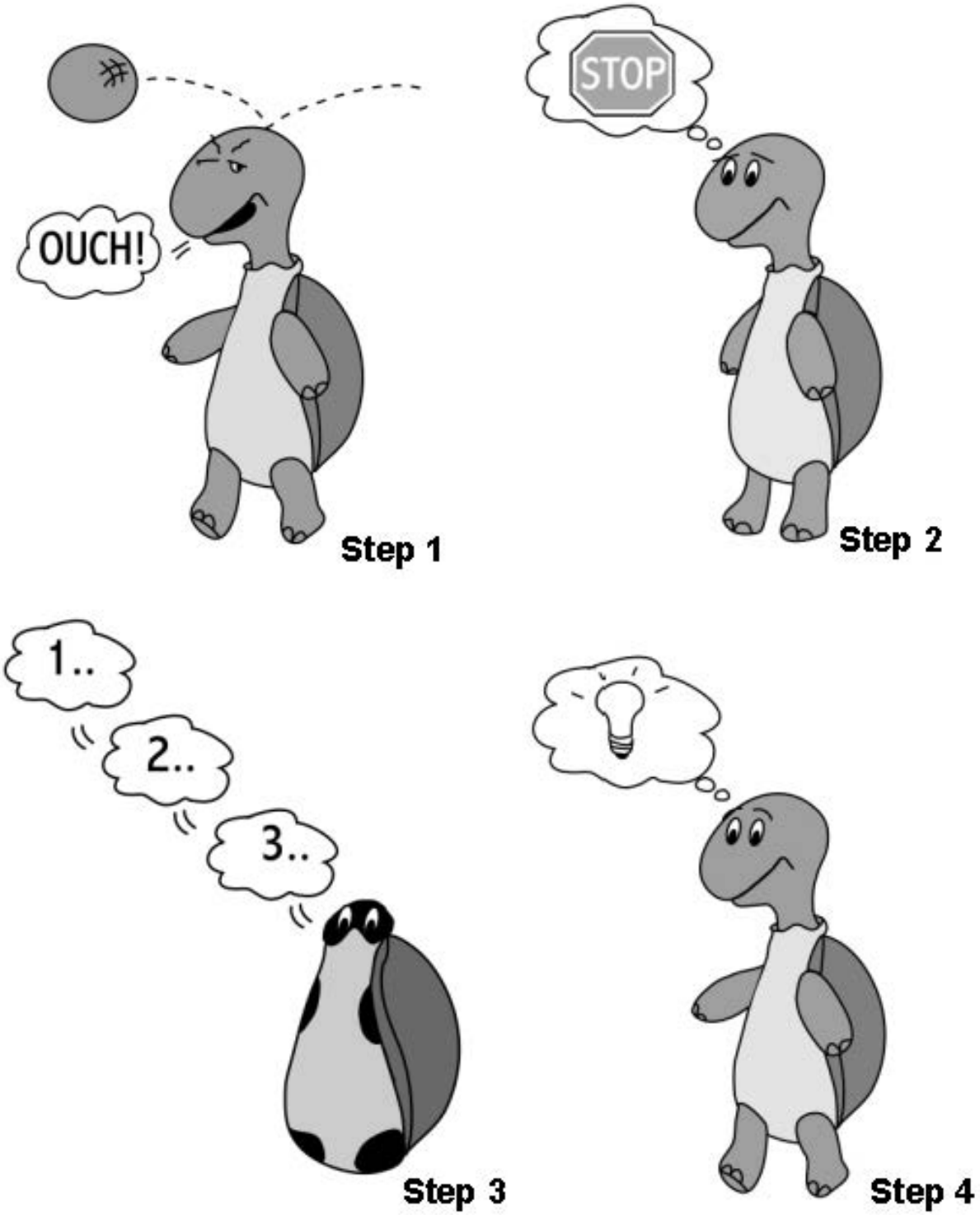
Pyramid Model

for Promoting Social Emotional Competence in Infants and Young Children

Center on the Social and Emotional Foundations for Early Learning
www.vanderbilt.edu/csefel

Technical Assistance Center on Social Emotional Intervention for Young Children
www.challengingbehavior.org

The Turtle Technique



3 X 3 SOLUTION KIT CUE CARDS

3 X 3 SOLUTION KIT CUE CARDS

PM Breakout Session #3

Perinatal Substance Use: Mitigating the Risks Through Timely Assessment and Comprehensive Treatment

Erin Lund, MD, MPH
Family Physician, Santa Rosa Community Health, Maternity Care Director Santa Rosa Family Medicine Residency
Marena Koukis, Ph.D.
Behavioral Health AODS Specialist, Drug Free Babies Perinatal Placement Specialist/Dependency Drug Court Coordinator

Erin Lund, MD, MPH is a Family Physician at Santa Rosa Community Health and Maternity Care Director Santa Rosa Family Medicine Residency. She graduated medical school from Harvard University and completed residency in Family Medicine here in Santa Rosa in 2008. Following residency she completed a two year fellowship in Maternal, Child and Reproductive Health as well as an MPH at the University of New Mexico where she first became interested in managing women with perinatal substance use. Since 2010 she has worked at the Vista campus of Santa Rosa Community Health and directs the OB curriculum for family medicine residents at the UCSF-affiliated residency program.

Dr. Marena Koukis joined the team at Sonoma County Behavioral Health in 2008. In 2013 she became Coordinator for Dependency Drug Court, a program for parents in substance use treatment reunifying with their children, as well as the Drug Free Babies program for pregnant women and moms of babies seeking support and treatment for substance use.

Women, Substance Use and Adverse Childhood Experiences (ACES)

- Women are more likely than men to initiate substance use because of traumatic life events
- Women are more likely than men to be drawn into substance use by either family members or partners who use
- Women whose partners continue to use will have a harder time quitting
- Women with substance use disorders are more likely than men to have poor self-esteem
- Co-morbid psychiatric conditions such as depression, anxiety, bipolar disorder and PTSD are more common among female substance users than men

Ashley, O.S., Marsden, M.E, & Brady, T.M. (2003)

Substance Use Disorder and ACES

- Prior traumatic experiences from exposure to physical, sexual or emotional violence are common among women with SUD
- Studies suggest between 50-85% of women with SUD have significant trauma histories
- Pregnancy can be a vulnerable and triggering time for women w/ trauma histories
- One study of pregnant or recently delivered women with SUD showed all women reported adverse childhood events and 77% reported prior sexual abuse
- Ongoing adult traumatic experiences are also common in this population w/ many experiencing intimate partner violence during pregnancy

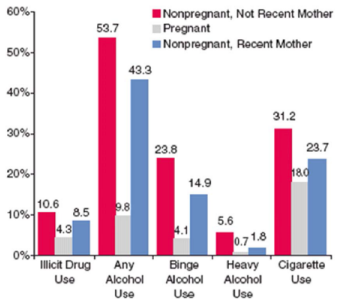
Torchalla et al, 2015

Substance Use Disorder and Pregnancy

- Many women who use drugs or alcohol pre-pregnancy are able to stop on their own, but those with substance use disorder often unable to quit without help
- 5.4% of pregnant women are current users of illicit drugs
- Rates decrease by trimester (9%, 4.8% and 2%)
- Rates are highest in pregnant teens 15-17 (14.6%) followed by women 18-25 (8.6%)
- Many obstetric risks are increased for those who continue to use, specifically preterm delivery, low birth weight, NICU admission
- Women continuing to use substances are much more likely to present late to prenatal care or receive none at all

Helmbrecht and Thiagarajah, 2008; SAMHSA - NSDUH results 2013

Rates of Past Month Substance Use by Women 15-44 by Pregnancy Status



Source: SAMHSA – NSDUH 2002

Barriers to Care in Pregnancy

- Unintended pregnancies, late pregnancy awareness
- Unreliable transportation
- Increased social stigma of using drugs while pregnant
- Fear of criminal or child welfare consequences
- Lack of access to gender-specific substance use treatment
- Limited child-care availability at treatment facilities
- Lack of providers with obstetrics and addiction treatment expertise
- Low income women and women of color are at highest risk of barriers to care

Brady & Randal, 1999; Burns et al, 2004; Schempf, 2008; Young, et al, 2007.

Barriers to Disclosure of Substance Use

- Fear of exposure and reporting to child welfare authorities or police
- Feelings of shame, fear and low self-esteem corrode the trust necessary for full disclosure of substance use
- Co-morbid depression, anxiety and trauma can impede formation of a therapeutic alliance with care providers
- Past negative experiences with judgement or stigma from providers
- Past involvement with child welfare services
- Denial that level of use is a problem

ACOG committee opinion, No. 422, 2008; Kandall, S., 1996; Jessup, 2003.

Importance of Prenatal Care

- Regular prenatal care improves obstetric outcomes whether or not a woman is able to stop using drugs during her pregnancy
- Multiple studies show a reduction in preterm delivery rates when women using substances receive adequate prenatal care compared to those receiving late or no prenatal care
- Large cohort studies support a policy of universal screening for substance use at the first prenatal visit and subsequent assessment and treatment integrated into prenatal visits to optimize obstetric outcomes

Andres & Larrabee,1996; Andres, et al, 1992; Racine, Joyce & Anderson,1993; Goler, et al. 2008; Sweeney, et al, 2000.

Kaiser Early Start Program

KAISER PERMANENTE®

- Began as a pilot program in 1990
- Implemented across Kaiser Permanente Northern California over subsequent years
- By time the study was published in 2008, Early Start was the standard of care across 40 KPNC obstetric clinic sites, screening over 40,000 women annually
- Three key components:
  - Placing a licensed substance abuse expert into the department of OB/GYN whose assessment appointments are linked to the patient's prenatal visits
  - Universal screening of all women for alcohol and drugs by screening questionnaire and (with signed consent) a urine toxicology test
  - Education of all providers and patients about the effects of drugs, alcohol and cigarette use in pregnancy

Goler et al. 2008

Kaiser Early Start Study

- Retrospective Cohort Study – 21 Kaiser Northern CA sites with active Early Start Programs, included nearly 50,000 female Kaiser patients completed initial screening questionnaires over 4.5 year period
- Screen positive group includes women who either screened positive for use of drugs of abuse on self-report or who tested positive on the initial urine drug screen (universally administered)
- All screen positive women were referred for assessment with Early Start Specialist
- Following that assessment women in the treatment group had at least 1 follow-up visit with the Early Start Specialist

Goler et al. 2008

Kaiser Early Start Results

	Controls-Screened Negative (46,533)	Screened, Assessed and Treated (2,073)	Screened and Assessed Only (1,203)	Screened Positive Only (156)
Low Birth Weight	4.7%	6.5%	7.7%	12.4%
Preterm Delivery	6.8%	8.1%	9.7%	17.4%
NICU Admission	10.3%	16.4%	15.3%	21.4%
Placental Abruption	0.9%	0.9%	1.1%	6.5%
IUFD	0.6%	0.5%	0.8%	7.1%

Goler et al. 2008

Importance of SUD Treatment in Pregnancy

- Women who receive SUD treatment early in pregnancy are more likely to stop using and have improved outcomes compared to women not receiving treatment
- Retrospective study in Massachusetts, 2003-2007
  - 375,851 deliveries
  - SUD rate of 5.5%
  - Only 66% of these women received treatment pre-delivery
  - Women with SUD were poorer, less educated, had more health problems
  - Women with SUD utilized less prenatal care but more ER visits and hospitalizations
  - Increased risk of prematurity and Low Birth Weight among women with SUDs
- Women with SUD treatment prenatally had lower risk of preterm birth (AOR 0.61), low birth rate (AOR 0.54) and neonatal mortality (AOR = 0.49), compared to women with SUD not receiving treatment

SAMHSA/CSAT, 2001; Kotelchuck, et al. 2016

Gender Sensitive SUD Treatment

- For decades most substance use treatment was tailored with men in mind
- Willpower driven
- Beat you down before building you up
- Recent research shows that gender sensitive treatment programs that are trauma-informed are more effective for women
- Specifically address the common comorbidities that affect women and barriers to treatment that are more common for women
- Attention to relationships is essential to engaging women in treatment as well as helping achieve long term recovery

Mandell & Werner, 2008

Co-morbid mood disorders

- Approximately 45% of women with SUDs have co-occurring mood disorders, especially depression and anxiety
- Infants of untreated, depressed mothers have demonstrated the following:
  - Lower scores for motor adaptation and self-regulation
  - Higher arousal scores
  - More difficult to console
  - Developmental delay
  - Poor attachment
- Recent case study looked at challenges of providing obstetric care to women w/ PTSD and SUDs and stressed the importance of early screening and coordinated, multidisciplinary care to improve outcomes for mother-infant dyad

ACOG Practice Bulletin 2008; Goodman et al, 2015

Illicit doesn't mean worse than legal

- Alcohol and tobacco are known to cause more pregnancy complications than any illegal drug
- Prescription drugs (ACEI/ARB, statins, antiepileptics, warfarin, psych meds) likely cause more damage to developing fetuses than drugs of abuse

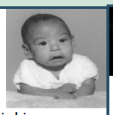
No woman using drugs in pregnancy wants to intentionally hurt her baby

These are women with addiction disorders that became pregnant, not pregnant women who started using drugs.

Smoking

- 16.5% of pregnant women use tobacco
- Fetal effects include IUGR, prematurity, low birthweight, and sudden infant death syndrome
- Poorer attention and impulsivity, poor language acquisition noted in nicotine exposed children
- Obstetric complications include PPROM, placenta previa, placental abruption, ectopic pregnancy and spontaneous abortion
- Harms likely both related to nicotine (vasoconstriction) and carbon monoxide from smoking (hypoxemia)
- Spontaneous smoking cessation among women who become pregnant ranges from 11-65%

Alcohol Use



- 9.4% of pregnant women report current alcohol use and 2.3% report binge drinking
- Known teratogen, poses serious risks to neuro-development throughout gestation, no known safe amount of use
- Teratogenic effects of alcohol mediated by maternal age, genetics, and nutrition
- Obstetric risks include spontaneous abortion, prenatal and postnatal growth restriction, birth defects, and neurodevelopmental deficits (mental retardation and fetal alcohol spectrum disorders)
- Leading preventable cause of birth defects and developmental disabilities in the US.
- FAS affects 1 in 1,000 newborns, FASD in 1 in 100.

SAMHSA – NSDUH results 2013

Stimulants – Cocaine & Meth

- May have teratogenic effects on the brain, in particular cortical development, affecting executive function
- Studies consistently show elevated risk of SGA/low-BW babies (OR 3.5) – get serial US
- Increased risk of abruption (about 3x increased)
- Unclear whether other complications increased (HTN, stillbirth, PTL) – consider antenatal testing and possible IOL if actively using
- Withdrawal syndrome in newborns described – irritable, sedated, poor feeding. No specific scoring system or treatment available other than supportive care
- Mixed results regarding long term effects on school achievement, IQ, behavioral problems--many confounders

Marijuana in Pregnancy

- Women smoking MJ in pregnancy more likely to also smoke cigarettes and drink ETOH
- 48-60% of MJ users continue to use in pregnancy believing it is relatively safe
- Fetal THC levels approx 10% of maternal levels in animal models, higher concentrations present after repeated exposure
- Smoking MJ produces 5x as much carbon monoxide as cigarettes, affecting fetal oxygenation
- Australian study showed mildly increased rates of SGA, low BW, PTL and NICU admit after controlling for tobacco and other drugs – *Hayatbakhsh - 2012*

Long-Term Effects of Prenatal MJ Exposure

- Decreased visual problem solving skills and visual-motor skills in elementary school children exposed prenatally
- Other studies show decreased attention span and increased behavioral problems in exposed children
- Prenatal exposure is an independent predictor for marijuana use in adolescence and school underachievement
- Rats showed increased affinity for opiates after prenatal exposure to marijuana

ACOG Committee Opinion #637, July 2015

Opioid Use in Pregnancy

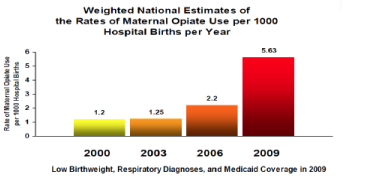
- Approx 0.5% of pregnant women have an opioid use disorder
- Rates rising significantly over past decade, including prescription opioids and heroin
- Illicit opioid use associated with growth restriction, preterm birth, STDs, polysubstance abuse
- Medication assisted treatment recommended for pregnant women with opioid use disorders

Opioid Use Disorder in Pregnancy on the Rise

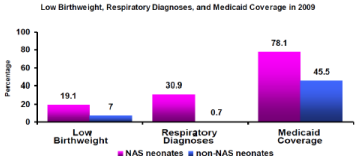
- From 2002-2013 the largest increase in heroin use was among US women
- Current rate of opiate use in pregnancy is 0.9% compared to non-pregnant women of childbearing age 2.6%. ~5-fold increase since 2000
- Rates of neonatal abstinence syndrome have also increased 5-fold over the past 15 years
- >85% of pregnancies among women with opioid use disorder were unintended
- Opioid agonist therapy in pregnancy is standard of care and results in improved engagement in addiction treatment, prenatal care and in-hospital delivery

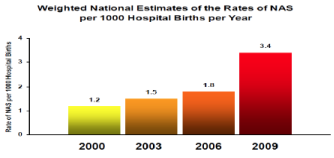
CDC, MMWR 2015; Patrick, et al. 2012; Heil, et al. 2011; Jones, et al. 2008; Smith & Lipari, 2017.

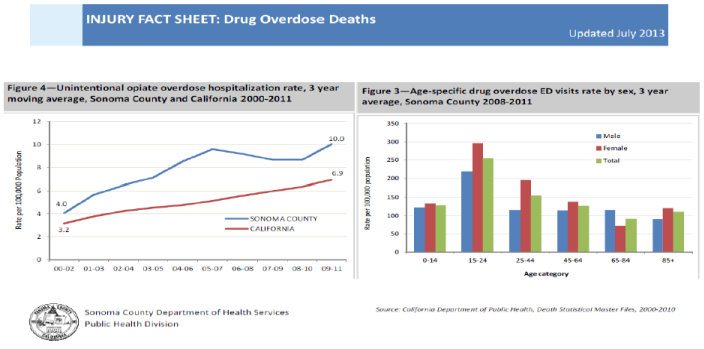
Current Trends in Opioid Use During Pregnancy

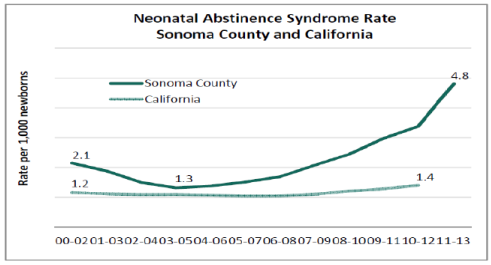


One infant every hour is born with NAS in the US









California and Sonoma County, 2000-2012
Neonatal Abstinence Syndrome[1] (NAS) Rates per 1,000 Newborns[2]
NAS: ICD9-CM Diagnosis Code of 779.5 (drug withdrawal syndrome in a newborn)
Data Source: OSHPD Patient Discharge Data, 2000-2012

Medication-Assisted Treatment for Opiate Use Disorder in Pregnancy

- Methadone or buprenorphine maintenance associated with improved prenatal care and infant birth weight compared to heroin
- Maintenance treatment can decrease exposure to STDs, hepatitis and HIV as well as other substances
- Maintenance treatment has lower risk of relapse than abstinence-based treatment
- Abrupt withdrawal of opioids in pregnancy may cause SAB, preterm labor, growth restriction or fetal death
- All opioids place infants at risk for neonatal abstinence syndrome

Methadone use in Pregnancy

- Goal is adequate dose to remove drug cravings
- Current recommendations are toward higher doses, increasing as needed throughout pregnancy to avoid withdrawal symptoms and cravings
- Refer to local methadone clinic for ongoing therapy (SRTP or DAAC-REAP)
- NAS can be severe and prolonged
- Methadone highly regulated and often unavailable outside urban areas
- Methadone requires daily or frequent visits
- Women addicted to prescription narcotics resist stigma of methadone
- Methadone viewed as harder to "kick" than heroin or shorter acting opioids

Buprenorphine in Pregnancy

- Alternative to methadone for treatment of opiate use disorder
- Mixed agonist/antagonist acts on multiple opioid receptors
- May be dispensed by physicians after 8 hour course and additional DEA license, PA/NP after 24 hour course
- Growing evidence for safety and efficacy in pregnancy
- Decreased incidence of neonatal abstinence syndrome and shorter hospital stays (MOTHER study NEJM 363:24, Dec '10)
- Does not show up as opioid on drug screen, need to send separate test to detect
- Patients usually are seen weekly to monthly rather than daily, easier for patients in rural settings
- No role for changing pregnant women on methadone to buprenorphine in pregnancy

MOTHER Study 2010

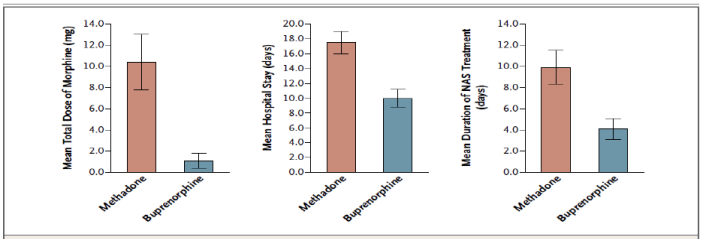


Figure 2. Mean Neonatal Morphine Dose, Length of Neonatal Hospital Stay, and Duration of Treatment for Neonatal Abstinence Syndrome.

Neonatal Abstinence Syndrome

- Expected and treatable consequence of chronic opioid exposure in utero
- NAS is not "addiction" but due to physiologic dependence
- Can occur in babies of mom's using any opiate
- Recommend at least 72 hour hospital observation for all babies at risk regardless of which opioid mom used
- Methadone withdrawal usually appears within 72 hours, but can can be 5-7 days before symptoms become more severe. Ideally observe 4-5 days prior to discharge
  - 24 hrs 42%
  - 48 hrs 73%
  - 72 hrs 87%

Harper R. et al. 1974

Other Factors Contributing to NAS

- Structural
  - The NAS assessment
  - Medication initiation
  - Weaning protocols
  - NICU or rooming in
- Postpartum
  - Breastfeeding
  - Skin-to-skin contact
  - Environmental stimuli
- Non-Modifiable
  - OPRM1 – opioid receptor
  - CYP – placental transfer
  - Gestational age at del
- Other Substances
  - Benzodiazepines
  - SSRIs
  - Cigarette Smoking

Urine Drug Screen Interpretation

- Methadone and Buprenorphine do not show up as opiates on urine drug screens
- Most urine screens test specifically for methadone
- Not all screens test for buprenorphine
- Confirmatory tests should be sent on all positive screens to verify presence of a controlled substance as many common medications can cause false positive screens
- Should always get mother's permission to send a drug screen on her urine. No consent needed to test baby if clinical concern for exposure.

Breastfeeding and Substance Use

- **Breastfeeding encouraged if:**
  - Engaged in treatment (including MAT) and plan to continue in treatment
- **Breastfeeding contraindicated:**
  - Active use, not engaged in treatment, no prenatal care (?)
- Stimulants concentrated in breastmilk, associated with fussiness, poor infant sleep, rarely seizures
- Marijunana (controversial) – AAP recommends not breastfeeding, long term outcome data lacking
- Breastfeeding conversation – opportunity to support smoking cessation

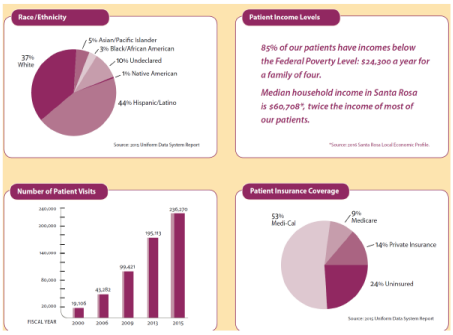
Breastfeeding

- For women able to stop using illicit substances and alcohol during pregnancy who are engaged in prenatal care and participating in drug treatment programs, we strongly encourage breastfeeding
- Reduces severity and duration of treatment for baby with neonatal abstinence syndrome if mom is on buprenorphine or methadone maintenance therapy
- Breastfeeding encourages ongoing sobriety for mother
- Improved maternal-infant bonding
- Improved maternal self esteem
- If maternal relapse (especially on stimulants), advise cessation, caution with rapid weaning if mom on chronic opioids as may cause mild withdrawal in baby

New Beginnings Clinic: Mitigating the Risks of Substance Use in Pregnancy

Santa Rosa COMMUNITY HEALTH

- Largest FQHC in Sonoma County, CA
- Provide health care to >25% of Santa Rosa's population
- 236,270 pt visits in 2015
- 53% Medi-cal
- 24% uninsured
- 63% racial/ethnic minority
- 85% living below the federal poverty level



OB Care at SRCH

- Staff providers deliver over 700 babies/yr
- Two major clinic sites care for >1000 prenatal patients/yr
- All care provided by family medicine physicians
- Clinical home for family medicine residency program with 36 residents
- 6 surgically trained family physicians provide majority of surgical and high risk obstetrics care for the clinic
- FP-OB providers at SRCH offer high risk consultations and surgical back-up to surrounding community FQHC's and local birth center CNM's
- Back-up OB/GYNs affiliated with Sutter Hospital provide consultative and surgical back up for the highest risk cases
- Maternal fetal medicine consultations through California Pacific Medical Center but no on-site MFM at delivering hospital
- Level III NICU at Sutter Santa Rosa accepts babies 27 weeks GA and above

new beginnings Clinic for pregnant women

- Founded in March of 2015 at the Vista Family Health Center in Santa Rosa to serve our most socially complex pregnant patients
- Largest FQHC clinic in Sonoma County, home of FM Residency
- Needs Assessment: Clinic HROB chart review process identified many high risk women receiving sub-standard care
- Frequent no-shows, lack of continuity among providers, poor follow-up on community referrals, poorly documented treatment plans
- Residents commonly felt overwhelmed by this patient population

Traditional Model of Care

- Primary OB provider identifies medical and social risks at initial OB visit
- Referral to Mental Health for management of mood disorders and counseling
- Referral to SUD treatment
- Referral to social services (if available)
- Standard OB referrals for labs, genetic screening, ultrasounds, diabetes management, antenatal testing, etc....

When the Traditional Model Fails

Patients who are late to care or have frequent no-shows are labeled "non-compliant" and getting standard OB care completed often becomes the priority rather than addressing barriers to care and ongoing mood disorders or SUD

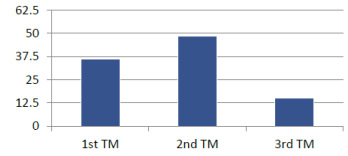
Date	Time	Type	Status	Provider	Resource	Facility	Reason
03/15/2013	01:00 PM	OV Femal	N/S	LEWIS, JOEL M	Stand by clinic	OV	complications from
03/13/2013	11:20 AM	OV - OB	CNCL	LUND, ERIN E	LUND,ERIN E	GV	ob 37 weeks
03/08/2013	09:20 AM	OV - OB	N/S	DONLON, DEBBIE	DONLON,DEBBIE	BV	FU bp
03/05/2013	12:00 PM	OV - OB	CHK	DONLON, DEBBIE	DONLON,DEBBIE	GV	ob 36 weeks
02/28/2013	06:00 PM	OV Femal	N/S	BROWN, LAURENCE J	BROWN,LAURENCE J	RV	BP check
02/26/2013	09:00 AM	OV - OB	N/S	zzzMURPHY, SARAH	zzzMURPHY,SARAH	GV	OB F/U 35 weeks
02/22/2013	02:30 PM	OV Femal	CHK	KOZART, MICHAEL F	KOZART,MICHAEL F	BW	
02/20/2013	10:40 AM	OV - OB	CHK	LUND, ERIN E	LUND,ERIN E	GV	IUP
01/30/2013	08:40 AM	OV Femal	STF/ERR	LOZARES-LEWIS, ELE	LOZARES-LEWIS,ELE	BV	OB
01/18/2013	08:40 AM	OV - OB	CHK	zzzMURPHY, SARAH	zzzMURPHY,SARAH	GV	OB
01/15/2013	03:40 PM	OV Femal	CANCPHO	ZZZCHRISTENSEN, CA	ZZZCHRISTENSEN,CA	GV	OB
01/03/2013	11:40 AM	OV - OB	N/S	LUND, ERIN E	LUND,ERIN E	GV	ob
12/20/2012	11:00 AM	RV - OB	N/S	LUND, ERIN E		CV	CPSP 2nd Trimeste
12/14/2012	02:40 PM	MH 45	N/S	zzzSILVERSTEIN, JENN	zzzSILVERSTEIN,JENN	MV	mh intake iup

Multidisciplinary Care in High Risk Pregnant Women

- Wrap-around services at time of the obstetrics visit
- Increase access to mental health services, prenatal education, community resources
- Increased frequency of prenatal visits
- Decrease barriers to care
- Active case management to engage patients when no-shows occur
- Consistent continuity care by providers experienced in caring for women with SUDs, trauma histories, mental health conditions
- Collaboration with community treatment facilities, public health nurses, jail, hospital social workers, and child welfare department

new beginnings Clinic for pregnant women

- From 3/2015 – 12/2016 we cared for **107** pregnant women
- Mean # of prenatal visits 7.6 (range 1 – 22)
- Entry to Care:



new beginnings Clinic for pregnant women

- Primary diagnoses:
  - Substance Use Disorders (SUD) -79% (illicit substances 65%)
  - Mental health diagnoses – 59%
  - Homelessness – 23%
  - Incarceration – 29%
  - Active domestic violence – 13%
- Among those with SUD: 76% stimulants, 44% opioids, 3% benzos
- For those w/ Opioid Use Disorder
  - 22% on buprenorphine from NBC providers
  - 24% on methadone from another treating facility

NBC Structure

- Meets every Tuesday afternoon 1:30-5:30 PM
- Schedule up to 30 patients/shift includes OB, postpartum, & newborn visits
- Patients have specific appointment times but are seen whenever they arrive, with or without an appointment
- Typically about 60-70% show rate
- Team based care:
  - 2 fellowship trained FP-OB Faculty
  - 1 rotating FM resident (R2 or R3)
  - 1 OB RN case manager
  - 1 mental health provider (LCSW)
  - 3 medical assistants
- Additional resources: onsite pharmacy, smoking cessation counselor, perinatal drug treatment placement coordinator, public health nurses, psychiatry (in house)

NBC Flow

- Multidisciplinary team helps limit times patients are waiting alone
- FP-OB provider +/- resident sees patient each visit and bills for care
- MH provider sees all new patients and patients with active MH issues
- RN Case manager collaborates w/ outside providers both during and between clinics, provides brief targeted perinatal education during visits, and connects women with in-house birth prep and lactation resources
- MA's coordinate the flow to make sure patients seen by each necessary team member and ensure appropriate follow-up in 1-3 wks
- Mom and baby receive follow-up care in New Beginnings for at least 6-12 months following delivery and then are transitioned into regular PCP care

NBC Outcomes (3/2015-12/2016)

- Delivery data on 88/107 – 82%
- Preterm delivery rate 18%
- Low Birth Weight (<2500g) – 13.6%
- Mean BW 3145g
- Cesarean delivery rate 37% (23% primary LTCS)

NBC Outcomes

Urine Tox Results:	1st TM	3rd TM
Positive for illicit substance	52%	21%
Positive for methadone/buprenorphine	14%	15%
Negative	34%	64%

NBC Outcomes

- Child Protect Services involvement - 50%*
- Any PP visit – 81%
- Any well child visit in NBC – 83% (excludes those w/o custody)
- PP Depression – 20%*
- Tier 1 contraceptive rate – 52% (64% among those w/ a PP visit)

*data limitations

NBC Successes

- Increased number of prenatal visits for this population
- More frequent visits
- Improved identification and focused treatment of psychiatric co-morbidities
- Increased retention of patients after transitions into/out of jail or residential treatment programs
- Role modeling high quality collaborative care for family medicine residents
- Reduced stress and increased satisfaction for providers caring for this population

Ongoing Advocacy and Projects

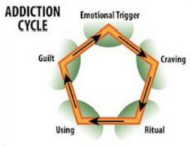
- Advocating for needed change within our community
  - Acceptance of women on MAT into residential treatment facilities
  - Allowing women to continue MAT in all child welfare cases
  - Changing attitudes towards this patient population by staff on L&D and in clinic
  - Increased community awareness about the availability and success of treatment
- Working to increase access to LARCs in our hospital setting
- Need for improved data collection process
- Increase peer support for our patients in NBC

Recommended Components of Care for Pregnant Women with Substance Use Disorder

- Access to opioid agonist treatment options for women with Opioid Use Disorder
  - Methadone or buprenorphine
- Access to obstetric care
  - Recovery-affirming and trauma-informed
  - Comprehensive obstetric and addiction medicine services
- Access to psychiatry consultation: assessment and treatment options for co-occurring disorders
- Access to behavioral health counseling: individual or group
- Resource guides for community-based relapse prevention
  - Mutual aid support groups
  - Mothers-in-recovery groups
- Development of enhanced postpartum care: program development to intensify recovery support potentially utilizing peer supports
  - Close follow-up (<2 weeks from delivery)
  - Allow for multiple postpartum visits (every 2 weeks for 3-6 visits)
  - Breastfeeding/lactation support
  - Screening/treatment for postpartum depression
  - Transition to primary care provider familiar with substance use disorder and its treatment

Saia, K.A. et al, 2016

Let's explore Perinatal Substance Use Disorder in more depth From the woman's perspective



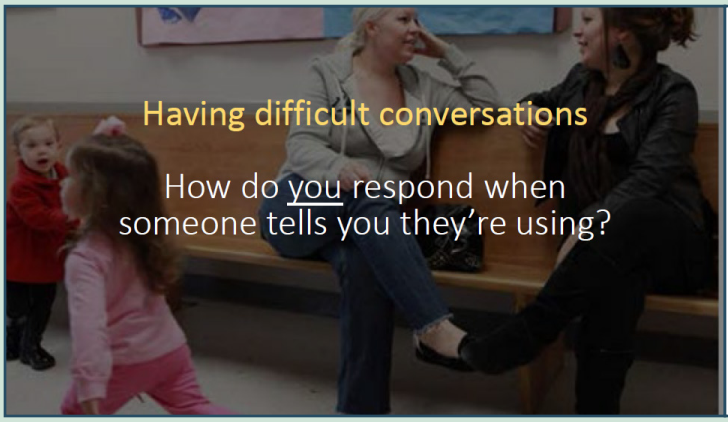
Humanistic Approach –

Being person centered

Recognizing where they are at this point in time

Helping them to move forward in a positive way

Unconditional positive regard



Why Don't Women Tell Us About their Substance Use?

- Fear of child welfare authorities or police
- Feelings of shame, fear and low self-esteem
- Co-morbid depression, anxiety and trauma
- Past negative experiences with judgmental providers
- Past involvement with child welfare services
- Denial that level of use is a problem

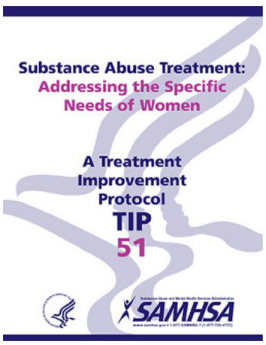
ACOG committee opinion, No. 422, 2008; Kandall, S., 1996; Jessup, 2003.

You're so hard on yourself.
Take a moment.
Sit back.
Marvel at your life:
at the grief that softened you,
at the heartache that wisened you,
at the suffering that strengthened you.
Despite everything,
you still grow.
Be proud
of this.

"After A Traumatic Experience, The Human System Of Self-Preservation Seems To Go Onto Permanent Alert, As If The Danger Might Return At Any Moment."

Drug Free Babies

Types of treatment & services



Referral to care – level of care

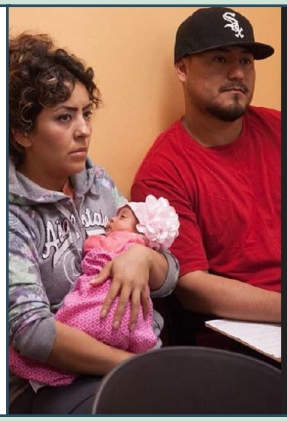
Pregnant women prioritized!

And those using IV drugs

Medication Assisted Therapy

–

why, what, how - but what about the baby?!?!



Postpartum period – 4th trimester

Vulnerable time for moms – risk for relapse

Focus shifts to baby, while moms need extra support

Encourage BF and provide extra support – these moms are vulnerable

Start talking to moms – before their baby comes - help them make a plan for this period

PM Breakout Session #4

2017
Sonoma County
Early Childhood
Mental Health Summit
Building Relationships to Support
Families in Times of Stress

How Music, Rhythm & Movement Help Heal Trauma & Develop Self-Regulation

Nick Dalton, Assistant Director, Hanna Boys Center, Co-Founder of "heART without borders"
Roberta Acevedo, Music Director, Child Parent Institute Creative Arts Department
Ozlem Ozdener, Certified Kidding Around Yoga Instructor

Nick Dalton serves as the Assistant Director of the Hanna Institute at Hanna Boys Center, which serves as a Trauma Informed Care and Resiliency hub in Sonoma County and the North Bay. With an extensive background in Arts as Healing for over the past decade worldwide, some highlights include building the education program at Transcendence Theatre Company; serving as Director of "The MAYA Project" for Teach For India - where slum children's academics soared an average of 2 grade levels in 9 months using a combination of arts integration, SEL activities, and more; and helping spearhead the Artist As Citizen movement for college students nationwide through the Kennedy Center. He also spent 15 years in the Broadway community as an interdisciplinary artist.

Roberto Acevedo serves as Music Director for Child Parent Institute's Creative Arts Department, leading music programs for school-based groups and summer camps serving children and youth who have experienced early trauma. An experienced musician, composer, and teacher, Roberto studied jazz performance and composition at New World School of the Arts. He has served as band director at several Sonoma County elementary schools, instructor of music performance and technology at New Song Music Camp, and youth orchestra creator/instructor/conductor at Orchestra Seinem de Montezuma Costa Rica.

Ozlem Ozdener is a certified Kidding Around Yoga instructor, working with children of all ages around Sonoma County. Her classes explore playfulness, motivation, movement, and storytelling, while practicing yoga with music. She trains teachers to create mini yoga lessons and to integrate in-class yoga breaks and mindfulness practice.

PM Breakout Session #5

2017
Sonoma County
Early Childhood
Mental Health Summit
Building Relationships to Support
Families in Times of Stress

Efectos de abuso de substancias durante y despues de el embarazo y como afecta en la paternidad (Perinatal substance abuse & how it affects pregnancy and parenting)

Analilia Gonzaga, Child Parent Institute
Gabriel Gopar, Child Parent Institute

Analilia Gonzaga - Bilingual Parent Educator at Child Parent Institute
Masters of Arts Degree in Sociology- Sacramento State University
Currently enrolled in the Human Services Department at
Santa Rosa Junior College with emphasis on the Drugs and Alcohol Program.

Gabriel Gopar -Bilingual Parent Educator at Child Parent Institute
Bachelor Degree in Philosophy and Theology –Puebla Mexico
Certificate on Drugs and Alcohol- Berkeley, CA

- Efectos de substancias en el estado prenatal; salud de la madre y de el bebe
- Efectos en la paternidad
- Preocupaciones de el desarrollo
- Prevencion efectiva y metodos de intervencion

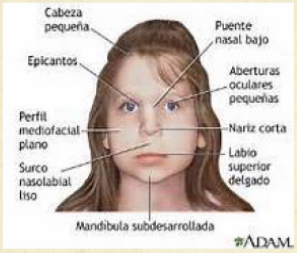
Drogas de abuso mas utilizadas

- Opiaceos: heroina, metadona, morfina, codeina
- Hipnotico: sedantes, alcohol
- Cannabioides: marihuana
- Estimulantes: cocaina, anfetaminas

- **Heroina:** los pequenos desarrollan la adiccion desde que estan en el vientre, por lo que durante los primeros dias o semanas de nacimiento presentan syndrome de abstinencia, que causa irritabilidad, disminucion de los estados de alerta, temblores, movimientos anormales, hypertonia (tension exagerada del tono muscular), y alteraciones del sueno. Durante el primer ano de vida son frecuentes los transtornos de coordinacion motora y altos niveles de actividad, ademas de poco auto-control.

www.salud180.com

Sindrome de alcoholismo fetal



Abuso de substancias y efecto en la salud de la madre y de el bebe

Los danos para el bebe

- **Marihuana:** Provoca que llegue menos oxigeno y nutrientes al feto, por lo que es comun que nazca con un alto riesgo de desarrollar desordenes de atencion y problemas de aprendizaje que no pueden ser detectados hasta la edad escolar.
- **Cocaina:** Interfiere con el flujo de oxigeno y nutrientes que recibe el feto. Al nacer suelen tener un peso y tamano mucho menor que el que tendria un bebe cuya madre no consumio drogas en el embarazo.

<www.salud180.com>

Alcohol

- se registra desde un ligero a grave retraso mental, distraccion, falta de concentracion, retraso al hablar, problemas para oir o ver, problemas al relacionarse con otras personas y en controlar su comportamiento.
- El consumo de etanol durante el embarazo puede ocacionar sindrome de alcoholismo fetal (SAF).
  - Bajo peso al nacer, menor perimetro craneal, retraso de crecimiento y desarrollo, disfuncion organica, anomalias faciales; ojos de tamano inferior al normal, mejillas aplanadas y surco nasolabial poco desarrollado.

- **Tabaco:** disminuye los movimientos respiratorios fetales, altera la frecuencia cardiaca y representa un mayor riesgo de parto prematuro y de abortos espontaneos, asi como de retardo del crecimiento fetal.

<www.salud180.com>

Problemas perinatales

Hijo de madre adicta a drogas

- Placenta previa y desprendimiento de placenta
- Prolapso de cordon
- Retraso de crecimiento intrauterino
- Prematuridad
- Asfixia perinatal

Sindrome de abstinencia neonatal

Entre el 55% y el 94% de los recien nacidos expuestos a heroina, Metadona y otros opiaceos desarrollan un sindrome de abstinencia.

- Hijos requieren major atencion medica y cuidado en el hogar
- Muerte subita- 3 a 7 veces el riesgo
- Evitar humo de Tabaco
- No dormir con los ninos en la misma cama
- Ninos inquietos/nerviosos con problemas de sueno
- Problemas de comportamiento
- Dificultad de aprendizaje y concentracion.

Efectos en la Paternidad

Efectos en la paternidad cont.,

- Medio ambiente
- Expectativas realistas
- Disciplina
- Cuidado personal
- Influencia familiar
- Respuestas ala conducta
- Trampas de escalacion
- Dar indicacioness
- Observar
- Consequencias/castigar
- Relacion entre los padres
- Finanzas
- Violencia
- Abandono
- Divorcio

Preocupaciones de el desarrollo

Preocupaciones de el desarrollo

- Nacimiento prematuro
- Peso de nacimiento
- Defectos de nacimiento
- Incapacidades en el desarrollo
- Necesidad de asistencia social

Problemas postnatales

de hijos de madres adictas a drogas

- Sindrome de abstinencia neonatal; problemas respiratorios
- Problema de aprendizaje, la memoria y control emocional
- Alteracion de desarrollo psicomotor y del crecimiento
- Incidencia aumentada de Sindrome de muerte subita

Prevencion efectiva y metodos de intervencion

Red de influencia

- Individuo
  - Familia
  - Sociedad/ambiente
  - Comunidad
  - Escuela
  - Pares

Factores de proteccion

- 5 aspectos claves
- Familias
- Escuelas
- Comunidades

5aspectos claves

- Crear un ambiente seguro e interesante
- Crear un abmbiente de aprendizaje positivo
- Utilizar la disciplina asertiva
- Tener expectativas realistas
- Cuidado personal

La familia

- La relacion entre padres e hijos y la participacion de los padres con los hijos.
- Monitoreo y supervision; establecer reglas, tecnicas para el monitoreo de actividades, elogio por conducta adecuada, consistencia.

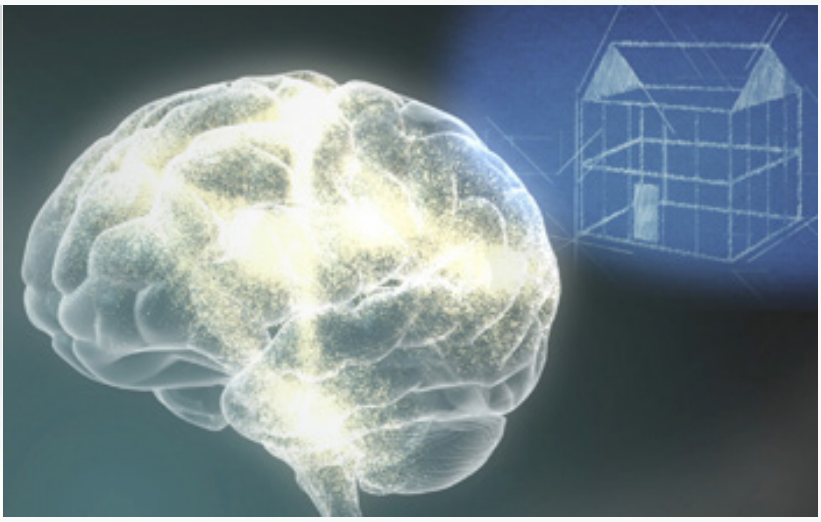
Escuela

- auto control
- comunicacion
- Relaciones con los companeros
- Auto-eficiencia y reafirmacion personal
- Abilidades para recistir las drogas
- Fortalecimiento del compromiso persona contra el abuso de drogas

Programas comunitarios

- Escuelas, clubes, organizaciones religiosas, y medios de comunicacion son mas eficaces cuando se presentan a travez de mensajes consistentes en cada uno de los ambientes a lo largo de la comunidad.
  - <NIDA>

Brain Architecture Game



The brain architecture game helps people appreciate the impact of early childhood experiences on outcomes across the lifespan.

The Brain Architecture Game builds understanding of the powerful role of experiences on early brain development– what promotes it, what derails it, with what consequences for society.

The goal is to build a brain that is as tall as possible, which represents functionality, and as sturdy as possible, which represents the ability to withstand stresses. Groups of four to six players work together, drawing Life Experience cards to gain materials for brain building.

Positive experiences earn a pipe cleaner and a straw for support. Negative experiences? Pipe cleaner, but no straw. After the initial period of early childhood brain development, weights must be hung from the structure of the brain when life hands out stressors. Will the foundation withstand these weights, or will it collapse? Afterward, groups use the notes in their Life Journals to discuss the experiences that strengthened, or weakened, the architecture of their developing brains.

3:00-4:30pm
Empire Room

Introduces core concepts from developmental science.

Easy to understand and simple to play - but hard to forget.

Establishes a strong, shared frame for productive conversations on a range of early childhood issues, policies and programs.

References/Resources

AM Breakout Session #3: Adverse Childhood Experiences (ACEs) in the Perinatal Period
Resources

- Child Trauma Academy: www.childtrauma.org
- Harvard Center on the Developing Child: www.developingchild.harvard.edu
- ACE Study: https://www.cdc.gov/violenceprevention/acestudy/index.html
- Sonoma County ACEs Connection: http://www.acesconnection.com/g/sonomacounty-aces-connection
- Postpartum Support International: Postpartum.net
- Child Parent Institute: Calparents.org
- Mothers Care: Mothercaresupport.com
- Mothertobaby.org
- 2020mom.org

AM Breakout Session #4: Sensory Implications of Early Childhood Trauma
Reference

- Ayres, A.J. (2005/1976). Sensory Integration and the Child. Los Angeles: Western Psychological Services.
- Bodison, S., Watling, R., Kuhaneck, H.M. & Henry, D. (2008). Frequently asked questions about Ayres Sensory Integration. American Occupational Therapy Association. https://www.aota.org/-/media/Corporate/Files/Practice/Children/Resources/FAQs/SI%20Fact%20Sheet%202.pdf
- Chesler, A.T., Szczot, M., Bharucha-Goebel, D., Ceko, M., Donkervoort, S., Laubacher, C., et. al. (2016). The role of PIEZ02 in human mechanosensation. New England Journal of Medicine, DOI: 10.1056/NEJMoa1602812
- Koomar, J.A. (2009). Trauma- and attachment-informed sensory integration assessment and intervention. Sensory Integration Special Interest Section Quarterly, American Occupational Therapy Association, Inc., 32 (4).
- Miller, L.J., Anzalone, M. E., Lane, S.J., Cermak, S.A. & Osten, E.T. (2007). Concept evolution in sensory integration: A proposed nosology for diagnosis. American Journal of Occupational Therapy, 61(2) 135-140.
- Mori, A.B. (2015). Addressing Sensory Integration and Sensory Processing Disorders Across the Lifespan: The Role of Occupational Therapy. American Journal of Occuaptional Therapy fact sheet. https://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/CY/Fact-Sheets/FactSheet_SensoryIntegration.pdf

Resources

- The Trauma Center at Justice Resource Institute, Brookline MA.: SMART (Sensory Motor Arousal Regulation Treatment: Elizabeth Warner, Alexandra Cook, Anne Westcott, Jane Koomar, 2014.
- Spiral Foundation: http://www.thespiralfoundation.org/
- Sensational Brain: https://www.sensationalbrain.com/
- Koomar Center/Occupational Therapy Associates Watertown: http://www.otawatertown.com/
- STAR Institute: https://www.spdstar.org/

PM Breakout Session #1: Families as Complex Cultural Systems
Reference

- Carter, R.T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. Counseling Psychologist, 35, 13-105.
- Falender, C. A., Shafranske, E. P., & Falcov, C. J. (2014). Diversity and multiculturalism in supervision. In Carol A. Falender, & Shafranske, Edward P. (Eds.), Casebook for clinical supervision: A competency-based approach. (pp. 121-136). Washington, DC, US: American Psychological Association.
- Hook, J. N. (2015). Cultural humility: The cornerstone of positive contact with culturally different individuals and Groups? American Psychologist, Oct. 661-662
- Lowe, S. M., Okubo, Y., & Reilly, M. F. (2012). A qualitative inquiry into racism, trauma, and coping: Implications for supporting victims of racism. Professional Psychology: Research and Practice. 43(3), 190-198.
- Okazaki, S. (2009). Impact of racism on ethnic minority mental health. Perspective on Psychological Science,4(1), 103 -107.
- Ong, A. D. & Burrow, A. L. et al. (2013). Racial microaggressions and daily well-being among Asian Americans. Journal of Counseling Psychology, 60(2), 188-199.
- Sotero, M.M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. Journal of Health Disparities Research and Practice, 1(1), 93-108.
- Stroud, B. (2015). Intentional Living: finding the inner peace to create successful relationships. North Charleston, SC.
- United States Department of Health and Human Services (2001). Mental Health: Culture, Race, and Ethnicity –a Supplement to Mental Health.Rockville, MD: US Department of Health & Human Services.