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SHORT NOTE

Clinician Attitudes about Health Care Services Addressing Adverse Childhood Experiences

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Abstract

Objectives: Study objectives were to elicit feedback from clinical experts in areas with demonstrated health disparities to assess: (1) Perceptions of the relations among Adverse Childhood Experiences (ACEs), parenting, and childhood health disparities; and (2) Recommendations about pediatric health care services to address ACEs and toxic stress.

Methods: Qualitative interviews were conducted with clinical experts (n = 5) in pediatric primary care, asthma and allergy, obesity, and trauma. Interviews were transcribed and coded through iterative thematic extraction.

Results: Two major themes emerged: (1) Need for improved health care access; and (2) Need for family-centered care. Clinicians reported several health care service implications to address the two themes.

Conclusions: Clinicians emphasized collaborative models that integrate physical and behavioral health services to meet needs of at risk populations in partnership with community centers (i.e. head start centers and schools). Strategies identified aim to prevent and address ACEs in specialty and primary care.

Keywords

Adverse childhood experiences, Toxic stress, Family-centered care, Integrated care, Qualitative research

Introduction

Toxic stress resulting from chronic exposure to Adverse Childhood Experiences (ACEs), including trauma exposure, parent mental health problems, and family dysfunction, can lead to numerous health, social, and behavioral problems throughout the lifespan [1]. Further, children of parents with high numbers of ACEs are at greater risk for ACEs themselves [2], producing a multi-generational cycle that leads to a range of health disparities [3]. ACEs have been linked to a range of negative health outcomes in children, including presence and severity of asthma [4,5]; obesity [6,7]; type II diabetes [8]; and mental health and behavioral problems, such substance abuse, school and behavioral problems, anxiety, depression, and Post-Traumatic Stress Disorder (PTSD) [6,9,10]. Disproportionate ACEs exposure and risk for toxic stress is related to health disparities experienced by racial/ethnic communities [11,12]. Growing recognition of the contribution of ACEs to negative health outcomes and health disparities has led to calls for ACEs screening in pediatric primary care and innovative health care strategies to prevent toxic stress transmission [13,14]. Pediatric health care providers' perspectives on ACEs may inform the role of health care services in promoting resilience among children and families.

We conducted a qualitative study among clinicians from a children's hospital with expertise in behavioral and physical health problems related to ACEs. The objectives were to elicit: (1) Perceptions about the relations among ACEs, parenting, and childhood health disparities from clinical experts who treat pediatric health conditions that are associated with lower socioeconomic status and racial/ethnic minority status, includ-

ing mental health problems, asthma, and obesity; and (2) Recommendations about effective methods of leveraging community-level, maternal/family-level, and individual-level supports and services to reduce the number and severity of ACEs in young children and mitigate the negative health outcomes associated and health disparities associated with ACEs.

Methods

The study was approved by the Children's Mercy Hospitals Institutional Review Board (IRB). We conducted qualitative interviews with five clinical experts, including two primary care pediatricians, one pediatric asthma and allergy specialist, and two child clinical psychologists specializing in childhood obesity and trauma, respectively. The mean years of clinical experience were 11.2, and the sample included two African American female clinicians and three white female clinicians.

Clinicians were recruited based on their areas of expertise via a study informational flyer and volunteered to participate by contacting the study team to schedule an interview and providing informed consent. All interviews were conducted by two of the study authors with extensive training and experience in qualitative research methods and lasted 50 minutes on average. The semi-structured interview guide began with open-ended questions about ACEs and health outcomes and then moved to questions designed to elicit prevention and resilience promotion health service intervention recommendations (see Appendix A). We used audio-recording, professional transcription, standardized data coding in Atlas.ti Version 7, and iterative thematic extraction to support internal validity [15]. The lead study author proposed preliminary codes based on the first two interview transcripts, and presented them to the study analysis team for further refinement. After developing the

Table 1: Key themes, health care service implications, and exemplar quotations.

Unmet need	Health care service implications	Exemplar quotations (participant id)
Health care access	• Integrate physical and behavioral health • Provide cohesive, coordinated care • Increase community-based access • Address mental health stigma • Address transportation problems	*"As much as parents want to address their child's mental health concerns or their mental health concerns, when there's physical needs, that often times takes precedence over the mental health needs. So being able to see that those are also addressed"* (P102) *"I've recommended mental healthservices because I think it's affecting their disease and how they're managing their disease, and families a lot of times are very, very reluctant…Maybe starting first with…educational materials that take away that stigma…* (P101) *"You go to where parents are. You go to schools. You go to daycares. You go to churches…You look at your community and you say, 'Where do parents gather?' And…you go in and do education and interventions…"* (P104) *"I think sometimes the easiest thing to do is to make it* [conversation about toxic stress] *part of every preventative visit"*. (P105) *"Having reach…reduces mental health stigma…I have this fantasy of buying a bus to bring into my neighborhoods and see my patients where they are… as well as primary care offices and schools"* (P103)
Family-centered care	• Partner with families at risk to tailor services to meet their needs • Treat parent and family mental health problems to improve children's health • Build trusting relationships • Improve case management and "warm hand off" to providers	*"I think the first thing is talk to families and see what they would find helpful… asking what families see as valuable and worthwhile".* (P105) *"In a lot of communities, mental health problems aren't discussed in the home…So I think trying to make people aware that these are real diseases… if it's a parent that has mental disease that is not being treated, how that affects the kids in the house and the whole household…There's treatments out there for them".* (P101) *"That is my number one barrier to treatment success* [in children] *is a lack of mental health treatment and access for the parents.* (P103) *"Parents trust this place* [acute pediatric clinic at a Head Start community center], *so they trust us as an extension of it. Two, they're here anyway. It's part of their daily life".* (P105) *"So if you're trying to provide anticipatory guidance on basic parenting interventions…'Here's a provider who can help you...'"* (P102)

codebook, the remaining transcripts were coded by the first author and code reports were generated to identify patterns emerging across transcripts. The analysis study analysis team discussed these patterns and developed broader categories to group codes and identifies prominent themes, health care service implications, and exemplar quotations.

Results

All of the clinicians described extensive knowledge of ACEs and emphasized the importance of assessing and responding to ACEs in their treatment planning. Two key themes emerged from the qualitative interviews: (1) Need for improved health care access; and (2) Need for family-centered care (Table 1).

Discussion and Conclusions

Findings from this qualitative study support prior recommendations for improved health care access and implementation of family-centered care models to prevent and address Adverse Childhood Experiences (ACEs) [13]. Although clinicians called for collaborative models that integrate physical and behavioral health services, they described a dearth of easily accessible adult behavioral health and parenting-focused services as well as substantial barriers to accessing existing services (e.g., not conveniently located, stigma of mental health treatment, provider mistrust, transportation and scheduling problems). Clinicians discussed the importance of tailoring services to families by making contact in community locations that families frequent. Collaborations between pediatric hospitals and community centers frequently accessed by at risk populations, such as Head Start centers and schools, can improve health care access for families at risk for toxic stress.

In addition to making it easier for families to access needed services, clinicians recommended spending time to educate parents about mental health problems and available services in order to address mental health stigma and other concerns. Trust and communication in the clinician-parent relationship emerged as a key element of successful implementation of family-centered care. Families can be further engaged in family-centered care via pediatric providers' referrals to behavioral health resources during treatment encounters for health problems associated with ACEs, such as preventative pediatric care, treatment for childhood asthma, allergies, and obesity, and acute care. Trusted providers are best poised to educate families about the links between ACEs and health, normalize treatment for mental and behavioral health problems, and provide a "warm hand off" to appropriate services for children as well as for their parents.

These results are limited by insufficient support for external validity due to our small sample size. This study was developed to inform pediatric health care services in our community setting, and some results may not be relevant in other institutional and community settings.

In sum, implementation research guided by partnerships with families through a patient-centered or Community-Based Participatory Research (CBPR) approach is needed to illuminate effective policies and processes for delivering accessible family-centered care. CBPR-informed family-centered care approaches to addressing and preventing toxic stress in early childhood could play a vital role in the mitigation of health disparities [16-19].

Ethical Statement

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This study was approved by The Children's Mercy Hospital Institutional Review Board.

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Appendix A:

Semi-structured Interview Guide for "Clinician attitudes about Health Care Services Addressing Adverse Childhood Experiences" Manuscript

Introduction

I want to start by thanking you for helping us with this project today. You were asked to help us better understand your thoughts and experiences pertaining to the associations between Adverse Childhood Experiences (ACEs) and health outcomes in children and families and what services and programs you think would be most beneficial in alleviating the damage caused by toxic stress.

There is no right or wrong answers, and I am not here to judge your comments in any way. Your experiences and perceptions are very important to us, and we are interested in learning from you. Please be creative with your suggestions. We want to know all the different things we could do and what we should do. Because we want to make sure that we catch everything you say, we will be audio-recording our discussion if that is OK with you. There is a lot to cover, and I need to make sure we get input on specific things in our discussion, so I apologize in advance if I have to redirect our conversation at any point in time.

Do you have any questions?

Great, let's get started.

I want to remind you that you can skip any question you do not want to answer and stop the interview at any time. I'd like you to please read through this informed consent form that explains more about your rights as a participant. If you would like to continue with the interview, please sign two copies of the informed consent.

(Administer the informed consent)

I would like to have your permission to audio record this interview. The recording will be used to help us write a report about the things we talk about here today.

Begin Recorder: *This is participant ID [insert ID number here] for project [insert project number]. Do I have your permission to record this interview? I want to confirm that you have read and signed a consent form.*

ACEs and Health Outcomes

Share ACEs Screening Form with Clinical Expert

1. In your clinical practice, what do you see as the relationship between various ACEs and health outcomes?

2. Which ACEs do you think are most common in your patient population?

3. A project done in Philadelphia identified three additional ACEs: (1) Witnessing violence; (2) Experiencing racism; and (3) Living in an unsafe neighborhood. Do these ACEs affect your patient population? If so, how?

4. How do ACEs affect health care service delivery?

5. How do ACEs affect health disparities?

6. Some of the measures that have been considered for evaluating health outcomes related to toxic stress resulting from ACEs include:

- Obesity (BMI)

- Asthma severity

- Mental health symptoms and diagnoses

- Trauma symptom severity

- Diabetes risk

- Inflammation

- Stress hormone levels

- Cardiovascular reactivity

- Telomere length

- Oxidative stress

Which of these do you think would be important and relevant to measure in evaluating children and families at risk of poor health outcomes associated with ACEs and toxic stress and why?

7. Are there other measures we should consider for evaluating health outcomes related to toxic stress resulting from ACEs?

ACEs Prevention and Resilience Promotion Intervention Recommendations

1. What would you do if you were developing ACEs prevention resources?

2. What would you include if you were developing resources to help children and parents with mental health problems related to ACEs?

3. What would you include if you were developing resources to help children and parents with physical health problems related to ACEs?

4. What do you think is important to help keep your patients from health risks related to toxic stress?

5. What do you think is important to help your patients deal with mental health and emotional problems?

[Information about ACEs to disseminate-Share toxic stress video (http://developingchild.harvard.edu/index.php/resources/multimedia/videos/three_core_concepts/toxic_stress/) and ACEs handout]

6. What did you learn from the toxic stress video and ACEs handout that you think is important for your

patients to know?

[Recommendations to reach parents and children with Unmet Mental and/or Physical Health Needs]

7. What do you think are barriers for families with ACEs in accessing preventative health care (e.g., vaccines, screenings, well-visits)?

8. How can children and parents with health problems who are not getting help be reached (online, telephone, one-on-one, group, performing arts events, etc.)?

9. How can children and parents with mental health problems who are not getting help be reached (online, telephone, one-on-one, group, performing arts events, etc.)?

10. Where should we go to reach children and parents with health problems in the community?

11. Where should we go to reach children and parents with mental health problems in the community?

[Closing]

Is there anything else you would like to share today?