一、 Colorado Department of Human Services 文宣

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Working Together Project Overview

PURPOSE

Working Together applies a two-generation focus to support families enrolled in evidence-based home visiting to increase their self-sufficiency. The project impacts caregiver access to and completion of the GED, short-term college certificate programs, workforce training, and financial literacy education. While caregivers are working toward their goals, their young children will simultaneously receive quality care and support services to optimize their development. Working Together is an innovative approach, based on theory and research, which streamlines and augments existing programs that support vulnerable families.

"Education is a key component of two-generation approaches, but the power of education is enhanced when families also have access to Economic Supports, Social Capital, and Health and Well-being."[1]

DESCRIPTION

Wraparound services will be provided to 110 families to support the successful return to school and work. Families will receive evidence-based home visiting, financial literacy education, access to high-quality child care, connections to counseling, public assistance such as child care subsidy, basic needs support, and ongoing case management. Caregivers may choose to enroll in GED classes, short-term college certificate programs, or a bridge curriculum to prepare for community college classes. Caregivers will also enroll in targeted employment readiness skills and career placement services.

These integrated services will be provided through a seamless referral network and series of warm hand-offs by a Collective Impact team. The following organizations support implementation:

- La Llave: Parents as Teachers, backbone agency
- Trinidad State Junior College (TSJC): higher education
- San Luis Valley Early Childhood Council (ECC): Child Care Resource & Referral, ECC professional development
- San Luis Valley (SLV) Behavioral Health Group: Healthy Steps, counseling
- Colorado Workforce Center: employment readiness skills and career placement
- Mpowered: financial literacy
- La Puente: basic needs and family advocacy
- County Departments of Human Services: Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Colorado Child Care Assistance Program (CCCAP)
- Civic Canopy: collective impact support
- Colorado Department of Public Health and Environment: evaluation
- Colorado Department of Human Services, Office of Early Childhood: grant administration

Two foundations offered matching funds for expenses that are necessary but not allowable under Working Together. The Temple Hoyne Buell Foundation will purchase a modular child care center to serve MIECHV families, and the El Pomar Foundation will support the provision of basic needs such as auto repair or utility assistance.

ELIGIBILITY

Families enrolled in the MIECHV Parents as Teachers, Healthy Steps, Nurse Family Partnership, or SafeCare Colorado program between February 1, 2017, and November 30, 2018, may enroll in Working Together. Eligible counties include Alamosa, Saguache and Costilla.

[1]Retrieved from: http://ascend.aspeninstitute.org/pages/education

DESIRED RESULTS

Goal 1: Increase the short, medium, and long-term earning capacity of MIECHV families via formal education and training programs.

- *Objective 1:* Within one year of enrollment, 75% of enrollees pursuing additional education will pass a general high school equivalency test, complete a bridge education program that prepares the enrollee to engage in post-secondary education, or complete credit hours toward a short-term certificate program at TSJC with a passing grade.
- *Objective 2:* Within one year of enrollment in workforce center services, 50% of enrollees will secure employment.

Goal 2: Increase the competency and knowledge of MIECHV caregivers around financial planning and budgeting via financial literacy training.

- *Objective 1:* Within one year of enrollment in financial literacy programming, 75% of families will have utilized a spending plan (budget).
- *Objective 2:* Within one year of enrollment in financial literacy programming, 75% of families will improve at least two measurements on an evidence-based financial capability scale, such as the Mpowered Financial Capability Scale.

Goal 3: Improve coordination of the Early Childhood, Economic Security, and Higher Education Systems in the San Luis Valley.

- The implementation team will form a partnership based on the five components of Collective Impact: Common Agenda, Common Progress Measures, Mutually Reinforcing Activities, Continuous Communication, and Backbone Agency.

COMMUNITY CONTEXT

The target project area identifies communities with high rates of poverty, unemployment, low educational attainment, lack of public transportation, high rates of substance abuse, and rates of homelessness that are ten times the national average.[2] Additional barriers include challenges with travel (distance and cost of mileage), availability of infant and toddler child care, fear of returning to school, and unplanned costs of returning to work and school.

Working Together will serve families in highest need of education and workforce services. In 2015-16, 37.5% of families enrolled in Colorado's federally funded home visiting programs earned incomes under 50% of the federal poverty level ($12,125 for a family of 4) and nearly 60% of families earned incomes under 133% of the federal poverty level ($32,252 for a family of 4).[3]

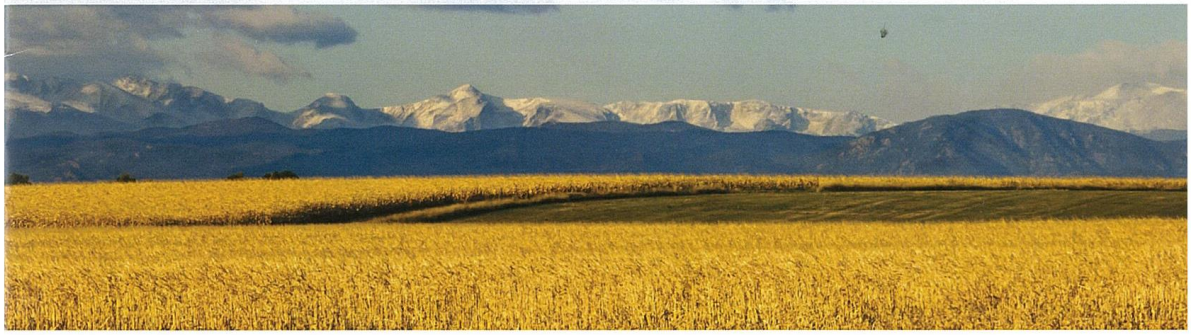
Community strengths include strong leaders who have demonstrated vision in tackling complex social problems, investments in creating pathways out of poverty, and a history of successful collaboration.

RESEARCH

- Research shows that for every dollar invested in adult education (GED programs), a core component of Working Together, the community sees a $60 return in decreased welfare costs, tax revenue, and economic activity.[4]
- Working Together is based on research by the Annie E. Casey Center for Working Families (CFW) initiative. The Greater Detroit CFW Collaborative served 2,465 individuals from 2008 to 2010 in a similar program, and evaluation demonstrated a 405% return on investment (ROI) over that time frame.[5]
- This innovation is based on CWF research showing clients who received bundled services were five to six times more likely to experience an increase in income and net worth than clients receiving only one service.[6]
- Studies on evidence-based home visiting program demonstrate a return on investment of $9.50 per dollar invested, with state and federal governments realizing $8.30 of the ROI.[7]

[1]Cheslock, L. (2015). Counting the Homeless: A Daunting Task. San Luis Valley Health. Retrieved 10 May 2016, from http://www.sanluisvalleyhealth.org/news/counting-homeless-daunting-task/2015-2-24
[2]Colorado Department of Public Health and Environment, 2/16/2017 email from Amber Viitanen, Senior Evaluator.
[3]COABE, Retrieved from: http://www.coabe.org/adult-education- is-needed- now/
[4]Financial Stability Through Integrated Service Delivery: Highlights from the United Way System, Retrieved from: http://unway.3cdn.net/a6b53e-050d6a0507f4_y0m6yx1rg.pdf
[5]Ibid
[6]Ibid

Parental History of Adversity and Child Well-Being: Insights from Colorado



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In this report, we utilize data from the Adverse Childhood Experiences module of the Behavioral Risk Factor Surveillance System and from a linked state-initiated Child Health Survey to evaluate the impacts of parental history of adversity not only on their own adult health, but on the current health and well-being of their children. These data provide a window on the intergenerational transmission of adversity, and a clear call to action. Cross-sector stakeholders including those from the research, policy, state-government, education, health, philanthropy, business, and legal communities in Colorado are working together to identify and protect against the serious life-long consequences of early life adversity. In this report, we highlight selected projects and efforts in Colorado to identify and prevent the short and long-term consequences of early life stress through family-centered approaches.

Supported by The Ben & Lucy Ana Walton Fund of the Walton Family Foundation

The Adverse Childhood Experiences (ACE) Study

Beginning in 1998, results from the Adverse Childhood Experiences (ACE) Study, a collaboration between the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente with over 17,000 participants, have had a tremendous impact (Felitti et al., 1998). This seminal study asked Kaiser patients in San Diego beginning in 1995 to respond to a 26-item survey about adverse experiences in their childhood (before the age of 18) and used their responses to calculate an ACE score ranging from 0 (no adversity in childhood) to 10. This ACE score was then linked to patients' health records, including health behaviors, chronic conditions, and mortality.

Some of the most impactful findings include the fact that two-thirds of respondents from the original sample reported at least one ACE, making adversity experienced in childhood a broad public health concern (Felitti et al., 1998). Childhood adversity was also related to health outcomes in a dose-response fashion, with greater adversity predicting both increased severity of symptoms and a broader range of chronic health conditions (Anda et al., 2006; Chapman et al., 2004; Dong et al., 2004). Perhaps most alarmingly, experiencing six or more ACEs was associated with a 20-year life span reduction among the Kaiser Permanente population [Brown et al., 2009]. These findings have also spurred an expansive literature base, with 2,404 scientific citations as of March, 2017 (see Figure 1), yet there remain limitations to the original ACE study. For example, as this was a retrospective report of adversity experienced in childhood, it may introduce the issue of recall bias and a lack of verification of experienced adversity. In addition, it is also possible that other early adversities and key protective factors may help to explain health outcomes.

Citations in Each Year

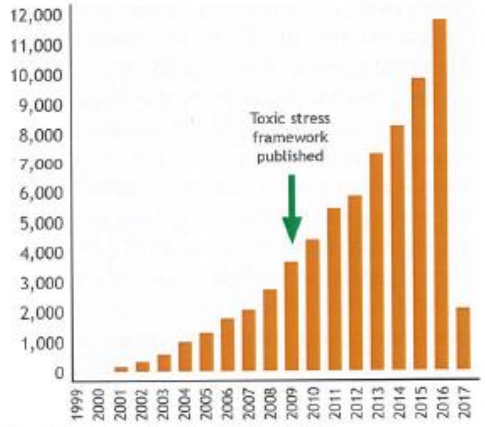

Figure 1: Citations of the 1998 ACE Study Article

The Toxic Stress Framework

In 2009, Shonkoff, Boyce and McEwen published their first paper on Toxic Stress in the *Journal of the American Medical Association*. This paper presented an organizing framework that integrated findings from animal models, human retrospective designs like the ACE study, and from studies of children. In this framework, the effects of stress are best understood by considering not only the severity and chronicity of stressors in childhood, but by considering the presence or absence of protective adult relationships (see Figure 2).

Stressors are considered toxic when chronic and/or severe stressors occur in the absence of the buffering support of an adult. When adult buffering is available, even chronic or severe stressors may be "tolerable" – that is, they may not require the child to reorganize their brain and body systems to cope. It is this reorganization of brain architecture and body systems to cope directly with severe

and/or chronic stress that can result in both short-term adaptation and long-term health consequences. For example, when a child faces chronic and severe stress in the absence of adult buffering, they cue their brain and body to be on the lookout for threats in the environment and to store energy to cope with future threats. We store energy in fat and stress results in fat deposits in particular around the midline (Aschbacher et al., 2014). This provides an energy store in the short run *and* is a major risk factor for heart disease in the long run (Onat et al., 2004). When, however, children can rely on adults in the face of stress, they can avoid this type of costly adaptation and preserve their long term health.

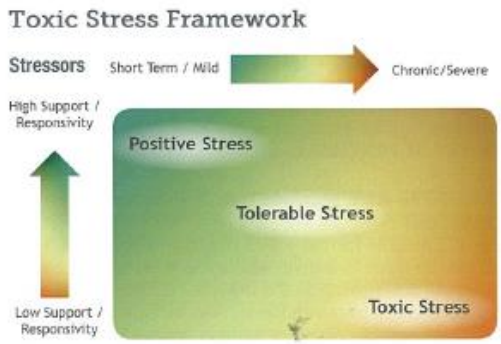

Figure 2: Toxic Stress Framework

The Power of Pairing the Toxic Stress Framework with the ACE Study Results

Paired together, the Toxic Stress Framework and the ACE study results have galvanized the research, policy, and practice communities to come together to understand this public health problem and to work toward prevention and intervention solutions. This is in part because the Toxic Stress Framework offers an explanation for when and how stress gets "under the skin" to result in the types of long-term health consequences captured by the ACE Study [Schlueter & Watamura, 2017].

Adapting the ACE Survey for State-Level Data

The ACE study and subsequent efforts with similar surveys have asked adults about their own childhood experiences and collected information from health records to document the lasting impacts of childhood adversities on health outcomes.

To make it possible to understand the impact of childhood adverse experiences on a wider scale, the CDC developed a shorter ACE module which can be used as an optional add-on to the Behavioral Risk Factor Surveillance System (BRFSS) survey used yearly by all states, Washington, D.C., and three territories (http://www.cdc.gov/brfss/). The BRFSS is a population-based annual survey used by the CDC to assess the nation's health status and includes information on health behaviors and chronic health conditions. By adding the ACE module, states are able to collect data on ACE exposure and on the connection between childhood adversity and individuals' reports of their current health behaviors and conditions. Because of the way the BRFSS is designed and administered, it allows states to estimate population level prevalence rates and to calculate odds of disease outcomes by risk factors such as ACEs. Several states including Alaska and Wisconsin have produced reports of their ACE findings, (Wisconsin: https://preventionboard.wi.gov/Documents/REVISEDWisconsinACEs.August2012.pdf; Alaska: http://dhss.alaska.gov/abada/ace-ak/Documents/ACEsReportAlaska.pdf) and a report inclusive of data from five states is also available [Bynum et al., 2010] (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5949a1.htm).

Overwhelmingly, when using the modified BRFSS ACE module as recommended by the CDC, states are telling the same story as the original ACE study. Specifically, ACEs are common and they have a lasting and significant impact on adult physical and mental health.

In states where economic data are available, this significant public health burden also has sizable economic consequences as chronic physical and mental health problems are costly to treat and severely decrease productivity. Furthermore, child maltreatment is costly for special education, criminal justice, and child welfare programs (Anda et al., 2004; Fang, Brown, Florence, & Mercy, 2012).

The BRFSS ACE Module & ACE Prevalence in Colorado

The ACE module for the BRFSS results in a maximum score of 8 adversities from 11 individual questions, as compared to a maximum score of 10 on the original 26-items (see Table 1). Key differences between the surveys include the fact that the BRFSS ACE module does not include neglect (9 items that resulted in 2 ACE points on the original survey) and the 4 items that assessed physical abuse of the mother or mother figure in the original 1995 survey have been reduced to a single item assessing domestic violence in the home. For exact wording of the questions asked on the BRFSS, see https://www.cdc.gov/violenceprevention/acestudy/pdf/BRFSS_Adverse_Module.pdf.

As established in prior research on ACEs, 4 or more ACEs are considered high exposure, with profound impact on health. Even experiencing 1-3 ACEs can increase risk for poor health, though this depends on the outcome.

BRFSS ACE Items by Type (Experienced before age 18)

Item Type	Items	Score
Abuse		
Emotional abuse (verbal)	1	1
Physical abuse	1	1
Sexual abuse	3	1
Household Dysfunction		
Parents ever separated or divorced	1	1
Household domestic violence	1	1
Household member substance abuse	2	1
Household member mental illness	1	1
Household member incarcerated	1	1
TOTAL	**11**	**8**

Table 1: BRFSS ACE Items by Type (Experienced before age 18).

A total of 3,677 Colorado adult residents, 18–98 years old, completed the ACE module as part of the 2014 BRFSS survey. As seen in Figure 3 and reported by the Colorado Department of Public Health and Environment (CDPHE) Health Watch 99 (http://www.chd.dphe.state.co.us/Resources/pubs/AdverseChildhoodExperiences.pdf), the ACE score results from Colorado are consistent with previous findings; approximately 62% of adult respondents reported experiencing at least one or more ACEs. Similar to other samples, nearly 15% of Colorado adults reported high ACE exposure (4 or more ACEs) as compared to 12.5% of the original ACE sample. The prevalence of women reporting 4 or more ACEs is greater (17.4%) than the prevalence among men (12.1%). Assessing educational attainment, the prevalence of reporting 4 or more ACEs among those who did not graduate from high school is higher (72.6%) than that of high school and college graduates (60.5%).

Percent of Adult Coloradans with Each ACE Score

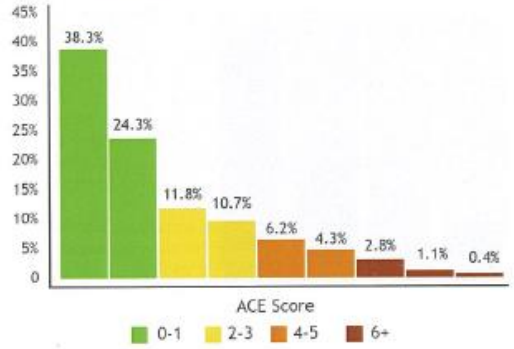

Figure 3: Percent of Adult Coloradans with Each ACE Score

ACE scores can be broken down into two categories:

1. Abuse
2. Household Dysfunction

As seen in Figure 4, among those experiencing abuse in childhood, the majority of adults reported emotional abuse followed by physical and sexual abuse. Among ACEs associated with household dysfunction, the majority reported parental divorce followed by substance abuse, mental illness, domestic violence, and parental incarceration. For more information on prevalence and demographics for Colorado ACE data, please also see: http://www.chd.dphe.state.co.us/Resources/pubs/AdverseChildhoodExperiences.pdf.

Although these rates are comparable to those reported in other states, this level of exposure to adversity in childhood is unacceptably high, with negative impacts for individuals, families, communities and our region.

Percent of Adult Coloradans Reporting Each Type of ACE

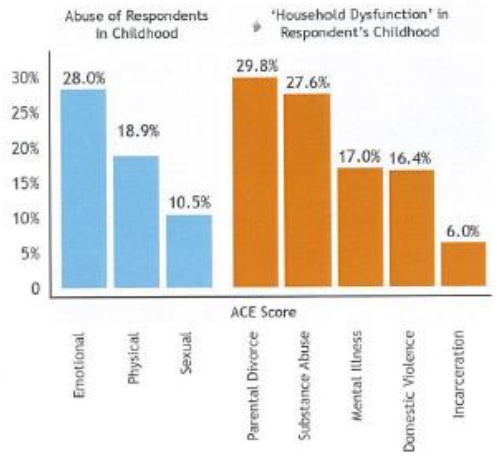

Figure 4: Percent of Adult Coloradans Reporting Each Type of ACE

ACE Exposure & Current Health Conditions in Colorado Adults

As in other states and the original study, ACE exposure is also connected to chronic health conditions creating substantial hurdles to overcome. In particular, controlling for respondent's age, sex, education level, and race, individuals reporting 1-3 ACEs were more likely to suffer from arthritis, disability, chronic obstructive pulmonary disease, and depression, and those reporting 4 or more ACEs were between 2 and 5.5 times more likely to suffer from a range of chronic conditions from cancer to depression. Figure 5 depicts the odds ratios reported by CDPHE as hurdles to illustrate that while significant, having experienced adverse childhood experiences is not deterministic.

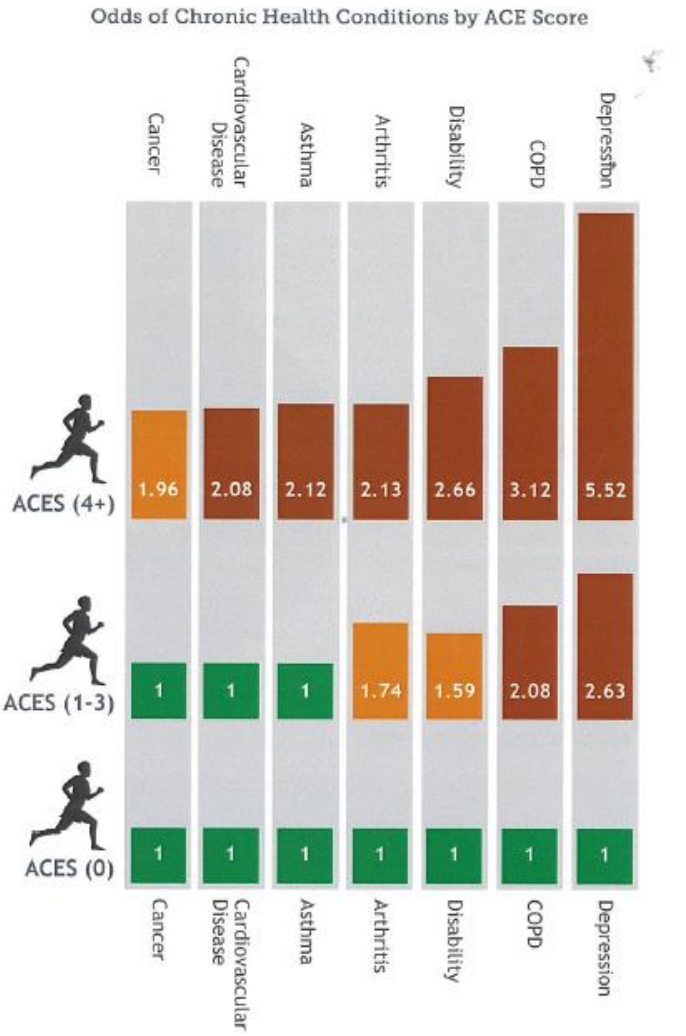

Figure 5: Odds of Chronic Health Conditions by ACE Score, controlling respondent age, sex, race, and educational level and using population weights

ACE Exposure & Current Health Behaviors in Colorado Adults

In the original publications from the ACE study it was proposed that childhood adversity resulted in long-term poor health outcomes primarily by increasing health risk behaviors (smoking, alcoholism, illicit drug use, insufficient exercise, risky sexual behavior, etc.; e.g., Anda et al., 1999; Dube et al., 2003). Indeed, associations between ACE scores and these health risk behaviors were found. This raises two important points. First is the question of whether childhood adversity impacts chronic health conditions exclusively or primarily because childhood adversity increases health risk behaviors. If this is the primary mechanism, programming that targets reductions in health risk behaviors, especially for individuals with high ACE scores, would be recommended. However, it could be the case that experiencing childhood adversity increases health risk behaviors and leads to chronic disease, without the only or primary mechanisms being engaging in increased health risk behaviors.

For example, there is evidence that childhood adversity changes the way the brain and body process and handle later stressful experiences, and these neural and physiologic changes could lead to chronic health conditions even in individuals with healthy lifestyles (e.g., Pechtel & Pizzagalli, 2011). This pathway could happen alongside or without increased health risk behaviors. In this case, programming that only targets reducing health risk behaviors would not be sufficient to prevent chronic health conditions.

Given the importance of this question for intervention, we first examined whether a higher ACE score was related to health risk behaviors/preconditions in the Colorado BRFSS data using complex samples in SPSS Version 23. Specifically, we examined whether respondents with higher ACE scores also reported more alcohol consumption, smoking, or obesity (which can be more likely when individuals have poor nutrition and exercise behaviors, among other factors).

In the 2014 Colorado BRFSS sample, controlling for respondent's age, sex, race and educational level, individuals with more childhood adversity were no more or less likely to be obese (i.e., a body mass index of 30 or greater) or to drink heavily (i.e., 15 or more drinks per week for males, 8 or more drinks per week for females). Those with 1-3 ACEs are 1.5 times more likely to report binge drinking (i.e., 5 or more drinks for males and 4 or more drinks for females on a single occasion) than are those with no ACEs; however those with 4 or more ACEs are indistinguishable from those with no ACEs with regard to binge drinking.

However, controlling for respondent's age, sex, race, and educational level, those with 1-3 ACEs are 1.87 times more likely to smoke and those with 4 or more ACEs are 3.5 times more likely to smoke than are Coloradans with no ACEs (see Figure 6).

Odds of Smoking by ACE Score

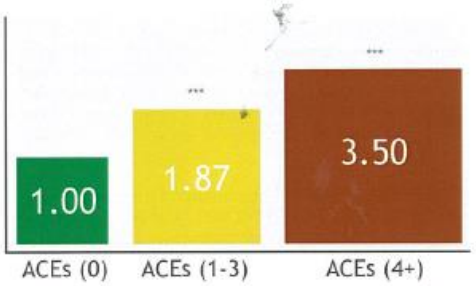

Figure 6: Odds of Smoking by ACE Score controlling for age, sex, race, and education level; *Note.* ***$p<.001$

Smoking is a predictor for each of the chronic health outcomes below. Importantly, however, smoking did not account for the effects of childhood adversity on health outcomes. That is, while both smoking and ACEs predicted current health, the effects of ACEs on current health did not result from the health effects of smoking. See Table 2 for details on health outcomes when controlling for smoking.

Taken together, the available data on these health risk behaviors from the BRFSS for Colorado adults does not suggest that health behaviors account for the strong and consistent relationships between ACE score and health outcomes and suggest other mechanisms should be explored.

Odds Ratios of Health Indicators by ACE Score

Chronic Conditions	Low ACE		High ACE	
	OR	95% CI	OR	95% CI
Arthritis	1.68	1.36 - 2.09	2.37	1.72 - 3.26
Cancer	ns	-	2.83	1.85 - 4.34
Cardiovascular Disease	ns	-	1.87	1.20 - 2.93
Chronic Obstructive Pulmonary Disease	1.92	1.30 - 2.85	3.03	1.84 - 4.97
Depression	2.58	1.88 - 3.54	5.18	3.52 - 7.62
Disability	1.53	1.21 - 1.95	3.16	2.25 - 4.46

Table 2: Odds Ratios of Health Indicators by ACE Score, controlling for smoking as well as age, sex, race, and education level; *Note.* OR=Odds ratio, CI=Confidence Interval

Parental Adversity & Child Well-being

In Colorado, we are focused on understanding and preventing intergenerational transmission of adversity across our research, policy, and program efforts. An important step in that process is determining the extent to which parents' experiences of adversity are linked to current outcomes in their children. To do this, we have taken data from the BRFSS that asks one parent (mother or father) about the adversity they experienced in childhood using the BRFSS ACE module, and linked it to reported characteristics of their current household, and to their child's current well-being as assessed in the Colorado Child Health Survey Questionnaire (CCHSQ). Linked BRFSS and CCHSQ data were available for 338 families (BRFSS respondents who completed the ACE module, who were parents of a child between the ages of 1-14, and who completed a follow-up interview about a selected target child; see Figure 7). These data were analyzed in SPSS Version 23 using Complex Samples and all analyses controlled for parent age and sex and child age and race.

In this subsample of parents, nearly 19% reported 4 or more ACEs, 47% reported 1-3 ACEs, and 34% reported no ACEs. We examined whether parental ACE score was related to current health and safety behaviors and environmental hazards, access to and use of medical care, reported discipline techniques, the child's need for and receipt of mental health services, and whether the parent had been told by a medical professional that their child had depression, anxiety, behavior or conduct problems, or attention deficit (hyperactivity) disorder. Details on each outcome are as follows.

Conceptual Model of Data Origin

Retrospective (0-18 years old) ACEs from one parent (BRFSS)

Current Data Collection

One Parent's Current Health (BRFSS)

Target Child's Current Health (CCHSQ)

Figure 7: Conceptual Model of Data Origin

Parental ACEs & Health & Safety

Parents were asked about potential environmental hazards including cigarette smoking in the home (which could result in second or third-hand smoke exposure), exposure to marijuana products or marijuana smoking, and driving safety including the use of seatbelts as well as drinking and driving. Parental ACE score was unrelated to reported cigarette smoking in the home, use of seatbelts, and/or drinking and driving. However, when parents reported high childhood adversity, they also reported more marijuana presence and use. The odds of exposure to marijuana products and marijuana smoking were substantial, with parents who reported 4 or more ACEs over 10 times more likely to also report marijuana exposure (see Figure 8). Both recreational and medical marijuana were legal at the time parents were asked to report on its possession and use.

Odds of Exposure to Marijuana Products and Use in the Home by Parental ACE Score

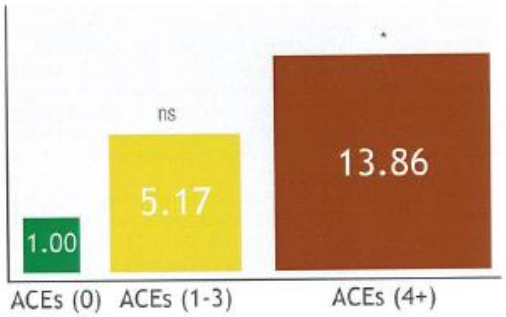

Figure 8: Odds of Exposure to Marijuana Products and Use in the Home by Parental ACE Score, controlling for parent age and sex and child age and race; *Note.* ns=non-significant, *p<.05

Parents were asked three questions that, combined, provided a portrait of medical care and access for their children. Specifically, they were asked whether their child had health insurance coverage, whether their child received mental health counseling, and whether their child received medical care in the past 12 months. Nearly 30% of parents with 4 or more ACEs reported having no health insurance or not using medical or mental health services in the past 12 months vs. 8% for those parents with no reported childhood adversity (see Figure 9).

Percentage of Parents Reporting Children Without Medical Coverage or Care

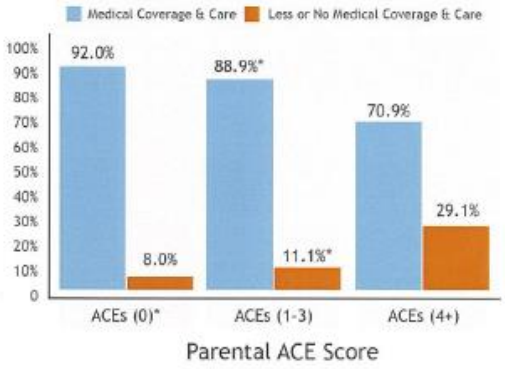

Figure 9: Percentage of Parents Reporting Children Without Medical Coverage or Care; *Note.* *statistically significant

Parental ACEs & Parental Discipline Practices

Parents were asked about their discipline practices and how often they use each method. These methods included yelling, spanking, time out, taking away toys, and/or explaining to their child the appropriateness of behavior. Prior research indicates that exposure to early adversity may have lasting effects on how one raises their own offspring (e.g., Oliver, 1993).

Most parents in this sample (85.9%) indicated that they used time outs, taking away toys, and/or explaining sometimes or often, and 71.4% reported yelling or spanking sometimes or often. Parents' own history of adversity was not associated with their current use of yelling or spanking to discipline children (see Figure 10).

Odds of Yelling or Spanking by ACE Score

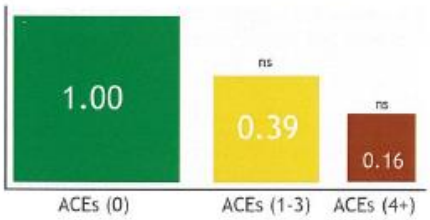

Figure 10: Odds of Yelling or Spanking by ACE Score, controlling for parent age and sex and child age and race; *Note.* ns=non-significant

Parental ACEs & Parents' Report that Child Needs Mental Health Counseling

Approximately 9% of parents with no childhood adversity felt their child needed mental health treatment or counseling. That rose to nearly 33% of parents reporting 4 or more childhood adversities (see Figure 11). Of these, 17.4% did not receive mental health services despite parent-identified need.

Percentage of Parents Reporting Child Needs Mental Health Services

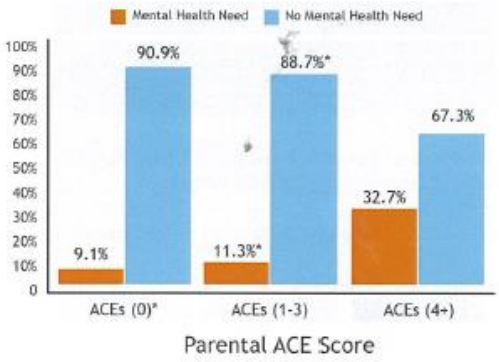

Figure 11: Percentage of Parents Reporting Child Needs Mental Health Services; *Note.* *statistically significant

Parental ACE & Child Mental Health Diagnoses

Parents were asked to indicate whether or not a doctor or health care provider had ever told them that their child had one of the following four types of mental health conditions: attention deficit disorder or attention deficit hyperactivity disorder (ADD or ADHD), depression, anxiety problems, or behavioral or conduct problems such as oppositional defiant disorder or conduct disorder. Prevalence rates of each diagnosis by parental ACE score suggested that ADD/ADHD, anxiety problems, and behavior or conduct problems were more common in families where parents reported higher exposure to childhood adversity, while depression diagnoses were more common among parents reporting no childhood adversity. However, significant differences using sample weights and confidence intervals were only evident between 0 and 4 or more ACEs for ADD/ADHD and behavior/conduct problems (see Figure 12).

Percent of Parents Reporting Child Mental Health Diagnoses by ACE Score

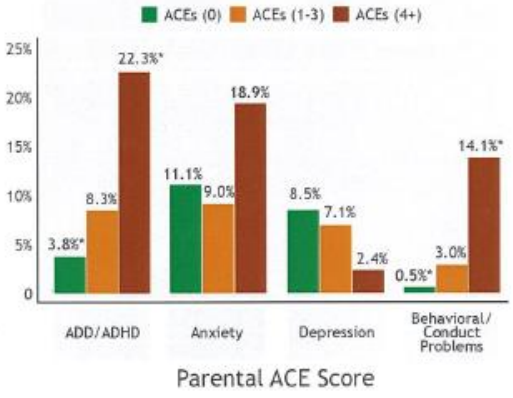

Figure 12: Percent of Parents Reporting Child Mental Health Diagnoses by ACE Score; *Note.* *statistically significant

For these two categories of mental health diagnoses, parental adversity had a dramatic impact. Children of parents with 1-3 ACEs were over twice as likely to be labeled with ADD/ADHD, and 4.76 times more likely to be labeled with a behavior or conduct disorder. Children of parents with 4 or more ACEs were 5.65 times more likely to be labeled with ADD/ADHD and 27.39 times more likely to be labeled with a behavior or conduct disorder (see Figure 13).

Odds of ADD/ADHD and Externalizing Behavior Problems by Parental ACE

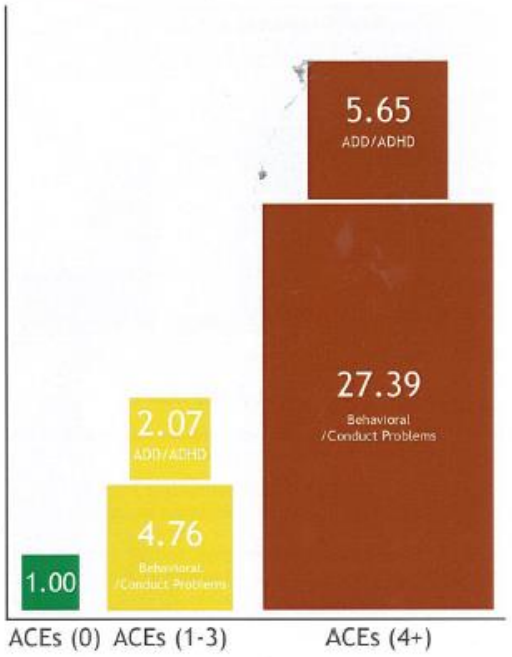

Figure 13: Odds of ADD/ADHD and Externalizing Behavior Problems by Parental ACE Score, controlling for parent age and sex and child age and race; *Note.* **p<.01, ns=non-significant

Summary: Parental ACEs & Child Outcomes

In sum, greater parental history of adversity was related to less reported parental use of and access to medical care, more presence of marijuana in the home, to parents feeling their children needed mental health services, and to child labeled with ADD/ADHD and behavior or conduct problems.

Prevalence, Costs, & Consequences of ADD/ADHD & Behavior/Conduct Problems

ADD/ADHD and behavior/conduct problems are serious and costly mental health concerns, with moderate stability into adulthood and associations with other behavioral health concerns (see Table 3). Efforts to support families with significant parental ACE scores to reduce contextual stressors and improve the buffering potential of relationships may be important for reducing intergenerational costs of adversity experienced in childhood.

ADD/ADHD & Behavior/Conduct Problems

	Prevalence	Stability in Adulthood	Cost
ADD/ADHD	6.4 million children in U.S. aged 4-7 have ADHD diagnosis as of 2012 This is a 43% increase since 2003 1/3 of children received diagnosis before the age of 6	Diagnosis persists into adulthood among 1/3 of children with ADHD Consequences include lower educational and career attainment, co-occurring psychiatric disorders and higher rates of suicide	The societal cost of childhood ADD/ADHD is estimated between $38-$72 billion annually
Behavior or Conduct Problems (Oppositional Defiant Disorder, ODD; or Conduct Disorder, CD)	The prevalence of disruptive behavior disorders has increased to 6.1% in 2015 from 4.9% in 2014	ODD persisted in a 10-year longitudinal study starting at age ~10 and following up at age ~20 Co-morbid CD and ODD are associated with major depressive disorder The presence of ODD significantly increased risk of CD, antisocial personality disorder, substance abuse and bipolar disorder	Children with behavioral disorders incur health care costs similar to children with physical health conditions Further research is needed to determine the exact cost to society including social and health services Additionally, criminal behavior is often associated with ODD, CD, and antisocial personality disorder

This does not account for the likely significant and undocumented costs associated with those children and families who are unable to obtain treatment, which may in turn result in untreated behavioral problems that subsequently impact children's well-being and opportunity to succeed in school.

Table 3: Prevalence, Costs, and Consequences of ADD/ADHD and Behavior/Conduct Problems

Summary of Key Findings

- Overall, in the larger BRFSS dataset from Colorado, greater childhood adversity predicted worse adult physical and mental health as has been widely documented in other states. Coloradans with greater childhood adversity were also more likely to smoke cigarettes, but were no more or less likely to drink heavily or be obese.
- Even when accounting for smoking, strong relationships between experienced adversity in childhood and adult health were clearly evident.
- Looking within the smaller subsample of families who also reported child data, parental history of adversity also predicted their child's need for mental health services and labeling with ADD/ADHD and behavior/conduct problems. Despite reporting these mental health needs, 30% of parents with greater childhood adversity reported less use of or access to health care.
- Parental history of adversity did not predict current smoking in the home, drinking and driving, or lack of seatbelt use, but it did predict use and presence of marijuana products in the past 30 days. When these data were collected, recreational and medical marijuana use were both legal in Colorado.

Summary of Key Limitations and Recommendations for Future Research

- The sample size for the linked data is small which limited some analyses and should temper conclusions. In particular, interpretation of null results and estimated effect sizes should be interpreted cautiously; results are expected to be more stable with larger samples.
- Given the concerning nature and potential significance of some of these findings, we strongly recommend additional years of linked data collection via the BRFSS ACE module & CCHSQ.
- Data are self and parent-report. We recommend pairing participant report with linked medical record data.

Highlighted Colorado Research Efforts

A number of teams in Colorado are evaluating the impact of parental history of adversity on current family and child well-being. For example, as part of the national Buffering Toxic Stress Consortium (The Buffering Toxic Stress Consortium Principal Investigators, Meyer & Fortunato, 2013), a team at the University of Denver and one at the University of Colorado Anschutz Medical Campus have documented impacts of parental history of adversity on both parents' current mental health symptoms and on child mental health symptoms in early childhood. In that work we have also documented that, even when parents have very high ACE scores, specific parenting behaviors and skills are protective against poor outcomes in children.

Early Childhood Leadership Commission (ECLC)

The ECLC was created in 2010 to advance a comprehensive service delivery system for pregnant women and children birth to age eight and their families, using data to improve decision-making, alignment, and coordination among federally- and state-funded services and programs. Comprised of parents, early childhood professionals, Head Start, school districts, local municipalities, foundations, businesses and five state departments, the ECLC plays a critical role in advising and aligning early childhood systems that ultimately lead to better outcomes for children and families.

Broader Colorado Prevention & Intervention Efforts

Colorado has many programs and initiatives that strengthen the health and well-being of children and families. A few initiatives are highlighted and described below. These are meant to be illustrative but are not inclusive of the many important initiatives planned or underway.

Shared Message Bank

In partnership with Frameworks Institute and GroundFloor Media, the Early Childhood Colorado Partnership created a Shared Message Bank that provides messaging for early childhood stakeholders to use in order to speak from a collective voice, engage more audiences, and mobilize action. The tools and resources generated support consistent messaging when discussing early childhood adversity and toxic stress and are designed to shift social norms toward positive change for family and child well-being in Colorado. For more information about the Shared Message Bank along with additional relevant toolkis and resources available to support community mobilization, please visit http://eccp.civiccanopy.org/.

First 1,000 Days Initiative, Children's Hospital Colorado

The First 1,000 Days Initiative prioritizes a child's first thousand days of life through five strategic areas:

1) **Public awareness:** A broad media campaign to elevate *public awareness* and reach caregivers, community members and providers.
2) **Policy and advocacy:** Advancing family-friendly workplaces, particularly those that impact the caregivers of young children.
3) **Provider training:** Increasing healthcare provider awareness and understanding of the importance of the First 1,000 Days by offering comprehensive and impactful training to health professionals and community partners working with young children and their families.
4) **Screening, identification, and care coordination:** Implementing universal psychosocial screening using standardized tools to identify young children at risk or already facing adversity. Identified families receive triage, referral, care coordination, and targeted intervention.
5) **Targeted interventions:** Expanding partnerships with prenatal and early childhood providers to reduce premature births, increase referrals to settings that prioritize socioemotional health and integrated behavioral health services, and ensure more babies and parents receive care within medical homes.

https://www.childrenscolorado.org/community/community-health/prematurity/

Early Childhood Colorado Framework

Colorado has developed a shared vision for comprehensive early childhood systems work called the *Early Childhood Colorado Framework*. The *Framework*, which was revised and endorsed in 2015, promotes collaborative efforts among state and local early childhood stakeholders to ensure that all children reach their full potential. The core guiding principles are: whole child and family-centered; prenatal through age eight; strengths-based; culturally relevant and responsive; outcomes focused; informed by evidence-based and promising practices; and cross-sector collaboration. The *Framework* aims to enhance access, quality, and equity to improve outcomes for Colorado's children and families across several systems (see Figure 14). For more information, please visit www.earlychildhoodframework.org.

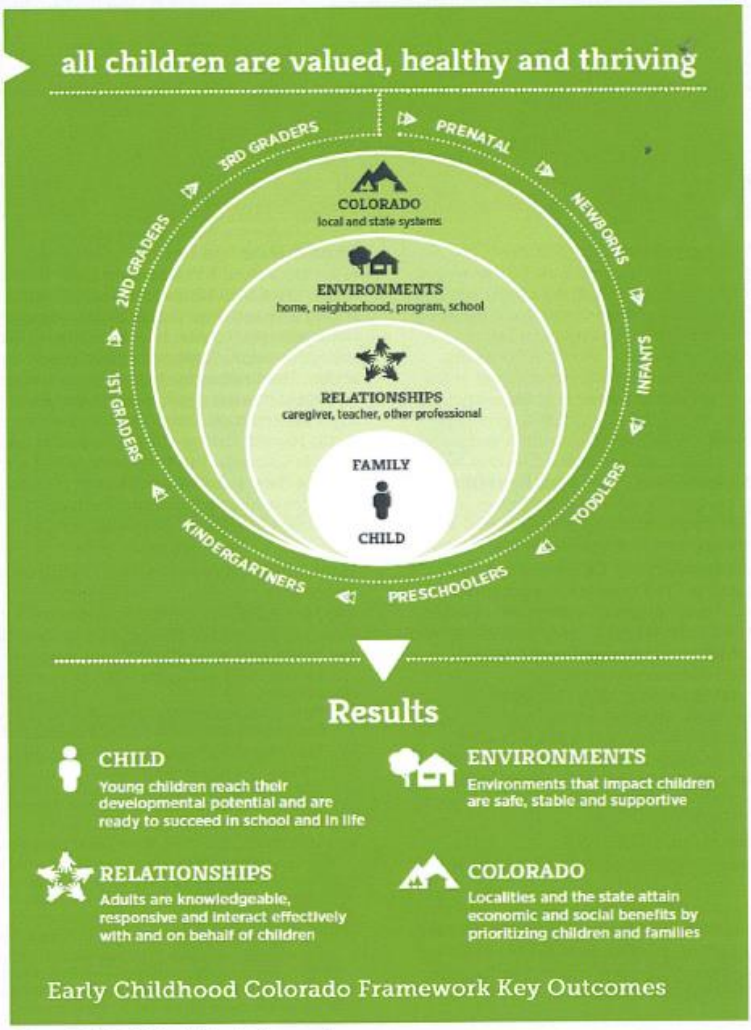

Figure 14: Early Childhood Colorado Framework

Child Maltreatment Prevention Framework for Action

This framework is designed as a tool to guide strategic thinking, at the state and local level, about resource investments to prevent child maltreatment and promote child well-being. As this tool is used collectively across the state, the resulting alignment of strategies will maximize the impact on shared outcomes.

Anchored by six foundational principles, the framework outlines potential strategies that when implemented will achieve four overarching outcomes to ensure that all children are valued, healthy and thriving (http://co4kids.org/prevention).

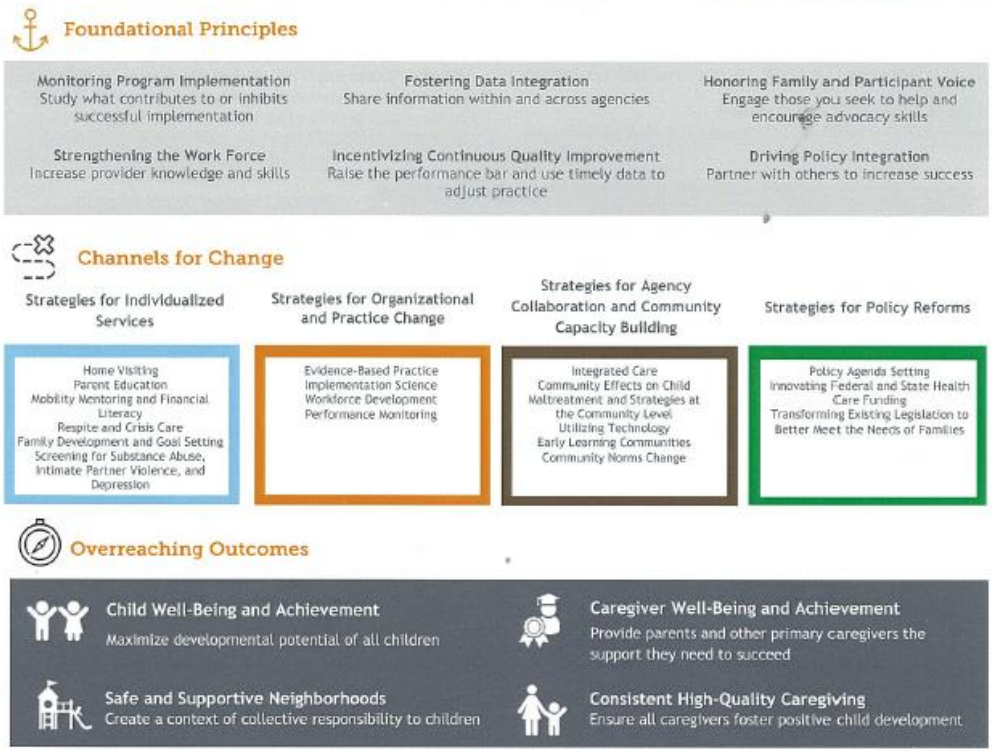

Figure 15: Child Maltreatment Prevention Framework for Action

Colorado Early Childhood Mental Health Strategic Plan

Colorado adopted an Early Childhood Mental Health (ECMH) Strategic Plan in 2015. This plan was designed to reflect the Early Childhood Framework, with specific attention to the social emotional health and well-being of young children birth to age eight and their caregivers. The ECMH Strategic Plan has a vision that all children and families are valued, in good social and emotional health, and their relationships are thriving. In order to accomplish this, Colorado will focus for the next 3-5 years on three priorities found in the plan.
http://coloradoofficeofearlychildhood.force.com/oec/OEC_Resources?p=Resources&s=StatePlans&lang=en

Colorado Health Institute

The Colorado Health Institute, founded in 2002, is Colorado's leading nonprofit and nonpartisan health policy research institute. They support health policy discussions with data, evidence and analysis. But that's just the beginning of their work. They also serve as trusted strategic advisors, facilitators and evaluators. They are a valued partner with the individuals, groups and communities across the state working to make Colorado No. 1 in health .
http://www.coloradohealthinstitute.org

CHI released a report on links between maternal and child mental health using data from the two surveys included in this ACE report. More information can be found here:
http://coloradohealthinstitute.org/uploads/postfiles/Final_Brief.pdf

Project LAUNCH & LAUNCH Together

The Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) initiative is guided by a federal-level partnership among the Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration for Children and Families (ACF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). It aims to promote the physical, social, emotional, cognitive, and behavioral health of young children ages birth to eight, thereby ensuring that children are ready to learn and succeed in school.

In order to promote healthy child development, Colorado organizations have developed programs and policies to improve access and services for young children and their families. Specific core prevention and promotion strategies include screening and assessment, enhanced home visiting through increased focus on social and emotional well-being, mental health consultation in early care and education, family strengthening and parent skill training, and integration of behavioral health into primary care settings (see Figure 16). For more information, please visit www.healthysafechildren.org/grantee/project-launch.

Project LAUNCH Framework

LAUNCH Together builds on and expands Project LAUNCH by supporting additional Colorado communities in enhancing children's health and well-being through evidence-based prevention and coordinated systems of care. LAUNCH Together aims to invest in communities to implement effective strategies to support early childhood and caregiver mental health, train professionals to better support children's mental health and bring together public and private partners to evaluate the project and support scaling of effective approaches. Together, Project LAUNCH and LAUNCH Together are providing supportive and effective services for thousands of families across Colorado. For more information, please visit www.earlymilestones.org/launch-together/

Figure 16: Project LAUNCH Framework

The Funders Learning Network on Early Childhood Mental Health

A number of foundations have been key partners in these efforts. For example, the Funders Learning Network on Early Childhood Mental Health (FLN) has been instrumental in developing a shared knowledge of young children's mental health among foundations and supporting independent and collaborative grantmaking among its 11 members. The Network is a diverse group of Colorado grantmaking organizations that fund in many areas and have a shared interest in young children's mental health. Members have come together since 2013 to share ideas, learn, and work together to improve the social, emotional, and mental health of children birth to age three. The FLN have been active partners in understanding and addressing ACEs in Colorado, and they have been key supporters of LAUNCH Together, the ECMH Strategic Plan, and behavioral health services in pediatric offices. The Network partners are the Aloha Foundation, Ben and Lucy Ana Walton Fund at the Walton Family Foundation, Caring for Colorado Foundation, the Colorado Health Foundation, Colorado Springs Health Foundation, Community First Foundation, Constellation Philanthropy, Kaiser Permanente, The Piton Foundation at Gary Community Investments, Rose Community Foundation, and Temple Hoyne Buell Foundation.

Call to Action

We believe these data provide a clear call to action. ACEs impact not only the health and well-being of the adults who report having experienced them, but they also impact the health and well-being of the next generation. Therefore, ACEs are too common and too costly. These costs accrue not only to individuals and families, but to society as a whole. ACEs are preventable with strong family supports, and family-centered supportive prevention, early identification and intervention would benefit our entire community.

We can do more

- to track the impacts of ACEs with systematic multi-year population-based data collection efforts using tools like the BRFSS and the CCHSQ or with more intensive research efforts like those at the University of Denver.
- to reach additional families, using integrative behavioral health models like those being tested and disseminated at the University of Colorado School of Medicine.
- by moving efforts like Project LAUNCH and LAUNCH Together into all Colorado regions. Public health problems of this magnitude take creative, dedicated, and collaborative cross-sector solutions.

With all of our efforts and voices, we can change what has been a steady level of ACEs across generations to support, protect, and enhance our future.

Acknowledgements

The authors kindly thank Connie Fixsen and Jordana Ash for collaboration on this project, The Ben and Lucy Ana Walton Fund of the Walton Family Foundation for financial support of this work, Colleen Church, Whitney Connor, Indira Gujral, Jodi Hardin, Steve Vogler, and several other community partners for helpful comments on earlier versions or following presentations of this report, Amy Anderson and Indira Gujral for assistance with analyses, and Lauren Montoya, Estee Hamo, and Adam Anderson for assistance with report preparation. While gratefully acknowledging the input and assistance of many partners, the authors assume responsibility for any errors and the opinions expressed here.

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Parental History of Adversity and Child Well-Being: Insights from Colorado

May 2017

COLORADO
Office of Early Childhood
Department of Human Services

二、Rocky Mountain Youth Clinic 文宣

"They saved my daughter's life."

Soon after Nathalie Garza was born, she faced a series of critical health problems, including an inability to ingest food and a collapsed lung. Her mother, Jenny Seppelt, credits the doctors and nurses at Rocky Mountain Youth Clinics with identifying life-threatening issues and taking quick action. She also appreciated the calm, reassuring care and extra attention from RMYC doctors and staff.

Nathalie spent over a year on a feeding tube and underwent numerous medical procedures. Today she is healthy and thriving. Jenny knows she can call Dr. Kimberly White or Physician Assistant Cassidy Hogan anytime and they will call her back and follow up on any issues. "I won't go anywhere else."

"It's a 45-minute drive but it's worth it to me because I trust them. They care. They know my kids. I think they care about my kids just as much as I do."

Locations

Our primary sites provide medical care, behavioral health services, wellness programs, access to emergency food and supplies, and other social services.

Aurora Clinic
1550 South Potomac Street
Suite #130
Aurora, CO 80012
303.360.8111

Thornton Clinic
9197 Grant Street
Suite #200
Thornton, CO 80229
303.450.3690

Denver Clinic
1601 East 19th Avenue
Suite #6600
Denver, CO 80218
303.869.2182

Administrative Office
9197 Grant Street
Suite 100
Thornton, CO 80229
303.962.1517

Mobile Care Units

We take medical and dental services to you through fully-equipped mobile units that travel to different locations in the metro Denver area.

Medical Mobile 720.837.4761

Dental Mobile 303.523.3728

School-Based Health Clinics

The School-Based Health Clinics are an important piece of fulfilling our mission of providing affordable, accessible, and high quality health care to youth across Colorado.

We partner with Aurora Public Schools, Aurora Mental Health Center, and the Healthy Smiles Clinic to provide comprehensive care to all students in Aurora Public Schools at facilities that are located on school grounds. These sites have convenient hours, including evenings and weekends to accommodate families' busy schedules.

Crawford Elementary
1600 Florence Street
Aurora, CO 80010
303.326.2090

Laredo Elementary
1350 Laredo Street
Aurora, CO 80011
303.326.1953

Rocky Mountain Youth Clinics partners with School-Based Health Clinics in the Roaring Fork and Poudre School Districts by providing medical services oversight, administrative support, and fiscal support.

Centennial High School Health and Wellness Center
330 East Laurel Street
Fort Collins, CO 80524
970.443.7470

Roaring Fork School Health Centers
151 Cottonwood Drive
Basalt, CO 81621
970.384.6060

/TheRMYC @TheRMYC

ROCKY MOUNTAIN YOUTH CLINICS

connecting kids to healthy lives

三、 北卡州威克郡社會局文宣

RESOURCES

WAYS TO GET INVOLVED

Donations for seasonal programs	(919) 212-7083
Volunteering and Internship opportunities	(919) 212-7083

ADMINISTRATION

Director's Office	(919) 212-7302
Deputy Director/Chief of Staff's Office	(919) 212-7302
Deputy Director/Operations Office	(919) 212-7584
Human Services Board	(919) 212-7351
Medical Director's Office	(919) 250-3807
Finance Office	(919) 212-7584
Program Integrity (Fraud Investigations)	(919) 857-9211
Quality Management	(919) 250-3807

ONLINE SERVICE RESOURCE LIST

Wake Network of Care
wake.nc.networkofcare.org

OTHER INITIATIVES WE SUPPORT

We support many community initiatives throughout the year, such as:

Summer Nutrition Program
Child Abuse Prevention
Capital Area ReEntry
Warmth for Wake
Wake County Holiday Cheer

For more information, visit:
wakegov.com/HumanServices

VOICE OF THE CUSTOMER

Customer complaint line	(919) 212-7155
'Say It Forward' line for staff appreciation or service recognition	(919) 212-7189
Transportation feedback and complaints	(919) 212-7005

VOICE OF THE CUSTOMER

Great customer service is our goal at Wake County Human Services! We value your input and need it to improve the customer experience.

We created the **Voice of the Customer** system to give our customers several different ways to give feedback on their service experiences:

CUSTOMER SATISFACTION SURVEY

A short survey to share your customer service experience.

SERVICE COMPLIMENTS

A program to let us know when you receive excellent customer service.

COMPLAINTS

A way to report problems or share if you are dissatisfied with our service.

There are three ways to participate in the Voice of Customer system. Choose the option most convenient for you!

1 WRITE DOWN YOUR FEEDBACK

Paper forms and drop boxes are available at each Human Services location. Ask any employee where to find them.

2 CALL US

To report a complaint, call 919-212-7155. To compliment us on our service, call 919-212-7189.

3 COMPLETE AN ONLINE FORM

Visit wakegov.com and search "Voice of the Customer."

WAKE COUNTY NORTH CAROLINA Human Services

2017 AGENCY GUIDE

wakegov.com/HumanServices
@WakeHumanServices

Customer Support	(919) 212-7000
Service Compliments	(919) 212-7189
Customer Complaints	(919) 212-7155

WELCOME

ION

Wake County will be one of the healthiest places to live and all residents will have opportunities to improve their lives.

SION

Wake County Human Services, in partnership with the community, will facilitate full access to high quality and effective health and human services for Wake County residents.

UES

- PROACTIVE & STRATEGIC THINKING
- PROVIDING ACCESSIBLE SERVICES
- PROVIDING GREAT CUSTOMER SERVICE
- PROVIDING QUALITY SERVICES
- RESPECT FOR ALL

LITY

PS

AVIOR

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GREETINGS

FROM WAKE COUNTY HUMAN SERVICES

We invite you to take a look at our 2017 Agency Guide. The guide is prepared annually and is made available to the public to inform you about the services we offer.

Use it to find a Human Services location near you, telephone numbers and emergency listings.

We are always interested in developing partnerships that help families be safe, healthy and become more self-sufficient. If you are interested in partnering with us, please call me at 919-212-7302.

Best regards,

Regina Petteway, MSPH
Wake County
Human Services Director

Regina V. Petteway

NORTH CAROLINA Accredited Health Department 2015-2019 Local Health Department Accreditation Board

SERVICES

ARE

ervice Reports	**(919) 212-7990**
ervice Reports	**(919) 212-7963**
ervices and otion	(919) 212-9529
becoming a ptive parent	(919) 212-7474
Services	(919) 250-4597

T

Center	(919) 250-3770
	(919) 212-7000

HOUSEHOLD

nce (Cary/Apex)	(919) 463-8431
y	(919) 212-7000
orcement	(919) 856-6630
munity Revitalization	(919) 856-5689
and Support	(919) 212-7000
s	(919) 212-7083
pment	(919) 250-1100

UTRITION

EBT t Transfer)	(919) 212-7000
tal Nutrition Program ts, and Children	(919) 250-4720

HEALTH: ADMINISTRATION

Medical Records	(919) 250-3074
Public Health Emergency Preparedness	(919) 212-9394
Vital Records (Register Births-Deaths)	(919) 250-3917

HEALTH: MEDICAL

Child Care Health Consultants	(919) 212-7572
Child Health	(919) 250-4570
Dental (Pregnant women, children)	(919) 250-4610
Foreign Travel Immunizations	(919) 250-3900
Health Promotion	(919) 212-8376
Immunizations	(919) 250-3900
Immunization Record Requests	(919) 212-7349
Maternal and Child Health	(919) 250-4636
Pharmacy (Wake Human Services only)	(919) 250-4418
Prenatal Care	(919) 250-4701
School Based Nursing and Dental	(919) 250-4637
Teen Clinic	(919) 250-3913
Women's Health	(919) 250-3913

HEALTH: COMMUNICABLE DISEASES

Communicable Disease Reports	**(919) 250-4462**
HIV Clinic (Testing)	(919) 250-4410
HIV Community Testing	(919) 250-3950
HIV Primary Care/Social Services	(919) 250-3999
HIV/AIDS Case Management	(919) 212-7801
HIV/STD Community Program	(919) 212-7832
STD Clinic (Diagnosis/Treatment)	(919) 250-4410
STD Community Testing	(919) 250-3950
Tuberculosis	(919) 250-1228

HEALTH INSURANCE (MEDICAID)

For adults and disabled persons	(919) 212-7000
For families and children	(919) 212-7000

SERVICES

HOUSING AND/OR SHELTERS

Housing Services - main number	(919) 212-9379
Cornerstone (Homeless Services)	(919) 508-0777
South Wilmington Street Center (homeless shelter for men)	(919) 857-9428

SENIOR AND ADULT

Adult Protective Services: 24 Hour Abuse/Neglect Hot-line	**(919) 212-7264**
Adult Guardianship Services	(919) 212-7168
Senior Services	(919) 212-7264

TRANSPORTATION

Medicaid Transportation Unit	(919) 212-7005
TRACS Transportation	(919) 212-7005

BEHAVIORAL HEALTH MANAGING PARTNER

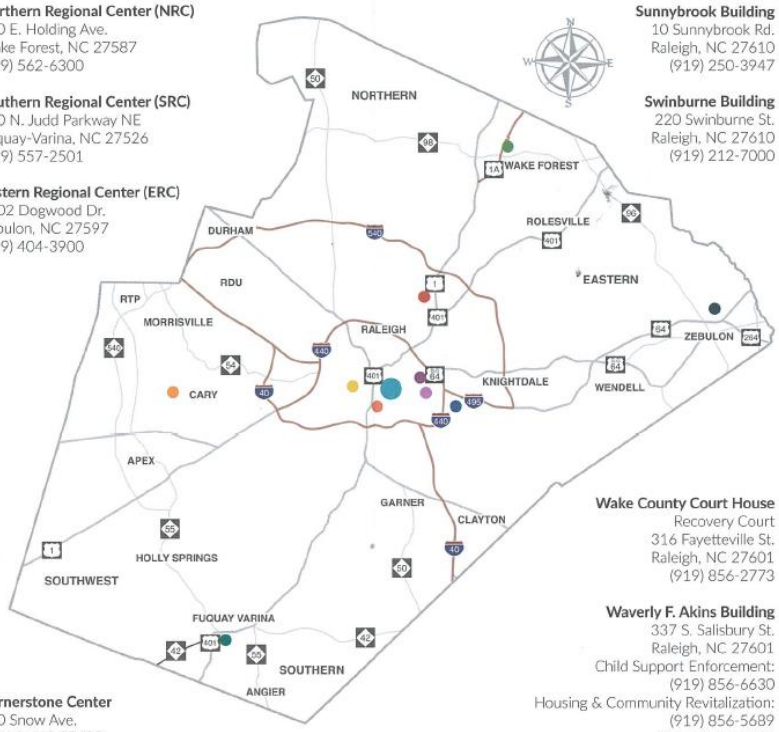
In Wake County, mental health, substance abuse and developmental disability services are managed by Alliance Behavioral Healthcare	1-800-510-9132

SERVICE LOCATIONS

Northern Regional Center (NRC)
350 E. Holding Ave.
Wake Forest, NC 27587
(919) 562-6300

Southern Regional Center (SRC)
130 N. Judd Parkway NE
Fuquay-Varina, NC 27526
(919) 557-2501

Eastern Regional Center (ERC)
1002 Dogwood Dr.
Zebulon, NC 27597
(919) 404-3900



Sunnybrook Building
10 Sunnybrook Rd.
Raleigh, NC 27610
(919) 250-3947

Swinburne Building
220 Swinburne St.
Raleigh, NC 27610
(919) 212-7000

Wake County Court House
Recovery Court
316 Fayetteville St.
Raleigh, NC 27601
(919) 856-2773

Waverly F. Akins Building
337 S. Salisbury St.
Raleigh, NC 27601
Child Support Enforcement:
(919) 856-6630
Housing & Community Revitalization:
(919) 856-5689
Program Integrity:
(919) 857-9211

Cornerstone Center
220 Snow Ave.
Raleigh, NC 27603
(919) 508-0777

Western Wake Human Services Center
150 Cornerstone Dr., Suite 100
Cary, NC 27511
(919) 463-8445

Larry B Zvierink Sr. Center
3000 Falstaff Rd.
Raleigh, NC 27610

South Wilmington Street Center
1420 S. Wilmington St.
Raleigh, NC 27601
(919) 857-9428

Millbrook Human Services Center
2809 E. Millbrook Rd.
Raleigh, NC 27604
(919) 431-4000

Crosby Garfield Center
568 E. Lenoir St.
Raleigh, NC 27601

Agriculture Building
4001 East Carya Dr.
Raleigh, NC 27610
Cooperative Extension/4H:
(919) 250-1100

MAKING PROUD CHOICES

Addressing Sexual Health Disparity: ***Enhancing collaboration between Wake County Human Services to improve Sexual Health Outcomes Among in out-of-home Foster Youth***

Introduction:

Wake County Human Services (WCHSS) is the consolidation of programs and services that include Social Services, Public Health, Job Search Assistance, Child Support, Housing and Transportation. Its mission is to facilitate full access to high quality and effective health and human services for Wake County residents. Wake County is a large county with a population of over a million residents with a diverse set of needs and resources. In order to effectively meet the needs of Wake County residents, integration of services and establishing effective partnerships is essential.

A new WCHS partnership opportunity emerged in 2012 when Public Health was invited to participate in a multi-states pilot project, along with two other counties in North Carolina to implement the adapted version of the curriculum *Making Proud Choices*! (MPC) for youth in foster care ages 12 to 18. The aim of the project was to identify the required data to assess outcomes for the foster care youth as it relates to reduction of teen pregnancy, parenting and Sexually Transmitted Infections (STDs). The implementation of MPC for foster youth provided the opportunity to Public Health to enhance current HIV and Sexually Transmitted Disease (STDs) prevention efforts the HIV/STD Public Health Educators provide.

Background: ***Public Health Integration of services experiences***

Wake County Public Health strives to prevent and stop the transmission of HIV and STD's by implementing innovative strategies align with emerging STDs trends. The current syphilis outbreak and the high rates of STD's among youth and young adults essentially have prompted the changes on the ways Public Health is traditionally provided. Wake County has taken a more comprehensive approach implementing several public health interventions designed to reach young people at the highest risks for HIV and STDs. Some of the efforts include the use of media outlets and social media to create awareness among vulnerable populations. Aggressively has launched educational meetings with heath care providers in the county to encourage them to screening and test youth for STD's. Additional efforts have been made to integrate current services such as the clinics, the Communicable Diseases and HIV/STD Community Program to reduce gonorrhea and chlamydia infections among vulnerable individuals, specifically youths. Field Delivery Therapy (FDT) and presumptive treatment by the Disease Intervention Specialists (DIS) nurses was implements a few years ago. Later, FDT was also expanded to the non-traditional testing sites in Wake County. In addition, effective in July 2015 all Public Health clinics began to screen for HIV, Syphilis, chlamydia and gonorrhea clients ages 13-64 at every preventive visit, this new guidance is expected to reduce the chance of missing young people with STD's to go

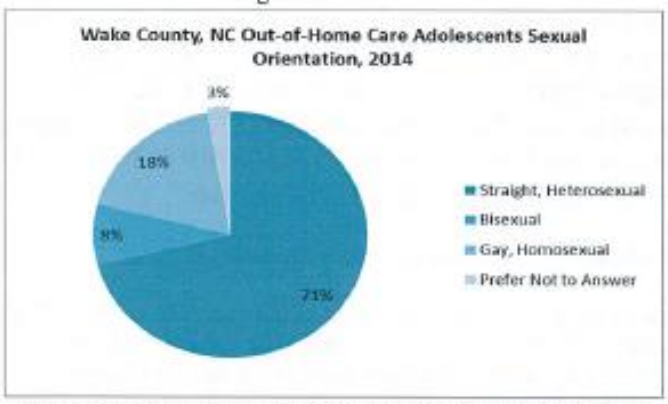
untreated. Therefore the implementation of MPC for Foster youth provide the opportunity to Public Health to enhance current collaborations within Public Health and initiate new partnerships to better serve one of the most vulnerable group of adolescents; out-of-home foster youth.

Demonstrated Disparity

On September 30, 2015, there were 427,9 10children in foster care nationwide of which 18% were between the age 11 to 15 and 16% were between the 16 to 20 years old[1]. According to Child Welfare, Work First, and Food & Nutrition Services in North Carolina data, for the month of April 2016 North Carolina had 10,344 children and youth in foster care of which 753. Minority groups are the most affected with 56 % (black 24%, Hispanic 22% and 10 % were multiracial). Unfortunately, many children in foster care never end up in a safe, permanent family[2].

Before the implementation of MPC, a survey was conducted to assess the needs of youth in out-of-home care in Wake County as it relates to HIV and STDs. A short questionnaire to collect data on HIV and STD knowledge, risk behaviors, and questions on accessibility to services was administered. A total of 38 youth ages 12-21 in foster care in Wake County completed the survey. Of all the respondents, 11 were male and 27 were female and the average age was 15 years old. The majority (42.0%) were Black/African American, 15% white/Caucasian, and 10% Latinos /Hispanic. They identified themselves as straight/heterosexual (71%), and slightly over 25% of the respondents identified themselves with the LGBT community (bisexual (8%), gay or homosexual (18%) and 3% preferred not to answer the question. (See appendix for results and questionnaire).

Figure 1



Source: Youth in Foster Care Need Assessment HIV/STD Community Program 2014

Although all teens exhibit risk-taking behavior, the past experiences of foster care youth make them more susceptible to engage on behaviors that could place then at higher risks for sexually transmitted diseases. Research shows that foster youth are more likely to be a) sexually active earlier than their peers same age in the general population, b) have more sexual partners, c) experience sexual assault or rape, d) not use contraception,

[1] U.S. Department of Health and Human Services. (2015). *The AFCARS report: Preliminary FY 2015.*

[2] **Management Assistance for *Child Welfare*, *Work First*, and *Food & Nutrition Services* in North Carolina.** http://ssw.unc.edu/ma/

and e) experience teen pregnancy. Many factors and social determinants may contribute increase sexual risky behaviors that lead to poor sexual health outcomes. Often youth in foster care experience traumatic events from early age both before and during foster care placement. Their history of abuse and neglect, separation from family and friends, instability caused by multiple home placement and exposure to violence children in foster care are more likely than other children to exhibit high levels of behavioral and emotional problems that can lead to an increase in sexual risk behaviors. Also, there some risks factors within the Child Welfare system itself that can place youth in foster care to negative sexual health outcome. For example, the absence of policy or guidance for fosters parents and providers on how to approach the topic of sexual health or absence of knowledge. Also, social services providers may not feel comfortable talking about sexual health with the youth for fear of possible repercussion therefore failing to provide young people the necessary tools like sexual health knowledge, skills, and services they need to avoid unintended pregnancy or infection with HIV and other STDs.

Sexually Transmitted Diseases Trends among youth:

According to the Centers for Disease Control (CDC) the incidence and prevalence estimates in the United States suggest that young people aged 15–24 years acquire half of all new STDs. Compared with older adults, sexually active adolescents aged 15-19 years and young adults aged 20-24 years are at higher risk of acquiring STDs for a combination of behavioral, biological, and cultural reasons. The literature consistently shows that adolescents and young adults have more partners, engage in unprotected sex and have sex with partners who have an STD.

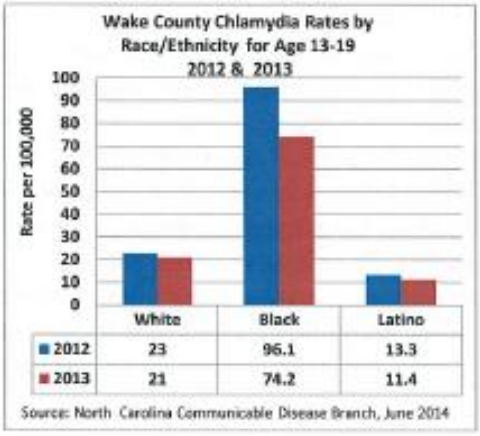
In the United States

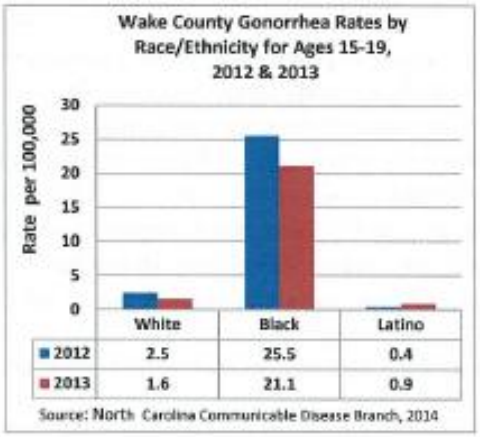
In 2014, there were 948,102 reported cases of chlamydial infection among persons aged 15-24 years of age, representing 66% of all reported chlamydia cases.

- During 2013-2014, the rate of reported gonorrhea cases decreased 5.0% for persons aged 15-19 years and increased 2.8% for persons aged 20-24 years
- During 2013-2014, the rate of reported primary and secondary (P&S) syphilis cases increased 11.6% among persons aged 15-19 years and 13.1% among persons aged 20-24 years.

North Carolina and Wake County

From 2009 to 2013, Wake County has had a total of 15,197 cases of chlamydia amongst adolescents/young adults age 13 to 24 and 3,823 cases of gonorrhea from the same age range. From 2012 to 2013, adolescents age 15-19 represented 40 percent of chlamydia cases; with the highest percentage of both, chlamydia and gonorrhea cases among African American youth. The rates for chlamydia and gonorrhea in Wake County are generally lower than the overall rates in North Carolina however; both North Carolina and Wake County rates are higher than national rates for both of these diseases.





<u>The Implementation Public Health Approach</u>: *Foster Care, STDs and Pregnancy Prevention Integration*

The Public Health HIV/STD Community Program partnered with the Child Welfare's LINKS Program to implement the adapted version of *Making Proud Choices!* for foster care youth. LINKS is the North Carolina Foster Care Independence Program for youth and young adults who have experienced extended time in foster care. The program provides services and resources to older youth in foster care so that when they leave the system, they will have a network of supports and are better equipped with the skills and tools necessary to be successful in life. In Wake County, youth who participate in LINKS typically meet once a week in the evening hours, to discuss current topics of interest, and engage in fun and rewarding conversation and activities. After completion of the pilot project of the implementation of the Making Proud Choices curriculum was adopted and integrated into the LINKS and HIV/STD Community Programs regular services.

Leveraging on the LINKS' expertise of the foster care system and awareness of the unique needs of youth in out-of-home care and the experience of public Health Educators implementing HIV/STD prevention programs on Sexual Health, Reproductive Health, Decision-making skills and Healthy relationships strengthened the implementation of the adapted MPC curriculum.

On January 2013, Wake County Human Services began to implement the curriculum Making *Proud Choices for Youth in Out-of-Home Care*. Making Proud Choices for Youth in Out-of-Home Care is a ten-module evidence-based curriculum that provides adolescents with the knowledge, confidence, and skills necessary to reduce their risk of sexually transmitted diseases (STDs), HIV, and pregnancy. In addition to addressing the consequences of sexually transmitted infections, teen pregnancy, communication, condom use, refusal skills, and strategies for prevention, the modules of the curriculum have been revised to address sexuality and relationships with social workers, medical providers, care givers and sexual partners. The curriculum is based on threes theories; the social cognitive theory, the theory of reasoned action and the theory of planned behavior. In addition to promote the importance of protecting one's community and family ; Sexual Responsibility and Accountability, and Role of Pride as major themes; the new adaptation for in out-of- home care youth incorporates 2 additional themes that are intended to address the needs that are unique to foster care youth. The two additional themes are 1) *Role of Healthy Relationships* to help youth you distinguish between healthy and unhealthy relationships, an issue of particular importance to youth in care because they are hungry for love and understand how being in a

healthy relationship facilitates the successful negotiation of safer-sex behaviors 2) *Strength-Based Approach* to help youth in care that have experienced past trauma and a lack of consistent loving/supportive relationships. For many, their inner strength and resilience have allowed them to survive these tough challenges. The curriculum has separate activities designed for younger youth age 12-14 and older adolescents age 15-18 and participants from both age groups are recruited to attend the class. The recruitment is basically done by Wake County Human Services Child Welfare Division Adolescent Social Work Team.

Wake County had six facilitators trained to offer *Making Proud Choices for Youth in Out-of-Home Care*. The facilitators representing three government agencies such as Wake County Human Services' Public Health and Child Welfare Divisions and North Carolina Cooperative Extension's 4-H Youth Development. Facilitators from youth community-based organizations such as Strengthening the Black Family, Inc. and My Goal, Our Mission, Inc. were also trained. Facilitators need to have experienced working with youth and knowledge on HIV/STDs to be able to teach subjects covered in the curriculum Making Proud Choices!

As of November 2014, fifty-three youth have completed the *Making Proud Choices for Youth in Out-of-Home Care* curriculum. During the implementation of the curriculum, the facilitators faced some challenges with recruitment, transportation, and staffing. To address the recruitment and transportation challenges, additional efforts and collaboration went to engage staff from existing adolescent programs to assist the implementation coordinator to recruit youth form their programs located in Wake County Human Services Swinburne Building where the Child Welfare Division is sited. The additional transportation also was address by holding the MPC classes in the Swinburne Building, the same location where the youth go for services. Finding facilitators to teach the curriculum continues to be an issue because of the increase of children in Wake County care and reduction in staffing. To address the shortness of facilitators and increased the pool of trained new facilitators, two staff were selected to become *Making Proud Choices for Youth in Out-of-Home Care* Train-the-Trainers to be able to locally train new facilitators. After they complete the Train-the-Trainer course at *the National Campaign to Prevent Teen and Unplanned Pregnancy* Headquarters in Washington, DC, additional staff they will be able to teach the curriculum to youth in out-of-home care in Wake County, NC.

Key Findings:

The finding can be broken down in two main categories, one youth sexual behavior and the great collaboration among the HIV/STD Community Program, LINKS, 4 H Youth Program and two community partners; Strengthening the Black Family and Our Mission.

Youth Findings

- Contraceptive use among foster youth participating on LINKS has improved. Participants are asking for contraceptives on a regular basis.
- Increased in the number of youth in the LINKS program asking for contraceptives and also taking more on a regular basis.
- No pregnancies have been reported from any youth that participated in the program.
- Increased in the number of youth in the LINKS Program asking for condoms and taking them more consistently.

Collaboration

- The effective collaboration between the facilitators from the WCHS HIV/STD Community Program, Child Welfare -LINKS and 4H Public Health, as well as both community agencies partners; Strengthening the Black Family and Our Mission; made the intervention seamless to the youth participants.
- Partnerships were enhanced and community partners were able to be trained on how to deliver evidence based curriculum acquiring new skills and experience that they can take with them to their respective agencies.
- The partnership and collaboration of the HIV/STD Community Program, LINKS and 4-H Public Health Team strengthened the implementation of MPC and allowed the sustainability of the program. Making Proud Choices now one of the LINKS regular programs to the youth in out-of-home care.
- The Collaboration among the HIV/STD Community Program, LINKS and 4 H still stronger and thriving.

Next Steps:

- To sustain the program we would need money for marketing the program, incentives and assistant innovative ways of broadcasting (streaming online) the programs for youth who can't participate in person.
- HIV/STD Program Manager is seeking to become a TOT Certified on MPC, therefore there is a possibility for future recruitment of staff that is interested to become facilitators and have a larger pool of facilitators to consistently provide the Making Proud Choices program.

References:

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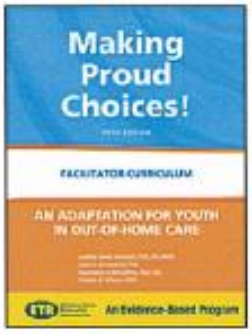
6. http://www.aecf.org/~/media/Pubs/Initiatives/KIDS%20COUNT/D/DataSnapshotFosterCarePlcmnt/DataSnapshot_Final Web.pdf Assessed May 24, 2016

7. http://www.cdc.gov/std/stats14/adol.htm#foot2 Assessed May 24, 2016
8. http://ncfy.acf.hhs.gov/library/2011/foster-care-data-snapshot Accessed May 16, 2016
9. U.S. Department of Health and Human Services. (2015). *The AFCARS report: Preliminary FY 2014*
10. http://www.cdc.gov/std/stats14/adol.htm

Resources:

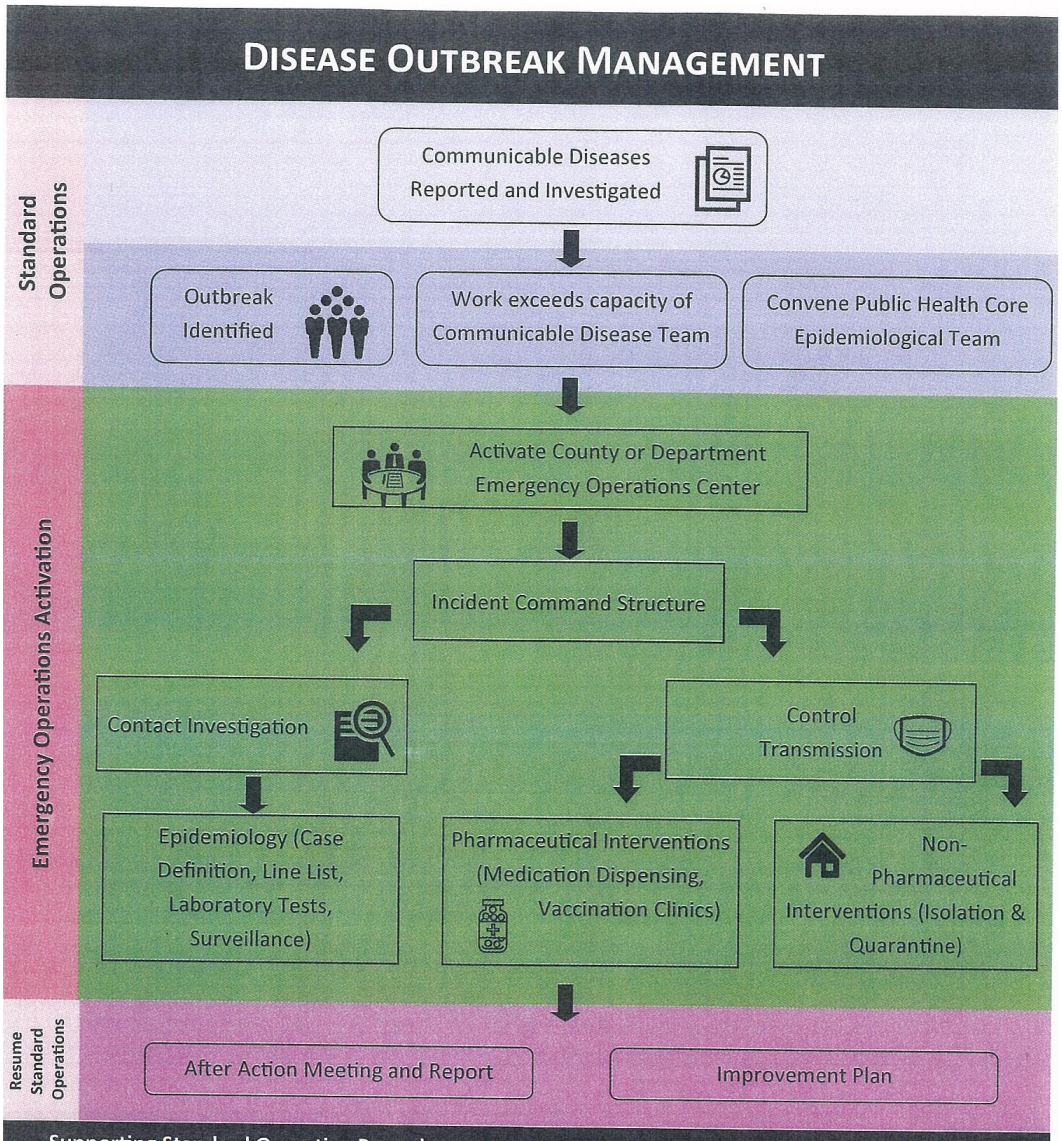


http://www.etr.org/ebi/programs/making-proud-choices/

The modules in the program for youth in out-of-home care include:

- **Module 1**: Setting the Stage and Making Your Dreams Come True
- **Module 2**: Relationships and the Consequences of Sex
- **Module 3**: The Consequences of Sex: Pregnancy
- **Module 4**: The Consequences of Sex: STDs
- **Module 5**: The Consequences of Sex : HIV Infection
- **Module 6**: Attitudes and Beliefs about HIV/AIDS and Condom Use
- **Module 7**: Sexuality 411
- **Module 8**: Strategies for preventing HIV Infection: Stop, Think, and Act
- **Module 9**: Developing Condom Use & Negotiation Skills:
- **Module 10**: Enhancing Refusal and Negotiation Skills

Disease Outbreak Management



Supporting Standard Operating Procedures:

High Consequence Pathogen
Isolation and Quarantine
Medical Countermeasures

Partners:

Wake County Environmental Services
Wake County Emergency Management
Wake County Hospitals and Medical Providers
North Carolina Division of Public Health

Wake County Human Services
Division of Public Health

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