



NEUROSCIENCE

EPIGENETICS

ADVERSE CHILDHOOD EXPERIENCES

RESILIENCE

NEAR@Home

*Addressing ACEs in Home Visiting by
Asking, Listening and Accepting*

Version 2 | January 2016
Prepared by Region X ACE Planning Team

CONTRIBUTORS AND REVIEWERS

The Region X ACEs Planning Team would like to thank everyone who contributed to this project. People from different perspectives and roles contributed their wisdom, technical skills, reflections, pushback, word-smithing and experiences. We offer a special thank you to the home visitors who volunteered countless hours of thinking, discussing, writing, sharing their deep knowledge of use of self, and bringing this work to the families they serve.

We apologize if we forgot to include anyone in this list or spelled your name wrong. Please send your information and we will update the list.

Adrienne Matthias
Alicia Gregory
Andrea Ryker
Annelisa Tornberg
Beth Gebstadt
Brenda Hayes
Bridget Hutchens
Cara McCartney
Christi Lyson
Courtney Miller
Cynthia Ikata
Daphne Beck
Dave Kucklick
Deb Ward
Deborah Drain
Elizabeth Kang
Erika Boyd
Erinn Havig
Evelyn Patrick
Floyd Marshall
Gretchen Thaller
Heather Parker
Holly Wyrwich
Ifeanyi Chukwu

Janet Peterson
Jennifer Pere
Jennifer Wall
Judy Ziels
Karen Brozovich
Karin Paulsen
Kathy Carson
Kathy Reschke
Kendall Appell
Kerry Caverly
Kerry Shaughnessy
Laura Alfani
Laura Porter
Linda Clark
Linda Miner
Lisa Mowbrey-Meuleman
Lisa O'Neil
Lisa Sutter
Larraine Clayton
Lorrie Grevstad
Marcy Miller
Marian Birch
Marilyn VanOostrum
Mary Jo Mackenzie

Melanie Dilger
Melissa Gorgone
Molly O'Fallon
Nina Evers
Petra Smith
Quen Zorrah
Rachael Gray
Rachel Moore
Rebecca Levenson
Rebekah Morisse
Renee Slaven
Rhonda Crooker
Rob Colombini
Robin Hill-Dunbar
Shannon Bayne
Shannon Blood
Shirley Pittz
Tamie Nielson
Tedd McDonald
Trish Dauer
Trishelle Tate
Valeri Lane

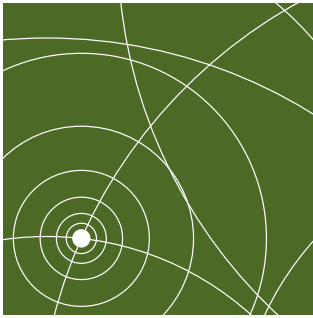
This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number 27391; 27399; 27413; and 27463, representing Alaska, Idaho, Oregon and Washington, Region X Maternal and Infant Early Childhood Home Visiting Program. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

TABLE OF CONTENTS

CONTRIBUTORS AND REVIEWERS	2
TABLE OF CONTENTS (cont.)	4
WELCOME	5
INTRODUCTION	7
EXECUTIVE SUMMARY	8
SOCIAL JUSTICE – PARENTS HAVE THE RIGHT TO KNOW THE MOST POWERFUL DETERMINANT OF THEIR CHILDREN’S FUTURE HEALTH, SAFETY AND PRODUCTIVITY.	9
BECOMING NEAR INFORMED	11
NEAR EDUCATION	11
REFLECTIVE SUPERVISION	11
DIMENSIONS OF SAFETY	11
CLIENT-CENTERED	12
RELATIONSHIP-CENTERED	12
LEARNING THE CORE ELEMENTS OF A NEAR HOME VISIT	15
CORE ELEMENTS OF A NEAR HOME VISIT	17
Preparing	17
Asking	19
Listening	21
Accepting and affirming	25
Remembering	26
Following up	27
THE SCIENCE OF NEAR – WHAT’S BEHIND THIS?	29
SEQUENTIAL DEVELOPMENT	30
AGE, GENDER, TYPE OF EXPERIENCE	30
EXECUTIVE FUNCTION	31
THE ADVERSE CHILDHOOD EXPERIENCE STUDY	32
RESILIENCE	34
RESILIENCE DEFINITIONS	35
FOSTERING RESILIENCE	36
APPLYING CONTINUOUS QUALITY IMPROVEMENT	38
OBJECTIVES FOR APPLYING CQI WITH NEAR PROCESSES	38
CONTRIBUTION TO THE ONGOING LEARNING AND IMPROVEMENT OF THE NEAR TOOLKIT	38

TABLE OF CONTENTS (cont.)

RECOMMENDED NEAR CQI PROCESSES	38
SUGGESTED IMPROVEMENT OPPORTUNITIES	41
APPENDIX	42
READINESS CHECKLIST FOR NEAR HOME VISITING EDUCATION	1
RESOURCES	2
FROM THE RESEARCH	3
CLIENT STORIES	4
THE ROLE OF TIME	6
¿CUÁL ES MI PUNTAJE DE EXPERIENCIAS INFANTILES ADVERSAS (ACE)?	7
FINDING YOUR ACE SCORE	8
THEORY OF CHANGE	9



WELCOME

Dear Reader,

Translating science into policy and practice is not always an easy task. In evidence-based home visiting, we rely heavily on science. During the 2013 Region X MIECHV and ECCS Fall Forum, the participants had an opportunity to attend an incredible presentation on the latest science regarding Neuroscience, Epigenetics, ACEs, and Resilience (NEAR).

Afterward, in a lively discussion among the presenters and representatives from throughout Region X, it was agreed that it is important to explore how to move this science into home visiting.

Throughout 2014 and most of 2015, a small facilitating workgroup and a large planning committee have come together virtually, in person and by phone to discuss the opportunities and challenges to this work. The first and more obvious discussion was the importance of training; that led to the recognition of what was necessary in the community and the environment in order for the work to be successful.

“This NEAR Toolkit, created by visionary MIECHV leaders of Region X, provides sensitive and transformational guidance for home visitors and all early childhood professionals to address the adverse childhood experiences (ACEs) of young at-risk families. This state-of-the-art instrument captures the power of the NEAR science, the sensitivity of the HV relational context, the wisdom of reflective supervision and the sophistication that strengthens resiliency of every courageous parent. By incorporating NEAR knowledge into home visiting practice, Region X hopes to demonstrate significant impact to address toxic stress, to mitigate social determinants, to prevent health and developmental disparities and thereby, to strengthen the MCH goals of improved population health.”

– Dr. David Willis, director of the Division of Home Visiting and Early Childhood Systems, Department of Health and Human Services, Health Resources and Service Administration, Maternal and Child Health Bureau

Staff from top to bottom need to be involved and committed to the work. It is critically important that all staff understand what the NEAR framework is and is not! It also has become important for staff to privately consider exploring their own ACEs history to best understand the respect

and compassion needed to discuss ACEs with families. Determining how best to address training needs turned out to just be the tip of the iceberg as those of us in Region X explored how best to introduce this work in the MIECHV programs.

As usual, new journeys are often slower than expected. However being thorough and methodical has helped us better identify all the parts of this work, pre- and post-, that are necessary for success. In this case, success is respectful supportive conversations with families about this science and what it may mean to them and to their children.

I want to thank all the MIECHV and ECCS staff across Region X for their willingness to take this work on, on top of their already challenging workloads. They were quick to identify and agree that the ACEs framework and the NEAR science has the ability to strengthen the work in home visiting and improve outcomes for children and families. And I especially want to thank Laura Porter and Quen Zorrah for providing content expertise and hours of their time to bring this work to life. Petra Smith, as our MIECHV Technical Assistance Liaison for Region X, has helped shepherd this work, facilitating and organizing the efforts and the technical challenges to a “virtual” environment.

We hope that this toolkit will encourage others to consider this work in their programs, whether through the direct use of the toolkit or through adapting it to their unique environments. Please let us know what works best for you and share your feedback with us. Journeys like this are always improved as we learn from each other how best to move ahead.

Appreciatively,

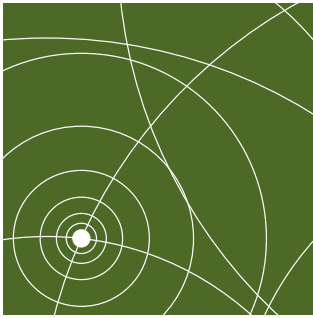
Lorrie Grevstad, RN MN

Federal Project Officer

Region X, Division of Home Visiting and Early Childhood Systems

HRSA/MCHB

Department of Health and Human Services



INTRODUCTION

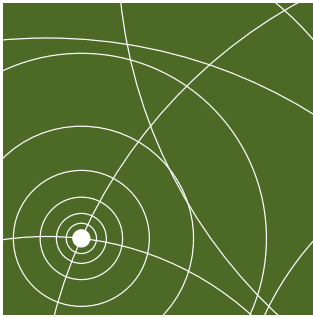
We have learned so much in the past two years! Especially in the last year as many of you have reviewed and used the NEAR@Home Toolkit and shared your thoughts and edits. We are very grateful to all of you for your time and your input. The science clearly continues to reinforce the need to share this information broadly and to those who can most benefit from the knowledge. We hope the review of the science and the emphasis on social justice helps others realize this information represents the most powerful determinant of children’s future health and development.

The toolkit reminds us of the critical importance of reflective supervision, safety, and the relationship-centered nature of this work, as we have represented in the theory of change. In sample scripts, you will find core elements of a “NEAR” home visit and examples to guide your approach. Emphasis on asking, listening, accepting, affirming, and remembering can assist you in preparing for these significant conversations with your families and in reducing the adverse experiences of generations to come.

The NEAR@Home Toolkit continues to be a work in progress. Our aim is to model continuous quality improvement and ways we can strengthen and enhance the toolkit to remain state-of-the-art. As you incorporate this knowledge into your practice and home visits, please also recognize the value of building this work into your program’s continuous quality improvement and early childhood systems efforts.

We hope the toolkit will continue to be a resource for you in your work. Please continue to share your suggestions and thoughts.

Thank you again for your commitment to improve the lives of children and families.



EXECUTIVE SUMMARY

Parents deserve to know the largest public health discovery of our time. They should have the opportunity to talk about their own life experiences and consider how they might like to use new scientific discoveries to give their children greater health, safety, prosperity and happiness than they had.

Just in the past two decades, new technologies, new ways of thinking, and new alliances among experts from many disciplines have combined to reveal key answers to an age old debate: nature versus nurture. We now understand how adversity becomes embedded into biology, behavior and risk, and how simple supports and opportunities can deliver stunning improvement in the lives of the people we are, and the people we serve.

Life is complex. And the story of how lives unfold is equally complex. In this toolkit we combine into one science discoveries from:

- **Neuroscience**
- **Epigenetics**
- **Adverse Childhood Experiences (ACE) Study**
- **Resilience research.**

We are calling this science: **NEAR**.

Home visiting professionals are uniquely positioned to talk with parents about NEAR – especially about how their ACE histories may be impacting their lives and may influence their parenting. Voluntary participation assures parent interest in learning and improving family life. Because home visiting is relationship-based and occurs within each family's comfort zone, home visitors have the opportunity to ask, listen, and affirm. Then, over time, home visitors can recognize the unique history and gifts of each parent, while committing to work with the parent as she or he navigates the journey of building resilience and giving the biggest gift to a child: low ACEs and low risk for a lifetime.

The toolkit is based on a theory of change with five core elements: Preparing, Asking, Listening, Affirming and Remembering. These core elements are essential for success and reflect a process for improving the service of home visiting, as well as the systems that support home visitors and the families they serve. For the sake of brevity and simplicity we most often use female pronouns when referring to home visiting clients, but NEAR home visits should also include fathers and male caregivers.

This toolkit was created for home visitors and managers or leaders of home visiting programs. Materials in the toolkit may be valuable for other people who are working with parents and children to improve health, safety and well-being.

SOCIAL JUSTICE – PARENTS HAVE THE RIGHT TO KNOW THE MOST POWERFUL DETERMINANT OF THEIR CHILDREN'S FUTURE HEALTH, SAFETY AND PRODUCTIVITY.

The most powerful people for reducing ACE scores in the next generation are parenting adults. Parents have the most opportunity and the most potential for changing the trajectory of the public's health for generations. But parents must actually know about ACEs and their effects in order to realize this potential.

We used to think that a person who experienced one type of adversity – for example, physical abuse – as a child was more likely to pass that type of adversity on to their children. In other words, more likely to physically abuse their children. But, data about ACEs shows that intergenerational transmission is not that simple. Normal responses to experiencing maltreatment during development can, for example, include depression, risk for alcohol dependence, and difficulty with emotional regulation that can lead to relationship problems. These risks, when manifested, become ACEs for the next generation. Parents can do a great job protecting their children from physical abuse, and if they don't know the importance of also protecting their children from other experiences that generate childhood toxic stress, they don't have the opportunity to protect their children from the effects of that stress.

Because ACEs can affect emotional state, behavior, and illness, adult history of ACEs can affect the climate inside a family or household. Parenting adults may affect this climate through over-disclosure or through avoidance (including numbing of emotions and avoiding reminders of past experience) or through a chronic illness that can make it difficult to actively engage with children. Parents who know the impact of ACEs and have a chance to reconstruct personal narrative about their lives can make meaning from their experiences and intentionally choose a more protected developmental path for their children. They also report feeling more self-worth and fulfillment in their lives.

One, parent, after learning about ACEs and having a chance to talk with other parents about her experience reports:

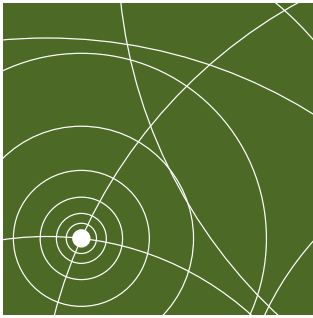
“The ACE Study gave me my humanity – my mind and body adapted to the experience I had as a child just like everyone else's did. I just had more adversity.”

Another parent reports:

“I feel human now. When I want something for my children, people know it's because I want something better for them than I had for myself.”

When we avoid talking about ACEs, we may inadvertently be sending a message that people should be ashamed of their childhood experiences. Shame can increase risk of intergenerational transmission because it reinforces one of the pathways for transmission: avoidance. A parent may re-create the emotional conditions of past adversity without consciously choosing this path for her children. People need to have an opportunity to appropriately and voluntarily share information about their personal histories as a part of a healing process.

Home visiting professionals have relationships with clients over the course of many years. They are highly skilled in building trust and creating safe spaces for meaningful conversations, and they are practiced in the art of family support. Adopting a protocol of asking, listening, affirming and remembering the life experience of each parent, including her ACE history, can be an important part of strengthening each family.



BECOMING NEAR INFORMED

We recommend that agencies considering or planning to bring NEAR into home visiting first address each of the suggestions and concepts below.

NEAR EDUCATION

Implementation science tells us that for an intervention to be successful, all layers of the organization must be informed, involved and committed to the process. Bringing NEAR science into home visiting will require all staff involved to have education about NEAR. We recommend that all staff also complete their own ACE histories privately, without sharing the score. Completing a personal ACE history is an important process for staff to have a felt experience of what home visitors will be doing with families. Having this experience will facilitate team cohesion and support for each other. It is possible that a significant portion of staff will have high ACE scores. We suggest the agency move toward trauma-informed practices as a way to support staff and clients.

REFLECTIVE SUPERVISION

Before introducing NEAR into the work, we recommend that home visiting programs have established ongoing, quality reflective supervision (RS). RS is required by all evidence-based home visiting models. There are different models of RS, but there are some shared goals and processes. RS provides critical emotional support to staff who carry a heavy burden of secondary trauma and high expectations for improved family outcomes. RS builds staff capacity to deliver services to families with safety, integrity, quality and fidelity; it provides a model for the home visitor of how to be with the client and family. Quality RS requires a trusting relationship built by regularity, predictability and mutual respect. Becoming reflective is a developmental process and is best supported when both the supervisor and supervisee are committed to the process and bring attitudes of curiosity, empathy, openness and self-awareness. While a home visitor might carry a caseload of 25 families, a supervisor or manager might carry all 100 families in the program through her provision of RS. Ideally, the provider of RS will also have her own reflective support.

Resource: *S. Scott Heller & L. Gilkerson (Eds.), A Practical Guide to Reflective Supervision. Washington DC: Zero To Three.*

DIMENSIONS OF SAFETY

The most common type of safety discussed in the majority culture in the United States is physical safety, yet that is not the only kind of safety we should consider as we infuse NEAR Science into home visiting.

Physical safety, psychological safety, social or relational safety and moral safety are all important capacities that we need to foster in ourselves and the environments we create, as well as in the families we serve.

Physical safety means that the physical environment is protective – designed in a way that prevents problems before they arise.

Psychological safety refers to the ability to be safe with oneself, to rely on one's own ability to self-protect against any destructive impulses coming from within oneself or deriving from other people, and to keep oneself out of harm's way. This ability to self-protect is one of the most shattering losses that occurs as a result of traumatic experience, and it manifests as an inability to protect one's boundaries from the trespass of other people. Another loss is a sense of self-efficacy, which is having the ability to relate to the world on one's own terms without abusing power and without being abused by it. A sense of personal safety is achieved as the injured individual learns how to be effective in protecting herself from violations of personal and psychological space.

A socially safe environment is one that is free from abusive relationships of all kinds. People are not isolated but are connected in a network of support. Emotion is successfully managed and the level of emotional intelligence is high. The past can be looked at, dealt with, and finally left behind. There is tolerance for diverse opinions, beliefs and values but what ties everyone together is a shared belief in the importance of being safe. Boundaries are clear and firm, but flexible.

Moral safety includes giving attention to the question, "Are we helping, or are we hurting?" Organizations and groups that invest in reflection, honest appraisal, open dialogue and principle-centered practice promote moral safety.

Resource: *Sanctuary Model* <http://www.sanctuaryweb.com/safety.php>

CLIENT-CENTERED

A client-centered, goal-oriented approach to working with families is based on viewing challenges or problems as an opportunity for growth. Being client-centered is deeply knowing the client has the ability to make changes and to move forward. The client-centered home visitor focuses on the client's positive achievements, however large or small, to encourage continued movement toward the goal. The client sets her goal through the home visitor's facilitated exploration of possibilities. The home visitor, while focusing on solutions, does not ignore or make light of challenges but acknowledges them with openness and belief in the client. The home visitor offers partnership in moving toward the goal. Key concepts: The client is the expert on her life. Focus on strengths. Only a small change is needed. Assume her intentions are for the best.

Resource: *Solution-Focused Brief Therapy* http://www.sfbta.org/about_sfbt.html

RELATIONSHIP-CENTERED

Home visiting prioritizes the relationship between the home visitor and the caregiver as the primary tool to support engagement and learning, and to motivate the parent to reflect on and make positive changes in the family environment. A central goal of this relationship is to ensure a strong and safe attachment relationship between the caregiver and child. Attachment processes interact with and impact brain development, epigenetics, and physical and socio-emotional health and development. Our attachment relationships in infancy are the foundation for all emotionally intimate relationships throughout the life span: familial, romantic and parental.

Attachment is a biologically driven process intended to keep the species alive.

- The young child survives, stays safe and develops by engaging with a protective parent.
- A child adapts to his or her family as a way to keep the parent engaged and protective.

In healthy families, the adults prioritize the infant's needs and change their life to care for and protect the infant. In families who are coping with a lifetime of overwhelming stress, the parents are sometimes so focused on survival that the infant's needs for protection and nurturing are unmet. ACEs can be experienced by the very young child as life-threatening because their survival depends on a protective relationship. Attachment theory posits that the infant feels, "I must be unlovable if my own parents don't protect and care for me." If this is the constant relationship environment, without protective relationships and experiences, the child internalizes these experiences and views herself as inadequate, unworthy, shameful and lacking adequate self-regulation; she experiences the world as unsafe. Note that ACEs research has all of childhood in the same category, though we know some periods of development are more vulnerable.

Coping with unsafe attachment and ACEs can lead to similar behaviors: risk-taking, impulsivity, substance use, mental illness, and unsafe and revolving relationships. Thinking about clients in the context of ACEs and attachment helps us better understand a client's behavior. Home visitors can be flexible and adaptive in interpreting and responding to the client's behaviors. For the ACE survivor with an unsafe attachment history, the experience of being with someone who can think about her and see her as an important and capable person might be difficult and scary. The opportunity to be heard, understood and accepted by the home visitor can be a powerful experience for the ACE survivor in developing healthier and more flexible coping and adaptive strategies.

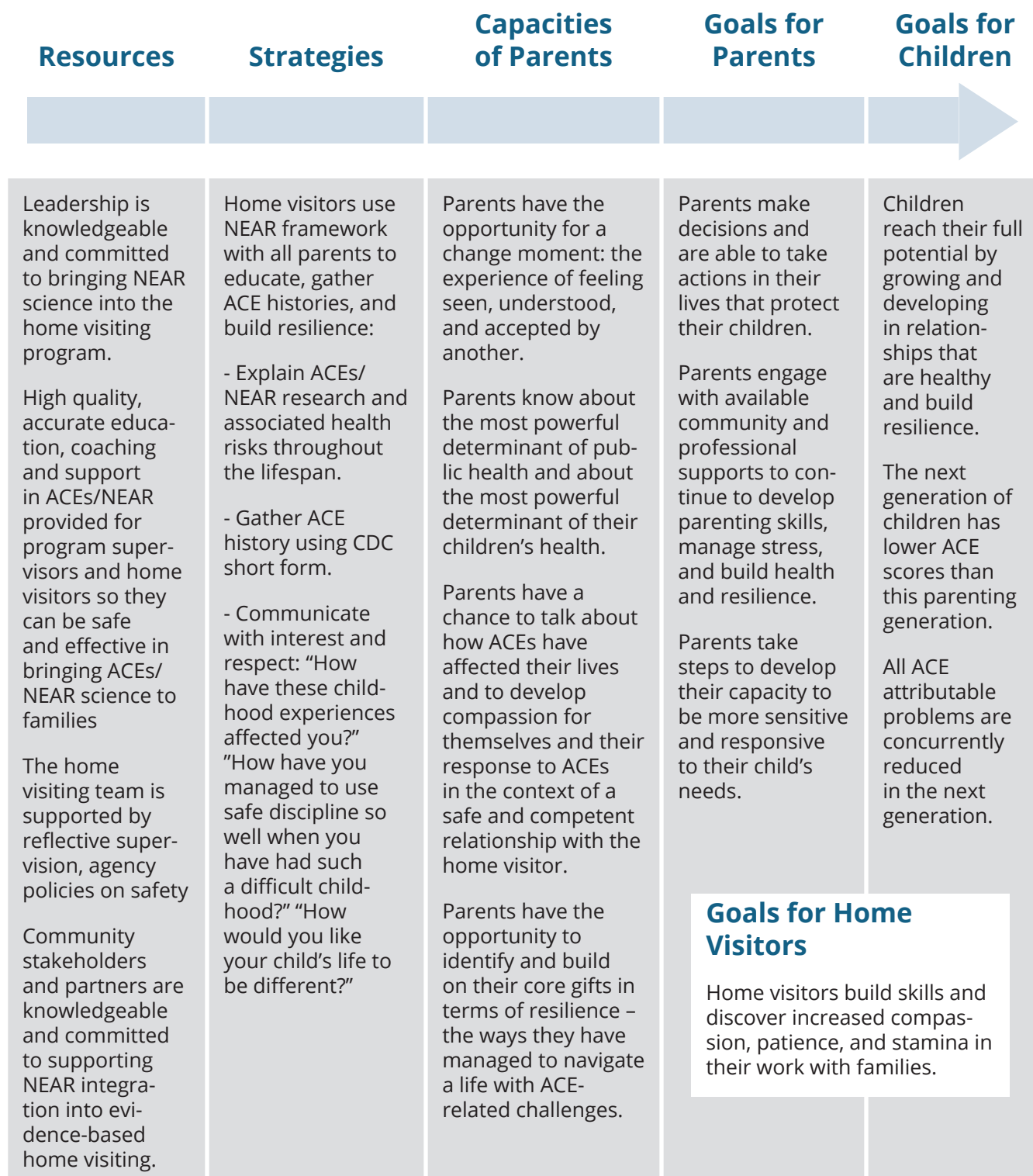
With different stages of development and a widening circle of relationships come potential opportunities for adapting a more flexible, balanced way of relating. The Core Elements section of this toolkit guides the home visitor with safe, empathetic and therapeutic strategies to support the home visitor and the client in developing a safe relationship.

Home visitors carry a heavy responsibility for program goals and outcomes, as well as the responsibility to improve outcomes for each individual and family. Bringing NEAR processes into the practice helps home visitors find compassion, patience and stamina to:

- Meet the client where she's at
- Stay engaged with her even when she is acting difficult
- Understand that what might appear to be small steps of change are really leaps forward
- Develop with her accommodations that will ease ACE-related challenges in her life, and help her better protect her children from ACE accumulation.

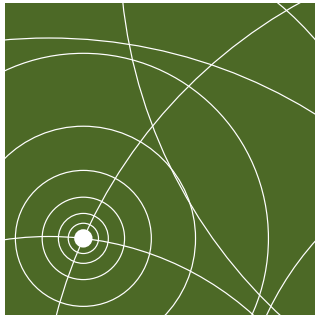
Resource: *Patricia McKinsey Crittenden, Raising Parents: Attachment, Parenting and Child Safety. Willan Pub., 2008*

Theory of Change for Integrating NEAR Science in Evidence-Based Home Visiting



Goals for Home Visitors

Home visitors build skills and discover increased compassion, patience, and stamina in their work with families.



LEARNING THE CORE ELEMENTS OF A NEAR HOME VISIT

The Core Elements document is intended as a guiding and training tool. The Core Elements tool represents our best practices at this moment but it will be refined and expanded as needed by the growing knowledge and developing expertise. This tool was contributed to and vetted by home visitors from multiple models working with diverse populations, as well as mental health and infant mental health providers, and program supervisors and managers.

The Core Elements are based on many home visitors' wealth of experience and expertise in other sensitive conversations within the client-home visitor relationship, such as depression and mental health screening, substance use assessments, and screening for Intimate Partner Violence. The Core Elements can be a useful tool for less experienced home visitors and those who are learning how to have these and other sensitive conversations. We suggest, however, that learning this process of bringing NEAR science into home visiting is most suited to home visitors who have been practicing in their evidence-based model for at least one year.

Most home visiting programs have an initial period of assessment and planning with newly enrolled families. This can be an ideal time to introduce NEAR science and complete the ACEs questionnaire with families. Skillful home visitors introduce this by informing the client: "In our first couple of visits we will be getting to know each other and sorting out how I can be most helpful to you and to discover your goals as a new parent. I will bring some assessments we can do together to see what kind of challenges might get in the way of achieving your goals. These include screening for depression, substance use and difficult childhood experiences. We will also be talking about your unique strengths and how to move forward to meet your goals." Each program and each home visitor will decide on the best time to introduce NEAR.

The Core Elements include scripts to support learning and bring a degree of consistency to this process. They reflect the diversity of roles and experiences among home visitors; each home visitor should use and adapt scripts that feel authentic. The scripts are not intended to be memorized.

"How have these experiences affected you?" is the script shown to be effective when used by physicians in the original research project at Kaiser-Permanente. They also discovered that contrary to their initial expectations, not a single person of the approximately 17,000 patients needed to access the crisis response team organized to support patients traumatized by the ACEs questionnaire.

For the sake of brevity and simplicity we most often use "her" when referring to the client. NEAR home visits should include fathers and male caregivers.

We know from the science of adult learning that just reading through the Core Elements tool will not be sufficient to safely and effectively change home visiting practice. There must be an opportunity for practice and coaching. We suggest planning for several months of focus on this learning process. Some home visitors who are already highly skilled in other sensitive processes might need just a few months of support to integrate NEAR into their practice; less experienced home visitors will likely need much longer to develop expertise. Ideally, learning the Core Elements

would be in person, facilitated and coached by someone experienced with NEAR home visiting. If this is not possible, we suggest you develop your own facilitator. This might be a staff member who is a champion of the NEAR process.

1. All staff are educated in Neuroscience, Epigenetics, ACEs, and Resilience and have completed their own ACEs questionnaires privately.
2. Program staff and home visitors are committed to using ACE questionnaires to discover ACE scores.
3. Supportive structures are in place (reflective supervision and reflective case conferencing).
4. Relevant protocols or policies are written (mandated reporter, documentation, HIPPA, crisis process and resources). This should include guidance indicating that the CDC short form of the ACEs questionnaire is used, as well as guidance for the format of this tool (card sort and laminated page are two options). To protect privacy, no paper forms should be collected. Also, consider making a cutoff score. Capping ACE score documentation at seven provides greater safety for clients and still allows full data comparisons.
5. A member of the team is identified as the champion of this new process.
6. Each staff person should read the entire document before the education session. Expect resistance and/or ambivalence. Home visitors are already overburdened! This is where your champion can be so helpful. Explore how this process can contribute to your program goals.
7. For your NEAR education session: As a team, take turns reading out loud each section of Core Elements of a NEAR Home Visit, then discuss. This allows deep reflection. We are more likely to remember and repeat what we have said out loud to another person. The scripts are not intended to be memorized but used for learning. "How have these experiences affected you?" is the script used by providers in the original research project at Kaiser-Permanente and has data to prove its effectiveness. Adapt and write your own scripts to fit your needs but honor the intention and process of the original script.
8. Practice, practice, practice! In groups of three, if possible, home visitors and supervisors or managers role-play using the provided scripts. Rotate being the client, the home visitor and the coach who observes the process and offers suggestions to the home visitor. Discuss in your larger group what it was like to be the client and the home visitor.
9. Ask each home visitor to commit to doing a NEAR home visit within one week and continue to prioritize as many NEAR visits as possible in the following six weeks. Expect some messiness as expertise is developed. It is more important to bring NEAR to families than to be perfect.
10. Supervisors and managers use reflective supervision and case conferencing to facilitate this learning.

CORE ELEMENTS OF A NEAR HOME VISIT

“Slowly, I have come to see that Asking, and Listening, and Accepting are a profound form of Doing” – Vincent J. Felitti, M.D.

Home visitors have described feeling great relief on reading the “asking, listening, accepting” quote from Dr. Felitti, so the Core Elements are organized around his wise words. Home visits and human interactions are rarely linear events. Understand that these Core Elements in practice will flow in response to the needs of the family and the home visitor.

Preparing

A. WHAT:

Supervisor/manager and home visitors think together about how to introduce NEAR and gather an ACEs history (a NEAR visit) so that it will successfully fit the model’s process and the curriculum.

WHY:

Honor fidelity of model and staff expertise in knowing families and model. Support professional development of staff.

CONSIDERATIONS:

Strategies that have worked: As part of intake assessment over first four visits; as part of parent/pregnant woman assessments such as depression screening; or when discussing goals for parenting. A new possibility suggested by home visitors: Explain to prospective clients that offering NEAR information and history will be a benefit of participation in home visiting.

Best to plan a NEAR visit before 32 weeks’ gestation for pregnant clients: psychology of pregnancy is to turn inwards and prepare for birth during last phase of pregnancy.

B. WHAT:

Set program-wide goals for when to introduce NEAR and gather an ACEs history.

WHY:

Shared expectations of how and when the NEAR visit occurs will increase the busy home visitor’s accountability and motivation in achieving this goal and contributing to program data.

CONSIDERATIONS:

Supervisor/manager should be tracking NEAR visits and using reflective supervision to explore and help if a home visitor is consistently not achieving NEAR visits.

C. WHAT:

As staff are learning this process, the supervisor/manager prioritizes supporting home visitors in preparing for a NEAR visit, utilizing case conferencing and reflective supervision. Home visitor can also use self-reflection on previous NEAR visits.

WHY:

Goal is safety and accountability: Reflective supervision provides privacy and safety in deeper exploration, and team meetings allow for learning from peers and support peer leadership.

D. WHAT:

Some expert home visitors find it helpful to tell the client that on the next visit they will be discussing some private, sensitive information. If not possible to ask in advance, ask at the start of the visit. Ask the client to think about who should be present and how to be private. The ACEs questionnaire generally should not be completed with the client's older children or her parents present. The home visitor should use professional judgment in deciding who else can overhear or participate in the ACEs questionnaire and subsequent discussion.

Plan for the NEAR discussion to be the main content of the visit and introduce it early in the visit.

On the day of NEAR visit, the home visitor asks the client if this is a safe day to discuss sensitive, personal information. If in doubt, delay until another visit. Clients have expressed appreciation in being asked.

WHY:

This trauma-sensitive approach avoids surprises, demonstrates respect for client, and promotes her self-efficacy by offering a choice.

CONSIDERATION:

Privacy needs to be considered as part of safety. It might not be safe for her partner or friends to hear this conversation.

E. WHAT:

The home visitor needs to feel calm and self-regulated, and able to be fully present with the client. If the home visitor is having a bad day, is not feeling well, or the home environment doesn't feel safe, consider postponing the NEAR discussion. Consider balancing the day so that some visits are likely to be lighter in content.

WHY:

The home visitor's state of mind is critical for a safe and respectful NEAR visit. People with a trauma history, whether ACEs or other trauma, will be very sensitive to home visitor who is not fully present. As many home visitors themselves contend with significant ACEs history, they too are sensitive and may have unintentional emotional responses to the discussion if they are engaging in it while under personal stress.

Asking

A. WHAT:

Set the context by offering information on NEAR science. Offer accurate information in a manner tailored for each client/family. Show the client the staircase diagram of the impact of increasing ACEs (see Appendix) and offer handouts.

“... And now the scientists have proven that the things that happen to you when you are young – good and bad – can affect your health for your whole lifetime. The good news is we also know some things you can do to buffer some of those experiences, so you can be the kind of parent you really want to be, be healthier, and do the things in life you hope to do.”

“Part of my job is to help you know about and use the latest, best scientific findings on how to be the best parent you can. And right now the big breaking news is that our brains are powerfully affected by the stuff that happens to us, especially when we are little and our brains are growing and changing so much and so fast every day.”

B. WHAT:

Explain that the ACEs questionnaire will let her discover her own ACE score and that you will think with her about what this means in her life and for her as a parent.

“This assessment will help me understand how to better support you and also helps our program support other families in our community.”

“We ask all our moms these questions.”

“Many of the moms/parents I work with have found it very helpful to learn about their own ACE score/number. Knowing this score lets us think together about how you can protect your children from having these experiences. I have a questionnaire we can do right now to see what your score is. Everything we talk about is confidential. Remember that I need to report any concerns about child abuse or neglect. Is this a good time for you to do this?”

C. WHAT:

Remind the client that home visitor is a mandated reporter.

WHY:

Home visitors are mandatory reporters. Reporting contributes to family safety. Staff members need to be familiar with state and agency policy on mandated reporter status.

CONSIDERATIONS:

When an ACEs questionnaire is completed by a person under 18, if the questions about abuse are circled, checked or otherwise indicated, the home visitor is legally obligated to respond. Each agency should have a policy or guidelines on what steps need to be taken. Some choose to offer only the education and not the questionnaire to minors; other agencies have the client share only the total score, not individual answers, and do not use any paper forms.

“One of my very important responsibilities is to keep kids safe. Anyone who works with kids and families is legally required to report to CPS any possible abuse or neglect. This is called being a mandatory reporter. As your home visitor I am a mandatory reporter. If I am concerned about your baby’s safety I will talk to you, and we can make the call together.”

“I will keep your answers confidential unless you share something that I need to report.”

“I will keep answers confidential unless you tell me about abuse that is happening to children or vulnerable adults, or have intent to harm yourself or someone else.”

D. WHAT:

Ask if this is a good time to do the ACEs history questionnaire.

WHY:

Asking if this is a good time offers a choice and contributes to trust and self-efficacy, while also indicating this questionnaire is important to do. This is a trauma-informed strategy.

CONSIDERATIONS:

Experienced home visitors might be able to have a sense of a client’s capacity to complete the ACEs questionnaire and stay regulated. Home visitors can use their professional judgment in deciding to offer education but not ask the ACEs questions. This decision should be brought to reflective supervision for support.

E. WHAT:

If the client agrees to do the ACEs questionnaire, explain that together you’ll discover her total score and do not need to discuss the details of any of these experiences. Inform her of your commitment to protecting her privacy and demonstrate this by offering her a choice in how she uses the questionnaire. Ask if she prefers to look at the questions herself or prefers you to read them out loud. Have her count on her fingers, make marks on a piece of scrap paper, or use a laminated copy of the questionnaire. Some home visitors use the Resilience Trumps ACEs deck of cards (see Resources) asking clients to sort the cards into two piles: one for ACEs, one for resilience. Then the client informs the home visitor of the number of ACE cards without revealing specific ACEs. Make note of the resilience cards for goal-setting.

If the client declines to complete the questionnaire: “So today is not so good. If it’s OK with you, I’ll ask again at our next visit.” If client says it’s not OK to ask again, thank her for being clear that she is not interested and tell her that if she does want to do questionnaire, she can ask.

WHY:

The science is clear: No one category is more important than another. It is the cumulative load of experiences that contribute to the life course impact.

Respecting her decision to decline the questionnaire is trauma-informed and client-centered. You have offered her important information even if she does not want to take the next step of completing the questionnaire. Informing her you will offer it again later gives her time to process this information and supports accountability to program goals.

F. WHAT:

All in one visit: review the questionnaire, calculate the score and discuss the score with the client. Home visitors can bring NEAR visits to case conferences so that everyone can share what has worked, analyze why it didn't work so well and create adaptations for different families.

IMPORTANT:

The total score is important. There is no need – and, in fact, it may be harmful and out of scope of practice – for a home visitor to ask for or probe for details of each experience. See below for options when the client chooses to share.

Listening

A. WHAT:

After you have asked, “How have these experiences affected you?” Wait, wait, wait. Thirty to 60 seconds of waiting for her response can seem like forever (consider practicing in case conferences or RS with a timer). This pause also supports clients who use English as a second language. Focus on keeping yourself calm, receptive and present. Notice how your body feels. You can count your breaths or pulse your feet into the floor to stay calm and alert.

How home visiting clients have responded to learning their ACE scores:

- “Well, duh!”
- “No wonder I’m so messed up! ... Sick all the time ... Can’t quit using.”
- “Now my life makes sense.”
- “My kid has already had some of these experiences.”
- “I want it to be better for my child.”

WHY:

Listening is the critical intervention! You honor her life story through your spacious listening. Self-regulation and being fully present is vital at this moment. Home visitor responses such as chattering to fill the silence, flipping papers or changing the topic suggest a need for support and reflective supervision.

B. WHAT:

Consider that the score might not reflect the client's history. Some people are not ready to share their reality. It is not the home visitor's job to force the truth. This script offers support and important information so that the client can stay safe and know the home visitor is a resource when or if she becomes ready to discuss her ACE score.

For low scores, or score of zero, some options for home visitor responses:

“Thank you for thinking about these difficult questions. Many of us who have had some of these experiences find we have to work harder at just about everything in life: staying healthy, quitting smoking and being a good mom. If you know someone who might have had these kind of experiences you can be helpful by being there for her and sharing this information.”

“We tell all of our parents this information because we are trying to help children not have these difficult experiences.”

An important part of building resilience is making meaning of ACEs. This script lets the client know you have heard her and are open to hearing the meaning she has made of her life.

For scores over 0, some options for home visitor responses:

“Thank you for thinking about these difficult questions. I see you have had some/many/all of these difficult childhood experiences. How do you think these experiences have affected you?”

“Thank you for thinking about these difficult questions. Many of us who have had some of these experiences find we have to work harder at just about everything in life: staying healthy, quitting smoking and being a good mom.”

“As your baby grows we will keep talking about how brains work, how to manage stress. We will talk about things you can do to make sure your child has a lower ACE score”

WHY:

These responses are both trauma-informed and client-centered. These responses respect her need to share only what feels right and safe while still offering her support and maybe a new way of thinking about her life.

There is no need to ask for details of her experiences. The ACEs science is clear: no one category is more important than another; it is the cumulative load of experiences that contribute to lifetime impact.

CONSIDERATIONS:

This is an opportunity for universal education and builds resilience. This is also an opportunity for reducing shame by normalizing having ACEs as part of one’s life story. The home visitor can choose to make a joining, normalizing statement by subtly sharing that she has ACEs in her life story. Of course, it would be inappropriate to share details of either the home visitor’s ACE score or specific experiences. Consider discussing as a team how you can develop a shared peer culture of openness about ACE scores. As with clients, the details do not need to be shared; it is the cumulative load of ACEs that has power.

“Many of us with high ACE scores have found we have to work harder to achieve our goals, but we get there!”

“You might not have known this, but many people, all kinds of people, have high ACE scores: doctors, teachers, and others.”

C. WHAT:

If she says, “My whole life is messed up,” the home visitor needs to breathe and pause. Don’t rush to say nice things or become swamped with your own emotions. Follow the client’s lead. If she seems sad or pensive, or she wants to think and reflect, stay with her. But don’t probe for details of her experience. We want to recognize what she said, let her lead, clarify her statements and remain open to her needs. This helps build her own reflective capacity and resilience.

“You’ve had a lot of tough/difficult things happen in your childhood, this is so hard to think about” (Then wait, wait, wait)

“It sounds like these questions brought up some feelings for you. If you want we can talk more.”

“I heard you say ____.” I’m wondering if this is something you want to talk about now, or maybe later?”

If she is silent or says she doesn’t know how these experiences have affected her, pause. Don’t fill the space. She is not ready or doesn’t feel safe to go further at this time.

“It is hard to think about all this right now. We can talk another time if you want. Who can you talk to tonight, or tomorrow who will support you?”

“We can keep thinking about this together.”

D. WHAT:

Her score is higher and she says, “It hasn’t bothered me at all. I’m fine.” Do not challenge her response or agree with her; remain neutral.

“Maybe you have also had some helpers who helped you through hard times.”

“How do you think you have protected yourself?”

E. WHAT:

If she starts to share details of her experiences: Breathe, self-regulate and find a safe way, within your own scope of practice, to respond to her sharing details.

WHY:

It is not the role of home visitors to probe for details. It is a critical part of the therapeutic relationship to respond to her sharing details in way that keeps her safe and respects your own capacity.

CONSIDERATIONS:

Finding this balance between listening and containment is very skilled and difficult work. To avoid burnout and compassion fatigue, and to avoid home visitors shutting down or blurring boundaries REQUIRES lots of attention, case review, reflective supervision, peer support and self-care.

“I see you’re getting pretty upset. I want to support you, but first of all I want to help you be safe, emotionally as well as physically. This is very powerful, painful stuff. How do you usually help yourself feel calm?”

“I really appreciate your courage in thinking about and sharing these difficult experiences, but I do not have the right expertise to help you walk through these details. I can help you find the right person who can help you.”

“Let’s take some deep breaths together. It’s so hard to think about these things. I really appreciate your courage! Are you ready to shift and think about how would you like your child’s life to be different?”

“As you are telling me these things I notice my stomach is hurting. I’m guessing you are also feeling pretty bad inside.” (This joining statement requires skill to be authentic and not add to her burden.)

WHY:

Home visitors have different levels of skills in responding to disclosures and discussions of specific trauma incidents.

Home visitors should use their professional judgment in choosing how to respond. However, not responding is not safe or respectful for the client. It is better to make a mistake than to ignore her emotional state and verbal statements. See below for thoughts on repair when this process was messy.

It takes practice and reflective supervision to develop the skill of being fully with someone without sharing her despair and pain, and to know when to move the conversation toward building resilience and hope.

CONSIDERATIONS:

Survivors of childhood abuse and trauma – both client and staff – might need some firm, calm support to cope with a flood of feelings. Co-regulating and guiding keeps her safe. Many survivors have not experienced co-regulation with a safe adult around intense negative emotions. This is an opportunity for the home visitor to model a strong protective stance, which is what we want her to do with her child.

Home visitors can use reflective supervision for their own firm, calm support in coping with a flood of strong feelings.

F. WHAT:

Move to discovering and building hope and resilience. Be very intentional about affirming the courage it took to look at such things. Make a concrete connection that the willingness to look at her ACEs is a solid start in adding good experiences that can build resilience for parent, child and family.

Be sure to finish the NEAR discussion with a clear emphasis on building resilience. If the client cannot think of a specific goal in the moment, assure her you will work with her to discover what is important to her.

“I’m so impressed with your strong determination to be a great mom! With all the things that happened in your childhood, how have you found a way forward?” (spoken with sincere admiration, not doubt)

“How would you like your child’s life to be different than yours?”

“We didn’t know back then that the bad things that happened to kids stuck with them. We thought they forgot, but now we know. How will you make things different for your child?”

WHY:

Assuming her best intentions builds self-efficacy and resilience. Making meaning contributes to resilience.

Sharing a statement that this is new research, which we didn’t know “back then,” is a way to defuse defensiveness and tension between your client and her parents. It opens a door to think differently about their relationship.

Accepting and affirming

A. WHAT:

Sometimes the home visitor will know enough about the client to know that an ACE score of 0 does not accurately reflect the client’s life story. The home visitor should accept the client’s stated ACE score.

WHY:

A client might not feel ready or safe to disclose her ACE history and will indicate no or low ACEs. We assume she has a really good reason for not disclosing. It is the client’s right to protect herself in this way. Even if she appears to be ignoring you, know you have planted a seed and assume her best intentions.

“Thank you for thinking about these difficult experiences. This is hard work! We can talk more about this another visit.” (Pause) “Are you ready to have some fun now? Do you want to try this new activity I brought for you and your baby?”

“We hope all parents can learn about this science of stress and brains. Maybe you have a friend or sister you can share this pamphlet and information with.”

B. WHAT:

Before you move away from the discussion of her ACE score, offer her some anticipatory guidance on how she might feel some extra stress after the visit.

“Sometimes after talking about ACEs people find they are extra sensitive or touchy. Maybe they don’t sleep well that night, or maybe they feel very tired. This is a good time to be gentle and patient with yourself. Take good care of yourself. Maybe go for a walk, take the kids to the park, talk to a friend and eat some healthy food. Who would you call if you were feeling pretty stressed? I’ll be thinking about you and check in with you on our next visit. Or call me sooner if you want.”

C. WHAT:

End the visit with a summary of the NEAR discussion and with hopefulness. Find a moment to thank her for thinking about some difficult topics and exploring her goals to help her child have a better, safer childhood than she experienced.

Remembering

A. WHAT:

Find a strategy to remind yourself to be sure on the next visit to check in on the NEAR process.

“Last time we talked about some difficult things, your high ACE score. That was hard work! I imagine you might have been thinking about it since then. How has this last week been for you? Any thoughts you want to share with me today?”

B. WHAT:

If during the NEAR home visit you didn't respond to her in the way you wished you had, you can revisit it. It is better to repair than avoid talking about NEAR because you feel you don't have the skills.

WHY:

Messing up presents a golden opportunity for repairing and strengthening the relationship. Acknowledge that everyone can mess up. This is an opportunity to model healthy relationships.

CONSIDERATIONS:

Even the most skilled, experienced home visitor will have an opportunity to practice repairing the interaction or relationship. Reflective supervision is a crucial support.

“In our last visit when we talked about your ACEs history, I wish I had given you more time to talk. I'm sorry I rushed you. Would you like to talk about it some more now?”

C. WHAT:

Consider offering other relevant assessments, such as depression screening, and bringing her ACE score into the discussion of those assessments.

“Depression has many causes but having a high ACE score increases the risk that a person will struggle with depression.”

D. WHAT:

Find times or events – success and challenges – in the course of your relationship to bring up, and link her ACE history to the topic or challenge. Use natural or program anniversaries to offer a thought that links her ACE score to her accomplishments.

“I see how gently you respond to your baby's crying. I wonder how you are able to do this when you did not have this kind of parenting and have such a high ACE score.”

“You are trying so hard to quit those cigarettes. Those of us with a high ACE score have to try many, many times but do succeed. Keep trying!”

“Your baby is 1 year old! He is so smart and happy! I very much appreciate how hard you are working to keep him safe from all the fighting going on around you. I remember you told me your ACE score was 7. How are you able to find the inner strength to do this for him?”

WHY:

It builds resilience and reminds her you are a safe and accepting person who she can talk to about difficult things.

CONSIDERATION:

This takes practice, to know when to link back to ACEs. Not too much, not too little. Too little or no referencing suggests her life (and, by extension, she) is too shameful to think about.

Following up

A. WHAT:

Documentation: Follow agency policy and HIPPA guidelines. Recommended practice is to not have a completed ACEs questionnaire in client records – only a total score. Sample documentation:

1-1-2014

NEAR HV completed: Client very interested in info on brain development, ACE history completed, score 7, client expressed relief at learning her ACE score and stated she felt the impact on her life might be her anxiety and choosing not safe partners. Agreed to plan of continuing to think about this and how to build her resiliency. Client goal is for her baby not to witness IPV.

1-1-2014

NEAR HV completed: Client interested in info on brain development and was able to think about her child’s brain with their current stress of being homeless. ACE history completed score 9, client became flat affect where she had been animated during discussion of brain development. Client denied knowing of any impact to her life from her ACEs. Offered containment and support for this being a difficult conversation. Emphasized her successes in keeping her children safe and quitting smoking. Client agreed that we will revisit her ACE score and impacts on our next visit. By end of visit client was not flat but seemed tired, thanked me for visit. Plan for next visit: check in, offer depression screen, do some floortime play.

WHY:

This protects confidentiality in case of records release, subpoenas, custody disputes, etc. Having a total score helps other agency employees not see the individual experiences and think they need to address or intervene. Having only a total score honors the science that shows the impact is from an accumulation, not any one category of experience.

B. WHAT:

Reflective supervision should include how home visitor felt preparing for the visit, during the visit, and after the visit, as well as client response. Avoidance, dysregulation, or too little, too much or incongruent affect (either positive or negative), indicates a need for addressing this in reflective supervision.

“What was it like for you to have this conversation with your client?”

“What was the turning point for you to believe that this conversation was important and useful?”

“How do you think your own ACE history is showing up here?”

C. WHAT:

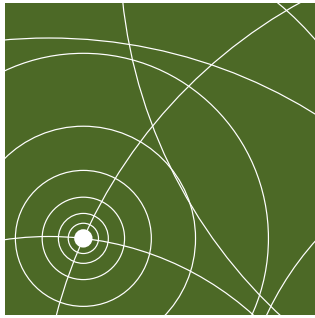
Reflective case conferencing: Home visitors can be encouraged to share what it was like for them, and how they felt, as they prepared for the visit, asked and listened.

Home visitors can include clients' responses to NEAR home visits as well as ACE scores. The team can help reflect on how the ACE score might link with other events in the client's life.

“Maybe her anger at the housing authority case manager, or her relapse, or the fact that she stays with a violent partner is related to her ACE history?”

WHY:

Reflective case conferencing is an opportunity to go beyond reporting out and seeking solutions. Reflective case conferencing can contribute to professional development and team cohesion for all members when they are able to think and feel deeply together. Becoming reflective in a group setting takes guidance, commitment and practice.



THE SCIENCE OF NEAR – WHAT'S BEHIND THIS?

Parents deserve to know the largest public health discovery of our time – to have opportunity to talk about their own life experiences and consider how they might like to use new scientific discoveries to give their children greater health, safety, prosperity and happiness than they might have for themselves.

Just in the past two decades, new technologies, new ways of thinking, and new alliances among experts from many disciplines have combined to reveal key answers to an age old debate: nature versus nurture. We now understand how adversity becomes embedded into biology, behavior and risk, and how simple supports and opportunities can deliver stunning improvement in the lives of the people we are, and the people we serve.

Life is complex. And the story of how lives unfold is equally complex. In this toolkit we combine into one science discoveries from:

- **Neuroscience**
- **Epigenetics**
- **Adverse Childhood Experiences Study**
- **Resilience research**

We are calling this science: **NEAR**.

Neuroscience findings help us to understand how human beings adapt biologically to stress during development. Their recent discoveries give us answers to our questions about biologic pathways that explain why ACEs have so much impact on the public's health, safety and well-being. Epigenetics findings help us to understand why some groups of people seem to have more challenging lives generation after generation, and give us clues about how to help. The ACE Study explains the magnitude of the solution that is in our hands, and provides new ways of thinking that help us develop powerful preventive supports for people throughout the life course. Resilience findings remind us that our actions matter, and remind us that human beings live in nested environments of families, communities and societies – any and all of these nested environments can be more or less resilient, and have a powerful influence on individual health and well-being.

The human nervous system includes the brain, spinal cord and peripheral nerves throughout the body. Sensory information is conveyed by the peripheral nerves through an elaborate system of chemical and electrical signaling system that delivers information so fast, our bodies understand and act upon that information almost instantaneously. The signaling system – including the ways that we process and use information – are shaped by patterns of experience during development. From conception ... as the first cell is formed, then divided into two, four, sixteen ... cells begin to specialize into a beating heart, tiny spinal cord, and organs that filter toxins, process nutrients, and help us develop immunities from disease ... experience has powerful effects on how we relate

to ourselves and relate to the world around us. Experience also has a powerful effect on health, safety and prosperity throughout the life course, and shapes patterns in population wellbeing, including intergenerational transmission of adversity.

In any major public health discovery, individuals save lives by: 1) telling everyone, and 2) changing actions within their own sphere of influence. People have a right to know the most powerful determinant of the public's health. When parents know about the powerful impact of adversity on development, they can be more compassionate with themselves, and can better protect their children from accumulation of ACEs. Parents who experienced a great deal of adversity when they were children deserve to know that their normal responses to that adversity have the potential to make parenting more difficult. And, parents have the most power for dramatically improving the future of the public's health – because they have the most opportunity to protect children from accumulation of Adverse Childhood Experiences. Parents who have been most affected by Adverse Childhood Experiences while they were growing up are learning, giving help and support to other parents, and working together to create healing communities where everyone can flourish.

SEQUENTIAL DEVELOPMENT

Human brain development is sequential. By the time of birth, capabilities that are essential for survival – regulation of internal functions, ability to suck and swallow, recognition of face and breast – are well developed. Our capabilities unfold over the course of many years. As we enter adulthood – indeed, well into the second decade of our lives, our brains continue to form neural connections and fine tune major pathways of communication among and between brain regions. These connections and pathways enable us to master abstract reasoning, goal-directed action, and the emotional and physiological abilities that help us navigate life challenges. Human brains are literally shaped by experience; brain mass and functioning are shaped by experience during childhood. Specific impacts to brain development reflect a biological assumption that adult life will continue to be as safe, or as dangerous, as childhood experience. Biological adaptation prepares the species for survival in the anticipated world – whether peaceful or malevolent. Our brains become hard-wired for the world we anticipate we will be living in throughout our lives. Our experiences generate our “state of mind.”

Until very recently, scientists believed that some changes to brain mass or functioning were adaptive, and some were mal-adaptive. But that isn't true. Neuroscientists now have broad agreement that childhood experience affects changes to brain architecture and chemical-electrical functioning; and that these changes are adaptive. They help to keep the species alive when conditions remain consistent throughout the life span. And, these same adaptations can be difficult when they don't match with societal expectations, or when they don't match with what we need to accomplish in an important life task – like parenting.

AGE, GENDER, TYPE OF EXPERIENCE

Neuroscientists have found that, when children experience neglect, abuse, even bullying, three factors influence outcomes: age, gender and type of experience.

Age has a powerful effect because each brain region has critical and sensitive developmental periods, when the mass and functioning of that region is especially affected by experience. When people experience chronic adversity or toxic stress during the critical or sensitive developmental period of a region of the brain, that region of the brain will adapt biologically. For example, a study published in 2012 reports that the hippocampus, a part of the limbic system in the brain, is highly affected by experience from age 3 through age 5. Parents, who, when they were of that age, experienced abuse, neglect, verbal aggression at home or verbal aggression by peers, may have impacts to the volume and functioning of the hippocampus. One role of the hippocampus is to help us to stay emotionally regulated during psychologically stressful situations. Good emotional regulation helps us to be able to think and act in ways that help resolve the original psychological stress, or help us to cope with the situations we find ourselves in. The hippocampus also has important roles in risk for stress-induced cravings for drugs and/or relapse, psychiatric disorders, short term and autobiographical memory, processing of visual information, navigation through space, and our ability to experience joy when something good unexpectedly happens in our lives. All of these are certainly relevant to how a home visitor helps a family with parenting, attachment, and establishing healthy patterns of family life.

Boys and girls have different biological responses to some types of chronic adversity or trauma. For example, the Corpus Collosum is the superhighway of nerve cells that connect the right and left sides of the brain, and connect the front and back of the brain. These connections are vital for complex thinking, integration of creativity and rational analysis, and integration of language and math, and more. The Corpus Collosum is most impacted by experience from conception through middle childhood. Within that time period, the brains of boys and girls respond differently to experience. For boys, the largest impact on the Corpus Collosum comes from neglect in the infant and toddler years; for girls the largest impact comes from sexual abuse in middle childhood (around ages 9-10). While both boys and girls are affected by both neglect and sexual abuse, the effect size for the mass and functioning of the Corpus Collosum varies by gender.

Adversity during development may become hard-wired into brain and body functioning across the life course. There are at least five sensitive periods for brain development, when experience has powerful effects on the mass and functioning of specific brain regions. Earlier sensitive periods can set a trajectory for later brain development. As we develop ... in utero, in the first three to five years, in middle childhood, pre-puberty, and from adolescence through early adulthood ... experience is shaping us. Parenting can feel more difficult for people because it is more difficult – biologically. And, every human being has core gifts to offer to the world, strengths to build upon, and the possibility of making significant contributions to the health and wellbeing of future generations.

EXECUTIVE FUNCTION

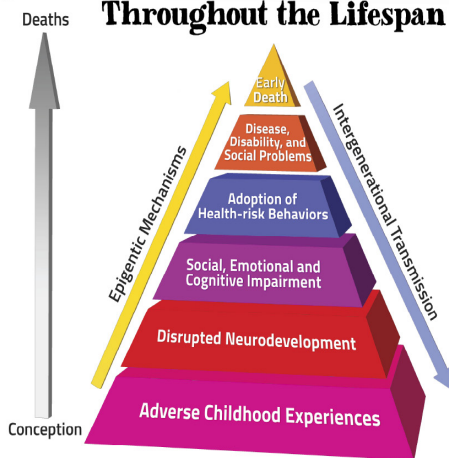
Many parents who receive home visiting services are young adults – under age 30. And, that is great news in terms of the neuroscience of adaptation. Executive function is a complex array of cognitive and self-regulation abilities that allow us to set a goal and take systematic actions to achieve that goal. Executive function requires lots of neuronal connections throughout the brain, along with well-developed habits of using those connections in specific ways. Elements of executive function include: working memory, response inhibition, flexible thinking, emotional control, sustained attention, task initiation, planning, prioritizing, organization, time management, persistence, and metacognition (thinking about thinking). All of these elements come together to help individuals and groups to achieve our goals and aspirations.

Scientists believe that executive function continues to develop well into the later part of the second decade of life. That means that many of the parents we are serving are still in one of the powerful sensitive periods of brain development: the period when connections among brain regions and development of capabilities necessary for goal-directed action can be positively impacted by experience. Home visitors can infuse into practice an array of experiences that help to further develop executive function skills, and help clients understand how stress might be impacting these skills. (In “Tips and Tools,” see Deborah Gray, 2014, 10 Tips—Adjustments for people with Stress-induced Executive Dysfunction)

THE ADVERSE CHILDHOOD EXPERIENCE STUDY

The Adverse Childhood Experience Study (ACE Study) is the largest epidemiologic study of its kind, and reveals the most powerful determinant of the public’s health. The study began in the early 1990s as a partnership between the Department of Preventive Medicine at Kaiser Permanente in San Diego, Calif., and the Centers for Disease Control and Prevention in Atlanta, Ga. Over 17,400 Kaiser Permanente members participated in the study, answering dozens of questions about their childhood experiences, and giving permission for the investigators access to medical records. The study findings include correlations between ACEs and mental, physical, and behavioral health, and continue to provide findings across the life course.

Mechanisms by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan



Two physicians were co-principal investigators of the ACE Study: Dr. Vincent Felitti, in San Diego, and Dr. Robert Anda, in Atlanta. At the time the study was designed, the state of the art for preventive medicine research was to identify risks for disease so that risks could be reduced, and thereby, disease and early death could be reduced. After award-winning work in the field of heart disease prevention, Dr. Anda recognized that risk for heart disease did not occur randomly in the population – something had to be driving the risk. He and Dr. Felitti hypothesized that adversity during development was impacting neuro-development, which in turn, drives risk, disease and early death.

The investigators considered 10 types of experience that occur within households, and can be prevented.

Five categories of household dysfunction:

1. Mentally ill, depressed or suicidal person in home
2. Drug addicted or alcoholic family member
3. Parental discord – indicated by divorce, separation, abandonment
4. Witnessing domestic violence against the mother
5. Incarceration of any family member

Three categories of abuse:

1. Child physical abuse
2. Child sexual abuse
3. Child emotional abuse

Two categories of neglect: physical and emotional.

Major findings from the ACE Study include:

1. ACEs are common: about two-thirds of the population has at least one; over a quarter of the population has three or more; over 5 percent of the population has six or more.
2. ACEs are common in all socio-economic groups.
3. ACEs tend to cluster – where there is one category, there are likely others. Of the people in the ACE Study who experienced one ACE category, 87 percent experienced others and over half experienced four or more.
4. Accumulation of ACE categories matters – the higher the number of ACE categories experienced (ACE Score) the higher the population risk for mental, physical, behavioral and productivity challenges.
5. There's a strong graded relationship between the ACE Score in a population and the rates of many mental physical, behavioral and social problems, including the leading causes of death in the United States of America.
6. ACE Scores are a good proxy measure of the dose of toxic stress experience during development. While ACEs are not the only kinds of stress that shape neuro-development, this list of 10 categories of experience provides a solid indicator of toxic stress that children experience.
7. We have a very strong case for asserting that the relationship between ACEs and ACE effects is a causal relationship. The ACE Study meets all of the tests for inferring cause in epidemiology. In the years after the ACE Study publications began, neuroscience findings have affirmed the causal relationship between ACEs and ACE effects by explaining the biological pathways that make ACEs so powerful. For example, research about the impact of maltreatment on the hippocampus (a region in the Limbic System of the brain) found that "Subfields of the hippocampus were significantly smaller among research subjects with an ACE Score of three or more."

8. ACEs are the most powerful known determinant of health because they drive the rates of so many problems, and because they drive such a high percentage of the rates of those problems.

After analysis of ACE prevalence in Washington in 2009, Dr. Robert Anda, co-principal investigator of the ACE Study explained: “For an epidemic of influenza, a hurricane, earthquake, or tornado the worst is quickly over; treatment and recovery efforts can begin. In contrast, the chronic disaster that results from ACEs is insidious, constantly rolling out from generation to generation.”

“The great news is that what’s predictable is preventable.”
- Dr. Robert Anda, 2009

The ACE Study is a study of population health. Knowing the prevalence of ACEs in a population reliably predicts the prevalence of many kinds of health and social problems. While learning the ACE Score of an individual provides a personal history, an ACE Score is not an assessment or screening tool for an individual. When we learn about ACE History, we something about what questions we could ask in order know the person more appreciatively. ACEs are not destiny. Talking with a parent about her ACE History opens an important conversation and provides a foundation for trust and partnership between a customer and a home visiting professional.

RESILIENCE

“Understanding a parent’s adverse childhood experience takes nothing away from understanding her resilience. It puts into perspective how spectacularly resilient she may be, the strengths she is building on for the next phase of her life, and opens the space to talk about the life she wants for her family and her new baby.” -Laura Porter

After learning about brain science, epigenetics and Adverse Childhood Experience, almost everyone wants to talk about resilience. We want to learn how noticing and acting with strengths, core gifts, and healthy processes can generate solutions and focus communities on the best people have to offer. Our profound appreciation and respect for every human being draws us toward resilience as a centerpiece for our work. But, where does the term “resilience” come from, and what does it mean?

Resilience is a term that comes from the physics of materials. In that context it means the ability to return to original form after having been bent or compressed. For example, bamboo is considered to be resilient because the plant can be bent to the ground, but will spring back, grow well, and be essentially unchanged.

But human beings aren't based on the physics of materials. In humans, resilience means the ability to return to original form is actually changed by experience through a complex process of adaptation. Adversity brings about a new form and function that fits the new environment. Resilience is more than the absence of psychopathology. It is not just recovery immediately after crisis. Resilience is like surfing – it requires continuous balance and grace, ability to spontaneously respond to the demands of the unforeseeable dynamics of life, eagerness to learn and use new skills and maintenance of one's physical and emotional health and one's spirit for living life with joy. We don't bounce back – we bounce forward, hopefully to a joyful and fulfilling life. Resilience is a journey.

Resilience is a developmental process. Essentially, this means that individuals develop the skills, characteristics and attributes that are necessary to adapt to the environment as it changes and as it challenges us. We have lots of opportunities to practice our resilience. Every new situation, every challenge, every disappointment allows us to practice our resilience muscles — and with the help of relationships, culture and environment, to build them up. None of us is perfect. We have all had experiences where we didn't adapt very well. Maybe we got a new boss at work. Or a teenage child brought home a new and terrible girlfriend. Or we got a divorce. And for a time — maybe a long time — we had difficulty doing work, communicating, or having an even temper. Maybe we cried or yelled or acted inappropriately. It's important to recognize that because resiliency represents our ability to have and apply skills and attributes when faced with challenges, it occurs along a continuum. It is possible to be perfectly resilient in one setting and to do very poorly in another.

RESILIENCE DEFINITIONS

In research articles, there are many definitions of resilience. Here are a few:

“Resilience refers to a class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development.” (*Ann Masten, Ordinary Magic: Resilience Processes in Development*)

“Resilience is the result not only of biologically given traits, but also of people's embeddedness in complex and dynamic social contexts, contexts that are themselves more or less vulnerable to harm, more or less amenable to change, and apt focal points for intervention.” (*Mary Harvey, Towards an Ecological Understanding of Resilience in Trauma Survivors*)

The capacity to absorb disturbance and re-organize while undergoing change, yet still retain essentially the same function, structure, identity, feedbacks. (*Walker et al., 2002*)

The ability of an individual, system or organization to meet challenges, survive, and do well despite adversity. (*Kirmayer, 2009*)

The natural human capacity to navigate life well. (*HeavyRunner & Marshall, 2003*)

FOSTERING RESILIENCE

We know that all human beings fare better when they live in healthy relationship with others. People do better with a history of nurturing for generations, a current experience of belonging in nurturing and healthy families, and when they live in healthy communities. We are affected by nested environments, and by both our generational history, and our hope and aspirations for the future. Individuals, as well as families and communities can be more or less resilient.

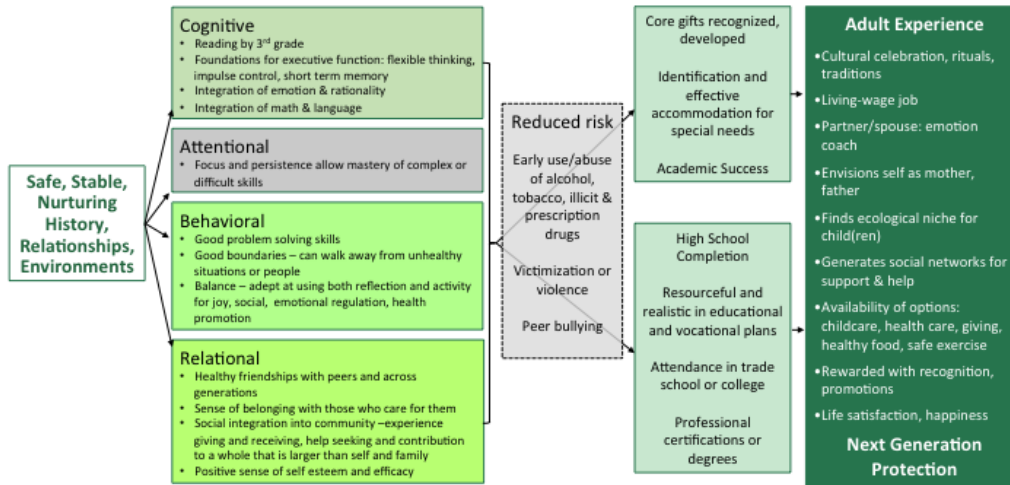
There are three systems for promoting resilience in individuals, families and communities.

1. Capabilities
2. Attachment and belonging
3. Community, culture and spirituality

Referring to these three systems, Dr. Ann Masten, a leader in resilience research explains: “These systems afford the most important preparation or ‘inoculation’ for overcoming potential threats and adversities in human development. Similarly, damage or destruction of these systems has dire consequences for the positive adaptive capacity of individuals.” (Masten, 2009)

What kinds of capabilities have resilience researchers found to be important for fostering resilience? Capabilities are developed sequentially; early accomplishments form a foundation for later strengths. For individuals, there are developmental milestones that are associated with resilience – milestones like reading well by age 10, emotional regulation, self-efficacy and self-esteem. These capabilities can be affected by adversity; while we certainly want to foster these capabilities, we also want to keep in mind that these can be harder for people who experienced toxic stress during development. When one capability is difficult, another may be possible. As we support development of capabilities in individuals, we need to keep in mind the individual’s core gifts, and help to develop capabilities that are a good match to those gifts. Capabilities can be developed throughout life, and some are especially important to develop during early adult years as people are becoming parents. Dr. Katherine Barnard found that young pregnant women and new moms who imagined themselves as parents, and who found an ecological niche for their children – a circle of friends for themselves that included playmates for their babies and toddlers – had better child and mom well-being. Young parents who have options for childcare and who are recognized for their strengths and talents are also more likely to flourish.

Progressive Nature of Flourishing



Emotional regulation is important for lifelong resilience; yet emotional regulation can be more difficult for people who experienced lots of adversity during childhood. Here is a list of things that help adults self-regulate: mindfulness, reflection, biofeedback, massage, movement and music, exercise and play (including activities that integrate visual information with fine- and gross-motor movements like striking, kicking and catching, or physical activities for exploration of environment), and practicing connection with other people.

Self-efficacy is a person's belief that her actions influences what happens to her. People who have experienced trauma have also experienced the loss of choice or the loss of efficacy. That makes it very hard to answer a challenge with effort or to believe in oneself or others. That is why it is important to focus on choice instead of control, to offer options and ask about preference, rather than promoting one way of being or doing. Facilitating opportunities for people to give to their community or family something of real value helps build efficacy. People want to give – and in the act of giving, we can build skills that are complex and take time to develop. Those skills help to further develop self-efficacy. Self-efficacy is a good thing; but the truth is that none of us can control many of the things that happen to us. So, it's important to develop relationships with people who help us to find a balance between knowing that our efforts are valuable, and accepting that some things are beyond our control.

Endnotes

- i. Childhood maltreatment is associated with reduced volume in the hippocampus subfields CA3, dentate gyrus, and subiculum; Teicher, M; Anderson, C; Polcari, A; February 28, 2012, *Proceedings of the National Academy of Sciences of the United States of America*, vol. 109 no. 9
- ii. Guare and Dawson, 2013, pp. 42-43
- iii. Childhood maltreatment is associated with reduced volume in the hippocampus subfields CA3, dentate gyrus, and subiculum; Teicher, M; Anderson, C; Polcari, A; February 28, 2012, *Proceedings of the National Academy of Sciences of the United States of America*, vol. 109 no. 9
- iv. Krista Goldstine-Cole, 2008, *The High Cost of Adverse Childhood Experience*; Washington State Family Policy Council

APPLYING CONTINUOUS QUALITY IMPROVEMENT

OBJECTIVES FOR APPLYING CQI WITH NEAR PROCESSES

1. Promote the achievement of the NEAR principles.
2. Provide guidance for policy- and decision-making.
3. Achieve efficiencies and effectiveness around NEAR implementation.
4. Promote the implementation of NEAR core elements in a safe and confidential manner.
5. Develop and incorporate new knowledge and practices about ACEs using a data-driven process.
6. Increase the availability of ongoing and up to date ACE resources and competency development.
7. Promote a climate of process improvement rather than focusing on people.

CONTRIBUTION TO THE ONGOING LEARNING AND IMPROVEMENT OF THE NEAR TOOLKIT

It is the vision that a well-executed improvement process not only contributes to the improvement of localized home visiting processes, but also makes a difference on a larger scale. This process can also contribute to the ongoing improvement of this toolkit in the future.

The goal is to gather the needed information we, to learn from the work and each another, and to apply that learning over time. The intent is to improve home visiting processes and to improve the lives of home visiting client families. Information will be collected about successes and challenges, and also about the learning process – the goal is to continuously improve home visiting services and also continuously improve systems processes related to NEAR science. Observations and feedback from users of this toolkit are important for both client outcome and program improvement (success).

RECOMMENDED NEAR CQI PROCESSES

Home visiting programs implementing NEAR principles and strategies in this toolkit should commit to an organizational culture of continuous quality improvement where all implementation activities are constantly monitored to improve services. CQI emphasizes the continuous study and improvement of the processes of providing services to home visiting families.

CQI is most effective when it becomes a natural part of the NEAR implementation and when it is integrated with the program's large CQI process. Using evidence-based scientific method, it is possible to achieve continual improvement through small, incremental change. To realize this purpose it is essential to implement a procedure that systematically reviews the recommended NEAR implementation processes and outcomes, and create plans for improvement. This will help determine whether services and activities meet the recommended expectations of quality and progress, as well as other outcomes outlined in this toolkit. Home visiting programs should incorporate several values to achieve a high quality CQI process for examining the application of NEAR. Several specific strategies build a culture of quality throughout the process of implementing NEAR.

A. WHAT:

Evaluate systems issues to improve processes, with the knowledge that a great process guides people toward compassion and success. A learning community should provide the method for developing concepts, theoretical mental models and improvement theories.

WHY:

1. Most problems are found in processes, not in people or programs. As such, a participatory method of identifying specific root causes and analyzing objective aggregate data is a neutral practice to identify improvements in organizational structure.
 2. Systems thinking is the cornerstone of such a learning community. In a learning community, the aim is to educate participants with up-to-date knowledge to produce competent and safe ways to promote NEAR quality. In a culture that supports learning, participants improve the environment and the service delivery practice; they are motivated contributors and implementers of improvement practices. This safe process allows an environment where members can challenge each other's ideas and assumptions.
-

B. WHAT:

The NEAR CQI process should involve management staff, home visitors, subject matter experts, parents and other stakeholders in the evaluation of the effectiveness.

WHY:

As indicated in an earlier section of this toolkit, implementation science makes clear that for the NEAR intervention to be successful, all layers of the organization must be informed, involved, and committed to the process. A wide variety of expert knowledge assures that the process builds staff capacity to deliver services to families with integrity, quality and fidelity. It provides a model for examining client reflective practice, dimensions of safety, and the client- and relationship-centered approach, as well as the core elements of NEAR, before developing continuous improvement models and theories.

Every staff member, manager, family member or other stakeholder contributes a unique perspective to the process.

1. Nice NEAR involves a highly reflective and collaborative process. It can elicit strong feelings in family members. For this reason it is of particular importance to also engage family members in the evaluation process.

2. It is also of particular importance to involve home visitors in this process. The home visitor knows the families and their circumstances of delivering NEAR. The home visitor can support families and advocate on their behalf better than anyone else involved in the program.

It is this variety of contribution that enables the learning community to develop and test new and innovative strategies that better support families.

C. WHAT:

Examination of the NEAR processes should occur regularly (at a minimum, quarterly) and in a safe manner.

WHY:

Mastery is the result of continuous and ongoing learning. Each process builds consistent incremental change over time and increases the core competencies of the home visitor. This learning will only occur when a continuous process is applied to measure current baseline data, when gaps are assessed between this baseline and the desired result.

Regular examination and discussion builds positive anticipation for learning and improving one's work. As each team member experiences the process of learning in a non-judgmental and safe environment, she begins to anticipate reflective discussions and review of evaluative data with curiosity. Thereby, she will be able to more fully participate in dialogue about how to use that data to improve services and systems.

D. WHAT:

Incorporate the NEAR CQI principles and processes into existing home visiting CQI procedures.

WHY:

1. The burden to home visiting programs should be kept to a minimum. Thus, incorporating principles of NEAR in current evidence-based processes of continuous improvement yields efficiency and effectiveness.
 2. Because NEAR principles are an integral part of the home visiting process and fidelity measures themselves, it makes sense to also examine the implementation quality of NEAR principles within the larger context of other home visiting processes and systems.
-

E. WHAT:

Home visiting programs should commit to using data to improve quality. The purpose of leadership at the state and local levels is to equip, support and assist staff on the front lines to do their jobs well.

WHY:

Gathering data about program procedures, systems and process is an effective, efficient, supportive and instructive approach to improving the quality of NEAR.

F. WHAT:

Home visiting professionals should regularly reflect on whether the data being collected is the right data. Does it help home visitors have the conversations needed to have in order for services and programs to improve? Does the data being collected inform deep discussions and help illuminate whether efforts are leading to the aspirational goals? What information, if it were reviewed regularly, would be most helpful for learning and improving?

WHY:

NEAR science is new science. This one is the first generation to be incorporating this science into home visiting practice, and to be developing good indicators and reflective practices that support continuous quality improvement. It is reasonable to assume that evaluation methods will improve.

SUGGESTED IMPROVEMENT OPPORTUNITIES

Several opportunities for improvement should be monitored on a consistent basis. These opportunities are anchored in the NEAR principles of agency readiness and the implementation of the Core Elements of a NEAR Home Visit.

Home Visitor Support	Service Delivery and Fidelity	Family Satisfaction
<ul style="list-style-type: none">• Meeting Prerequisites• Training of Home Visitors and Supervisors• Reflective Supervision• Reflective Case Conferencing• Continued Competency Development• Effectiveness of Supportive Policies and Procedures	<ul style="list-style-type: none">• Safety• Confidentiality• Reach• Core Elements of NEAR<ul style="list-style-type: none">- Preparing- Follow-up	<p>Core Elements of NEAR</p> <ul style="list-style-type: none">• Asking• Listening• Accepting and Affirming• Remembering

NEUROSCIENCE

EPIGENETICS

ADVERSE CHILDHOOD EXPERIENCES

RESILIENCE

NEAR@Home

APPENDIX

READINESS CHECKLIST FOR NEAR HOME VISITING EDUCATION

All program staff-administrators, supervisors/managers, home visitors have basic NEAR knowledge

YES

NO

Program staff and home visitors are committed to using ACE questionnaires to discover ACE scores

YES

NO

Program has identified a NEAR champion for this process

YES

NO

HV staff have completed their own ACE questionnaire

YES

NO

Program and staff have at least one year of experience in current model

YES

NO

Supportive structures are in place:

Reflective case conferencing

YES

NO

Reflective Supervision

YES

NO

Relevant policies/protocols in place:

Mandated Reporter

YES

NO

HIPPA/Documentation

YES

NO

Crisis response plan and resource list

YES

NO

Staff commit to preparing for NEAR HV education by reading the entire manual and discussing as a team

YES

NO

Agency and home visiting staff commit to using the NEAR process within one week and prioritize NEAR home visits for the 6 weeks rapid learning cycle

YES

NO

Optional: complete the pre-learning survey and 6-8 weeks after starting to use the Core Elements complete the post learning survey.

YES

NO

RESOURCES

Resilience Trumps ACEs

resiliencetrumpsaces.org

- cards
- pamphlets

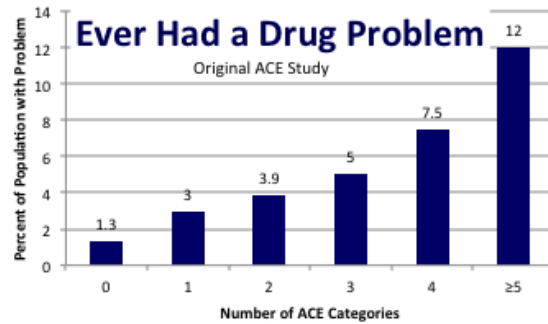
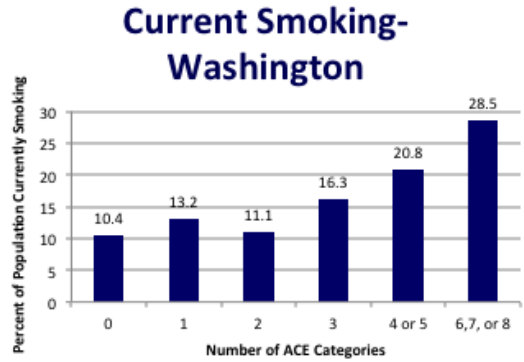
1-2-3 Care: A Trauma-Sensitive Toolkit for Caregivers of Young Children

srhd.org/123care.asp

FROM THE RESEARCH

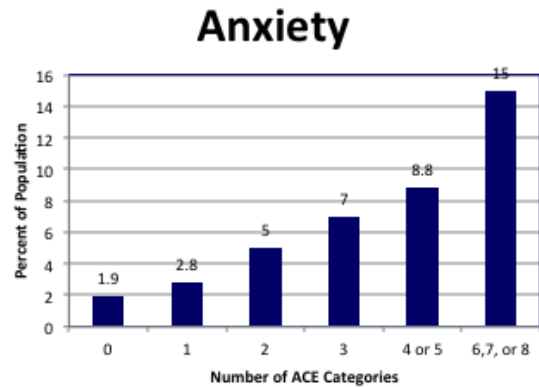
**A Significant Portion
Of Risk for Disease
Is Attributable to ACEs...**

- Smoking**
- Heavy Drinking**
- Binge Drinking**
- Drinking and Driving**
- Had a Drug Problem**
- Addicted to Drugs**
- Ever Injected Drugs**

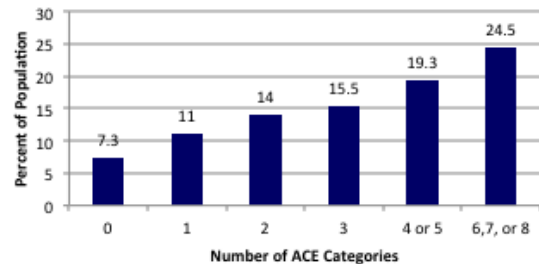


**A Large Portion
of Mental Illness
Is Attributable to ACEs...**

- Depression**
- Serious & persistent mental illness**
- Frequent mental distress**
- Nervousness**
- Suicide attempts**
- Emotional problems restrict activities**



**Treatment for Mental
Health Condition**



CLIENT STORIES

Home visitor Erika, speaking about her experiences:

"I was quite surprised that this client (with a two-month-old baby) had an ACE score of 9, given how high functioning she is. She was transferred to me from another home visitor, who had not done ACEs with her yet. The conversation started after I had asked her how she got interested in studying Criminal Justice. She ended up sharing some of her trauma history with me and said she had not told anyone but her mother. She said she had not even told her husband about it, which she clearly felt bad about. So at our next visit, we did the ACEs questionnaire, and she shared with me that since our last visit, she had told her husband about her trauma and how helpful it was to talk about it with me. She said her husband then shared his trauma history with her and how helpful it was for him. She felt such a sense of relief and was very appreciative of having the discussion with me. Her decision to go into Criminal Justice was motivated by her ACEs, as she wants to help young girls who have also experienced what she did and may not have anyone to talk to about it.

Another opportunity came up with a client I saw recently who is in a domestic violence relationship. We had done her ACE score during her pregnancy (child is 1 year old now). She was sharing her ambivalence about leaving her partner, and in tears, kept saying she didn't know what she did to deserve being treated this way. After providing support and validation, I mentioned ACEs and reminded her of her exposure to domestic violence in utero (she has some slight developmental delays as a result), as well as what she was exposed to as a child, explaining the connection. It was amazing to see her put it together and share her desire to protect her child from exposure and from becoming like her partner, as well as realizing that her current situation wasn't her fault. This was quite remarkable to witness, as she had clearly moved from pre-contemplation to contemplation. It's something we've talked about often and to see the change happen felt like a significant breakthrough. She also realized she doesn't have a Plan B, which is why she hasn't left him yet and identified that she needs to figure this out! I am looking forward to continuing the conversation with her at our next visit, as it was near the end of our visit that all of this came up.

The inclusion of NEAR (Neuroscience, Epigenetics, ACEs, Resilience) is such a nice complement to the Life History Calendar, and definitely provides another level of meaningful conversation. Clients have shared more of their trauma history with me since introducing NEAR, and it has allowed for deeper reflection and a way to draw meaning from the experiences they've had. One of my clients said, 'I know those things that happened to me were really bad, but I believe they have made me a stronger and better person.'

There is another family that comes to mind. It may have actually been the second time I had ever brought ACEs/NEAR to a visit. After going through the questions with my client, the father of the baby (who is typically at the visits, very involved in them) almost jumped up off the couch, asking if we were going to talk about his. He said he had a LOT to share. After finishing with my client, we did his ACEs questionnaire, and it turned out that he wanted to talk about each and every question that was answered yes (it was a high number). His anger at what had happened to him was so palpable as he was sharing. After we finished processing, you could see how much more relaxed and contained he felt, like a huge burden had lifted. I also explored the idea of getting

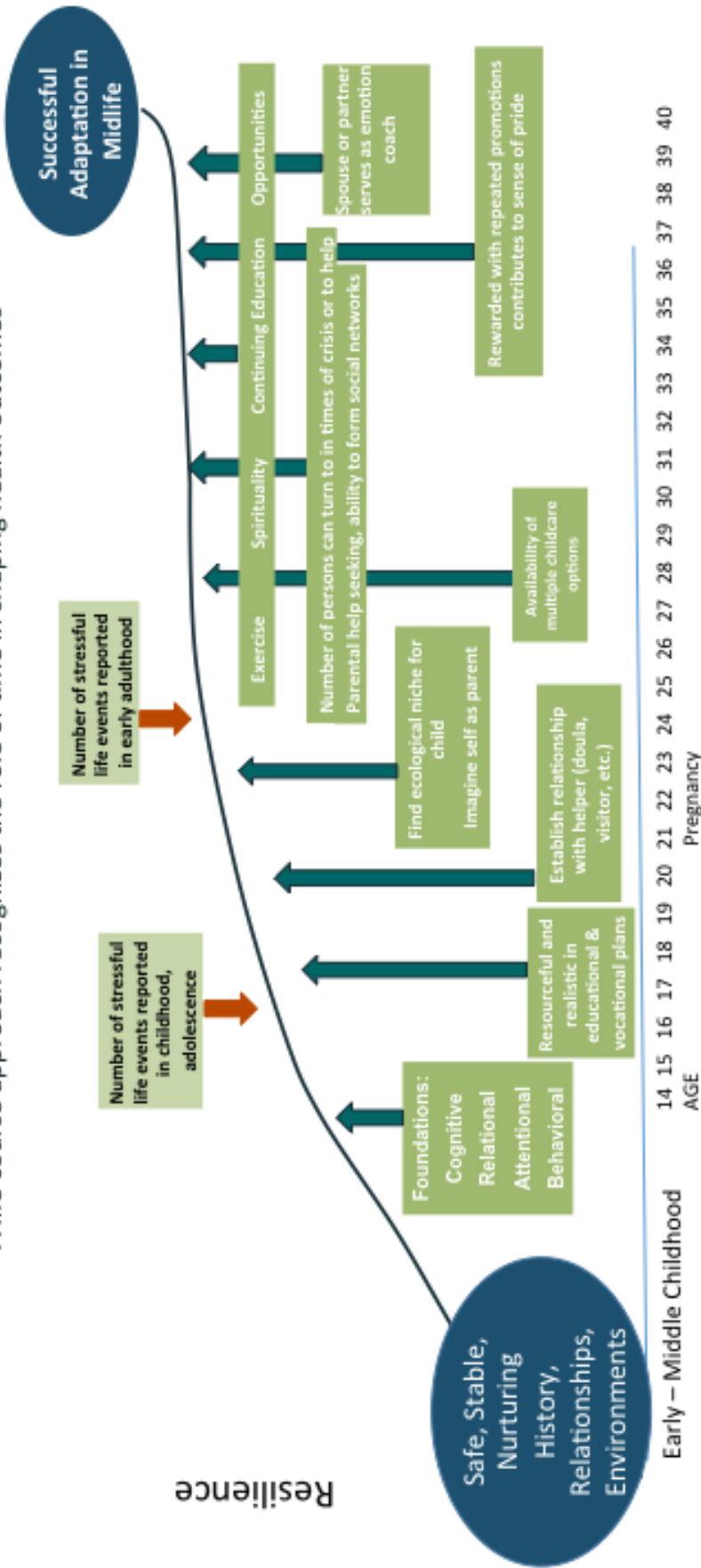
into counseling, given what he was still struggling with, and he identified that he “probably” needed it. So he actually followed up, got into counseling and found it to be a helpful experience. I’ve seen such growth in his confidence and belief in himself ever since.

ACEs/NEAR@Home has been such a profoundly meaningful tool in my practice. It has opened the door for deeper, more meaningful conversations, insights and understanding.”

Have stories to share about your use of the toolkit or integrating ACEs into home visits? Email them to NEAR@thrivewa.org.

THE ROLE OF TIME

A life course approach recognizes the role of time in shaping health outcomes



¿CUÁL ES MI PUNTAJE DE EXPERIENCIAS INFANTILES ADVERSAS (ACE)?

Antes de cumplir 18 años:

1. Alguno de sus padres u otros adultos en su casa **con frecuencia o con mucha frecuencia...**
La/o ofendían, la/o insultaban, la/o menospreciaban, o la/o humillaban?
o
Actuaban de tal forma que temía que le fueran a lastimar físicamente?
Si No Si la respuesta es SI anote 1 _____
2. Alguno de sus padres u otros adultos en su casa **con frecuencia o con mucha frecuencia...**
La/o empujaban, la/o jalaban, la/o cacheteaban, o le aventaban cosas? _
o
Alguna vez la/o golpearon con tanta fuerza que le dejaron marcas o la/o lastimaron? __
Si No Si la respuesta es SI anote 1 _____
3. Algún adulto o alguna otra persona por lo menos 5 años mayor que usted **alguna vez...**
La/o tocó o acarició indebidamente o le dejó que le tocara el cuerpo de alguna forma sexual?
o
Intentó tener relaciones sexuales orales, anales o vaginales con usted?
Si No Si la respuesta es SI anote 1 _____
4. Se sentía usted **con frecuencia o con mucha frecuencia** que...
Nadie en su familia la/o quería o pensaba que usted era especial o importante? o
En su familia no se cuidaban unos a los otros, no sentían que tenían una relación cercana, o no se apoyaban unos a los otros? __
Si No Si la respuesta es SI anote 1 _____
5. Se sentía usted con **frecuencia o con mucha frecuencia** que...
No tenía suficiente comida, tenía que usar ropa sucia, o no tenía nadie que lo protegiera?
o
Sus padres estaban demasiado borrachos o drogados para cuidarla/o o llevarla/o al medico si es que lo necesitaba?
Si No Si la respuesta es SI anote 1 _____
6. Alguna vez perdió un padre o una madre biológico(a) debido a divorcio, abandono, o alguna otra razón?
Si No Si la respuesta es SI anote 1 _____
7. Fue su madre o madrastra:
Con **frecuencia o con mucha frecuencia** la/o empujaban, jalaban, golpeaban, o aventaban cosas? o
A veces, con frecuencia, o con mucha frecuencia le pegaban, la/o mordían, la/o daban puñetazos, o la/o golpeaban con algún objeto duro? o
Alguna vez la/o golpearon durante varios minutos seguidos o la amenazaron con una pistola o un cuchillo?
Si No Si la respuesta es SI anote 1 _____
8. Vivió usted con alguien que era borracho o alcohólico, o que usaba drogas?
Si No Si la respuesta es SI anote 1 _____
9. Algún miembro de su familia sufría de depresión o enfermedad mental, o alguien en su familia trató de suicidarse?
Si No Si la respuesta es SI anote 1 _____
10. Algún miembro de su familia fue a la cárcel?
Si No Si la respuesta es SI anote 1 _____

Ahora sume las respuestas en que anoto "SI." _____
Esta es su Puntaje de Experiencias Infantiles Adversas (ACE)

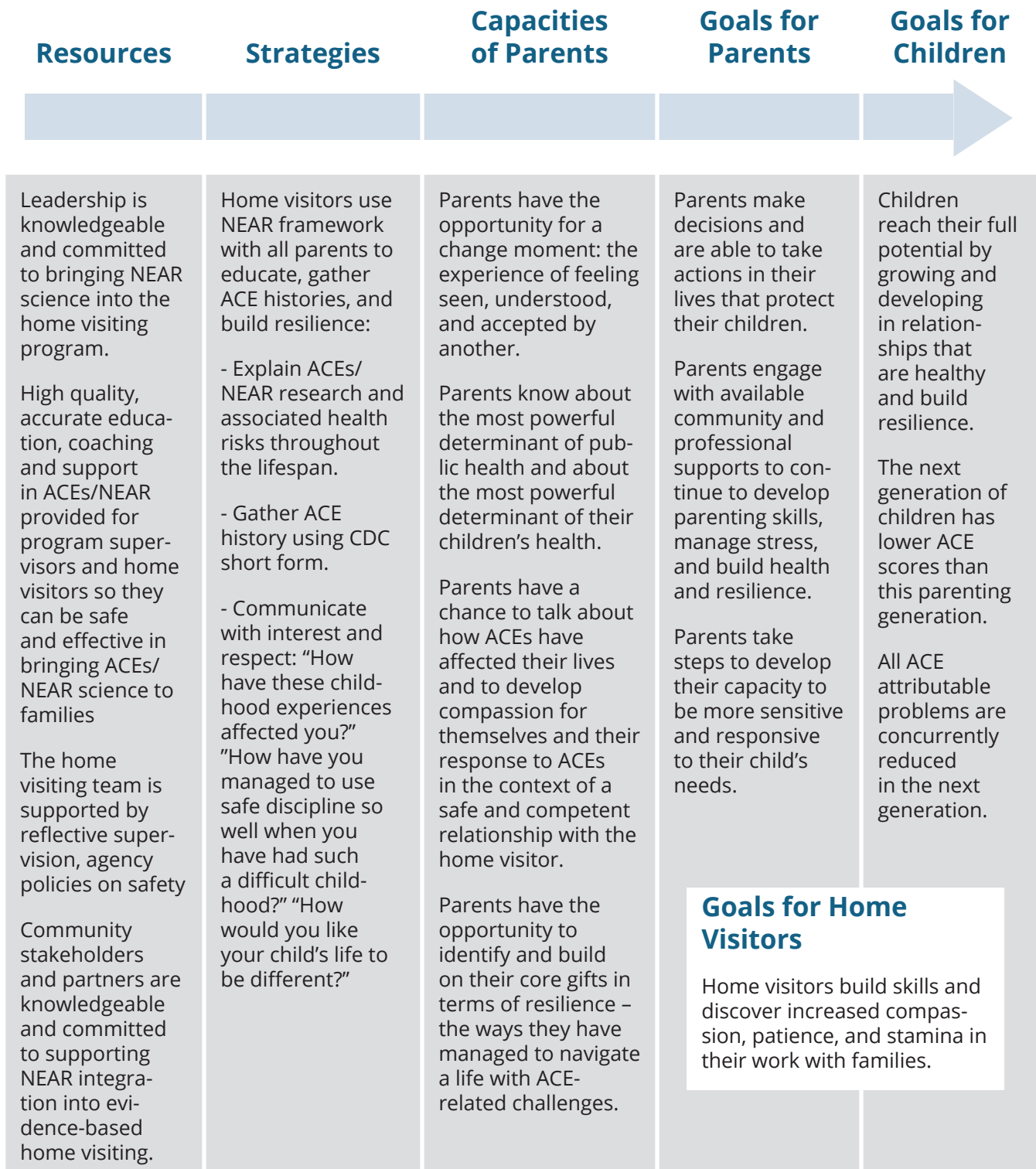
FINDING YOUR ACE SCORE

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

1. Did a parent or other adult in the household **often or very often**...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often or very often**...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**...
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 _____
4. Did you **often or very often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **often or very often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.


Theory of Change for Integrating NEAR Science in Evidence-Based Home Visiting



Goals for Home Visitors

Home visitors build skills and discover increased compassion, patience, and stamina in their work with families.

THEORY OF CHANGE




Flourish

Children reach their full potential by growing and developing in relationships that are healthy and build resilience.

The next generation of children has lower ACE scores than this parenting generation.

All ACE attributable problems are concurrently reduced in the next generation.




Flourish

Home visitors feel respected and safe in their work.

Home visitors build skills in having sensitive conversations.

Home visitors discover increased compassion, patience, and stamina in their work with families.




Prepare

Leadership is knowledgeable about and committed to bringing ACEs/NEAR into the program.

High quality, accurate education, coaching, and support in ACEs/NEAR science provided for program supervisors and home visitors so they can be safe and effective in bringing ACEs/NEAR to families.

Home visitors are supported by reflective supervision and agency policies on safety.

Community stakeholders and partners are knowledgeable about and committed to supporting ACEs/NEAR integration into programming.



Ask, Listen, Affirm, Remember

Home visitors build trust and model safety with parents through the use of the ACEs/NEAR framework :


- Educate about ACEs and associated health risks
- Offer the ACE questionnaire to all parents
- Focus on resilience while acknowledging trauma.

Home visitors communicate with respect and curiosity:

“How have these childhood experiences affected you?”

“How have you done so well with safe discipline when you have had such a difficult childhood?”

“How would you like your child’s life to be different?”




Parents have Opportunity

Parents have opportunity for a change moment: the experience of feeling heard, understood, and accepted.

Parents know about the most powerful determinate of public health.

Parents have a chance to talk about how ACEs have affected their lives and to develop compassion for themselves in the context of a safe and capable relationship.

Parents have the opportunity to identify and build on their core gifts in terms of resilience – the ways they have managed to navigate a life with ACE-related challenges.



Aspire

Parents make decisions and are able to take actions in their lives that protect their children.

Parents engage with available community and professional supports to continue to develop parenting skills, manage stress, and build health and resilience.

Parents take steps to develop their capacity to be more sensitive and responsive to their child’s needs.