FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

Memo

To: Commission Members

From: Alexander Khu

Re: September 13, 2021 Commission Meeting

To slow the spread of COVID-19, the Health Officer's Shelter Order of March 16, 2020, prevents public gatherings (Health Officer Order). In lieu of a public gathering, the First 5 Contra Costa Children's & Families' Commission meeting will be accessible via Zoom Meeting to all members of the public as permitted by the Governor's Executive Order 29-20.

Members of the public may participate in the meeting online, or by telephone but MUST register first (see below).

When: September 13, 2021 at 6:00 PM Pacific Time (US and Canada)
Topic: Commission Meeting

Register in advance for this webinar:
https://us02web.zoom.us/webinar/register/WN_-Ls5fGJOTH6MDEFhwAkuAw

After registering, you will receive a confirmation email containing information about joining the webinar.

In lieu of making public comments at the meeting, members of the public also may submit public comments before or during the meeting by emailing comments to Brian Kelley at bkelley@first5coco.org. If you have difficulty emailing a public comment, please contact Brian Kelley, First 5 Contra Costa Communications Department, at 925-289-9758.

Please let me know if you have any questions.

Kind Regards,

Alexander Khu, Executive Assistant
First 5 Contra Costa
1485 Civic Court
Concord, CA 94520

FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

Commission Meeting
A G E N D A
Monday, September 13, 2021, 6:00 pm

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All comments submitted by email to the above email address before the conclusion of the meeting will be included in the record of the meeting. When feasible, the Commission Chair, or designated staff, also will read the comments into the record at the meeting, subject to a two-minute time limit per comment.

The Commission Chair may reduce or eliminate the amount of time allotted to read comments at the beginning of each item or public comment period depending on the number of comments and the business of the day. Your patience is appreciated.

1.0 Call to Order and Roll Call

2.0 Public Comment
The public may comment on any item of public interest within the jurisdiction of the First 5 Contra Costa Children and Families Commission. In accordance with the Brown Act, if a member of the public addresses an item not on the posted agenda, no response, discussion, or action on the item may occur.

3.0 Approval of Consent Calendar **Action**
A Commissioner or member of the public may ask that any of the following consent items be removed from the consent calendar for consideration under Item 4.

3.1 Approve the Commission Minutes from the July 12, 2021 meeting.

3.2 Accept Executive Committee Minutes from the June 14, 2021 meeting.

3.3 Accept Executive Committee Minutes from the Special Meeting on August 03, 2021.

3.4 Approve Grants Docket

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3.4.1 RATIFY grant application, ACCEPT grant funding, and APPROVE and AUTHORIZE First 5's Executive Director, or her designee, to enter into the agreement with Sunlight Giving in an amount not to exceed $25,000 for general operating support for the term July 1, 2021 to June 30, 2022. FY2021-22 budget line: Administrative: Administrative Expenses ($25,000). Funded 100% Sunlight Giving.

3.5 Accept First 5 Contra Costa Program Reports for July and August 2021.

3.6 Appoint Chair to serve as negotiator for unrepresented employee: Executive Director.

4.0 Consider for discussion any items removed from the consent calendar.

5.0 Receive presentation of First 5 Association of California's Executive Director Melissa Stafford Jones on First 5 Association's state-level efforts.

6.0 Consider appointing the Nominating Committee for 2022 Officers' Election **ACTION**

7.0 Receive Executive Director's Report

8.0 Communications

- The Rules for Participating by Teleconference received from the Clerk of the Board memo dated August 24, 2021.
- Preventing Childhood Toxic Stress: Partnering with Families and Communities to Promote Relational Health, Paper by the American Academy of Pediatrics.

9.0 Commissioner F.Y.I. Updates

10.0 Adjourn

The First 5 Contra Costa Children and Families Commission will provide reasonable accommodations for persons with disabilities planning to participate in Commission meetings who contact the Commission's offices, at least 48 hours before the meeting, at (925) 771-7300.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the First 5 Contra Costa Children and Families Commission to a majority of members of the First 5 Contra Costa Children and Families Commission less than 96 hours prior to that meeting are available for public inspection at 1485 Civic Court, Suite 1200, Concord, CA 94520 during normal business hours.

In consideration of those who may suffer from chemical sensitivities or who may have allergic reactions to heavy scents, First 5 Contra Costa requests that staff and visitors refrain from wearing perfume, cologne, or the use of strongly scented products in the work place. We thank you for your consideration of others.

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FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

September 13, 2021

Agenda Item 3.1

Approve the Minutes from the July 12, 2021 Commission Meeting.

FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

Commission Meeting Minutes

Monday, July 12, 2021, 6:00 pm

1.0 Call to Order and Roll Call

Executive Director, Dr. Ruth Fernández announced Language Interpretation Webinar Instructions in English and Spanish.
Gareth Ashley called the meeting to order at 6:02 PM on behalf of absent officers: Chair Marilyn Cachola Lucey, Vice-Chair Lee Ross, and Secretary/Treasurer Dr. Rocio Hernandez.

Due to COVID-19, the meeting was held on a web-based platform. Meeting protocols were introduced.

Commissions present during roll call were:

District 1 Alternate: Genoveva Garcia Calloway
District 2 Alternate: Srividya Iyengar
District 4 Commissioner: Gareth Ashley
District 5 Commissioner: John Jones
Health Services Department: Dr. Chris Farnitano
Board of Supervisors: Candace Andersen
EHSD: Kathy Gallagher
Children & Families Services Alternate: Roslyn Gentry – *(**present** but was unable to respond immediately due to technical issues).*

Also present: County Counsel Keiko Kobayashi

Commissioners absent: District 1: Dr. Rocio Hernandez, District 2: Marilyn Cachola Lucey, District 3: Lee Ross, Children and Families Services: Kathy Marsh.

Alternates absent: District 4: Matt Regan, Health Services Department: Daniel Peddycord, Board of Supervisors: Diane Burgis.

2.0 Public Comment

No public comment received.

3.0 Approval of Consent Calendar

A motion was made by Candace Andersen seconded by John Jones to accept the consent calendar.

Roll call vote:

District 1: Genoveva Garcia Calloway	Yes
District 2: Srividya Iyengar	Yes
District 4: Gareth Ashley	Yes
District 5: John Jones	Yes
BOS: Candace Andersen	Yes
Health Services Department: Dr. Chris Farnitano	ABSTAIN
EHSD: Kathy Gallagher	ABSTAIN
Children & Families' Services: Roslyn Gentry	ABSTAIN

Nos: None

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Absent: District 1: Dr. Rocio Hernandez, District 2: Marilyn Cachola Lucey, District 3: Lee Ross, Children & Families Services: Kathy Marsh

The Consent Calendar **APPROVED**.

5.0 Receive the presentation from the First 5 Center Community Advisory Councils (CAC) on their 2020-2021 accomplishments.

Lisa Korb, Family Support Program Officer and Randee Blackstock, Program Assistant gave a brief introduction on the 5 different First 5 Center Community Advisory Councils (CAC) throughout the County, namely: West County CAC, Delta CAC, East County CAC, Antioch CAC, and Monument CAC.

Slide presentations were made by each of the CACs of their 2020-2021 accomplishments:

West County CAC	Mabel D'Arrigo, Karla Galvez-Lima, Irma Gayoso and Cynthia Cuautzo
Delta CAC	April Elam
East County CAC	Amira Smith
Antioch CAC	Kim Dickerson
Monument CAC	Somia Bakhouche

After the presentation, the Chair invited public comment.
Gareth Ashley and John Jones each expressed gratitude for the work that the CACs had put together.

6.0 Receive Staff presentation on the findings from the 2021 COVID-19 Community Impact Survey.

Tatiana Hill, Evaluation Analyst and Natalie Blackmur, Communications Manager gave presentation on the findings from the 2021 COVID-19 Community Impact Survey that gathered responses from 533 Contra Costa families. Survey was conducted March through May 2021.

After the presentation, the Chair invited comments from the public.

Commissioner Ashley commented on the alarming data from the survey that points towards the mental health struggles children are having during these trying times.

Dr. Farnitano noted that it was clear to him that during the pandemic the poor became poorer, and that the impact was hardest on low-income families. He also noted disproportionate economic impacts on people of color. He said that the affordability of child care is now even worse during pandemic. Survey about vaccines attitude (reasons why some families will not plan to receive the vaccine) is very helpful and he will share with Health Services Department and will reach out to their Vaccine Outreach Team. He noted data adds to their knowledge and thanked the presenters for the information shared.
Genoveva Garcia Calloway thanked the presenters and informed the public that she is very involved with the Health Department task force working to outreach to all communities at the grassroots level. She indicated interest to connect First 5 CC staff with the United Latino Voices coalition working to amplify knowledge and access about the COVID vaccine through the implementation of "Platicas con el Doctor" or "Talks with a Doctor" aimed at assisting Spanish speaking families in the county have their questions and concerns regarding vaccine safety be answered by a Latino Doctor. Deputy Director Camilla Rand said that First 5staff with the Community Engagement Team had been involved but will also reach out to Lisa Korb about connecting First 5 Centers.

John Jones expressed that we should be cautious not to assume it is just the vaccine safety that is of concern. He commented on the lack of trust with the health system as another reason for vaccine

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concerns, and pointed to the importance of taking this factor into consideration when adopting outreach strategies. Commissioner Jones also inquired about data collected in the survey with families with one child vs. families with more than one child. First 5 staff were to follow-up on this data point.

7.0 Receive presentation of First 5 Contra Costa's 2021-2023 Strategic Plan by Ruth Fernandez, Executive Director and Nicole Young, Consultant.

Dr. Ruth Fernández and Nicole Young, provided a high-level overview of First 5 Contra Costa's 2021-23 Strategic Plan using a slide presentation. The presentation included an update of the internal organizational work completed over the first two years of the Plan to operationalize the goals and strategic priority areas. Dr. Fernández concluded the presentation with a broad overview of the organizational tactical plan and the ways in which First 5 CC is reflecting, assessing, and preparing to more holistically plan and leverage resources to optimize the impact of Prop 10 funding in the county.

After the presentation, the Chair invited comments from the public.

Commissioner Iyengar commented on the presentation and wondered how the pandemic has caused our internal operation to change?

Ruth commented on First 5 CC's intentional bi-directional communication with community partners, service providers, and families to collect critical/relevant data that allows the organization to remain abreast of community needs and challenges in the context of current landscape. Also, Ruth noted that the strategic plan serves as the roadmap for staff to plan and coordinate critical services and interventions.

Gareth Ashley noted the one difference from the previous Strategic Plan and the current one is the shift in a more holistic, systems based approach. The intent of the Plan is to provide a "high level" view of the operations and because it is systems based, he did not see any need for immediate change. The high level vision is what kept children's wellbeing intact during the pandemic.

Ruth added that the Plan was meant to be a living document that would be reviewed and revised as needed. Over the past year and a half, we have learned so much more about the disparities that have been magnified by the pandemic, which has also lead us to focus and to deepen collaboration in innovative ways.

8.0 Communications

None Received

Chairman Gareth Ashley noted that he received a request from an attendee asking to be able to introduce himself to the Commission.

Aaron Alarcon-Bowen, new Executive Director of Community Services Bureau (EHSD) introduced himself, and was welcomed by the Commission. He looks forward to strengthening the relationship of First 5 Contra Costa and the Community Services Bureau.

9.0 Commissioner F.Y.I. Updates

Gareth Ashely shared that being a dad can be very difficult. There is tremendous amount of unreasonable expectations and the best thing one can do is learn from one another. He encouraged fathers to reach out for help and shared that he recently had participated in a fatherhood support group where he spoke

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of his own struggles. He valued the opportunity to participate in such fatherhood support meetings such as the ones at the Monument First 5 Center.

10.0 Adjourn

Meeting adjourned at 7:56 PM.
Next standing meeting: Monday September 13, 2021.

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FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

September 13, 2021

Agenda Item 3.2

Accept Executive Committee Minutes from the June 14, 2021 meeting.

Executive Committee
M I N U T E S

Monday, June 14, 2021
5:00 p.m.

1.0 Call to Order

Executive Committee meeting of June 14, 2021 was called to order @ 5:01 pm.
The meeting was held on a web-based platform.

Officers who were present:

- Chair, Marilyn Cachola Lucey
- Secretary/Treasurer, Lee Ross
- Additional Non-Voting Member, Genoveva Garcia Calloway

Staff who were present: Ruth Fernandez, Sandra Dalida, Camilla Rand and Shawn Garcia.

Absent was Vice-Chair, Dr. Rocio Hernandez

2.0 Public Comment

There was no comments from the public.

3.0 CONSIDER accepting the report on significant program, financial or contracts matters, and on any personnel matters relating to Commission staff.

Sandra Dalida gave brief highlights the 3rd Quarter FY 2020-21 financial statement.

Camilla Rand gave these program updates:
(a) First 5 is contracting with VIVA Social Impact Partners to conduct an early intervention landscape assessment. The purpose is to understand what local service models exist and resources exist among locally and in the neighboring counties that present innovative and sustainable models in the early childhood mental health system. will take multi-faceted approach including data collection, focus groups and surveys and will begin in late June. We anticipate it to be a 9-month process that will conclude with a comprehensive report.
(b) First 5 is applying for a grant called All In For Kids, funded through Genentech & Blue Shield of California for up to $250,000 a year for three years for a total of $750,000. The plan is to bring collaborative partners together who focus on Trauma Informed Care and Healing and violence prevention services. The grant is still in its conception phase, but will include Learning Communities, a training series and an online learning hub. The collaborative will offer a place for partners to learn and grow together.

Shawn Garcia gave an update on staffing. She announced Emily Hampshire as the new Trauma & Resiliency Coordinator. She also announced the re-posting or the Ready Kids East County Coordinator position. The results to the "Return to Work" survey to staff will be shared at the July Executive Committee meeting.

Ruth Fernandez reported that the organizational assessment is soon to begin with a scheduled a "Kick-Off" meeting at the end of June. It is anticipated to have a 20-week timeline consisting of data collection, surveys and interviews. It is expected to conclude in November 2021.

Strategic Plan Tactical Plan was unveiled at the first Staff Learning Session in May. Ruth would like to request a Special Meeting for the Executive Committee in July to discuss Commission activities in

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connection to the new Strategic Plan. Ruth plans to conduct a Strategic Plan review as a refresher for all Commissioners at the July meeting and will share Tactical Plan categories.

The Thrive by Five Proposal for Young Children for ARPA funding was submitted to the BOS and CAO on May 3rd. The first allocation of ARPA funding of $110 million is expected in July/August. Discussion about ARPA funding is expected at the BOS in the coming weeks.
– Ruth continues to participate in Host Table meetings of the Office of Racial Equity and Social Justice. To date 34 listening sessions have been completed (320 participants), and these will continue in May/June. A website was created with information about current activities and a tool kit for conducting listening sessions. A presentation to the BOS is scheduled by Host Table participants on June 22nd.

4.0 DISCUSS issues regarding the operation of the Commission.
Ruth Fernandez asked for input from the Executive Committee on the Commission Administrative Calendar.

Ruth also asked to identify a special meeting of the Executive Committee between July and September to discuss some of the opportunities for the Commission to discuss Strategic Planning.
Lee Ross suggested the possibility of an in-person meeting.
Ruth mentioned that she will likely survey Commissioners about this topic and to assess preferences for meeting modality presuming that virtual meetings continue to be allowed under Brown Act.

5.0 CONSIDER accepting the report on statewide activities pertaining to children 0-5, including the activities of the First 5 Association of California, First 5 California, and other statewide advocacy groups.
Ruth Fernandez gave the following report:

Early Childhood Systems Integration Budget Ask – During this legislative session there was a budget ask championed by Senator Newman that put forward a proposal from the First 5 Association of California that would have allocated $20 million in one-time General Fund dollars to early childhood system integration funding across all 58 counties in order to braid and build upon comprehensive and cross-sector systems to support families as they continue to grapple with and prepare to emerge from crises generated by the COVID-19 pandemic. This proposal is stalled for the year, along with numerous other stakeholder budget requests. We generated great momentum through our strong legislative sign-on letter which collected 37 signatures from the field. The Association will look to build on this in the future.

Prop 10 Revenue/ Ban on Flavored Tobacco Products –
Ruth provided a brief update on SB 793. On August 28, 2020, Governor Newsom signed SB 793 (Hill) which banned the sale of flavored tobacco products. In January 2021, a referendum placed SB 793 on hold and qualified it for the November 2022 ballot.

6.0 Review agenda items for upcoming Commission meetings
Ruth stated that she will have a refresher overview of the current Strategic Plan for the Commission meeting at the July meeting.
She also announced that the First 5 Centers Community Advisory Councils will be making their annual presentation to the Commission also at the July 12 scheduled meeting.
.
There will be a planned update of COVID-19 second round survey as well as a report on the "Return to Work" plan.

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7.0 Adjourn

Meeting adjourned at 5:51 pm

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FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

September 13, 2021

Agenda Item 3.3

Accept Executive Committee Minutes from the Special Meeting of August 3, 2021.

Special Meeting of the Executive Committee
MINUTES

Tuesday August 3, 2021
3:00 p.m.

1.0 Call to Order
Marilyn Cachola Lucey called the meeting to order at 3:01 pm.

2.0 Public Comment
There were no comments received from the public.

3.0 CONSIDER accepting the report on significant program, financial or contracts matters, and on any personnel matters relating to Commission staff.

Camilla Rand, Deputy Director gave the following updates:
"Antioch Change" housing survey closed July 30, 2021 and we received over 1,000 community survey responses, surpassing the response goal. The success stemmed from not only the on-line surveys but also the leadership of the East County Regional Group (ECRG) members together with the First 5 Contra Costa Community Engagement Team who went door to door in Antioch to get respondents to answer the survey.

To recap, the Antioch Community Housing Needs Assessment Research Project is an assessment of housing needs, gaps and equity towards change and is a joint effort with ECRG, First 5 Contra Costa, Urban Habitat and Healthy and Active Before 5 (HAB45). Survey results are currently being analyzed. There will be a "Save the Date" on September 25th with a "kick-off" meeting sharing the data with the community partners and residents. More information to come.

Shawn Garcia, Administrative Manager gave the following updates:
First 5 Contra Costa conducted a Return to the Office staff survey in the month of June. The plan is to have staff return to the office at least twice in August and a hybrid /scattered schedule model from September through December 2021 where staff work in the office 2 days a week and remotely three days a week. The plan will be re-evaluated in January 2022 depending on Health Officers orders at that time. Ruth Fernandez, Executive Director informed that staff expressed various levels of discomfort and concerns over the planned return to office, and we are assuring them that safety will remain priority.

Sandra Dalida, Finance & Operations Director gave the following updates:
Annual audit is expected to be completed within the second or third week of September 2021. The auditors are currently awaiting the CCCERA (Contra Costa County Employee's Retirement Association) actuarial and final financial statements. We are also completing our interim actuarial valuation for our other Public Employee Benefits which will also be included in the audit report. Also completing the fiscal year financial report for the year that just ended in addition to the annual audit report.

Ruth Fernandez gave the following report:
a) First 5 launched the Organizational Assessment (now called Organizational Study) last July. This is an opportunity for us to get to know our strengths and solidify roles and what we can do with our assets. We have a core team of staff that meet with the consultants bi-weekly. The consultants conducted an

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orientation with all-staff and generated an overview and timeline of what to expect throughout the Organizational Study.

b) The updated COVID-19 Survey Findings report was emailed to staff and All-Commissioners with live links to the report's website. Communications Manager, Natalie Blackmur will provide public comment on our behalf at the Board of Supervisors ARPA (American Rescue Plan Act) Workshop, and will highlight the survey findings as critical data for the Board and other organizations as the county looks to prioritize services and resources for young children and their families through ARPA funding and other state and federal funding. We will be elevating the survey as a resource. Please share the COVID-19 Survey Findings data and website link with others.

c) The administrative office is currently in the last year of the lease and we are currently working to re-negotiate the renewal timeline within the contract. We are also consulting with the County to explore other potential opportunities, citing recent increase in violence and unfavorable conditions surrounding the area as key reasons for looking into different options. More information to come.

4.0 **DISCUSS** issues regarding the operation of the Commission**.**

Ruth gave the following updates:

a) We have a newly appointed District 3 alternate: Rhoda Butler, who will join us at the September Commission meeting.
b) Commission's Administrative Calendar is on track with our deliverables.
c) Board of Supervisors Triennial Report: it is due on December 31, 2021, staff is currently completing a draft report for Commission approval at the December meeting.
d) Ruth sent information on First 5 Association's sponsored REDI webinars and encourage all to participate. Great opportunity for Commissioners to network with other County Commissioners and staff across the state.

5.0 **RECEIVE** presentation and **DISCUSS** ongoing efforts and future planning related to the First 5 Contra Costa Strategic Plan 2020-2023.

Ruth Fernández started by providing context for the presentation and articulating that the purpose for the presentation was to reconnect with the principles, goals and strategic priorities outlined in the Plan and commented that the same presentation was provided at the Commission meeting on July 12, 2021. Nicole Young began the presentation by reviewing all elements in the plan and the process that lead to the identification of goals and priorities. The presentation described ongoing work and future plans related to the 2020-2023 First 5 Contra Costa Strategic Plan. After the presentation, Finance Director, Sandra Dalida noted that we are focused on technology innovations to move from 90% paper to automated processes and reporting, and the ability to forecast and make fiscal projections.

After the presentation, questions and answers followed:

Commissioner Lucey asked to clarify RBA Evaluation. Ruth stated that RBA stands for Results Based Accountability framework an evaluation tool currently being used by other First 5 Commissions to measure the impact of their investments and success of their strategic goals.

Commissioner Lucey asked if we already have certain result metrics already planned. Ruth informed that the next step is to work on developing an agency-wide "Theory of Change" – that describes the why, the what and the how of the work sponsored by the Commission to address root cause issues and address the needs of the early childhood system in the county. Following development of a Theory

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of Change, we will develop an Evaluation Plan grounded on the RBA framework. The plan is to unveil the Theory of Change at the December Commission meeting.

Commissioner Garcia Calloway commented that social justice wording in the Strategic Plan is missing. Ruth agreed that social justice is not strongly defined in our strategic plan. That is something we could improve. The Commission has an opportunity to update and/or revise the Plan annually and report on these changes in the Spring when we a public hearing is held on the progress of the Strategic Plan.

Commissioner Ross commented on the importance of using the terms such as 'Developmentally Appropriate Practices' when we are addressing children's needs and that we strive to scale research based models with our investments. Marilyn Lucey commented on the importance of being culturally responsive in how we define terms such as research based a culturally appropriate.

Commissioner Hernandez stated that since it is an internal focus document, the words that we are using need to come with a definition, mindful of our children's and the entire family's developmentally appropriate needs. We bring it back to what our core values and principles.

The meeting paused for a 10-minute break.

Ruth added that we want to segue into looking at impacts of COVID-19. Because of competing priorities, it has been critical that we remain steady and follow the strategic plan while doing the work and being responsive to the "now". We developed a tool that we call the "decision making matrix".

Camilla discussed the purpose of the tool: to measure priorities based on impact, urgency and effort and provided an example of a recent grant opportunity in which the team completed the matrix.

Commissioner Lucey commented on the positive shift she has noticed with the use and comfort level exuded by staff with using social justice and equity conscious vocabulary in their communications. It has been really positive thing to see how fluent the vocabulary of justice equity and inclusion, all those things we are aspiring to be and do at every single level is something she has observed.

The discussion continued with multiple comments made by Commissioners related to the findings of the COVID-19 survey and ways in which First 5 CC is responding to parental isolation and parental stress. Additionally, comments were made related to data collected on concerns with vaccination and opportunities to collaborate with other countywide groups like United Latino Voices to specifically outreach to marginalized communities that are disproportionally impacted by the pandemic. Opportunities to address vaccination concerns from families and disproportionally affected communities.

Commissioner Calloway noted that the Commission might consider forming an Ad Hoc Committee, to continue to analyze, brainstorm with the staff, and discuss potential development of organizational policies.

Ruth concluded the discussion by recapping the conversation and next steps:

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- We are almost midway through the Strategic Plan.
- There are some critical inquiries we should collectively look into.
- Opportunity to be more explicit about our work and intentional about our vocabulary.
- Continue to plan intentionally our next steps with something to share in April to Commission and stakeholders.

6.0 **REVIEW** agenda items for upcoming Commission meetings.

We have few things to bring:

- Melissa Stafford Jones, from the First 5 Association will present at the September Commission meeting.

Commissioner Garcia Calloway asked for the State Association's strategic plan. Ruth will email to the officers once the Association's Plan is approved.

7.0 **Adjourn**

Commissioner Lucey adjourned the meeting at 4:59 pm

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FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

September 13, 2021

Agenda Item 3.4

Accept the First 5 Contra Costa Program Reports for July and August 2021.

PROGRAM UPDATES

JULY 2021

Community Engagement Program

*Our **Community Engagement Program** (CE) supports three Regional Groups made up of 200 parents and residents to make Contra Costa County safer, healthier and more equitable for families.*

Antioch CHANGE Data Collection is Complete

After 3 months of peer-to-peer data collection, the Antioch CHANGE survey is closed. We collected over 1,000 surveys, far surpassing our goal. Overall, the project's first phase was a great success, providing substantial information about Antioch families' experiences and ideas for housing stability and equity. The East County Regional Group's (ECRG) volunteer outreach and hard work was remarkable.

CE staff and partners continue conducting stakeholder interviews with community leaders to provide additional insight into the opportunities and challenges for housing equity in Antioch.

This fall, the CE Program and ECRG will host an Antioch community townhall to share the survey data and identify families' priorities for housing security. Stay tuned for more details.

Park Improvements Complete at DeAnza Park in Pittsburg

Construction at DeAnza park is complete. Pittsburg's young children and families have an improved DeAnza park that includes a new all-purpose path and 4 fitness stations for diverse ages and abilities. The park improvements are the result of ECRG advocacy and partnership with Kaiser Permanente, the City of Pittsburg, and Healthy & Active Before 5. The ECRG and CE Program will host a celebration to inaugurate the improvements as soon as conditions and timing permit.

Regional Groups Elect New Leadership

Each new fiscal year, the Regional Groups elect new officers to the positions of Chair, Co-Chair, Secretary and Treasurer. Serving as a Regional Group Officer provides parents with increased leadership training, coaching, and opportunities to apply skills with supportive mentorship. We congratulate all the nominees and welcome the new Regional Group elected officers.

CE Program Staff Team Transitions

After 20 years of dedicated and extraordinary work with the Regional Groups and CE Program, Alejandra Plascencia stepped down from her position with First 5 Contra Costa in June. Alejandra's contribution to parent leadership, advocacy and the Regional Groups' success is unparalleled. Her impact will reverberate throughout the agency and community for years to come. We will miss Alejandra deeply and wish her continued success and happiness in her next chapter.

Also in June, another member of the CE Team, Carolina López Flores, began her maternity leave and has since welcomed a healthy baby to the world. The family is well, and we wish Carolina all the best during this special time.

PROGRAM UPDATES
JULY 2021

Early Intervention

*Our **Early Intervention** (EI) initiative aims to ensure that families have access to prevention and early intervention supports and services that foster the optimal development of all children.*

Help Me Grow System Activities

Help Me Grow (HMG) Café

Everyone is invited to the upcoming HMG café, happening on August 17 at 9:00 AM, which offers a networking opportunity for all community service providers working with families and their young children ages 0-5. Contra Costa Health Services (CCHS) will present information for providers to help promote family and child health and overall wellness. Because of the COVID-19 pandemic, pediatric health providers witnessed a drop in well-child checks and many families missed time-sensitive preventative services for their children. CCHS will share information and resources so we can encourage all our families to catch up on their child's development, vaccines, lead screening, and more.

System Coordination

The Contra Costa Interagency Council has identified a strong need for resource navigation support for families from service providers. The pandemic has exacerbated some of the challenges and barriers faced by families in navigating the early intervention service system. A subgroup of its members engaged in care coordination and system navigation will be exploring this issue—Liliana Gonzalez, our HMG Coordinator, is part of the subcommittee.

Return on Investment (ROI)

HMG Contra Costa is a participant of a Help Me Grow National ROI Workgroup that will support the development of a ROI calculator—this is an important step in elevating and effectively communicating the impact of the HMG model and support our advocacy efforts. The ROI Calculator is scheduled to be launched this fall.

HMG Health Provider Outreach

Due to the pandemic, we are continuously learning and adapting to conducting outreach virtually and remotely. Our HMG Health Provider Outreach contractor is now offering quarterly developmental screening trainings via Zoom for health care providers. These quarterly sessions are set in advance and shared with our pediatric partners to offer a flexible and ongoing opportunity for receiving training and technical assistance. Families of our HMG developmental playgroup continue to prefer virtual groups at this time due to concerns regarding the delta variant.

First 5 Fellows Advancing Early Childhood Resiliency and Trauma Training

First 5 Fellows Julia Kittle-White and Ruth Hunter held a Building Resiliency in Early Childhood Module 102 (part 1 and part 2) on May 25 and 27 for Employment & Human Services Department (EHSD) staff. They will complete part 1 of Module 103 on August 18 and part 2 on August 19—this is the start of their rolling out of the training for all EHSD staff. So far, they have reported that the trainings were well received and staff enjoyed the opportunity to discuss concepts in breakout rooms. From this experience, they plan to build in more time for discussion.

First 5 Fellows Angela Fantuzzi and Roxanne Belotti will be offering the Building Resiliency in Early Childhood Module 102 on September 11 and 18, and offer Module 103 on October 16 and 23 to a group of early learning educators in partnership with our ECE initiative.

ACEs Grant in Review

Building Resilience with ACEs Round 2
On July 14, the Office of the Surgeon General shared the second in a series of webinars exploring the science of Adverse Childhood Experiences (ACEs) and toxic stress. The webinar's emphasis on the importance of resilience—and how to effectively talk with patients about their capacity to build resilience—resonates deeply with our ACEs team's development of a resilience checklist to be used within the clinical ACEs screening interaction at La Clínica de la Raza. The checklist allows a patient to self-select from a list of offerings that can support their wellness, with options both internal to La Clínica and external via Contra Costa Crisis Center referrals. This trauma-informed tool builds patient empowerment and self-efficacy, centering patient voices and choice in receiving care that targets the roots of the toxic stress response. The checklist enhances strengths-based clinical approaches by facilitating referrals based on patient resilience rather than only upon deficits or needs.

Strengthening our County-Wide Network of Care
Tune into our Network of Care online hub to join upcoming Learning Conversations this summer. After our Spring Convening, we heard the request from participants to access additional space and resources to learn what it takes to practically implement trauma-informed practices. We see these Learning Conversations kind of like a book club, where the "book" is a resource we would like to unpack and reflect on with each other, and the club is not too big of a commitment—come when you can, participate however, you would like. To join, please fill out this Google Form to let us know your availability, and dive into our first set of discussion materials, the online module "Collectively Taking Care" by Families Thrive. For those of you hungry for even more trauma-informed learning, stay tuned for Advanced Trauma-Informed Leadership Teams (TILTs) coming up in late summer or early fall, facilitated by First 5 and our partners at Trauma Transformed.

Early Childhood Education

*Our **Early Childhood Education** (ECE) Initiative aims to ensure that all children have access to high-quality, affordable child care and early learning.*

Quality Matters: End of Year Survey Data

The final milestone for Quality Matters (QM) participants culminated with an end of year survey. The results from the survey offered great feedback and will inform the plans for the upcoming QM Program year. Related to the First 5 Coaches, almost 97% of QM participants indicated the virtual coaching visits were "valuable" or "somewhat valuable", with 75.5% selecting the highest value option. Related to coaching visits, participants found they were helpful as an opportunity to ask questions, receive resources for a focus area, discuss the bigger picture, and offer ongoing support for teachers. Participants appreciated the PPE supply delivery, community resources to help with COVID related issues, and having someone guide them through the pandemic.

The end of year survey results indicated QM participants most common successes of the 2020-2021 year included: 1) making it through the pandemic without sacrificing quality; 2) attending virtual trainings; 3) gaining access to needed supplies and PPE; and 4) developing a health and safety protocol. The top

challenges encountered while participating in the Quality Matters Program in 2020-2021 included: 1) communication; 2) finances; 3) remote assessments; and 4) not being able to interact with the coaches as much. Staff recruitment, low enrolment, and lack of finances are the highest concerns related to the next program year. Approximately 70% of QM participants indicated they would be most comfortable attending virtual trainings in the 2021-2022 school year. Participants also shared information regarding interests for professional development, availability for engagement, and more. The Contra Costa Quality Matters programs are continuing to use this data to plan trainings, events, and coaching.

Contra Costa Early Childhood Steering Committee

The Contra Costa Early Childhood Steering Committee is comprised of members from First 5 Contra Costa, Contra Costa County Office of Education, CocoKids, Contra Costa College, Diablo Valley College, and Los Meadnos College. This Steering Committee continues to meet monthly to plan and discuss topics related to Early Childhood in Contra Costa County. During the July 14, 2021 Steering Committee Meeting, the consortia shared organizational updates, analyzed the aforementioned Quality Matters End of Year Survey Data, and discussed plans for the Fall Quality Matters Kickoff Event. Additionally, the Steering Committee established a process for collaborating virtually through Google Docs to collectively edit upcoming guides and materials.

BUILD Conference

Camilla Rand, Deputy Director; Melissa Cunningham, Early Childhood Education Program Officer; and Kim Stadtlander, Quality Improvement Coaching Coordinator, attended BUILD 2021: Reinvent Early Care and Education Quality Improvement to Advance Racial Equity. During this virtual conference from July 20-22, they had the opportunity to attend a variety of sessions and plenaries including a conversation with Dr. Ibram X. Kendi and Anna Deavere Smith. Following the BUILD conference, Kim reflected, “One theme that ran though most sessions I attended at BUILD was the reality that after all these years of advocacy, equitable wages is not a reality in early education. Most of the dollars we spend on training gets lost because teachers are forced to leave the field for better, more livable wages.” Melissa synthesized, “The BUILD conference illuminated the relationship between past and present. In order to advance racial equity, we need to understand the history on multiple levels. A reimagined system accounts for the history and actively seeks to dismantle structures that get in the way of equity.” The opportunity to convene with early childhood enthusiasts across the country provided a dose of inspiration and helped to reground in a vision of equity and excellence.

Family Economic Security Partnership

*The **Family Economic Security Partnership** (FESP) is a public, private and nonprofit collaboration dedicated to increasing the income and building the assets of low-income families and individuals living in Contra Costa County.*

Family Economic Security Partnership (FESP) activities

The FESP Executive Committee met to discuss the feedback from the FESP survey and possible next meeting topics. Given the survey responses, the committee suggested that there be a focus on advocacy, asking FESP members for more information to identify how FESP could be of most help. Some of the questions would include: What do you do as a leader? Line staff? Individual? Part of an organization? How do you talk to your board? What can FESP do to make it easier for you? There was also discussion about what the next focus area might be—suggested topics included health and wealth, guaranteed basic income, updates from the Office of Racial Equity and Social Justice and Measure X. The Executive Committee will be meeting again to discuss further.

Fran and Mariana from Ensuring Opportunity met with United Way of the Bay Area representatives to talk about their new strategic plan and how to better coordinate policy efforts.

Fran continues to send out relevant information to FESP members on COVID, Measure X, listening sessions for the Office of Racial Equity and Social Justice, Budget Justice Coalition meetings, vaccine distribution, rental assistance, and other issues as they arise.

Community Advocacy + Partnership Project (CAPP)

The month of June was spent confirming participants, selecting the date for the kick-off meeting of CAPP (July 27) and future monthly meetings (second Wednesday of each month), creating/preparing curriculum, and selecting and meeting with the LeaderSpring consultants hired to facilitate the project. The session on July 27 happened on Zoom (safety first!) and participants received a gift certificate for lunch—interpretation services are available for all sessions.

Cohort sessions will cover advocacy training, cross issue work, building movements, narrative change, power mapping, budget knowledge, and more. Participants will have an opportunity to work in small learning pods as well within and across teams. A Steering Committee is also being established with three community advisors and five members of the cohort.

The core project team (Ensuring Opportunity, FESP and LeaderSpring) presented at the Contra Costa Funders Forum on July 19 and a slide deck about the project is available. The first year of the project will end with the cohort identifying a policy issue(s) that they will work together on and action planning for year two. CAPP aims to build a broader, better-connected, and more powerful base to advocate for policies and systems that increase equity in Contra Costa.

Measure X: Healthy and Safe Contra Costa

The Measure X Community Advisory Board (MXCAB) is close to wrapping up its Wednesday meetings and will soon transition to making funding recommendations to the Board of Supervisors. Anyone can sign up to receive the agendas for the meeting, or to review past agendas. The session on July 14 focused on the safety net and on July 21 the focus was on immigration and racial equity. https://www.contracosta.ca.gov/agendacenter.

Partnerships

Budget Justice Coalition (BJC)

The BJC meeting on July 22 hosted Tim Ewell from the County Administrator's Office (CAO) to talk about the August 3 Board of Supervisors (BOS) meeting on the use of American Rescue Plan Act (ARPA) funds (ARPA). Tim provided an excellent explanation of the many funds coming into the county (Fiscal Relief Funds, Emergency Rental Assistance) and expenditure categories and requirements; most of the funds at this point are planned to go directly to the county departments. At the August 3 BOS meeting the CAO and the county departments will provide updates and expenditure intent. BJC will be sending a letter to the BOS expressing the desire that some of those funds address the needs of the county's residents most affected by COVID and is planning to hold a Town Hall in August to review and discuss ARPA. Fran participates on the monthly BJC Coalition meetings, which focus on the county budget and how best to engage community in budget decisions.

West and Central/East County CARES Coalitions

Fran participates on the West and Central/East County CARES Coalitions where a tremendous amount of information is shared and later distributed to FESP members and others.

PROGRAM UPDATES

JULY 2021

Family Support

*Our **Family Support** (FS) initiative helps families build healthy relationships, strengthen support systems, and nurture their children's development.*

First 5 Centers Get Kidpower

Kidpower, a global nonprofit leader in 'People Safety' education, received funding to provide social emotional safety skills education to families with young children. Families attending our First 5 Centers will soon have the opportunity to attend Parentpower workshops that aim to empower and teach them the skills for keeping their children safe. Kidpower is a widely accepted approach to preventing violence and abuse by helping adults and children build and recognize strong and healthy relationships. First 5 Center staff will also benefit from Kidpower's professional development training which will also be provided at no cost.

First 5 Centers Offer In-Person Classes

As of July 19, 2021, each of the Centers had held their first in-person class since closing in March 2020. Offerings range from 5-13 classes per week, depending on the size of the Center. The largest sites are able to accommodate up to 8 families per class, while others are being kept small to ensure social distancing can be maintained. The response from families who have come back to the Centers has been excitement and joy, while other families remain apprehensive referencing fear associated with the Delta variant. The majority of programming offered by the Centers remains online, distributions of material goods (diapers, cleaning supplies, books and activity bags) continue to be available to families and car seat installations have resumed in-person. Not surprisingly, the most sought out in-person experiences are related to school readiness and self-care themed classes for parents, including a popular group of dads who continue to meet online with the Monument First 5 Center. The Centers will continue to follow strict COVID policies and procedures that require masking and screening of all participants except those under 2 years of age. Until there are vaccines available for young children, the Centers feel obligated to take every precaution to ensure the safety of those who work and visit our Centers.

Distribution and Storage of Donated Supplies

Since last summer the City of Concord has generously gifted us access to the vacant Kmart building on Clayton Road, which allowed us to receive and store multiple pallets of supply donations. The space was only meant to be temporary until December 2020, however, we were able to utilize the space for an additional seven months. The First 5 Team, headed up by Randee Blackstock, secured a new space in Concord and coordinated a move in less than two weeks, all while managing incoming supply deliveries.

PROGRAM UPDATES
AUGUST 2021

Community Engagement Program

*Our **Community Engagement Program** (CE) supports three Regional Groups made up of 200 parents and residents to make Contra Costa County safer, healthier and more equitable for families.*

Antioch CHANGE Data is Ready

The Antioch CHANGE survey data has been compiled from over 1,000 surveys and will be shared at an upcoming Antioch CHANGE Community Townhall on Saturday, September 25, 2021. During the Townhall, Antioch families will discuss the survey findings and inform priority areas for recommendations and action. The Townhall will be the first in a series of community meetings to mobilize Antioch families for improved housing security. Click here for the event flyer—please distribute widely among Antioch networks.

Central County Regional Group (CCRG) Housing Advocacy Continues

CCRG families continue to advocate for an end to landlord harassment of renting families. Reports of landlord harassment has increased during the pandemic and is a potential driver of tenant displacement. Concord's Housing and Economic Committee will discuss landlord harassment on September 29, 2021. The CCRG hopes Council will take action to protect Concord renting families and ensure safe, livable conditions for all children.

The CCRG is also preparing to engage in and inform Concord's Housing Element plan. CE staff participated in a focus group meeting this month to inform the City's community engagement plan and promote participation of underrepresented families with young children, The CCRG and CE team will continue to follow the process to advocate for anti-displacement housing policies and long-term strategies for housing security and equity.

Early Childhood Education

*Our **Early Childhood Education** (ECE) Initiative aims to ensure that all children have access to high-quality, affordable child care and early learning.*

Dual Language Learner Initiative: Course Two Kickoff

Thirty-six early care educators are enrolled in a two-part Dual Language Learner (DLL) university course series. The second course started August 18, 2021 and builds off of the foundations of DLL addressed in the first course. Participants will learn the Personalized Oral Language Learning (POLL) strategies to support implementation in early care settings such as family child care homes and preschool centers.

To prepare participants for the course, the First 5 Contra Costa ECE team hosted a dual language learner part-two kickoff event on August 12, 2021. This virtual experience was an opportunity to energize participants around the beginning of the second DLL course, a chance for educators to share ideas around implementing DLL practices at their sites, and a space for First 5 Contra Costa to gain mid-point data from the perspectives of the participants.

Dual Language Learner Initiative: Creative Connections Training of Trainers

For the DLL Initiative, First 5 Contra Costa is in a regional collaboration with First 5 San Francisco and First 5 Santa Clara. These three Bay Area regions offered the Creative Connections Training of Trainers to build regional capacity through family workshops and underscore the importance of relationships with families for the initiative. Eight trainers from Contra Costa attended a two-day training of trainers on

August 19-20, 2021. The Creative Connections curriculum focuses on supporting strong partnerships between families of DLL children and educators, introduces concrete practices for supporting children's dual language learning, and is aligned with the content of the State-approved two-part DLL course.

On August 18, 2021, the Bay Area team was invited to share about the Creative Connections Training of Trainers and regional approach at the state-wide DLL Community of Practice. Melissa Cunningham, ECE Program Officer, shared Contra Costa's plan for training First 5 Center Directors, First 5 Quality Improvement Coaches, CocoKids Quality Improvement Navigator, and DLL Course Participant Providers to deliver the family workshops.

Quality Matters Planning Retreat

On July 29, 2021 the First 5 Contra Costa ECE team and the Contra Costa County Office of Education Early Care and Educations Programs Team convened virtually for a daylong Quality Matters Planning Retreat. Through the course of the retreat, the teams grounded in a shared vision, discussed and determined a plan to assess and rate Quality Matters Programs during the 2021-2022 program year, and planned training experiences using end of year survey data. The retreat helped to inform how First 5 Quality Improvement Coaches support Quality Matters sites for the program year.

Quality Matters
IMPROVING EARLY LEARNING IN CONTRA COSTA

Family Support

*Our **Family Support** (FS) initiative helps families build healthy relationships, strengthen support systems, and nurture their children's development.*

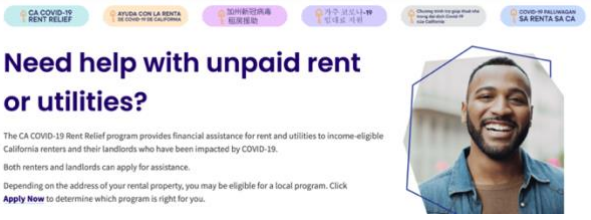
First 5 Center Teacher Elevates the "Back to School" Needs of Young Children

Myesha Smith, one of the instructors at the Monument First 5 Center, interviewed with KRON4 for their streaming platform on Friday, August 13. Armed with core talking points and storylines, Myesha spoke about the importance of understanding how young children might express and externalize big feelings, how parents need to establish two-way communication with their school community, and how to build on their child's collective resilience and adaptability.

East County First 5 Centers Receive Grants to Help Families with Rental Assistance

Through the new Emergency Rental Assistance Program (ERAP), over $100 million in federal funds, designated for rent and utility assistance, will keep Contra Costa County residents' housing stable during the COVID-19 pandemic. The problem is getting the word out to eligible residents, those with incomes below 80% of Area Median Income (AMI), have experienced a loss in income related to COVID-19 and are at risk of homelessness or housing instability are eligible for assistance.

The East County, Antioch and Delta First 5 Centers were each awarded a $5,000 grant from the County to conduct outreach to ensure families know about and those who are eligible are able to access this important rental assistance program when families need this most.



First 5 is also a part of a larger coalition of community organizations helping to get the word out about ERAP fund availability through flyers, social media, and mass advertising.

PROGRAM UPDATES

AUGUST 2021

Early Intervention

*Our **Early Intervention** (EI) initiative aims to ensure that families have access to prevention and early intervention supports and services that foster the optimal development of all children.*

Breaking News: ACEs Supplemental Training is now ACEs Certified

The Early Intervention team is thrilled to share that First 5 Contra Costa's supplemental training "Changing the Lives of Children: Attending to ACEs (Adverse Childhood Experiences) in Ages 0-5" has been officially stamped, approved, and certified by the California Office of the Surgeon General.

Our grant liaison, Trish Violett, wrote "Congratulations! Your ACEs Aware supplemental training "Changing the Lives of Children" has been approved. Dr. Burke Harris really liked the training and appreciated your hard work with the review team throughout the process. The end result is a valuable training that adds to the field."

The supplemental training grant was a part of the funds we received in the first round of grant funding. Supplemental grants are to augment knowledge of Medi-Cal providers in becoming ACEs aware in California. Reaching certification is a rigorous process and only a limited few of the grantees have achieved this status. Stay tuned for our next steps in launching the training—the training will be offered both live and in a recorded format. Kudos to the Early Intervention Team!

Advancing Practice

During our round 1 Aces grant, First 5 in partnership with Trauma Transformed, hosted a series of Trauma-Informed Leadership Teams (TILTs) comprised of diverse medical and social service providers within and across regions of Contra Costa with the goal of building a coordinated, connected, and relationship-centered Trauma-Informed Network of Care. In feedback from those TILTs and our Spring Convening, we heard participants ask for continued networking, conversation, and action-oriented collaboration necessary to apply the skills to implement trauma informed practices. On August 26, we will be bringing many of these professionals back to the table to hear their vision for what future advanced TILTs might encompass and to help co-design their format. First 5 and Trauma Transformed will be hosting this initial conversation; we will keep you posted on our advancements.

The first online hub 'Network of Care Learning Conversations' occurred this month. There were 25 attendees who zoomed in to unpack and reflect on a "Collectively Taking Care" module offered by Families Thrive. A 'book club' format was used to engage in a lively discussion on the module content and the tools it offers.

Every Day Moments

First 5, in partnership with Early Childhood Prevention and Intervention Coalition, received a Mental Health Services Act (MHSA) grant to meet the social emotional needs of children 0-5 and their caregivers. First 5' s Communication Team has developed outreach materials to promote the program that will be distributed countywide by the coalition members' communication channels. Here is a sneak preview of one of the posters (and in Spanish), and here is more information located on the First 5 website.

PROGRAM UPDATES
AUGUST 2021

Help Me Grow (HMG) System Update

Heather Little, after 6 years, will be transitioning out of her role as the System Director for the First 5 Association of California. The Association is still in the process of determining what the HMG California role will be going forward. We wish Heather well in her new endeavors.

EI team members Liliana Gonzalez and Emily Hampshire will provide three trainings to medical providers throughout August to support screening implementation of the ASQ3 screening tool and to share information on our ACES work.

This month's virtual HMG Café had 33 attendees. The attendees voiced their continued appreciation for this mechanism in enhancing system knowledge and building a shared community of support. One attendee stated, "Thank you for the great trainings and updates!"

Family Economic Security Partnership

*The **Family Economic Security Partnership** (FESP) is a public, private and nonprofit collaboration dedicated to increasing the income and building the assets of low-income families and individuals living in Contra Costa County.*

Family Economic Security Partnership (FESP) activities

The FESP Executive Committee had a great and lengthy conversation about the next FESP meeting, to be held in October. The overall theme will be on assessing/supporting advocacy capacity (and we will tie it into some of the work of Community Advocacy + Partnership Project). We will be inviting a few agencies to share their experience of incorporating advocacy into their direct service provision in a variety of ways. This might include the Food Bank and their leadership-training program, Rubicon and their policy work, SparkPoint and how they have incorporated advocacy into their programming through their deeper dive pilot project a few years ago, and Opportunity Junction for becoming a polling site. Each would have a few minutes to talk about their work in order to give a sense of what agencies can do that does not require either a lot of time or money. Following the presentations, FESP members will break into small groups and talk about what resonated, what they think their agency could do and what they could do as individuals, and what their main barriers are and how might they get around them.

After the presentations, we will conduct a poll to see what topics members would like to learn about for the next FESP meeting (January or February). We will include topics such as: quality jobs and compensation; minimum vs. living wages; guaranteed basic income (vs. universal); handling the changing nature of COVID/self-care; advocating for families and children during COVID; racial equity/ORESJ; budget justice (could include ARPA); relief to resilience (from the Asset Funders Network); and community leadership development.

FESP Executive Committee members also addressed the deep pain that many families are experiencing as COVID continues, such as children's return to school (safely?), families possibly facing eviction, job status and low-wages, and stress and social isolation. We want to both acknowledge this reality and offer support/ideas for coping.

Fran Biderman, Special Projects Coordinator, continues to send out relevant information to FESP members on COVID, Measure X, listening sessions for the Office of Racial Equity and Social Justice, Budget Justice Coalition meetings, vaccine distribution, rental assistance, and other issues as they arise. The new District Director for Senator Skinner's office reached out to FESP to discuss getting the word out about the rental assistance program and we will be meeting in early September. Fran also worked with

the Communications Team to create and distribute information about the available tax credits and stimulus funds available to low-income families if they file their taxes by October 15.

Community Advocacy + Partnership Project (CAPP)

We officially launched CAPP on July 27 with 65 people in attendance. The four-hour session went well as participants reviewed the overall purpose of CAPP—to build a broader, better-connected, and more powerful base to advocate for policies and systems that increase equity in Contra Costa. Cohort members met in small groups and in pairs, developed community norms, and participated in an exercise led by LeaderSpring on power, privilege and oppression. All CAPP sessions are interpreted in Spanish and all materials will be translated.

The next session is on August 31 and will be a review of the community norms, establishment of learning pods, and a training on advocacy by Alliance for Justice; the core team zoomed with AFJ staff to discuss the training. Because of the complexity of the advocacy training material, a separate training will be conducted in Spanish for those Spanish speakers that wish to attend on September 1.

An eight-person Steering Committee was also established to provide overall thought partnership and input to the core team. The core team selected three members as community advisors; five CAPP members were selected for the remaining slots: one from a direct service agency, one from an advocacy organization, and three residents. In addition, Fran formed a “First 5 CAPP support team” and shared highlights from the first CAPP meeting.

Planning is ongoing in anticipation of the monthly cohort sessions. Future sessions will focus on collaboration, community driven advocacy, cross issue advocacy incorporating advocacy into direct service provision, and more. Cohort members also receive regular updates from the core team, reminders to do their homework (this month it was to attend a public meeting), and notices about upcoming dates and agendas.

Measure X: Healthy and Safe Contra Costa

The Measure X Community Advisory Board (CAB) held a special session on August 20 and anticipates holding their last session on August 25 to make funding recommendations to the Board of Supervisors (BOS). The CAB reviewed a treasure-trove of data from the myriad of presentations that were made in the last few months. We rallied the Early Learning and Leadership Group (ELLG) to make public comments in support of funding for early childhood issues. The final funding decisions are ultimately up to the BOS.

Partnerships

Budget Justice Coalition (BJC)

The BJC met on August 26 for a special session to define goals and strategies for budget related issues moving forward. BJC members made public comments at the August 3 Board of Supervisors meeting on the use of American Rescue Plan Act funds (ARPA) and made a request that at least some of those funds be used to address the needs of the county’s residents most affected by COVID.

CalFresh Working Group

The CalFresh Working Group met on August 5 to review the original charter of the group and to discuss next steps, including a potential merger with the county’s nutrition task force. The group decided to continue to meet quarterly instead of monthly and to focus on data and advocacy strategies to ensure that eligible CalFresh recipients receive benefits.

FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

September 13, 2021

Agenda Item 5.0

Presentation of the First 5 Association's State-Level Efforts

First 5 Association Presentation to First 5 Contra Costa

Melissa Stafford Jones, Executive Director

First 5 Association/California Children & Families Foundation

September 13, 2021

FIRST 5 ASSOCIATION OF CALIFORNIA

Presentation Overview

- 2021 State and Federal Policy Developments for Young Children and Families
- Overview of First 5 Association Strategic Plan 2022-24
- First 5s Advancing Race, Equity, Diversity, Inclusion (REDI)
- Upcoming Learning and Engagement Opportunities
- Q &A

State Policy Developments

State Budget 2021-22

- ***Family Supports***: PFL Extension, Golden State Stimulus, CalWorks Grant Increase, UBI Pilot
- **Health & Development**: Children & Youth Behavioral Health Initiative, New Medi-Cal Benefits (dyadic care,doula care, Community Health Workers, Postpartum Continuous Eligibility), Additional funds for Regional Centers and IDEA early intervention services, Ends sunset for Prop 56 $ for developmental and other screenings
- ***Early Care and Learning***: Rate Increases/Rate Reform, Ratifies CCPU Contract Terms, 200,000 additional slots, Facilities $, Stipends, Waive Family Fees 1 year, Hold Harmless extension 1 year, CCIP investment, UTK, Child Care Data Systems, CIBC/Early Childhood Mental Health Consultation,

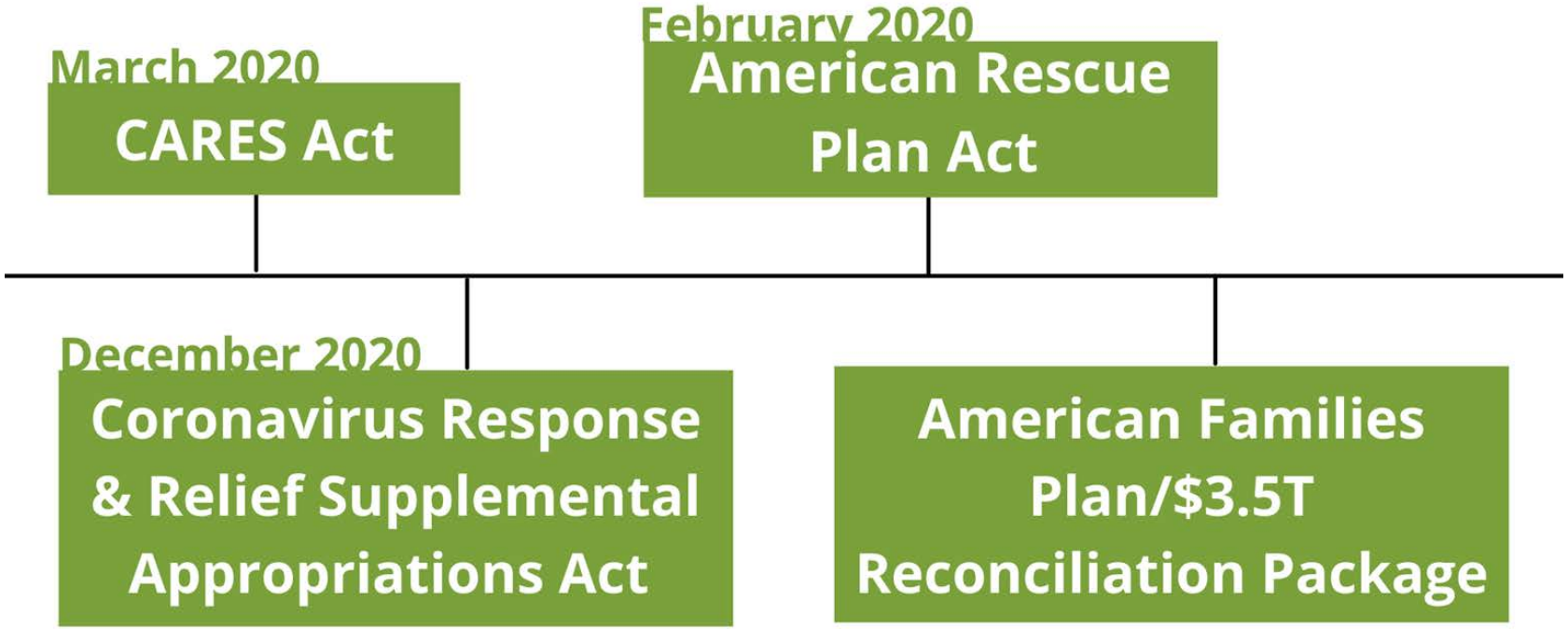
State Legislation

- SB 395 (Caballero) Vape Tax

On the Horizon

- Flavors Ban Referendum November 2022 General Election

Federal Policy Landscape



Our Focus

The First 5 Association 2022-2024 Strategic Plan

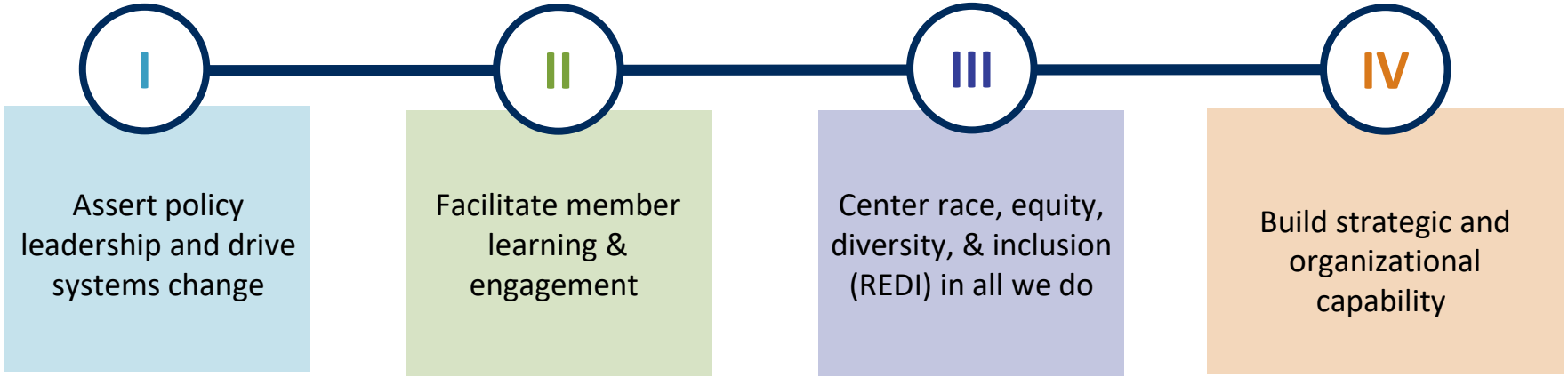
The power of First 5 is in our expertise and experience as systems change leaders and backbone organizations in our communities.

The First 5 Association aims to unify the collective First 5 work at the state level, and amplify the diverse First 5 county voices to create systemic change across California.

Our Focus, Our Future *2022-2024 Strategic Plan builds on First 5s' history of leadership and partnership to ensure young children are safe, healthy, and ready to succeed in school and life.*

It provides clear goals and strategies for the next three years that will focus our collective efforts and sharpen our impact.

LEADERSHIP, SYSTEMS CHANGE, LOCAL IMPACT



POLICY AND SYSTEMS CHANGE

How We'll Drive Change

PROVIDE LEADERSHIP ON POLICY AND SYSTEMS CHANGE PRIORITIES

Effect tangible policy change in the following three areas:

1. **Universal Home Visiting and Family Strengthening**
2. **Early Childhood Mental Health**
3. **Early Identification and Intervention Systems Development**

SUPPORT OTHERS AND WORK IN PARTNERSHIP

Work in partnership with others to advance a holistic early childhood policy platform that advances:

- Family resilience and economic supports
- Comprehensive health and development
- A strengthened system of quality early learning and child care
- Overall sustainability and scale of comprehensive, integrated services for children and families.

REDI: A CORE PRINCIPLE

In addition to our specific REDI strategic objectives, the principles of race, equity, diversity, and inclusion are integrated into every section of this plan, and will be embedded throughout our work.

This means:

- Grounding policy and systems change approaches in targeted universalism—universal goals for all children, with targeted strategies to meet the needs of specific groups
- Strengthening the role and influence of parents and families in our advocacy work, including lifting up diverse voices and elevating families as leaders and drivers of change
- Building a diverse next generation of equity-centered leaders
- Creating opportunities for REDI learning and practices among member agencies
- Centering REDI in the Association's governance, strategy, and internal capacity building

Advancing Race, Equity, Diversity, and Inclusion

- First 5 Association REDI Committee and REDI Core Team
- Two-Year REDI Learning and Action Initiative
- Key Frameworks: Targeted Universalism; Individual, Organizational, Policy/Systems
- New Strategic Plan Centers and Embeds REDI in All We Do
- Parent and Family Engagement
- First 5 REDI Dashboard

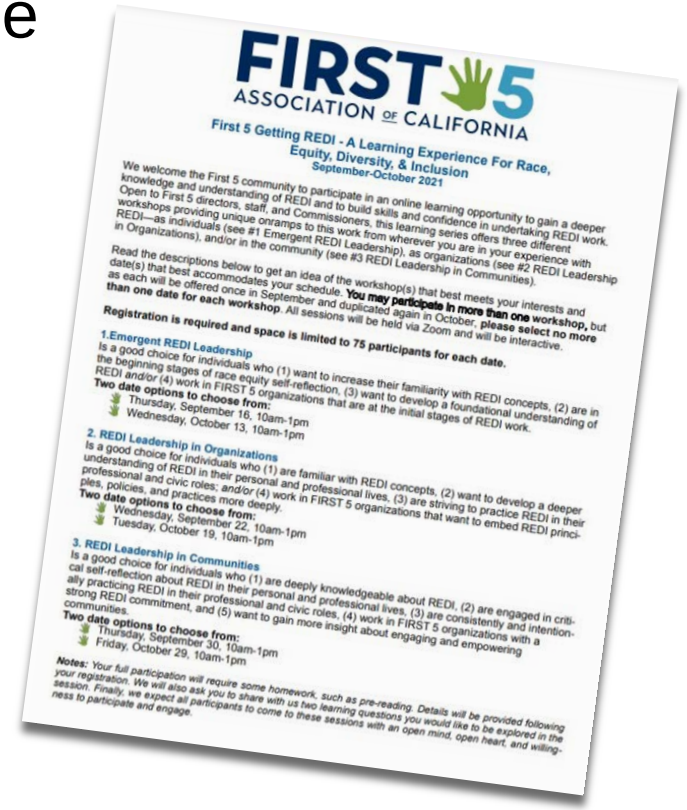
Commissioner Opportunities to Engage

REDI Learning and Action Initiative

- Cohort Trainings in September and October
- Workshops in October and November

First 5 Association Annual Summit

- December 6-10, Details to Come
- REDI, Key ECD Learning Sessions, Policy and Political Landscape in 2022



FIRST 5 ASSOCIATION OF CALIFORNIA

First 5 Getting REDI - A Learning Experience For Race, Equity, Diversity, & Inclusion
September-October 2021

We welcome the First 5 community to participate in an online learning opportunity to gain a deeper knowledge and understanding of REDI and to build skills and confidence in undertaking REDI work. Open to First 5 directors, staff, and Commissioners, this learning series offers three different workshops providing unique onramps to this work from wherever you are in your experience with REDI—as individuals (see #1 Emergent REDI Leadership), as organizations (see #2 REDI Leadership in Organizations), and/or in the community (see #3 REDI Leadership in Communities).

Read the descriptions below to get an idea of the workshop(s) that best meets your interests and date(s) that best accommodates your schedule. **You may participate in more than one workshop,** but as each will be offered once in September and duplicated again in October, **please select no more than one date for each workshop**. All sessions will be held via Zoom and will be interactive.

Registration is required and space is limited to 75 participants for each date.

1.Emergent REDI Leadership
Is a good choice for individuals who (1) want to increase their familiarity with REDI concepts, (2) are in the beginning stages of race equity self-reflection, (3) want to develop a foundational understanding of REDI *and/or* (4) work in FIRST 5 organizations that are at the initial stages of REDI work.
Two date options to choose from:
- Thursday, September 16, 10am-1pm
- Wednesday, October 13, 10am-1pm

2. REDI Leadership in Organizations
Is a good choice for individuals who (1) are familiar with REDI concepts, (2) want to develop a deeper understanding of REDI in their personal and professional lives, (3) are striving to practice REDI in their professional and civic roles; *and/or* (4) work in FIRST 5 organizations that want to embed REDI principles, policies, and practices more deeply.
Two date options to choose from:
- Wednesday, September 22, 10am-1pm
- Tuesday, October 19, 10am-1pm

3. REDI Leadership in Communities
Is a good choice for individuals who (1) are deeply knowledgeable about REDI, (2) are engaged in critical self-reflection about REDI in their personal and professional lives, (3) are consistently and intentionally practicing REDI in their professional and civic roles, (4) work in FIRST 5 organizations with a strong REDI commitment, and (5) want to gain more insight about engaging and empowering communities.
Two date options to choose from:
- Thursday, September 30, 10am-1pm
- Friday, October 29, 10am-1pm

Notes: *Your full participation will require some homework, such as pre-reading. Details will be provided following your registration. We will also ask you to share with us two learning questions you would like to be explored in the session. Finally, we expect all participants to come to these sessions with an open mind, open heart, and willingness to participate and engage.*

Q & A

FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

September 13, 2021

Agenda Item 6.0

Consider appointing the Nominating Committee for 2022 Officers' Election.

2022 NOMINATING COMMITTEE PROCESS AND TIMELINE

SEPTEMBER 13, 2021	The Executive Committee Appoints Nominating Committee Chair and Members
LATE SEPTEMBER TO EARLY OCTOBER 2021	Nominating Committee sends an email to the entire Commission to elicit interest to participate in Executive Committee
OCTOBER – EARLY NOVEMBER 2021	Nominating Committee meets to discuss and approve the nomination of Chair, Vice Chair, and Secretary/Treasurer for 2022
NO LATER THAN NOVEMBER 16, 2021	In accordance with the Bylaws the Nominating Committee sends out the Slate of Officers for election for 2022 to the Commission 2 weeks prior to the voting meeting on December 13, 2021.
DECEMBER 13, 2021	Commission votes and approves the Slate of Officers for Election for 2022.

FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

September 13, 2021

Agenda Item 7.0

Executive Director's Report

Executive Director's Report

COMMISSION MEETING

SEPTEMBER 13, 2021

FIRST 5

Essential Strategies

'20–'23 STRATEGIC PLAN

SYSTEMS DEVELOPMENT

STAKEHOLDER ENGAGEMENT

POLICY ADVOCACY

Internal Updates

- Organizational Study in progress
- Return to the Office Plan and Staffing Updates

County Updates

- Contra Costa Network of Care: Learning Conversations & Advanced TILTs
- Antioch CHANGE Town Hall
- Tax Credits, Stimulus, & Emergency Rental Assistance Outreach
- Measure X and ARPA Update

FIRST 5 CONTRA COSTA
CHILDREN AND FAMILIES COMMISSION

September 13, 2021

Agenda Item 8.0

Communications:

- “The Rules for Participating by Teleconference” received from the Clerk of the Board in a memo dated August 24, 2021.
- Preventing Childhood Toxic Stress: Partnering with Families and Communities to Promote Relational Health, Paper by the American Academy of Pediatrics.

From: Lauren Hull <Lauren.Hull@cob.cccounty.us>
Sent: Tuesday, August 24, 2021 9:27 AM
To: Lauren Hull <Lauren.Hull@cob.cccounty.us>
Cc: Jami Morritt <Jami.Morritt@cob.cccounty.us>
Subject: Upcoming Hybrid Meeting Rules

Good morning Advisory Body Staff Persons,

Given the upcoming requirement to conduct in-person meetings effective October 1, 2021, the Clerk of the Board's Office has received a lot of questions about hybrid meeting options. County Counsel has provided the below guidance and attached rules for hybrid meetings.

Starting October 1, 2021, for hybrid meetings:

a) Bodies must comply with the attached rules. There does not have to be a quorum of Advisory Body members at a single meeting location, just a quorum participating from within the body's geographic jurisdiction.

b) Bodies must allow live public comment at the regular meeting location as well as any teleconference location.

c) Bodies have a variety of options for conducting meetings and taking public comment:
   1) Hold live meetings with only live public comment;
   2) Hold live meetings with live and phone in and/or virtual public comment;
   3) Hold hybrid meetings, with only live public comment at the regular and teleconference locations;
   4) Hold hybrid meetings with live public comment at the regular and teleconference locations and also allow phone in or virtual comment.

d) In any case, agendas must reflect all methods by which the body will take public comment.

If anything changes, I will let you know. Please let me know if you have any questions.

Kind regards,

Lauren Hull
Management Analyst
Contra Costa County Clerk of the Board

1025 Escobar Street, 1st Floor | Martinez, CA 94553
☎ (925) 655-2007 – Direct | (925) 655-2000 – Office
✉ Lauren.Hull@cob.cccounty.us

Rules for Participating by Teleconference- Effective October 1, 2021

The Brown Act permits Advisory Body members to participate in the body's meetings by teleconference, but only when certain legal requirements are met. (Gov. Code, 53953 (b).) If these requirements are not met, then the member calling in cannot be counted as part of the quorum for the meeting, can only listen to the meeting, and cannot discuss any item or vote.

If an Advisory Body member wishes to be able to discuss items and vote by telephone or virtually, then, in addition to the usual agenda posting requirements, the following must occur in advance of the meeting:

1. Quorum Required. Staff to the body, or its chair, must ensure that during the teleconference meeting at least a quorum of the body will participate from locations (teleconference and live) in the body's geographic jurisdiction.

2. Agenda Requirement- all teleconference locations must be listed. Each teleconference location and the regular meeting location must be shown on the agenda for the meeting. In addition, the agenda must provide an opportunity for members of the public to give public comment from each teleconference location, as well as from the live meeting location. So, for example, if a member is participating in a meeting from his or her office, then the location for the meeting shown on the agenda would include both the live meeting address and the individual member's office address. Under these circumstances the member's office is considered a meeting location, and the public would be entitled to attend the meeting at that location.

3. Agenda Requirement - Posting. In addition to the usual agenda posting locations and County website, an agenda must be posted at each teleconference location 96 hours in advance of the meeting. The member participating from his or her office would have to post the agenda at that office 96 hours in advance of the Advisory Body meeting. Agendas must be visible to the public for the entire 96-hour period.

4. Public Participation at Remote Location. Each teleconference location must be open and accessible to members of the public. Thus, if a member's office is a teleconference location, it must be open to the public during the meeting. The member would need to have a speaker phone (or access to an easily visible computer screen if participating virtually) so that the public attending the meeting from the member's office would be able to hear the meeting and to address the Advisory Body directly from the member's office. The chair will need to remember to call for public comment from the regular meeting location and each teleconference location.

5. Roll Call Vote. All votes taken during a teleconference meeting must be by roll call.

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health

Andrew Garner, MD, PhD, FAAP,[a,b] Michael Yogman, MD, FAAP[c,d]
COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS, COUNCIL ON EARLY CHILDHOOD

By focusing on the safe, stable, and nurturing relationships (SSNRs) that buffer adversity and build resilience, pediatric care is on the cusp of a paradigm shift that could reprioritize clinical activities, rewrite research agendas, and realign our collective advocacy. Driving this transformation are advances in developmental sciences as they inform a deeper understanding of how early life experiences, both nurturing and adverse, are biologically embedded and influence outcomes in health, education, and economic stability across the life span. This revised policy statement on childhood toxic stress acknowledges a spectrum of potential adversities and reaffirms the benefits of an ecobiodevelopmental model for understanding the childhood origins of adult-manifested disease and wellness. It also endorses a paradigm shift toward relational health because SSNRs not only buffer childhood adversity when it occurs but also promote the capacities needed to be resilient in the future. To translate this relational health framework into clinical practice, generative research, and public policy, the entire pediatric community needs to adopt a public health approach that builds relational health by partnering with families and communities. This public health approach to relational health needs to be integrated both vertically (by including primary, secondary, and tertiary preventions) and horizontally (by including public service sectors beyond health care). The American Academy of Pediatrics asserts that SSNRs are biological necessities for all children because they mitigate childhood toxic stress responses and proactively build resilience by fostering the adaptive skills needed to cope with future adversity in a healthy manner.

abstract

[a]*Partners in Pediatrics, Westlake, Ohio;* [b]*School of Medicine, Case Western Reserve University, Cleveland, Ohio;* [c]*Cambridge Hospital, Cambridge, Massachusetts; and* [d]*Harvard Medical School, Harvard University, Boston, Massachusetts*

Dr Garner collaborated in conceptualizing and drafting this document, took the lead in reconciling the numerous edits, comments, and suggestions made by many expert reviewers, and made significant contributions to the manuscript; Dr Yogman collaborated in conceptualizing and drafting this document and made significant contributions to the manuscript; and all authors approved the final manuscript as submitted.

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In order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Someone's got to be crazy about that kid. That's number one. First, last and always.

Urie Bronfenbrenner[1]

INTRODUCTION

The term "toxic stress" refers to a wide array of biological changes that occur at the molecular, cellular, and behavioral levels when there is prolonged or significant adversity in the absence of mitigating social-emotional buffers.[2] Whether those adversity-induced changes are considered adaptive and health-promoting or maladaptive and "toxic" depends on the context. For example, in an abusive context, biological changes, such as the methylation of the glucocorticoid receptor gene,[3–5] an increase in the size or activity of the amygdala,[6–8] and a hypersensitivity to potentially threatening cues[9] could be considered adaptive, at least initially, because those changes might promote survival in a threatening environment. But those same biological changes could prove to be maladaptive, toxic, and health harming over time.[10,11]

This toxic stress framework is powerful, because it taps into a rich and increasingly sophisticated literature describing how early childhood experiences are biologically embedded and influence developmental outcomes across the life course.[12–14] This was the focus of the original technical report on toxic stress from the American Academy of Pediatrics (AAP) in 2012.[2] Current threats to child well-being and long-term health, such as widening economic inequities, deeply embedded structural racism, the separation of immigrant children from their parents, and a socially isolating global pandemic, make the toxic stress framework as relevant as ever.

That said, the toxic stress framework is a problem-focused model because it is focused on what happens biologically in the absence of mitigating social and emotional buffers. Conversely, a solution-focused approach would focus on relational health[15] (see the Appendix for a glossary of terms, concepts, and abbreviations) by promoting the safe, stable, and nurturing relationships (SSNRs) that turn off the body's stress machinery in a timely manner.[1,16,17] Even more importantly, a strengths-based, relational health framework leverages those SSNRs to proactively promote the skills needed to respond to future adversity in a healthy, adaptive manner.[16,18,19] The power of relational health is that it not only buffers adversity when it occurs but also proactively promotes future resilience. The toxic stress framework may help to define many of our most intractable problems at a biological level, but a relational health framework helps to define the much-needed solutions at the individual, familial, and community levels (see Table 1).

This revised policy statement on childhood toxic stress builds on the 2012 policy statement[12] and technical report[2] by:

- Acknowledging that a spectrum of adversity exists, from discrete, threatening events (such as abuse, bullying, or disasters) to ongoing, chronic hardships (such as poverty, racism, social isolation, or neglect). These varied adversities share the potential to trigger toxic stress responses and inhibit the formation of SSNRs.
- Reaffirming an ecobiodevelopmental framework[2] because early childhood experiences, both adverse and nurturing, are biologically embedded and influence the development of both disease and wellness later in life.
- Asserting that adults with core life skills are essential, not only to form and maintain SSNRs with children but also to scaffold and develop the basic social and emotional skills that enable children to be resilient and flourish despite adversity. A multigenerational perspective is fundamental.
- Promoting a public health approach that not only prevents, mitigates, and treats toxic stress but, more importantly, proactively promotes, reduces barriers to, and repairs relational health (the capacity to develop and maintain SSNRs with others).
- Emphasizing that the vertical integration of this public health approach or the layering of primary, secondary, and tertiary preventions and/or interventions is necessary because the heterogeneity of responses to adversity seen at the population level will need to be addressed through a menu of programs that are layered and matched to specific levels of individual need (universal preventions, plus targeted interventions for those at risk, plus indicated therapies for those with symptoms or diagnoses).
- Proposing that the public health approach also be integrated horizontally across multiple public service sectors (eg, health care, behavioral health, education, social services, justice, and faith communities) because SSNRs are promoted in safe, stable, and nurturing families that have access to safe, stable, and nurturing communities with a wide range of resources and services.

This policy statement asserts that to move forward (to proactively build

TABLE 1 A Comparison of the Toxic Stress and Relational Health Frameworks

	Toxic Stress	Relational Health
Definition	Toxic stress refers to the biological processes that occur after the extreme or prolonged activation of the body's stress response systems in the absence of SSNRs.	Relational health refers to the capacity to develop and sustain SSNRs, which in turn prevent the extreme or prolonged activation of the body's stress response systems.
Contribution	Toxic stress explains how a wide range of ACEs become biologically embedded and alter life-course trajectories in a negative manner.	Relational health explains how SSNRs buffer adversity and promote the skills needed to be resilient in the future.
Approach to clinical care	Toxic stress is a deficits-based approach because it is focused on the problem: those biological processes triggered by significant adversity in the absence of SSNRs.	Relational health is a strengths-based approach because it is focused on solutions: those individual, family, and community capacities that promote SSNRs, buffer adversity, and build resilience.
Primary preventions in the framework	Primary preventions in the toxic stress framework are focused on how to prevent the wide array of adversities that might precipitate a toxic stress response.	Primary preventions in the relational health framework are focused on how to universally promote the development and maintenance of SSNRs.
Secondary preventions in the framework	Secondary preventions in the toxic stress framework are focused on identifying individuals at high risk for poor outcomes resulting from toxic stress responses by using population-based risk factors (eg, ACE scores) or emerging biomarkers (eg, methylation patterns).	Secondary preventions in the relational health framework are focused on identifying the potential individual, family, and community barriers to SSNRs by developing respectful and caring therapeutic relationships with patients, families, and communities.
Tertiary preventions in the framework	Tertiary preventions in the toxic stress framework are focused on the evidence-based practices that treat toxic stress-related morbidities such as anxiety, depression, oppositional defiant disorder, posttraumatic stress disorder, and substance abuse disorder.	Tertiary preventions in the relational health framework are focused on the evidence-based practices such as ABC, CPP, or PCIT that repair strained relationships and assist them in becoming more safe, stable, and nurturing.
Summary	Toxic stress defines the problem. Toxic stress explains how many of our society's most intractable problems (disparities in health, education, and economic stability) are rooted in our shared biology but divergent experiences and opportunities.	Relational health defines the solution. Relational health explains how the individual, family, and community capacities that support the development and maintenance of SSNRs also buffer adversity and build resilience across the life course.

not only the healthy, happy children of today but also the well-regulated parents and productive citizens of the future) family-centered pediatric medical homes (FCPMHs) (see the Appendix for a detailed description) need to universally promote relational health. SSNRs not only buffer adversity when it occurs but also proactively build the foundational social and emotional skills that lead to resilience in the face of future adversity. Although pediatric and early childhood professionals have long recognized the parent-child relationship as foundational,[20–22] the elemental nature of relational health is not reflected in much of our current training, research, practice, and advocacy. To prevent childhood toxic stress responses and support optimal development across the life span, the promotion of relational health needs to become an integral component of pediatric care and a primary objective for pediatric research and advocacy.

A SPECTRUM OF ADVERSITY

The previous policy statement[12] and technical report[2] on childhood toxic stress noted the 10 adverse childhood experiences (ACEs) studied in the landmark ACEs Study that began in the 1990s: physical, emotional, or sexual abuse; physical or emotional neglect; problematic parental substance misuse; parental mental illness; parental separation or divorce; intimate partner violence; and an incarcerated house member.[23] These adversities are associated with a wide array of negative outcomes in a dose-dependent manner, such that the higher the ACE score (1 point for each category experienced before the age of 18 years), the higher the risk for unhealthy behaviors such as tobacco, alcohol, and other substance use; risky sexual behaviors; and obesity.[23,24] Dose-dependent relationships have also

been found between ACE scores and several of the leading causes of adult morbidity and mortality,[23,24] including cardiovascular disease,[25] lung disease,[26] liver disease,[27] mental illness,[28] and cancer.[29]

These well-established associations between ACEs and poor health outcomes decades later highlight the importance of understanding the biological mechanisms that allow adversity in childhood to "get under the skin" and to negatively impact life-course trajectories.[30–36] As discussed in the 2012 AAP technical report,[2] toxic stress responses, in which the physiologic stress response to adversity is large, chronic, and unmitigated by social-emotional buffers, are one such mechanism. Toxic stress responses are known to alter multiple systems that interact in a reciprocal and dynamic manner: genomic function, brain structure and connectivity, metabolism, neuroendocrine-immune function, the inflammatory cascade, and the microbiome.[13,14] Toxic stress-induced alterations also influence the adoption of maladaptive coping behaviors decades later.[37–40]

Several researchers have noted that many other experiences in childhood are also associated with poor outcomes later in life, and these include being raised in poverty,[41] left homeless,[42–44] exposed to neighborhood violence,[45–47] subjected to racism,[48–50] bullied,[51,52] or punished harshly.[53] This finding suggests that there is a wide spectrum of adversity that runs from discrete, threatening events (such as being abused, bullied, or exposed to disasters or other forms of violence) to ongoing, chronic life conditions (such as exposure to parental mental illness, racism, poverty, neglect, family separation or a placement in foster care, and environmental toxins or air pollution; unrelenting anxiety about a global pandemic, climate change, or deportation; or social rejection because of one's sexual orientation or gender identity). Although children experiencing discrete catastrophic events such as abuse are at a high risk for toxic stress responses, epidemiology suggests that the largest number of children at risk for toxic stress responses are those affected by ongoing chronic life conditions such as neglect.[54,55] This finding suggests that although interventions targeting children with acute threats are needed urgently (eg, efforts preventing physical abuse, child trafficking, and gun violence), those interventions alone will almost certainly miss large segments of the population (eg, those experiencing the threats of parental mental illness, racism, poverty, social isolation) who may also develop toxic stress responses and their associated poor outcomes. To minimize the burden of toxic stress responses at the population level, the entire pediatric community needs to identify and address not only the acute threats to child wellness such as abuse and physical violence but also the ongoing, chronic life conditions such as racism, poverty, and isolation that are rooted in deep-seated social constructs, societal inequities (including those within the health care system), and public policies that inhibit social cohesion, equity, and relational health. Acute threats to childhood wellness such as abuse need to be taken seriously; similar attention should be given to the social inequities and ongoing, chronic life conditions that similarly imperil a child's biological wellness and life-course trajectory.

This wide spectrum of adversity underscores the fact that ACE scores and other epidemiologically derived risk factors at the population level are not valid or reliable predictors of outcomes at the individual level.[56] Toxic stress, by contrast, refers to an individual's physiologic response to these adversities, and biomarkers of this physiologic response have the potential to be more sensitive and specific measures of experienced adversity at the individual level.[37] Validated biomarkers also offer transformational potential as measures of responsiveness to specific interventions.[37,57] With these applications in mind, the pediatric research community is hoping to develop clinic-friendly, noninvasive biomarkers for different forms and degrees of adversity.

Finally, the diverse conditions included in a broader spectrum of adversity make the formation of SSNRs more difficult. Consequently, the challenge is not only to prevent a broad spectrum of adversities from occurring but also to prevent them from becoming barriers to the SSNRs that allow individuals from across the spectrum of adversity to be resilient and flourish despite the adversity.[17,58,59]

An important consideration across many harmed and exploited communities (such as American Indian or Alaska Native populations) is the accumulation of toxic stress responses across generations, sometimes referred to as historical trauma.[60] Although higher levels of historical trauma are associated with poorer health outcomes, the science underlying these associations is only now being studied rigorously.[61] A detailed discussion of historical trauma and the special needs of these communities is beyond the scope of this policy statement, but the layered, integrated public health approaches presented here to prevent childhood toxic stress and promote relational health might inform efforts to address historical trauma as well.

THE ECOBIODEVELOPMENTAL MODEL OF DISEASE AND WELLNESS

Fortunately, adversity in childhood is only half the story, as positive experiences in childhood are associated with improved outcomes later in life. For example, positive relational experiences, such as engaged, responsive caregivers,[59,62–65] shared children's book reading,[66–68] access to quality early childhood education,[69–71] and opportunities for developmentally appropriate play with others[66,72–74] are associated with positive impacts on learning, behavior, and health. Early childhood experiences, both adverse and positive, appear to be biologically embedded and influence both disease and wellness across the life course.[30] The ecobiodevelopmental model of disease and wellness explains how the ongoing but cumulative and reciprocal dance between ecology and biology leads to changes at the molecular (eg, methylation patterns), cellular (eg, brain connectivity patterns), and behavioral levels (eg, tobacco, alcohol, or other substance use).[2,17] These changes are either adaptive or maladaptive depending on the context, and they are either benefits or risks to future health, academic success, and economic productivity.[75]

For example, significant adversity in the last trimester of pregnancy is associated with methylation of the child's glucocorticoid receptor gene.[76] In adults, the methylation of this gene is associated with the expression of fewer glucocorticoid receptors in the brain.[5] Because cortisol downregulates its own production via negative feedback loops in the brain that use glucocorticoid receptors, children with fewer glucocorticoid receptors would be expected to have higher cortisol levels and be more irritable and harder to console.[77] These changes could be considered adaptive and beneficial in the short-term because they might prepare the newborn infant for a stressful world in which the infant may need to be more vocal to have his or her needs met. But these same changes could be considered maladaptive over time because the higher cortisol levels could impair learning, and the infant's irritability could impair the formation of a strong parental bond with the infant. Conversely, early supports that allow new mothers more opportunities to bond with, breastfeed, and simply stroke their children are associated with decreases in the methylation of the glucocorticoid receptor gene, perhaps allowing infants to downregulate their stress responses more effectively.[78,79] This finding is one of the most significant predictions of the ecobiodevelopmental model: the biological mechanisms that underlie the embedding of significant childhood adversity may also underlie the embedding of positive relational experiences in childhood. The challenge, then, is not only to prevent adversity but also (for mothers, fathers, and other engaged adults) to actively promote positive relational experiences throughout infancy and childhood.

COMPONENTS OF A PUBLIC HEALTH APPROACH TO TOXIC STRESS

The ecobiodevelopmental model suggests that, to improve the likelihood of positive developmental outcomes across the life span, efforts should be made to improve the salient features of the child's environment. Changing all of the potentially salient features of a child's environment cannot be reduced to a single intervention or program, so there will be no singular panacea when it comes to addressing childhood toxic stress responses. Rather, an integrated public health approach (see Fig 1) is needed to support all children, including those with delays in development and special health care needs.[80–82] The foundation for any public health approach is universal primary prevention. In the case of toxic stress responses, universal primary prevention means trying to prevent the precipitants of toxic stress responses (eg, advocating to address the spectrum of adversities discussed above) as well as promote healthy, adaptive responses to adversity through the provision of social supports that nurture the development of foundational resilience skills (such as task persistence, curiosity, and self-regulation).[16,19,59,83]

For children at higher risk for toxic stress responses, targeted secondary interventions with tiered services (eg, HealthySteps[84,85]) may be needed. Children with known adversity but no overt symptoms,[18] children with parents who experienced significant adversity as a child,[86] and families struggling with the social determinants of health (SDoHs) (eg, poverty leading to food or housing insecurity,[87,88] language barriers, or acculturation leading to conflicts within immigrant families[89]) may benefit from an array of interventions that mitigate specific risk factors. For example, the AAP currently recommends screening parents for postpartum depression[90] and food insecurity.[87,88] Similarly, when clinical markers for an individual child's biological sensitivity to context[91–94] (see the Appendix for a glossary of terms, concepts, and abbreviations) are available, children of high (versus low) sensitivity may also benefit from different types of interventions.[95] In concordance with a layered public health approach, these various targeted interventions will

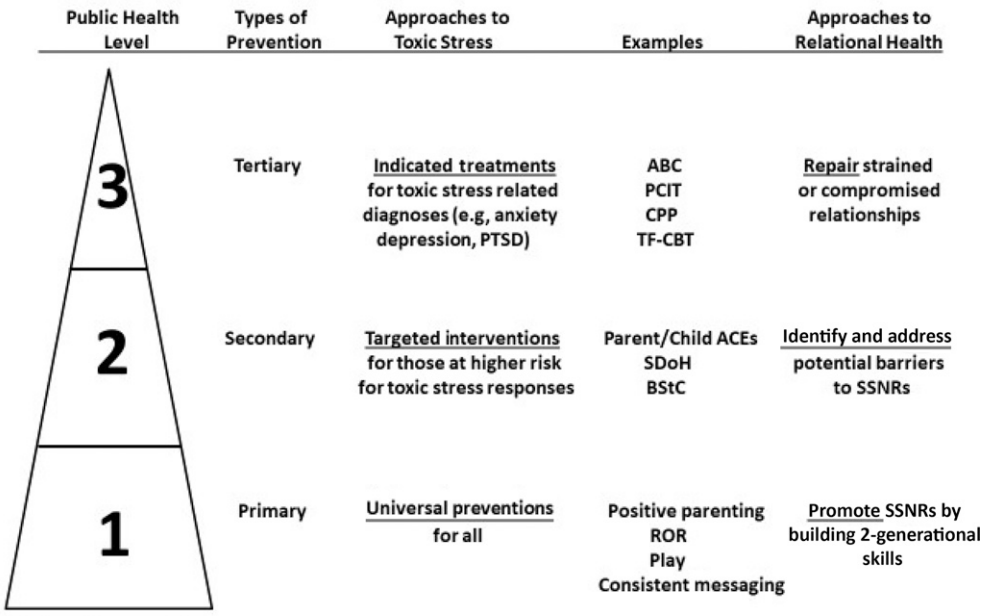

FIGURE 1 A public health approach to prevent childhood toxic stress is a public health approach to promote relational health. Many of the components of a public health approach to prevent, mitigate, and treat toxic stress responses (see examples) are also components of a public health approach to promote, identify barriers to, and repair SSNRs. The examples provided are illustrative and not intended to be comprehensive or exhaustive. See the Appendix for full descriptions of the abbreviations. BStC, biological sensitivity to context; PTSD, posttraumatic stress disorder. Adapted with permission from Garner AS, Saul RA. Thinking Developmentally: Nurturing Wellness in Childhood to Promote Lifelong Health. Itasca, IL: American Academy of Pediatrics; 2018

supplement but not replace the universal primary preventions.

For children who are symptomatic or meet criteria for toxic stress-related diagnoses (eg, anxiety, oppositional defiant disorder, or posttraumatic stress), indicated, evidence-based therapies are needed. For younger children, these therapies may include attachment and biobehavioral catch-up (ABC),[96–98] parent-child interaction therapy (PCIT),[99–102] and child-parent psychotherapy (CPP).[103–105] For older children, trauma-focused cognitive-behavioral therapy (TF-CBT) may be beneficial.[106,107] The effectiveness of these evidence-based therapies may be reduced if targeted interventions are not used to address emerging areas of risk or if universal primary preventions are not applied as well.[59,108] A layered public health approach mirrors the concept of proportionate universalism (see the Appendix for a glossary of terms, concepts, and abbreviations), in which the delivery of universal services is at a scale and intensity that is proportionate to the degree of need.[109–112] For example, if access to healthy foods is a universal objective, a proportionate response would recognize that some families may only need education about which foods are healthy, whereas some may need education about healthy foods and additional financial resources to purchase those healthy foods, and still others may require education about healthy foods, additional financial resources, and access and/or transportation to stores that sell healthy foods.

THE EMERGING SCIENCE OF RELATIONAL HEALTH

The concept of childhood toxic stress taps into a rich literature on the biology of adversity and explains the danger in overlooking significant adversity in childhood. To move forward (to proactively build healthy, resilient children), the pediatric community needs to embrace the concept of relational health.[15] Relational health refers to the ability to form and maintain SSNRs, as these are potent antidotes for childhood adversity and toxic stress responses.[57,113] Not only do SSNRs buffer adversity and turn potentially toxic stress responses into tolerable or positive responses, but they are also the primary vehicle for building the foundational resilience skills that allow children to cope with future adversity in an adaptive, healthy manner.[16,17] These findings highlight the need for multigenerational approaches that support parents and adults as they, in turn, provide the SSNRs that all children need to flourish.

Developmental science is only beginning to understand the way relational health buffers adversity and builds resilience, but emerging data suggest that responsive interactions between children and engaged, attuned adults are

paramount.[1,16,114,115] Not only are infants programmed to connect socially and emotionally with adult caregivers,[116] but the brains of parents of newborn infants appear to be reprogrammed to connect with their infants.[117] Imaging studies of new parents demonstrate changes in several major brain circuits, including a reward circuit, social information circuit, and emotional regulation circuit.[117,118] The reward circuit includes the striatum, ventral tegmental area, anterior cingulated cortex, and prefrontal cortex, where dopamine and rising levels of oxytocin interact to make social interactions more rewarding, thereby encouraging more parental engagement in infant care.[118,119] The social information circuit includes structures such as the anterior insula, inferior frontal gyrus, superior temporal gyrus, and supplemental motor area, which support internal representations of what others may be experiencing and more empathic responses to infant behaviors.[118,119] Finally, the emotional regulation circuit includes the amygdala, superior temporal sulcus, temporoparietal junction, and prefrontal cortex, which promote social cognition and a downregulation of the stress response.[118,119] The convergent conclusion from these preliminary imaging studies of the parental brain is clear: much like the infant brain, the parental brain is programmed to connect.

Recent research suggests that this dyadic need to connect promotes the development of biobehavioral synchrony between parents and infants.[119,120] Feldman[119] states, "Such coordination is observed across four systems: the matching of nonverbal behavior; the coupling of heart rhythms and autonomic function; the coordination of hormone release [eg, oxytocin following contact with both mothers and fathers]; and brain to brain synchrony [eg, coordinated brain oscillation in alpha and gamma rhythms]." Because the human brain is so immature at birth, the infant is dependent on this biobehavioral synchrony not only for survival but also for laying the foundation for future self-regulation and social-emotional skills. One expert has written that "this synchronous biobehavioral matrix builds the child's lifelong capacity for intimacy, socio-affective skills, adaptation to the social group, and the ability to use social relationships to manage stress."[117] Early relational experiences with engaged and attuned adults have a profound influence on early brain and child development.

LINKS BETWEEN RELATIONAL HEALTH AND RESILIENCE

The importance of engaged and attuned adults does not end in the newborn period. In fact, there is increasing evidence that strong social-emotional supports, such as high family resilience and connection and the provision of positive childhood relational experiences, are associated with children who are resilient and flourish despite their level of adversity.[59,121] This finding has renewed interest in defining the critical elements that children, families, and communities need to thrive despite adversity.[18,19,65,122–124] Resilience, for example, is now understood to be the manifestation of capacities, resources, or skills that allow some children, families, and communities to respond to adversity in a healthy, adaptive manner.[16,83,124] At the child level, foundational capabilities (such as social skills, emotional regulation, language, and executive functions like impulse inhibition, working memory, cognitive flexibility, abstract thought, planning, and problem solving) are the building blocks of resilience and need to be modeled, taught, learned, practiced, reinforced, and celebrated.[16] A recent literature review identified 5 modifiable resilience factors relevant to clinical pediatric care: (1) "addressing maternal mental health problems"; (2) "encouraging responsive, nurturing parenting"; (3) "building positive appraisal styles and executive function skills"; (4) "teaching children self-care skills and routines"; and (5) "using trauma-focused interventions and educating families about trauma."[83] The emphasis on building new skills underscores the AAP's concern that excessive screen time might limit opportunities to develop more adaptive and generalizable skills.[125]

Flourishing despite adversity is another construct that has been studied. Three indicators of flourishing are amenable to parental report and are rough markers of executive function: (1) "the child shows interest and curiosity in learning new things," (2) "the child works to finish tasks he or she starts," and (3) "the child stays calm and in control when faced with a challenge."[59] In analyses of data from the 2016–2017 National Survey of Children's Health, "the prevalence of flourishing children increased in a graded fashion with increasing levels of family resilience and connection."[59] In fact, a higher percentage of children with high adversity (ACE scores 4–9) but high family connection and resilience were flourishing (30.5%) than children with low adversity (ACE score of 0) but low family resilience and connection (26.8%).[59] Approaches to minimizing toxic stress that only look at measures of adversity (such as ACE scores or biomarkers) will miss out on opportunities to support the relational health that promotes

flourishing despite adversity. Measures of both resilience and "flourishing despite adversity" suggest that much more can be done to build the SSNRs and overall relational health that buffers adversity and builds both the skills and contexts necessary for children to thrive. The Healthy Outcomes From Positive Experiences framework promotes relational health through positive childhood experiences, such as "being in nurturing, supportive relationships; living, developing, playing, and learning in safe, stable, protective, and equitable environments; having opportunities for constructive social engagement and connectedness; and learning social and emotional competencies."[126,127]

A PUBLIC HEALTH APPROACH TO BUILD RELATIONAL HEALTH

Applying a public health approach to the promotion of relational health (see Fig 1) reveals that many of the universal primary preventions for toxic stress are also effective means of promoting the development of SSNRs (eg, positive parenting styles, developmentally appropriate play with others,[66,73,74,128] and shared reading[129,130]). Similarly, many of the risk factors for toxic stress responses that are the targets of secondary interventions are also potential barriers to the development of SSNRs that need to be identified and addressed (eg, child ACE scores, parent ACE scores, SDoHs, or even a strong biological sensitivity to context). Finally, many of the indicated treatments for children who are symptomatic as a result of toxic stress are programs that focus on repairing strained or compromised relationships (eg, ABC, PCIT, CPP, and TF-CBT). In short, a public health approach to prevent childhood toxic stress is a public health approach to promote relational health.

Vertical Integration to Match Levels of Need With Specific Interventions

Emerging data supporting a biological sensitivity to context (see the Appendix for a glossary of terms, concepts, and abbreviations) begin to explain heterogeneous responses to both adversity and interventions at the population level.[92,131–136] Consequently, there is an urgent need for a battery of biological, behavioral, and contextual markers that might better stratify both the risks and predicted responsiveness to interventions at the individual level.[37] FCPMHs (see the Appendix for a detailed description) are well placed to begin matching levels of need with specific types of interventions, a process known as vertical integration.[82]

Public health approaches are vertically integrated when they are founded on universal primary preventions (eg, promoting family resilience and connection and positive childhood experiences), with tiered, targeted interventions (eg, addressing SDoHs) and indicated treatments (eg, PCIT) being layered on this foundation, depending on the specific needs of the particular child, family, or community. This emphasis on universal primary preventions is congruent with the fact that more children are mentally and socially well and flourish as adults, regardless of their level of childhood adversity, if they also are afforded positive relational experiences and high family resilience and connection during childhood.[59,121] Relational health includes more than "nurturing" in its traditional, spoken sense (eg, verbal warmth or responsivity); it also includes the activities that support the relationship more broadly (eg, reading aloud and a prescription to play), and research has documented that nurturing words and actions are inextricably linked.[137] Although there are both practice-based (eg, Reach Out and Read [ROR],[129,138,139] the Video Interaction Project [VIP],[66,72] HealthySteps[84,85]) and community-based programs (eg, positive parenting programs,[140,141] home visiting programs,[142,143] quality early child care settings[69,71]) that promote these early positive relational experiences, they are not funded at levels that would make them universally accessible. More importantly, they are rarely integrated vertically with other programs that layer on additional efforts to address barriers to relational health (eg, SDoHs) or already strained or compromised relationships (eg, PCIT) when needed. A vertically integrated public health approach acknowledges that universal primary preventions are absolutely necessary yet insufficient to promote relational health.

For children deemed to be at high risk for toxic stress responses, potential barriers to relational health need to be identified and addressed through team-based care[144] and collaborative community partnerships (eg, food banks,[145,146] medical-legal partnerships[147]). These additional interventions are supplemental to and do not replace universal primary preventions. Similarly, symptomatic children need to be referred to evidence-based treatment programs (eg, ABC, PCIT, CPP, TF-CBT), but these are supplemental to and do not replace either targeted interventions for potential barriers to SSNRs or the aforementioned universal primary preventions. Efforts to repair strained or compromised relationships are likely to be more effective if other potential barriers to SSNRs are being addressed (eg, parental mental illness and basic needs) and additional efforts are being made to actively promote

SSNRs (eg, the provision of developmentally appropriate play).

Horizontal Integration Across Sectors at the Community Level

A public health approach to promoting relational health should also be integrated horizontally (or across sectors) at the local level.[81,82,148] SSNRs are easier to form when safe, stable, and nurturing families are able to live in safe, stable, and nurturing communities.[124,149,150] The FCPMH is ideally placed to educate families about what a safe, stable, and nurturing family environment looks like for a child, but doing so will require changes at the provider and practice levels (see Table 2). However, FCPMHs are also called to advocate for policies at the federal, state, and local levels that promote safe, stable, and nurturing communities. In doing so, FCPMHs become the anchor for "medical neighborhoods,"[149] in which community resources across multiple sectors (eg, health, education, justice, social services, faith communities, and businesses) collaborate not only to address barriers to SSNRs (such as home visiting programs,[142] HealthySteps,[150,151] medical-legal partnerships,[147] coordinated responses to disasters,[152,153] and efforts to promote access to healthy foods, safe housing, potable water, and clean air) but also to advocate for public policies (such as paid parental leave,[154,155] income support,[87,88] restorative justice,[156–158] and implementation of the Family First Prevention Services Act) that intentionally and actively foster SSNRs (Table 2).[149,159–161]

THE CENTRALITY OF RELATIONSHIPS IN PEDIATRIC CARE

A public health approach to relational health is built on the SSNRs that buffer adversity and build resilience. Such an approach will require pediatricians, other pediatric health care professionals, and FCPMHs in general to partner with families and communities in practical and innovative ways to universally promote SSNRs, address potential barriers to SSNRs in a targeted manner, and afford indicated treatments that repair relationships that have been strained or compromised (see Table 2). But underlying this approach are 2 fundamental assumptions. The first is that pediatric providers will have the financial supports needed to expand their capacity for developing respectful, continuous, trusted, and nurturing relationships with both the patients and caregivers of the patients who they serve. Without strong therapeutic alliances with patients, caregivers, and families, few of the recommended universal primary preventions will be implemented, few of the targeted interventions will be used, and few of the indicated treatments will be sought. To promote SSNRs at the practice level, both financial incentives (eg, payment reforms) and enhanced training needs to be provided.[162,163] Pediatric providers should be afforded the following: (1) sufficient time with patients and families, (2) the benefit of long-term continuity with patients and families, and (3) opportunities to learn about and practice the interpersonal and communication skills needed to form respectful, trusted, and collaborative therapeutic relationships.[162] For parents to trust, pediatric providers need to listen and understand parental concerns and beliefs before making recommendations. Communication could be further enhanced by cultural humility,[164,165] implicit bias training,[166–171] a more diverse health care team (eg, providing families and patients the opportunity to seeing themselves reflected in the sex, ethnicity, and cultural backgrounds of the team members), and access to professional interpreters. In the end, the ability of the FCPMH to leverage change within the family context is entirely dependent on the capacity of the pediatric providers to form strong therapeutic relationships with the patients, caregivers, and families.

The second assumption is that the FCPMH will have the capacity to form working relationships with a wide array of community partners. The FCPMH alone cannot leverage significant change within the community context. Changing community contexts will require healthy, trusting, and robust partnerships with a wide array of local community partners from multiple sectors (education, social services, and businesses), not only to facilitate family access to the requisite community interventions but also to coordinate effective advocacy campaigns to secure both those interventions and family-friendly public policies. Simply put, successfully implementing a public health approach that prevents childhood toxic stress and promotes SSNRs will require FCPMHs to put relational health at the center of everything they do.[172]

ACKNOWLEDGING THE ROLE AND TOLL OF SOCIAL ISOLATION

There is an emerging evidence base that social isolation is on the rise and detrimental to both individual[173] and community health.[174] Social scientists have documented the fragmentation of society at the community level[175] as well as its negative impact on how communities view their collective stewardship of their most treasured resource: their children.[176] Psychologists have decried a "crisis of connection" and point to a culture that values the self over relationships and individual

TABLE 2 Implementing a Public Health Approach to Relational Health Will Require Changes at the Provider, Practice, and Community Levels, as Well as Horizontal Integration Across Sectors

Types of Prevention	Approaches to Relational Health	Examples at the Provider Level	Examples at the Practice Level	Examples at the Community Level
Tertiary	Repair strained or compromised relationships	Build the therapeutic alliance; employ a common-factors approach; explain behavioral responses to stress; endorse referral resources.	Colocate counseling services (warm handoffs); facilitate, track, and follow-up on referrals offered.	Embrace restorative justice and social inclusion (over punitive measures and exclusion).
Secondary	Identify and address potential barriers to SSNRs	Build the therapeutic alliance; surveil for possible barriers to SSNRs; champion screening at practice level; endorse referral resources.	Universal screening for prevalent barriers seen in that practice; facilitate, track, and follow-up on referrals offered.	Identify and address sources of inequity, isolation, and social discord (poverty and racism).
Primary	Promote SSNRs by building 2-generational relational skills	Build the therapeutic alliance; promote positive parenting; encourage developmentally appropriate play.	Provide or support positive parenting classes; participate in ROR, VIP, and other programs that support the dyad.	Implement home visiting; support extended family medical leave.

See the Appendix for full descriptions of the abbreviations.

successes over the general welfare, leading to declining levels of empathy and trust.[177] Epidemiologists have demonstrated that an individual's degree of social isolation is a powerful predictor of mortality, much like traditional clinical risk factors (eg, obesity or hypertension) or ACE scores.[178] Both epidemiologists and economists have pointed to increasing levels of inequity as correlating with poorer levels of overall health for both the impoverished and the wealthy.[174] Finally, physiologists have long known that social deprivation in childhood alters the programming of the body's stress response.[179,180]

Taken together, these diverse lines of inquiry suggest that it may not actually be the wide spectrum of childhood adversity that drives poor outcomes but the degree to which that adversity drives shame, guilt, anger, alienation, disenfranchisement, and degree of social isolation.[181,182] If so, the proposed public health approach toward the promotion of SSNRs is needed, not only to buffer adversity and promote resilience but also to begin bridging political, religious, economic, geographic, identity-based, and ideological divides that increase social isolation, encourage tribalism, diminish empathy, and, ultimately, drive poor outcomes in the medical, educational, social service, and justice systems.

For many resource-poor families and older children, overall relational health is dependent not only on dyadic serve and return interactions with family members but also on trusted, SSNRs with others in the community through interactions at the medical clinic, school, recreation leagues, faith-based and civic organizations, community improvement efforts, and employment opportunities. Along

these lines, the Aspen Institute has created the Social Fabric Project to incentivize local projects that prioritize the building of relationships and community connections over a focus on self-absorption and hyperindividualism.[183] Similarly, more attention could be given to the built environment and need for public green spaces, such as parks, to promote social cohesion and a sense of community belonging.[184,185]

Finally, it should be noted that public health mandates to maintain "social distancing" during the coronavirus pandemic actually refer to physical distancing and are not intended to further isolate, alienate, or disenfranchise already vulnerable populations. If nothing else, pandemic-mandated stay-at-home orders should increase our collective awareness of the distress associated with being socially isolated or vulnerable. The coronavirus pandemic has highlighted the urgent need to provide all children with the SSNRs that buffer unexpected adversities and build the skills necessary to be resilient.

A RENEWED COMMITMENT TO SCIENCE-BASED POLICY FORMATION

In the decade since the first AAP policy statement and technical report on childhood toxic stress were published, even more evidence has accumulated that:

1. "What happens in childhood does not stay in childhood."[186,187] Adverse experiences in childhood are not destiny, but for many children, significant adversity bends life-course trajectories for the worse.
2. In the absence of SSNRs, many different forms of childhood adversity (from catastrophic episodes of abuse or violence to chronic conditions, such as exposure to racism, poverty, and/or neglect) can lead to toxic stress responses that result in changes at the molecular, cellular, and behavioral levels and negatively impact outcomes in health, education, and economic productivity.
3. Individual variation in biological sensitivity to context (see the Appendix for a glossary of terms, concepts, and abbreviations) contributes to heterogeneity in both responses to adversity and responses to interventions. This has important implications for how we nurture and fulfill the potential of all children, not just those who are relatively less sensitive to their contexts and appear to be relatively more resilient despite adversity.
4. In the presence of SSNRs, a limited degree of childhood adversity (eg, normative childhood frustrations and setbacks) can lead to the positive stress responses that build the rudiments of resilience: a set of social and emotional skills that allow children to adapt to future adversity in a healthy manner.
5. Relational health, in the form of at least one SSNR, is a universal, biological imperative for children to fulfill their potential; to be healthy and resilient; to be successful academically, economically, and socially; and, perhaps most importantly, to be the caregivers that value and build SSNRs with subsequent generations.

Society is currently trending toward division, marginalization, alienation, and social isolation.[177] In opposing this trend and calling for a public health approach that builds SSNRs, the AAP is working to translate the latest developmental science into practices and public policies (see Table 2) that build healthy, resilient children. With almost a century of service to children, families, and communities, the field of pediatrics has made critical contributions at the interface of science and public policy. Be it child labor laws, federal grants to states to promote maternal-child health, support for paid parental leave after childbirth, required immunizations to attend school, the use of car safety seats, the adoption of children by same-sex parents, the harms of corporal punishment, the safe storage of firearms, the care of immigrant children in federal custody, the negative effect of toxins and global warming on child health, or the importance of nutrition and income support for healthy families, pediatric professionals have been a powerful force for bringing a scientifically grounded, evidence-based perspective to public debates. The AAP remains committed to respond when empirical evidence and the latest developmental science shine new light on the issues and trends of the day. Simply put, public policies, social constructs, and societal norms that divide, marginalize, alienate, and isolate are clear threats to the well-being of all children. The commitment of the AAP to the well-being of all children requires that it not only address a wide spectrum of adversities but, also, that it speak against public policies, social constructs, and societal norms that perpetuate the ongoing, chronic precipitants of toxic stress responses such as poverty[87,88] and racism[166] and for public policies that promote relational health, inclusion, and equity.[111,188–191]

APPLICATION OF SCIENCE-BASED PRINCIPLES TO STRENGTHEN PEDIATRIC PRACTICE

Drawing on a framework produced by the Center on the Developing Child at Harvard University,[192] this policy statement highlights the following 3 science-informed principles to prevent toxic stress

responses and to build healthy, resilient children.

Support Nurturing Relationships

Of the 3 principles, this is the one that aligns most clearly with the core functions of the FCPMH and is, therefore, the primary focus of this policy statement. The use of trusted, supportive relationships within the FCPMH to promote the relational health of families is an emerging focal point for pediatric clinical research, and pediatric primary care is increasingly seen as a venue for fostering social-emotional health.[193,194] These universal primary prevention strategies form the base of the public health pyramid (Fig 1 and Table 2), but additional, layered interventions that recognize and address child-level (eg, delays in development and a biological sensitivity to context), family-level (eg, poverty and parent mental illness), and community-level (eg, racism and violence) barriers to SSNRs may also be required for some families, whereas others will need even more intensive, evidence-based treatments (eg, ABC, PCIT, CPP, TF-CBT) to repair relationships that are already strained or compromised. The buffering and skill-building roles of responsive relationships are biologically embedded, and they are essential promoters of healthy development.[59] Existing AAP reports on managing perinatal depression,[90] supporting grieving children,[195] fostering male caregiver engagement,[196] partnering with home visiting programs,[142] encouraging developmentally appropriate play,[74,197] discouraging screen time,[125] and promoting shared-book reading[67,68] include additional recommendations on ways primary care pediatricians might promote SSNRs.

Reduce External Sources of Stress on Families

This principle points to the potential benefits of addressing stressors from across the spectrum of adversity, including those that might have been considered well beyond the scope of traditional pediatric practice in the past. Poverty, food insecurity, housing insecurity, racism, community violence, discrimination, alienation, disenfranchisement, and social isolation are examples that impose significant hardships on families and become potential barriers to developing SSNRs. FCPMHs could work to reduce these barriers by partnering with their AAP chapter, local organizations (such as schools, businesses, and faith-based organizations), and other community assets (including parents, extended family, child care providers, community health workers, and patients) to form medical neighborhoods[149,159,161] that work collaboratively to address the SDoHs while also advocating for policies that support safe, stable, and nurturing families and communities. For example, expanding family leave policies[154] could reduce family stress and promote positive childhood experiences. Similarly, advocating for a Health in All Policies approach could advance health equity and minimize family and community distress by addressing the underlying economic inequities.[198–200] The commitment of the AAP to decreasing family stress is manifest in many of its official statements, including poverty,[87,88] racism,[166] maternal depression,[90] disasters,[152,153] father engagement,[196] home visiting,[142] and the importance of play.[74,197]

Strengthening Core Life Skills

The strengthening of core life skills (eg, executive function and self-regulation) is needed for families and communities to provide well-regulated, nurturing environments. Although intensive, capacity-building efforts for parents and other caregivers with limited executive function skills is beyond the scope of most pediatric settings, providing information and support around basic child-rearing practices and establishing daily routines is a cornerstone of traditional primary care. Caregivers with core life skills are essential for the development of executive function and self-regulation skills in their children. The guidelines on parent education and support in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (4th edition) is a starting point for all families,[201] but there is a need to provide more effective, individualized, evidence-based parenting supports (eg, ROR, HealthySteps, VIP) beyond simply providing information about child development. Integrated behavioral health services as part of the FCPMH team might be the next layer for parents who need additional assistance (eg, parental depression), and the need for more intensive skill building (eg, PCIT) for some parents becomes yet another focus for collaboration with key services within the community (eg, ABC, PCIT, CPP, and TF-CBT). Understanding, practicing, and reinforcing executive functions and self-regulation skills (eg, managing strong emotions, ensuring adequate sleep, and getting regular exercise) is essential because all caregivers need these skills to create the kinds of environments in which children thrive.[16,37,59] Whether an adult coaching or skill-building component is incorporated within a FCPMH or connected to it in a collaborative manner, the essential role that these programs play in promoting the healthy development of children is clear, especially for those who are the most disadvantaged.[1,16]

Realizing the full impact of these principles within primary care practice, however, will also require fundamental changes in medical education and payment models. To usher in these fundamental reforms, more pediatricians will need to assume leadership positions outside the realm of clinical care.[202,203] In addition, pediatric training programs will need to educate residents about the ecobiodevelopmental model, train them on how to develop strong therapeutic relationships with parents and caregivers, teach them how to model nurturing and affirming interactions with children of all ages, train them how to encourage caregivers to have positive relational experiences with children of all ages, prepare them to work as part of interdisciplinary teams[144,150] (eg, integrated with behavioral health and social service professionals), educate them on how to develop collaborative partnerships with community referral resources, and encourage them to become vocal advocates for public policies that promote safe, stable, and nurturing families and communities.

Foremost on the advocacy agenda will be the need for serious payment reforms that consider the complexity of care attributable to adverse family and community contexts and include financial supports that incentivize families to engage with an FCPMH.[204] Payment reforms need to be sufficient to allow FCPMHs to spend more time with families, function as interdisciplinary teams, integrate into their community's initiatives and services to support children and families (horizontal integration), and anchor medical neighborhoods that not only foster wellness in childhood but promote positive outcomes across the life span.

SUMMARY AND RECOMMENDATIONS

Preventing childhood toxic stress responses, promoting resilience, and optimizing development will require that all children be afforded the SSNRs that buffer a wide range of adversities and build the foundational skills needed to cope with future adversity in an adaptive, health-promoting manner. The 3 principles described above, each of which is grounded in the research literature, provide a science-based framework for developing innovative strategies to promote SSNRs at the dyadic level, family level, and community level. Translating these principles into pediatric practice will require FCPMHs to:

1. Understand the toxic stress framework, which explains how many of our society's most intractable problems, such as disparities in health, education, and economic stability, are rooted in our shared biology but divergent experiences and opportunities (see Table 1).
2. Understand the relational health framework, which explains how the individual, family, and community capacities that support the development and maintenance of SSNRs also buffer adversity and build resilience across the life course (see Table 1).
3. Foster strong, trusted, respectful, and supportive relationships with patients and their families to encourage the acceptance of individualized prevention, intervention, and treatment strategies. Doing so will require all health professionals to address their implicit biases, develop cultural humility, and provide culturally competent recommendations.
4. Foster strong, trusted, respectful, and effective collaborations with the community partners who are well-positioned to provide the individualized prevention, intervention, and treatment strategies.
5. Acknowledge that a wide range of adversities, from discrete, threatening events to ongoing, chronic life conditions, share the potential to trigger toxic stress responses and inhibit the formation of SSNRs.
6. Embrace an ecobiodevelopmental model for understanding how both adverse and positive relational experiences in childhood become biologically embedded and impact both negative and positive outcomes across the life course.
7. Move beyond singular, panacea programs toward a layering of interventions that are integrated, both vertically and horizontally, into the local public health efforts to promote safe, stable, and nurturing communities, families, and relationships.
8. Employ a vertically integrated public health approach to promote relational health that is founded on universal primary preventions (such as positive parenting programs, ROR, and developmentally appropriate play) but also offers more precise screening for relational health barriers (such as maternal depression, food insecurity, or exposure to racism) as well as indicated treatments to repair strained or compromised relationships (such as ABC, CPP, PCIT, and TF-CBT).
9. Become hubs for medical neighborhoods, horizontally integrating a wide array of local efforts and early childhood initiatives that not only support families with resources and programs but also advocate for

the public policies that promote safe, stable, and nurturing families and communities.

10. Advocate that health systems, payers, and policy makers at all levels of government align incentives and provide funding to promote the universal primary prevention work discussed in this policy statement. FCPMHs are well-suited and even inclined to support the formation and maintenance of SSNRs as outlined in this policy statement, but they are not currently funded to do so.[205]

Finally, to develop the physician leadership for the FCPMHs of the future, pediatric training programs will need to:

1. Educate residents about the ecobiodevelopmental model and the implications for not only health care but education, juvenile justice, and public policy.
2. Provide longitudinal experiences that train residents on how to develop strong, trusted, respectful, and supportive relationships with parents and caregivers. Doing so will require all trainees to address their implicit biases, develop cultural humility, and provide culturally competent recommendations.
3. Teach residents how to identify and develop collaborative relationships with the local referral resources and early childhood initiatives in their communities.
4. Prepare residents to work as part of the interdisciplinary teams[144] that transform FCPMHs into hubs for medical neighborhoods.[161]
5. Educate residents about the many different facets of a fractured early childhood system of care (eg, Medicaid, Individuals with Disabilities Education Act Parts C and B, Child Care and Development Block Grants, Head Start, etc), as there is little collaboration or communication between the systems, funders, and programs that address child health, out-of-home child care, education, special education, protective services, or public health. Trainees need to understand all of these many facets so they are prepared to be effective advocates for their patients and families.
6. Encourage them to become leaders in interdisciplinary early childhood systems work and vocal advocates for public policies that promote positive relational experiences in safe, stable, and nurturing families and communities.

APPENDIX

Glossary of Terms, Concepts, and Abbreviations

ABC

Acronym for Attachment and Biobehavioral Catch-up; ABC is an evidence-based program of interventions to assist foster parents in nurturing children who have experienced disruptions in care.

ACEs

Acronym for adverse childhood experiences. In the original ACE Study, 10 categories of adversity were examined: emotional, physical, and sexual abuse; 5 measures of household dysfunction, including the mother being treated violently (intimate partner violence), household substance abuse, household mental illness, parental separation or divorce, and incarcerated household member; and emotional or physical neglect. Other investigators have applied the term ACEs to additional adversities known to affect child health, such as poverty, neighborhood violence, and exposure to racism. Although this term is frequently used to refer to the child's experiences (child ACEs), it has also been applied to the adversities that parents experienced during their own childhoods (parental ACEs).

ACE Score

The ACE score is the sum of the 10 original categories of ACEs experienced before the 18th birthday. To determine an individual's ACE score, see http://acestoohigh.com/got-your-ace-score.

Biobehavioral Synchrony

Biobehavioral synchrony refers to the matching of nonverbal behaviors (eg, eye contact), coupling autonomic functions (eg, heart rate), coordination of hormone release (eg, oxytocin), and alignment of brainwaves between a parent and an infant.

Biological Sensitivity to Context

Biological sensitivity to context is a theory with emerging evidence "that children differ in their susceptibility to environmental influence in a 'for better and for worse' manner, depending on their psychobiologic reactivity to stress." As a consequence, "the very characteristics that are often thought of as children's frailties (eg, high stress reactivity) can also be their strengths, given the right context."*,[91,131,134,206]

Common-Factors Approach

The common factors are communication skills that help to build a therapeutic alliance (the bond felt between the clinician and

**The quoted material in this entry is from Ellis BJ. Biological Sensitivity to Context/Adaptive Calibration Model. University of Utah, Department of Psychology, College of Social & Behavioral Science. Available at: https://psych.utah.edu/research/labs/biological-sensitivity.php.*

patient and/or family, a powerful factor in facilitating emotional and psychological healing), which, in turn, increases the patient and/or family's optimism, feelings of well-being, and willingness to work toward improved health. Other common-factors techniques target feelings of anger, ambivalence, and hopelessness, family conflicts, and barriers to behavior change and help seeking. Still other techniques keep the discussion focused, practical, and organized. These techniques come from family therapy, cognitive therapy, motivational interviewing, family engagement, family-focused pediatrics, and solution-focused therapy. They have been proven useful and effective in addressing mental health symptoms in pediatrics across the age spectrum (as per the AAP policy statement on mental health competencies in pediatric care).

CPP

Acronym for child-parent psychotherapy; CPP is an evidence-based, psychoanalytic approach for treating dysfunctional parent-child relationships based on the theory that the parent has unresolved conflicts with previous relationships.

Ecobiodevelopmental

The ecobiodevelopmental framework asserts that the ecology becomes biologically embedded, and there is an ongoing but cumulative dance between the ecology and the biology that drives development over the life span.

Executive Functions

Executive functions are the cognitive skills needed to control behavior and attain goals. Executive functions are core life skills, and they include capacities like impulse inhibition, working memory, cognitive flexibility, abstract thought, planning, and problem solving.

FCPMH

Acronym for the family-centered pediatric medical home; in an FCPMH, the pediatrician leads an interdisciplinary team of professionals providing care that is:

- family-centered: the family is recognized and acknowledged as the primary caregiver and support for the child, ensuring that all medical decisions are made in true partnership with the family;
- accessible: care is easy for the child and family to obtain, including geographic access and insurance accommodation;
- continuous: the same primary care clinician cares for the child from infancy through young adulthood, providing assistance and support to transition to adult care;
- comprehensive: preventive, primary, and specialty care are provided to the child and family;
- coordinated: a care plan is created in partnership with the family and communicated with all health care clinicians and necessary community agencies and organizations;
- compassionate: genuine concern for the well-being of a child and family are emphasized and addressed; and
- culturally effective: the family and child's culture, language, beliefs, and traditions are recognized, valued, and respected.

An FCPMH is not a building or place; it extends beyond the walls of a clinical practice. A medical home builds partnerships with clinical specialists, families, and community resources. The medical home recognizes the family as a constant in a child's life and emphasizes partnership between health care professionals and families (as per the National Resource Center for the Patient/Family-Centered Medical Home at the AAP).

If properly funded, FCPHMs are well placed to implement the following functions:

- screening for behavioral and developmental risk factors and diagnoses, including mental health conditions, developmental delays, SDoHs, and family-level risk and resilience factors;
- care coordination, linking families to community-based supports to address SDoHs, parenting concerns, developmental delays, and behavioral and mental health concerns;
- integrated behavioral health and family support services through colocated, interdisciplinary teams that include case management, behavioral health services, and positive parenting programs;
- preventive and dyadic mental health services that do not requiring a psychiatric diagnosis code for payment, thereby enabling the deployment of primary and secondary prevention strategies before the emergence of behavioral or medical disorders;
- enhanced payment for prolonged medical visits, allowing for more patient-centered communication, interdisciplinary care, and development of therapeutic alliances; and
- ancillary support services (interpretation, telemedicine, transportation, etc) enabling youth with special health care needs to access the many layers of support that they frequently require.

HealthySteps

HealthySteps is an evidence-based, interdisciplinary pediatric primary care program that promotes positive parenting and healthy development for infants and toddlers, with an emphasis on families living in low-income communities. HealthySteps uses a tiered approach to match services with the level of need, and the core components include: (1) child development social-emotional, and behavioral screening, (2) screening for family needs, (3) child development support line (eg, phone,

text, e-mail, and online portal), (4) child development and behavioral consultants, (5) care coordination and systems navigation, (6) positive parenting guidance and information, (7) early learning resources, and (8) ongoing, preventive team-based well-child visits.

Horizontal Integration

A public health approach that cuts across traditional silos and funding streams; a horizontally integrated public health approach also includes the educational, civic, social service, and juvenile justice systems.

Medical Neighborhood

Extends the concept of the FCPMH into the local community; in a medical neighborhood, the FCPMH or health system anchors and supports cross-sector efforts to address family needs (eg, the SDoH), promote population level wellness, and collectively advocate for needed funding and policy changes.

PCIT

Acronym for Parent-Child Interaction Therapy; PCIT is an evidence-based intervention to change the patterns of parent-child interactions to improve the parent-child relationship.

Positive Childhood Experiences

Reciprocal experiences with engaged and attuned adults (like those that occur during developmentally appropriate play) that build SSNRs; they are warm, affirming, and inclusive, and they promote early relational health.

Relational Health

The capacity to develop and maintain SSNRs with others; relational health is an important predictor of wellness across the life span.

Resilience

The capacity to respond to adversity in a healthy, adaptive manner; resilience is the manifestation of skills (eg, social skills, emotional regulation, language, and executive functions) that can be modeled, taught, learned, practiced, and reinforced.

Restorative Justice

Refers to efforts to repair the harm that occurs with unjust behaviors, as opposed to retributive or punitive justice, which simply punishes those who have acted unjustly. Typically, restorative justice allows the victims and the offenders to mediate a restitution agreement that is satisfactory to both parties. In this way, the victims play an active role in communicating with and understanding the offenders, and the offenders have the chance to take responsibility for their actions, identify steps that might prevent offending behaviors in the future, and redeem themselves in the eyes of the victims and community (as per Garner and Saul[17])

ROR

Acronym for Reach Out and Read; ROR is a nonprofit organization and early literacy program. ROR provides age appropriate books and encourages parents to regularly read to and interact with their children to support school readiness and healthy parent-child relationships.

SDoHs

Acronym for the social determinants of health; SDoHs refer to conditions where people live, learn, work, and play (like socioeconomic status, social capital, or exposure to discrimination or community violence) that are known to affect health outcomes across the life span.

SSNRs

Acronym for safe, stable, and nurturing relationships; these allow the child to feel protected, connected, and competent.

TF-CBT

Acronym for Trauma-Focused Cognitive Behavioral Therapy; TF-CBT is an evidence-based, manualized, skills-based therapy that allows parents and children to better process emotions and thoughts related to traumatic experiences.

Toxic Stress

The biological response to frequent, prolonged, or severe adversities in the absence of at least one safe stable and nurturing relationship; these biological responses might be beneficial or adaptive initially, but they often become health harming or maladaptive or "toxic" over time or in different contexts.

Vertical Integration

A public health approach that includes primary universal preventions to promote wellness (like promoting positive parenting practices), secondary targeted interventions for those deemed to be at risk for poor outcomes (like using biomarkers both to identify those at higher risk and to monitor the effectiveness of various interventions), and tertiary evidence-based treatments for the symptomatic (like referring to providers trained in TF-CBT).

VIP

Acronym for the Video Interaction Project; VIP uses video-taped interactions of parent-child dyads to teach parents how to be more engaged, attuned, and responsive to their child's developing behaviors.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ABC: attachment and biobehavioral catch-up
ACE: adverse childhood experience
CPP: child–parent psychotherapy
FCPMH: family-centered pediatric medical home
PCIT: parent–child interaction therapy
ROR: Reach Out and Read
SDoH: social determinants of health
SSNR: safe, stable, and nurturing relationship
TF-CBT: trauma-focused cognitive-behavioral therapy
VIP: Video Interaction Project

appropriate.

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REFERENCES

1. National Scientific Council on the Developing Child. *Young Children Develop in an Environment of Relationships: Working Paper No. 1*. Cambridge, MA: Center on the Developing Child at Harvard University; 2004. Available at: https://developingchild.harvard.edu/resources/wp1/. Accessed June 28, 2021
2. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1):e232–e246
3. Romens SE, McDonald J, Svaren J, Pollak SD. Associations between early life stress and gene methylation in children. *Child Dev*. 2015;86(1):303–309
4. Labonte B, Yerko V, Gross J, et al. Differential glucocorticoid receptor exon 1(B), 1(C), and 1(H) expression and methylation in suicide completers with a history of childhood abuse. *Biol Psychiatry*. 2012;72(1):41–48
5. McGowan PO, Sasaki A, D'Alessio AC, et al. Epigenetic regulation of the glucocorticoid receptor in human brain associates with childhood abuse. *Nat Neurosci*. 2009;12(3):342–348
6. McCrory EJ, Gerin MI, Viding E. Annual research review: childhood maltreatment, latent vulnerability and the shift to preventative psychiatry - the contribution of functional brain imaging. *J Child Psychol Psychiatry*. 2017;58(4):338–357
7. Marusak HA, Martin KR, Etkin A, Thomason ME. Childhood trauma exposure disrupts the automatic regulation of emotional processing. *Neuropsychopharmacology*. 2015;40(5):1250–1258
8. van Harmelen AL, van Tol MJ, Demenescu LR, et al. Enhanced amygdala reactivity to emotional faces in adults reporting childhood emotional maltreatment. *Soc Cogn Affect Neurosci*. 2013;8(4):362–369
9. Sandre A, Ethridge P, Kim I, Weinberg A. Childhood maltreatment is associated with increased neural response to ambiguous threatening facial expressions in adulthood: evidence from the late positive potential. *Cogn Affect Behav Neurosci*. 2018;18(1):143–154
10. Danese A, McEwen BS. Adverse childhood experiences, allostasis, allostatic load, and age-related disease. *Physiol Behav*. 2012;106(1):29–39
11. Rogosch FA, Dackis MN, Cicchetti D. Child maltreatment and allostatic load: consequences for physical and mental health in children from low-income families. *Dev Psychopathol*. 2011;23(4):1107–1124
12. Garner AS, Shonkoff JP; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2012;129(1):e224–e231
13. Boyce WT, Levitt P, Martinez FD, McEwen BS, Shonkoff JP. Genes, environments, and time: the biology of adversity and resilience. *Pediatrics*. 2021;147(2):e20201651
14. Shonkoff JP, Boyce WT, Levitt P, Martinez F, McEwen B. Leveraging the biology of adversity and resilience to transform pediatric practice. *Pediatrics*. 2021;147(2):e20193845
15. Frameworks Institute. *Building Relationships: Framing Early Relational Health*. Washington, DC: Frameworks Institute; 2020
16. National Scientific Council on the Developing Child. *Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience*: Working Paper No. 13 Cambridge, MA: National Scientific Council on the Developing Child; 2015. Available at: https://developingchild.harvard.edu/resources/supportive-relationships-and-active-skill-building-strengthen-the-foundations-of-resilience/. Accessed June 28, 2021
17. Garner A, Saul R. *Thinking Developmentally: Nurturing Wellness in Childhood to Promote Lifelong Health*. 1st ed. Itasca, IL: American Academy of Pediatrics; 2018
18. Brody GH, Yu T, Beach SR. Resilience to adversity and the early origins of disease. *Dev Psychopathol*. 2016;28(4, pt 2):1347–1365
19. Flouri E, Midouhas E, Joshi H, Tzavidis N. Emotional and behavioural resilience to multiple risk exposure in early life: the role of parenting. *Eur Child Adolesc Psychiatry*. 2015;24(7):745–755
20. Bowlby J. *A Secure Base: Parent-Child Attachment and Healthy Human Development*. New York, NY: Basic Books; 1988
21. Ainsworth MD. Object relations, dependency, and attachment: a theoretical review of the infant-mother relationship. *Child Dev*. 1969;40(4):969–1025
22. Brazelton TB. *Touchpoints: Birth to 3: Your Child's Emotional and Behavioral Development*. 2nd ed. Cambridge, MA: Da Capo Lifelong Books; 2006
23. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245–258
24. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*. 2006;256(3):174–186
25. Dong M, Giles WH, Felitti VJ, et al. Insights into causal pathways for ischemic heart disease: adverse childhood experiences study. *Circulation*. 2004;110(13):1761–1766

26. Anda RF, Brown DW, Dube SR, Bremner JD, Felitti VJ, Giles WH. Adverse childhood experiences and chronic obstructive pulmonary disease in adults. *Am J Prev Med.* 2008;34(5):396–403
27. Dong M, Dube SR, Felitti VJ, Giles WH, Anda RF. Adverse childhood experiences and self-reported liver disease: new insights into the causal pathway. *Arch Intern Med.* 2003;163(16):1949–1956
28. Anda RF, Brown DW, Felitti VJ, Bremner JD, Dube SR, Giles WH. Adverse childhood experiences and prescribed psychotropic medications in adults. *Am J Prev Med.* 2007;32(5):389–394
29. Brown DW, Anda RF, Felitti VJ, et al. Adverse childhood experiences are associated with the risk of lung cancer: a prospective cohort study. *BMC Public Health.* 2010;10:20
30. Hertzman C. Putting the concept of biological embedding in historical perspective. *Proc Natl Acad Sci USA.* 2012;109(suppl 2):17160–17167
31. Hertzman C, Boyce T. How experience gets under the skin to create gradients in developmental health. *Ann Rev Public Health.* 2010;31:329–347
32. McEwen BS. Brain on stress: how the social environment gets under the skin. *Proc Natl Acad Sci USA.* 2012;109(suppl 2):17180–17185
33. Szyf M, Bick J. DNA Methylation: A Mechanism for Embedding Early Life Experiences in the Genome. *Child Dev.* 2013;84(1):49–57
34. Chae DH, Nuru-Jeter AM, Adler NE, et al. Discrimination, racial bias, and telomere length in African-American men. *Am J Prev Med.* 2014;46(2):103–111
35. Liu SY, Kawachi I. Discrimination and telomere length among older adults in the United States. *Public Health Rep.* 2017;132(2):220–230
36. Lee DB, Kim ES, Neblett EW. The link between discrimination and telomere length in African American adults. *Health Psychol.* 2017;36(5):458–467
37. Shonkoff JP. Capitalizing on advances in science to reduce the health consequences of early childhood adversity. *JAMA Pediatr.* 2016;170(10):1003–1007
38. Shonkoff JP. Leveraging the biology of adversity to address the roots of disparities in health and development. *Proc Natl Acad Sci USA.* 2012;109(suppl 2):17302–17307
39. Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. *JAMA.* 2009;301(21):2252–2259
40. National Scientific Council on the Developing Child. *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper No. 3.* Updated Edition. Cambridge, MA: National Scientific Council on the Developing Child; 2014. Available at: https://developingchild.harvard.edu/resources/wp3/. Accessed June 28, 2021
41. Non AL, Román JC, Gross CL, et al. Early childhood social disadvantage is associated with poor health behaviours in adulthood. *Ann Hum Biol.* 2016;43(2):144–153
42. Merrick MT, Henly M, Turner HA, et al. Beyond residential mobility: A broader conceptualization of instability and its impact on victimization risk among children. *Child Abuse Negl.* 2018;79:485–494
43. Cutuli JJ, Ahumada SM, Herbers JE, Lafavor TL, Masten AS, Oberg CN. Adversity and children experiencing family homelessness: implications for health. *J Child Poverty.* 2017;23(1):41–55
44. Jetelina KK, Reingle Gonzalez JM, Cuccaro PM, et al. The association between familial homelessness, aggression, and victimization among children. *J Adolesc Health.* 2016;59(6):688–695
45. James S, Donnelly L, Brooks-Gunn J, McLanahan S. Links between childhood exposure to violent contexts and risky adolescent health behaviors. *J Adolesc Health.* 2018;63(1):94–101
46. Saxbe D, Khoddam H, Piero LD, et al. Community violence exposure in early adolescence: longitudinal associations with hippocampal and amygdala volume and resting state connectivity. *Dev Sci.* 2018;21(6):e12686
47. Ma J, Grogan-Kaylor A, Lee SJ. Associations of neighborhood disorganization and maternal spanking with children's aggression: a fixed-effects regression analysis. *Child Abuse Negl.* 2018;76:106–116
48. Thurston H, Bell JF, Induni M. Community-level adverse experiences and emotional regulation in children and adolescents. *J Pediatr Nurs.* 2018;42:25–33
49. Evans SZ, Simons LG, Simons RL. Factors that influence trajectories of delinquency throughout adolescence. *J Youth Adolesc.* 2016;45(1):156–171
50. Wade R Jr, Cronholm PF, Fein JA, et al. Household and community-level adverse childhood experiences and adult health outcomes in a diverse urban population. *Child Abuse Negl.* 2016;52:135–145
51. Takizawa R, Danese A, Maughan B, Arseneault L. Bullying victimization in childhood predicts inflammation and obesity at mid-life: a five-decade birth cohort study. *Psychol Med.* 2015;45(13):2705–2715
52. Halpern J, Jutte D, Colby J, Boyce WT. Social dominance, school bullying, and child health: what are our ethical obligations to the very young? *Pediatrics.* 2015;135(suppl 2):S24–S30
53. Zolotor AJ. Corporal punishment. *Pediatr Clin North Am.* 2014;61(5):971–978
54. Odgers CL, Jaffee SR. Routine versus catastrophic influences on the developing child. *Annu Rev Public Health.* 2013;34:29–48
55. Keeshin BR, Dubowitz H. Childhood neglect: the role of the paediatrician. *Paediatr Child Health.* 2013;18(8):e39–e43
56. Anda RF, Porter LE, Brown DW. Inside the adverse childhood experience score: strengths, limitations, and misapplications. *Am J Prev Med.* 2020;59(2):293–295
57. Slopen N, McLaughlin KA, Shonkoff JP. Interventions to improve cortisol regulation in children: a systematic review. *Pediatrics.* 2014;133(2):312–326
58. Shonkoff JP, Fisher PA. Rethinking evidence-based practice and two-generation programs to create the future of early childhood policy. *Dev Psychopathol.* 2013;25(4, pt 2):1635–1653
59. Bethell CD, Gombojav N, Whitaker RC. Family resilience and connection promote flourishing among US children,

even amid adversity. *Health Aff (Millwood)*. 2019;38(5):729–737

60. Conching AKS, Thayer Z. Biological pathways for historical trauma to affect health: A conceptual model focusing on epigenetic modifications. *Soc Sci Med*. 2019;230:74–82
61. Gone JP, Hartmann WE, Pomerville A, Wendt DC, Klem SH, Burrage RL. The impact of historical trauma on health outcomes for indigenous populations in the USA and Canada: a systematic review. *Am Psychol*. 2019;74(1):20–35
62. Weisleder A, Cates CB, Dreyer BP, et al. Promotion of positive parenting and prevention of socioemotional disparities. *Pediatrics*. 2016;137(2):e20153239
63. Mendelsohn AL, Huberman HS, Berkule SB, Brockmeyer CA, Morrow LM, Dreyer BP. Primary care strategies for promoting parent-child interactions and school readiness in at-risk families: the Bellevue Project for Early Language, Literacy, and Education Success. *Arch Pediatr Adolesc Med*. 2011;165(1):33–41
64. Yousafzai AK, Rasheed MA, Rizvi A, Armstrong R, Bhutta ZA. Parenting skills and emotional availability: an RCT. *Pediatrics*. 2015;135(5):e1247–e1257
65. Hambrick EP, Brawner TW, Perry BD, Brandt K, Hofmeister C, Collins JO. Beyond the ACE score: examining relationships between timing of developmental adversity, relational health and developmental outcomes in children. *Arch Psychiatr Nurs*. 2019;33(3):238–247
66. Mendelsohn AL, Cates CB, Weisleder A, et al. Reading aloud, play, and social-emotional development. *Pediatrics*. 2018;141(5):e20173393
67. COUNCIL ON EARLY CHILDHOOD; COUNCIL ON SCHOOL HEALTH. The pediatrician's role in optimizing school readiness. *Pediatrics*. 2016;138(3):e20162293
68. High PC, Klass P; Council on Early Childhood. Literacy promotion: an essential component of primary care pediatric practice. *Pediatrics*. 2014;134(2):404–409
69. Campbell F, Conti G, Heckman JJ, et al. Early childhood investments substantially boost adult health. *Science*. 2014;343(6178):1478–1485
70. McLaughlin AE, Campbell FA, Pungello EP, Skinner M. Depressive symptoms in young adults: the influences of the early home environment and early educational child care. *Child Dev*. 2007;78(3):746–756
71. Schweinhart LH, Monte J, Xiang Z. *Lifetime Effects: the High/Scope Perry Preschool Study Through Age 40*. Ypsilanti, MI.: High/Scope Press; 2005
72. Cates CB, Weisleder A, Berkule Johnson S, et al. Enhancing parent talk, reading, and play in primary care: sustained impacts of the video interaction project. *J Pediatr*. 2018;199:49–56.e1
73. Chang SM, Grantham-McGregor SM, Powell CA, et al. Integrating a parenting intervention with routine primary health care: a cluster randomized trial. *Pediatrics*. 2015;136(2):272–280
74. Yogman M, Garner A, Hutchinson J, Hirsh-Pasek K, Golinkoff RM; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; COUNCIL ON COMMUNICATIONS AND MEDIA. The power of play: a pediatric role in enhancing development in young children. *Pediatrics*. 2018;142(3):e20182058
75. Garner AS. Thinking developmentally: the next evolution in models of health. *J Dev Behav Pediatr*. 2016;37(7):579–584
76. Palma-Gudiel H, Córdova-Palomera A, Eixarch E, Deuschle M, Fañanás L. Maternal psychosocial stress during pregnancy alters the epigenetic signature of the glucocorticoid receptor gene promoter in their offspring: a meta-analysis. *Epigenetics*. 2015;10(10):893–902
77. Oberlander TF, Weinberg J, Papsdorf M, Grunau R, Misri S, Devlin AM. Prenatal exposure to maternal depression, neonatal methylation of human glucocorticoid receptor gene (NR3C1) and infant cortisol stress responses. *Epigenetics*. 2008;3(2):97–106
78. Murgatroyd C, Quinn JP, Sharp HM, Pickles A, Hill J. Effects of prenatal and postnatal depression, and maternal stroking, at the glucocorticoid receptor gene. *Transl Psychiatry*. 2015;5:e560
79. Lester BM, Conradt E, LaGasse LL, Tronick EZ, Padbury JF, Marsit CJ. Epigenetic programming by maternal behavior in the human infant. *Pediatrics*. 2018;142(4):e20171890
80. Halfon N, Larson K, Son J, Lu M, Bethell C. income inequality and the differential effect of adverse childhood experiences in US children. *Acad Pediatr*. 2017;17(7S):S70–S78
81. Halfon N, Wise PH, Forrest CB. The changing nature of children's health development: new challenges require major policy solutions. *Health Aff (Millwood)*. 2014;33(12):2116–2124
82. Halfon N, Inkelas M, Hochstein M. The health development organization: an organizational approach to achieving child health development. *Milbank Q*. 2000;78(3):447–497
83. Traub F, Boynton-Jarrett R. Modifiable resilience factors to childhood adversity for clinical pediatric practice. *Pediatrics*. 2017;139(5):e20162569
84. Minkovitz CS, Strobino D, Mistry KB, et al. Healthy Steps for Young Children: sustained results at 5.5 years. *Pediatrics*. 2007;120(3):e658–e668
85. Johnston BD, Huebner CE, Anderson ML, Tyll LT, Thompson RS. Healthy steps in an integrated delivery system: child and parent outcomes at 30 months. *Arch Pediatr Adolesc Med*. 2006;160(8):793–800
86. Schickedanz A, Halfon N, Sastry N, Chung PJ. Parents' adverse childhood experiences and their children's behavioral health problems. *Pediatrics*. 2018;142(2):e20180023
87. Pascoe JM, Wood DL, Duffee JH, Kuo A; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; COUNCIL ON COMMUNITY PEDIATRICS. Mediators and adverse effects of child poverty in the United States. *Pediatrics*. 2016;137(4):e20160340
88. COUNCIL ON COMMUNITY PEDIATRICS. Poverty and child health in the United States. *Pediatrics*. 2016;137(4):e20160339
89. Kim SY, Schwartz SJ, Perreira KM, Juang LP. Culture's influence on stressors, parental socialization, and developmental processes in the mental health of children of immigrants. *Annu Rev Clin Psychol*. 2018;14:343–370
90. Earls MF, Yogman MW, Mattson G, Rafferty J; COMMITTEE ON PSYCHOSOCIAL

ASPECTS OF CHILD AND FAMILY HEALTH. Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics*. 2019;143(1):e20183259

91. Ellis BJ, Shirtcliff EA, Boyce WT, Deardorff J, Essex MJ. Quality of early family relationships and the timing and tempo of puberty: effects depend on biological sensitivity to context. *Dev Psychopathol*. 2011;23(1):85–99
92. Obradović J, Bush NR, Stamperdahl J, Adler NE, Boyce WT. Biological sensitivity to context: the interactive effects of stress reactivity and family adversity on socioemotional behavior and school readiness. *Child Dev*. 2010;81(1):270–289
93. Obradović J, Boyce WT. Individual differences in behavioral, physiological, and genetic sensitivities to contexts: implications for development and adaptation. *Dev Neurosci*. 2009;31(4):300–308
94. Boyce WT. *The Orchid and the Dandelion: Why Some Children Struggle and How All Can Thrive*. New York, NY: Knopf; 2019
95. Gleason MM, Goldson E, Yogman MW; COUNCIL ON EARLY CHILDHOOD; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS. Addressing early childhood emotional and behavioral problems. *Pediatrics*. 2016;138(6):e20163025
96. Dozier M, Roben CKP, Caron E, Hoye J, Bernard K. Attachment and Biobehavioral Catch-up: an evidence-based intervention for vulnerable infants and their families. *Psychother Res*. 2018;28(1):18–29
97. Dozier M, Bernard K. Attachment and biobehavioral catch-up: addressing the needs of infants and toddlers exposed to inadequate or problematic caregiving. *Curr Opin Psychol*. 2017;15:111–117
98. Bernard K, Dozier M, Bick J, Lewis-Morrarty E, Lindhiem O, Carlson E. Enhancing attachment organization among maltreated children: results of a randomized clinical trial. *Child Dev*. 2012;83(2):623–636
99. Bjørseth Å, Wichstrøm L. Effectiveness of parent-child interaction therapy (PCIT) in the treatment of young children's behavior problems. a randomized controlled study. *PLoS One*. 2016;11(9):e0159845
100. Thomas R, Herschell AD. Parent-child interaction therapy: a manualized intervention for the therapeutic child welfare sector. *Child Abuse Negl*. 2013;37(8):578–584
101. Thomas R, Zimmer-Gembeck MJ. Parent-child interaction therapy: an evidence-based treatment for child maltreatment. *Child Maltreat*. 2012;17(3):253–266
102. Thomas R, Zimmer-Gembeck MJ. Accumulating evidence for parent-child interaction therapy in the prevention of child maltreatment. *Child Dev*. 2011;82(1):177–192
103. Hagan MJ, Browne DT, Sulik M, Ippen CG, Bush N, Lieberman AF. Parent and child trauma symptoms during child-parent psychotherapy: a prospective cohort study of dyadic change. *J Trauma Stress*. 2017;30(6):690–697
104. Ghosh Ippen C, Harris WW, Van Horn P, Lieberman AF. Traumatic and stressful events in early childhood: can treatment help those at highest risk? *Child Abuse Negl*. 2011;35(7):504–513
105. Lieberman AF, Ghosh Ippen C, VAN Horn P. Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *J Am Acad Child Adolesc Psychiatry*. 2006;45(8):913–918
106. Cohen JA, Deblinger E, Mannarino AP, Steer RA. A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *J Am Acad Child Adolesc Psychiatry*. 2004;43(4):393–402
107. Cisler JM, Sigel BA, Kramer TL, et al. Amygdala response predicts trajectory of symptom reduction during trauma-focused cognitive-behavioral therapy among adolescent girls with PTSD. *J Psychiatr Res*. 2015;71:33–40
108. Merrick MT, Ford DC, Ports KA, Guinn AS. Prevalence of adverse childhood experiences from the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States. *JAMA Pediatr*. 2018;172(11):1038–1044
109. Bywater T, Berry V, Blower SL, et al. Enhancing social-emotional health and wellbeing in the early years (E-SEE): a study protocol of a community-based randomised controlled trial with process and economic evaluations of the incredible years infant and toddler parenting programmes, delivered in a proportionate universal model. *BMJ Open*. 2018;8(12):e026906
110. Egan M, Kearns A, Katikireddi SV, Curl A, Lawson K, Tannahill C. Proportionate universalism in practice? A quasi-experimental study (GoWell) of a UK neighbourhood renewal programme's impact on health inequalities. *Soc Sci Med*. 2016;152:41–49
111. Carey G, Crammond B, De Leeuw E. Towards health equity: a framework for the application of proportionate universalism. *Int J Equity Health*. 2015;14:81
112. *Team Marmot Report. Fair Society, Healthy Lives. The Marmot Review*. London, UK: University College of London Institute of Health Equity; 2010
113. Jaffee SR, Bowes L, Ouellet-Morin I, et al. Safe, stable, nurturing relationships break the intergenerational cycle of abuse: a prospective nationally representative cohort of children in the United Kingdom. *J Adolesc Health*. 2013;53(4, suppl):S4–S10
114. National Scientific Council on the Developing Child. *Building the Brain's "Air Traffic Control" System: How Early Experiences Shape the Development of Executive Function*: Working Paper No. 11. Cambridge, MA: National Scientific Council on the Developing Child; 2011. Available at: https://developingchild.harvard.edu/resources/building-the-brains-air-traffic-control-system-how-early-experiences-shape-the-development-of-executive-function/. Accessed June 28, 2021
115. National Scientific Council on the Developing Child. *The Timing and Quality of Early Experiences Combine to Shape Brain Architecture*.: Working Paper No. 5. Cambridge, MA: National Scientific Council on the Developing Child; 2007. Available at: https://developingchild.harvard.edu/resources/the-timing-and-quality-of-early-experiences-combine-to-shape-brain-architecture/. Accessed June 28, 2021
116. Schore AN. Attachment and the regulation of the right brain. *Attach Hum Dev*. 2000;2(1):23–47
117. Feldman R. The adaptive human parental brain: implications for

children's social development. *Trends Neurosci.* 2015;38(6):387–399

118. Watamura S, Kim P. *Two Open Windows: Infant and Parent Neurobiological Change*. Washington, DC: Aspen Institute; 2015
119. Feldman R. The neurobiology of human attachments. *Trends Cogn Sci.* 2017;21(2):80–99
120. Feldman R. The neurobiology of mammalian parenting and the biosocial context of human caregiving. *Horm Behav.* 2016;77:3–17
121. Bethell C, Jones J, Gombojav N, Linkenbach J, Sege R. Positive childhood experiences and adult mental and relational health in a statewide sample: associations across adverse childhood experiences levels. *JAMA Pediatr.* 2019;173(11):e193007
122. Heard-Garris N, Davis MM, Szilagyi M, Kan K. Childhood adversity and parent perceptions of child resilience. *BMC Pediatr.* 2018;18(1):204
123. Fritz J, de Graaff AM, Caisley H, van Harmelen AL, Wilkinson PO. A systematic review of amenable resilience factors that moderate and/or mediate the relationship between childhood adversity and mental health in young people. *Front Psychiatry.* 2018;9:230
124. Ellis WR, Dietz WH. A new framework for addressing adverse childhood and community experiences: the building community resilience model. *Acad Pediatr.* 2017;17(7S):S86–S93
125. COUNCIL ON COMMUNICATIONS AND MEDIA. Media and young minds. *Pediatrics.* 2016;138(5):e20162591
126. Sege RD, Harper Browne C. Responding to ACEs with HOPE: Health Outcomes From Positive Experiences. *Acad Pediatr.* 2017;17(7S):S79–S85
127. Sege R, Bethell C, Linkenbach J, Jones J, Kilkao B, Pecora PJ. *Balancing Adverse Childhood Experiences with HOPE: New Insights Into the Role of Positive Experience on Child And Family Development.* Boston, MA: The Medical Foundation; 2017
128. Shah R, DeFrino D, Kim Y, Atkins M. Sit down and play: a preventive primary care-based program to enhance parenting practices. *J Child Fam Stud.* 2017;26(2):540–547
129. Zuckerman B, Augustyn M. Books and reading: evidence-based standard of care whose time has come. *Acad Pediatr.* 2011;11(1):11–17
130. Needlman R, Toker KH, Dreyer BP, Klass P, Mendelsohn AL. Effectiveness of a primary care intervention to support reading aloud: a multicenter evaluation. *Ambul Pediatr.* 2005;5(4):209–215
131. Ellis BJ, Boyce WT. Differential susceptibility to the environment: toward an understanding of sensitivity to developmental experiences and context. *Dev Psychopathol.* 2011;23(1):1–5
132. Blair C. Stress and the development of self-regulation in context. *Child Dev Perspect.* 2010;4(3):181–188
133. Ellis BJ, Essex MJ, Boyce WT. Biological sensitivity to context: II. Empirical explorations of an evolutionary-developmental theory. *Dev Psychopathol.* 2005;17(2):303–328
134. Boyce WT, Ellis BJ. Biological sensitivity to context: I. An evolutionary-developmental theory of the origins and functions of stress reactivity. *Dev Psychopathol.* 2005;17(2):271–301
135. Humphreys KL, Telzer EH, Flannery J, et al. Risky decision making from childhood through adulthood: contributions of learning and sensitivity to negative feedback. *Emotion.* 2016;16(1):101–109
136. Essex MJ, Armstrong JM, Burk LR, Goldsmith HH, Boyce WT. Biological sensitivity to context moderates the effects of the early teacher-child relationship on the development of mental health by adolescence. *Dev Psychopathol.* 2011;23(1):149–161
137. Weisleder A, Cates CB, Harding JF, et al. Links between shared reading and play, parent psychosocial functioning, and child behavior: evidence from a randomized controlled trial. *J Pediatr.* 2019;213:187–195.e1
138. Needlman RD, Dreyer BP, Klass P, Mendelsohn AL. Attendance at well-child visits after Reach Out and Read. *Clin Pediatr (Phila).* 2019;58(3):282–287
139. Zuckerman B, Khandekar A. Reach Out and Read: evidence based approach to promoting early child development. *Curr Opin Pediatr.* 2010;22(4):539–544
140. Sanders MR. Triple P-Positive Parenting Program as a public health approach to strengthening parenting. *J Fam Psychol.* 2008;22(4):506–517
141. Sanders MR, Bor W, Morawska A. Maintenance of treatment gains: a comparison of enhanced, standard, and self-directed Triple P-Positive Parenting Program. *J Abnorm Child Psychol.* 2007;35(6):983–998
142. Duffee JH, Mendelsohn AL, Kuo AA, Legano LA, Earls MF; COUNCIL ON COMMUNITY PEDIATRICS; COUNCIL ON EARLY CHILDHOOD; COMMITTEE ON CHILD ABUSE AND NEGLECT. Early childhood home visiting. *Pediatrics.* 2017;140(3):e20172150
143. Garner AS. Home visiting and the biology of toxic stress: opportunities to address early childhood adversity. *Pediatrics.* 2013;132(suppl 2):S65–S73
144. Katkin JP, Kressly SJ, Edwards AR, et al; TASK FORCE ON PEDIATRIC PRACTICE CHANGE. Guiding principles for team-based pediatric care. *Pediatrics.* 2017;140(2):e20171489
145. Feigelman S, Dubowitz H, Lane W, Grube L, Kim J. Training pediatric residents in a primary care clinic to help address psychosocial problems and prevent child maltreatment. *Acad Pediatr.* 2011;11(6):474–480
146. Garg A, Sarkar S, Marino M, Onie R, Solomon BS. Linking urban families to community resources in the context of pediatric primary care. *Patient Educ Couns.* 2009
147. Sege R, Preer G, Morton SJ, et al. Medical-legal strategies to improve infant health care: a randomized trial. *Pediatrics.* 2015;136(1):97–106
148. Halfon N, Long P, Chang DI, Hester J, Inkelas M, Rodgers A. Applying a 3.0 transformation framework to guide large-scale health system reform. *Health Aff (Millwood).* 2014;33(11):2003–2011
149. Duby JC. Early childhood behavioral health: can the medical neighborhood move us forward? *Pediatrics.* 2018;141(5):e20180156
150. Help Me Grow National Center. The HMG Model System Model. Available at: https://helpmegrownational.org/hmg-system-model/. Accessed June 21, 2021
150. Zuckerman B, Parker S, Kaplan-Sanoff M, Augustyn M, Barth MC. Healthy

Steps: a case study of innovation in pediatric practice. *Pediatrics*. 2004;114(3):820–826

151. Valado T, Tracey J, Goldfinger J, Briggs R. HealthySteps: transforming the promise of pediatric care. *Future Child*. 2019;29:99–122
152. DISASTER PREPAREDNESS ADVISORY COUNCIL; COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE. Ensuring the health of children in disasters. *Pediatrics*. 2015;136(5):e1407–e1417
153. Schonfeld DJ, Demaria T; DISASTER PREPAREDNESS ADVISORY COUNCIL AND COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH. Providing psychosocial support to children and families in the aftermath of disasters and crises. *Pediatrics*. 2015;136(4):e1120–e1130
154. Heymann J, Sprague AR, Nandi A, et al. Paid parental leave and family wellbeing in the sustainable development era. *Public Health Rev*. 2017;38:21
155. Schuster MA, Chung PJ. Time off to care for a sick child–why family-leave policies matter. *N Engl J Med*. 2014;371(6):493–495
156. Ahlin EM, Gibbs JC, Kavanaugh PR, Lee J. Support for restorative justice in a sample of U.S. university students. *Int J Offender Ther Comp Criminol*. 2017;61(2):229–245
157. Riedl K, Jensen K, Call J, Tomasello M. Restorative justice in children. *Curr Biol*. 2015;25(13):1731–1735
158. Wenzel M, Okimoto TG, Feather NT, Platow MJ. Retributive and restorative justice. *Law Hum Behav*. 2008;32(5):375–389
159. Brown CM, Perkins J, Blust A, Kahn RS. A neighborhood-based approach to population health in the pediatric medical home. *J Community Health*. 2015;40(1):1–11
160. Beck AF, Sandel MT, Ryan PH, Kahn RS. Mapping neighborhood health geomarkers to clinical care decisions to promote equity in child health. *Health Aff (Millwood)*. 2017;36(6):999–1005
161. Garg A, Sandel M, Dworkin PH, Kahn RS, Zuckerman B. From medical home to health neighborhood: transforming the medical home into a community-based health neighborhood. *J Pediatr*. 2012;160(4):535–536.e1
162. Chang S, Lee TH. Beyond evidence-based medicine. *N Engl J Med*. 2018;379(21):1983–1985
163. Marsac ML, Kassam-Adams N, Hildenbrand AK, et al. Implementing a trauma-informed approach in pediatric health care networks. *JAMA Pediatr*. 2016;170(1):70–77
164. Derrington SF, Paquette E, Johnson KA. Cross-cultural interactions and shared decision-making. *Pediatrics*. 2018;142(suppl 3):S187–S192
165. Ruberton PM, Huynh HP, Miller TA, Kruse E, Chancellor J, Lyubomirsky S. The relationship between physician humility, physician-patient communication, and patient health. *Patient Educ Couns*. 2016;99(7):1138–1145
166. Trent M, Dooley DG, Dougé J, SECTION ON ADOLESCENT HEALTH; COUNCIL ON COMMUNITY PEDIATRICS; COMMITTEE ON ADOLESCENCE. The impact of racism on child and adolescent health. *Pediatrics*. 2019;144(2):e20191765
167. Hagiwara N, Elston Lafata J, Mezuk B, Vrana SR, Fetters MD. Detecting implicit racial bias in provider communication behaviors to reduce disparities in healthcare: challenges, solutions, and future directions for provider communication training. *Patient Educ Couns*. 2019;102(9):1738–1743
168. Schnierle J, Christian-Brathwaite N, Louisias M. Implicit bias: what every pediatrician should know about the effect of bias on health and future directions. *Curr Probl Pediatr Adolesc Health Care*. 2019;49(2):34–44
169. Poitevien P, Osman C. Tackling implicit and explicit bias through objective structured teaching exercises for faculty. *J Grad Med Educ*. 2018;10(3):353–354
170. Dehon E, Weiss N, Jones J, Faulconer W, Hinton E, Sterling S. A systematic review of the impact of physician implicit racial bias on clinical decision making. *Acad Emerg Med*. 2017;24(8):895–904
171. Johnson TJ, Winger DG, Hickey RW, et al. Comparison of physician implicit racial bias toward adults versus children. *Acad Pediatr*. 2017;17(2):120–126
172. Garner AS, Forkey H, Szilagyi M. Translating developmental science to address childhood adversity. *Acad Pediatr*. 2015;15(5):493–502
173. Lieberman MD. *Social: Why Our Brains Are Wired to Connect*. 1st ed. New York, NY: Broadway Books; 2013
174. Wilkinson RG, Pickett K. *The Spirit Level: Why Greater Equality Makes Societies Stronger*. New York, NY: Bloomsbury Press; 2010
175. Putnam RD. *Bowling Alone: the Collapse and Revival of American Community*. New York, NY: Simon & Schuster; 2000
176. Putnam RD. *Our Kids: the American Dream in Crisis*. 1st ed. New York, NY: Simon & Schuster; 2015
177. Way N, Ali A, Gilligan C, Noguera P, Kirkland DE. *The Crisis of Connection: Roots, Consequences, and Solutions*. New York, NY: New York University Press; 2018
178. Pantell M, Rehkopf D, Jutte D, Syme SL, Balmes J, Adler N. Social isolation: a predictor of mortality comparable to traditional clinical risk factors. *Am J Public Health*. 2013;103(11):2056–2062
179. Koss KJ, Hostinar CE, Donzella B, Gunnar MR. Social deprivation and the HPA axis in early development. *Psychoneuroendocrinology*. 2014;50:1–13
180. Tottenham N, Hare TA, Quinn BT, et al. Prolonged institutional rearing is associated with atypically large amygdala volume and difficulties in emotion regulation. *Dev Sci*. 2010;13(1):46–61
181. Murray DR, Haselton MG, Fales M, Cole SW. Subjective social status and inflammatory gene expression. *Health Psychol*. 2019;38(2):182–186
182. Sheikh MA. The potential protective effect of friendship on the association between childhood adversity and psychological distress in adulthood: a retrospective, preliminary, three-wave population-based study. *J Affect Disord*. 2018;226:21–27
183. Brooks D. A nation of weavers. *The New York Times*. February 18, 2019
184. Jennings V, Bamkole O. The Relationship between social cohesion and urban green space: an avenue for health promotion. *Int J Environ Res Public Health*. 2019;16(3):E452

185. Rugel EJ, Carpiano RM, Henderson SB, Brauer M. Exposure to natural space, sense of community belonging, and adverse mental health outcomes across an urban region. *Environ Res*. 2019;171:365–377

186. Breuer J, Freud S. *Sigmund Freud Collection (Library of Congress). Studies on Hysteria*. New York, NY: Basic Books; 1957

187. Lanius RA, Vermetten E, Pain C. *The Impact of Early Life Trauma on Health and Disease: the Hidden Epidemic*. Cambridge, UK: Cambridge University Press; 2010

188. Goldhagen JL, Shenoda S, Oberg C, et al. Rights, justice, and equity: a global agenda for child health and wellbeing. *Lancet Child Adolesc Health*. 2020;4(1):80–90

189. Douglas MD, Josiah Willock R, Respress E, et al. Applying a health equity lens to evaluate and inform policy. *Ethn Dis*. 2019;29(suppl 2):329–342

190. Mohammed M, Simha S, Clarke-Pearson K, et al. Community engagement and equitable policy: promoting resilience and stability for children in immigrant families in North Carolina. *N C Med J*. 2019;80(2):94–100

191. Welsh J, Strazdins L, Ford L, et al. Promoting equity in the mental wellbeing of children and young people: a scoping review. *Health Promot Int*. 2015;30(suppl 2):ii36–ii76

192. Center on the Developing Child at Harvard University. Three Principles to Improve Outcomes for Children and Families, 2021 Update. Available at: https://developingchild.harvard.edu/resources/three-early-childhood-development-principles-improve-child-family-outcomes/. Accessed May 5, 2019

193. Center for the Study of Social Policy. *Pediatricians Supporting Parents*. Washington, DC: Center for the Study of Social Policy; 2019

194. Doyle S, Chavez S, Cohen S, Morrison S. *Fostering Social and Emotional Health Through Pediatric Primary Care: Common Threads to Transform Practice and Systems*. Washington, DC: Center for Study of Social Policy; 2019

195. Schonfeld DJ, Demaria T; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, DISASTER PREPAREDNESS ADVISORY COUNCIL. Supporting the grieving child and family. *Pediatrics*. 2016;138(3):e20162147

196. Yogman M, Garfield CF; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH. Fathers' roles in the care and development of their children: the role of pediatricians. *Pediatrics*. 2016;138(1):e20161128

197. Healey A, Mendelsohn A; COUNCIL ON EARLY CHILDHOOD. Selecting appropriate toys for young children in the digital era. *Pediatrics*. 2019;143(1):e20183348

198. Hall RL, Jacobson PD. Examining whether the health-in-all-policies approach promotes health equity. *Health Aff (Millwood)*. 2018;37(3):364–370

199. Rigby E, Hatch ME. Incorporating economic policy into a 'health-in-all-policies' agenda. *Health Aff (Millwood)*. 2016;35(11):2044–2052

200. Shankardass K, Muntaner C, Kokkinen L, et al. The implementation of Health in All Policies initiatives: a systems framework for government action. *Health Res Policy Syst*. 2018;16(1):26

201. American Academy of Pediatrics. *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017

202. Cochran J, Kaplan GS, Nesse RE. Physician leadership in changing times. *Healthc (Amst)*. 2014;2(1):19–21

203. Hobson WL, Carey JC, Bale JF Jr. Academy of pediatric education and leadership: preparing leaders for educational innovation. *Pediatrics*. 2011;128(1):1–4

204. Price J, Brandt ML, Hudak ML; COMMITTEE ON CHILD HEALTH FINANCING. Principles of financing the medical home for children. *Pediatrics*. 2020;145(1):e20193451

205. Cohen Ross D, Guyer J, Lam A, Toups M. *Fostering Social and Emotional Health Through Pediatric Primary Care: a Blueprint for Leveraging Medicaid and CHIP to Finance Change*. Washington, DC: Center for the Study of Social Policy; 2019

206. Sijtsema JJ, Nederhof E, Veenstra R, Ormel J, Oldehinkel AJ, Ellis BJ. Family cohesion, prosocial behavior, and aggressive/delinquent behavior in adolescence: moderating effects of biological sensitivity to context. *Dev Psychopathol*. 2013;25(3):699–712

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