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INTERDISCIPLINARY RESEARCH LEADERS

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High5 for Kids: A family-centered approach to address the health and mental health effects of trauma and adverse childhood experiences (ACEs)

KEY FINDINGS

- **Lack of access to mental health providers is a barrier to care**; few are in the community, many are costly, and they are a poor fit for families' goals of care
- **After *High5* participation:**
  - ✓ Increased understanding of trauma for parents
  - ✓ Decreased parent stress and anxiety
  - ✓ Decreased child distress
  - ✓ Increased child self-efficacy
- Trauma principles are not yet systematically incorporated into agency policies

HIGH5

WHY WE DID THIS STUDY

The penalties delivered by the US criminal-legal system are not limited to convictions; the system also breeds tremendous vulnerability in families. This country incarcerates more than two million adults and subjects 6.7 million people to community supervision, criminal justice involvement that can have devastating effects on mental and physical health, financial stability, and family systems.[1]

Cumulative adverse childhood experiences (ACEs) and trauma exposure increase the risk that an individual will face violence (both as victim and perpetrator), experience poor health outcomes, and have criminal justice involvement. The risk of violence is especially prevalent among youths of color. The CDC reports 51% of deaths in 2017-19 among all young people 10-19 years old were due to suicide or homicide. The rate is even higher (69%) among Black boys.[2]

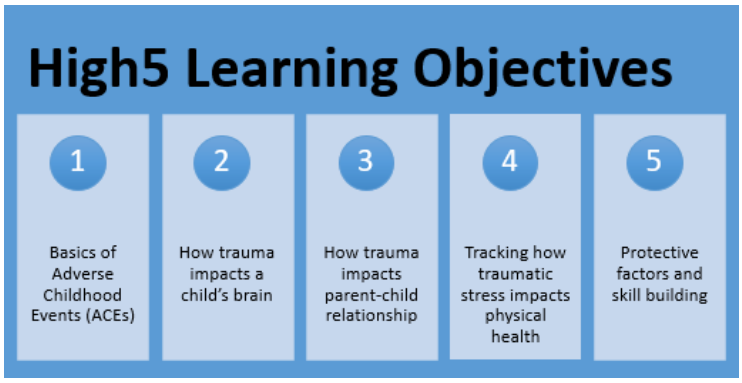
Protective factors—such as stable relationships and early service interventions—can diminish the negative impacts of ACEs and trauma exposure. Providing services to enhance and facilitate the development of protective factors and resiliency can reduce delinquency, violence, substance use, and criminal-legal contact. Research shows that early intervention enhances mental health and wellness yet nearly half of kids in need do not access care and over half drop out of services after the first or second meeting. This project aimed to examine **what prevents youth from using needed services** and to **pilot test a family-based intervention**.

HOW WE DID THIS STUDY

As we grow our understanding of the impact of trauma and ACEs on short- and long-term outcomes for kids and families, questions remain about how best to intervene with families. The research questions addressed in this project include:

(1) When services are needed to help address youth violent behaviors, emotional dysregulation, and overall distress, what keeps families from using these services?
(2) If childcare, cost, and transportation are not barriers to service use, does a short-term program for parents reduce family stress and improve physical and mental health?
(3) To what extent are policies at the local- and state-level trauma-informed?

Support for this project was provided by a grant from the Robert Wood Johnson Foundation Interdisciplinary Research Leaders program. Interdisciplinary Research Leaders is a national program of the Robert Wood Johnson Foundation led by the University of Minnesota.



The project team addressed these questions in three ways. In January 2019, we conducted a survey of over 1,000 families in the Midwest to illuminate what keeps families from using services that could address their needs. We also pilot-tested ***High5***, an intervention for parents of children in K-8th grade struggling with behavioral problems at home or at school. ***High5*** is a five-session hybrid intervention with four asynchronous sessions online and one synchronous session in person or via video conferencing. Sessions include an educational component on the impact of trauma and ACES on child and parent behaviors and skill building in daily interactions as well as stressful or explosive instances. Parents are also provided with information on strengthening protective factors. In the final session, parents come together to build community and provide support to one another as the facilitator summarizes the lessons and addresses questions. Families also wear Fitbits to self-monitor their sleep and daily activity levels.

Families were eligible for ***High5*** if their child was experiencing behavioral problems at school or home and had been exposed to two or more ACEs. Twenty families consented to take part in the ***High5*** pilot study, and eighteen completed the program. One family withdrew because the other parent did not consent to study participation; another did not return follow-up calls when scheduling the intervention. Primary caregivers and their child were interviewed before and after their participation and data were collected through Fitbits. Of the 18 families, 17 primary caregivers were mothers and 1 was a father. Children ranged in age from 5 to 15 and were enrolled in kindergarten through 8th grade.

We also conducted a policy review to examine how trauma-informed principles are integrated into local and state policy: we found that while an understanding of the topic is growing among human service agencies, policy and practice does not yet reflect what we know about the lasting effects of trauma and ACEs.

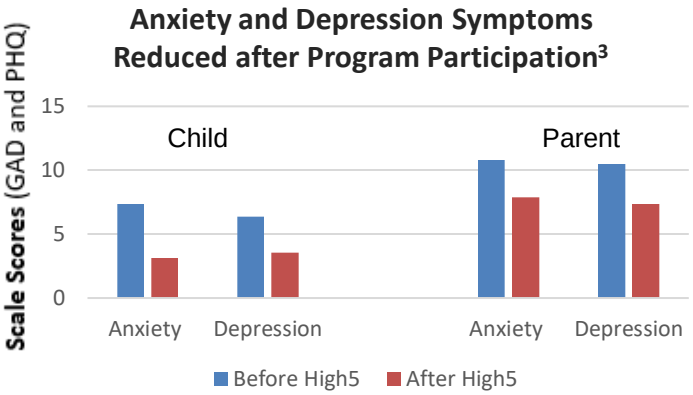
WHAT WE FOUND

Survey Findings

Approximately **80%** of our nearly 1100 survey respondents report that they have struggled at home or school with their child. **80%** also reported feeling embarrassed, angry, or judged due to their child's behavior. Nearly **30%** reported their child had been in trouble at school, and half of these respondents report the school's first response was disciplinary. Just over **40%** of survey respondents reported that someone had recommended they seek help for their child from a mental health professional, but **20%** of people did not use any of the services recommended.

Participants were asked what kept them from using recommended services. Responses fell into 11 broad categories:

- **Provider**: Access, no provider follow-up, length of time to service, restrictive appointment schedule
- **Financial**: No insurance, Co-pays too high, Fees due to out-of-network providers
- **Provider philosophy or goodness-of-fit**: Parents did not like approach or style; services perceived to be low quality
- **Parent perception:** Perceived no service need
- **No time**: Schedules are too busy
- **Transportation or childcare**
- **No services offered:** Services recommended but parents not provided information on where or how to find services or what specific services needed
- **Child-related**: Child refused to participate
- **Parent emotion or stigma**: Parent anxiety or own mental health challenges (e.g., AD/HD); concerns about child being stigmatized
- **Disagreement between parents**: One parent did not want treatment but the other did
- **School schedules**: Parent perceived school as unwilling to integrate clinical care



> *Taking this [High5] has been in itself very stressful because we're picking open some old scabs, sort of re-examining the scar tissue and then we're going to let it close…when we do, it'll be a little more healed.*
>
> — ***High5* Parent Participant**

High5 Intervention Findings

Most (85%) parents were employed and over half had a mental illness diagnosis at the time of consent. A quarter of our families experienced an episode of homelessness, 40% indicated parents with criminal justice system contact, and 30% had previous contact with the child welfare system. Parents reported struggling with their child's behavior problems when they entered the program including bullying; grabbing, hitting, and biting teachers and peers; cursing at peers, teachers, and parents; throwing and destroying property; impulsiveness; yelling and fighting with family members; and being expelled from programs.

Through ***High5*** participation, parents reported statistically significant reductions in anxiety and depression. Levels of parental distress declined, but not to statistically significant levels. Trauma knowledge significantly increased. Child depression levels significantly declined and self-efficacy significantly increased. Throughout the observation month, children averaged 7.6 hours of sleep per night and parents averaged 6.4 hours. Reports of behavioral outbursts when participants exited ***High5*** decreased, but that is likely also a result of COVID-19-related school closures; parents reported fewer issues, but many were due to the children simply not being in school.

Policy Analysis Findings

Local and state entities have far to go to fully integrate trauma-informed practices into models of care. While policy makers increasingly recognize the impact of trauma on children, our policy analysis found very few that operationalize these principles into written policy or procedures.

WHAT THESE FINDINGS MEAN

Findings from the ***High5*** study highlight the need to work closely with families when developing service options. Practitioners should act to de-stigmatize service use, create innovative platforms for service delivery, and offer childcare and flexible scheduling which may help to engage more families in the care they need.

Interventions like ***High5*** can have an impact on parental and child distress, knowledge, and child self-efficacy. ***High5*** was provided through an accessible online platform and included a session with other parents. Childcare and peer support were central components of the intervention. Future research is needed to better understand which parts of ***High5*** are most helpful in reducing symptoms and family stress. Policies should fund and allow support for these ancillary services to encourage family engagement.

Findings from the policy analysis suggests the need for ongoing training for front-line workers, supervisors, and administrators to build a culture in which trauma-informed practice can thrive.

[1] Alexi Jones (2018) *Correctional Control: Incarceration and supervision by state*, Prison Policy Initiative, Northampton, MA, available at https://www.prisonpolicy.org/reports/correctionalcontrol2018.html.

[2] Data available on https://www.cdc.gov/injury/wisqars/fatal.html.

[3] GAD refers to the General Anxiety Disorder scale, 7-item version; PHQ refers to depression items on the Patient Health Questionnaire, 9-item version.

ABOUT THE AUTHORS

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