



Blackpool
Better Start

Health Visitor Adverse Childhood Experience (ACE) Enquiry -
Survey Report September 2020.

Centre for Early Child Development

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II. Table of Abbreviations

ACEs	Adverse Childhood Experiences
BBS	Blackpool Better Start
CCG	Clinical Commissioning Group
CECD	Centre for Early Child Development
LA	Local Authority
NHS	National Health Service
NSPCC	National Society for Prevention of Cruelty to Children
REACH	Routine Enquiry into Adverse Childhood Experiences
REC	Research Ethics Committee
SPSS	Statistical Product and Service Solutions
TNLCF	The National Lottery Community Fund

Health Visitor ACE Enquiry Survey Report

Research and Evaluation Team (September 2020)

This paper reports on the telephone feedback surveys conducted by the Research and Evaluation team at the Centre for Early Child Development (CECD) to determine the acceptability and use of routine enquiry into Adverse Childhood Experiences (ACEs) conducted by Health Visitors with caregivers during their initial antenatal home visit.

1. What is the Routine Enquiry into Adverse Childhood Experiences (REACH) Training Programme?

The Routine Enquiry into Adverse Childhood Experiences (REACH) training programme was developed in Blackburn by Dr Warren Larkin. REACH uses routine enquiry whereby service providers routinely ask individuals about traumatic/adverse experiences. In such a way it was designed to increase health and social care service providers' knowledge about the impact of Adverse Childhood Experiences (ACEs) on adult health and social outcomes enabling service providers to provide appropriate support, which may reduce the impact of childhood adversities on adult health and well-being.

Research suggests that although ACEs (e.g., abuse, neglect and household dysfunction) are common, people who have experienced them can often be reluctant to disclose them. It can often be at least ten years after the event that they feel able to do so (Anderson et al., 1993; Read et al., 2007). Evidence from the REACH pilot in Blackburn suggests that by routinely enquiring into a service users ACEs, providers have the potential to engage in positive and meaningful conversations about the impact of early adversity (Larkin, 2012).

2. Why is the REACH programme needed in Blackpool?

There is compelling evidence to show that what a child experiences during the early years provides a foundation for the rest of their life (Shonkoff & Phillips, 2000; Shonkoff, Richter, van der Gaag & Bhutta, 2012). In communities of high socioeconomic deprivation such as that encountered in Blackpool, there is a high propensity of caregivers that face multiple and complex needs (e.g., substance misuse, mental ill health or domestic abuse) which can subsequently impact the health and developmental needs of the child.

Exposure to high levels of trauma and toxic stress at a young age can be harmful, predisposing children to problems in learning, behaviour and health across their life course (Fuller-Thomson, Baird, Dhrodia & Brennenstuhl, 2016; Middlebrooks & Audage, 2008; Shonkoff, Boyce, & McEwen 2009; Shonkoff, Garner

et al., 2012). In addition, there is now knowledge of the impact of trauma upon the developing brain with the potential for the intergenerational transfer of negative gene changes leading to impaired health, diminished learning capacity, and poor parenting of the next generation (Shonkoff et al, 2010).

The first ACE study (Fellitti et al., 1998) conducted in America demonstrated a strong relationship between the breadth of exposure to abuse or household dysfunction during childhood and their risk of health issues experienced in adulthood e., heart disease, cancer, chronic lung disease, skeletal fractures & liver disease. Research from within the UK found a similar relationship between ACE scores and adverse outcomes in adulthood (Bellis et al., 2014). Research by Public Health Wales and Liverpool John Moores University found that nearly 50% of the Welsh population had at least one ACE, and 13% had four or more, a number which seems to indicate a ‘tipping point’ in terms of risk of poorer outcomes (Bellis et al., 2016).

Routine enquiry has the potential to contribute towards breaking the historical intergenerational cycle of abuse and trauma across Blackpool as part of a wider trauma-informed approach currently being developed and implemented across the town. The implementation of routine enquiry into ACEs by Health Visitors in Blackpool may enhance Health Visitor knowledge of the impact of trauma for families, and has the potential to increase Health Visitors confidence in discussing ACEs (Davies, 2013). In opening the conversation surrounding ACEs it is hoped to provide caregivers with the time and space to reflect with their Health Visitor on their own childhood experiences. It is possible that they will be more motivated to ensure that children within their care do not experience ACEs as suggested in the CECD developed Theory of Change.

3. Theory of change

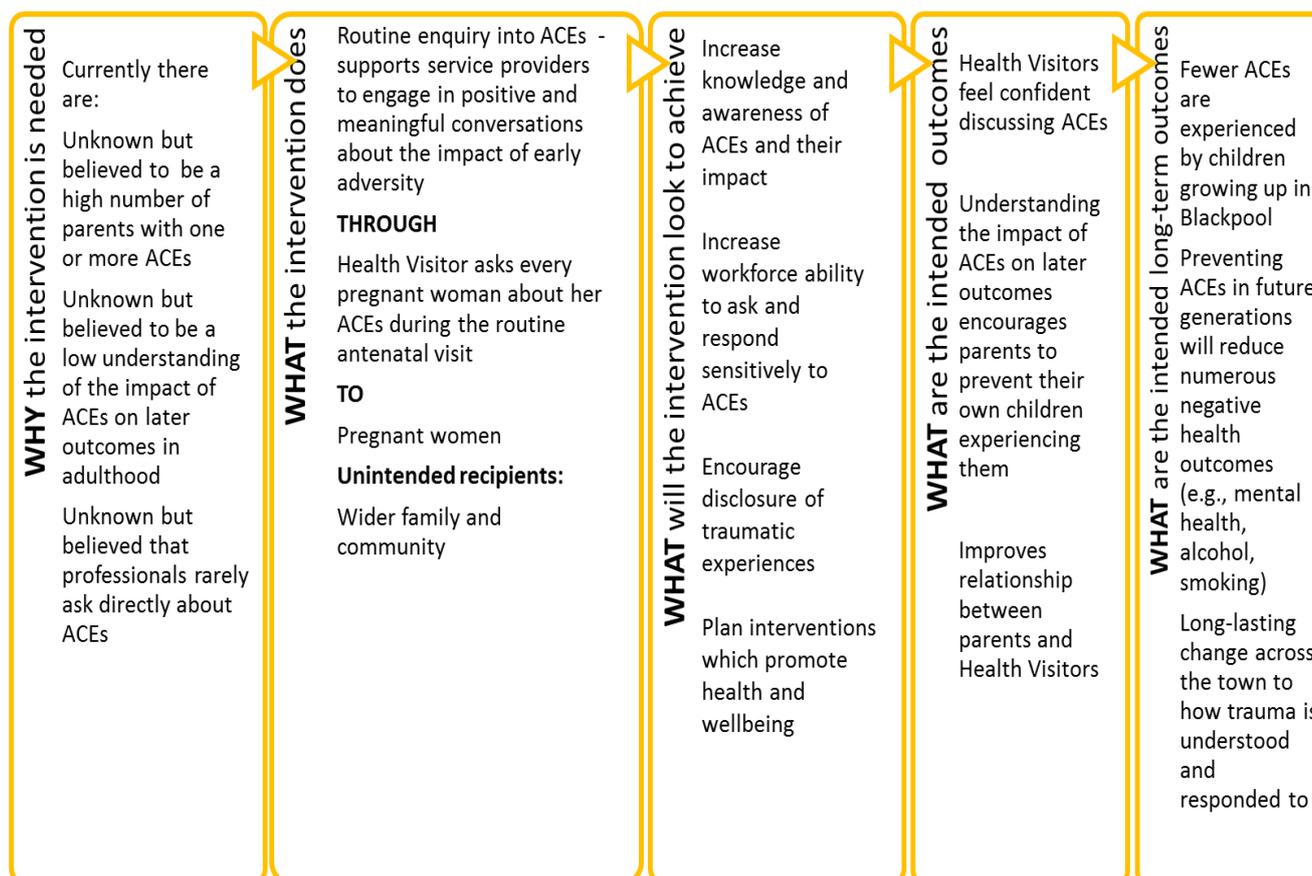


Figure 1: Health Visitor Adverse Childhood Experience (ACE) Enquiry Theory of Change

4. Implementation and Evaluation

The REACH training programme was delivered to Health Visitors as part of the Blackpool Better Start partnership's commitment to ensuring that services across the town are trauma-informed, with the aim of achieving long-lasting change to how trauma is understood and responded to. The REACH training supports Health Visitors to ask the ACE questions and helps them to develop appropriate responses to disclosed experiences of trauma. During the routine antenatal visit all Health Visitors in the study were asked to discuss ACEs with every woman. They introduce the concept of ACEs and provide the ACE questionnaire. Their responses and the potential impact of ACEs on mental health, pregnancy, birth and becoming a parent were then discussed.

The Blackpool evaluation of REACH contributes to a growing body of research examining the impact of routine enquiry into ACEs on both service providers and service users. The evaluation conducted in Blackpool will provide insight into caregiver's perceptions and experience of routine enquiry by their Health Visitor. This study focused on the parent feedback forms conducted over the telephone as part of the mixed-methods evaluation framework developed by the CECD.

5. Method

All caregivers who received their initial antenatal visit between February 2019 and February 2020 were due to receive a routine ACE enquiry from their Health Visitor. Those who consented were informed of the details of the evaluation; a short telephone survey within four weeks of their initial antenatal visit. The telephone survey asked participants to rate a set of eight statements exploring how they felt about being asked about their ACEs by their Health Visitor with two questions at the end allowing participants to expand on their experience of the enquiry. Participants were reassured that the survey was around their experience of being asked and they would not be asked specifically about their own experiences of adversity. The telephone survey had a 64% response rate (n= 59) and phone calls were conducted between March 2019 and March 2020.

6. Analysis

Statistical Product and Service Solutions (SPSS) was used to analyse quantitative data. Qualitative data was subject to an inductive thematic analysis using qualitative data analysis software (NVivo 12) with codes developed by one researcher and confirmed by two others.

7. Telephone Survey Findings

Participants were asked to rate a series of eight statements enquiring into their experience of being asked about their ACEs, and if they were asked in a manner they deemed appropriate and useful. The rating scale ranged from 1 to 10 where 1 represented "Strongly disagree" and 10 represented "Strongly agree."

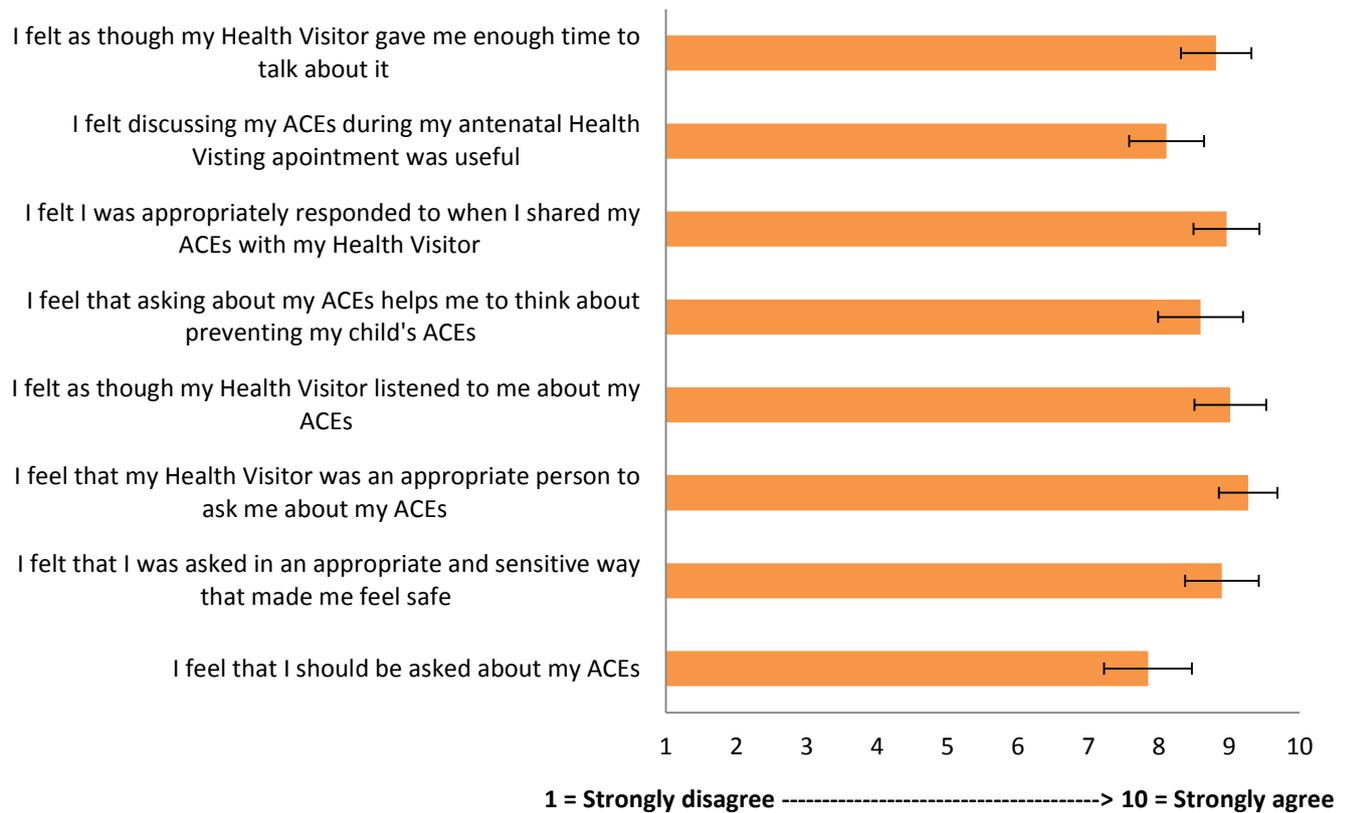


Figure 2: Average participant (n=59) ratings of eight statements posed with error bars representing 95% confidence intervals.

Results demonstrated that on average participants agreed with the statements presented to them with all average scores exceeding 7 on the rating scale with narrow 95% confidence intervals. This suggests that participants found the enquiry appropriate and useful, and that their Health Visitor succeeded in ensuring they felt safe and listened to when disclosing information about their ACEs.

To further examine caregiver experiences surrounding the ACE enquiry, after caregivers had rated the eight statements investigated, a conversation was opened exploring what participants found helpful about being asked about their ACEs and if any changes could be introduced to improve the experience. Thematic analysis identified three key themes; ACE Awareness, A Safe Space and ACE Enquiry Delivery.

7.1 ACE Awareness

It was apparent that routine enquiry facilitated participant's awareness of ACEs and their relevance throughout the perinatal period. The majority of participants acknowledged the importance of talking about ACEs and several suggested that raised awareness to prevent their child experiencing adversity.

Relevance of ACEs

Several caregivers implied they understood the need for the ACE enquiry and expressed that it ‘made sense’ why they were invited to talk about ACEs. The comments suggested that the impact previous trauma can have on long term behaviours was understood by a large proportion of participants.

“I just think all women should be asked about this kind of thing. It makes sense that you can be best supported if they know your background.”

“I think it's really important actually. So many people have experienced trauma when they were little, it makes sense.”

“People need to be aware about how much it can affect you even years later, counselling’s good and all but it doesn’t make it go away or not happen.”

“I think it’s great to bring it to my attention.”

Even those who openly disclosed no personal experience of trauma or felt they had managed their own past experiences of trauma, stated that ACE enquiry for caregivers who had experienced childhood trauma and may require additional support was important.

“I didn’t think it was particularly useful for me because I’ve dealt with my past already but for some people I can see why being asked would be really important.”

“I didn't have any ACEs to discuss but I can imagine it is useful for those that do.”

“I didn't have any experiences like that when I was a child so it was a bit hard but I think its going to be really good for people who have gone through stuff.”

“I was fortunate to have a good upbringing but I do think it is good to be asked about your childhood during the health visit and I felt it was appropriate to be asked.”

Intergenerational ACEs

The ACE enquiry appeared to have promoted self-reflection on some of the experiences participants had faced as a child. Some suggested they would parent differently to how they were parented. Those participants who self-reflected on their childhood experiences in a negative manner suggested they desired to ensure their child/children did not experience the same adversity.

“I think it’s really important that new mums are asked these questions. It helps you to bring perspective about what you want your own children to grow up experiencing. It makes you think about your own childhood and for me anyway how fucking much you want your babies to be nothing like that. I grew up with abuse all the time.”

“I've had some quite bad stuff happen when I was younger but that just makes me more determine to make sure mine doesn't have to go through what I have.”

“It made me think about the type of parent that I want to be - and that's nothing like mine.”

7.2 A Safe Space

The findings suggested that Health Visitors were successful in creating a safe space for caregivers. This appeared to positively impact caregiver-Health Visitor relationships, provide caregivers with an opportunity to open up, and aid in normalising talking about ACEs.

Caregiver-Health Visitor Relationship

The majority of participants reported positive interactions with their Health Visitor when discussing ACEs. It was suggested that the ACE enquiry strengthened the relationship between the caregiver and the Health Visitor. Caregivers expressed feeling cared for, and felt they could approach their Health Visitor if they required support. Although some participants did not want to disclose information regarding their ACEs at that moment in time, the enquiry appeared to reassure caregivers that they could approach their Health Visitor for support in the future.

“I felt like she actually cared and it wasn't just another part of her job to ask me even though I know it was. I didn't want to talk about it right then but I could talk to her about it all if my past began to bother me again in the future.”

“No, she gave me loads of stuff and she was really nice. She was like if you need me call and I can come round any time. She was really good.”

“I guess your going to talk to them about lots of other stuff so its good to start opening up that relationship.”

“I experienced quite a lot so I feel like it's important. I didn't tell my Health Visitor though because I didn't want to talk about it then. But I still think it's important she asked me because it was like she was trying to build my trust in her. Let me know I could if I wanted to. It takes me a while to trust people though. It was like, I don't know it's hard to explain.”

Opportunity to Open Up

Several participants acknowledged that the enquiry provided them with the space to open up and talk about their ACEs. Participants appeared reassured that their Health Visitor was someone who would listen and support them regarding their past experiences.

‘...It lets you know that it’s okay to talk about them, it gives you the space to open up, put things in place and get the support you need and plan around it.’

Moreover, some participants stressed the importance of having the opportunity to talk about ACEs, inferring a sense of reassurance in the Health Visitor that they were there to provide professional support beyond the scope of family or friends.

“It’s nice to know that someone cares and is interested in what has happened to you. It’s good to know that you have the option to share. There’s always friends and family but sometimes it’s easier to share and talk with someone that you don’t know.”

“I think it’s important that people get the chance to talk about these things. It lets you know that it’s okay to not be okay or to still be affected by stuff that might have happened in your past. There’s so many people talking about mental health now but without the opportunity to really talk about it unless you reach the top level and by then it’s too late.”

“This is a really good opportunity for people to think ohh you know what there is someone I can talk to about this type of thing if I need to. Especially as when you have a baby, loads of women get postnatal depression, so they need to know they can talk to someone.”

Other participants suggested that the approach highlighted a change in health services more widely. They suggested a movement towards service providers focusing on what the caregiver feels they need support with as opposed to the distribution of information and public health messages from professionals.

“You can tell there’s lots of change and things going on in Blackpool. When I had my last I was very much just being given all the information rather than being asked what’s important to you and letting you take control because everyone’s different.”

Normalising ACEs

For the majority, the ACE enquiry appeared to normalise experiences of ACEs. Participants felt comfortable in the delivery of the ACE enquiry which may be attributed to the Health Visitors establishing a situation where caregivers felt safe and comfortable to share their experiences.

“I’ve always been aware of not wanting my children to experience what I have. I think what was good is that - I mean I don’t want people to make a fuss about it, and she didn’t, she responded well - she made me feel like it was completely normal to have experienced some of these things which was good”

“It’s important to be able to talk about this and it to become normal and not something to be ashamed of.”

“No I was just happy that it was brought up so normally, it’s really important not to make new mums feel stigmatised against”

In contrast a minority of participants expressed a fear of being judged if they were to disclose information regarding their ACEs. This implies that the perceptions of negative stigmas surrounding ACEs may still exist for some caregivers.

“I’m not sure. There was nothing for me to discuss so it was fine. But I’m the type of person that if I had it might of offended me being asked. Like it would touch a bit of a nerve because I would be thinking just because something happened to me it doesn’t me I’m a risk or something will happen to my child. It might some women not share as much for fear of being judged.”

7.3 ACE Enquiry Delivery

The delivery of the ACE enquiry from different Health Visitors may have influenced how the caregiver experienced the enquiry and how comfortable they felt disclosing information about their ACEs.

Practical Implications

Participants preferred being physically handed the ACE questionnaire to allow them time to read and process the questions as opposed to the Health Visitor reading the questions aloud.

“Yes it was quite good. I liked that she just handed me the form and explained it.”

Physically giving the participants the ACE questionnaire appeared to reassure participants that it was their choice if they wanted to disclose any information to their Health Visitor. Therefore, they did not feel obliged to take part in the ACE enquiry. Participants appreciated the time spent explaining the enquiry and the clarity that it was their decision if they answered the questions or not.

“By giving the questionnaire it just lets you know you can if you want to rather than making you. That’s how it should be done I think.”

“I liked that she gave me the questionnaire first. I was given the chance to read through the questions and internally process them first. A friend of mine who’s pregnant was just read the questions by hers. That would have been awkward. You need to decide for yourself whether you want to open up to your Health Visitor at that point. By giving the questionnaire it just lets you know you can if you want to rather than making you. That’s how it should be done I think.”

“I felt as though it was my choice whether or not I wanted to have the discussion. She was really good.”

A couple of participants suggested that the structured questioning of the ACE enquiry made it feel direct and they would have preferred a more conversational approach to the enquiry.

“Maybe if it was a little bit more indirect and not as scripted so it feels like a real conversation”

“The wording of the questions. She just read off sheet. It could be more freehand than scripted. It felt a bit direct and could be gently introduced. Like, are there any things which happened in your childhood which were not okay. It would have been helpful to look at sheet before she did it.”

Communication Style

The Health Visitor’s approach and communication style appeared interwoven with the propensity of caregivers opening up and talking about their ACEs. Although very few in numbers, those participants who felt their Health Visitor was not comfortable delivering the ACE enquiry suggested this then influenced their willingness to disclose information regarding their ACEs.

“I didn’t really feel like she wanted to ask me. She clearly felt uncomfortable asking me, which made me feel not comfortable to tell her. She really wanted to move on to other stuff that I wasn’t really that interested in like breastfeeding. I’m not carrying on so it just wasn’t relevant”

“Maybe give them [Health Visitors] a bit more training so they feel okay to talk about it.”

“I think it’s important that you get asked and I think Health Visitors are the right people to do it. Just not this one. She just wasn’t bothered at all she literally kept checking her phone or watch all the time. She just made me feel like a massive pain in the arse and that this was yet another thing she had to ask me about that I was taking too long to think about.”

Time

The time given to conduct the ACE enquiry appeared inadequate for some participants. They suggested that there was insufficient time to process the questions. Others reflected on requiring more time talk through their responses with their Health Visitor without feeling rushed.

“I just felt like she didn’t really give me enough time to process what she was asking me. I don’t blame her though they need to be given more time or less things to ask about in this visit.”

“I needed a bit more time to talk about it - we moved on to other stuff that wasn’t that relevant to me quite quickly.”

“I think it would have been good to have a bit more time - some people will really need that - if you remind someone of it you need to give them enough time to work through that with you if you have been honoured enough to be the person they are sharing it with for what might be the first time, or the first time in a long time”

Prior Information

Some participants felt they were not given enough warning prior to the enquiry about the content of the ACE questionnaire.

“Maybe a bit more warning about what you are going to ask as some of the questions are quite hard-hitting.”

“It was fine. But I can imagine it being a really hard conversation for some people. So maybe it could be done more sensitively. It was a hard conversation to start. Maybe provide some information about it before the visit to give people time to process it first and weigh the pros and cons of telling.”

Some participants requested more information surrounding the purpose of the enquiry and detailed issues regarding the understanding of the more technical language used (e.g., Adverse Childhood Experiences). This language may be novel for some participants, and therefore require a more extensive explanation. A more thorough introduction to the enquiry could be implemented to further ensure caregivers understand its content and purpose.

“I think it would be better if you gave people a bit more information before it - people don't know what adverse childhood experiences means. It's the language used, if you don't understand what it is how can you know if you want to complete it.”

“Might be good to explain why they want to know. Just makes me feel a bit suspicious of why they're asking.”

Some participants who suggested more information was required prior to the enquiry made reference to the enquiry as a 'test' this inferred a lack of understanding of the purpose. Again, findings suggest a clearer introduction to the enquiry may be necessary.

“I didn't want to be given a score like a test so I just said no to them all because I don't know what she was going to do with it and if that would be on my record then in case social use it against me. But that's just me being paranoid and not about her, she was really sound.”

“I got it because of other stuff I've been to but it might be better to explain the test first for those people that haven't because I'm not sure they would have understood why they were being asked.”

8. Summary

Both quantitative and qualitative analysis suggested that caregivers found the ACE enquiry useful and felt they were asked in an appropriate manner. Participants demonstrated that they understood the importance and relevance of the enquiry regardless of having experienced ACEs or not. The enquiry appeared to

succeed in increasing their awareness of ACEs and provided caregivers with a space to open up to their Health Visitor regarding ACEs. It appeared to positively influence caregiver's motivation to ensure their own child/children do not experience ACEs, subsequently contributing to the aim of mitigating the impact of intergenerational ACEs within families. It was clear that participants appreciated that the enquiry and that it provided them with an opportunity to talk about their ACEs. This accompanied participants expressing appreciation for knowing there was someone there for them who cared and would provide support for present and future issues. The exercise of opening up a conversation regarding ACEs appeared to help normalise the topic and facilitated caregivers feeling less judgment surrounding ACEs.

The practical delivery of the enquiry by Health Visitors appeared to impact the caregiver's perceptions of how comfortable they felt engaging. Those who were physically handed the ACE questionnaire and were given sufficient time to process and understand the purpose felt they were fully informed and understood that they had a choice if they did not want to participate. By comparison, and although few in number, those that were not provided with a copy of the ACE questionnaire suggested they were unprepared for the personal nature of the questions and felt the verbal delivery was too direct. Several caregivers requested more information about the purpose of the ACE enquiry, with some interpreting the enquiry as a test. This implies there is need for a more comprehensive introduction to the enquiry, to ensure caregivers are fully informed of the purpose and to allow sufficient time for caregivers to familiarise themselves with the material.

Additionally, despite quantitative results suggesting participants agreed with the statement that their Health Visitor gave them enough time to talk about their ACEs, a minority of caregivers disclosed that they felt the enquiry was rushed and they were not given a sufficient amount of time to discuss their ACEs. This could deter caregivers from opening up to their Health Visitor in the future. Similarly, a very small number of participants felt their Health Visitor was uncomfortable when conducting the ACE enquiry. This may suggest Health Visitors should ensure they are confident conducting an ACE enquiry to ensure the caregivers feel comfortable in discussing their ACEs if they chose to do so.

To conclude, the ACE enquiry was perceived to be a positive experience for caregivers, increasing awareness of ACEs and their relevance during the early stages of parenting. Caregivers reported that they had the space to reflect on their ACEs and think about preventing their child's ACEs. Participants stated they found it important to be asked about their ACEs. Participants felt their Health Visitor cared, and they could contact them in the future if they required support. It is possible that the ACE enquiry achieved its original aim of providing caregivers with the opportunity to talk about their ACEs with their Health Visitors, however issues with communication and delivery could be addressed to increase future engagement.

9. Recommendations

Recommendations for the delivery of the ACE enquiry are as follows:

- Allow Health Visitors adequate time to introduce the enquiry and ensure caregivers fully understand its content and purpose as well as time for their responses to be discussed.
- Provide caregivers with a physical copy of the ACE questionnaire so they are aware of the style of questions in order to make an informed decision to continue.
- Ensure Health Visitors who may feel less comfortable with enquiring routinely about ACEs receive further training.

10. Declarations

10.1 Ethical approval

This study was approved by the Research Ethics Committee (REC) 2019 of the National Society for the Prevention of Cruelty to Children (NSPCC). Written and verbal consent was obtained from all participants.

10.2 Consent for publication

No images, videos or personally identifiable information is included in the report. Consent for using anonymised data in reports, conferences and for wider publication is stated in the participant consent form.

10.3 Availability of data and materials

Data sharing is not applicable for the qualitative data transcripts. There was no expectation for the raw data transcripts to be shared and as such the ethical application and consent process did not include permission to share this material. Use or inclusion of any portion of this document in another work intended for commercial use will require permission from the CECD.

10.4 Funding

This work was undertaken by the research and evaluation team at the CECD, the research and development hub of the Blackpool Better Start (BBS) partnership. The partnership is made up of the National Society for Prevention against Cruelty of Children (NSPCC), the Local Authority (LA), Blackpool Teaching Hospitals NHS Foundations Trust, Blackpool Clinical Commissioning Group (CCG) and representatives from the local community. The Blackpool Better Start initiative's lead organisation is the NSPCC and is funded by

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