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The Effectiveness of Family-Centered Social Services in Preventing Adverse Childhood Experiences (Aces): Review

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Abstract

Background: Adverse Childhood Experiences (ACEs) are linked to numerous long-term health issues and detrimental behaviors in adulthood. With a significant portion of the population experiencing ACEs, understanding effective prevention strategies is crucial. Family-centered social services have emerged as a promising approach to mitigate the impact of ACEs.

Methods: This review systematically examines existing literature on family-centered social services aimed at preventing ACEs. A comprehensive search of randomized controlled trials (RCTs) was conducted, focusing on interventions that engage families in the prevention of ACEs during the perinatal period. The study assessed the effectiveness of these interventions on maternal and child health outcomes.

Results: The review identified 53 interventions, primarily targeting secondary prevention strategies. Approximately 70% of the studies reported positive outcomes for mothers and children, underscoring the potential of family-centered approaches. Notably, interventions that incorporated multiple life course factors and engaged broader family dynamics were more effective in achieving favorable results.

Conclusion: Family-centered social services represent a vital component in the prevention of Adverse Childhood Experiences. By integrating a comprehensive approach that addresses structural and social determinants of health, these interventions can enhance the well-being of families and disrupt cycles of adversity. Future research should focus on longitudinal studies to evaluate the sustained impact of these interventions and explore the integration of anti-racist frameworks in program design.

Keywords: Adverse Childhood Experiences, Family-Centered Services, Prevention Strategies, Maternal and Child Health, Public Health

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1. Introduction

Adverse Childhood Experiences (ACEs) are distinctly correlated with various adult health disorders and risk-taking behaviors, demonstrating a graded dose-response connection [1]. Progress in neurobiology, epigenetics, and life cycle theory has led to the acknowledgment of credible mechanisms via which early life traumas may influence a child's evolving biological, psychological, and social processes [2, 3]. Once established in early childhood, these processes may be difficult to modify, particularly if they remain undiagnosed for an extended period [3].

Adverse Childhood Experiences (ACEs) are prevalent, with a recent estimate indicating that 61% of people in the United States encounter at least one ACE, and almost 1 in 6 endure four or more. The projected overall yearly expenses associated with ACEs are $581 billion in Europe (2.7% of GDP) and $748 billion in North America (3.6% of GDP). Proactively addressing and alleviating Adverse Childhood Experiences (ACEs) might enhance population health across the lifespan, save substantial suffering, and markedly decrease expenses, so establishing this as a public health need [4, 5]. Numerous inquiries persist for both policymakers and providers about the most effective strategies to tackle ACEs at the population level, particularly in terms of prevention, which proves to be especially difficult [6, 7].

2. Continuum of Public Health Prevention

The public health preventive continuum offers a valuable framework for researchers and interventionists aiming to effectively target their efforts to avoid or alleviate the effects of ACEs on long-term health [8]. Primary preventive initiatives aim to avoid or diminish the occurrence of Adverse Childhood Experiences (ACEs) from happening initially. These initiatives recognize that Adverse Childhood Experiences (ACEs) can arise from structural and Social Determinants of Health (SDOH) factors, including historical, local, and political contexts that impose multiple stressors on families—such as racism, discrimination, inadequate affordable housing, and obstacles to childcare—and may encompass actions addressing these 'upstream' factors [9–15]. Secondary prevention approaches concentrate on early identification, identifying individuals exposed to adverse childhood experiences (ACEs) after their occurrence but before the emergence of discernible symptoms, and facilitating access to therapies aimed at mitigating the risk of subsequent complications [16, 17]. Tertiary prevention emphasizes intervention for families, children, and adolescents who have been recognized as having undergone Adverse Childhood Experiences (ACEs) and their repercussions, aiming to alleviate further detrimental effects. All three tiers of preventive interventions are integral to a comprehensive, multi-faceted strategy that can significantly influence the prevalence and subsequent consequences of ACEs. Identifying the interventions with demonstrated efficacy at each stage of the prevention continuum will facilitate the selection of appropriate interventions for each level and establish priorities for intervention implementation. Moreover, life cycle frameworks propose additional pertinent factors for the formulation of successful ACEs preventive strategies [18-20].

3. Life Course Health Development Framework

The Life Course Health Development (LCHD) approach integrates the Socio-Ecological Model and posits that an individual's health is the outcome of intricate, adaptive relational interactions among their biology, behaviors, and social and environmental contexts [3, 19, 20]. Interventions aimed at enhancing health trajectories must take into account individual characteristics, familial and communal contexts, and the significance of interactions within and among these layers [21]. The approach recognizes the significance of social and structural determinants of health in the emergence of ACEs and the continuation of intergenerational cycles of adversity. Early childhood hardship and toxic stress may adversely affect maternal physical and mental health, hindering a mother's ability to provide caring care to her newborn and to avert other unpleasant experiences. Recent efforts to include life cycle principles in intervention

research have led to the identification of 12 features of life course interventions and the development of a Life cycle Intervention Research (LCIR) Framework; however, this framework has not yet been utilized to analyze ACEs preventative therapies. Determining the association between these lifespan parameters and the efficacy of therapies will aid in assessing the value of this strategy and in further refining these features as data accumulates [22].

4. Perinatal interventions

While preconception represents a rational moment for addressing ACE prevention for future generations, irregular engagement with the healthcare system and the absence of a clear delivery platform make interventions during this life stage difficult [23]. Researchers focused on the prevention of Adverse Childhood Experiences (ACEs) have frequently concentrated on pregnancy and the perinatal period as the initial phase when expectant parents regularly interact with the healthcare system, are committed to optimizing outcomes for their child, and may exhibit the greatest willingness and capacity to modify their behaviors [24]. Consequently, they may be inclined to examine events or experiences in their personal history or circumstances that could jeopardize their child (e.g., through their parenting or mental or physical health), and they may be driven to engage in interventions aimed at mitigating or eradicating those risks. Furthermore, early prenatal intervention programs may have the most potential for both efficacy and long-term cost savings across an individual's life span [25, 26].

A substantial amount of research investigates prenatal therapies aimed at enhancing overall child health outcomes. Nevertheless, to our knowledge, few evaluations directly address ACE preventative strategies throughout this life stage, and none use public health prevention and life cycle frameworks or concentrate on properly constructed experimental investigations. To fill this vacuum in the literature, we conducted a scoping assessment of prenatal therapies aimed at mitigating at least one risk or exposure associated with child ACEs. Our objectives were to execute a systematic review of published perinatal interventions evaluated in randomized controlled trials (RCTs) aimed at preventing or mitigating adverse childhood experiences (ACEs) and their associated risk factors, with reported outcomes for both mother and child; and to summarize which interventions exhibit efficacy in reducing the child's future exposure to ACEs and their consequences.

5. Mitigating Adverse Childhood Experiences (ACEs)

Mitigating Adverse Childhood Experiences (ACEs) is acknowledged as a public health need. The prenatal period presents a significant opportunity for effective preventative strategies to enhance children's health development trajectories and disrupt intergenerational cycles of adversity [28-30]. We examined 53 treatments that took place throughout the prenatal period, mostly concentrating on secondary prevention. The majority of research indicated a beneficial effect for either the mother or the kid. While the majority of therapies targeted individuals, the authors acknowledge the influence of structural social determinants of health (SDOH) on prenatal adverse childhood experiences (ACEs) and recognize that integrating the Socio-Ecological Model into intervention design will be beneficial in addressing this issue. The authors used the LCIR framework, which integrates the Socio-Ecological Model, to assess the degree of its incorporation into the treatments. A substantial correlation was identified between the quantity of life cycle variables included in an intervention and a reported beneficial effect on the mother and/or child. Limited interventions integrated community context or broader family participation, and hardly any addressed challenges like as racism and communal violence.

This scoping review enhances the current knowledge synthesis by summarizing the status of ACEs preventive research and beginning to identify the most effective techniques applicable to both at-risk and general populations. We discovered that few prenatal treatments were explicitly targeted at avoiding Adverse Childhood Experiences (ACEs) as a comprehensive category of adversities; nevertheless, many interventions were formulated to prevent and/or mitigate particular adversities and associated risk factors for negative experiences. Although identifying preventative treatments for individual hazards is beneficial, in reality, Adverse Childhood Experiences (ACEs) never manifest in isolation and often co-occur. This indicates a need for more intervention studies addressing various hazards. Seventy percent of the

randomized controlled trials we examined showed beneficial effects on the child and/or mother, indicating that the perinatal period may represent a viable phase for interventions aimed at preventing adverse childhood experiences.

6. Prolonged effect

Expectant parents are often extremely motivated to implement changes that will benefit their unborn child, presenting an optimal opportunity for community initiatives to capitalize on this moment in the life cycle [22, 31, 32]. This potential may be easily wasted if the treatments provided are not evidence-based, are too restrictive, or do not address the needs of families and communities. Optimal ACEs preventive strategies should have enduring effects that transcend temporary risk mitigations and enhance overall health trajectories over the lifespan. Since just over one-third (37%) of studies conducted follow-ups beyond one year, and only 26% surpassed two years, it is infeasible to ascertain the long-term effects of the majority of these treatments. Nonetheless, of the programs that conducted follow-ups for two years or more, 67% indicated a persistent favorable effect, which is an encouraging outcome. This may indicate a bias where better-funded studies with more intensive interventions are more likely to track participants over extended durations, and that long-term follow-up studies with favorable outcomes are more likely to be submitted and published than those with unfavorable results. It could also imply that these more thorough interventions may have enduring effects.

7. Home visitation programs

Nurse-family partnership home visiting programs are the most extensively researched prenatal interventions for the avoidance of adverse childhood experiences (ACEs). Although most home visiting initiatives are founded on the Olds model [33, 34], there exists significant variability in their content and implementation, including the leadership by nurses, paraprofessionals, or volunteers. A substantial body of work has produced inconclusive findings on their usefulness, efficacy, and potential for dissemination and scalability [35]. The Home Visiting Evidence of Effectiveness program operates a webpage that summarizes the evidence status for several approaches. Consequently, disagreements have arisen over the prioritization of adherence to the original model vs the need for substantial cultural and local changes. The issues have been exacerbated by the difficulty associated with identifying which program components are necessary vs adaptable, as well as the need for more detailed reporting on the content and activities conducted during visits for various groups [36, 37]. In our analysis, 63% of home visiting programs had beneficial outcomes; however, over one-third did not, which is a significant number given the resources allocated to home visiting. Only 20 (35%) integrated seven or more life cycle features into their design, 13 (26%) included family members other than the child's mother, two demonstrated any evidence of co-design, and only one research acknowledged the inclusion of anti-racist concepts. Modifications to home visiting programs that include these components may enhance effectiveness and merit more investigation.

The increased probability of a favorable prenatal intervention result, when a wider number of life cycle parameters were included into the intervention design, indicates that a broader inclusion of life course characteristics, beyond only home visiting programs, warrants more investigation. It would be very valuable to ascertain if the inclusion of all 12 criteria might provide therapies with enhanced favorable dyadic effects that are maintained over the life cycle. The Family Spirit program, which emphasizes secondary prevention and integrates 10 characteristics, demonstrated enduring good effects on mothers and children over three years, facilitated by robust, culturally driven, equity-focused co-design [38, 39]. Characteristics least likely to be integrated into current interventions encompass those identified by stakeholders as paramount for life course orientation, such as strengths-based methodologies, an emphasis on health optimization, collaborative co-design, and the inclusion of specific anti-racist elements [20].

8. Interventions within the framework of the developmental ecosystem

Life cycle methods recognize that adverse childhood experiences (ACEs) manifest and influence outcomes within the framework of a child's familial, neighborhood, social, and community setting; yet only a limited number of research in this review addressed or thoroughly examined this extensive

developmental ecosystem. The majority of research focused only on the mother, with some include the kid or newborn, while just 13% included the child's father, second parent, or other family members. This strategy signifies a lost opportunity for broader family and community involvement in ACEs prevention initiatives, potentially diminishing intervention efficacy [40]. Co-parenting programs like Family Foundations may be especially effective for preventing Adverse Childhood Experiences (ACEs), however, their implementation remains limited [41]. A deficiency in co-design, evident in merely 4% of interventions, signifies a lost opportunity for individuals and families to share their lived experiences and local knowledge in the creation of culturally and contextually relevant interventions developed in equal partnership. Merely one-fourth of treatments acknowledged individual, family, and community strengths, indicating a wasted opportunity and highlighting the need for a more comprehensive study on the definitions, principles, and applications of various strengths of character, talent, and resources [42]. These exclusions indicate a deficiency in research regarding innovative strategies for family and community participation in intervention studies to enhance comprehension of priority needs.

Only one of the fifty-three interventions in this study explicitly addressed racism as a fundamental contributing factor to adversity. This significant oversight indicates that existing remedial strategies fail to account for the influence of structural variables and societal prejudices that may exacerbate early adversity and perpetuate unfairness. Enhanced integration of equity objectives and anti-racist methodologies in intervention design and execution may contribute to the recognition of the fundamental causes of adversity and trauma [43].

Ultimately, while much data supports the short- and medium-term benefits of various prenatal therapies, each intervention individually targets the avoidance of certain adversities. A potential avenue for future study is to amalgamate numerous therapies or fundamental elements of evidence-based interventions into comprehensive, multi-tiered strategies, therefore explicitly connecting them with current programs to address various co-occurring needs [44, 45]. This method has shown potential in early childhood treatments to enhance early learning, although necessitates further investigation for the avoidance of ACEs [46].

9. Constraints

The limitations of this scoping review include our selection of search keywords and inclusion criteria, which influence the articles examined, as well as our restricted comprehension of the intervention's content, intensity, and activities as specified in the publications. This review included a specific demographic since it contained just papers published in English, which were mostly reported. The majority of interventions were conducted in English, with one or two other languages at most. Consequently, the extent to which our results may apply to non-English-speaking nations, communities, and cultures remains ambiguous. All review components were confined to the original text; for instance, if authors choose not to disclose negative effects or the absence of impact from treatments, this could not be included in our review. Comparisons between High-Income Countries (HIC) and Low and Middle-Income Countries (LMIC) were not done due to the disparity in their numbers. This indicates that our results cannot be extrapolated to non-English speaking nations and low- and middle-income countries (LMICs).

This review is informed by two conceptual frameworks: the public health preventive continuum and the Life Course Intervention Research framework, which provided valuable insights; however, other theories can provide different findings. Furthermore, the discovery about the integration of life cycle characteristics and parent/child outcomes should not be construed as causative due to the possibility of unmeasured confounding variables.

Interventions were deemed to have a positive impact if the statistical analysis presented in the manuscript corroborated this conclusion; however, few authors addressed the extent to which significant findings were clinically relevant or regarded as meaningful by the recipients of the intervention. The use of uniform metrics in ACE preventive research should enhance comparability across studies. The authors advocate for enhanced focus on the worldwide dissemination of intervention material and design methodologies to augment knowledge within the sector.

10. Implications for public health

The perinatal period is an opportunity for public health initiatives aimed at preventing adverse childhood experiences (ACEs) to positively influence the future health of both mother and child. Current service delivery programs that engage with perinatal populations, like as home visiting initiatives, should include supplementary evidence-based treatments for ACEs prevention described in this research, including co-parenting and integrative health strategies.

Integrated, multi-tiered, evidence-based treatments targeting social and structural determinants of health in their formulation and implementation should constitute a more holistic approach to preventing prenatal ACEs. The integration of life cycle factors, including the co-design of treatments with prospective receivers and the inclusion of trauma-informed aspects, is an approach deserving of future public health study.

11. Conclusions

This scoping review sought to synthesize evidence from randomized controlled trials of interventions pertinent to the prevention of adverse childhood experiences (ACEs) administered during the perinatal period, focusing on maternal and child health outcomes. The objective was to assess the current state of the evidence base, identify the types of interventions under investigation, and begin to clarify the essential components of interventions that significantly influenced maternal and/or child health. No interventions reported in this review specifically addressed ACEs. They focused on certain hazards or situations that endangered the child's exposure to ACEs. No one intervention examined was enough on its own to avoid and alleviate the effects of ACEs during the perinatal period or to effect transformational change. There is no universal solution or expedient remedy. Programs that integrate several components of effective treatments, tailored to diverse family and community settings in flexible and adaptive ways, may aid in the prevention of numerous Adverse Childhood Experiences (ACEs). The integration of co-parenting treatments into home visiting models, with broader flexibility to familial and communal contexts, may be very beneficial.

Examining ACEs prevention via a Life Course lens offers a chance to inform design initiatives aimed at intervening during the perinatal phase to mitigate or diminish the enduring effects of ACEs. Initial study indicates that including additional life cycle factors into treatments increases the probability of favorable results. This study advocates for enhanced efforts to comprehend the significance and influence of life cycle features on treatments aimed at preventing ACEs and enhancing health trajectories for mothers, children, families, and communities.

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فعالية الخدمات الاجتماعية الموجهة للأسرة في الوقاية من التجارب السلبية في الطفولة :(ACEs) مراجعة

الملخص

الخلفية :ترتبط التجارب السلبية في الطفولة (ACEs) بالعديد من المشكلات الصحية طويلة الأمد والسلوكيات الضارة في مرحلة البلوغ. مع تجربة نسبة كبيرة من السكان للتجارب السلبية في الطفولة، فإن فهم استراتيجيات الوقاية الفعالة أمر بالغ الأهمية. وقد برزت الخدمات الاجتماعية الموجهة للأسرة كنهج واعد للتخفيف من تأثير هذه التجارب.

الطرق :تستعرض هذه المراجعة الأدبيات الحالية بشكل منهجي حول الخدمات الاجتماعية الموجهة للأسرة التي تهدف إلى الوقاية من التجارب السلبية في الطفولة. تم إجراء بحث شامل عن التجارب السريرية العشوائية (RCTs) مع التركيز على التدخلات التي تشرك الأسر في الوقاية من ACEs خلال فترة ما حول الولادة. قيمت الدراسة فعالية هذه التدخلات على نتائج صحة الأم والطفل.

النتائج :حددت المراجعة 53 تدخلًا، تستهدف في الغالب استراتيجيات الوقاية الثانوية. أبلغت حوالي 70% من الدراسات عن نتائج إيجابية للأمهات والأطفال، مما يبرز إمكانية النهج الموجه للأسرة. ومن الجدير بالذكر أن التدخلات التي دمجت عوامل متعددة عبر مسار الحياة وشاركت ديناميات الأسرة الأوسع كانت أكثر فعالية في تحقيق نتائج ملائمة.

الخاتمة :تمثل الخدمات الاجتماعية الموجهة للأسرة عنصرًا حيويًا في الوقاية من التجارب السلبية في الطفولة. من خلال دمج نهج شامل يعالج المحددات الهيكلية والاجتماعية للصحة، يمكن أن تعزز هذه التدخلات رفاهية الأسر وتقطع دورات المعاناة. ينبغي أن تركز الأبحاث المستقبلية على الدراسات الطولية لتقييم التأثير المستدام لهذه التدخلات واستكشاف دمج الأطر المناهضة للعنصرية في تصميم البرامج.

الكلمات المفتاحية :التجارب السلبية في الطفولة، الخدمات الموجهة للأسرة، استراتيجيات الوقاية، صحة الأم والطفل، الصحة العامة.