Mitigating the Effects of Family Poverty on Early Child Development through Parenting Interventions in Primary Care

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ABSTRACT

Poverty related disparities in early child development and school readiness are a major public health crisis, the prevention of which has emerged in recent years as a national priority. Interventions targeting parenting and the quality of the early home language environment are at the forefront of efforts to address these disparities. In this article we discuss the innovative use of the pediatric primary care platform as part of a comprehensive public health strategy to prevent adverse child development outcomes through the promotion of parenting. Models of interventions in the pediatric primary care setting are discussed with evidence of effectiveness reviewed. Taken together, a review of this significant body of work shows the tremendous potential to deliver evidence-based preventive interventions to families at risk for poverty related disparities in child development and school readiness at the time of pediatric primary care visits. We also addresss considerations related to scaling and maximizing the effect of pediatric primary care parenting interventions and provide key policy recommendations.

KEYWORDS: disparities; parenting; poverty; primary prevention; school readiness

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SOCIOECONOMIC DISPARITIES IN child development and school readiness have been well documented. These disparities emerge as early as the first year of life and persist and worsen over time.[1,2] Importantly, such early disparities lead to reduced readiness to learn upon school entry, and contributing to long-term reductions in academic achievement, educational attainment, and overall well-being.[3,4] The etiology of the effects of poverty on early child development is multifaceted, with a combination of social and economic risk factors that affect the environments in which low socioeconomic status (SES) children are raised. Of particular detriment to families who live in poverty is the high incidence of toxic stress drawn from factors such as low levels of education, resources, and social support.[5] These factors have potential to also contribute to a home environment characterized by less frequent cognitive stimulation, parent responsivity, and lessened exposure to high-quality language interactions, essential for cognitive[6] and language development,[7,8] literacy acquisition,[9] and overall success in school.[10]

Because of the deleterious effects of poverty-related disparities in early development on long-term outcomes, they have been deemed a major public health crisis, the correction of which has emerged in recent years as a national priority.[11] At the forefront of efforts to address these disparities are interventions targeting parenting and the early home language environment. Such interventions often are delivered either in center-based programs or in the family's home. Delivery of parenting intervention in the home has particularly burgeoned because of legislation in 2010, which apportioned funding for states to establish home visiting program models for at-risk pregnant women and children from birth to age 5.[12] Thus far, there have been 17 home-visiting models (typically addressing parenting issues through strategies such as counseling, modeling behaviors, videotaping interactions with feedback, provision of learning materials such as toys and books, and motivational interviewing) for which "evidence of effectiveness" has been shown on the basis of rigorous research evaluation under the direction of the US Department of Health and Human Services.[13] Despite the documented success of interventions delivered via center- and home-based platforms, cost-related barriers to delivering such interventions at scale suggest a need for complementary prevention strategies.

PEDIATRIC PRIMARY CARE SETTING AND THE PEDIATRIC MEDICAL HOME

In addition to the work done in the spotlight of the home-visiting platform, and the continued efforts of more traditional models of early childhood intervention

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with center-based components (eg, Early Head Start), the pediatric primary care setting has been increasingly recognized as a powerful platform for addressing early poverty-related disparities in school readiness. The pediatric primary care setting is uniquely positioned to universally deliver preventive interventions at relatively low cost (Table 1). One of the reasons for this is the high number of preventive visits recommended by the American Academy of Pediatrics, which total 13 to 15 visits from birth to age 5 years.[14] Although there are differences in the adherence to recommended well-child visits among SES groups, families living at <100% the federal poverty line attend >50% of recommended visits on average[15]; additionally, preventive visits for medical problems (eg, obesity, asthma) are more common in low-SES populations.[16] This visit frequency allows the opportunity to deliver interventions with doses comparable with some of the most effective home-visiting models. Another attribute of this setting making it particularly apt for intervention is its access to at-risk populations, including families who live in poverty, who might otherwise be difficult to reach. This is, in part, because of expansions of insurance[17] together with vaccination requirements for school entry. Additionally, initiatives over the past several decades to transform preventive pediatric health care through the framework of the medical home model has significantly enhanced the opportunity to effectively work with parents through a multidisciplinary emphasis on family and psychosocial factors.[18] Delivering interventions to parents in the pediatric health care setting also carries the advantage of capitalizing on the existing relationship that parents have with providers; parents come to the pediatrician poised to focus on their child's development and behavior and prepared to take advice.

Importantly, by building on existing infrastructure and avoiding the need for staff travel (which is needed in home visitation programs) the health care setting offers a unique opportunity to deliver intervention at low cost. Low-cost intervention potential in this platform might be best exemplified by Reach Out and Read (ROR), a program targeting shared book-reading during well-child visits, which merely costs approximately $25 per child per year,[19] a cost that is negligible compared with home visitation programs, which range in cost from approximately $2000 to $6000 per child per year,[20] and center-based programs, which cost approximately $15,000 to $20,000 per child per year.[21] Although this comparison of cost must be considered with regard to varying scope, intensity, and dose potential of early child development interventions in each of these settings, it remains clear that the pediatric primary care setting offers tremendous opportunity for low-cost preventive programs to complement programs with similar goals in other more traditional intervention settings.

Table 1. Key Characteristics of Pediatric Primary Care Platform

- Population level access
- High frequency of visits from birth to school entry
- Potential for low cost through utilization of existing infrastructure and reduced staff travel
- Opportunity to build on existing relationships within patient-centered medical home

MODELS OF INTERVENTION IN PEDIATRIC PRIMARY CARE

Interventions delivered in the pediatric primary care platform seeking to prevent developmental and behavioral problems in young children have typically used 1 of 3 models: 1) primary prevention via promotion of parenting; 2) secondary prevention for families with already identified challenges related to parent–child interactions or related to child development and behavior; or 3) some combination of primary and secondary prevention (Table 2). Although only some of these interventions target families who live in poverty specifically, all aim to prevent issues related to parenting and adverse child developmental outcomes that are commonly experienced in the context of toxic stress, and many document effects on low-income populations. Furthermore, although programs vary with respect to level of intensity and documentation of effect, taken together, evidence indicates the far-reaching potential of the pediatric primary care platform and also suggests policy considerations for future efforts to scale and disseminate such programs.

MODEL 1: PRIMARY PREVENTION PARENTING PROGRAMS IN PEDIATRIC HEALTH CARE

Some of the first evidence documenting the potential to affect parenting behavior and child development in the context of this setting comes from studies that showed the success of ROR, a program in which pediatric health care professionals provide families with children's books, model shared reading activities, and provide guidance about the benefits of shared reading at well-child visits beginning in early infancy. ROR has been met with consistent effects on quantity of and attitudes about shared book-reading[22,23] and on child vocabulary development[23,24] despite its low intensity and cost.[25]

ROR has served as the flagship model of primary prevention of poverty-related disparities in pediatric primary care. A number of programs have since followed its example by either using adaptations of the ROR model in other countries or settings, or by developing intervention programs designed to complement ROR in the pediatric primary care setting. One example of a literacy promotion program in pediatric primary care modeled after ROR is Bookstart in the United Kingdom. This program, which delivers literacy packs (including a child's book, information about library resources, and information about the value of shared reading) to inner city families at health clinics and via health home visitors between child age 6 and 9 months, has been shown in some studies to enhance early book reading interactions as well as early child language and numeracy outcomes.[26]

Another example of a program modeled after ROR is the Let's Read program implemented in Australia. As part of Let's Read, nursing staff provide families universally with some counseling/modeling regarding shared

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