COMMUNITY AND FAMILY APPROACHES

ACE, Place, Race, and Poverty: Building Hope for Children

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ABSTRACT

Adverse childhood experiences research has focused attention on the importance of family safety, stability, and nurturing in ensuring healthy development. This safety, stability, and nurturing can be compromised by family poverty, discrimination and marginalization, and geographic location. Drawing upon census data, this report shows that place, race, and poverty are intertwined concepts with particular implications for young children. Examining census tracts according to their levels of poverty shows that the poorest census tracts also: 1) are the "richest" in the proportion of young children, 2) have the least realized social, physical, and educational, as well as economic capital, and 3) are highly racially segregated and separated from many sources of economic opportunity. The implications are that the country's poorest neighborhoods require substan-tially more supports for young children but currently have many fewer. This includes individual services to young children and their families but also publicly available services and volun-tary supports, such as parks, playgrounds, and libraries. These data suggest that improving child health trajectories and reducing health disparities according to race and socioeconomic status therefore will require concerted individual service as well as community-building efforts directed to poor and usually racially segregated neighborhoods and communities.

KEYWORDS: adverse childhood experiences; childhood trauma; children; neighborhood; poverty; race; social determi-nants of health

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THE SEMINAL ADVERSE childhood experiences (ACEs) research[1] has focused new attention on going beyond providing access to medical care to address health disparities and paying greater attention to children's healthy development and the social determinants of health (SDH) to improve overall population health. At the same time, the focus on ACEs, particularly the set of indicators generally used to show associations between adversity and health, can lead to a set of responses around incident-specific diagnoses and trauma-informed care that only scratch the surface in responding to health dispar-ities that are the consequence of ACEs and the absence of other supportive factors in the child's life.[2] Above all, this report calls for a much broader emphasis on the influences of the family, community, and SDH on healthy child devel-opment, particularly at the neighborhood level.

The World Health Organization defines SDH as "…the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribu-tion of money, power and resources at global, national and local levels."[3] Because of the foundational effect of SDH on the health of children and families, combined with the "new science of thriving"[4] and new knowledge on epigenetics and social-emotional neurocognitive devel-opment, it is not surprising that Healthy People 2020 has incorporated goals for economic stability (poverty), social and community context, and neighborhood and the built environment to improve population health.[5]

In this article we first examine census data to show dispar-ities among and the intertwined relationships between race, place, and poverty. Importantly, this national-level informa-tion can be disaggregated and used by states and communities to begin to determine what community-building steps to consider as they work to produce needed change. We next examine how these SDH increase the risk of childhood adver-sity, with a particular focus on race, place, and poverty, draw-ing upon a larger body of research than is generally referenced when ACEs are discussed in policy circles. This places a greater emphasis on building social and economic capital and community assets as primary strategies for improving child health. We conclude the analysis with recom-mendations to reduce ACEs at the local level by focusing on family, neighborhood, and community factors.

ACTIONABLE DATA ON RACE, PLACE, AND YOUNG CHILDREN

Making use of the 2000 census, Village Building and School Readiness[6] provides an analysis of the characteris-tics of all census tracts in the United States according to

their child-raising vulnerability, as well as describes needed and successful strategies to improve children's healthy development and readiness for school. This part updates that analysis, examining and categorizing census tracts according to their levels of child poverty. It confirms the profound differences, according to geographic location, that young children—and particularly children of color—face not only in terms of their own family's socioeconomic position but in terms of the neighborhoods in which they live. Although the census cannot provide information on the proximity of parks, recreation programs, community centers, and family- and child-friendly places, it can provide sufficient proxies for these to point to tracts and neighborhoods where special attention is warranted.

The following are key findings from the census tract analysis.

1. Poor neighborhoods are rich in young children.

Children are more likely than other age groups in American society to live in poverty, with the highest rates of poverty among very young children. Child poverty, however, is not spread evenly across states and communities. Some neighborhoods have much greater rates of child poverty. As census tracts increase in their overall child poverty rates, they also have larger proportions of children, and young children in particular. As Figure 1 shows, as census tracts move from rates of child poverty below 10% to rates of child poverty above 50%, the proportion of young children goes from 5.9% to 8.6% of the total population, an increase of 46%. This means, at a minimum, the country's poorest neighborhoods require half again as many early childhood services as the most affluent neighborhoods. At a very basic level, they also need more parks, playgrounds, and family- and child-friendly gathering spots to promote healthy social and emotional development.

2. Poor neighborhoods are very disproportionately home to children of color.

Although it is important to focus on poor neighborhoods when developing early childhood systems simply because they have large proportions of young children, the re-

sponses also need to reflect the different ethnic, cultural, and language composition of the children and families in these neighborhoods. Figure 2 shows that the racial and ethnic composition of census tracts varies greatly according to their levels of child poverty. The nation's poorest census tracts are disproportionately of color—for example, 81.3% of children living in census tracts with poverty rates greater than 50% are children of color. Further, Figure 3 shows that although 8.4% of white, non-Hispanic children live in census tracts where the poverty rate is >40%, 38.2% of African American children, 31.9% of Native American children, and 28.9% of Hispanic children do. More than half of all children of color, but only 1 in 6 white non-Hispanic children, live in neighborhoods where child poverty exceeds 30%, often considered key in comparing neighborhoods for their broader neighborhood effects on individual growth and development.[7] Although individual census tracts might be largely African American, Hispanic, or Native American, these tracts consist of young children who are growing up within a nondominant culture community—and doing so with much less economic capital and many more issues related to meeting basic needs. In such neighborhoods, it is critical there be cultural reciprocity and additional efforts to support and develop early childhood leadership and service provisions from within those neighborhoods.

3. Differences in terms of income, wealth, education, and social structure are profound and require community-building as well as individual service attention.

Although innate human capital exists within all neighborhoods, that human capital is developed and realized in the context of the opportunities that exist. Place-based research and analysis has shown that poorer neighborhoods are characterized by much less physical, economic, educational, and social capital than more affluent ones.[8–10] The census largely includes information about people, and not physical conditions, but it has sufficient information to provide a picture that relates to a census tract's income, wealth, educational levels, and some aspects of structural makeup such as family structure and home
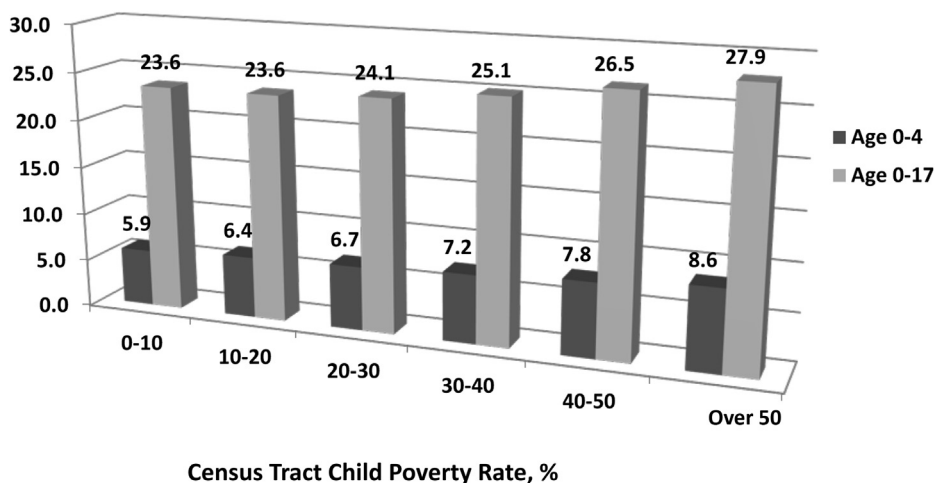
Figure 1. *Children age 0 to 17 years and young children age 0 to 4 years as a proportion of population according to census tract child poverty rates.*

ownership. It even includes a little information about young children (family-reported participation in preschool). There is growing discussion of a "tipping point" in terms of the fabric of a neighborhood or community[11] when the neighborhood conditions themselves present barriers to any child's growth and opportunity.

The Table provides a set of indicators that provide a starting picture of the capitals available within census tracts of different child poverty levels.[6 pp 13–14] Although this information can be augmented by additional administrative data, these indicators begin to provide an overall picture of the characteristics of neighborhoods across the various capitals that constitute the elements of a "village" needed to support families in raising their children. In many instances, these differences are so pronounced so as to constitute different norms for the community as a whole.[12] The more distressed a neighborhood, the more the daily toll of seeking to get by and stay safe produces stress. The more disinvested a neighborhood, the fewer models or reference points for success exist upon which children and their families can pin realistic hopes for their own likelihood of becoming successful. At some point, there must not only be a focus upon individually based services and supports for young children and their families, but for community-building activities to support and strengthen the community's overall capacity to support its children.

4. Every state has such disparities, but states differ in the composition of their poor neighborhoods and the young children most affected.

Although these data have been provided at a national level, they also are available for any state.[13] Whereas there is wide variation across states in their child population's racial and ethnic composition, reviews of any state data will show similar differences across census tracts. Moreover, it is at the state and community levels that this information can be mapped according to geographic areas—identifying the physical boundaries of high child poverty census tracts and augmenting the census tract information

with other available data about social, physical, and economic capital.[14] Ultimately, this is critical to early childhood systems-building, because the development of new or additional services and supports for young children must give consideration to their location and be accessible by and responsive to those who most need them.

ACE, PLACE, RACE, AND POVERTY—BEYOND INDIVIDUAL DIAGNOSIS AND RESPONSE

Because they originated in a medical context, the indicators developed and largely used to measure ACEs do not include neighborhood effects.[1] Rather, they relate to the immediate family home environment and to specific incidents of disruption to the safety and security within that home. Even when families are able to offer sanctuary in their homes, children can experience adversity outside the home that affects their healthy development. This includes neighborhood or school violence, bullying, and denigration in many forms, which can be the result of prejudice and differential responses from others to those perceived as "different." It also includes stresses caused by continuous exposure to discrimination and marginalization—including personal, institutional, and structural racism, sexism, or other "isms."[15]

ACEs related to community and societal actions affect children at all social strata.[16] As continued ACEs research is conducted, there might be opportunities to broaden the list of indicators to capture some of these community ACEs and their effects. Innovations to ameliorate the lack of ACEs indicators reflecting place and SDH are under way but still nascent and not yet validated.[17] However, we do not have to wait for such additional ACEs work to identify and seek to address issues of childhood adversity (and absence of social support) at a neighborhood and individual family level. We have enough knowledge and information to act now.

We know that some places where children live constitute hazards to healthy development and shape the trajectories of growth in profound ways. At the extreme, research on
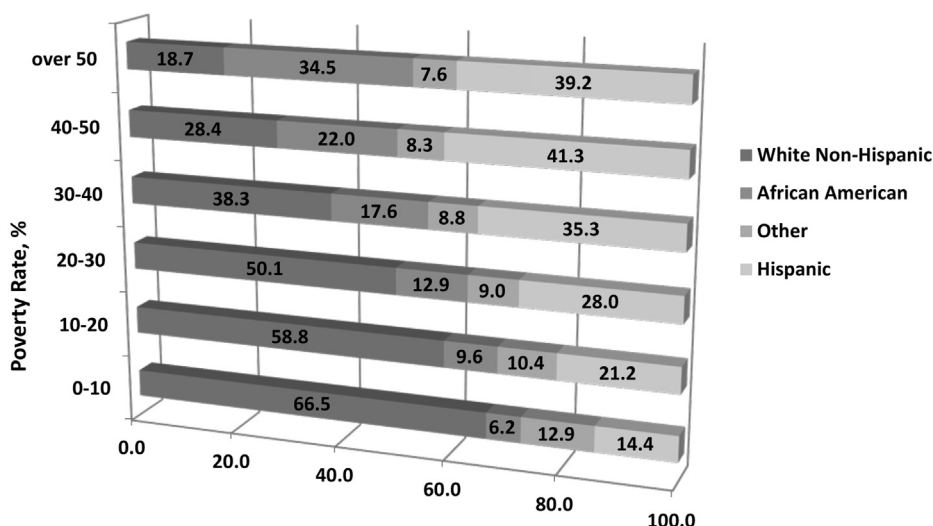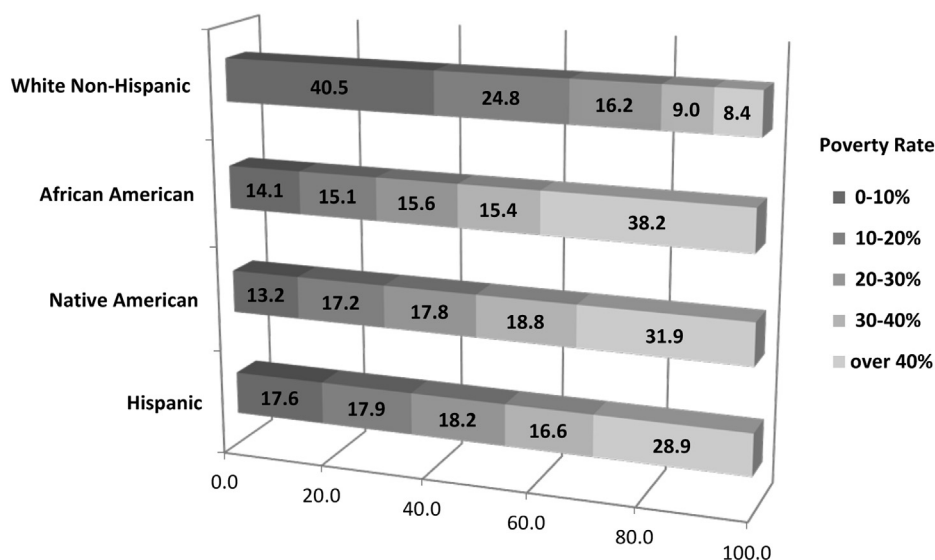
Figure 2. *Young child population (younger than age 5 years) according to race/ethnicity and child poverty.*

Figure 3. *Proportion of young children according to ethnicity and census tract poverty rates.*

children growing up in war zones and constant external violence shows the effects of such violence are even more profound on children than adults.[18] The Prevention Institute's report, *Adverse Community Experiences and Resilience*, speaks directly to the need to address violence and trauma at the community, as well as family, level.[19]

In the United States, many children currently are growing up in neighborhoods which, although they might not constitute war zones, profoundly compromise their healthy development. These neighborhoods are characterized by physical as well as economic conditions that give rise to adversity. They are places where families are under the greatest stress and ACEs in the home are more likely to occur. They also are places where there are more environmental hazards, such as exposure to lead, mold, and airborne pollutants, which jeopardize health. They are places where families often must struggle to find safe and supportive environments outside the home for their children to grow and explore the world. As practitioners, policy makers, program administrators, advocates, and researchers seek to determine how they can draw upon the findings from ACEs research to fashion policies and practices to improve children's health, they should recognize "early childhood adversity" is broader than the specific ACEs indicators and has a place component.

Moving beyond individual and family indicators of adversity has the further benefit of advancing beyond what often is an emphasis on individually focused service responses, targeted to specific adverse incidents and remediating what already has occurred (trauma-informed care). It moves toward neighborhood-focused and community-building strategies (population health) designed to create additional assets

Table. National Average Tract Rate According to Child Poverty Category for Vulnerability Factors

Vulnerability Factors Category	Census Tracts According to Child Poverty Rates, %					
	0–10	10–20	20–30	30–40	40–50	≥50
Families with children that are single-parent	24.6	32.4	38.4	43.9	49.5	60.1
Youth age 16–19 years not working or in school	5.4	7.8	10.0	12.1	13.8	16.4
Households with interest, dividend, or rental income	30.1	22.1	17.7	14.3	11.2	8.2
Households with wage income	78.3	75.6	73.6	72.2	70.9	66.4
Households receiving public assistance	1.5	2.4	3.2	4.0	5.2	7.2
Adults older than age 25 years with no high school degree	7.3	12.2	16.5	21.1	25.2	28.8
Adults older than age 25 years with college degree	41.1	27.0	21.0	17.6	14.9	12.7
Adults older than age 18 years with limited English	5.7	7.4	9.5	12.9	15.8	15.2
Owner-occupied housing	75.2	69.4	64.1	57.6	50.9	41.4
Children age 3 to 5 years in preschool	49.1	41.7	38.8	37.0	36.5	37.3
Children in poverty	4.1	14.8	24.8	34.7	44.5	62.0

Data are presented as percentages.

in the community, providing new opportunities for engaging those with the most at stake. Adversities might continue to be defined at the family level, but effective responses require building upon assets at the group and neighborhood levels, modeling many of the activities around "Health Outcomes from Positive Experiences" discussed in other articles in this special issue of *Academic Pediatrics*, such as the article from Sege and Harper-Brown.[20] The research is clear that it is not adversity, solely, that produces harm—it also is the absence of supportive factors that help children (and their parents and families) process adversity and setbacks and learn and move beyond them. Stable, consistent, and nurturing and resilient parents, of course, represent the foundation for most children's healthy growth, but they cannot achieve it alone.[21]

They need time, space, and opportunity to connect with a larger community that also supports their children's development, as their children connect with the larger world.[22] The importance of a broader community to healthy growth and development includes what have been referred to by different researchers as protective factors,[23] social buffers,[24] primary services,[25] mediating structures,[26] microsystems,[27] community resiliency,[28] and social capital.[29] Although there are different nuances in how these terms are defined, all speak to the presence of voluntary services and supports that are robust and diverse in their nature and offer the opportunity for participation as well as leadership. They foster individual resiliency through mutual assistance and reciprocity,[30] on the basis of some common affinity among members. For new parents, this affinity often is centered on their infant or toddler. Children and adults are social beings, and their health and resilience is based, in large measure, on their ability to have mutually beneficial social relationships.

DISCUSSION

What do these analyses lead us to understand about neighborhood, or place, and its effects on childhood adversity and healthy child development? What do we know about its relationship to race, adversity, and social connectedness? First, the data show that place matters most for young children, whose own mobility and ability to explore the world outside their home is dependent on their families. Although affluence affords parents the means and opportunity to transport their children to places outside their immediate neighborhoods for specific activities, young children's lives still are mostly spent in the blocks around their homes. Poorer families have much less access to transportation, and their children's lives are even more closely bounded around their immediate neighborhoods.

Second, we know that place is highly intertwined with the prevalence of ACEs, with respect to current ACE indicators and with respect to a broader definition of adverse experience. Where there has been mapping of parental incarceration, domestic violence, and child abuse and neglect (all ACEs), definite geographic areas emerge with high prevalence.[31] These same areas also correspond with areas of high incidences of child health problems

(asthma, obesity, infant mortality, lead poisoning, school behavioral disorder diagnoses, etc), as well as educational and social ones (school dropout, juvenile justice involvement, and lack of school readiness).[32] These are geographic areas with high rates of family instability (single-parenting and sequential male partners in the household, which are not current ACE indicators but have some of the same effects as divorce, which is).

Although some families succeed with their children in very tough neighborhoods, Jarrett and other researchers show they often do so by insulating their children from neighborhood influences and securing social ties and relationships outside the neighborhood. These actions often require almost heroic efforts and, even when they succeed, leave the neighborhood no more (and often less) capable of supporting other children's healthy development.[33–35]

Third, we know that place and race are highly intertwined and the poorest neighborhoods often are racially segregated and distant from sources of economic opportunity and support. Race itself is only a risk factor to the extent that personal, institutional, or structural discrimination and racism block opportunities for traditional success. However, as Canada notes, humans adapt to their environments.[36] Where environments are ones of disinvestment and distress, these adaptations have consequences that can perpetuate that disinvestment and distress.[12]

Fourth, we know that health systems—particularly federally qualified health centers, free clinics, maternal and child health centers, idealistic practitioners, and public hospitals (often historically located in center cities)—have important potential roles to play in community-building. These health systems often represent anchor institutions within the poorest and most disinvested neighborhoods and offer points of congregation for families that can begin to respond to social as well as biomedical needs.[37]

Finally, census data provide more than sufficient information to identify neighborhoods where economic, physical, social, and educational capital are insufficient to provide children with expectations for healthy growth and development that we espouse for all our children. National data on the country's 70,000 census tracts is presented, but it can be broken out for any state and mapped for any community.

CONCLUSION

Place matters most for very young children—first in the safety and security of their home environment and then their immediate environment and neighborhood. In this report we have argued that achieving equity of opportunity for young children requires attention to place and the intertwined issues of poverty, place, adversity, and race. Whereas ACEs research can contribute to greater understanding of the multiple challenges to be addressed to improve population health, many of the solutions—and particularly ones related to racial and ethnic disparities— go beyond most discussions around ACEs. Young children—directly as well as through their families—are harmed by racism, in all its forms.[38]

The diversity of America's population, and its child population in particular, can and should be a strength. This will not be the case, however, unless explicit attention is directed to developing equitable responses—starting in the earliest learning years. In this, the health system has major roles to play. Families with young children need the time, space, and opportunity to get together with each other and with their young children for mutual assistance and benefit. Particularly in poor neighborhoods, health centers and hospitals often are preferred loci, by the residents themselves, for a share of these activities and opportunities. There is a growing array of centers and hospitals that have developed effective and exemplary activities in this area, as well as primary health practitioners who have taken on such expanded roles.[39]

Policies need to support such institutions and practitioners, particularly those practicing within poor neighborhoods, to assume these roles. This includes defining safety, stability, and nurturing in the home (family and community) as a foundational child health outcome, ensuring the definition of "medical necessity" includes ecological responses that strengthen families and communities, and making additional investments to enable those practices and institutions within poor neighborhoods to be places and anchors of community-building.[40]

As the United States moves further into the 21st century, addressing issues of ACE, race, place, and poverty, are even more critical. *From Neurons to Neighborhood: The Science of Early Childhood Development*,[41] the seminal work linking brain science with early childhood systems development, has an apt title. It presents the opportunity as well as the challenge to health practitioners, early childhood advocates, and systems builders in this respect:

> [C]hildren in families of European origin [soon] will make up less than 50% of the population [younger than] five. … The opportunities offered by a multicultural society that is cohesive and inclusive are virtually boundless—including the richness that comes from a broad diversity of skills and talents, and the vitality that is fueled by a range of interests and perspectives. The challenges posed by a multicultural society that is fragmented and exclusive are daunting—including the wasted human capital that is undermined by prejudice and discrimination, and the threat of civil disorder precipitated by bigotry and hatred.[41 pp 65]

ACKNOWLEDGMENTS

REFERENCES

1. Felitti VJ, Anda RF, Williamson DF, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *Am J Prev Med*. 1998;14:245–258.

2. Bethell C, Carle A, Hudziak J, et al. Methods to assess adverse childhood experiences of children and families: towards approaches to promote child well being in policy and practice. *Acad Pediatr*. 2017;17:S51–S69.

3. World Health Organization. Social Determinants of Health. Available at: http://www.who.int/social_determinants/en. Accessed March 26, 2017.

4. Bethell CD. *The New Science of Thriving. Our Well-being—Individually and as a Society—Depends on Mindfulness*. Baltimore, Md: The Johns Hopkins Magazine: FORUM; 2016:18–21.

5. US Department of Health and Human Services. Healthy People 2020: The Road Ahead. Available at: http://www.healthypeople.gov/2010/hp2020/default.asp. Accessed March 16, 2017.

6. Bruner C. *Village Building and School Readiness: Closing Opportunity Gaps in a Diverse Society*. Des Moines, Iowa: State Early Childhood Policy Technical Assistance Network; 2007:13–14.

7. Kids Count. *Data Snapshot on High-poverty Communities*. Baltimore, Md: Annie E. Casey Foundation. Available at: http://www.aecf.org/m/resourcedoc/AECF-ChildrenLivingInHighPovertyCommunities-2012-Full.pdf; 2012. Accessed March 16, 2017.

8. Dreier P, Mollenkopf J, Swanstrom T. *Place Matters: Metropolitics for the Twenty-First Century*. Lawrence, Kans: University Press of Kansas; 2014.

9. Putnam R. *Our Kids: The American Dream in Crisis*. New York, NY: Simon & Schuster; 2015.

10. Quillian L, Redd R. Can social capital explain persistent racial poverty gaps?. In: Lin D, Harris D, eds. *The Colors of Poverty: Why Racial and Ethnic Disparities Exist*. New York, NY: Russell Sage Foundation; 2008:170–198.

11. Gladwell M. *The Tipping Point: How Little Things Can Make a Big Difference*. New York, NY: Little Brown & Co; 2000.

12. Wilson W. *More Than Just Race: Being Black and Poor in the Inner City*. New York: Norton & Company; 2009.

13. Data Resource Center for Child and Adolescent Health. Available at: www.childhealthdata.org. Accessed March 16, 2017.

14. Bruner C. *School Readiness Resource Guide and Toolkit: Using Neighborhood Data to Spur Action*. Des Moines, Iowa: State Early Childhood Policy Technical Assistance Network and National Neighborhood Indicators Partnership; Child and Family Policy Center; 2007.

15. Collins J, David R, Handler A, et al. Very low birthweight in African American infants: the role of maternal exposure to interpersonal racial discrimination. *Am J Public Health*. 2004;94:2132–2138.

16. Halfon N, Larson K, Son J, et al. Income inequality and the differential impact of adverse childhood experiences in US Children. *Acad Pediatr*. 2017;17:S70–S78.

17. Pachter L, Lieberman L, Bloom S, et al. Developing a community-wide initiative to address childhood adversity and toxic stress: a case study of the Philadelphia ACE Task Force. *Acad Pediatr*. 2017;17:S130–S135.

18. Parson E. Understanding children with war-zone traumatic stress exposed to the world's violent environments. *J Contemp Psychother*. 2000;30:325–340.

19. Pinderhughes H, Davis R, Williams M. *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma*. Oakland, Calif: Prevention Institute; 2015.

20. Sege RD, Harper-Brown C. Responding to ACEs with HOPE: Health Outcomes from Positive Experiences. *Acad Pediatr*. 2017;17:S79–S85.

21. Biglan A, Van Ryzin MJ, Hawkins JD. Evolving a more nurturing society to prevent adverse childhood experiences. *Acad Pediatr*. 2017;17:S150–S157.

22. Morris A, Robinson L, Hays-Grudo J, et al. Targeting parenting in early childhood: a public health approach to improve outcomes for children living in poverty. *Child Dev*. 2017;88:388–397.

23. Browne C. *The Strengthening Families Approach and the Protective Factors Framework: Branching Out and Reaching Deeper*. Washington, DC: Center for the Study of Social Policy; 2014.

24. Wilson W. *The Truly Disadvantaged*. Chicago: University of Chicago Press; 1987.

25. Richman H, Wynn J, Costello J. *Children's Services in Metropolitan Chicago: Directions for the Future*. Chicago, Ill: The Chapin Hall Center for Children, University of Chicago; 1991.

26. Connell J, Aber L. How do urban communities affect youth? Using social science research to inform the design and evaluation of comprehensive community initiatives. In: Connell J, Kubisch A, Schorr L, Weiss C, eds. *New Approaches to Evaluating Comprehensive Community Initiatives*. Washington, DC: Aspen Institute; 1995.

27. Bronfenbrenner U. Ecology of the family in a context for human development: research perspectives. *Developmental Psychology*. 1986;22:723–774.

28. Benard B. *Fostering Resiliency in Kids: Protective Factors in the Family, Schools, and Community*. Portland, Ore: Far West Laboratory; 1991.

29. Putnam R. *Bowling Alone: The Collapse and Revival of the American Community*. New York, NY: Simon & Schuster; 2000.

30. Bruner C. *Thirst to Contribute: Fostering Personal Growth, Building Social Capital, and Strengthening Community Through Public Policy*. Des Moines, Iowa: Child and Family Policy Center to the Annie E. Casey Foundation; 2011.

31. National Neighborhood Indicators Partnership. Available at: http://www.neighborhoodindicators.org. Accessed March 16, 2017.

32. Bethell C, Gombojav N, Solloway M, et al. Adverse childhood experiences, resilience and mindfulness-based approaches: common denominator issues for children with emotional, mental or behavioral problems. *Child Adolesc Psychiatr Clin N Am*. 2016;25:139–156.

33. Jarrett R. *Indicators of Family Strengths and Resilience That Influence Positive Child-Youth Outcomes in Urban Neighborhoods: A Review of Qualitative and Ethnographic Studies*. Baltimore, Md: Annie E. Casey Foundation; 1998.

34. Jarrett R. Successful parenting in high risk neighborhoods. *Future Child*. 1999;9:45–50.

35. Chetty R, Hendren N, Katz L. The effects of exposure to better neighborhoods upon children: new evidence from the Moving to Opportunity experiment. *Am Econ Rev*. 2016;106:855–902.

36. Canada G. *Fist Stick Knife Gun: A Personal History of Violence*. Boston, Mass: Beacon Press; 1995.

37. Bruner C, Schor E. *Clinical Health Care and Community Building: Addressing Racial Disparities in Healthy Child Development*. Des Moines, Iowa: National Center for Service Integration Clearinghouse and Child and Family Policy Center; 2009.

38. BUILD Initiative and Child and Family Policy Center. *Young Children's Healthy Development and Learning in a Diverse Society: An Outline for Designing a Culturally and Linguistically Relevant, Responsive, and Competent Early Childhood System*. Available at: http://www.buildinitiative.org/WhatsNew/ViewArticle/tabid/96/smid/412/ArticleID/285/Default.aspx; 2012. Accessed March 16, 2017.

39. Bruner C, Day V. *The Healthy Child Story Book: Policy Opportunities to Improve Children's Healthy Development*. Des Moines, Iowa: Child and Family Policy Center; 2013.

40. Bruner C, Fine A. *Going Beyond Coverage to Improve Community Health: Opportunities for Place-Based Initiatives in Health Reform Implementation*. Washington, DC: Center for the Study of Social Policy; 2011.

41. Shonkoff J, Phillips DA, eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development. Committee on Integrating the Science of Early Childhood Development*. Washington, DC: National Academies of Science; 2000:65.