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Michelle: Hello, everyone, and welcome to today's webinar, Parenting Ages Zero to Two. My name is Michelle Vatalaro. I'm with the training team here with the Healthy Start Ethics Center, and I'll be moderating today's webinar. We have approximately 60 minutes set aside for this webinar, and the webinar is being recorded. The recording along with the transcript and slides will be posted to the Ethics Center website following the webinar. So anyone who's unable to participate today can access it at his or her convenience. Before I introduce your great speakers for today I wanted to let you know that we do want your participation during this activity. So at any point if you have questions or comments, please chat them in at the bottom left corner of your screen.

As usual, we'll only be taking questions via chat, and we'll answer them at the end of the presentation. If we don't get to them by the end of the webinar, we'll include them in a document that we'll post to the Ethics website. This webinar will focus on recommendations for care of a child from birth to age two, the importance of well-baby checks, and warning signs that the baby or toddler might be at risk for medical or developmental problems. The Healthy Start benchmarks that are aligned with this webinar include health insurance, medical home, safe sleep, initiating and sustaining breastfeeding, smoking abstinence, well child visits, perinatal depression screening and follow-up, intimate partner violence, father and partner parenting involvement, and reading to child daily. The only other housekeeping reminder I want to make is that you'll be asked to complete an evaluation survey at the end of the webinar. It's gonna pop up immediately after we finish the webinar, and we appreciate your feedback. So please do take a moment to complete it. So now let me introduce to you our two speakers for today.

First we have Dr. Jan Shepard, who serves as the Maternal Health Technical Adviser for MCHB's Healthy Start Ethics Center. Dr. Shepard received her MD from Northwestern and completed a residency in obstetrics and gynecology at the University of Cincinnati. Dr. Shepard is an Associate Clinical Professor in Obstetrics and Gynecology at the University of Colorado School of Medicine, is a medical adviser for the Women's Wellness Connection at the Colorado Department of Public Health and Environment, and is a consultant for two women's health clinics in the Denver area. Dr. Shepard also has a continuing appointment as adjunct associate professor at Florida State University College of Medicine where she was a founding educational director for obstetrics and gynecology. In that role she participated regularly in the Panhandle Fetal and Infant Mortality Review sponsored by the Healthy Pregnancy Network at Capital Area Healthy Start Coalition, giving her

significant insight into the Healthy Start program.

We also have today Dr. Harold Bland, who is a Professor and Education Director for Pediatrics at the Florida State University College of Medicine where he coordinates the teaching of pediatrics across the FSU system. Dr. Bland completed a fellowship in neonatology and has practiced neonatology in both private hospitals and in medical school settings. In Tallahassee he was a member of the Capital Area Healthy Start Fetal and Infant Mortality Case Review team which reviews all infant deaths in a five county area looking at maternal and infant resource availability and utilization and reviewing healthcare policies or systems that may not have functioned optimally. Prior to joining faculty at FSU College of Medicine, Dr. Bland spent 10 years at the University of Missouri School of Medicine where he cared for infants in the Level 2 Neonatal Intensive Care Unit, was Director of the Well Baby Nursery, and was Director of the Neonatal High Risk Follow-up Clinic. Dr. Bland received his MD from the University of Nebraska and completed his pediatric residency and neonatal fellowship at the University of Nebraska Medical Center. So at this point I will hand it over to Dr. Jan Shepard. Jan?

Jan Shepard: Thanks, Michelle. Good afternoon everybody and welcome. My voice may be familiar to many of you because I've given several of these webinars. I gave one on preconception care, one on prenatal care, one on postpartum care, and you'll recognize three of the four P's that we've covered in the past. Today we're trying to complete this series by covering our fourth P, parenting ages zero to two. Now, as you just heard, I'm an obstetrician gynecologist. So my expertise was actually in the first three webinars that I gave. I know something about parenting, but I was very happy to have Dr. Bland join me for this webinar. He helped me to develop these slides. I need to give him credit for that, and he'll also be available for questions afterwards. Dr. Bland, as you heard, is a pediatrician with special expertise in the care of very young children.

My first slide is the objectives, but actually Michelle just reviewed these objectives with you. So I'm going to move onto the second slide and begin with a definition of parenting. I know that's a term that we throw around a lot, but how many times have we really looked at the formal definition? So here it is. Parenting is the process of promoting and supporting the physical, emotional, social, financial, and intellectual development of a child. Now, that's a tall order, no question about it, and certainly parenting is one of the most challenging tasks that any adult ever undertakes. So what we want to do in this webinar is talk about

some evidence-based guidelines that hopefully can make parenting easier, but even more important, more successful for our participants in Healthy Start. Now, we can look at these evidence-based practices, and they're very important, and these are what we want to emphasize, but the thing we need to realize is outside of those, parenting is a very individual practice. Parents raise their children the way they see best, the way they were raised, the way their ethnicity and culture raises children.

So we have to realize that as well, and there are big differences in parenting, especially between cultures. One example, one worldwide example, would be that culture in our country, in Europe, Western cultures, we talk to our babies face to face. We give our babies a lot of positive reinforcement for any expression they make, for anything that they do. We tell them how cute they are. That's how we raise our babies. But if you look for example in Africa at how Africans raise their babies in many areas, they don't look directly face to face at their babies. They actually hold their babies so that both the mom and the baby are looking out together, and they don't talk about the baby.

They talk about what the two of them are seeing. So big differences in parenting practices, and both work, although both raise different kinds of children as well. Children in our culture tend to grow up to be individualistic, independent, and self-reliant. Those are our goals. In the African cultures they grow up to be cooperative, communal, better at discipline, and in their value system that's important. So I just can't emphasize enough that as we talk about these important guidelines, evidence-based, across cultures, we certainly want to teach our participants about them, but we don't ever want to tell anybody how to raise their children. They'll raise their children in the way that's best for them in their own situation, but we will give them guidelines.

I want to start out with talking about our first evidence-based guideline that we can emphasize. So starting out with our first evidence-based guideline that goes across cultures would be the importance of father or partner involvement in the parenting process. Studies have actually shown that when a father, father figure, or partner is involved in parenting either a boy or a girl, that child turns out to be more self-reliant, more resilient, does better in school, and does better socially. So involvement of the father/partner, evidence-based, important across cultures, and that's of course why it is one of our benchmarks in Healthy Start. Our benchmark of course is to increase the proportion of Healthy Start women participants that demonstrate father and/or partner

involvement with their child to 80%.

What other evidence-based basics extend across all cultures? Well, it's important among all cultures of course that parents keep their infant and child safe, that they nurture and help the child feel secure, that they provide adequate nutrition, that they assure access to medical care, and in our culture that means knowing insurance sources and keeping scheduled appointments. But there's obviously more to it than that. Other things that extend across all cultures that we know help parenting are first of all that caregivers engage with their infant or toddler. Now, in our culture we engage face to face, and the recommendation is face to face that parents mirror their child's emotions, respond to their child's expressions, show approval for their child's expressions, and whatever their child does.

We also know that it's very, very important particularly for these young children and babies to get physical touch, to be cuddled, and finally something that we're learning increasingly is important is the child's exposure to words from its parents and caregivers. This is words from the parents talking to the child, from playing games with the child, from singing songs to the child, and especially reading to the child. Now, these are all very important parts of parenting, but sadly some of our participants in Healthy Start didn't learn these things because nobody did them for them. So we need to realize that parents can be taught these skills and the importance of these skills in either home visits or at a community center, and that of course is one of the roles of Healthy Start.

I can tell you about a study that demonstrated the importance of teaching parents these skills, particularly the skills with words. The study began back in Jamaica in the mid-1980's, and they followed 100-200 families, very disadvantaged families, the poorest part of Jamaica. They divided them into three groups. The first group they gave the families extra nutrition for their children from age zero to two. The second group they received a home visit once a week for an hour where the parents were taught about talking to their child and especially reading to their child. The third group was the control group. So they really didn't get either intervention. Now, these children were followed. Remember, the study was in the 1980's.

These children were followed through their school years and even into adulthood, and weekly the results of this were published, and the children in the group that had been exposed to the words and the

reading did better all through school, they became much more successful as adults. The children with the nutritional supplements actually weren't much different than the control group, showing us how important words are and exposure to words, and not only that, that parents can be taught to use words with their children. In fact, what we know now is that the number of words a young child is exposed to in those first couple years is directly proportional to their success at reading in the future.

So this brings us to another Healthy Start benchmark that I know you're all aware of. That is to increase the proportion of Healthy Start child participants younger than 24 months who are read to by a parent or family member three or more times a week to 50%. So why is reading in particular so important? It turns out that children acquire the skills needed to read beginning in infancy, and they acquire them from words and especially being read to. Now, it's not instinctive always to think that. You think that little infant, or your participant that you're working with may say, "You know, I'll read to my baby when it gets old enough to understand, but right now it's just in my arms laying there. How would reading to this baby help?" Then they might say, "I try to read to my six month old, and it just wants to eat the book." So how can this be helpful to these very young children?

But what we know now, and again, evidence-based, what we know is that reading even to that tiny infant begins to develop the portions of the brain that will eventually be involved in that child reading themselves. Reading to those very young children promotes language skill. Now, as we get a little older of course, reading also introduces numbers, colors, shapes, and any child that's read to learns how to listen, that's going to be very important in school, learns how to remember things, and builds vocabulary skills. So very important to set up this child to successfully learn how to read when they're five or six or seven, and we know that reading by third grade turns out to be an important predictor of future success as adults. I can't emphasize that evidence-based practice enough.

So we've looked at some important evidence-based basics of parenting that are positive, but now let's go into parental behaviors that place a child at risk. Any parent with a hard-to-control temper is going to have a hard time with little children, and certainly any parent or home where alcohol abuse or use of mood altering drugs is going on. We of course screen for that. It's very important to find out about that in homes with small children. Domestic violence, same thing. We know in fact that we

have a benchmark about screening for intimate partner violence. It's very important to do, very important to be aware of this which can place a child at risk. Finally, maternal depression places a child at risk. We talked about maternal depression on the postpartum webinar and we talked about the effect on mom, but of course this has serious effects on the baby as well. If you just look at the picture on this slide you see the mom just staring off into space. She's so depressed, she's unable to engage with her baby, unable to cuddle her baby, and of course that's gonna have long-term effects on the baby and their relationship.

So we want to keep the risk factors for postpartum depression in mind, we want to be always on the lookout for those women who might be at risk of this and detect it as early as possible. Risk factors include history of severe premenstrual syndrome, history of severe depression in the past, and certainly any woman who's had postpartum depression with a previous pregnancy is at significant risk for it to recur. Family history of postpartum depression is also a risk factor, but then there are environmental contributors, and these are the ones that we see most frequently I think in Healthy Start. If you just look at this list here, psychosocial stress, low income, these are the women we're working with, teen moms, women with inadequate emotional and social support. So we know that our Healthy Start participants are at especially high risk for postpartum depression.

So we want to be on the lookout for those risk factors, but then as we know, we have a benchmark about screening all women for postpartum depression, not just the ones we suspect, and this is very important because it turns out that fewer than 20% of women with postpartum depression will talk to their healthcare provider or their Healthy Start worker about their depression. Partly they're depressed. They're not talking about much of anything, but partly they're embarrassed because they have this nice, healthy baby and they think they should be happier. So they don't want to talk about it, but the screen will bring it out. So we want to screen all of our women, and then if we find it, of course we've got another benchmark, and that benchmark is that we be sure to refer this woman who turned out to be positive on the screen. We want to refer as soon as possible for aggressive treatment so that the mom feels better, which will make the baby feel better, and will help their relationship and their bonding. Treatment is usually antidepressant medication, but psychotherapy is also used as well.

So we've been looking at some evidence-based practices that extend from zero to two in all cultures, but as I talked to Dr. Bland about

developing this webinar, he pointed out that there's a big difference between a newborn baby and a two year old. So as we come up with these general guidelines we should look at specific age groups and see what specific evidence-based practices we would have for each of these age groups.

So we want to start from birth to six months. The first thing that I want to talk about with every one of these age groups is normal developmental milestones. What should be happening in an infant, a baby between zero and six months? Where should that baby end up at six months? We want to be aware of this, any of us who work with babies or moms and babies, we want to help parents be aware of this because if the child is not developing normally we want to find out right away and we want to make a referral and get that child back on track. So what to expect by six months in a babies development?

Well, socially we expect that baby to be able to recognize familiar faces and recognize strangers that aren't familiar faces. We expect by six months that a baby can respond to its own name, that it can repeat sounds and actions to get attention. We expect that it can roll over in both directions and begin to sit without support. We expect that it can bring objects to its mouth, move objects from hand to hand, and actually reach for objects that are out of reach. If we don't see these behaviors by six months, we are on the alert and we are considering a referral.

Now let's look at some other evidence-based basics of parenting these very small babies. With the newborns, of course a newborn really is helpless. Parents are responsible for all food, sleep, cleaning, and comfort when crying that that newborn baby's going to get. But also from the get-go that newborn needs to successfully form attachments. So again, that face to face engaging that baby is crucial to developing the baby's future self-esteem and relationships. Of course as we've said the things that can interfere are maternal depression, substance abuse, intimate partner violence, etc.

Now let's talk about sleep in these young babies. Infants need 12-16 hours of sleep per every 24 hours. So that is normal, and in order to help the infant sleep, especially at night, it's a good idea to make sure that the crib is in a quiet place, and place the infant in there at about the same time each night. So those are the basics of helping the baby sleep, but I think we're all aware by now of the importance of safe sleep, the ABC's of safe sleep.

Sudden infant death syndrome, SIDS, used to be a mystery. What's happening to these babies that are just dying in their sleep? Now we know that not always, but often, it had to do with how the baby was sleeping, and that's how we developed the ABC's of safe sleep. So I'm sure most of you are aware of these, but it never hurts to repeat these important guidelines, that babies should always sleep alone, that means not in the parent's bed, but by themselves in their own crib, but also without blanket or pillow or teddy bear or baby bumpers, anything that they could roll over, against, and might prevent them from breathing properly. The other one, the B, of course, is back to sleep, our slogan, that babies are so much better off if they sleep on their backs, because if they sleep on their tummies and get into a deep sleep, the head can fall forward, and again they can fail to be able to breathe. Finally the baby should have its own crib. Again, not being with the parents but not being on a pillow or something like that. We know many of our participants have trouble obtaining a crib on their own, but I'm sure most of you are in touch with programs like Cribs for Kids that can provide something that can allow that baby to have its own crib.

Now, it's not a bad idea to have the crib right next to mom's bed. We don't want the baby in the bed with the mom, but you sure can have the baby within arm's length of the mom in its own crib, and that's comforting to both mom and baby. Just to emphasize the importance of safe sleep, we know that we have a Healthy Start benchmark to increase the proportion of Healthy Start participants who engage in safe sleep practices to 80%.

Let's move onto nutrition. Of course I think we're all pretty aware, too, that the best nutrition for a baby from birth to six months is exclusive breastfeeding. Again, we have benchmarks for instituting breastfeeding by our participants and also for continuing exclusive breastfeeding for six months. Only 79% of women began breastfeeding in the hospital now, and only 49% continue for six months. So we're working at getting those numbers up by providing positive reinforcement for breastfeeding, by reinforcing the benefits of exclusive breastfeeding for six months, and by addressing our participants' questions and concerns about breastfeeding. Now, I know that a lot of you have improved your skills on this because we've had community trainings going on, and I also know that many of you in Healthy Start are going to be trained as lactation counselors, or maybe some already have been, but I know that's coming up for more of you, and that is certainly going to help address questions and concerns and hopefully help our participants continue breastfeeding for six months.

Now, one important supplement when women are breastfeeding is vitamin D. The participant has usually received vitamin D from the pediatrician, but we want to be sure that the participant is giving that to her infant, and probably breastfeeding, it's a good idea for her to be taking vitamin D as well. That is the one supplement that this infant needs.

Of course there are going to be some participants who can't breastfeed for medical reasons or just aren't interested in breastfeeding, and very importantly we don't want to judge them. We want to encourage breastfeeding, but if somebody decided to formula feed, then we want to support that and help them do that as safely and effectively as possible. The most important thing there is that the participant understands the directions for preparing formula successfully and follows those directions exactly. Now, that mother who doesn't breastfeed, she won't get the benefits that breastfeeding would provide, and neither will her baby, but she'll get the nutrition. The nutrition is in iron-supplemented formulas, and she'll get the same amount of calories that a baby that's breastfed would. The infant should be growing the same way. So we can help her and support her in formula feeding as well. The most important thing for her to remember is that she should never over dilute the formula in order to save money. It's tempting sometimes when the budget's getting tight, but we all know about WIC and we all know that [inaudible 00:27:08] and be sure that she can get adequate formula, because if she dilutes it, then the baby won't be getting proper nutrition or calories, and it won't have the chance to grow successfully.

We talked about what it normal development for a baby up to six months, but I want to reinforce some developmental concerns. So when would we worry about a young child that it isn't developing normally? What would be some red flags? Well, here you see listed some things, and these are things that, if you're seeing a mommy and her baby, be on the alert and also help moms to be alert. So if the baby shows no affection for its caregivers, doesn't respond to sounds, doesn't try to get things that are in reach, has difficulty getting things to its mouth, doesn't roll over, doesn't laugh or make squealing sounds, seems very stiff, or on the flip side, very floppy, or doesn't make vowel sounds, which would be important for future language development. You know, it turns out that 17% of babies have some kind of developmental issue. So it's very important for us to be alert to these kind of things and refer babies with any suspicion of a problem for early treatment. That's how it can be best managed.

Finally I want to, with every one of these age groups we'll be looking at, give some safety guidelines. You may be aware that the number one cause of death in these young children and the number one cause of significant injury is accidents. So we can't be too careful about our safety counseling. So what kind of safety issues do we have in these very young babies? Well, first of all, they should always be in a car seat if they're in a car, and the car seat should be correctly positioned in the center of the back seat with the baby facing backward.

Another cause of injury in these very young babies is leaving the baby alone for even a really short time on any elevated surface. The baby can roll off. Maybe you've never seen the baby roll that direction before, but this will be the time they do. So never leaving a baby alone on an elevated surface of any kind. Another guideline is not carrying a baby and a hot liquid at the same time, and then very importantly we've said that these young babies very quickly learn to reach for things, grab them with their hands, and they immediately put whatever they grab in their mouth. So we need to be very careful to keep small objects that the baby could choke on out of the baby's reach. Finally, one can't emphasize to parents enough that they should never shake a baby. We know now that shaking a baby causes brain damage.

It turns out that in the United States 1,200-1,400 infants a year are seriously injured or killed by shaken baby syndrome. So how does that happen? Well, I think any of us who've ever dealt with a little baby know that it can be very frustrating. Babies cry normally one to three hours a day. That can drive parents crazy, but some babies cry even more than three hours a day. When babies cry more than three hours a day, we call that colic. It can be very difficult to manage, very difficult to try everything to get this baby to stop crying, and it just won't. So the caregiver can get frustrated, and that is when shaken baby syndrome can occur.

So we want to talk to parents about this, the fact that we know you're gonna get frustrated. Everybody does, but if you do get the impulse to shake the baby, immediately place the baby down in its crib, go into another room, and take care of yourself. In that other room do whatever will help you. Phone a friend for support, put on some music, exercise, but the baby will be okay for a little while. You don't want to go outside the house, but if you're in the next room the baby will be okay and you can take time to calm yourself down.

Now, of course shaken baby syndrome doesn't just happen with parents. In fact, it may be more common with caregivers. So we need to remind our parents that they need to make sure all caregivers understand the dangers of shaking a baby, and often if you're placing a baby in another person's care and you have any doubt that they understand this, it's a good idea to give them an alternate caregiver's name that they can call if things get too hard. Also the baby should never be left with anybody that you know is easily irritated or has a bad temper or a history of violence. There's also a child's health USA hotline for parents at their wits end, and that's a good thing to give out as well.

Okay, let's move on to seven to 12 months. I love this little picture. This little guys is adorable, I think. Let's look at what is important in his life for parents to know. So where do we expect this little guy to be in 12 months? What kind of development do we expect between six and 12 months? Well, he should be getting even more attached to his parents and cry when they leave the room. If you read him from a picture book, he should look at the pictures. He should be able to play peek-a-boo. By the end of 12 months he should know mama and dada, be able to say it, shake his head no, wave bye-bye, imitate, copy gestures, he should be able to pull to a standing position and cruise by holding onto furniture. Some babies are even taking some steps by now. He should be able to drink from a cup and finger feed himself, all of this by 12 months. If we don't see this by 12 months, again, we're concerned.

So what about sleep in a seven to 12 month old? Well, they should still be in its own bed, still continue to have naptime, but it gets to be a little easier at this stage to have an established sleep time routine, to put the baby down at the same time every night, put the baby down by himself, and hopefully establish some routine sleeping through the night. As far as naps are concerned, it becomes a little easier to tell when the baby needs a nap. Early on little babies cry for anything. Maybe they're tired, maybe it's something else, but at this age you begin to see the baby rub its eyes, becomes fussy. That's a good clue that it's time to put the baby down for a nap.

What about nutrition? Well, big changes at six months because this is when we can transition that baby to table food. Table foods of course need to be cut into thin, small bites, or baby food, and we don't want to give cow's milk yet until the baby is a year old. We also want to be very careful with anything that the baby could choke on.

What are some developmental concerns that you see a baby 11-12

months old, especially 12 months, and these things are not happening? When are you going to be worried? Well, if the baby doesn't crawl and stand when supported, doesn't search for things you hide, can't say momma and dada, doesn't wave or shake his head, doesn't point to things, these need a referral, but the most important thing would be if you ever saw a baby that had skills and now lost them. That is a major red flag and that's an emergency referral to a pediatrician for developmental assessment.

What about safety, seven to 12 months? Well, we're still going to be paying a lot of attention to car seats whenever that baby's in the car. But this is when we begin to baby-proof the home. Remember, this baby's crawling now. This baby can get into things. One suggestion for baby-proofing the home is to crawl around yourself on the floor and see what the baby could get into, because if it can be gotten into, this baby probably will. So baby-proofing of course includes covering electrical outlets, keeping cleaners, chemicals, and medicines tightly closed and out of reach, removing sharp-edged or hard furniture, using gates on stairways, and closing doors to rooms where the child may get injured.

Some other dangers we begin to see at this time, one of them is using a baby walker. Pediatricians like Dr. Bland advise against using baby walkers because sometimes babies actually tip over and get injured in baby walkers, and they have even been known to fall down the stairs in their baby walker. Another danger that appears at this time is drowning. This is the age when babies can begin to sit alone and be placed in the bathtub, sit alone in there in just a few inches of water maybe, but if you leave that baby alone or even with a sibling for a few moments, it's possible that baby could drown even in a couple inches of water. So you need to be sure never to leave the child alone in a bathtub, but never to leave the child alone around water, because children are attracted to water and might climb into the bathtub or the wading pool at this point, crawling around, and again the danger of drowning. Burns, never leaving hot liquids in the child's reach, and choking again, being careful that anything that baby can reach is not small enough that the baby can get it in its mouth and choke on it, and balloons are a particular danger.

So we always look at some cases in these webinars. Here's our first case, and this is a safety case. Here we have JR. JR is seven months old, seems to be doing well, looks pretty healthy, looks like he's a got a good relationship with his mom, but mom tells that he's getting frequent ear infections. He also coughs a lot and he's recently been diagnosed with asthma. So if you're wondering if anything is going on associated

with this, you ask the mom if she smokes and she says, "No, I smoked before I was pregnant, but I gave it up and I haven't smoked since." Then you ask about dad, and indeed dad is smoking in the house, sometimes even when he's carrying JR.

So how are we gonna counsel these parents? Well, it's so important to know that secondhand smoke is right in there on that safety list that we just looked at. Secondhand smoke is dangerous for infants and small children. In fact, babies in the home where there is secondhand smoke have a higher risk of SIDS, but as they get a little older, like JR, the risks that they face with secondhand smoke are more ear infections, more colds and coughs, bronchitis, even pneumonia, and asthma, and the asthma can get worse and end up with the baby in the hospital. So very important to keep JR away from the secondhand smoke, especially since he's already showing signs that it's causing him harm. We need to tell dad he's got to smoke outside and only outside, and when you come back in, pick up your coat and don't hold JR until you've got your smoke-filled clothes off either, because JR can even get the toxins from cigarette smoke from clothes.

Now, we certainly don't want to discourage dad from carrying JR around, but he does need to be careful with the smoking, and of course the best would be if we could encourage dad to join a stop smoking program and stop smoking.

Okay, finally we want to look at children from one to two, and this is when of course they begin to walk and become a toddler. I love this little cartoon because it shows us all the things that little toddlers do, and of course it's very fun for them, very much fun for us to watch them, but also pretty chaotic. Sometimes it's difficult to watch them, and you can see that there are dangers inherent in some of these activities as well. So what should a toddler be developing? What should a toddler be like after its first year of life, by 24 months? What should a toddler be able to do?

Well, at 24 months a child should be able to play with other children and even have an idea about sharing, should know what to do with common items like a fork, spoon, brush, should be becoming more independent and beginning to show defiant behavior. Remember, this child's heading for what we call the terrible twos. Speech should be understandable by 24 months. The child should be saying sentences containing two to four words, following simple instructions, naming the items in the picture book that you've been reading to the child, pointing to the dog, the cat,

body parts. The child should be able to build a small tower of blocks, climb on and off furniture, look out, walk up and down stairs holding on, begin to run, stand on tiptoe, kick a ball, and throw a ball overhand. If we don't see these behaviors, we're concerned. Help mom and dad recognize these behaviors as well.

What are some other evidence-based basics of parenting a toddler 12 months to two years? Well, the important thing is to know that all those activities we saw on that cartoon are normal and that the baby needs to do these things, the baby needs this free physical activity to explore, to learn on his or her own. So we need to deal with the chaos, but we certainly need to keep a good eye on the toddler.

Now, the other thing that begins to happen is toddlers can get frustrated when things go wrong, and this is when we begin to see tantrums, and this is difficult because before two years of age, toddlers aren't really able to be disciplined. They don't understand the concept of discipline. So all we can really do with these tantrums is be as patient as possible and try to redirect the child's attention, but you can see that managing these tantrums would be especially difficult for parents with a history of abuse.

What about nutrition in toddlers? Well, toddlers are going to need a healthy diet with lots of iron-rich foods and protein, meat, eggs, cereals, beans, but by 12 months a child can generally take cow's milk, and because the child is so active, burning a lot of calories and it may not gain much weight. So we don't want parents to worry about that. In fact, they tend to lose their baby fat at this time. But we surely don't want them to be losing weight, and we want to be sure that the parent isn't struggling to put food on the table, is able to provide all the calories this child needs, and of course that's where WIC comes in once again.

When are we concerned about development in a one to two year old? Well, by two years that child should be using two word phrases, know what to do with common items, copy actions and words, follow simple instructions, and walk steadily. Again, if a child loses any skills they once had, that's an emergency referral for evaluation.

So let's look at a case where we might have detected a developmental problem. This is Delray. Delray is 23 months old and he's at his two year well child visit at the pediatrician actually, and it's noted and his mom even says, "He doesn't follow my instructions and he's not using two word phrases, and I was told that he should be by now." But otherwise

he seems to be doing okay. He mimics the actions of his older brothers and sisters, he knows what to do with a spoon and fork, and he knows about phones. He keeps grabbing his mom's phone and acting like he's talking into it. So what about development and what counseling can we give Delray's parents? Well, the parents are right that he should be using two word phrases and following instructions by now. Fortunately his other activities are all normal for his age. It looks like the things he's having problems with all have to do with language, and the most common cause of language delay is hearing problems. So importantly, Delray needs a hearing test, and probably they'll find that his hearing is impaired from something. Hopefully that can be managed, and if not, we can teach him language skills other ways, but this is a case where it's so important to find out early on that he's got this issue, and help him and his parents deal with it.

How about safety between one and two years? Well, we've got many of the same things that we talked about before. I'm not going to read the first five points, but mainly it's keeping an eye on this child that's kind of into everything. We do have two new things on this list, and one of them would be environmental toxins, especially lead. This is when we check children for lead poisoning if we're concerned about it. We become concerned if the child has a sibling or playmate with lead poisoning, might have gotten it the same way, or if the family lives in or the child regularly visits a very old building or lives in a house that was built before 1978 that has recently been or is being renovated. The other thing we begin to worry about with these toddlers getting into everything is any guns in the home. Hopefully there aren't any, but if there are, they are way out of reach of this child and they are locked.

Okay, we have a few additional parenting benchmarks that we want to talk about. I know these will look familiar to all of you, but we want to increase the proportion of Healthy Start women and child participants with health insurance to 90%, we want to increase the proportion of women and children participating in Healthy Start who have a usual source of medical care to 80%, and we want to increase the proportion of Healthy Start child participants who receive the last age appropriate recommended well child exams to 90%. So we want to be sure basically that our Healthy Start kids have insurance, a medical home, and are getting their follow-up. So what are those recommended well child visits from the American Academy of Pediatrics?

Well, you see they're pretty frequent there at one, two, three, four, six, nine, 12, 15, 18, and 24 months. So it must be important if they're

recommending so many visits. Let's see why. Well, this is what's done at a well child visit. The baby is examined. That's important. History taken, blood tests, and the baby's growth is being assessed. That's huge. Height, weight, head circumference. Immunizations, very important part. More on that later. But at these visits children will obtain hearing tests, vision tests, cognitive, motor, and speech development screens, socioemotional development screens, and of course these visits are always a chance for mom and dad to ask questions, but I want to point out and talk a little bit more about immunizations or vaccines, how important those are, and those are one of the most important things that happens at these visits.

You know, vaccines prevent infectious diseases that used to kill babies or seriously harm them, and actually even in this day in age if children aren't immunized, they are still susceptible to many of these infections. I'm sure you've heard about the measles epidemic that took place at Disneyland last year because people had not been immunizing their children. Whooping cough has arisen in several communities in our country where patients weren't immunizing their children. So we can't overemphasize the importance of immunization, and I want to tell you about a recent study that showed that community health workers can have a huge impact on children getting immunized. The study showed that parents understood a lot more about immunizations and that their children were more likely to get immunizations if the community health worker taught them and encouraged them to get vaccines.

This is our immunization schedule. Lots of immunizations on there, no question about it, and here's a case involving immunizations. Serena has followed her doctor's recommendations for vaccines so far, but she's beginning to feel that her son, Damien, has gotten enough of these shots. You know, we just looked at how many of these shots there are. Plus she's heard that vaccines can be dangerous, and Damien cries every time and these shots are hurting him. Now I'm gonna counsel Serena. The main thing for Serena to understand is that the worse that can happen with vaccines is that, yeah, shots hurt [inaudible 00:50:28] and the spot where the shot was given can become a little red and swollen. Occasionally a baby will develop a low-grade fever for a few days as well, but some of the other things she's heard about like maybe vaccines are associated with autism or seizures or mental retardation, they've been proven false, proven many times false. So we need to be sure Serena understands that.

The worst that can happen are these little irritations, and you don't want

to skip even one dose of the vaccine because they're timed the way they are for a reason. They're timed that way because that's when babies are particularly susceptible to these infections. We don't want to miss a vaccine. There's no question that the benefits of getting vaccines are much greater than the risk for almost all children, just occasional children who have immune problems, maybe not, but that is very rare.

And there are ways to make shots easier for babies. There are studies that have looked at this. These are all evidence-based tips. For example with very little babies, if the baby's breastfed during the injection, they tolerate it better. If the baby is being bottle-fed, put sweet liquid in the bottle, and that can help. If the baby's older, give a cup of sweet liquid. See how the woman on the picture here is holding her baby front to front? That is also evidence-based that it makes shots easier. The babies feel more comforted. Children can of course also be distracted by talking to them, playing with them. In many places where our children get vaccines, there's actually toys and videos to distract them as well. So we can make these shots a lot easier, and they're totally worth whatever pain there may be.

I just have two more slides. This one comes from our American Academy of Pediatrics, and it's questions to ask parents to help find those developmental problems that we've been looking at. So just asking parents if they think their child is hearing okay, if they think their child is seeing okay or if they're seeing anything unusual going on with their child's eyes. Parents are who's going to notice this. Then you think your child is developing normally. If you have other children is this child doing what the others did at this age? Is this child doing what your friend's children are doing that are the same age? And finally have you noticed any usually behavior problems? Does this child have constant tantrums, constant crying, or maybe inability to bond with parents?

We of course want to help our parents recognize when there's a serious medical problem potentially going on, too, and those of you who've worked in Healthy Start may be asked this by a parent, "Is it time for me to call the doctor? Is it time for me to go to the emergency room?" This is a list of guidelines for when to worry. If the child refuses to eat or drink or can't tolerate feedings or food because it's vomiting for 12 hours, it's time to call the doctor. If a child is dehydrated, pure wet diapers, no tears when crying, time to call. Fever more than 102, definitely call for any fever in a very young baby less than three months old. The baby seems to be breathing hard, fast, having trouble breathing, that's time to call. Maybe blue or grey in their skin, loss of consciousness or decrease

of alertness, difficulty keeping the child awake, and abnormal shaking movements which could be seizures. So just some guidelines to share with parents about when to be concerned medically.

As in all of these webinars we have covered a lot of material and it's a lot for Healthy Start workers, community health workers to think about as they work with our participants, but luckily we've got the screen tools coming and hopefully the parenting screening tool will help us be sure to cover all the things we've talked about. We know that good parenting is really important, vital to the health of the baby, the parents, and the family, and makes for happy kids. I love this picture. Happy kids, that is our goal. Here are some resources, but I'm going to turn back to Michelle and see if we have any questions.

Michelle: Thank you so much, Dr. Shepard. That was really great. At this time we're going to take some of your questions. So operator, if you could unmute Dr. Bland, that would be wonderful. So go ahead and chat in your questions. We'll be happy to take some. We do have a few minutes. Okay, I'm seeing our first question. The first question is, "How would you recommend the Healthy Start programs coach parents to manage temper tantrums?

Harold Bland: I think that to coach parents how to manage temper tantrums, basically you just have to make them aware that it is a normal thing that children do particularly in the toddler stage, and the best way to do it is, I know it sounds hard to do, but try to ignore it because a lot of times with children doing temper tantrums what they're really trying to do is gain attention, and the more the parent reacts to the temper tantrum, the more the child recognizes very quickly that one of the ways to get mom or dad's attention is to throw these temper tantrums. So as much as possible, try to make the child interested in something else.

Sometimes it helps to have a little corner that you can make a child go to a quiet spot in a room, but remember that a toddler has such a short attention span that trying to make them sit still as a closed punishment for a period of five or 10 minutes isn't going to work. So the best thing to do is try to make sure that, again, you're not letting the child think that you're responding positively to it, that you're trying to show that it doesn't bother you too much, but at the same time you want to make sure that you're trying to redirect the child, and the most important thing for a temper tantrum is you make sure that the child is not in a position to hurt himself or herself. So you want to make sure that wherever the child is throwing that temper tantrum, that at least they're in a safe place, but

generally try to ignore it because when the child doesn't get attention from it, very quickly they're going to quit throwing it.

Michelle: Thank you. That's really helpful. So again I'd just like to remind everyone that we're taking questions via chat. So if you have any, go ahead and chat them in. Our second question is, "Could you tell us more about colic?"

Harold Bland: Sure. A lot of times I think caretakers and parent assume that anytime a baby is crying loudly for a long period of time that it's colic. We have to recognize that there are multiple causes for a baby to cry. It may be that the baby is hungry. It may be that the baby has got wet or soiled diapers. It might be that they have some pain somewhere. So there are multiple reasons for a baby to cry, and certainly colic is one of them, but in order to say that it's really colic, the baby has to cry for more than three hours in a 24 hour period of time more than three days in one week. So the first time the baby starts to prolong crying, you can't necessarily say that it's due to colic. The frustrating thing to both parents and physicians about colic is we don't really know the cause. It used to be thought that it was because a baby was having abdominal pain or some kind of a GI upset, and we now know that that's not true, but we don't know what causes it. We also don't know how to treat it successfully, because what works for one baby won't work for another. Sometimes you can try to snuggle the baby, wrap them tightly in a blanket, snuggle them in close to you, rock them gently, sing quietly to them, and that will work. Other times you kind of lay the baby's tummy over your lap, rub its back, and sometimes that will tend to work.

Other times putting the baby in its car seat and taking it for a ride will work, but there's nothing that works for every baby 100% of the time. So unfortunately what you have to do is, when the baby is having these episodes, put the baby in its crib in its room, and as long as you have checked to make sure that the baby is not in any way ill as far as running a fever or the baby's been feeding okay and acting otherwise normally, make sure the baby's nice and the diapers and dry and not soiled, put the baby in its crib in its room, shut the door, and let the baby cry. That's very difficult to do, but it's not gonna hurt the baby, and eventually they do stop crying. Again, as Dr. Shepard so nicely pointed out, these are very frustrating times. It's very easy for parents to get overwhelmed and shake the baby or slap the baby or something. So they need to really make sure that they put the baby in a protective place, and they go to a room where they can get some peace and quiet.

The other thing that one can always assure parents is that as frustrating as this is, almost always the baby has totally outgrown all the symptoms well before three months of age. It usually starts around two weeks of age. Often times the baby doesn't any longer have colic by two months of age. Certainly they always are over it by three months of age. So my take-home message to parents is not every crying is colic. Make sure that it isn't due to one of the causes that you can correct, and if it is colic, you just have to let the baby cry it out and it will resolve.

Michelle: Okay, thank you. We do have another question. So this is about immunization. What can you do if you have tried to educate a parent on why it's best to immunize, but they're stuck on what they've heard and they still don't want to immunize?

Harold Bland: That's a very good question and it's one that's currently had two major articles in our last pediatric journal and was addressed at the Florida chapter of the Academy of Pediatrics a couple of weekends ago. It's very difficult. We try to show the parents the scientific evidence that there's clearly no documentation, no scientific evidence at all that vaccines cause any kind of major problems. I think what parents need to understand is that babies do get seriously ill and do die from some of the diseases that we're trying to prevent. Babies can get very seriously ill from whooping cough, they can get seriously ill from measles. It's uncommon, but babies have died from both of those within the last few months from vaccine preventable diseases. The other thing that you have to try to make the parents understand is that not only are you trying to protect their child, but you're trying to protect the community at large and other children and children who are immunocompromised.

Let's say for example a child who has cancer or who is immunocompromised for some other reason, if that child gets an infectious disease from their child because their child isn't immunized, their child might have only a mild illness, but it may cause the child that catches that illness to actually die because they can't fight that illness. So what you have to try to make the parents understand is that it's really, in my opinion it's kind of a selfish decision not to get their child immunized because this attitude that, "Well, if everybody else is immunized, I don't need to worry about it," is no longer true because there's such a higher percentage of parents who are now declining vaccinations. So it's becoming a public health issue, a community health issue, not just an individual issue. I know parents think they're doing what's good for their child, but they're really not. They're putting their child at risk for some serious illnesses, and illnesses that could actually

cause the child ultimately to suffer a disease serious enough that it might die.

Michelle: Thank you. Those are really good insights. So we have two more questions. I know we're a bit over time, but I do think we'll take these last two questions. So the first is, "Can you tell us how to encourage mom when she's having some depression and is having a hard time responding to baby?"

Harold Bland: I think that is a really great question, and I think it's an important one and I think we as pediatricians, I speak for us as a group, I think we've been not very good at eliciting mom's feelings and how she's doing. One of the things that I always made it a routine to do when I had moms in clinic, because I ran a neonatal hydrocele clinic was, one of the first questions I asked was, "Mom, how are you feeling?" You can usually detect pretty quickly if mom is depressed, and then oftentimes then I would ask what's going on. Oftentimes it's something. Perhaps there might be marital stress, it might be some financial stress, it might be just true depression because mom has just not felt well since the delivery, but I think it's exceedingly important to assess that, and if it's something that she wants to talk to you about and you feel you can talk to her about, it may help her just to unload and be able to talk about it, but I think these are ladies that need referral to professionals that know how to help them because a lot of times if they are depressed early on in their postpartum period, if they don't get help, it becomes even worse, and we have good documentation that a mom who has significant postpartum depression not only has a hard time bonding with her baby, but has a hard time caring for the baby appropriately. So I think it's one of the major things that we need to be addressing, how is mom doing when we do the assessments of both mom and baby.

Jan Shepard: Can I add something there, too, since I'm an obstetrician? When I have found a woman with that issue and she's clearly depressed and not interacting with the baby so well, of course the first thing is to get her to help and get her on some medication and get her some psychotherapy, but I've always encouraged if at all possible to get somebody else to come in and be with her, with the baby, somebody else that while she's healing and when she's unable to interact, somebody else that can interact with that baby, often her mom, her sister, her best friend, her brother, the baby's father, anybody that can sit with that baby a good portion of the time until this mom is feeling better.

Harold Bland: I think that's absolutely critical. Thank you for bringing that up. You're absolutely right.

Michelle: Thank you, Dr. Shepard and Bland. Wonderful. Okay, our last question, "Would you highly suggest or encourage healthcare Healthy Start workers to teach parents who have a history of abuse or high risk factors coping skills when dealing with an infant or toddler? And what are some examples?"

Harold Bland: I think that's, again, an excellent question, and I'm glad they brought that up. Yes, I think that it's vital that parents be taught coping skills. I think that they can be taught those, but I think they have to be, number one, I think in order for the parents to really accept coping skills and be willing to be taught these skills, they have to recognize and admit that there is a problem, that they do have a problem with their temper or violence or whatever it might be. So if parents recognize that they are at risk for that type of situation, I think that they definitely should be referred to programs that teach different types of coping mechanisms and coping skills. Then I think that, depending on what community they're in, obviously there will be different resources depending upon the community, but all communities I am sure have people who are very well qualified to work with the parents on these coping skills, and I think that's an excellent suggestion that that person had who offered that question.

Michelle: Wonderful. Thank you. Okay, well thank you again, Dr. Shepard and Dr. Bland. Thank you to all of you for participating today. I will say that before we end we want to have you mark your calendars for next week, September 20th from 3:00-4:30 p.m. Eastern time when we'll be broadcasting a special initiative about quality improvement, care coordination, and evaluation. This webinar will review the link between the Healthy Start screen tools, the Healthy Start benchmarks, and the national Healthy Start evaluation. You can register and get registration information about this from the Ethics Center Training Alert or from the Ethics Center website, and of course we hope that we'll see you at the Healthy Start Convention taking place in Washington D.C. on September 26-28. It's going to be a great time and we hope that you are looking forward to it. For more information you can check out the Ethics Center website, and I do see a question that came in that we aren't unfortunately going to have time to answer, but I will say it's regarding convincing caregivers to put baby in a safe sleep space. There is going to be a session at Convention about that. So you can get all your questions answered in detail at the convention on September 26-28. So

this concludes our webinar for the day. Thank you all for your participation and I hope you have a great day.