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How to screen for ACEs in an efficient, sensitive, and effective manner

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WHY DON'T PAEDIATRICIANS AND FAMILY DOCTORS SCREEN FOR ADVERSE CHILDHOOD EXPERIENCES?

The adverse childhood experiences (ACEs) screening instrument is a validated, accessible screening tool that can be used for early detection of common childhood traumas. Modifications to the original adult questionnaire have been made in paediatric practices so that the questions are appropriately phrased for asking children and youth directly about their experiences (1,2) (Figure 1), but the 10 specific ACE exposures remain the same in the adult and child questionnaires. As Jacob et al. note, ACEs are common and toxic to children, with lifelong impacts on their neuroendocrine, inflammatory, immune, metabolic, and other physiologic systems (3). ACEs meet evidence-based criteria for screening: they are prevalent, detectible, and their associated conditions have evidence-based early interventions. However, most paediatricians and family doctors do not routinely screen for ACEs. This is termed a 'knowledge-to-action gap', where the research evidence has not yet changed standard clinical practice. This is due in part to perceived barriers that doctors may have regarding ACEs. For example, paediatricians and family physicians may view ACEs as psycho-social, or strictly in the domain of mental health, and thus outside of their expertise. They may also feel under-prepared to address possible traumas, or concerned that there is no effective response to the clinical 'can of worms' they've opened by screening for ACEs (4).

Reassuringly, the emerging literature on ACEs screening tells us that it is not a time-consuming process and does not require extensive mental health training. Sensitive and effective screening can be integrated into a routine clinical appointment in approximately 10 minutes. Parents report that ACEs screening is acceptable and helpful to their children's care (5), and addressing ACEs in standard paediatric care affords an opportunity to improve health outcomes for children (6). Therefore, despite perceived barriers, paediatricians and family doctors are well-positioned to screen for ACEs, just as they screen for other childhood health concerns (7).

How to screen

Screening for ACEs involves asking children and their caregivers about exposures to the emotional stresses known to impact their health. Screening with these 10 yes/no questions generates the child's 'ACE Score', by giving one point for each 'yes' answer. This ACE score then informs treatment planning for child and family, as follows:

1. **Parent and child answer the ACE questions.**

a. **Explain the rationale for the questionnaire and limits of confidentiality:** Physicians can explain that certain stresses are known to increase children's risk for illness across their lives. Note that these questions are now being asked of all patients to identify these stresses early and help reduce them. Explain that their answers are confidential, except in those cases where the child is at risk of serious harm from abuse or neglect.

b. **Complete the questionnaire:** This can be done by the parent and child/youth each filling out the ACE 10-item questionnaire with their physician, or answering verbally in the clinical meeting. Both children and their parents should be asked about the child's ACEs separately. For clarity and accuracy, children under the age of 12 can answer the questions verbally, asked by their doctor. Differences in how parents and children answer

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	Score Yes = 1, No = 0
A person in the household often or very often acted in a way that made the child/teen afraid that they would be physically hurt (e.g., sworn at, insulted, put down, humiliated)	
A person in the household often or very often hit, pushed, grabbed, or slapped the child/teen so hard that they had marks or were injured	
A person in the household touched the child/teen in a sexual way	
Child/teen often or very often felt that people they lived with did not love them, look out for each other, feel close to each other, or were a source of strength and support	
Child/teen often or very often did not have enough to eat or clean clothes to wear, and did not have someone to take care of and protect them	
Child/teen's parents or guardians were separated or divorced	
Child/teen witnessed a person in the household being pushed, grabbed, hit, or physically threatened	
Someone the child/teen lived with had a problem with drinking or used street drugs	
Someone the child/teen lived with had mental illness	
Someone the child/teen lived with served time in prison	
Total:	

Figure 1. ACE Questionnaire, adapted for use in paediatric practice (1,2). Sources: Center for Youth Wellness, ACEs Too High (https://acestoohigh.com/got-your-ace-score/).

the questions can be addressed in the meeting, as parents may not be aware of their child's perceptions, or one or the other may under-report the stresses present in the family. For instructional videos on quick ACEs screening with parent and child, see: www.porticonetwork.ca/web/childhood-trauma-toolkit/developmental-trauma/how-does-it-present

2. **Discuss the results.** Reviewing and explaining the significance of the ACE score is an essential part of the process. Engaging nonjudgmentally with parent and child is important to maintaining your treatment alliance, and taking a stance that emphasizes collaboration and support is central to trauma-informed care. Physicians should explain to parents that early intervention can reduce these ACE stresses. Describing the intervention as an investment in the child's lifelong physical and mental health may help reduce perceived stigma around the results of the screen, and increase engagement (5). Link the ACE score to any health concerns the child may currently have, emphasizing that addressing ACEs will help regulate the child's health by lowering stress hormones, and could therefore improve health and learning (2). If Child Protective Services must be notified, discuss this with the parent as an effort to assist the family and ensure the long-term health of the child.

Sample scripts for how to discuss the ACE score can be found at: centerforyouthwellness.org/advancing-clinical-practice/ www.aap.org/en-us/Documents/ttb_addressing_aces.pdf.

3. **Collaborate on treatment planning.** As part of the discussion with parent and child, physicians can tailor their recommendations to the child's specific ACE score, for example recommending that a parent obtain treatment for their own mental health or substance use, or referring for family therapy. Paediatricians and family physicians might not conduct the treatment interventions themselves, but in their roles as service gate-keepers and treatment-planners, they can use the ACEs data to make appropriate referrals. Evidence-based interventions to address ACEs include parenting therapy, individual psychotherapies, and treatment of parental mental health and substance use concerns, among others.

4. **Revisit the ACE score.** Periodically redoing the ACE questionnaire with parents and children will assist in monitoring the effectiveness of treatment interventions and ensuring that risk factors are being addressed.

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Potential Conflicts of Interest

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