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Letter to the Editor

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Routine ACEs screening is NOT recommended

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Letter to the Editor in response to the article: Watson P. How to screen for ACEs in an efficient, sensitive, and effective manner. Paediatr Child Health. 2018; 1–2. doi:10.1093/pch/pxy146

An increasing number of stakeholders are calling for the implementation of universal screening for adverse childhood experiences (ACEs). While there is little doubt that ACEs increase the likelihood of negative sequelae, this does not automatically translate to benefits from universal ACEs screening. This is the situation for other proposed universal screenings. For example, while developmental delays in childhood are important, the Canadian Task Force on Preventive Health Care recommended against universal screening for such delays in 1-to-4-year-olds given the lack of evidence that commonly-used screening tools would identify otherwise unrecognized cases, and the likelihood of a high proportion of false positives (1). Similarly, while child maltreatment is a serious problem (as well as a core component of ACEs), the limited evidence of benefits of screening resulted in recent guidance from the updated World Health Organization Mental Health Gap Action Programme NOT recommending universal screening for child maltreatment (2).

Finkelhor and others have identified multiple problems with the recommendation for widespread ACEs screening including the lack of evidence-based programs that map onto high ACEs scores and the potential adverse impacts of false positives, among others (3). As well, in systematically examining the research evidence for ACEs screening using recommended health screening criteria (4), none of the key criteria were met (5). In particular, screening without a clear connection to available and effective interventions may be harmful. Importantly, while there are some evidence-based interventions for those that experience negative sequelae from ACEs (e.g., post-traumatic stress disorder), there are no evidence-based interventions tied to scores on an ACEs checklist. Furthermore, there is no compelling evidence that a coherent and effective pathway to accessing evidence-based child and parent mental health interventions would result from guidance from 'yes/no' responses on a checklist of ACEs. Given these concerns, we think it is inappropriate to engage in universal ACEs screening at this time. Decisions to implement universal ACEs screening should be based on rigorous evaluations to determine if benefits outweigh harms. A formal review by the Canadian Task Force on Preventive Health Care could inform this critical question.

While Dr. Watson's article (6) may serve to raise awareness of the importance of adverse exposures in childhood, we disagree with her recommendation to implement ACEs screening in primary and paediatric care. We also disagree that the current ACEs instrument has been adequately validated and that ACEs screening meets screening criteria. In conclusion, we believe that at this time there is no evidence to justify the rollout of ACEs screening in clinical and public health practice.

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