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Promising Practices for Implementing Adverse Childhood Experiences and Resilience Screening in Obstetric Care

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ADVERSE CHILDHOOD EXPERIENCES (ACEs), including abuse, neglect, having a parent with substance use or mental health problems, separation from a parent, and witnessing domestic violence, are robust predictors of mental and physical health problems and increased social and financial costs throughout the lifespan.^{1–10} The strong relationship between ACEs and poor health¹¹ makes ACEs a critical public health issue of our time.^{12–14}

Pregnant women are important to prioritize for ACEs screening and intervention. ACEs are associated with increased risk for negative perinatal outcomes (*e.g.*, peripartum depression and anxiety, unplanned pregnancy)¹⁵ and children of parents with ACEs are at risk for poor outcomes, highlighting the intergenerational impact of trauma.¹⁶ Standardized screening for ACEs during pregnancy may disrupt this intergenerational cycle, thereby minimizing the effects of ACEs on both parents and children.¹⁷ Goals of perinatal ACEs screening include patient education, intervention, and connection to resources.¹⁸ Furthermore, simply sharing about past trauma with a supportive care provider can be healing.¹⁹

Although state and national organizations increase efforts to address this critical public health problem across health care settings,^{10,20,21} there are no best practices for implementing ACE screening in obstetric practices. Furthermore, although trauma-informed care tenets highlight a strengths-based framework, methods for incorporating this into ACEs screening are lacking.²²

To address these gaps, we summarize pilots examining the feasibility and acceptability of ACEs/resilience screening during prenatal care in five medical centers (pilot 1:3/2016–6/2016; pilot 2:4/2018–3/2019) in Kaiser Permanente Northern California (KPNC). We modified the CDC ACEs questionnaire from a research tool to a patient-friendly screener (*i.e.*, decreasing word count and increasing literacy accessibility) and included a letter explaining the screening rationale. Staff trainings included education about ACEs, resilience, and associated health outcomes.

Clinicians were taught to convey key messages to patients (*e.g.*, “Our childhood experiences can affect our health,” “You can consider the kind of parent you hope to be.”). We then tested screening during prenatal care. Clinician surveys before and after the first pilot demonstrated increases in knowledge and comfort in ACEs screening and discussions, and decreases in concerns that screening would be too time-consuming.¹⁷ Clinicians reported that longer conversations were rare but important: “Most often the screen is negative and it’s really easy. But when you find that person, you’re so glad you did.”¹⁷

Patient survey data indicated that most felt strongly or somewhat strongly that ACEs screening should be included in prenatal care (87%), felt very or somewhat comfortable completing the screening (91%), and felt very or somewhat comfortable discussing ACEs with their clinicians (93%).¹⁷ Notably, most patients had never before been asked by health care professionals about ACEs (71%) and nearly all (95%) indicated the conversation did not negatively impact the patient–clinician relationship. Internal unpublished data demonstrated that patients appreciated the cover letter framing the screening as a means of support.

Our second pilot refined clinician scripts and explored patient preferences.²³ Survey results indicated that patients continued to strongly support prenatal ACE/resilience screening and believed that healthy coping skills can help reduce the effects of ACEs. Notably, most supported screening partners, recognizing that their partners’ ACEs have a tremendous impact on family well-being. When asked how to improve screening, some desired more provider empathy, more education, that the screening be led by a mental health professional, and the inclusion of additional stressors (*e.g.*, adulthood trauma). In response, we further refined scripts and training to include more empathy and education. Future research is needed to evaluate the impact of the screening itself on pregnant patients’ physical and mental health.

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Challenges and Discoveries

We encountered several challenges during our pilots. First, introducing new concepts into the medical setting is difficult. The original ACEs study was conducted >20 years ago²⁴; however, the science of ACEs is newer to medical curriculum. Thus, most practicing clinicians are unfamiliar with toxic stress and resilience, and education was required. We collaborated across departments to create novel educational content, clinician scripts, workflows, and follow-up algorithms. Staff and patient input were critically important to improve these processes. Trainings must be trauma-informed and post-training resources should be available, as many staff and clinicians have experienced ACEs themselves. Since then, the California ACEs Aware Initiative created screening workflows and scripting; however, these are not pregnancy specific.²⁵

The novelty of resilience screening also presented a challenge. Resilience was commonly perceived by staff as related to mood; therefore, low resilience was interpreted as requiring mental health support yet that is necessarily so. Moreover, focus groups highlighted that clinicians ultimately appreciated pairing ACEs/resilience screening as a way to incorporate patients' current strengths into discussions to guide follow-up.¹⁷ Notably, our data showed that high resilience may mitigate the impact of ACEs on perinatal behavioral health, further highlighting the value of resilience screening.²⁶

A related set of challenges had to do with establishing the best follow-up for ACEs. Mental health follow-up is not necessarily recommended for ACEs and/or low resilience in the absence of other mental health concerns. However, well-defined follow-up and mental health support was helpful for staff buy-in. We made numerous resources available, including books, apps, videos, online resources, and KPNC resources (*e.g.*, classes, mental health, and psychiatry referrals). The second pilot demonstrated that most patients with a history of ACEs do not desire additional mental health support, and instead many report satisfaction using low-cost and/or online resources.²³ This suggests that implementing ACEs screening is unlikely to overwhelm a health care system with new requests for mental health support. Needs may be different in health care settings with fewer resources.

Finally, although nearly all patients (95%) indicated the conversation did not negatively impact the patient-clinician relationship, a negative impact for 1 out of 20 patients screened is significant. We plan to learn more from patients and work to minimize this in future screening.

Conclusions

ACEs and resilience screening have the potential to improve health outcomes for pregnant women and their children. This commentary offers a practical model for obstetric practices to implement ACEs/resilience screening.^{17,23} This promising practice is feasible, valued by both clinicians and patients, and does not necessarily require additional high-intensity referrals. Future research should address the interplay of ACEs, resilience, and health outcomes on a larger scale and further refine postscreening conversations and next steps.

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