Rationale for ACEs Screening

Screening can improve clinical decision-making and prevent negative health outcomes.

Universal screening for Adverse Childhood Experiences (ACEs) is critical. For some children the effects of toxic stress are seen in externalizing behaviors, such as poor impulse control and behavioral dysregulation. In these children, externalizing behaviors may be symptoms of the neurodevelopmental impacts of toxic stress. For other children, the effects of toxic stress may be more hidden. Routine screening offers the opportunity to identify individuals at high risk of toxic stress and offer anticipatory guidance before the child becomes symptomatic.

ACEs accumulate over time, providing opportunity for early detection and prompt intervention

Though there are children who experience multiple ACEs in their first few years of life, most children accumulate ACEs over the course of childhood. In a multi-site study of children exposed to or at risk for maltreatment, it was found that by age 6 children had an average ACE score of 1.94. Between ages 6 and 12, on average they accumulated an additional 1.53 ACEs, and then between ages 12 to 16, another 1.15 ACEs (Flaherty et al., 2013).

Age	Average ACE score
0-6 years	1.94
6-12 years	3.47
12-16 years	4.62

Source: Flaherty et al., 2013

Additionally, outcomes associated with ACEs tend to appear in adulthood, suggesting a latency phase between exposure and disease outcome. The existence of a latency phase offers an opportunity to mitigate the potential long-term negative health outcomes.

One of the important characteristics of the ACEs screening tool is that it takes advantage of this latency phase—the hope is to improve outcomes by early detection/intervention. While the plasticity in the brain during early childhood and adolescence is a source of vulnerability to ACEs, it is also an opportunity for intervention and treatment.

The pediatric primary care setting is an ideal setting for universal screening, health promotion and disease prevention

The primary care medical home is uniquely positioned to be the site for routine universal screening for ACEs. Some reasons why:

- Primary care physicians are trained in disease prevention and to understand the important role of parents and communities in determining a child's wellbeing.
- Interacting with children and their families at regular intervals can allow patients and providers to develop a trusting relationship, which can facilitate the disclosure of ACEs.

In a survey of 302 pediatricians, 81% agreed screening for family social emotional risk factors is within their scope and 79% agreed that their advice can impact how parents care for their children (Kerker et al., 2015).

With universal screening, we can:

- Raise awareness of the importance of preventing further exposure to ACEs
- Identify needed specialized treatment for children who have been exposed
- Better tailor health care measures based on an understanding of the child's odds of illness or disease

The American Academy of Pediatrics (AAP) calls on pediatricians to identify and treat adversity and toxic stress

Particularly harmful and stressful relational experiences such as child abuse and neglect can compromise healthy development and negatively impact health in both childhood and later during adulthood (Johnson, Riley, Granger, & Riis, 2013; Felitti et al., 1998; Flaherty 2013; Kalmakis & Chandler, 2015; Oh, et al., 2016).

A dose-response relationship between the number of adversities and likelihood of disease has also been substantiated with children experiencing a greater number of adversities being at greater likelihood of negative health outcomes (Bethell et al 2016; Bright et al., 2016).

Given the tremendous research on the negative impacts of adversity on child health and opportunity for meaningful prevention, the AAP has called on pediatricians to play a role in identification and treatment of adversity and toxic stress (Garner et al., 2012).

ACEs screening is accepted by patients and can improve health care utilization

Research has shown that screening for adversity is acceptable among patients. In an adult primary care setting:

- 79% of patients were comfortable being asked about ACEs
- 86% felt comfortable being screened for ACEs (Goldstein, Athale, Sciolla, & Catz, 2017)

Inquiry of early adversity can also be met with appreciation. For example, in a pediatric setting, parents were reported to be engaging in conversations about trauma and found the topic to be of value to their child's care (Gillespie & Folder, 2017). Additionally, parents are largely unaware that adverse experiences can have a lasting health impact when children are exposed under the age of 5 (CYW Market Research, 2017). Given that medical providers are cited as one of the most trusted resources for parents on topics related to their children, this finding calls on clinicians to provide guidance in this area.

Addressing childhood adversity in the medical setting has great potential to improve health care utilization. One year after screening for Adverse Childhood Experiences (ACEs) in the Health Appraisal Clinic at Kaiser Permanente of San Diego, clinicians saw a 35% decrease in office visits and an 11% decrease in emergency room visits among participants compared to the prior year. In comparison to a control group that did not undergo screening, screened participants saw an 11% decrease in office visits (Felitti & Anda, 2014).

With screening	Without screening
35% decrease in office visits	11% decrease in office visits
11% decrease in ED visits	

Source: Felitti & Anda, 2014

Clinical integration of ACEs screening into the workflow is possible

Pediatric clinics implementing adversity screening have found that screening can be feasible in a limited resource setting. For example, in an outpatient pediatric setting, office visits improved without impeding factors such as limited time or resistance from caregivers or providers (Gillespie & Folder, 2017).

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