Letter to the Editor

Moving upstream: The case for ACEs screening

Priya Watson MD MSc FRCPC

Department of Psychiatry, University of Toronto, Toronto

Correspondence: Priya Watson, 80 Workman Way, Toronto, Ontario M6J 1H4. Telephone 416-535-8501 ext 36544, fax: 416-979-4685, e-mail Priya.Watson@camh.ca

I thank the authors for their thoughtful letter and invigorating critique of routine screening for adverse childhood experiences (ACEs). This is a rapidly developing field, and one that warrants urgent attention to ensure best practices and effective interventions. ACEs are a growing public health priority due to their high prevalence and serious sequelae in childhood and across the lifespan. The brief ‘Practical Tips for Paediatricians’ format of the initial article did not allow for an exhaustive review of the evidence of the toxic effects of ACEs, but this has been well established elsewhere (1), motivating governmental bodies and professional practice associations such as the American Academy of Pediatrics to call for ACEs screening in conjunction with other initiatives to educate and support clinicians (2).

Screening is indicated for ACEs because, unlike developmental delays, ACEs typically go undetected in childhood (3,4). Pediatric ACEs screening has been shown to be feasible by clinicians and acceptable to patients (5,6). The authors state that there are “no evidenced-based interventions tied to scores on an ACEs checklist.” However, as described in the Practical Tips column and other literature (7,8), simply arriving at an aggregate ACE score is not the goal; rather, screening is intended to prompt and inform a subsequent conversation with the child/youth and their caregiver about their specific experiences and needs. This conversation then guides the “pathway to accessing evidence-based child and parent mental health interventions”.

The authors note a “lack of evidence-based programs that map onto high ACE scores”, as per Finkelhor (9). In the same issue, however, Dube questions Finkelhor’s critique of the diagnostic use of ACE scores (8), noting instead their importance in guiding clinical conversations and providing public health data. In fact, there are evidence-based interventions for specific ACEs such as parental mental illness, parental substance misuse, and family dysfunction (10,11), which comprise the bulk of the ACE questions. Other questions ask about severe abuse or dangerous neglect, which paediatricians agree is relevant to their practice (3). Anticipatory guidance may also increase resilience, because

simply having the conversation may be beneficial: evidence from adult trauma literature and early ACE study findings show that being asked sensitively about adverse experiences is perceived as useful and beneficial by patients (12–15), and simply disclosing these experiences can positively impact health (16). The authors rightly note that there are resource challenges, with limited access to specialized services. However, the economic and social impacts of ACEs themselves are massive (17), and also strain an already-burdened system. Identifying and addressing toxic exposures hold the promise of improving child health (18), and thereby decreasing lifetime economic burdens.

The ACE questions have been adapted for paediatric use. Validated paediatric trauma instruments can be unwieldy in routine clinical care, so validation of a brief paediatric-adapted ACEs screen is needed, along with longitudinal studies of early intervention. As with any screening instrument, the risks associated with screening must be weighed against the benefits of screening and the risks of nondetection. Not asking the questions maintains the status quo. The adult ACEs research details the later disastrous consequences of early toxic exposures; paediatric ACEs research guides us to mitigate and reduce these exposures as they are happening, to move ‘upstream’ to the source of these serious lifelong consequences.

References

1. Hughes K, Bellis MA, Hardcastle KA, et al. The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *Lancet Public Health* 2017;2(8):e356–66.
2. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 2012;129(1):e232–46.
3. Kerker BD, Storfer-Isser A, Szilagyi M, et al. Do pediatricians ask about adverse childhood experiences in pediatric primary care? *Acad Pediatr* 2016;16(2):154–60.
4. American Academy of Pediatrics. Addressing Adverse Childhood Experiences and Other Types of Trauma in the Primary Care Setting. https://www.aap.org/en-us/Documents/ttb_addressing_aces.pdf (Accessed March 2019).
5. Bethell CD, Carle A, Hudziak J, et al. Methods to assess adverse childhood experiences of children and families: Toward approaches to promote child well-being in policy and practice. *Acad Pediatr* 2017;17(7S):51–69.

6. Gillespie RJ, Folger AT. Feasibility of assessing parental ACEs in pediatric primary care: Implications for practice-based implementation. *J Child Adolesc Trauma* 2017;10(3):249–56.
7. Bethell CD, Carle A, Hudziak J, et al. Methods to assess adverse childhood experiences of children and families: Toward approaches to promote child well-being in policy and practice. *Acad Pediatr* 2017;17(7S):51–69.
8. Dube SR. Continuing conversations about adverse childhood experiences (aces) screening: A public health perspective. *Child Abuse Negl* 2018;85:180–4.
9. Finkelhor D. Screening for adverse childhood experiences (aces): Cautions and suggestions. *Child Abuse Negl* 2018;85:174–9.
10. NICE guidelines. <https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions> (Accessed March 2019).
11. Bunting L. Parenting programmes: The best available evidence. *Child Care in Practice* 2004;10(4):327–43.
12. Becker-Blease KA, Freyd JJ. Research participants telling the truth about their lives: The ethics of asking and not asking about abuse. *Am Psychol* 2006;61(3):218–26.
13. DePrince AP, Freyd JJ. Costs and benefits of being asked about trauma history. *Journal of Trauma Practice* 2006;3(4):23–35.
14. Jaffe AE, DiLillo D, Hoffman L, Haikal M, Dykstra RE. Does it hurt to ask? A meta-analysis of participant reactions to trauma research. *Clin Psychol Rev* 2015;40:40–56.
15. Felitti VJ, Anda RF. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare. The impact of early life trauma on health and disease: The hidden epidemic, 77–87. Cambridge, England: Cambridge University Press.
16. Frisina PG, Borod JC, Lepore SJ. A meta-analysis of the effects of written emotional disclosure on the health outcomes of clinical populations. *J Nerv Ment Dis* 2004;192(9):629–34.
17. Fang X, Brown DS, Florence CS, Mercy JA. The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse Negl* 2012;36(2):156–65.
18. Purewal Boparai SK, Au V, Koita K, et al. Ameliorating the biological impacts of childhood adversity: A review of intervention programs. *Child Abuse Negl* 2018;81:82–105.