Letter to the Editor

Addressing childhood trauma with ACEs screening initiatives

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I thank the authors for their letter, and the Journal for a further opportunity to respond. Adverse childhood experiences (ACEs) and other developmental traumas are now beginning to receive much-needed scientific and public policy attention. The authors' notable work in this field has been an invaluable contribution to understanding the impacts and high prevalence of childhood trauma. While we disagree on the need and timeliness of ACEs screening initiatives (1,2), scientific progress depends on discourse such as this to advance the field of research in childhood trauma, for the benefit of the children we are all trying to help.

We agree that health care providers must be aware of ACEs and address them in an evidence-based way. We also agree that rigorous evaluation must be undertaken of all initiatives in childhood trauma, including screening, with an emphasis on health outcomes. Such research is currently underway, with promising results supporting screening: a recent systematic review of randomized controlled trials that involved detecting and addressing ACEs in children found that "five of six studies that directly involved pediatric primary care practices improved outcomes, including three trials that involved screening for ACEs" (3).

The authors' critique of ACEs screening also involves 'conceptual' support. For example, the authors cite a paper on lung cancer screening, yet lessons learned from cancer screening can inform, but should not preclude, initiatives in childhood trauma. In addition, while the intimate partner violence trials cited by the authors unfortunately did not result in benefits to the women, notably the papers do not report on any mental or physical health outcomes for the children in those homes. It is also worth noting that although the authors state that there is no evidence that screening for ACEs links children to evidence-based interventions, a lack of evidence is not the same as evidence of harm. Although the authors state that asking about ACEs when indicated is 'already the expectations of good

practice', paediatricians report that they do not do so, though a majority agree that they should (4,5). Meanwhile, we have extensive evidence that this status quo, with high rates of ACEs and low rates of 'case finding', results in lifelong poor health outcomes for traumatized children (6).

Undoubtedly the science of ACEs screening and detection will improve and evolve through screening initiatives and their evaluations. The CMAJ framework (7) provides an excellent input for the design of these evaluations, for example. As more health care providers, scientists, and public policy experts continue to engage with the issue of childhood trauma and its lifelong health impacts, there will be increasing opportunities for innovation, evaluation, and collaboration in this vital field of research.

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