Maximizing the Benefit of Screening for Adverse Childhood Experiences

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Adverse childhood experiences (ACEs), first described by Felitti et al[1] in 1998, affect over two-thirds of US adults[2] and have been linked to numerous deleterious longitudinal health, mental health, and social outcomes, including cancer,[3] pulmonary disease,[3] liver disease,[4] autoimmune dysfunction, depression, anxiety, psychopathology, and suidicality.[5] A growing awareness of ACEs' impact on child health has given way to initiatives to screen for ACEs in clinical settings and, especially, in primary care, with the assumption that such screening can ameliorate health outcomes.

In this issue of *Pediatrics*, Loveday et al[6] present results from a systematic review of screening for ACEs in children. The goals of this study were to review the rationale for screening for ACEs and examine impacts of screening on access to referrals and services for identified needs. This is an important clinical question because new efforts to mandate ACEs screening are being adopted in states such as California.[7] Cautions about such implementation have been raised, even by one of the original ACE study authors.[8] Critics have warned that population level ACE questionnaires being used are not validated screening instruments and that they do not have predictive value at the individual level[9] and can induce an expectancy effect, in which identified problems may lead to unnecessarily proactive identification of future toxic stress and resultant problems.[10]

In their systematic review, Loveday et al[6] identified a dearth of studies relevant to child ACEs screening and point out that none of the studies reported on child or parent mental health outcomes. We know from our previous work that there is an intergenerational effect of ACEs[11] and also a possible hesitancy to answer questions that are sensitive and potentially retraumatizing.[12] Having only 4 studies of this systematic review that meet moderate criteria speaks to the limited evidence for the value of ACEs screening and a lack of evidence that screening improves access or receipt of necessary services. Indeed, although combined in this study, there may be a qualitative difference between screening for a need for resources (broader social determinant of health screening) and for exposure to adversity within the caregiving relationship (eg, abuse, neglect, exposure to intimate partner violence). For the latter, without linking exposure questions with mental health symptom screening, the opportunity to refer appropriately those who could benefit most from evidence-based trauma therapy or other appropriate mental health services may be lost.

As primary care providers for children and families who suffer from the burden of ACEs, we recognize that having a framework for understanding ACEs and identifying symptoms within a safe and responsive relationship with patients and families is critical to providing trauma-informed care in the pediatric medical home.[13] We

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understand that there are many barriers to ensuring that those with identified adversities are linked to community resources, such as limited time, staff resources to reach beyond the clinical space, and competing clinical demands,[14] especially with the current pandemic in which acute COVID-19 concerns are taking precedence over preventive care.[15]

Consensus has highlighted the need to focus on safe, stable, and nurturing relationships and change the paradigm from simply identifying ACEs to promoting resilience.[16] Resilience-informed relational care[15] allows pediatricians to provide support for all children from the pediatric setting. Providers should create a safe and empowering environment to raise and respond to a family' specific social determinants of health (SDOHs) or ACE concerns. When needs exceed capacity to address these within the medical setting, pediatricians can partner with community organizations to link children to resources and trauma-informed services. This work includes preparing the next generation of providers to respond sensitively and appropriately to toxic stress symptoms and the SDOHs[17] and understanding the intersectionality of ACEs with SDOHs to promote equity.[18] Screening without appropriate office-based guidance and supported linkages to community resources appears to have limited evidence of benefit, as noted in the Loveday et al[6] review and may be potentially harmful; yet, pediatricians can use a resilience-informed team-based and community approach to assist families in navigating their most pressing health and social needs.

ABBREVIATIONS

ACE: adverse childhood experience
SDOH: social determinant of health

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