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Q&A Summary
Adverse Childhood Experiences Part II: ACE Screening in Pediatrics
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1. Recently, I heard an interview on NPR regarding the types of children studies categorized as "Orchids" or "Dandelions." It was referencing the book and studies by Thomas Boyse (*Science of Kindness*). How does adverse childhood experience (ACE) affect Orchids vs. Dandelions?

    - Toxic stress results from a combination of exposure to and insufficient buffering or protective factors from adverse childhood experiences.
    - Protective factors can be biological, psychological and social.
    - Dandelions (children who continue to thrive, even in challenging conditions) may have greater natural and learned/acquired protective factors that make them more resilient, even when parental/caregiver buffering is controlled for. Orchids may have greater susceptibility and require more active and consistent parental/caregiver buffering to navigate adversities.

2. Could deployment of a military parent equate similarly to incarceration of sorts?

    - Deployment is an experience wherein a child is separated from his or her parent/caregiver. This can be experienced as an adversity and result in increased stress. Whether it is experienced as a trauma or adversity that results in the prolonged dysregulation of the neuro-endocrine-immune systems (i.e. toxic stress) depends on multiple factors: the age of the child; other adversities or stressful life events to which the child has been exposed; the manner in which the parent/caregiver who remains at home is handling the deployment; the stories the family tells about the deployment (whether the stories are focused on loss, fear, etc., or the narrative one of pride, hope, etc.).
    - Often incarceration includes not only the physical and emotional separation of the parent/caregiver from the child/family, but also includes a narrative of shame, anger, and loss that contributes to its impact.

3. Like David Finkelhor, I am concerned about the widespread use of ACEs screening before we have answered critical questions related to the costs and benefits of screening. Specifically, how can we ensure that practitioners are trauma-informed, and what are the potential negative outcomes to screening? Screening could be stigmatizing, intrusive, stressful, actually be harmful to health care relationships, and create counterproductive reactions to screening, particularly when false-positives and over-diagnosis could actually outweigh benefits. I believe it is still premature to start screening, particularly in a pediatric population.

    - We agree that screening should not be entered into without preparation. Practices and providers should have a foundational understanding of trauma-informed care. They should clearly understand what they are screening for and why. Our ACEs screening tools – Center for Youth Wellness ACE Questionnaire and the PEdiatric ACEs Related Life-events Screener (PEARLS) are used to screen for risk of toxic stress physiology. We are not screening for trauma or abuse. Medical providers using our tools and protocols are: 1) increasing awareness of the relationship between exposure to adversity, stress,

and possible physical and behavioral health outcomes; 2) promoting stress-reduction/-management practices (i.e. six domains of wellness: sleep, physical activity, nutrition, supportive relationships, mindfulness, and mental health treatment, when appropriate); 3) linking to additional services (e.g., behavioral health, nutrition, etc.) when indicated; and 4) reinforcing that the pediatric clinic is an appropriate place to seek support if or when adverse life events occur.
- We believe that the combination of screening and provision of anticipatory guidance within the pediatric practice is a powerful intervention.

4. How will you screen for ACEs while simultaneously balancing mandatory reporting of maltreatment?
    - We have not seen an increase in Mandated Reporting at Bayview Child Health Center (BCHC) or the participating pediatric clinic at Children's Hospital Oakland with the introduction of routine de-identified/aggregate ACEs screening (i.e. asking *how many types* of adversity the child has been exposed to, not which ones). Once again, we are not screening for trauma or abuse, we are screening for risk of toxic stress physiology.
    - Providers need to follow all applicable mandated reporting laws. If there is reasonable suspicion of abuse, they need to report it. The ACEs screening tool is just one piece of information they consider.
    - If the ACE score for section #1 (the traditional 10 ACEs from the Felitti and Anda study) is a nine or 10 out of 10, then providers do need to assess for possible abuse (i.e. there are three abuse items in section #1; two of the abuse categories, childhood physical and sexual abuse, require follow-up).
    - We encourage practices to track reporting statistics when implementing ACEs screening and to review it regularly (e.g., monthly or quarterly) for continuous quality-improvement efforts.

5. Mandatory reporting is in place for great reasons; children need to be protected. There are parents who will hide it, but more often when parents bring their child in, they are begging for help. They may appear guarded, but if they are willing to talk about it, they are typically crying out for help and are unsure if they are going to get it and be able to keep their kiddos safe. Isn't the most important part of starting these screenings ensuring we have identified the supports/resources necessary? What do you think is the best way to de-stigmatize the fears around mandatory reporting?

    - Yes, we encourage all practices to consider access/linkage to supportive services (i.e. behavioral health services, nutritional counseling and specialty care) before beginning to screen. What do they have access to internally? What is available within their system of care? Are there trusted community-based providers?
    - One way that we de-stigmatize screening for ACEs is to have posters in the waiting room and in each exam room that announce that "We ask everyone about adversity and trauma because we know that stressful life events can have an impact on the health and wellbeing of children. Understanding what your child has experienced is part of giving you good care." Poster templates are available on the National Pediatric Practice Community (NPPC) website.
    - With respect to discussing mandated reporting, we encourage providers to validate the parent/caregiver's concerns, acknowledge that institutional racism exists within systems like child welfare (for families of color), and reiterate that the laws are in place to keep children safe — a goal the provider and parent/caregiver share.
    - If a report needs to be made, explain to the family that a report will be made and why; discuss specific next steps; and when explaining the reason for reporting it is advisable to keep in mind that the purpose of Child Protective Services/Child Welfare is to help, not remove children from their homes.

- We encourage providers to include the parent/caregiver as much as possible in the process (e.g., making the phone call with the parent/caregiver present, etc.), when it is safe to do so. If there are integrated behavioral health staff, providers should consider bringing them into the process to support the family during and after the report. When possible, communicate what the internal next steps will be (e.g., is there a follow-up appointment, what they can expect from the provider/clinic moving forward, etc.).
- Helpful to look up county and state statistics to better understand reporting outcomes (i.e. only a small number of reports result in removal).

6. Where can we get information on the NextGen template for ACES? Do you have a list of ACES screening tools in the various electronic health record (EHR) vendors?

    - Screenshots from NextGen are available in the slides from this webcast. We are not aware of standardized ACEs screening builds in any of the top five EHR vendors currently. All builds have been custom built.

7. How does toxic stress cause physical symptoms like ear infections?

    - Toxic stress doesn't cause ear infections, it reduces the body's immune response, creating the opportunity for more frequent infections due to the neuro-endocrine-inflammatory cascade.

8. Is the CYW ACE-Q a de-identified tool?

    - Yes, the items on the CYW ACE-Q are de-identified.

9. Do you provide the screen in the waiting room or in the patient room?

    - Every clinic's workflow looks different. Some clinics administer the screen in the waiting room along with other paperwork while some clinics administer the screen in the exam room due to patient privacy concerns and/or workflow logistics. We recommend administering the screen where it is least disruptive to your clinic's workflow.

10. What does "P-E-A-R-L-S" stand for and where can I find it?

    - PEARLS stands for Pediatric ACEs and Related Life-Events Screener. It can be found on the NPPC member site. Please join the NPPC to access the member site and download this tool: nppcaces.org/join.

11. Can you inform us of the changes implemented in PEARLS section two?

    - PEARLS section screens for other social determinants of health (SDOH) or social needs/adversities beyond the tradition 10 ACEs that are risk factors for toxic stress or negative health outcomes, including hardship (food insecurity, housing instability) and other significant life events (caregiver's serious physical illness or death, community violence, bullying, discrimination). The CYW ACE-Q section two asks about community violence, bullying and racial discrimination.

12. Can you share your experiences with children in foster care and dealing with the courts? Most of these children have suffered one or many traumas.

    - We advocate for universal screening in pediatrics as a way of identifying children at risk of toxic stress. The majority of children we screen do not screen "positive" (i.e. have a

score of one–three with symptoms or score 4+). For those that do, we complete a comprehensive assessment process (intake interview and administration of standardized instruments) to determine how best to address needs in four core areas: child's behavioral health, child's physical health, parent/caregiver stress, and family natural support. We conduct an ACEs Assessment during this process to identify which adversities the child has experienced.

- For children we know have been exposed to adversities (i.e. children involved in child welfare, juvenile justice), the ACE screen does less to "identify" (i.e. we already know they are at increased risk) but helps introduce an ACEs/toxic stress lens to the work of existing treatment teams.
- When we screen children in foster care, we are using it as an opportunity to provide education to the foster parent and child welfare worker on the impact of adversity on the stress-response systems. We work to incorporate the pediatric primary care provider into the care team.

13. How do you integrate culture into the screenings?
    - When reviewing ACE-screening results, we encourage providers to acknowledge that ACEs are common across the population (i.e. normalize ACEs exposure, state that people from all walks of life and socioeconomic levels experience childhood adversities). For families of color, immigrant families, families living in poverty, families from marginalized communities, providers can also acknowledge that there are income and racial/ethnic disparities in rates of exposure to child adversity.

14. Is there concern surrounding a parent assisting a child filling out the ACE questionnaire? Such as the inaccurate reporting?

    - A child ages 0–12 would not be filling out the ACE screen. A parent/caregiver would complete it on his or her behalf. There is also a Teen Self Report for children 13–18 and a parent report on behalf of the teen.

15. In Idaho, we are now implementing the CANS — Child and Adolescent Needs and Strengths screening. Is there a correlation or information on such between ACE responses and scores on the CANS?
    - We are not aware of studies looking at correlations/associations between ACE screening tools and trauma module scores on the CANS. The CANS Trauma Module (Potentially Traumatic/Adverse Childhood Experiences items) includes most of the adversities in the CYW ACE-Q and PEARLS tools.
    - The CANS is widely used in children's services in California. It is used as an assessment tool for care planning and monitoring of service outcomes. It is not used as a screening tool in pediatric settings.
    - Within our Bayview Child Health Center/BCHC-CYW model, we screen children and adolescents for exposure to ACEs with a de-identified tool (currently the CYW ACE-Q) to determine risk of toxic stress. If identified at intermediate or high risk, we conduct a comprehensive assessment. During that process, we conduct an ACEs assessment, determining to which adversities the child has been exposed. We do not use the CANS, but we use similar tools to assess both needs and strengths of the child/family during the intake to guide care planning.

16. How about parental death?

    - This raises a good question about what additional ACEs should be included. The original ACE study by Felitti and Anda looked at 10 categories, but since then there is continually emerging research about additional stress that lead to risk for poor health. We at CYW consider death of a parent as parental separation, as it is likely to be a traumatic experience and may cause toxic stress.

- Parental death is included as an adversity in the PEARLS tool.

17. What is the web address for NPPC?

    - www.nppcaces.org

18. Dr. Wang mentioned "Cues and Triggers Therapy", is there a specific resource?

    - Cue-Centered Therapy (CCT). Cue = trauma trigger
    - https://www.cebc4cw.org/program/cue-centered-treatment-cct/detailed

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