

Screening for Parental ACEs: Lessons Learned

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Case Study: The Children's Clinic

- 30 providers in three practice sites
- Strong interest in early childhood development / developmental promotion
- Since 2008 have implemented multiple standardized universal screening protocols
 - Developmental delay
 - Autism
 - Maternal Depression
 - Adolescent Depression
 - Adolescent Substance Abuse
- Adolescent questionnaire has always included questions about dating violence; many providers ask about bullying in their history for school aged children.





The assumption

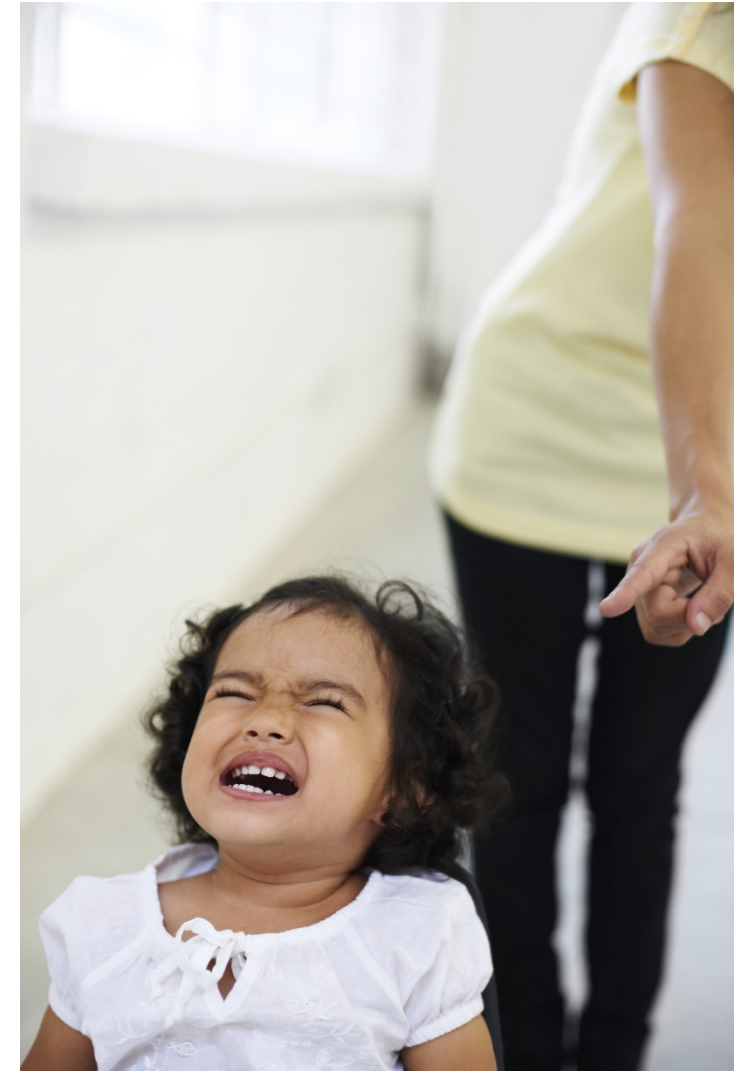
If...

- we can identify parents who are at greatest risk
- bring their trauma histories out of the closet
- agree to support them when they feel most challenged in a non-judgmental way

... we will be able to create a new cycle of healthier parenting.

The Theory...

- Certain moments in the life of an infant or toddler will be stressful
 - Tantrums, colic, toilet training, hitting / biting, sleep problems are examples
- What happens to a parent who has experienced trauma? Will their response be:
 - Fight?
 - Flight?
 - Freeze?
 - Can it be something else?
- How can we better prepare at-risk parents for these inevitable moments?



And thinking further...

- If a parent experienced trauma, do they have appropriate skills / ideas for:
 - Taking care of themselves?
 - Identifying when they need help?
 - Modeling appropriate conflict resolution?
 - Discipline that is developmentally appropriate?
 - Playing with their child?
- In other words, can we teach parents and children to be more resilient?



How do I Find it? Our First Step

- Eight providers piloted screening
- At the four month visit, parents are given the ACE screener, along with a questionnaire about resilience and a list of potential resources.
 - Cover letter explaining the rationale for the screening tool, and what we plan to do with the information
- Created a confidential field in the EMR that does not print into notes, but perpetuates into visits to document results while minimizing risk to families.



Big Lesson #1

Assessing for ACEs in practice is within our skill set.



When asked, parents want simple things...

- The most common resources requested are parenting classes, parent support group, and more information about trauma and its effects.
 - This mirrors the AAP policy statement about what we should offer – positive parenting and better anticipatory guidance.
 - Evidence-based interventions within primary care practice include trauma education (*see Traub and Boynton-Jarrett, Pediatrics April 2017*).
- Parents have rarely needed mental health referrals.
- For kids who have experienced trauma, think outside the box about what might be helpful – mentoring programs, big brother / big sister programs, clubs and activities that offer connection.

Big Lesson #2

Start small but think big.



Implementation should be careful and thoughtful...

- Start with a small group of provider champions who are willing to get their feet wet.
 - We started with 8 of our 30 providers, then spread once we had enough experience to answer questions.
 - Do you know who in your practice is an innovator, middle of the pack, or laggard when it comes to QI?
- Remember that staff members are affected by the assessment process.
 - Front desk, nursing / MA staff, and others have a role in completing the assessment tools.
 - This may be concerning (or even triggering) for staff who have experienced trauma.
 - Consider ongoing Trauma Informed Care training for staff.

Big Lesson #3

Keep your end goal in mind.



What are you trying to get out of the assessment tool?

- To me, the goal of the assessment is NOT to force a disclosure.
- It's far more important to create an environment of safety for the patient... that my office is a safe place to address whatever the parent is facing.
- Assessment tools are also a launching point for educating patients and families about trauma, as well as opening a conversation about resilience.
- Part of my message is that ACEs are not destiny...

Big Lesson #4

Commit to discussing ALL assessment tools...
positive or negative.



What is your intended or unintended message?

- The message of silence can be damaging to a trauma survivor... and may have impacts on the provider-patient relationship.
- Silence implies that either...
 - The provider thinks the story is unimportant,
 - Or the survivor is not safe disclosing their story.
- It's far better to be upfront if you're not in a good space...
 - “This is a very important story, and I want to spend some time talking through this with you. Would you be willing to schedule a follow up appointment?”
- Disclosures can be hard – be sure to thank the person for their honesty and vulnerability (this validates the importance of the story).

Big Lesson #5

Remember the purpose of your assessment tool.

got purpose?

Adjusted risk for suspected developmental delay

	Relative Risk (95% CI)	
	^a Maternal (n=311)	^b Paternal (n=122)
^c ACE		
≥ 1	1.25 (0.77, 2.00)	2.47 (1.09, 5.57)**
< 1 (Ref)	-	-
≥ 2	1.78 (1.11, 2.91)**	3.96 (1.45, 10.83)***
< 2 (Ref)	-	-
≥ 3	2.23 (1.37, 3.63)***	0.82 (0.12, 5.72)
< 3 (Ref)	-	-
Payer source		
Public	1.67 (1.05, 2.67)**	0.87 (0.37, 2.03)
Private (Ref)	-	-
Gestational age at birth		
< 37 weeks	1.70 (0.89, 3.24)	7.76 (3.12, 19.33)***
≥ 37 weeks (Ref)	-	-

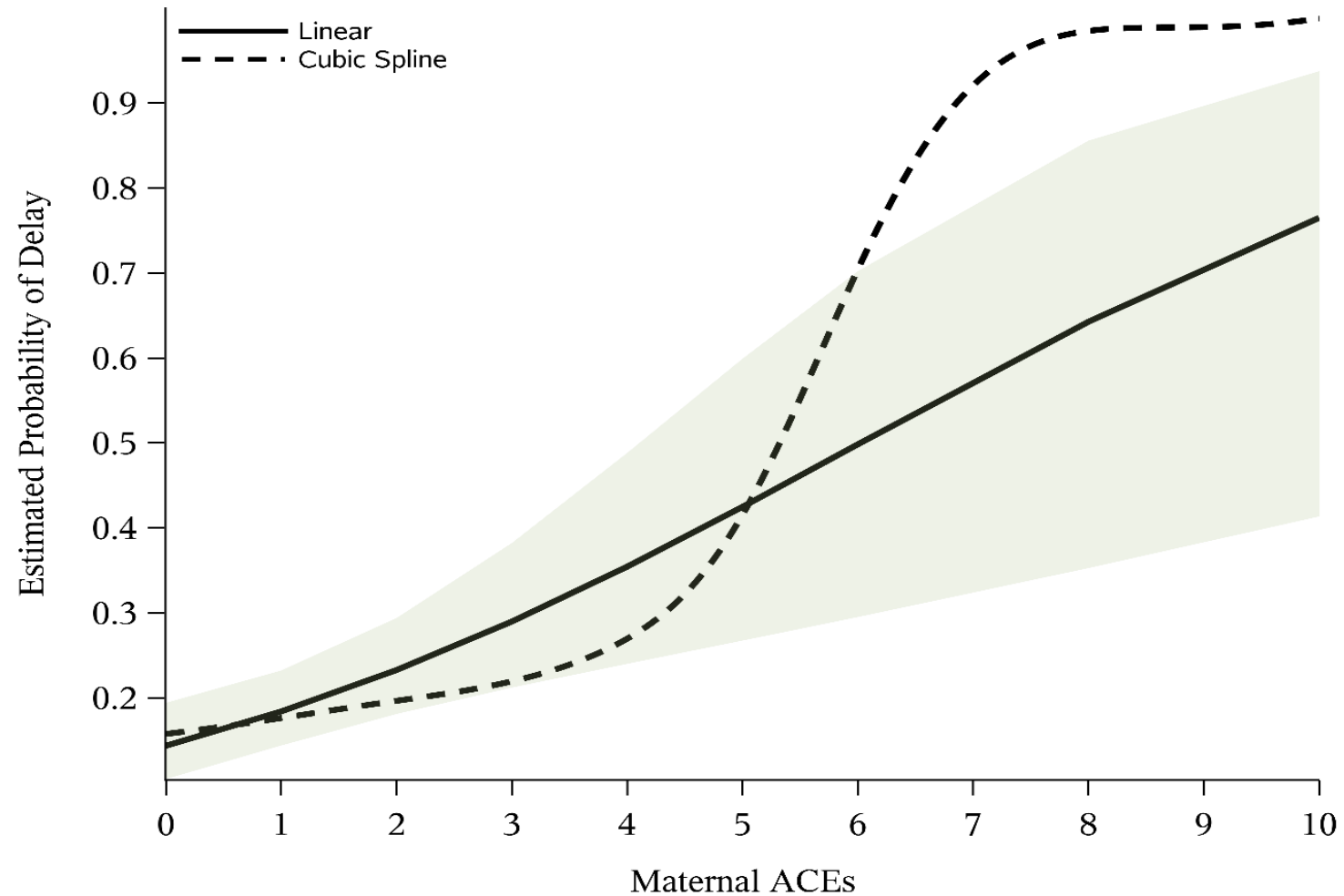
* = p < 0.1, ** = p < 0.05, *** = p < 0.01

Domain-specific developmental risk by Maternal ACE exposure

	Maternal ACEs		Relative Risk (95% CI)
	≥ 1 (n=149)	<1 (n=162)	
Communication, <i>n</i> (%)	24 (16.3)	18 (11.1)	1.47 (0.83, 2.60)
Gross Motor, <i>n</i> (%)	20 (13.5)	17 (10.6)	1.28 (0.70, 2.35)
Fine Motor, <i>n</i> (%)	18 (12.1)	16 (9.9)	1.22 (0.65, 2.31)
Problem Solving, <i>n</i> (%)	17 (11.6)	8 (5.0)	2.31 (1.03, 5.20)**
Personal-Social, <i>n</i> (%)	19 (12.9)	17 (10.6)	1.22 (0.66, 2.26)
	≥ 2 (n=60)	<2 (n=251)	
Communication, <i>n</i> (%)	12 (20.3)	30 (12.0)	1.69 (0.92, 3.11)*
Gross Motor, <i>n</i> (%)	12 (20.0)	25 (10.0)	1.99 (1.06, 3.73)**
Fine Motor, <i>n</i> (%)	9 (15.0)	25 (10.0)	1.51 (0.74, 3.06)
Problem Solving, <i>n</i> (%)	11 (18.3)	14 (5.7)	3.23 (1.55, 6.76)***
Personal-Social, <i>n</i> (%)	9 (15.0)	27 (10.9)	1.38 (0.68, 2.77)
	≥ 3 (n=39)	<3 (n=272)	
Communication, <i>n</i> (%)	10 (26.3)	32 (11.8)	2.23 (1.19, 4.16)**
Gross Motor, <i>n</i> (%)	9 (23.1)	28 (10.4)	2.23 (1.14, 4.36)**
Fine Motor, <i>n</i> (%)	8 (20.5)	26 (9.6)	2.15 (1.05, 4.40)**
Problem Solving, <i>n</i> (%)	6 (15.4)	19 (7.1)	2.17 (0.92, 5.10)*
Personal-Social, <i>n</i> (%)	8 (20.5)	28 (10.4)	1.97 (0.97, 4.01)*

* = $p < 0.1$, ** = $p < 0.05$, *** = $p < 0.01$

Dose response relationship between Maternal ACE and risk for suspected developmental delay



Corroborating Evidence

- Mothers of children being seen in the ED were given ACE questions and PEDS.

Maternal ACEs	Risk of single concern on PEDS	Risk of 2+ concerns on PEDS
1-3 ACEs	1.86 (CI 1.16-3.00)	1.7 (CI 1.26-3.87)
4+ ACEs	2.21 (CI 1.07-2.72)	1.76 (CI 1.02-3.05)

- Highest correlations found for specific maternal ACEs of household substance abuse, mental health, and parental incarceration.
- “Mothers’ ACEs are significantly associated with their children’s developmental risk. If replicated, findings suggest that addressing intergenerational trauma through focus on childhood adversity among young children’s caregivers may promote child development.”

Sun et al. Am J Prev Med 2017;53(6):882–891.

Corroborating Evidence

- Retrospective cohort study of 1172 maternal-child dyads in early childhood home visiting program – examining relationship of maternal interpersonal trauma and ASQ:SE results.
- Interpersonal trauma associated with a 3.6 point higher ASQ:SE score, indicating higher developmental risk.
- Conclusion: maternal interpersonal trauma can negatively impact child social emotional development (but we still need to study why).

Folger, et al. Paediatric and Perinatal Epidemiology. 2017.

Parental ACEs and Behavioral Outcomes

- Compared to children whose parents have no ACEs, a child whose parent has 4+ ACEs has:
 - 2.3 point higher score on the Behavior Problems Index (BPI)
 - 2.1x higher odds of hyperactivity
 - 4.2x higher odds of emotional disturbances
- Correlations were stronger for maternal ACEs than paternal ACEs.

Schickedanz et al., *Pediatrics*. 2018;142(2).

Parental ACEs and Health Outcomes

- For each additional parental ACE:
 - Worsening overall health status (aOR 1.19)
 - Increase rates of asthma (aOR 1.19)
 - Increase in excessive media use (aOR 1.16)
- Since these effects are cumulative, if a parent has 6+ ACEs, their child has 6.38x the risk of asthma.

Lê-Scherban et al., *Pediatrics*. 2018;141(6).

Parental ACEs and Utilization Patterns

- For each additional maternal ACE, there is a 12% increased risk of missing well visits in the first two years.
- This did not result in missing immunizations.
- However, given the risk of developmental delays, it is likely that:
 - Parents are not receiving anticipatory guidance on developmental promotion.
 - There may be an increased risk of missing on-time administration of standardized developmental screens, meaning a potential delay in referral to services.

Eismann EA et al., J Pediatr 2019;211:146-51.

Knowing major outcomes for our kids keeps us anchored to our purpose...

- Parent ACEs are correlated with:
 - Higher rates of failed developmental screens.
 - Higher rates of behavior concerns.
 - Higher rates of asthma.
 - Higher rates of missed well visits.
 - Higher rates of poor parenting practices.
- Doing the assessments just to “click a box” comes across to patients... but...

Can we use our knowledge to improve outcomes? What's next for TCC

- Given what we know about parental ACEs and developmental screening, how do we...
 - Change our developmental promotion / anticipatory guidance to prevent failed screens?
 - Intentionally assess, build, and repair (when necessary) attachment and attunement in the parent-infant dyad?
 - Measure child ACEs to see if, eventually, our interventions will prevent child ACEs from happening at all?