

# Employing an Adaptive Leadership Framework to Childhood Adversity Screening

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Providers of pediatric health care have been motivated and inspired by the research on childhood adversity, which has shown that in the early stages of life, critical neurodevelopmental pathways can be disrupted through exposure to adverse childhood experiences (ACEs) and resultant toxic stress.<sup>1,2</sup> Early detection of ACEs and subsequent intervention has the potential to decrease the development of associated poor health and psychosocial outcomes<sup>3</sup>; therefore, many pediatric medical homes are starting to discuss and implement screening for childhood adversity.

As providers start to consider how screening for ACEs will fit into their clinic workflow, we recommend approaching this task through an adaptive leadership framework. This unique leadership approach focuses on 6 specific behaviors of leaders to guide organizations and individuals through periods of change and uncertainty (Fig 1).<sup>4,5</sup> At the root of the adaptive leadership framework is (1) identifying the change required as an adaptive challenge, one that can provoke emotion or incite conflict or disagreement and for which there is usually no established best practice.<sup>4,5</sup> Leaders are encouraged to (2) step back to reflect on the conflict that may be created, (3) create safe environments to uncover barriers to change, and (4) ensure that individuals do not avoid the proposed change. Central to the adaptive leadership framework is a shared leadership model to (5) prioritize that all affected individuals contribute to finding solutions and, particularly, (6) that those individuals who may feel marginalized are able to safely express their opinions.<sup>4,5</sup> What adaptive leadership ultimately encourages is to lean into any resistance felt against proposed initiatives to understand its roots so that any technical process requirements become easier to conduct.

As our experience illustrates, failing to use this approach could ultimately undermine implementation efforts. Our institution sought to initiate ACE screening in an adolescent medical home that serves ~10 000 patients ages 12 to 21, using the Center for Youth Wellness Adverse Childhood Experiences Questionnaire, Teen Self-Report.<sup>6</sup> Over several months, we followed a step-by-step quality improvement approach guided by the American Academy of Pediatrics' "Trauma Toolbox for Primary Care,"

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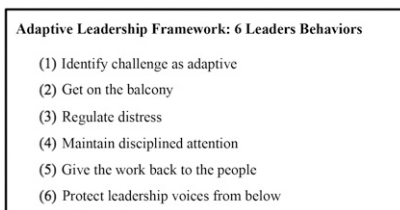
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which supports adversity screening in pediatric medical homes and highlights the importance of assessing staff readiness to change before implementation.<sup>7</sup> To promote staff readiness, we provided a didactic session and educational handouts to all clinic staff. Education focused on the relationship between childhood adversity and health outcomes and on trauma-informed responses to positive ACE screen results.

When we initiated our pilot week of ACE screening, we were met with immediate resistance from clinic staff. We then halted our screening pilot to consider the best way to proceed productively. Subsequent, targeted conversations with staff revealed their disagreement with ACE screening, specifically regarding the appropriateness and utility of a health care clinic inquiring about such personal topics. Some staff also acknowledged their own histories of trauma and the effect this had on their perspective on ACE screening. Although we sought to promote staff readiness for implementation, we did so without understanding their underlying beliefs about the content. We also failed to include them in the early stages of planning, which added to their resistance. The multidisciplinary staff involved in the initial planning stages came from positions of clinic leadership and not from the front-line team who was tasked with handing out the screens. As a result, staff had not been able to fully explore or express their thoughts on the principles that underlie ACE screening, and the educational efforts we provided therefore failed to foster collective buy-in.

With further reflection, we recognized that there is an adaptive component to the work of adversity screening, and the ideals of an adaptive leadership framework clarify our areas of oversight when implementing the ACE screen. In our instance, we had been guided by



**FIGURE 1**

Adaptive leadership framework: 6 leader behaviors. Adapted from Figure 11.2 "Adaptive Leadership Framework Developed By Heifetz and Linsky." In: Northouse PG. *Leadership: Theory and Practice*. 7th ed. Los Angeles: CA: Sage Publications; 2016:278.

traditional quality improvement methods and had approached screening as a technical challenge, one that prioritizes consideration of structured and incremental processes. We had taken care to select an appropriate screening tool and had set up a detailed process workflow for distribution, collection, and responses. We understood the sensitive nature of the screen for patients but did not fully appreciate the emotion that the introduction of adversity screening would elicit and the attention needed for the shift in attitude it would require.

As we recognized the challenge as adaptive, we were then able to "get on the balcony" and create a safe environment to understand the resistance to ACE screening and "regulate distress." By doing so, we recognized that when introducing the concept of adversity screening in a health care setting, there must be accessible and trauma-informed opportunities for discussion of content well before process. As our experience underscores, many in the helping professions have their own personal trauma histories, which may be exacerbated by working with others with similar experiences. Without requiring that staff reveal their own histories of trauma, it is important to broadly assess what "trauma" and "adversity" mean to staff. To be most productive, this may require separating these discussions

from the ultimate end goal, that is, ACE screening.

How these conversations go can provide valuable feedback on the readiness of the work environment to implement sensitive screens, and what these discussions can foster and inspire is a shared leadership model in which all level of staff have a mutual understanding on the need to focus on adversity and provide valuable feedback on processes, such as the implementation of sensitive screens. It is important to acknowledge, however, that for some staff, the topic of adversity and trauma is not one they will explore in the workplace. These boundaries should be respected, even if that includes accepting ultimate refusal to support ACE screening.

In our clinic and at our institution, as we came to understand the perspectives surrounding ACE screening, we decided to halt our clinic-based pilot. Instead, the goal has shifted to cultivate a shared space to understand adversity and its impacts. As a start, through a partnership with the Substance Abuse and Mental Health Services Administration, we have trained >700 multidisciplinary staff in the relationship between adversity and health and in trauma-informed responses. We are prioritizing building equitable opportunities for staff across the hospital to learn about and engage with the science of ACEs and to think through, together, ways we can mitigate the health effects. We are learning through this multidisciplinary work that screening for ACEs may not be required to address the health effects of adversity, and are instead brainstorming trauma-informed approaches both for the clinic and institution setting.

Our experience highlights that traditional quality improvement initiatives that view ACE screening as a technical challenge may need to be

augmented with an adaptive leadership approach to be successful. We should acknowledge the effect that the topic can have on staff, approach their onboarding with the same empathy and understanding we provide our patients and families, and include multidisciplinary staff early on as key stakeholders in finding the solutions to approach childhood adversity.

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#### ABBREVIATION

ACE: adverse childhood experience

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