

Screening For Adverse Childhood Experiences: Current Practices and Family Policy Implications

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Background

Adverse childhood experiences (ACEs) have the ability to impact children's health and well-being both concurrently and into the future (Shonkoff & Garner, 2012). Some adversities that children face originate within the family system (e.g., parental divorce, child maltreatment; Anda et al., 2008; Chapman et al., 2004), whereas others create risk not just for the child but for the family unit as a whole (e.g., poverty, neighborhood violence; Braveman & Barclay, 2009). As such, ACEs not only impact children, but may originate from and impact the family system. Research shows that the earlier ACEs are identified and treated, the greater the likelihood is of remediation and reduction of the negative consequences associated with these risks (Shonkoff, 2010). Thus, ACEs screening that begins early and occurs regularly is an important aspect of fostering family and child resilience. Pediatric and family medicine practitioners are one type of professional that come into regular contact with children and families, and are therefore positioned to provide regular screening for ACEs. More research is needed to explore pediatric and family medicine practitioners' screening practices so as to better understand the factors related to engagement in screening, and the barriers to screening.

The current study had three aims: (1) to understand the prevalence of screening among family and pediatric medicine practitioners, (2) to describe the factors that contribute to practitioners engaging in screening, and (3) to describe the perceived barriers to screening.

Method

A web-based survey, was distributed to family and pediatric practitioners (MDs, DOs, and PAs) in a Midwestern state. Names were accessed through state licensing and by reaching out to community members. Letters, postcards, and emails with the survey link were subsequently sent. The online survey consisted of 61 questions including demographic information, beliefs about ACEs, current screening practices, follow-up techniques after positive screenings, and perceived barriers to screening.

Results

Sample. 46 respondents participated. Sixty-three percent were female; 87% were Caucasian, 4% American Indian, and 9% Asian/Pacific Islander. In the sample, 63% were MDs, 11% DOs, and 25% physician assistants (PAs). Participants indicated that they had been practicing medicine for a range of 1 - 37 years ($M = 15.04$, $SD = 10.7$).

Beliefs. When asked their beliefs about ACEs, 100% of the sample endorsed a belief that ACEs impact children's health both concurrently and into adulthood, and 60% indicated that they were familiar with research on ACEs. However, only 21% had received training related to ACEs and less than half (44%) currently screened for ACEs in their practice.

Screening Prevalence. We explored several factors that could be related to screening prevalence: length of time in field (greater or less than 10 years), type of medical training (MD, DO, or PA), rural or urban setting, familiarity with research on ACEs, and training related to ACEs. Of these, familiarity with research and training were both significantly related to whether or not screening took place $\chi^2(1, N = 41) = 7.67, p < .01$; $\chi^2(1, N = 41) = 9.66, p < .01$, for familiarity and training, respectively.

Barriers. All respondents were provided with a list of 10 barriers to screening and asked to check all that apply. The barriers were as follows: lack of appropriate screening tools, lack of professional education on ACEs, lack of community resources, lack of collaborative relationships, lack of time due to needing to screen for other conditions, lack of time due to high case load, lack of financial resources, infrequent patient contact, discomfort with asking questions of a personal nature, and unsure of how to respond if an ACE is identified.

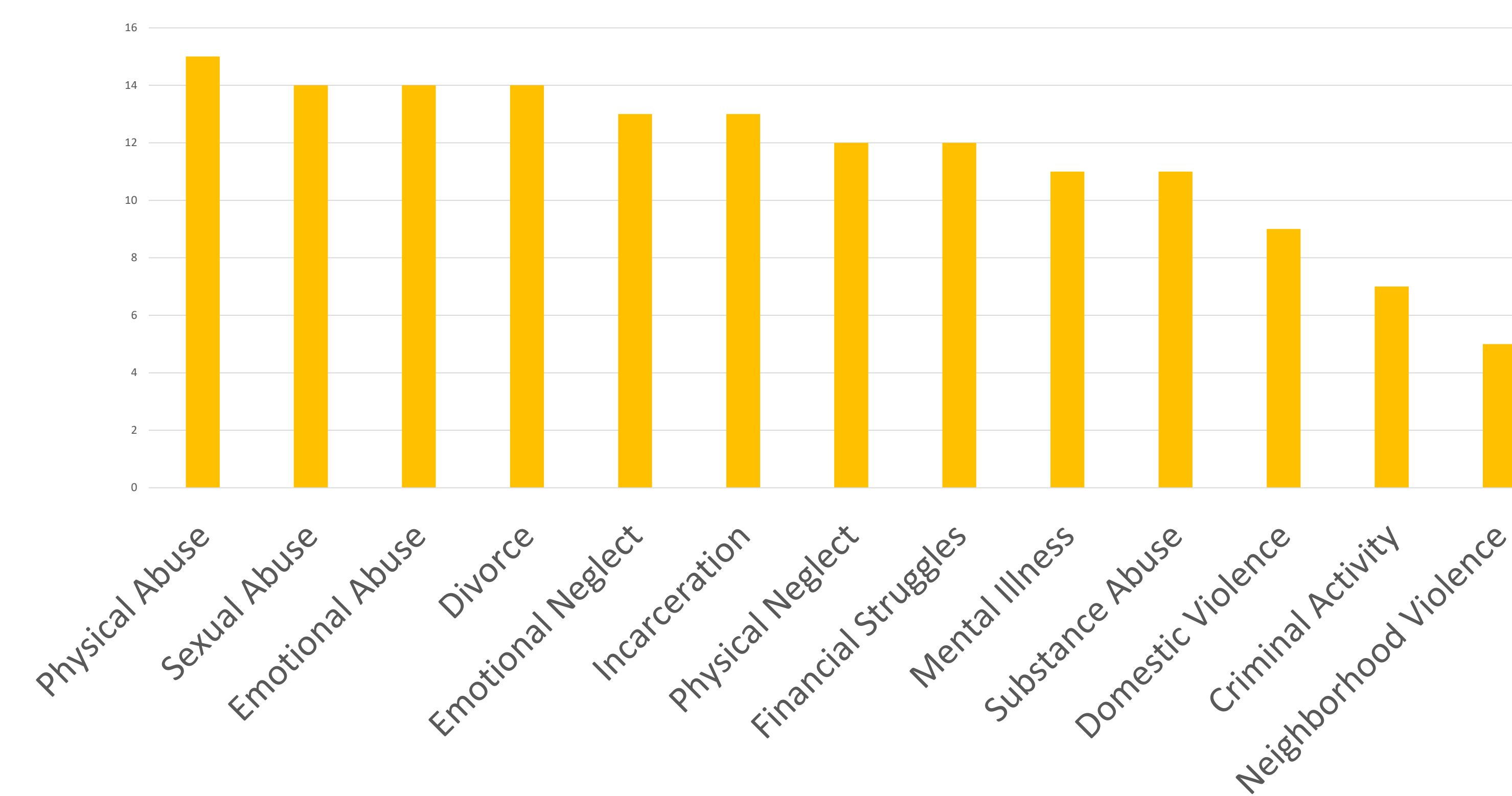


Figure 1. Number of practitioners that screen for individual adverse childhood experiences (n=18).

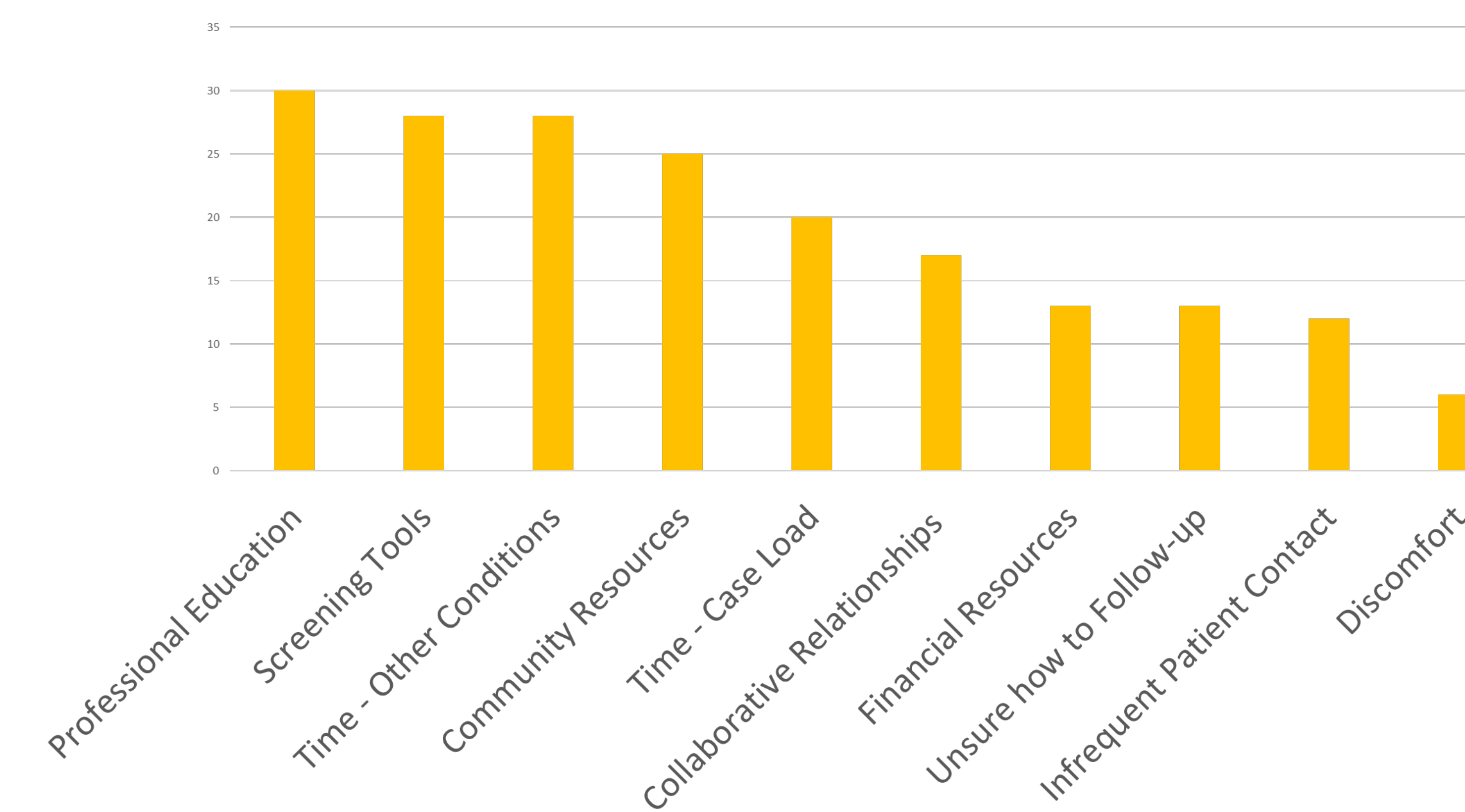


Figure 2. Number of participants who indicated each individual item was a barrier to screening for ACEs (N = 46).

Implications

Previous research on adverse childhood experiences, as well as the findings of this study, have important family policy implications. Raising healthy children is clearly a family issue. Adverse childhood experiences often either originate within the family or negatively impact the entire family.

Results of this study suggest that while medical professionals believe that adverse childhood experiences impact health outcomes, less than half screen for ACEs. Those who do had familiarity with research and/or training regarding ACEs, but recency of medical education and type of medical training were unrelated to screening practices. Further, most commonly, practitioners screened for mandatory reporting issues (e.g., abuse and neglect), further supporting the idea that education and training may be associated with more screening. Indeed, lack of professional education was one of the most frequently identified barriers to screening, in addition to lack of appropriate screening tools, and not enough time due to the need to screen for many other conditions.

Collaboration between family scholars and medical professionals on the development of effective screening measures, as well as advocating for policies that ensure children are being screened and receiving evidence-based interventions when ACEs are identified, can help address the needs of children and parents who have experienced significant trauma or ongoing toxic stress. One avenue for supporting screening and treatment of ACEs is advocating for the coverage of both screening and intervention services by health insurance. In addition, advocating for state and federal support of trauma-informed services for both children and parents as a wise investment for improving health outcomes is an important next step.