American Academy of Pediatrics
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Addressing Adverse Childhood Experiences and Other Types of Trauma in the Primary Care Setting

For many pediatricians, addressing exposure to traumatic events that could cause toxic stress in their patients is seen as difficult for a number of reasons, including lack of time, complexity of the topics, limited referral resources, and discomfort. At the same time, the study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente on adverse childhood experiences (ACEs)[1] emphasized the effect of trauma on the developing brain and health across the life span—a natural concern for all pediatricians. Importantly, ACEs described in the study are present in every socioeconomic level and can be devastating to a child's physical, mental, and emotional health and well-being into adulthood. This document provides initial suggestions for pediatricians to consider when addressing ACEs in their practices.

THE MEDICAL HOME: IDEAL FOR ADDRESSING TRAUMA

The medical home model is an ideal approach to caring for children, especially those with complex conditions. The medical home is considered vital for children and youth with special health care needs (CYSHCN) because they benefit greatly from the emphasis on coordinated care and family-centered approaches. Children who have been exposed to traumatic events like ACEs often have similar needs to CYSHCN in that they

- *Are at risk for poor health outcomes*
- *Would likely require additional services compared with other children*
- *May benefit from tracking to assist with referrals and follow-up completion*
- *Are at risk for numerous social-emotional and developmental problems*

According to the American Academy of Pediatrics (AAP) definition, *a medical home* should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective for all children. Children and youth with special health care needs, including those affected by trauma, benefit significantly when pediatric practices reflect these characteristics. Some practical activities would include

- *Identify the children at risk through routine screening or surveillance.*
- *Consider using a registry like with CYSHCN as a reminder for additional follow-up in future visits.*
- *Assess family and patient strengths and assets as well as challenges, to help identify needs for specific services and supports in the future.*
- *Establish relationships with community resources to address trauma in children.*
- *Have a comprehensive list of community resources available (local United Way organizations often are a source).*
- *Make referrals to community resources.*
- *Follow up on referrals; close communication loops.*
- *Equip patients and families with behavioral management tools (see* ***"Bring Out the Best in Your Children"****).*

THE PROCESS

For practices that have not addressed exposure to trauma in any formal way, starting this process can seem like a daunting task. While some practices actually have a mental health professional situated in the practice structure, this is not a feasible option for most. Common concerns include the need overwhelming the practice's resources and the process taking too long, families being offended by the pediatrician asking about these "sensitive issues," and physicians and other staff not knowing how to begin the conversation or respond when traumatic events are identified. This document outlines a 4-step process that practices can use to prepare to begin identifying children who have experienced trauma or who are affected by the traumatic events experienced by their parents and caregivers, with the goal of being prepared to respond should an issue be identified. The 4-step process is framed with 4 questions.

- ***Why*** *are we looking at this issue?*
- ***What*** *are we looking for?*
- ***How*** *do we find it?*
- ***What do we do*** *once we have found it?*

Additional material will also be provided to help practices prepare and highlight the quality improvement framework that can be used to implement the process. Finally, throughout this document, a case study will demonstrate how this process was successfully used in a general pediatric practice setting.

ASSESSING READINESS TO CHANGE

As with any significant change in practice, there will be key components that need to exist if any new process or approach is to be successfully implemented. These components are not unique to the introduction of exposure to trauma into the patient visit but are vital for that activity to occur. To be successful in implementing activities related to identification and treatment of exposure to trauma, a practice needs

- *A champion who recognizes the importance of the issue and is able and willing to move it forward*
- *A significant number of staff, including other clinicians and front office and back office staff, who are willing and ready to change*
- *A practice environment that supports open, honest questions, dialogue, feedback, and confidentiality*
- *Opportunities to educate and train staff prior to and during implementation*
- *An established goal or vision: what do you want to accomplish?*
- *Financial resources available to support practice change*

If these components are in place, the practice can move forward with pursuing implementation of trauma-related activities.

STEP 1 Why are we looking at this issue?

Obviously, understanding the effect that exposure to traumatic events has on a child's short- and long-term physical and mental health is important before changing practice. It will be important to educate other clinicians, office staff (including front office staff), and the patients themselves as to why this is such an important issue. For each group, the purpose of this awareness building is different.

- *Clinicians will want to be sure that the science is supporting their change in practice.*
- *Office staff and clinicians require this background to drive the quality improvement change, which can affect all areas of the practice, including the content and length of the patient visit, office work flow, and approach taken by all levels of staff.*
- *Children, youth, and families need to understand the effect these issues have on their physical and mental health, well-being, and future academic success to understand why the pediatrician is addressing it.*

These efforts to educate are often led by the practice champion, who has identified this as an important issue for the practice. It would be helpful to have a staff person from each area of the practice who is willing to lead the education efforts for that particular group. Together, the practice can identify ways to begin educating families. It has been reported that families often feel relief from stress just because of the initial inquiry.

CASE SCENARIO

After reading the policy statement from the AAP on toxic stress, several of our clinicians felt that this was an issue that we had to address within our clinical practice. Those of us who were most engaged in doing some sort of screening decided to pilot screen on our own, collect a little data that described our results, and present that information to the rest of the practice during one of our internal journal clubs. The education experience really was 2-fold: the **policy statement** helped to focus the practice on the "why" we needed to screen, but the practical experience from the pilot helped us to convince the other clinicians that it really was doable, which helped alleviate the fear that this type of screening would somehow disrupt our usual office flow in terms of the time required to screen and have conversations with families.

STEP 2 What are we looking for?

Once the practice has decided to proceed with addressing the issue of exposure to trauma, the next step will be to determine who should be identified and how. Existing AAP materials, such as the *Bright Futures Guidelines,* provide some entry points for these issues. Overarching questions to consider for your practice include

- *Who should we assess and when?*
  - Are we targeting the incidence of ACEs within our patients (children and adolescents) themselves? If so, when do we assess? Some options that others have considered include
    - Everyone during the toddler years (universal assessment).
    - Pre-identified periodic assessments.
    - Children who present with apparent somatic complaints for which there is no organic, obvious cause.
    - Children experiencing school problems or failure.
    - Teens with mental health concerns.
    - All patients after age 2 years.
    - Children with previously identified adverse experiences, including those with parents with risk factors (eg, substance use, mental illness).
    - Children living in poverty.
  - Do we look at parents' experiences instead of or in addition to children's experiences?
    - The majority of what we learn about being a parent comes from our own experiences of being parented.
    - How do ACEs affect parenting choices?
    - Children's ACEs are often a result of or associated with the parents' behavior.

CASE SCENARIO

As a first step into addressing ACEs within our practice, we decided to ask parents with infants about their own experiences. Our thought was that we could perhaps identify parents who might need extra support in learning positive parenting practices before they repeated maladaptive patterns from their own childhoods. We felt that it was important to have a parallel conversation about resilience with parents and found some great information (including a resilience questionnaire that we are using) at **www.resiliencetrumpsaces.org.**

STEP 3 How do we find it?

The original screening tool for ACEs was designed for adults. There are a few new approaches being tested and used in practice that are geared toward identifying ACEs in children, many of which can be found at **www.aap.org/medhomecev/diagnostictools.** The work in this area is new and the evidence base is still in development. Your practice will need to determine how it wants to proceed with what questions to ask and when to ask them. Some questions that can be considered include

- *How will we ask the questions?*
  - A pre-visit questionnaire provided to parents before the visit
  - A direct interview during the patient visit
  - Written or verbal inquiries
- *If we use a questionnaire*
  - How will it be distributed and explained to patients?
  - How will it get returned to the physician or other staff who will address the issues?
  - How do we consider patient privacy as questions are answered?
  - Consider literacy levels and translation needs.
- *If we use a direct interview approach, what decision supports will help us remember the questions?*
- *How do we document the results? Some considerations include*
  - How will we consider the safety of the child and the adult being abused if intimate partner violence is identified?
  - How do we create an environment in which families are not stigmatized?
  - How do we reconcile meeting needs of patient confidentiality with the safety of the patient?
  - How will appropriate follow-up be completed?

CASE SCENARIO

As an example of a pilot that has worked for a large practice, 8 of our 27 clinicians decided to screen parents at the 4-month well-child visit. We wrote a cover letter that explained why we were doing the screening and had parents (both parents if they were both at the visit) complete the ACE questionnaire as well as a survey about resilience. We ended the questionnaire with a list of potential resources to understand what parents perceived their own needs to be. As we were rolling out the pilot, we created a confidential field within our electronic medical record for documentation; with this field, the clinician can see the results of the screen during a visit, but the field does not print into notes, so the information is not inadvertently released if a parent transfers care. This was important to the privacy of the parents completing the questionnaire.

STEP 4 What do we do once we have found it?

Thinking through what will happen if some kind of ACE or exposure to trauma is identified with the child or family is important to the success of this process. The practice will need to be prepared to respond—not by handling all the issues from within the practice, but knowing the community resources available to families so referrals can be made.

There may be no need to create a new list; especially in urban communities, these resources are often already catalogued and available. The champion in the practice can enlist the help of someone else in the office, a volunteer parent, or even a college student looking for volunteer hours to track down lists of community resources. Some common places these lists can be found include

- *Local department of public health*
- *Local department of human services*
- *Child abuse hotlines*
- *Larger child care centers, including Head Start*
- *Local Title V division or state program for CYSHCN*
- *Local chapters of Family-to-Family Network or other family-centered organizations such as Family Voices, child protective services, and Children's Advocacy Center*
- *Nonprofit social service organizations that offer a broad range of programs and services for youth and families*
- *Local United Way organization*
- *Local 211/311 program*

The lists you find may be overwhelming. The practice may want to highlight a few that staff are familiar with or that reflect the needs of the families you serve. Some questions to consider when organizing your resources include

- *What resources do your parents want? What are the most common needs for the families in your practice? Ask them. Hold a focus group. Create a parent advisory group.*
- *What does the practice want to provide in-house and what requires a referral?*
- *Is there a care coordinator in the practice who will take on this task? If not, would having a care coordinator reduce the time the physician spends in addressing these concerns, and would this time allow for a large enough increase in visits to cover the salary of the care coordinator?*

CASE SCENARIO

Our practice struggled with the "what do we do" question first—ie, what are we going to do when we find parents who have experienced ACEs? We decided the best approach was to ask parents directly about what they wanted through a simple questionnaire that was attached to the ACE screener during the small pilot that a few of our clinicians conducted. We found that the majority of parents were interested in parenting classes and support groups, with a few asking for home visiting programs, relief nurseries, and online information about ACEs. Once we knew that information, we were able to track down the resources that families requested the most. Several of the clinicians also used resources and anticipatory guidance materials from Connected Kids, which includes brochures about discipline and positive parenting, understanding developmental expectations, and how children best learn. The resources within the Ages & Stages Questionnaires also provided games and activities that parents could do with their children, which helps to facilitate bonding between parents and children in the context of developmental promotion.

The pediatric medical home is a trusted resource for families. This can include guidance on parenting that will support building resilient children. While referrals to more intensive parenting programs may be necessary in some cases, is it possible for the pediatrician or other dedicated staff to provide counsel and support to parents to help them make different decisions about parenting?

There are resources to support this type of discussion. Some of these include materials from the AAP Connected Kids program **(www2.aap.org/connectedkids/).** Practices can consider

- *Keeping selected Connected Kids resources stocked in examination rooms*
- *Using guidance from Connected Kids to supplement conversation during subsequent examinations*

There are also a number of excellent, evidence-based parenting programs available (eg, the Triple P—Positive Parenting Program). The practice could consider incorporating elements from these programs or even hosting more intensive programs on site. Additional programs can be found at **www.childwelfare.gov/preventing/programs/types/parented.cfm.**

With any child or family that has experienced a traumatic event, additional support will be necessary. It is important for the practice to have a process in place to complete follow-up with the family to assist them with successfully using services.

IDENTIFYING ADVERSE CHILDHOOD EXPERIENCES AND OTHER SOURCES OF TRAUMA IS QUALITY IMPROVEMENT

We now understand the significant effect that exposure to trauma can have on a child's short- and long-term physical and mental health. With that in mind, supporting the practice's efforts becomes a way to improve the care being offered in the practice and, hopefully, health outcomes for children. Thinking of this process as a quality improvement activity provides a framework that can guide the types of changes being proposed and methods for implementing and evaluating those changes. This approach also allows practices that may not be ready for formal screening to begin setting the stage for a more formal process in the future by taking one small step at a time.

Here are some strategies to begin creating a practice environment that recognizes the importance of ACEs and encourages families to discuss these concerns in the medical home.

- *Set the tone. Let the parents of your patients know that these issues are important, affect the child, and are OK to talk about in the medical home. Let them know that they are not alone, it is not their fault, and there are people in the practice who can help.*
- *Use other modalities for opening the door to conversation, such as*
  - Examination room posters
  - Resource lists and Web site links readily available or posted
  - "Did you know?" statements on clipboards used to fill out office paperwork
- *Continue to encourage developmental promotion.*
- *Create a parent advisory group.*

For practices that are ready to start a more formal screening but find addressing all ACEs or forms of trauma overwhelming, a staged approach can be used. A practice can start by asking about one type of violence rather than all at once or just begin by asking a broader question like, "Since the last time I saw your child, has anything really scary or upsetting happened to your child or anyone in your family?"[1]

As is the case with any quality improvement effort, there is really no end point. The practice can be continually looking to improve the way it addresses ACEs and trauma with the children and families it sees. After a more comprehensive approach to screening for ACEs has begun, consider asking some of the following questions to push the effort forward:

- *How do we improve detection rates?*
- *Traditional medical models have focused primarily on the physical, behavioral, and emotional health of the patient, but working with ACEs requires a shift to considering the family as a whole. Parents and families are not used to this dynamic, so how do we facilitate a culture change in the physician-patient relationship?*
- *Review and evaluate the process of asking the questions.*
  - Are we asking the right questions?
  - Are response rates different if asked as part of an interview instead of on paper?
  - What other times do we need to be asking these questions?
  - Do we want to use universal screening? If so, what ACEs are our patients experiencing in various age groups (eg, toddler, school age, adolescence)?
  - Do we want to use a targeted screening approach? If so, what would be the indicators?
    - Screening at mental health visits
    - Screening when unexplained somatic complaints arise
    - Screening in the context of school failure
    - Attempting a screening after multiple missed appointments
    - Other scenarios

CASE SCENARIO

When we started our pilot, we really wanted to know if screening parents for ACEs was feasible, whether screening would be accepted by families and clinicians, and whether we could tailor a reasonable response to the results of the screening. Our initial experiences were positive, and the process of screening has enhanced relationships with our families. Now we want to know how to spread screening to the rest of the practice, how to better incorporate the information about parents' resilience into our responses, and what additional ACEs we should be screening for (eg, community violence, food insecurity, bullying, racism/prejudice). Ultimately, we want to be able to prove that we are improving outcomes for our parents and patients, so our final question relates to better understanding what outcomes we are hoping to affect. We have further ideas about screening at other ages and in other circumstances, so we are beginning to expand our focus into other areas.

- Consider conducting a pilot test to answer some preliminary questions.
  - Is it feasible?
  - Will our patients complete it?
  - Will our clinicians accept it?
  - Can we tailor a response to the screening results?
- Moving forward, we will need to consider
  - If we started by assessing a small group, how do we expand assessment to a broader audience?
  - What are the outcomes we hope to see?
  - Are we interested in particular types of ACEs?

PREPARING PHYSICIANS AND STAFF FOR THE PROCESS

As discussed at the beginning of this document, there are certain characteristics that a practice needs to have to be ready for change. In addition, physicians and all levels of staff need to actively acquire new skills and frameworks to identify and respond to ACEs and trauma as successfully as possible, including

- *Understanding that listening is therapeutic.*
  - When something becomes speakable, it becomes tolerable.
  - Making the connection between the emotional brain and the thinking brain is the first step toward healing and integration.
- *Physicians, in particular, often carry the mind-set of needing to make all things right, right now. Another approach to consider is focusing on what solutions parents, patients, and families can come up with for addressing their own challenges.*
- *Self-care is so important; this is difficult work. "Put your own oxygen mask on first, before helping others." See more tips for self-care in the handout* ***"Protecting Physician Wellness."***
- *This is not something to be done in isolation. The child's and family's health is dependent on multiple systems working together. Find like-minded partners in your community for support for you and the child's family.*
- *Your families can be a great resource for you. Consider asking families what they would like to see in the practice to address these issues. This could even be formalized with the development of a family advisory group.*

Finally, perhaps the most significant thing a pediatric practice can provide a family is the knowledge that they are not alone; the medical home will not be a place for assigning blame but rather to help support the family and connect them with the services they need. For one practice, it comes down to this key message to families: "You are not alone, it is not your fault, and I will help."

References

[1] Cohen JA, Kelleher KJ, Mannarino AP. Identifying, treating, and referring traumatized children: the role of pediatric providers. *Arch Pediatr Adolesc Med.* 2008;162(5):447–452

Please see the AAP Web site for the online version of this document as well as additional information at www.aap.org/traumaguide

The recommendations in this toolkit do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.