

Screening for Adverse Childhood Experiences and Trauma

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IN BRIEF

As trauma-informed care continues to gain traction, more and more providers are beginning to screen patients for exposure to adverse childhood experiences (ACEs) and trauma. However, variation exists regarding when and how to screen in both adult and pediatric populations. This technical assistance tool offers various approaches and considerations for screening adults and children for ACEs and trauma. It draws from the experiences of pilot sites that participated in [Advancing Trauma-Informed Care](#) (ATC), a multi-site demonstration made possible by the Robert Wood Johnson Foundation that sought to identify how trauma-informed approaches can be practically implemented within the health care sector.

Many experts in the field agree that screening for adverse childhood experiences (ACEs) and trauma is an integral component of a trauma-informed approach to care. There are varying opinions, however, on when and how to screen in adults and children, and what to do with the information obtained from screening.[†] This technical assistance tool, made possible by the Robert Wood Johnson Foundation, outlines how organizations participating in the [Advancing Trauma-Informed Care](#) (ATC) initiative are screening for childhood and adult ACEs and trauma. Drawing on the experiences of the ATC sites, this tool offers key considerations for health systems and provider practices looking to integrate screening for ACEs and trauma into their clinical workflow, including when and how to screen, and the importance of identifying appropriate referral pathways.

Considerations for Screening for ACEs and Trauma

There are a variety of considerations that providers should acknowledge prior to screening for ACEs and trauma. While best practices related to screening for ACEs and trauma are still evolving, many providers agree on the following:

1. **Treatment setting and patient population should guide screening.** Upfront, universal screening may be more appropriate in primary care settings, particularly among those working with pediatric populations. Other providers, such as behavioral health clinicians, may prefer to screen for trauma after a patient and provider have an established relationship. Variation in the frequency and type of screening tool used might also exist between treatment settings, and between those working with adult and pediatric populations.

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† For the purposes of this TA tool, the terms “screening” and “assessment” tool are used interchangeably. The Center for Health Care Strategies does not endorse any specific tool to screen or assess for adverse childhood experiences, trauma, or toxic stress.

2. **Screening should benefit the patient.** Providers screening for trauma must have a clear strategy in place for utilizing the information in a way that supports patients' health, including an established referral network.
3. **Care coordination should be employed to avoid rescreening.** Sharing results across treatment settings with appropriate privacy protections may help reduce rescreening and the potential for re-traumatization. However, in pediatric populations, screening for exposure to ACEs is often conducted periodically since exposure may occur after initial screening and throughout childhood and adolescence.
4. **Ample training should precede screening.** Health care professionals should be proficient in trauma screening and conducting patient follow-up in a manner that is sensitive to cultural and ethnic characteristics.

When to Screen

Providers and other health care professionals have differing opinions regarding *when* to screen for ACEs and trauma. Some providers believe that patients should be screened upon intake, when the patient-provider relationship is first developing. Proponents of this approach argue that upfront screening provides a more complete understanding of a patient's history, helps guide interventions, identifies potential risk for chronic disease later in life, and is helpful for educating patients and caregivers on the long-term impacts of trauma. Others, however, believe that screening should not occur until after a trusting relationship is established due to the sensitive nature of the information being requested. Those who favor later screening assert that screening upon intake before relationships are established may hinder patients' decisions to share their history of adversity and trauma, may re-traumatize a patient, and negatively impact the patient if no appropriate interventions are undertaken. Regardless of the approach a provider takes, there is consensus that in general it is important to avoid rescreening whenever possible.

How to Screen

A number of considerations exist around *how* to screen patients in a trauma-informed way, including: (1) which screening and/or assessment tool should be used; (2) who should administer the tool, and how; and (3) which patients should be screened.

Selecting the Right Tool

A variety of screening and assessments tools exist, such as the original ACE questionnaire (*see Exhibit 1, next page*) and the Center for Youth Wellness' Adverse Child Experiences Questionnaire (CYW ACE-Q).¹ Health care practices are encouraged to adopt tools based on the needs of their patient population and clinical workflow. As referenced in the Appendix, many providers have also adapted screening and assessment tools, and other providers are exploring integrating ACEs questionnaires with other relevant assessments (e.g., social determinants of health).

Administering the Screen

Screening tools can be administered in a variety of ways. Some providers opt for face-to-face screening in which a staff member (e.g., social worker, physician, or community health worker) asks the patient each question on the tool. Others have patients complete the tool independently (e.g., in a waiting or private room), as they may feel more comfortable disclosing information than discussing it verbally with a clinician.

Another important consideration when screening for exposure to adversity and trauma is determining whether or not patients should be asked to disclose exposure to specific experiences (e.g., physical abuse). Some providers feel that treatment can be better tailored to the individuals’ needs when the specific adversities or traumas are disclosed, while others simply ask patients to provide the total number of categories of adversity experienced in order to triage appropriately.

Exhibit 1. Finding Your ACE Score

The ACE questionnaire is a simple scoring system that attributes one point for each category of adverse childhood experience. The 10 questions below each cover a different domain of trauma, and refer to experiences that occurred prior to the age of 18. Higher scores indicate increased exposure to trauma, which have been associated with a greater risk of negative consequences.²

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often ... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	YES	NO	If yes, enter 1 _____
2. Did a parent or other adult in the household often or very often ... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	YES	NO	If yes, enter 1 _____
3. Did an adult or person at least five years older than you ever ... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	YES	NO	If yes, enter 1 _____
4. Did you often or very often feel that... No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other?	YES	NO	If yes, enter 1 _____
5. Did you often or very often feel that ... You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	YES	NO	If yes, enter 1 _____
6. Were your parents ever separated or divorced?	YES	NO	If yes, enter 1 _____
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?	YES	NO	If yes, enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	YES	NO	If yes, enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	YES	NO	If yes, enter 1 _____
10. Did a household member go to prison?	YES	NO	If yes, enter 1 _____

Now add up your “Yes” answers: _____. This is your ACE Score.

Identifying a Target Population

Organizations should also consider how to determine *who* to screen for ACEs and trauma. Some take a universal approach to screening for trauma, while others target select patient populations (e.g., pregnant women). The most common approach appears to be universal screening, as it allows providers to better understand the needs of the entire patient population and reduces the risk of racial/ethnic bias.

Addressing Trauma

Referring to Trauma Treatments

Prior to screening for ACEs or other traumatic experiences, providers should have referral processes in place to ensure that patients identified with behavioral, social, or trauma-specific service needs can be connected to trained professionals (who are ideally also “practitioners” of trauma-informed care). Some organizations have integrated or co-located services, and are thus able to conduct “warm hand-offs” to referral partners. Others must build referral networks outside of the clinical setting and develop the ability to effectively track and follow-up with patients to ensure they have connected to needed supports.

Adapting Electronic Health Records to Improve Trauma Screening and Referral Pathways

When incorporating ACEs and trauma screening into the clinical workflow, many ATC sites recognized that their electronic health records (EHRs) needed to be updated to reflect new clinical processes to better coordinate and manage care among providers. Below are examples of how ATC sites have updated their organization’s EHRs to support trauma-informed screening and referral practices.

- The **Center for Youth Wellness (CYW)** in San Francisco recently implemented Salesforce Health Cloud,³ a secure patient management software system that integrates information from multiple data sources, to streamline and better coordinate care for patients who also receive services from Bayview Child Health Center (BCHC). Once fully operational, Health Cloud will allow BCHC and CYW staff to access patients’ records in a centralized online location and refer patients between practices with greater efficiency. Eventually, patients and families will have real-time access to their care plans, have the ability to connect with their providers, and fill out forms in advance through the Health Cloud.
- **Montefiore Medical Group** in The Bronx, New York, hired an EHR technician to create a template within its health record where providers can input patients’ ACE scores after the screen is administered. Automated reminders built into the EHR, referred to as best practice alerts, also prompt providers to screen all patients in its outpatient network for ACEs. Ultimately, Montefiore’s goal is to use these EHR strategies to improve the overall ACEs screening rates among its outpatient practices.
- The **Women’s HIV Program at the University of California, San Francisco (UCSF-WHP)** worked with a consultant to adapt its health record to align more appropriately with trauma-informed services provided at the clinic. Prior to adapting the EHR, clinic staff could only track patients’ basic health status and medical services. Information collected by social workers was only available through text notes and nearly impossible to track over time. Furthermore, UCSF-WHP staff lacked the ability to track internal and external referrals to mental health and trauma-specific services. The trauma-specific updates to the EHR address these issues and give UCSF-WHP providers a more complete understanding of patients’ medical, social, and emotional needs, as well as the services they are accessing.

Supporting Integrated Services to Address Trauma

Many of the ATC sites have noted the benefits of providing integrated services. The Women’s HIV Program at the University of California, San Francisco (UCSF-WHP) recently formed a partnership with the Trauma Recovery Center (TRC), which offers comprehensive services to adult survivors of trauma, violence, and loss. Originally, UCSF-WHP’s clinic referred patients to receive care at the TRC.

They quickly realized, however, that patients felt more comfortable receiving services at the clinic, and in turn developed an arrangement to have a trained TRC clinician onsite to offer trauma-specific services on select days of the week. The Center for Youth Wellness (CYW) has long recognized the benefits of integrated care — its offices are located directly across the hall from the BHC and credentialed CYW clinicians are embedded within BHC. When families come to BHC for pediatric wellness visits, they are screened for ACEs using the CYW ACE-Q (see [Appendix](#) for more information). Children who screen positive are introduced to a CYW clinician with whom they develop an individualized integrated care plan that addresses both the child’s physical and behavioral health needs, and includes goals aimed at supporting the parent in his or her role as the primary caregiver.

Learn More

This technical assistance tool is a product of *Advancing Trauma-Informed Care*, a multi-site demonstration project focused on better understanding how to implement trauma-informed approaches to health care delivery. Supported by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies (CHCS), this national initiative is developing and enhancing trauma-informed approaches to care and sharing emerging best practices.

To learn more about practical strategies for implementing trauma-informed approaches across the health care sector, including screening for ACEs and trauma, visit CHCS’ *Trauma-Informed Care Implementation Resource Center* at [TraumaInformedCare.chcs.org](https://traumainformedcare.chcs.org).

Endnotes

¹ For more information on the Center for Youth Wellness’ ACE-Q, download the Center for Youth Wellness ACE-Q and User Guide. Available at <https://centerforyouthwellness.org/cyw-aceq/>.

² Got Your ACE Score? *ACEs Too High*. Available at <http://acestoohigh.com/got-your-ace-score/>.

³ For more information on Salesforce Health Cloud, see: <https://www.salesforce.com/solutions/industries/healthcare/health-cloud/>.

Appendix. Advancing Trauma-Informed Care Site Approaches to Screening for ACEs and Trauma

Organization	Site Description and Population Served	Population Screened	Screening Approach	Post-Screening and Referral Process	Additional Details
BRICK Academy Newark, New Jersey	Nonprofit school system creating safe and supportive schools for low-income children and families living in the South Ward of Newark, New Jersey	Students in grades K-2 and grade 5	The school social worker collaborates with teaching staff to discuss concerns regarding their students, and to determine whether any require on-site counseling from the behavioral health clinician or a referral for offsite services. Students may also be referred to the school behavioral health clinician based on their “DREAMer score,” which assesses students based on: (1) diligence; (2) respect; (3) empathy; (4) self-control; and (5) ability to be a model student. Students who work with the behavioral health clinician are screened for trauma using the Trauma Symptom Checklist for Children to guide counseling services.	The on-site behavioral health clinician reviews referrals and assesses which students may have experienced trauma. Based on this assessment, students are grouped into the following tiers: <ul style="list-style-type: none"> ■ Tier 1: Student would benefit from school resources, such as a counselor or connection to a mentor or family liaison. ■ Tier 2: Student meets criteria for working with on-site clinician through individual, family, and/or group therapy on as-needed basis. ■ Tier 3: Needs of student and family are beyond what school clinician can manage. Student and family referred to external provider. 	BRICK Academy partners with the South Ward Children’s Alliance (SWCA), a nonprofit focused on improving the cradle-to-career pipeline for children living in the South Ward of Newark. Through SWCA, all students have access to health, housing, and family supports. In addition, the school partners with community-based organizations to support students dealing with death or life-altering illness of a family member, and to provide small-group counseling.
Center for Youth Wellness San Francisco, California	Children's health organization partnering with a primary care pediatric home serving children and families in San Francisco	Pediatric patients, ages 0-19	CYW administers its proprietary tool (CYW ACE-Q) to all new patients, nine months and older, at nine- and 24-month well-child appointments. The tool is re-administered yearly thereafter. The CYW ACE-Q is either an informant (CYW ACE-Q Child and CYW ACE-Q Teen) or self-report (CYW ACE-Q Teen SR) instrument, and includes the 10 original ACE questions, as well as additional questions about early life stressors (e.g., death of parent or guardian, bullying or harassment at school, neighborhood violence, etc.). The score provides an indication of a patient’s risk of toxic stress.	Interventions are administered based on the following guidelines: <ul style="list-style-type: none"> ■ Low Risk of Toxic Stress - 0 with no symptoms: Anticipatory guidance and education on ACEs and toxic stress. ■ Intermediate Risk of Toxic Stress - 1 to 3 ACEs with no symptoms: Anticipatory guidance and education on ACEs, toxic stress, and protective factors. ■ High Risk of Toxic Stress - 1 to 3 ACEs with symptoms or 4 or more ACEs: Anticipatory guidance and referral to treatment (i.e., the Center for Youth Wellness for multidisciplinary intervention). 	Currently, all behavioral health services are provided at CYW. However, the BCHC is focused on increasing its capacity to provide onsite therapy for children and teenagers that may not need or be ready for care at CYW. CYW is considering expanding screening for parents of children ages zero to five for ACEs, and incorporating ACEs screening with social determinants of health assessments.

Organization	Site Description and Population Served	Population Screened	Screening Approach	Post-Screening and Referral Process	Additional Details
Crittenton Children’s Center Kansas City, Missouri	Psychiatric care provider for children, adolescents, and their families in Kansas City and across the region	Children and their parent/ caregiver	A modified ACE questionnaire (which includes additional questions about neighborhood safety, involvement in the foster care system, etc.) is completed by both the child and his/her parent. The questionnaire is administered at intake for inpatient care and embedded into the electronic health record. The tool is also administered in outpatient care and foster care settings.	Children and parents are referred to clinical trauma treatments (e.g., Attachment, Regulation, and Competency model).	The ACE questionnaire is completed by both children and parents/guardians as the care team has found that the children’s experience and perceptions may be different from that of their parent or caregiver. At the organizational level, Crittenton assesses for organizational readiness via the Attitudes Related to Trauma-Informed Care Scale. [‡]
Montefiore Medical Group The Bronx, New York	Integrated care system providing primary and specialty care to adults and children from low-income and diverse communities in the Bronx and lower Westchester County	Children and adult primary care patients	Use a modified ACE questionnaire that is available in English and Spanish . Parents of primary care patients ages one and older complete the ACE screen on behalf of their child. Patients age 18 years and older complete the screening tool themselves, and are screened only once for ACEs as the questions ask about experiences prior to age 18.	For infants, parents are asked to report on their own and their baby’s ACE score. For children ages one to five, an elevated ACE score results in a referral to HealthySteps , a pediatric primary care program that is focused on improving the health, wellbeing, and school readiness of children. Children over five years old with an elevated ACE score discuss the results with their primary care provider, and possibly receive a referral to integrated behavioral health services. For adults (18 and older), an ACE score of four or higher results in a discussion with their primary care provider and a possible referral to integrated behavioral health services.	At any point in time and regardless of a child’s ACE score, providers can refer children to HealthySteps or integrated behavioral health services if deemed clinically necessary. Montefiore is currently testing a cut-off score of two or more ACEs for children in an effort to determine whether or not earlier referrals can prevent future trauma. [§]

[‡] For more information on the Attitudes Related to Trauma-Informed Care Scale, visit the Traumatic Stress Institute at <https://traumaticstressinstitute.org/the-artic-scale/>.

[§] L. Udesky. “Montefiore to test out lower ACE score cut-off in pediatric population.” ACEs Connection, September 18, 2018. Available at <https://www.acesconnection.com/blog/montefiore-to-test-out-lower-ace-score-cut-off-in-pediatric-patients>.

Organization	Site Description and Population Served	Population Screened	Screening Approach	Post-Screening and Referral Process	Additional Details
<p>Stephen and Sandra Sheller 11th Street Family Health Services Philadelphia, Pennsylvania</p>	<p>Nurse-managed community health center serving low-income, medically underserved residents of North Philadelphia</p>	<p>Children, pregnant women, and adults</p>	<p>Children and Teenagers - 11th Street uses the same screening protocol as CYW (see above). Pregnant women - The behavioral health consultant discusses ACEs science during each initial prenatal visit and the patient completes the original ACE questionnaire (see Exhibit 1). Adults - During registration, each patient completes a number of assessments on an iPad, including the ACE questionnaire. The medical assistant and nurse practitioner review scores, and if there is a positive response, the behavioral health consultant is brought in to meet with the patient. The questionnaire is completed once. Nurse practitioners also work questions about ACEs into ongoing discussions with the patient.</p>	<p>The screening data is sent to a behavioral health consultant within primary care who coordinates follow-up treatment. The information is also shared with the dental team as those services are embedded within the primary care setting. A psychiatric nurse practitioner is also on hand if needed. Most referrals are made internally to the behavioral health or creative arts therapies teams.</p>	<p>Screening does not always occur during the first visit, as the providers want to make sure the patient is comfortable.</p>
<p>Women’s HIV Program, University of California San Francisco San Francisco, California</p>	<p>Ryan White HIV/AIDS clinic providing primary care and behavioral health services to women and adolescent girls living with or at risk for HIV</p>	<p>Adult women and adolescent girls who are HIV positive.</p>	<p>Upon intake, all patients are screened by a social worker for intimate partner violence (IPV) and consequences of past trauma including depression, anxiety, suicidality, Post-Traumatic Stress Disorder, and alcohol and other substance use. The IPV screening tool, which was adapted from existing evidence-based tools, is re-administered by the medical provider every six months. Tools to screen for the consequences of past trauma are re-administered annually.</p>	<p>UCSF-WHP has developed on-site and community-based referrals for the various consequences of trauma that are trauma-informed and appropriate for the readiness and circumstance of its patients. The clinic is updating its screening and referral protocol based on data from its prospective study of the clinic’s transformation to being trauma-informed.</p>	<p>Providers do not screen for details of past trauma, but rather assume a history of trauma among all patients. UCSF-WHP’s providers believe that details of past trauma will emerge gradually throughout the course of the patient-provider relationship. All patients are provided universal education on the link between trauma and health.</p>