

Implementing Adverse Childhood Experiences Screening Tool in Outpatient Mental Health  
Clinic

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## Abstract

**Problem:** Adverse Childhood Experiences (ACEs) have negative outcomes regardless of background. Exposure to ACEs is linked to premature deaths, high-risk behaviors, cancer, mental health problems, and heart diseases. It is estimated that 50 to 60% of American children below 18 have at least one ACE, with 25% having three or more. This community mental health clinic does not screen for ACEs. Baseline data showed that many children were exposed to divorce, substance abuse, domestic violence, sexual abuse, incarceration, and separation of parents or guardians. Its lack of specialized trauma care increases ACE-related poor outcomes. Implementing ACEs screening will promote early detection and prompt referral. **Purpose:** This Quality Improvement (Q.I.) project implemented the Center for Youth Wellness Adverse Childhood Experiences Questionnaires (CYW ACE-Q) in a mental health clinic for patients ages 10-18 and evaluated its effectiveness in early detecting high-risk patients and referrals. **Methods:** ACEs screening forms are completed with other new intake forms during the initial psychiatric evaluation. Providers review completed forms, and referrals are made based on the ACE scores. Staff education was done before the commencement of implementation. A weekly chart audit was used to retrieve screening information. Therapy placement is confirmed at the two-week follow-up. **Results:** 326 children were seen during the 14-week implementation, and 88% (n=269) met eligibility. Of all eligible patients, 88% had ACE scores  $\geq 4$  and received referrals for therapy. Of which 83% secured placement on two weeks follow-ups. Of all patients seen, 9.3% refused screening. **Conclusions:** CYW ACE-Q effectively identifies at-risk patients, supporting evidence that children with more than four ACEs often have mental, emotional, and/or behavioral issues. Screening questions were sensitive; aggregate screen scoring mitigated this barrier. **Keywords:** Adverse childhood experience screening (ACEs), Center for Youth Wellness Adverse Childhood Experiences Questionnaires (CYW ACE-Q).

### **Implementing Adverse Childhood Experiences Screening Tool in Mental Health Clinic**

Adverse childhood experiences (ACEs) are traumatic events occurring in childhood between 0 and 17 years of age. The prevalence of ACEs is high; it is estimated that 50 to 60% of American children under 18 years of age are exposed to at least one ACE, with more than 25% experiencing three or more ACEs (Bethell et al., 2017). Examples of ACEs include violence, abuse, or neglect at home or in the community, a family member who attempts or dies by suicide, a family with mental health problems, a family member with substance abuse, parental separation, and incarceration (Center for Disease Prevention and Control ([CDC], 2022).

A landmark epidemiological study funded by the CDC evaluated the effects of ACEs on 17,500 adults who are Kaiser Health maintenance organization members. Among the 64% who had an ACE score of one or more, 40% had a score of two or more; and 12% had an ACE score of four or more (Felitti et al., 1998). It was found that increased ACE scores were associated with adverse outcomes such as chronic obstructive pulmonary disease, depression, and suicidality. ACEs are now recognized as a public health problem. It has been linked to premature death, increased risk behaviors, and chronic diseases like cancer and heart disease (Chang et al., 2019).

The lifetime costs of ACEs could range between \$124 billion to \$585 billion due to chronic medical conditions, lost productivity, mental health issues, crime engagement, incarceration, and poverty (Bryant & Van Graafeiland, 2019). ACE increases the likelihood of smoking, alcohol abuse, substance abuse, and risky sexual behavior (Zarnello, 2018). Considering the strong association of ACEs with mental illness and many leading causes of chronic disease, the American Academy of Pediatrics (AAP) and the CDC recommend screening for Adverse Childhood Experiences (ACEs) during well-childcare visits by pediatric healthcare providers to enable early identification and treatment (Bryant & VanGraafeiland, 2019).

This Doctor of Nursing Practice project aimed to implement the Center for Youth Wellness Adverse Childhood Experiences Questionnaires (CYW ACE-Q) in an outpatient mental health clinic for patients 10-18 years of age during the initial intake process. This mental health clinic serves patients of all ages, diverse backgrounds, and economic backgrounds in an urban area in the mid-Atlantic. A random chart review of 30 patients was done at this site, focusing on biopsychosocial history. Appropriately 50% of patients reported exposure to divorced or separated parents; sexual abuse; domestic violence; exposure to substance use, and incarcerated parents. However, none of these patients were further assessed for ACEs using a formal screen tool. Consequently, the lack of specialized trauma care places this patient population at increased risk ACE related adverse outcomes. Implementing an evidence-based ACEs screening program, such as CYW ACEs, can pave the way for trauma-exposed persons in this community to get essential mental health services through early detection and prompt referral for appropriate treatment.

Prior to implementing the screening program, a literature review was done to identify a valid and reliable screening instrument and build a workflow method tailored to the outpatient mental health clinic environment that served as the project implementation site. The review evaluated 16 unique ACEs screening tools, each with its target population and administration process. These instruments varied in the types and amounts of ACEs they addressed, the number of items on the tool, psychometrics, scoring, reporting of findings, and whether they managed ACE exposure in the parent or child. Although no assessment tool was recognized as more potent than others in the literature review, numerous sources rated the Center for Youth Wellness Adverse Childhood Experiences Questionnaires (CYW ACE-Q) as reliable, valid, practical, and well-received in the pediatric care context (Purewal et al., 2016).

Most assessment tools include guidance on introducing the topic of ACEs, framing the questions, and providing information on how to handle positive screens. Gillespie & Folger (2017) report that screening tools that rely on aggregate-level information may be more effective in detecting ACEs than item-level screening tools. This is because item-level screening tools require participants to identify specific ACE exposure. In contrast, aggregate-level tools only require patients to indicate the number of applicable exposures in numerical form. Most studies found that clinicians felt comfortable carrying out the screening, perceived the screening as valuable and feasible, and perceived caregivers as receptive to the screening (Rariden et al., 2021; Gillespie et al., 2017; & DiGangi, & Negriff, 2020). The evidence supported using an aggregate response tool, such as the CYW ACE-Q, to screen the pediatric population for mental health risks (Bethell et al., 2017; Marie-Mitchell & O'Connor, 2013). (Tables 1 and 2)

The Promoting Action on Research Implementation in Health Services (PARIHS) Framework guided this Q.I. project implementation. Kitson, Harvey, and McCormack created the Framework, first published in 1998 (Rycroft-Malone, 2004). It depicts successful research implementation as a function of evidence, context, and facilitation (Rycroft, 2004). This Framework proposes that implementation success depends on clarity about the nature of the evidence being used, the quality of context, and the type of facilitation necessary to ensure a successful change process (Rycroft, 2004).

A gap in practice which was the absence of this essential tool recommended by the CDC and APA prompted this change in practice. The PARIHS Framework will guide this implementation process. Next was to review research evidence to support the need for the identified problem. Six studies were included in the literature review: systematic reviews, one meta-analysis, and two quasi-experimental studies. All studies support that the ACE screening

tool is feasible in outpatient settings and effective in the early identification of ACE exposure and prompt referral. The third part of this Framework is facilitation. Fortunately, this Q.I. program has strong leadership and management support at the project site. The context is suitable for implementing a practice change as it is an outpatient mental health clinic serving individuals at high risk for ACE. This project relied on champions to enable and sustain the Q.I. project and maintain a favorable implementation environment. These champions have worked together to achieve structure, process, and outcome goals. The leadership team provided the needed support and resources and addressed challenges. (Figure 1).

### **Methods**

The site for this Q.I. project was an outpatient clinic that served patients of all ages, diverse backgrounds, and economic statuses in the urban area of a mid-Atlantic state. Commonly seen mental health conditions at this clinic included Anxiety disorder, Mood Dysregulation Disorder, Depression, Oppositional Defiant Behavior, substance use disorder, schizophrenia, Autism, and Attention Deficit Hyperactive Disorder. The clinic staff provides care to 50 to 70 patients weekly; approximately 40 % are children and adolescents. There is one psychiatrist, two dual certified CRNA-PMH nurse practitioners, five Registered Nurses rotating shifts, one office manager, two front desk staff, four therapists, one medical assistant, and other administrative staff.

During the initial mental health evaluation, patients ages 10 -18 were screened with CYW-Q ACE during the 14 weeks of implementation. Upon arrival, patients and/or caregiver sign-in at front desk, vital signs were taken, and parents and patients were directed to the waiting room. Patients 10 – 18 years old were offered the screening form with the other new-intake

forms by the front desk staff /medical assistants offered the screening tool and explanations of how to complete the forms provided. Patients were allowed to opt-out if desired. Patients 13 to 18 years were given the 'teen version (Appendix A). For patients 10 to 12 years old, the parents completed the 'parent and child versions' of the CYW-Q forms (Appendix B).

Parents and patients were instructed to return the completed forms to the receptionist along with other new-intake forms. The receptionist then forwarded the completed screen to the provider, who evaluated the scores and discussed the following action. Children who score three or less are considered to have a negative ACE score (Purewal et al., 2016). Regardless of relevant symptomatology, ACE scores of one to three with symptomatology or four or more are considered positive and require referral to individual psychotherapy. At the bottom of the screening tool, the provider indicated if a referral for trauma-specialized care was made. The screening tools were filed in the patient's chart for project lead weekly retrievals. Patients who refused to screen were also indicated on their CYW-Q form and filed in the patient's chart. Extracted data were de-identified. The project leader filed the forms in the patient's chart with a follow-up tracking form to be completed when the patient returned for a follow-up visit after two weeks. After follow-up visits, charts were audited to noted psychotherapy placement securement (figure 2).

During the pre-implementation phase, various strategies and tactics were employed to build momentum and ensure that the Q.I. project moved forward. First, leadership was engaged in discussing adverse childhood experiences, their causes, presentation, the effect of screening and early identification, and how the implementation of this screening will improve the patient outcomes of the clinic. Stakeholders' (nurses, psychiatrists, associate directors, therapists, CRNA-PMH, office managers, medical assistants, and other administrative staff) attitudes and

goals regarding the initiative were explored to understand potential resistance. Also, the current and desired processes of the implementation were discussed. With the help of the clinical site representative (CSR), champions were selected to mitigate barriers and improve the outcomes of implementation efforts. A multidisciplinary team was also assembled to participate in the initiation planning session. The necessary support and approvals were received before kick-off implementation date was selected. The project lead also developed the initiative's activation algorithm, workflow processes, and debriefing documentation with the team. Before launching the initiative, barriers such as resources, knowledge, negative attitude, and lack of engagement were identified and managed, including integrating the CYW ACE-Q in the electronic health record (EHR) and establishing the referral process. The project lead worked with CSR and other team members to create an action plan with a timeline.

Staff education commenced at the end of the summer of 2022, and all 22 staff members at this clinic also completed in-person training. Training was done in-person in a lecture form over a period of three weeks to ensure every staff member was trained (Appendix C). The demonstrate-back method at end of each training was utilized to assess staff member knowledge of the material provided during each training session. The staff sign-in sheet was used to track the staff training compliance. Educational resources were available as the Project lead printed blank CYW ACE-Q forms and placed each in new intake packets. Extra forms were also placed in visibly and correctly identified binders. After the screening, the providers analyzed and discussed the results of the ACE scores with the patients and/or caregivers, and appropriate decisions were made. The provider indicated whether a patient was referred or not with a reason clearly stated. When the patient returned for a two-week follow-up, the provider confirmed if the

patient secured referral placement or not and indicated that on the bottom of the ACE form for easy retrieval by the project lead. (Appendix A and B).

The project lead's weekly data retrieval included the total number of patients seen at this clinic each week, the total number of patients screened each week, the total number of eligible patients who refused to screen, the total number of patients who met the criteria for referral, the total number of patients who did not meet criteria, the total number of patients who received a referral, the total number of patients who did not receive a referral, and the number of patients who secured appointments after a referral (Appendix D). The collected data were analyzed using descriptive statistics for staff training and redcap run charts for the percentage of eligible patients screened for ACEs, the percentage of screened patients who tested positive, the percentage of positively screened patients who were referred, and the percentage of referred patients who were placed. (Figures 4, 5, 6). Staff training was tracked by utilizing staff training tracking tool (Appendix C). Completed ACE-Q screening forms were collected weekly and documented by the project lead in Redcap in a designated private area (Appendix E). The progress of the practice change was reported to the stakeholders at regular intervals.

ACE Screening compliance was the process measure for this Q.I. project because it captured if the intervention was completed as required. Compliance was measured by determining the percentage of patients who were screened. All staff at this clinic complete the in-person face to face lecture style training. (Figure 3). Outcome measures were determined by the rate of positively screened patients who received referrals and the percentage of referred patients who obtained placement within two weeks after their initial appointment.

This project received a Non-Human Subjects Research (NHSR) determination from the UMB Institutional Review Board, and the clinic's medical director approved the Q.I. project. The

project lead only had access to data collection to minimize the risk of privacy violation; a project summary was submitted to an Institutional Review Board and was designated as a non-human subject's research. The data extraction was done in a private area to maintain HIPAA practices. Data are de-identified before inputting Redcap, a VPN-required, password-protected server, to ensure confidentiality.

## Results

Over the 14-week implementation period, the screening tool was distributed to 326 (88%) eligible participants, and 269 (88%) met eligibility after the screening. Considering the overall eligible patients and caregivers that received a screening, 88% were considered positive based on the scoring criteria. 9.3% (n=25) refused to screen. All patients who screened positive had ACE scores of four or more. 100% (n= 236) of all positively screened patients received a referral for appropriate mental health therapy. 83% (n= 195) of all referred patients received a secured appointment with a therapist by their return on a two-week follow-up appointment (figure 5). 100% (n=21) of staff at this clinic completed staff education and training and provided feedback as the implementation progressed. (figure3)

There were no shifts, shifts, short or long runs; the 14 data points were random and predictable. Week six demonstrated low data points due to new front desk staff covering that week. This was mitigated by staff training on the screening tool. No shifts, short runs, or long runs were noted on the referral run chart. (Figure 6). The results from this project support the findings from the literature that an ACEs Screening Program using the CYW ACE-Q tools is an effective way for early identification of at-risk patients. The 100% staff training rate met the structural measure identified for this quality improvement project (figure 3). Staff training tracking audit form indicated 100% of staff completed training on ACE screening tool (FIGURE

3). Screening rates of eligible patients met the completion rate met over 80% of the process measure. The 100% staff training rate met the structural measure identified for this quality improvement project (figure 3). The referral rate met 100% of outcome measures and showed the feasibility and receptiveness of providers and caregivers/patients to the screening program.

### **Discussion**

The program successfully identified trauma-exposed patients, resulting in prompt referrals. An incidental finding during the project was the refusal of some parents to complete the questionnaire due to the sensitivity of the questions. Moreover, by using aggregate data scoring, the project leader hoped to mitigate this sensitivity without divulging specific situations. The findings in this project also support evidence that children with four or more ACEs often already have mental, emotional, and/or behavioral health conditions. A noted strength of this Q.I. project is integrating evidence-based practice, AAP recommendations, and literature reviews to change practice.

The 'screened' note at the bottom of each form by the providers enhances the accuracy of the findings. This structural process helped the project lead identify no gaps in the screening and referral process. The spread of the findings is also limited as the program's specifics are not intended to apply to similar healthcare settings due to differences in office processes, procedures, systems, and populations. The high number of positive-screening patients already securing therapy placement validates the sensitivity and reliability of the CYW ACE-Q tools in identifying at-risk. Data collection facilitators included CSR, who encouraged staff to ascertain that blank ACE forms were available in the new-intake packets, the receptionists/medical assistants, and the project lead's exclusive access to patient charts provided security for the obtained data. Other facilitators included providers and willing parents. One significant barrier

was the parental refusal to screen. Since screening is entirely voluntary, it was documented on their chart if patients refused.

### **Conclusions**

This Q.I. project provides initial support regarding the feasibility and effectiveness of implementing an ACEs Screening Program using the CYW ACE-Q tools in an outpatient mental health setting to increase the identification and referral of at-risk patients. Implementing this program also shows success in increasing stakeholder knowledge, ability, and value toward screening for ACEs. The 100% referral rate further validates the ability of the screens to identify patients already under care for mental health, strengthening the screening tool's reliability. Numerous changes in structures and processes will be considered to promote the sustainability of the practice change. First, a policy and procedure to guide the practice change, ACE screening forms in the new-intake package, and incorporation of the tool into the Electronic Health Record. Other sustainability measures include practice change training in new staff orientation and developing a sustainability measurement plan to continue tracking screening progress and outcomes. While findings from the Q.I. project may not be generalizable, the information gathered from this implementation can be used to establish an ACEs Screening Program in similar pediatric or adult primary care settings.

Implications for pediatric mental health practice include initiating ACEs Screening Programs in other mental health care settings. A potential standardization of ACEs screening Programs in primary mental care practices across the United States should become part of the universally recommended pediatric screenings; there will be an increased need for accessible, trauma-informed mental health specialists for collaboration and referral. Potential future Q.I. projects include investigating and implementing evidence-based methods to increase screening

distribution and completion rates, increase provider recognition and value towards the relevant symptoms specified by the CYW ACE-Q program, and increase referred patient follow-up with mental health services.

## References

- American Academy of Pediatrics. (2014). Addressing adverse childhood experiences and other types of trauma in the primary care setting.
- Barrow, J. M., Annamaraju, P., & Toney-Butler, T. J. (2020). Change Management. In StatPearls. StatPearls Publishing.
- Bergström, A., Ehrenberg, A., Eldh, A. C., Graham, I. D., Gustafsson, K., Harvey, G., Hunter, S., Kitson, A., Rycroft-Malone, J., & Wallin, L. (2020). The use of the PARIHS framework in implementation research and practice-a citation analysis of the literature. *Implementation science: I.S.*, 15(1), 68. <https://doi.org/10.1186/s13012-020-01003-0>
- Bethell, C. D., Carle, A., Hudziak, J., Gombojav, N., Powers, K., Wade, R., & Braveman, P. (2017). Methods to assess adverse childhood experiences of children and families: Toward approaches to promote child well-being in policy and practice. *Academic Pediatrics*, 17(7S), S51-S69. DOI: 10.1016/j.acap.2017.04.16
- Bryant, C., & VanGraafeiland, B. (2020). Screening for adverse childhood experiences in primary care: a quality improvement project. *Journal of Pediatric Health Care*, 34(2), 122-127.
- Centers for Disease Control and Prevention ([CDC], 2022.) *Fast Facts: Preventing Adverse Childhood Experiences*. Retrieved from <https://www.cdc.gov/violenceprevention/aces/fastfact.html>

- Chang, X., Jiang, X., Mkandarwire, T., & Shen, M. (2019). Associations between adverse childhood experiences and health outcomes in adults aged 18-59. *PloS one*, 14(2), e0211850. <https://doi.org/10.1371/journal.pone.0211850>
- Child and Adolescent Health Measurement Initiative (CAHMI). (2017). *Adverse Childhood Experiences Among U.S. Children* [PDF]. [https://www.cahmi.org/wp-content/uploads/2018/05/aces\\_fact\\_sheet.pdf](https://www.cahmi.org/wp-content/uploads/2018/05/aces_fact_sheet.pdf)
- DiGangi, M. J., & Negriff, S. (2020). The implementation of screening for adverse childhood experiences in pediatric primary care. *The Journal of Pediatrics*, 222, 174-179.
- Felitti, V. J., Anda, R. F., Nordenberg, D., & Williamson, D. F. (1998). Adverse childhood experiences and health outcomes in adults: The Ace study. *Journal of Family and Consumer Sciences*, 90(3), 31.
- Gillespie, R. J., & Folger, A. T. (2017). Feasibility of assessing parental ACEs in pediatric primary care: Implications for practice-based implementation. *Journal of Child & Adolescent Trauma*, 10, 249-256.
- Helfrich, C., Weiner, B., McKinney, M., Minasian, L. (2007). Determinants of Implementation Effectiveness: Adapting a Framework for Complex Innovations. *Medical Care Research and Review*, 64(3), 279–303. <https://10.1177/1077558707299887>
- Lippitt, R., & Watson, J. J., and Westley, B. (1958). The dynamics of planned change. A comparative study of principles and techniques.

- Marie-Mitchell, A., & O'Connor, T. G. (2013). Adverse childhood experiences: translating knowledge into identifying children at risk for poor outcomes. *Academic pediatrics*, 13(1), 14–19.
- Purewal, S. K., Bucci, M., Gutiérrez Wang, L., Koita, K., Silvério Marques, S., Oh, D., & Burke Harris, N. (2016). Screening for adverse childhood experiences (ACEs) in an integrated pediatric care model. *Zero to three*, 37(1), 10-17.
- Ragelienė, T. (2016). Links of adolescents' identity development and relationship with peers: A systematic literature review. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 25(2), 97.
- Rariden, C., SmithBattle, L., Yoo, J. H., Cibulka, N., & Loman, D. (2021). Screening for adverse childhood experiences: literature review and practice implications. *The Journal for Nurse Practitioners*, 17(1), 98–104. Review. *Journal of the Canadian Academy of Child and Adolescent*.
- Rycroft-Malone, J. (2004). The PARIHS framework—a framework for guiding the implementation of evidence-based practice. *Journal of nursing care quality*, 19(4), 297–304.
- Zarnello, L. (2018). The ACE effect: A case study of adverse childhood experiences. *Nursing2022*, 48(4), 50–54.

Table 1: Evidence Review Table

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<p><b>Citation:</b> Loveday, S., Hall, T., Constable, L., Paton, K., Sancu, L., Goldfeld, S., &amp; Hiscock, H. (2022). Screening for adverse childhood experiences in children: a systematic review. <i>Pediatrics</i>. <a href="https://doi.org/10.1542/peds.2021-051884">https://doi.org/10.1542/peds.2021-051884</a></p>					<p><b>Level: I</b> <b>Quality: B</b></p>
Purpose	Evidence types	Sample – Population, Size, Setting	Intervention/Procedures	Primary Outcome/Measures	Results/Conclusions
<p>To systematically review whether screening for ACEs in children leads to an increase in (1) identification of ACEs, (2) referrals to services, (3) increased uptake of services, and (4) improved mental health outcomes for children and parents.</p>	<p>Systematic Review</p>	<p><b>Sampling Technique:</b> Four electronic journal databases were used to identify peer-reviewed publications: Ovid Medline, PsycINFO, CINAHL, and Cochrane. <b>Eligible:</b> Articles that screened children aged 0-12 years for current adversity were published between 2009 and 2021. <b>Accepted:</b> Studies double-screened by three authors for inclusion using Covidence software (v2431) 5816 records identified. <b>Sample demographic:</b> four Studies enrolled families with children aged &lt; 5 years. 3178 children were enrolled across the four studies. <b>Power analysis:</b> not indicated <b>Group Homogeneity:</b> The study populations differed in ethnicity. Three studies had both mixed or majority Black populations and high rates (&gt;80%) of Medicaid enrollment.</p>	<p><b>Control:</b> clinicians who are unwilling to screen for ACEs for lack of clarity on referrals and Low socioeconomic children receiving a low rate of referrals. <b>Intervention:</b> Screening for ACEs was followed-up with motivational interviewing. One study used 12 children's Health Watch survey questions to screen for childcare needs, food security, household heat, housing, and education. Another study used the Personal Health Questionnaire Depression Scale to screen for maternal depression. <b>Intervention fidelity:</b> There was low fidelity to the study protocol, so only 32% of families received case management.</p>	<p><b>DV:</b> Referral rates, uptake of referrals rates, community service engagement rate, and mental health service involvement rate. <b>Measurement:</b> The measurement of the dependent variable is not clearly described for each of the four studies included in the review.</p>	<p><b>Statistical Results:</b> Mothers in the intervention group received significantly more referrals than those in the control group (70% vs. 8%; adjusted odds ratio [OR] 5 29.6; 95% confidence interval [CI] 14.7–59.6). Screening for ACEs in a low-socioeconomic population decreased referral (OR 1.5; 95% CI not reported). <b>Clinical Significance:</b> Screening for ACEs improves the identification of adversity and referral to services, uptake of services, and better mental health outcomes for children and their parents. <b>Conclusions:</b> There is limited evidence that screening for ACEs improves the identification of childhood adversity and referrals to community services. There is no evidence for improvements in mental health outcomes for children or parents. Further RCTs are needed in settings outside the U.S. that measure both harms and benefits of screening.</p>

Bethell, C. D., Carle, A., Hudziak, J., Gombojav, N., Powers, K., Wade, R., & Braveman, P. (2017). Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice. <i>Academic pediatrics</i> , 17(7S), S51–S69. <a href="https://doi.org/10.1016/j.acap.2017.04.161">https://doi.org/10.1016/j.acap.2017.04.161</a>					<b>Level: V</b> <b>Quality: C</b>
<b>Purpose</b>	<b>Type Evidence</b>	<b>Sample – Population, Size, Setting</b>	<b>Intervention/Procedures</b>	<b>Primary Outcome/Measures</b>	<b>Results/Conclusions</b>
To compare different methods to assess ACEs among children and families, assess the acceptability and validity of the National Survey of Children’s Health (NSCH)-ACEs measure, and identify implications for assessing ACEs in research and practice.	Literature Review and Key Informant interview and online	<b>Sampling Technique:</b> Key Informant interview and online structured search of published research literature. <b>Article Selection:</b> Published research literature and reviewed online resources from federal, state, local, academic, and community-based health programs recognized as being engaged in activities related to ACEs. <b>Accepted:</b> 14 ACE assessment methods were selected; ten focused on children and four focused on adults. <b>Sample Demographics:</b> Children 8 years to adults. The sample population's demographics should have been disclosed in greater detail. <b>Power analysis:</b> None disclosed. <b>Group Homogeneity:</b> none indicated.	<b>Control:</b> Not specified <b>Intervention:</b> ACE tools were compared to each other based on the following criteria: 1) Primary purpose and target population, 2) data source and collection methods, 3) types and numbers of adversities addressed, 4) scoring and reporting of results, 5) development and validation status, 6) concurrent information collected, and 7) availability and guidelines. <b>Intervention fidelity:</b> Strong internal validity with cumulative risk NSCH-ACEs score, which is more discriminating and predictive of outcomes. Results across CFA and formative and reflective analyses proved that a continuous score is a valid approach. There are no consistent patterns to provide evidence for creating subgroups based on types of adverse experiences.	<b>DV:</b> The number of constructs, survey items on the tools, ACEs topics addressed, scoring, and acceptability and efficiency of the NSCH-ACEs tool. <b>Measurement:</b> Analysis of each study, including their ACEs measurement tool, included on screen. The differential effect of ACEs across household income groups was evaluated separately, evaluating key child outcomes for four income subgroups across 4 NSCH-ACEs score categories.	<b>Statistical Results:</b> A single-factor model fit the data well (root mean square error of approximation $\frac{1}{4}$ 0.01; comparative fit index $\frac{1}{4}$ 0.99; Tucker-Lewis Index $\frac{1}{4}$ 0.98; chi-square $\frac{1}{4}$ 312.84; n $\frac{1}{4}$ 94,520; P < .01). <b>Clinical Significance:</b> While some significant differences among the ACE assessment instruments were examined, positive screenings consistently correlate with poorer health outcomes without protective variables and resilience. All the technologies studied aim to facilitate health education, promote health, and mitigate the harmful consequences of ACE exposure. <b>Conclusions:</b> ACEs were found in households of all income levels, suggesting that the prevalence of ACEs is not reliant on economic position. Based on this finding, population-wide ACE screening is suggested over a high-risk subgroup approach. Even for unexposed ACEs, measuring ACEs can be beneficial for educating children and their families about the relevance of ACE exposure, management, and development of resilience.

<p>DiGangi, M. J., &amp; Negriff, S. (2020). The Implementation of Screening for Adverse Childhood Experiences in Pediatric Primary Care. <i>The Journal of Pediatrics</i>, 222, 174–179.e2.  <a href="https://doi.org/10.1016/j.jpeds.2020.03.057">https://doi.org/10.1016/j.jpeds.2020.03.057</a>  <a href="https://doi.org/10.1016/j.jpeds.2020.03.057">https://doi.org/10.1016/j.jpeds.2020.03.057</a></p>					<p><b>Level: III</b>  <b>Quality: B</b></p>
Purpose	Type of evidence	Sample – Population, Size, Setting	Intervention/Procedures	Primary Outcome/Measures	Results/Conclusions
<p>To assess the implementation of screening, screening rates, and prevalence of adverse childhood experiences (ACEs) in an extensive integrated healthcare system.</p>	<p>Evidence from a single descriptive study</p>	<p><b>Sampling Technique:</b> Convenience sampling.  <b>Accepted:</b> 7056 (3241 3-year-olds, 2761 5-year-olds, 545 10-year-olds, and 509 13-year-olds at their well-child visits)  <b>#Control:</b> none provided.  <b>#Intervention:</b> All the accepted  <b>Power analysis:</b> none provided.  <b>Group Homogeneity:</b> the study showed a diverse population; child age (3-, 5-, and 10-year-old visits and 13), Sex (boys and girls), and race/ethnicity were obtained from the EHR. Race/ethnicity was coded as Asian, black, Hispanic, white, multiple, Native American/Alaskan, Pacific Islander, other, or unknown.</p>	<p><b>Control:</b> none specified  <b>Intervention:</b> At the participating clinic, ACEs questionnaires were given to the parents or patients at check-in. Parents fill out the questionnaire for their child at the 3-, 5-, and 10-year-old visits and 13-year-olds fill it out for themselves.  <u><b>Intervention fidelity</b></u> training and guidance on the impacts of ACEs, how physicians can converse comfortably with patients, and what to do if an ACEs score is positive to the providers. Also, optional online training through George Washington University to bolster their skill and comfort level with the subject matter. Additionally, the physician discusses the responses with the 13-year-old during the confidential section of the evaluation, which requires the parent to exit the room.</p>	<p><b>DV:</b> Screening rates and prevalence rates of adverse childhood experiences (ACEs).  <b>Measurement</b> Descriptive, with age group-specific data on those tested, those with one or more ACEs, and those with an ACEs score (0-10) (3-, 5-, 10-, and 13-year-olds). Crosstabs and two tests were used to compare the proportions of those having 0 vs. one or more ACEs by age group. To assess the main effect of race/ethnicity for the 4 principal racial/ethnic, logistic regression was utilized for age and sex. ANCOVA to compare the mean of the four racial/ethnic groups.</p>	<p><b>Statistical Results:</b> Since 2018, 3241 3-year-olds (53% of the target population), 2761 5-year-olds (53%), 545 10-year-olds (37%), and 509 13-year-olds (13%). Of the 3-year-olds who were screened, 15% had an ACEs score of 1 or higher. Of the 5-year-olds that were screened, 17.5% had an ACEs score of 1 or higher. Of the 10-year-olds, 30.5% had an ACEs score of 1 or higher, and of the 13-year-olds, 33.8% had an ACEs score of 1 or higher.  <b>Clinical Significance:</b> <u>The research discovered that the effectiveness of patient screening and engagement and the patient's valuation of their treatment choices are highly dependent on the initial screening and information offered to them. Additionally, they discovered that doctors and providers want more accessible training choices.</u>  <b>Conclusions:</b> While certain difficulties were encountered, most notably with the follow-up of individuals who tested positive for ACEs, screening was feasible. The data indicate a rising prevalence of ACEs in children aged three to thirteen, emphasizing the need for early education on ACEs to alleviate the impacts of toxic stress.</p>

<p>Gillespie, R. J., &amp; Folger, A. T. (2017). Feasibility of assessing parental ACEs in pediatric primary care: Implications for practice-based implementation. <i>Journal of Child &amp; Adolescent Trauma, 10</i>(3), 249–256. <a href="https://doi.org/10.1007/s40653-017-0138-z">https://doi.org/10.1007/s40653-017-0138-z</a></p>					<p><b>Level III Quality C</b></p>
Purpose	Type of Evidence Research Design	Sample – Population, Size, Setting	Intervention/Procedures	Primary Outcome/Measure s	Results/Conclusions
<p>Determine the feasibility and provider acceptability of implementing assessment for parental ACEs and comparison of parental ACE detection rates between an item-level response tool and an aggregate-level response tool.</p>	<p><b>Sampling Technique:</b> Convenience Sampling  <b>Eligible:</b> Parents at their child’s four-month well visit.  <b>Accepted:</b> A total of 2,283 parents representing 1780 children completed the ACEs assessment. 1308 parents completed the item-level response assessment, and 975 parents completed the aggregate response assessment.  <b>#Control:</b> No control indicated.  <b># In intervention:</b> 1308 parents completed the item-level response assessment. 975 parents completed the aggregate response assessment.                  Power analysis: None disclosed. <b>Group Homogeneity:</b> Race was reported to be 52.2 percent White, 16.1 percent Hispanic, 8.7 percent Asian, 1.1 percent African American, and less than 1% American Indian or Pacific Islander.</p>	<p><b>Sampling Technique:</b> Convenience sampling.  <b>Accepted:</b> 7056 (3241 3-year-olds, 2761 5-year-olds, 545 10-year-olds, and 509 13-year-olds at their well-child visits)  <b>#Control:</b> none provided.  <b>#Intervention:</b> all the accepted  <b>Power analysis:</b> none provided.  <b>Group Homogeneity:</b> the study showed a diverse population; child age (3-, 5-, and 10-year-old visits and 13), Sex (boys and girls), and race/ethnicity were obtained from the EHR. Race/ethnicity was coded as Asian, black, Hispanic, white, multiple, Native American/Alaskan, Pacific Islander, other, or unknown.</p>	<p><b>Control:</b> no control indicated  <b>Intervention:</b> Cohort one was given an item-level ACE assessment form, and parents were asked to describe the ACEs they had experienced. Cohort two was given an aggregate-level ACE assessment tool that just asked parents how many ACEs they had experienced. Both tools have been translated into Spanish.  <b>Intervention fidelity:</b> Parents are given this tool upon check-in for their four-month well-visit and are instructed to complete it in the waiting area or exam room. If both parents are present, both parents should be offered the screening. During the visit, providers gathered and discussed the results with the family.</p>	<p>DV: Number of ACEs approved by parents, the providers’ perception of the screening tool’s value, and parental receptiveness.  <b>Measurement procedure:</b> The item-level assessment instrument and the aggregate response tool were used to compare parental ACE ratings. Comparing pre-and post-implementation qualitative comments from providers on the usefulness, feasibility, and parental receptiveness to screens using electronic surveys.</p>	<p><b>Statistical Results:</b> Chi-square tests were used to determine the difference in the proportion of ACEs reported between the first cohort's item-level responses and the second cohort's aggregate replies. On the item-level answer tool, 8.1 percent of parents endorsed an ACE score of 4 or above, compared to 11.2 percent in the aggregate response group (p=0.013).  <b>Clinical Significance:</b> <u>All providers stated that the information acquired from the ACE evaluation tools was beneficial to their practice and was manageable in their hectic practice situation.</u> Detection rates were significantly higher with an aggregate-level reporting tool than the item-level tool (11.2% versus 8.1%, <math>p = 0.013</math>). Both providers and parents preferred the aggregate-level reporting tool over the item-level tool  <b>Conclusions:</b> An ACE assessment tool is feasible for a busy pediatric practice, viewed as extremely helpful by providers, and well received by parents.</p>

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. <i>The Lancet. Public health</i> , 2(8), e356–e366. <a href="https://doi.org/10.1016/S2468-2667(17)30118-4">https://doi.org/10.1016/S2468-2667(17)30118-4</a>					<b>Level II Quality B</b>
<b>Purpose</b>	<b>Type of Evidence</b>	<b>Sample – Population, Size, Setting</b>	<b>Intervention/Procedures</b>	<b>Primary Outcome/Measures</b>	<b>Results/Conclusions</b>
To determine the effect of multiple adverse childhood experiences on overall health.	Systematic Review and Meta-Analysis.	<p><b>Sampling Technique:</b> Five electronic journal databases were used to identify peer-reviewed publications on cross-sectional, case-control, or cohort-reporting risks of health outcomes: substance use, sexual health, mental health, weight and physical exercise, violence, and physical health status and conditions associated with multiple ACEs.</p> <p><b># Eligible:</b> 11621 Articles that presented risk estimates for individuals with at least four ACEs with sufficient data for meta-analysis (at least four populations).</p> <p><b># Accepted:</b> 37 cross-sectional, case-control, or cohort studies. The study sample must contain adults aged at least 18 years. A sample size of at least 100.</p> <p><b># in control:</b> None reported</p> <p><b># in intervention:</b> None disclosed</p> <p><b>Power analysis:</b> none disclosed.</p> <p><b>Group Homogeneity:</b> considerable heterogeneity (<math>I^2</math> of &gt;75%) between estimates for almost half of the outcomes.</p>	<p><b>Control:</b>None disclosed</p> <p><b>Intervention:</b>Articles that presented risk estimates for individuals with at least four ACEs were selected and compared with those with none for outcomes with sufficient data for meta-analysis</p> <p><b>Intervention fidelity:</b> Studies were Independently assessed for quality by two reviewers utilizing Standard principles of quality assessment (Max point of 7).</p>	<p><b>DV:</b> Overall health status in adults.</p> <p><b>State the instrument, reliability, and measurement procedure:</b> Odds Ratio (OR): for participants with at least four ACEs versus those with none. Using a random-effects model, it was calculated with pooled odds ratios (O.R.s).</p>	<p><b>Statistical Results:</b> Of 11 621 references identified by researchers, 37 included studies that provided risk estimates for 23 outcomes, with 253 719 participants. Individuals with at least four ACEs were at increased risk of adverse health outcomes compared with individuals with no ACEs and those with no risk factors for cardiovascular disease.</p> <p><b>Clinical Significance:</b> To sustain improvements in public health requires a shift in focus to include the prevention of ACEs, resilience building, and ACE-informed service provision.</p> <p><b>Conclusions:</b> Having several ACEs is a significant risk factor for a range of health problems. The outcomes most strongly linked to various ACEs represent ACE risks for the following generation (e.g., violence, mental illness, and substance use). To sustain advances in public health, a shift in focus is required to include ACE prevention, resilience building, and ACE-informed service provision.</p>

Rariden, C., SmithBattle, L., Yoo, J. H., Cibulka, N., & Loman, D. (2021). Screening for Adverse Childhood Experiences: Literature Review and Practice Implications. <i>The Journal for nurse practitioners: JNP</i> , 17(1), 98–104. <a href="https://doi.org/10.1016/j.nurpra.2020.08.002">https://doi.org/10.1016/j.nurpra.2020.08.002</a>						<b>Level III Quality B</b>
Purpose	Type of Evidence	Sample – Population, Size, Setting	Intervention/Procedures	Primary Outcome/Measures	Results/Conclusions	
To examine the acceptability, feasibility, and implementation of ACE screenings from the perspectives of clinicians and patients.	Systematic Review	<p><b>Sampling Technique:</b> The literature search was done with three electronic journal databases (Cumulative Index of Nursing and Allied Health Literature, Ovid MEDLINE, and PsycINFO) to identify peer-review publications.</p> <p><b># Eligible:</b> out of 2,361 studies, 22 studies that focused on screening for ACE were identified</p> <p><b># Accepted:</b> Publication dates from January 2012 to October 2019, written in English and conducted in the U.S., were included in the review.</p> <p><b># in control:</b> none identified</p> <p><b># in intervention:</b> none identified</p> <p><b>Power analysis:</b> none disclosed.</p> <p><b>Group Homogeneity:</b> Out of 13 studies, five were conducted in pediatric settings, 3 in adult primary care, 2 in perinatal settings, and 1 in an academic setting. Non-English-speaking clients were offered interpreters and materials written in English and Spanish. One study focused on clinicians' perspectives on conducting ACE screenings.</p>	<p><b>Control:</b> None indicated</p> <p><b>Intervention:</b> ACE screenings were completed during a visit that had few or no other screens scheduled. The form was given to families before the pediatric clinician arrived to make use of the time spent waiting.</p> <p><b>Intervention fidelity:</b> a 4-hour training on ACE health impacts and trauma-informed care; the sessions increased clinician comfort, knowledge, and screening confidence. Practice interviews and ACE screening simulations helped prepare staff and clinicians to ask questions and respond with sensitivity.</p>	<p><b>DV:</b> Clinician and patient discomfort level during screening, access to resources, including multidisciplinary behavioral health support.</p> <p><b>State the instrument, reliability, and measurement procedure:</b> Patients are asked to offer a summary score for each category of ACE in this manner, which avoids patients disclosing individual traumas. Without identifying traumas, the level of privacy is increased. In one research, aggregate-level reporting resulted in 11.2 percent of ACEs in parents, which was statistically significant when compared to 8.1 percent using a particular item tool.</p>	<p><b>Statistical Results:</b> Two studies proposed the use of aggregate-level reporting of ACEs to further enhance patient acceptability. In one study, Aggregate-level reporting yielded 11.2% ACEs in parents and was statistically significant compared with 8.1% with a specific item tool.</p> <p><b>Clinical Significance:</b> ACEs are associated with worse health outcomes in children and adults. A high rate of ACEs increases the chance of acquiring chronic health disorders; understanding such events may aid doctors in delivering patient-centered, holistic treatment.</p> <p><b>Conclusions:</b> This review demonstrates that trauma-sensitive education decreases physicians' discomfort and unwillingness to test for ACEs and that screening is feasible in a range of healthcare settings, including outpatient clinics.</p>	

Table 2: Evidence Synthesis Table

PICOT: In an outpatient psychiatric setting, does education regarding childhood adversity and screening methods, along with the implementation of an ACE screening for Adverse Childhood Experiences (ACEs) in patients 10 to 18 years associated with early identification of mental illness risk, promote the use of ACE screening tools and referral to mental health services in three months.			
Category (Level Type)	Total Number of Sources/Level	Overall Quality Rating	Synthesis of Findings
<b>Level II</b>	2	<p><b>B.</b> Loveday et al., 2022. Of greater significance, the studies in this Loveday et al., 2022 review included small samples and varied in methodology, clinical setting, and patient and clinician demographics. These variations limit the confidence in proposing recommendations for specific healthcare settings or groups of patients. Sufficient sample size and few published control trials of moderate quality for the study.</p> <p><b>B.</b> In this, Hughes et al. 2017. All investigations employed retrospective ACE reports, which may be influenced by recollection or reporting biases, even though retrospective reports of significant, well-characterized ACEs are considered to have good psychometric qualities. Although summarizing ACEs is a recognized technique, the quantity and kinds of ACEs reported by research varied. It does not consider any differences in the impact of various combinations of ACEs. Additionally, although most of the research assessed ACEs at any moment throughout childhood or adolescence (usually 18 years of age), the technique does not account for age or duration of exposure variance.</p>	<p>Loveday et al., 2022, Found that screening for ACEs increases the detection of childhood adversity and referrals to community resources. Still, there is no evidence of improved mental health outcomes for children or parents.</p> <p>Hughes et al. 2017, Highlight the extensive impacts of childhood adversity on health over the life cycle, with exposure to multiple ACEs. Although research on ACEs is far from comprehensive, there is a compelling argument for increasing worldwide emphasis on ACE prevention, developing resilience programs, and implementing policies that promote a sustainable life-course approach to health.</p>
<b>Level III</b>	3	<p><b>B.</b> DiGangi, &amp; Negriff, 2020. In this study, generalizability is limited by the screening approach, which is best suited for a large-scale, integrated healthcare system but might be modified for smaller community clinics. Additionally, the prevalence rates may vary from those of other health systems. Despite the member community's racial/ethnic diversity, other</p>	<p>DiGangi, &amp; Negriff, (2020). This research reveals that screening for ACEs is feasible in an extensive, integrated healthcare system and can detect a significant percentage of children experiencing adversity. Additionally, the researchers discovered that training and guidance on the impacts of ACEs, how physicians can interact comfortably with patients, and ongoing</p>

		<p>demographic variables may influence the ACE experience and report.</p> <p><b>B.</b> Gillespie, &amp; Folger, 2017. The short-term effects of children whose parents have suffered from ACEs are also being studied. It is unknown if parental ACEs influence variables such as a child's developmental trajectory, service use patterns, completion of preventative interventions, or health outcomes prior to entering kindergarten. If the ultimate objective of early childhood is to prepare children adequately for kindergarten, intermediate outcomes such as these should be considered. Additionally, additional study is required to determine the efficacy of therapies that may be performed by physicians in a private practice environment that lacks the resources of an academic setting. Findings cannot be generalized due to the limited sample size.</p> <p><b>C.</b> Rariden, et al. 202. Since this study of the literature was confined to peer-reviewed publications, publication bias may occur. More importantly, the thirteen studies included in this review had very small sample sizes and differed in methodology, clinical context, and patient and physician demographics. These differences weaken the confidence in making recommendations for certain healthcare settings or patient populations.</p>	<p>training and refreshers are critical. The researcher recommends obtaining early buy-in and support from an organization's leadership and stakeholder before implementation. The process required many months and at least five iterations to complete.</p> <p>Gillespie &amp; Folger, 2017 this study compares parental ACE detection rates between an item-level response tool and an aggregate-level response tool. In the end, the researcher discovered that both providers and parents preferred the aggregate-level reporting tool over the item-level tool for assessment. Providers found great value in having this information in the delivery of routine anticipatory guidance and parenting counseling that occurs during good visits.</p> <p>Rariden et al. 2021 this study provide evidence that implementing screening is possible in a variety of healthcare settings, including pediatric care, prenatal care, adult primary care, home visits, and schools.</p>
<p><b>Level V</b></p>	<p>1</p>	<p><b>C.</b> The measurement of this study was done with NSCH-ACEs. When comparing the NSCH-ACEs to a cumulative risk score, care should be taken to account for the significant degree of overlap across categories of ACEs and to explain the theoretical and conceptual justifications for treating experiences. The study did not assess the NSCH-ACEs' temporal stability or recommend classic test-retest analyses for this type of</p>	<p>Bethell et al. (2017). All strategies evaluated appear to correspond with broader objectives to enable health education, promote health, and, if appropriate, lessen the trauma, chronic stress, and behavioral and emotional sequelae that might occur with exposure to ACEs.</p>

		<p>measure, which is distinct in ways that limit the interpretability of any test-retest findings, and the measure may lack the greatest possible predictive power for specific versus more general outcomes evaluated in this study, despite evidence supporting a cumulative scoring method for the NSCH-ACEs. Certain NSCH-ACEs items are inherently more precise than others, which may result in increased variability and weaker inferences for these less exact ACEs. Also, findings cannot be generalized due to the limited sample size.</p>	
<p>Recommendations Based on Evidence Synthesis: All studies have identified that ACEs impact both pediatric and adult health outcomes. High ACEs increase the likelihood of developing chronic health disorders; understanding such events may help clinicians provide patient-centered holistic therapy. A clinician's role as a change agent and supportive family resource include assisting people and families in identifying and preventing ACEs. The acceptance of screening among doctors is clear; nonetheless, evaluation and availability of follow-up resources for positive ACEs are essential. Clinician support for the ACE screening approach is conditioned on simple access to resources or referrals. Clinicians may not be well-suited to screen for or manage ACEs if local services for extra help are lacking. The reviewed studies have recommended that clinicians be well prepared to provide supportive follow-up to address needs identified through ACE screening, including patients from all diverse socioeconomic backgrounds. The evaluation of resources should consider diversity, cost, location, transit alternatives to services, and wait time before appointments.</p>			

*Figure 1 implementation framework Promoting Action on Research Implementation in Health Services (PARIHS)*



Figure 2 Process Map Proposed change.

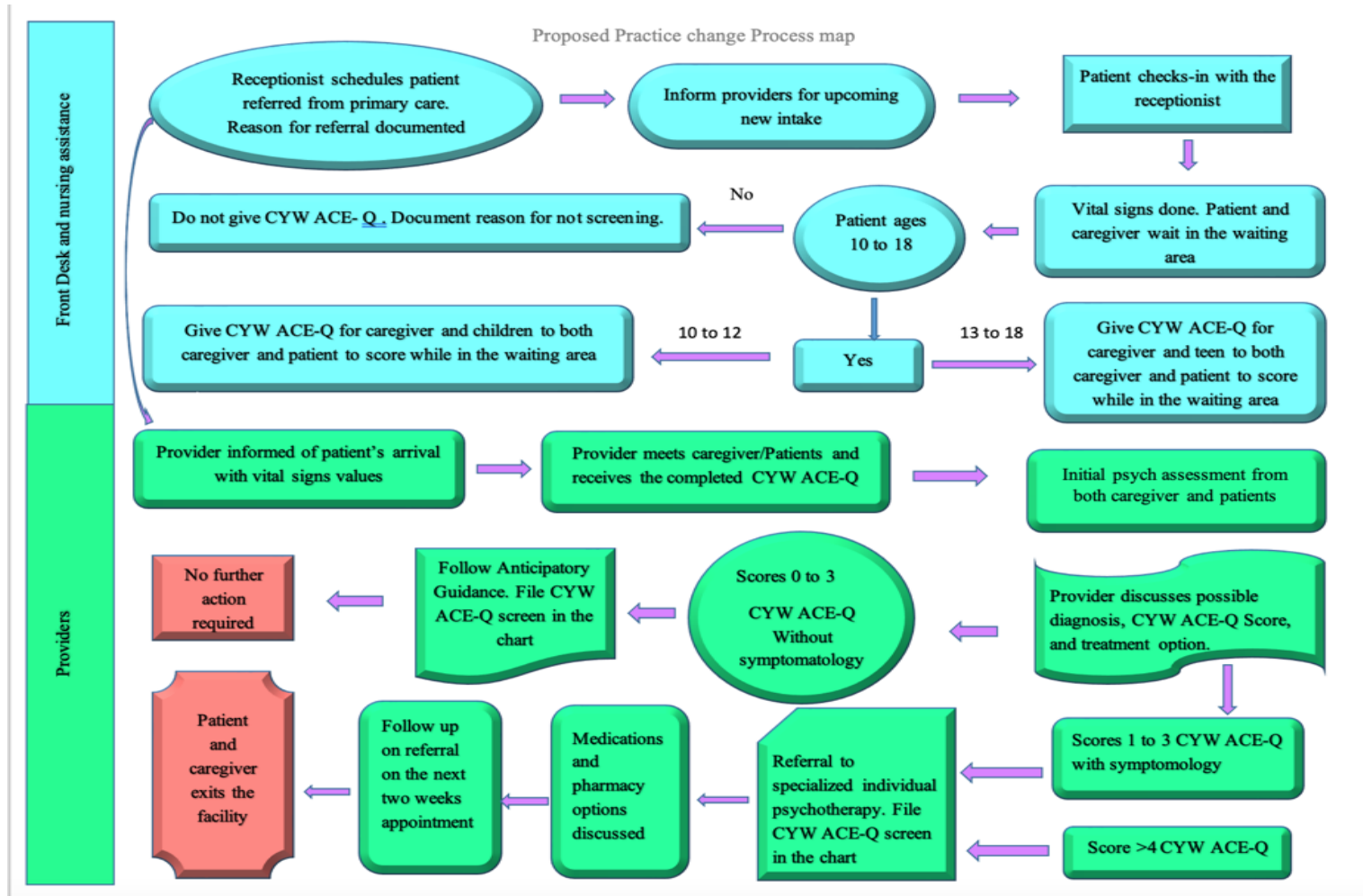


Figure 3: Percentages of staff trained.

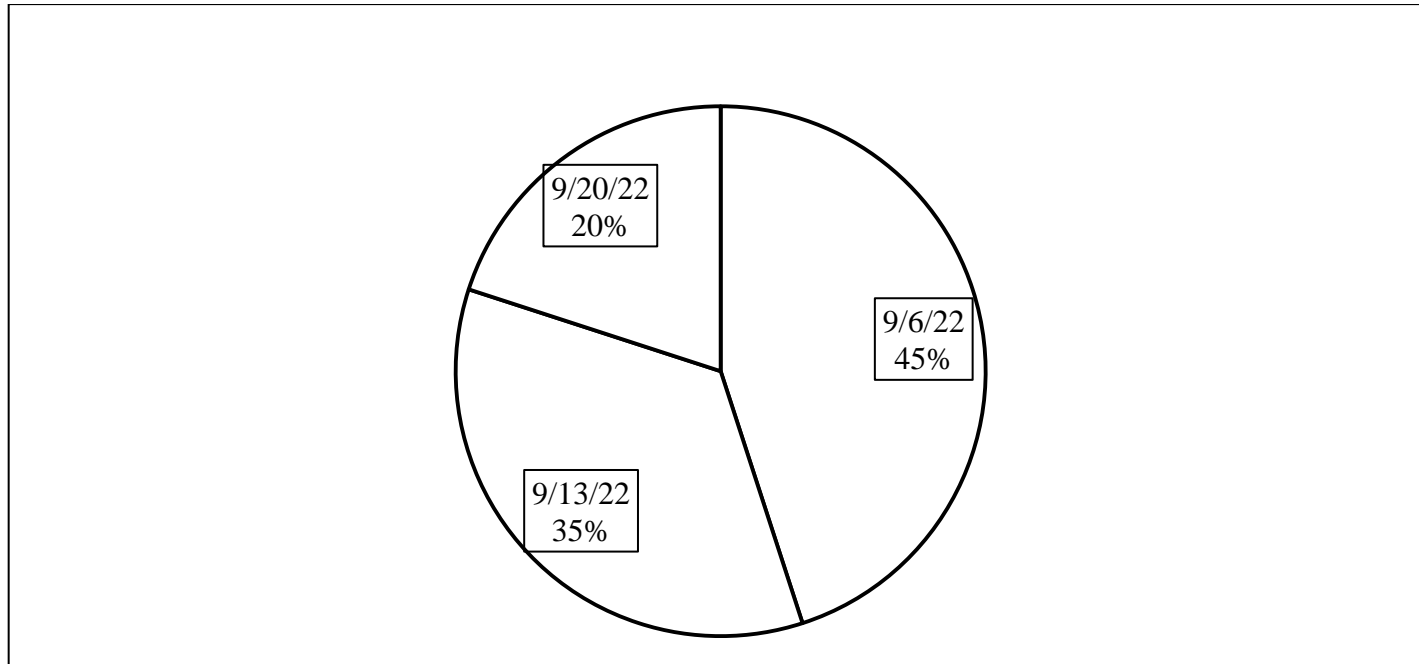


Figure 4: Run chart for the percentage of patients seen and screened.

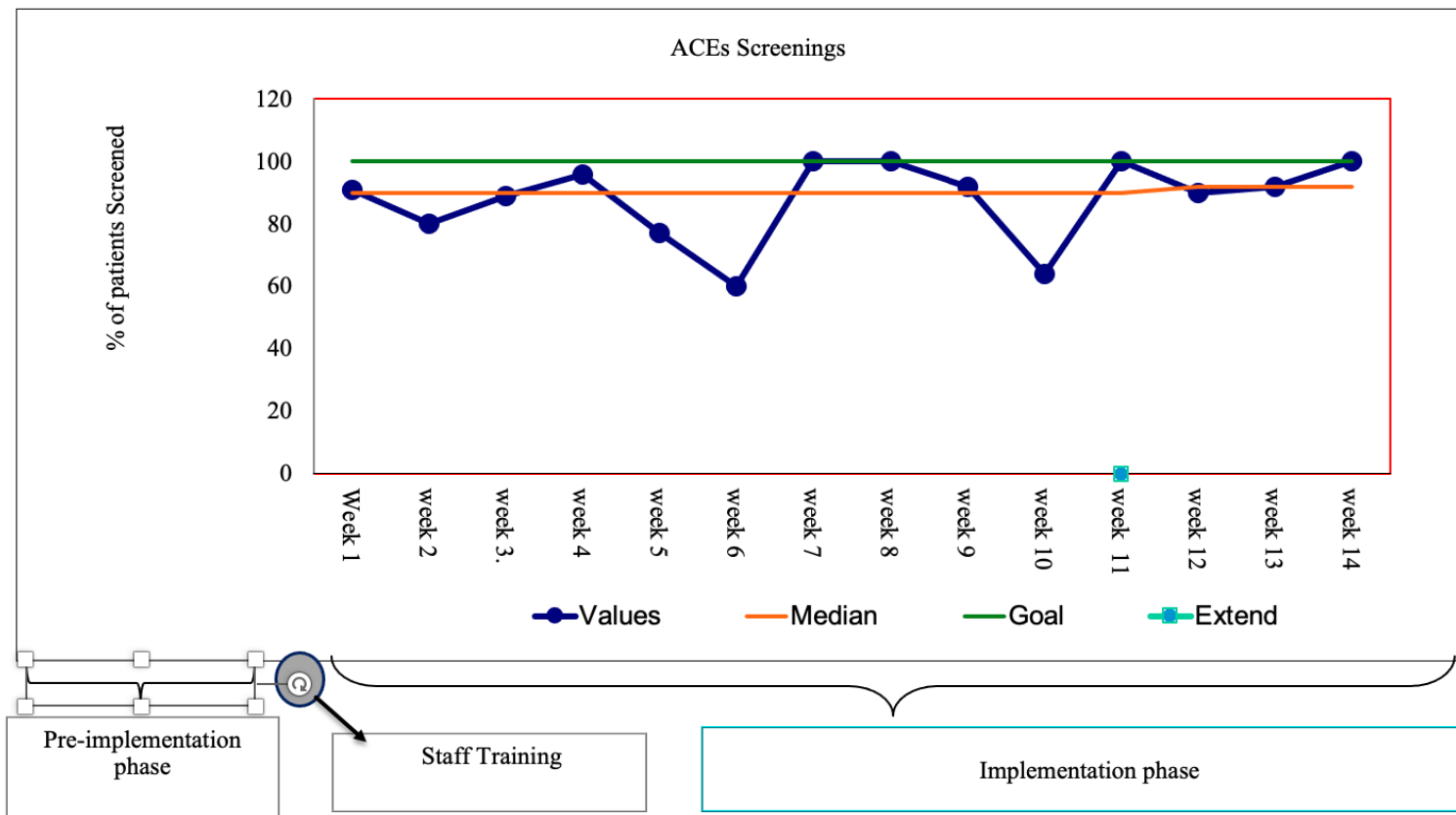


Figure 5: Positively screened patients who received a referral.

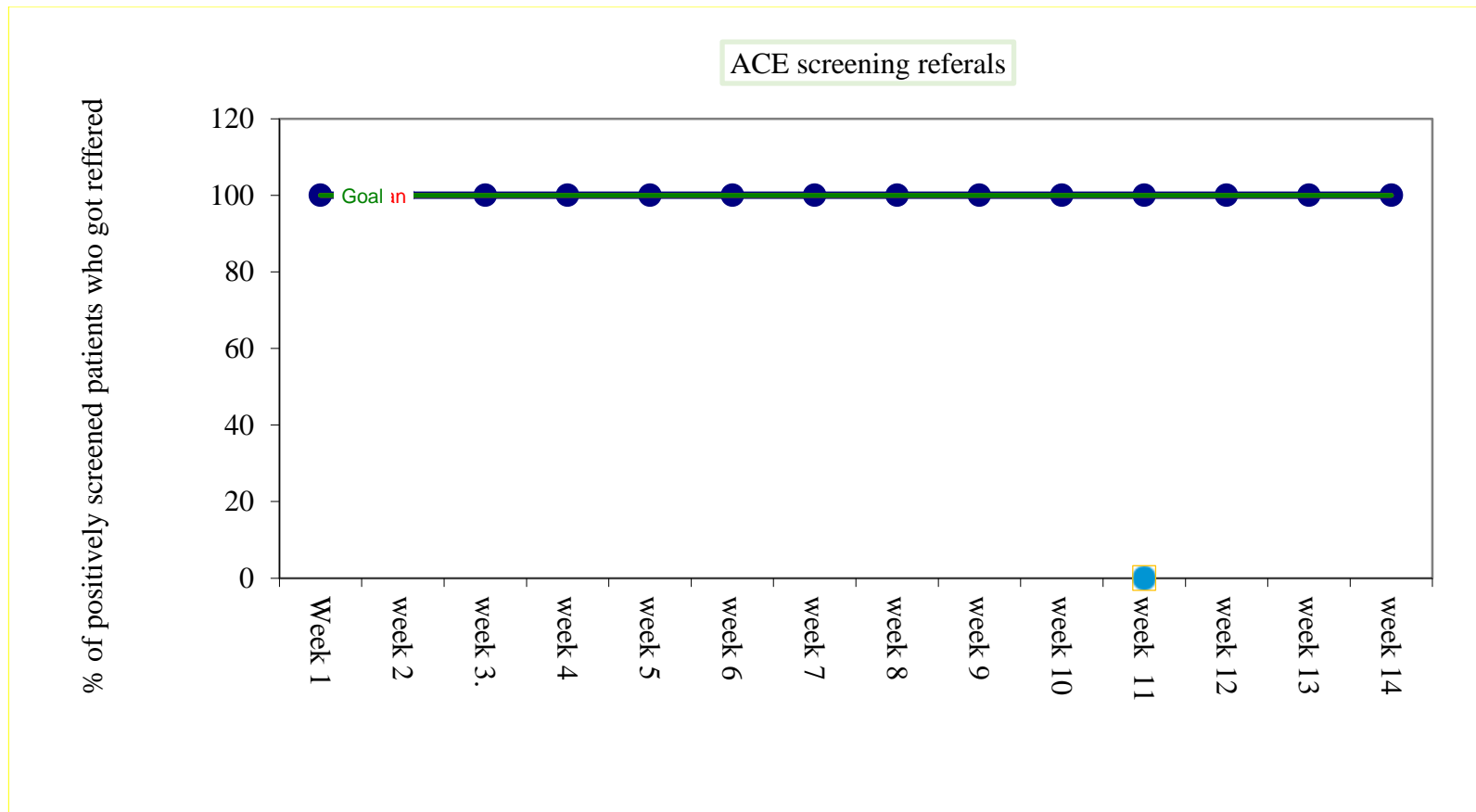
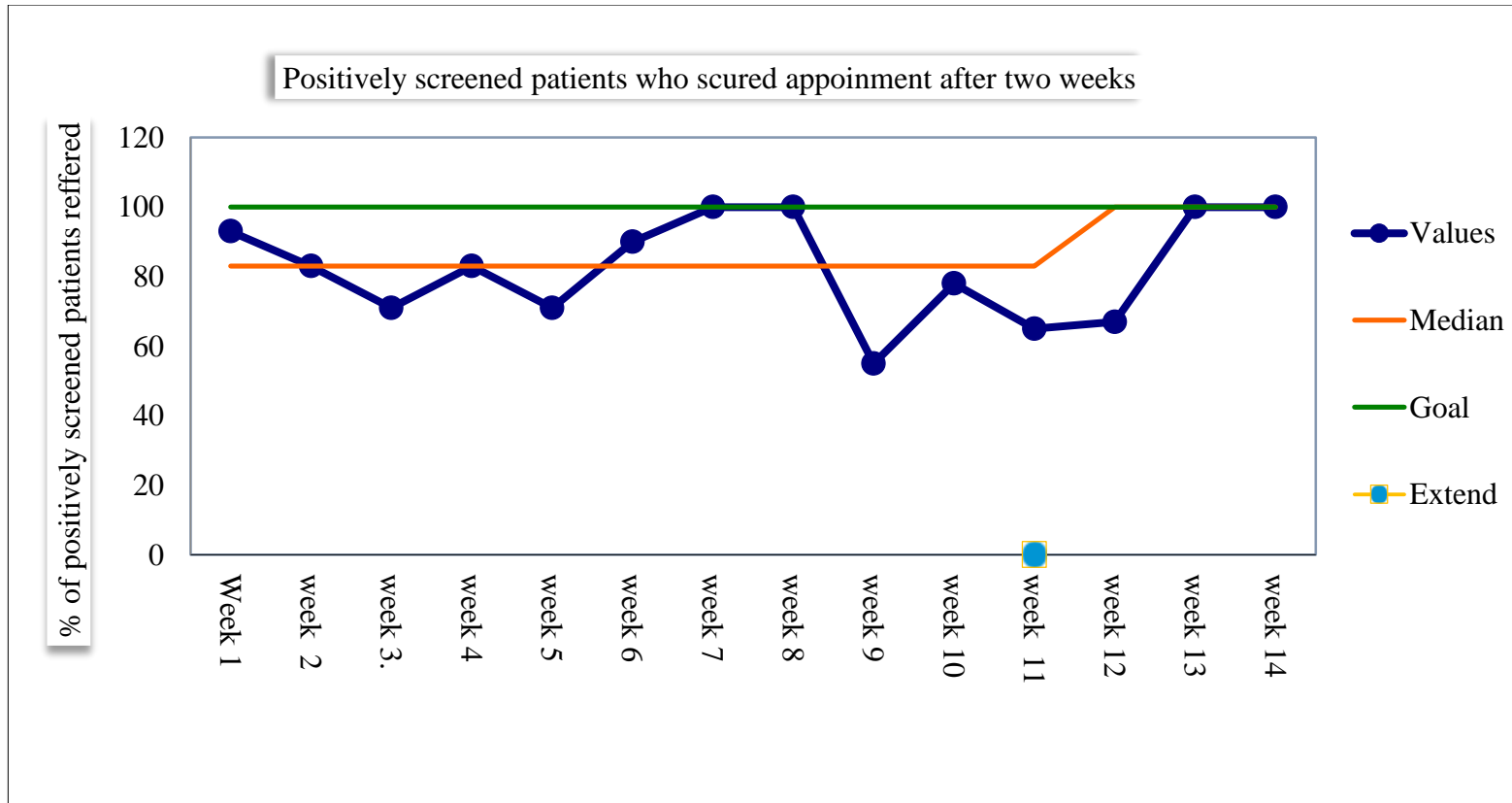


Figure 6: Percentage of referred who secured placement after two weeks.



## APPENDIX A: CYW ACE-Q for Teen Self-report

### CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Teen Self-Report

#### To be completed by Patient

Today's Date: \_\_\_\_\_

Your Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Many children experience stressful life events that can affect their health and development. The results from this questionnaire will assist your doctor in assessing your health and determining guidance.** Please read the statements below. Count the number of statements that apply to you and write the total number in the box provided.

**Please DO NOT mark or indicate which specific statements apply to you.**

?

**1) Of the statements in section 1, HOW MANY apply to you? Write the total number in the box.**

**Section 1. At any point since you were born...**

- Your parents or guardians were separated or divorced
- You lived with a household member who served time in jail or prison
- You lived with a household member who was depressed, mentally ill or attempted suicide
- You saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put you down in a way that scared you OR a household member acted in a way that made you afraid that you might be physically hurt
- Someone touched your private parts or asked you to touch their private parts in a sexual way that was unwanted, against your will, or made you feel uncomfortable
- More than once, you went without food, clothing, a place to live, or had no one to protect you
- Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks
- You lived with someone who had a problem with drinking or using drugs
- You often felt unsupported, unloved and/ or unprotected

?

**2) Of the statements in section 2, HOW MANY apply to you? Write the total number in the box.**

**Section 2. At any point since you were born...**

- You have been in foster care
- You have experienced harassment or bullying at school
- You have lived with a parent or guardian who died
- You have been separated from your primary caregiver through deportation or immigration
- You have had a serious medical procedure or life threatening illness
- You have often seen or heard violence in the neighborhood or in your school neighborhood
- You have been detained, arrested or incarcerated
- You have often been treated badly because of race, sexual orientation, place of birth, disability or religion
- You have experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)

## Appendix B: CYW ACE-Q for caregiver/child

### CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child ?

#### To be completed by Parent/ Caregiver

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Your Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

**Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.**

**Please DO NOT mark or indicate which specific statements apply to your child.**

?

**1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box.**

**Section 1. At any point since your child was born...**

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/ he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/ him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/ or unprotected

**2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box.**

?

**Section 2. At any point since your child was born...**

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/ his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/ his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

### Appendix C: Staff Training Audit tool

#### Staff Training Tracking

Page 1

Training Tracking

- 
- 1) Date in week  week 1  
 week 2  
 week 3

---

  - 2) Number of staff trained \_\_\_\_\_

---

  - 3) Number of staff needing training \_\_\_\_\_

**Appendix D: ACE Screening Tracking Audit tool**

**Patient Screen Tracking tool**

Page 1

ACEs Screening Data Tracking Audi

---

1) Date in Week 
 week 1  
 week 2  
 week 3  
 week 4  
 week 5  
 week 6  
 week 7  
 week 8  
 week 9  
 week 10  
 week 11  
 week 12  
 week 13  
 week 14  
 week 15

---

2) Total number of patients seen at this week \_\_\_\_\_

---

3) The total number of patients screened \_\_\_\_\_

---

4) Total number of eligible patients who refused to screen \_\_\_\_\_

---

5) The total number of patients met the criteria \_\_\_\_\_

---

6) Total number of patients who did NOT meet the Criteria \_\_\_\_\_

---

7) The number of patients screened received Psychotherapy referral \_\_\_\_\_

---

8) The number of patients who secured Psychotherapy appointments on two weeks follow up \_\_\_\_\_

---

9) Number of patients who did NOT secure psychotherapy appointment on two week follow-up visits \_\_\_\_\_

