NACCHO
National Association of County & City Health Officials

ADVERSE CHILDHOOD EXPERIENCES (ACES) QUESTIONNAIRE USE

Cautions & Recommendations for Local Health Departments

What is the ACEs questionnaire?

The Adverse Childhood Experiences (ACEs) questionnaire is a series of 10 'yes' or 'no' questions about family-based adverse experiences during childhood. The questions were developed by investigators of the ACE study for the purposes of collecting epidemiological data about childhood adversity.

In this original study, nearly two-thirds of participants reported at least one ACE, and there was a graded, dose response-relationship between ACEs and negative health outcomes. That is, as the number of ACEs increased, so too did risk for negative health outcomes.[1] These results were integral in informing the public health field about the relationship between childhood adversity and health outcomes and have been expanded on many times with similar findings. For more information about the ACE study visit the CDC's About the CDC-Kaiser ACE Study webpage.

Many local health departments (LHDs) and their community partners have long recognized the value of the ACE study findings and have incorporated the study's implications into their public health efforts. **There remains, however, uncertainty about *when* and *how* to utilize the ACEs questionnaire.**

What are the potential risks of using the ACEs questionnaire?

The ACEs Questionnaire is an assessment developed for use in an epidemiological study. It can be used to collect population-level data for public health surveillance or research. For example, several states regularly collect data on ACEs by using the questionnaire in the Behavioral Risk Factor Surveillance System (BRFSS).

As information about ACEs and the ACE Study has grown more widespread, interest in the use of the ACEs questionnaire as an individual-level screening tool has become increasingly common.[2] Some researchers[3], health systems[4,5], and organizations[6,7] have promoted or implemented ACEs screening as a means of identifying those at risk. The term "ACEs score" has been used to refer to the tally of an individual's ACEs when using the ACEs questionnaire (e.g., an ACEs score of 4 means that the individual has indicated 'yes' to 4 of the questions in the ACEs questionnaire).

While the intentions behind this application may include spreading awareness of ACEs and supporting people who have experienced ACEs, there are several reasons why NACCHO does not recommend using the ACEs questionnaire for individual-level screening or in ACEs education curriculum.

The ACEs Questionnaire is not a validated screening tool and does not meet the standards for use as a preventative care screening tool. Further, the tool has not been adequately researched to determine its appropriate administration.[8,9] While a high ACEs score *could* warrant referrals to a wide range of services (e.g., family services, grief counseling, behavioral health skills training, education on health risk behaviors), there is no evidence-based cut-off score to use for determining next steps or the most effective referral pathway for someone with a high ACEs score. Providing mental health resources as a follow-up to administering an ACEs questionnaire is common practice, but mental health resources aren't always warranted or wanted by the client. At this time, there is not sufficient research on appropriate, effective protocol to respond and or/intervene to ACEs Questionnaire responses.[9,10]

The ACEs Questionnaire is not a diagnostic tool. It can not be used to diagnose a mental health or physical health condition.

The ACEs Questionnaire is not a reliable predictor for individual-level health outcomes. Though ACEs have a a dose-relationship to negative health outcomes, the questionnaire is unable to predict health outcomes at the individual level.[8] What does this mean? While ACEs may be predictive across a population, the long-term impact of childhood adversity for an individual may be influenced or mitigated by other factors, such as positive childhood experiences[11].

The ACEs Questionnaire is not an exhaustive or comprehensive way to measure childhood adversity.

Questions are focused on family-based adversity and do not account for community- or societal-level adversity (e.g., discrimination, neighborhood violence, lack of safe or accessible housing). Community- and societal-level adversity also play a critical role in individual and population health outcomes.

Questions do not assess frequency, severity, or chronicity of each adverse event.[8] For example, an individual receives an ACEs score of 1 for abuse whether the individual's experience of abuse was repeated and long-term or a single incident event. Everyone's experience of adversity is different. Frequency, chronicity, and severity and a whole host of other variables, such as the availability and response of supportive networks following an adverse event, may contribute to trauma-related responses, diagnoses, outcomes, and treatment needs.[12]

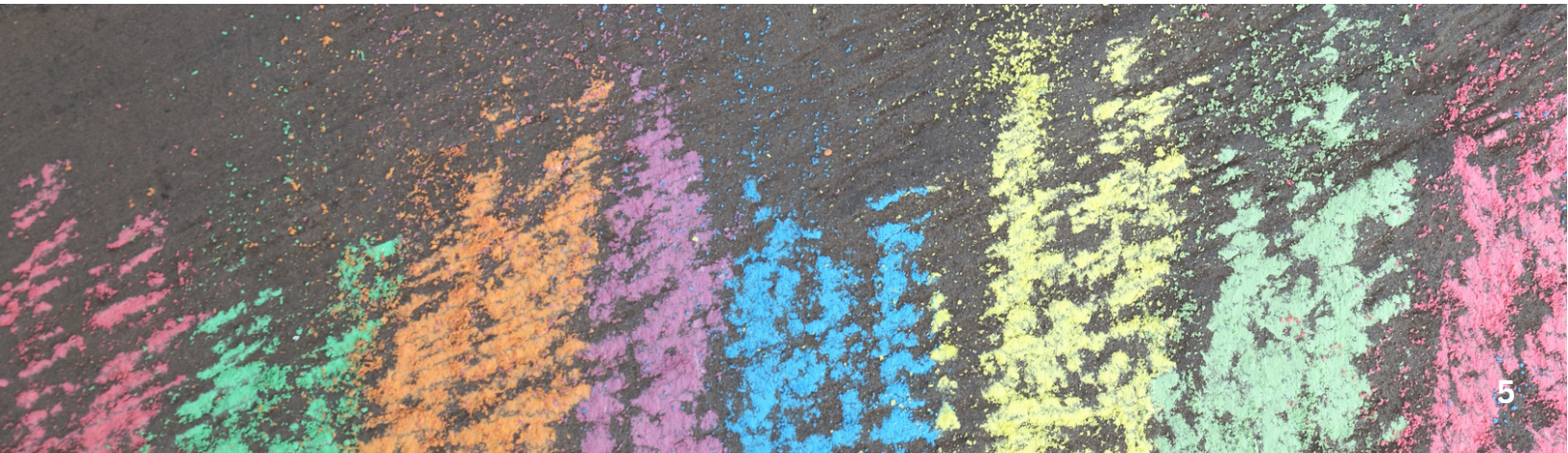
The ACEs Questionnaire is not a self-help quiz.

While educating the community on the ACE Study or the impact of ACEs may be an important step in ACEs prevention efforts, encouraging community-members to complete the ACEs Questionnaire as part of this education or on their own time does not align with the questionnaire's intended use and has the potential to cause harm.

What are the potential harms of using the ACEs questionnaire?

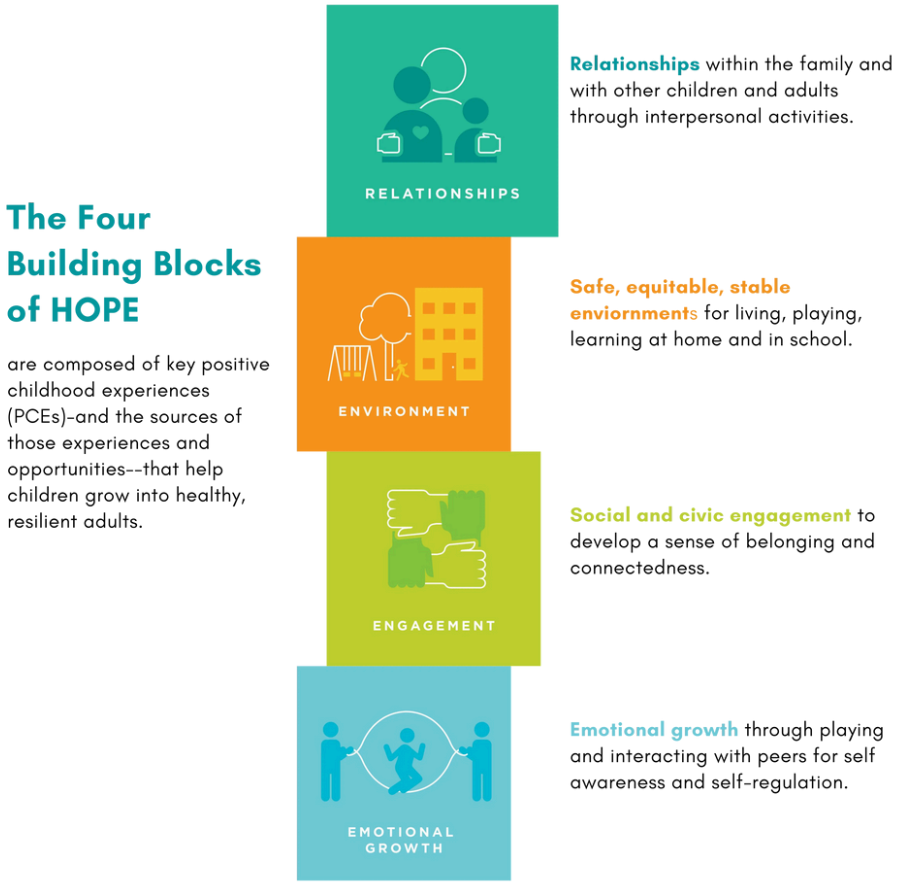
Because of the limitations of the ACEs questionnaire detailed above, using the ACEs Questionnaire as a screening tool or distributing it to the community as a part of ACEs education efforts could:

- Be distressing, retraumatizing, and/or stigmatizing to respondents.[8,10,13]
- Negatively impact the patient-provider relationship.[10]
- Lead to distressing misconceptions amongst respondents, i.e., *something's wrong with me*, and *I'm doomed*.[13]
- Lead to over- or under-referring to services and resources with incomplete information of individuals' current needs.[8]
- Negatively impact the LHD-community relationship. Communities may lose trust in LHD efforts when public health tools are misapplied or used without adequate justification.
- Limit the LHD's understanding of the community. Asking about ACEs without also assessing protective factors or positive childhood experiences (PCEs) provides a deficit-centered perspective on an individual/community's experience.



What are positive childhood experiences (PCEs)?

PCEs are factors or experiences in childhood or youth that promote healthy development and mitigate the impact of ACEs.[14] Findings in recent studies on the impact of PCEs support the use of PCE-related questions as a tool to understand child and family context through a strengths-based lens.[11,14] Shifting to an approach that centers PCEs in data collection and in interactions with individuals/families can circumvent the potential harms of utilizing the ACEs Questionnaire and root ACEs prevention efforts in an asset-focused framework rather than deficit-focused one. The infographic below from the Healthy Outcomes from Positive Experiences (HOPE) National Resource Center identifies four broad categories of key PCEs.



Healthy Outcomes from Positive Experiences (HOPE) National Resource Center. *The Four Building Blocks of Hope.* Retrieved form https://positiveexperience.org/resources/

The recommendations on the following pages highlight opportunities to incorporate PCE-related questions whenever possible.

Recommendations for Data Collection, Screening, and Education Related to ACEs

Purpose	Recommended Practices

Engage in population health surveillance.	• Incorporate PCE-related questions into local data collection plans to gather data on the continuum of childhood experiences, which can provide information about existing factors that may mitigate ACEs in the community. See the Healthy Outcomes from Positive Experiences (HOPE) Four Ways to Assess for Positive Childhood Experiences resource for more information.
	• Consider alternative data sources below. However, if choosing to use the ACEs questionnaire, limit its use to coordinated population health surveillance efforts
	  ◦ With detailed data collection plans
	  ◦ In a trauma-informed setting with on-site mental health support and access to appropriate linkages to care.

Use other data sources to understand the local burden of ACEs.	• Collect or utilize existing data related to ACEs risk factors at the community-level, such as:
	  ◦ Family poverty rates
	  ◦ Unemployment rates
	  ◦ Information on food access
	• Collect or utilize existing data related to ACEs protective factors at the community-level, such as:
	  ◦ Access to high-quality preschool
	  ◦ Strong community partnerships
	  ◦ Access to safe, stable housing
	• Utilize existing proxy data at the community-level, such as:
	  ◦ Child protective services data
	  ◦ Local service utilization
	• Local incarceration rates
	• Utilize state-level BRFSS data

Purpose	Recommended Practices
Screen for needs related to individual and family social determinants of health, which can increase the likelihood of ACEs exposure.	• Seek to understand individual and family economic challenges and basic needs, such as: • Housing and food security • Financial stability • Health Insurance status • Encourage staff in clinical settings to incorporate the Health-Related Social Needs Screening Tool into their practice. • Develop a process by which individuals and families are connected to the appropriate resources in a timely and efficient manner, such arranging caseworker availability for warm handoffs in clinical settings or maintaining up-to-date local resource lists. • Screen only for identified needs that have available and accessible resources for meeting such needs. If resources are not available to meet specific needs, do not screen for these needs. • Incorporate questions related to PCEs into interactions with children and families to understand the family context and set a foundation for strengths-based problem-solving around family needs.
Screen for mental and behavioral health needs, which can be potential outcomes of ACEs exposure.	• Use validated screening and assessment tools in the appropriate settings. The following resources and databases include several options: • National Child Traumatic Stress Network All Measure Review webpage • U.S. Department of Veteran's Affairs Trauma and Stressor Exposure Measures webpage • Chapter 4: Screening and Assessment in SAMHSA's TIP 57 Trauma-Informed Care in Behavioral Health Services • Ensure that referrals and interventions to meet the identified needs are available and accessible before employing these tools.

Purpose	Recommended Practices
Educate community members or internal staff on ACEs.	• Provide information about the continuum of childhood experiences, including PCEs. • Provide the most important findings from the ACEs studies rather than the ACEs Questionnaire items themselves. • Avoid providing details about the ACEs questionnaire items in your curriculum. Even a slide showing ACEs questionnaire questions can distract from the content and tempt the learner to privately respond to the items, effectively giving themselves an ACEs score. • Emphasize the way in which this information can be used for prevention efforts.

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