Child & Youth Mental Health & Substance Use (CYMHSU) Community of Practice (CoP) Webinar Series

ACEs 101: Part 1
An Introduction to Adverse Childhood Experiences (ACEs) in Primary Care

Presented by Dr Linda Uyeda
Facilitated by Dr Rob Lehman & Dr Shirley Sze

Questions & Answers

Question **Many parents who have experienced multiple ACEs have barriers in engaging with some of the community supports around parenting. How do you address those barriers? (e.g. I have recommended Confident Parents to many parents but only the families who have fewer social vulnerabilities are able to access it.)**

Answer Shame, mistrust and unfortunately poverty are frequent outcomes of multiple childhood traumas. As a caring health provider, you may be one of the only people around them that they trust. Your ability to help in a trauma-informed context is huge. It will be rejected, however, unless it is gently offered on their own terms when they are ready – that is, be patient.

By focusing on the relationship we have with the parents and gaining their trust, this will allow people to feel emotionally prepared to engage - when they are ready. This work can leave people feeling very vulnerable and it is important that they feel safe first. I believe this is where programs - i.e. Touchpoints - can really help us build this foundation.
In addition, if there are positive parenting resources in your community that you have experience with, you can provide a warm hand-over (phone introduction) for the patient. In some communities, these resources are listed on Pathways BC.
However, the main emphasis continues to be your ongoing connection and support for those vulnerable parents and take advantage of those opportunities to connect in the PN check-up, the well-baby checks, etc. Offering the parents the option to do some more education on their own with the Brain Story program may be helpful. For those without computer access, the local public library can assist.

Question **Thinking at more of a population or systems level, will the information you send out have some sort of key competencies list for physicians to achieve first before doing ACEs history-taking with the questionnaire? (e.g. Brain Story, neuroscience, epigenetics model basis, trusting relationship, understanding the limits of evidence, embodying resilience, etc.) or will that come out in ACEs 102?**

Answer The new GPAC Guidelines coming in Spring really emphasize the need for universal precautions around ACEs since the majority of our patients and healthcare providers have been impacted to some degree. It is really about the relationship-based continuity of care, the understanding and practice of trauma-informed care even in the design of the office space, the staff you hire, and the communication approach.
Also, we need to be aware of cultural safety and humility. There are online communication workshops that can assist in all of the aspects discussed here.

ACEs 101: Part 1
An Introduction to Adverse Childhood Experiences (ACEs) in Primary Care

Presented by Dr Linda Uyeda
Facilitated by Dr Rob Lehman & Dr Shirley Sze

Question **Why the long delay from the study back in 1998 to now in 2020? Why has this not spread to medical practitioners earlier on?**

Answer I believe that this information has been trickling very slowly into frontline workers however the BC CYMHSU Collaborative did help to bring it to the forefront in BC. Alberta has been years ahead of us as we see with the Palix Foundation and their creation of programs like the Brain Story.

I had heard about this information in multidisciplinary conferences as far back as the early 2000s, but it was aimed more at psychologists and counselors and less so at physicians. Recent documentaries and advocacy efforts by individuals (i.e. Dr Nadine Burke Harris) in the US along with others have also helped to elevate the awareness of ACEs. The two ACES conferences designed by our Collaborative and the CYMHSU Community of Practice have raised this profile in our province. We hope to further increase awareness with the release of the Provincial ACEs Guidelines this Spring along with the PSP small group learning sessions on ACEs and trauma-informed practice.

According to Dr Vincent Felitti who did the initial study, when this was presented, it was met with resistance as with any new and “surprising” information similar to “H pylori is a causative factor in gastric ulceration”. However, further research studies over the years have continually validated the initial landmark study.

Question **Is there an effort to ensure this is covered in medical schools across the country?**

Answer I believe this is coming. I know UBC has expressed some interest in sharing this information with medical students and residents however we are not sure how formalized this is at this point. Individually, this is being taught to Family Medicine Residents and students on a local level at varying rates. However, more work needs to be done to get entry into the entire Undergraduate and Postgraduate curriculum since ACEs impact all of health.

Question **How do you frame the reason why you are asking these questions in history-taking?**

Answer a) Selective or universal
b) Get permission to ask – It is incredibly important if you are asking the questions to explain the reasons why and have the back-up resources (i.e. parenting support, credible counsellors, trauma-informed services) if the ACES questionnaire reveals areas that may need follow-up which is, in experience less than 10% of cases in adults.
c) Ensure understanding and provide information that past adversity can impact health – soft approach

Question **How do you gather information in a sensitive way in patients that you surmise as having significant trauma in the past?**

Answer Be aware of the way you present – tone of voice, body posture – it is really important to have a strong trusting RELATIONSHIP. *(Answer continues on next page…)*

ACEs 101: Part 1
An Introduction to Adverse Childhood Experiences (ACEs) in Primary Care

Presented by Dr Linda Uyeda
Facilitated by Dr Rob Lehman & Dr Shirley Sze

Be very sensitive if the patient is unwilling to go there and weigh the risk of re-traumatization versus the benefit of enhancing your understanding with the patient in the moment. Always respect the direction that the patient outlines.

A suggestion from one psychiatrist is to ask as part of history-taking as an opener:

- Describe your childhood in one sentence?
- Was there any physical, mental abuse or neglect?
- Was there anything that happened while you were growing up that you think may still be affecting you today?

Question **How do you support the patient once trauma has been uncovered – processing the past versus what is present right now?**

Answer Validate what has happened to the patient and re-direct their perception that there is something wrong with them. Patients with a trauma history are not broken. Their nervous systems were built to help them survive; however, this upregulation of the stress response, may over time, lead to some chronic health conditions if left unchecked.

Generally, in adult patients, this information can enhance their awareness that adversity in childhood may contribute to their present state of health. The good news is that having a history of trauma is not a life sentence and does not automatically mean that chronic health problems are immutable. Evidence is telling us that we have the capability to learn new skills to change the long-term effects of trauma. Many people have sought different ways to deal with their past trauma.
For those that are severely impacted and continue in the cycle of trauma, one needs to support them unconditionally either through counseling within your own competencies or connecting the patient to credible practitioners in the community.

Be familiar with your trauma-informed community resources if you do not feel comfortable supporting the patient on your own (e.g. community counsellors, online resources, psychiatrists, psychologists, etc.)

Question **How do you deal with present trauma disclosure from youth?**

Answer The ACE Questionnaire is not meant to be a tool for youth and children at this time in BC although there are some pediatricians using it in limited ways.

a) Keep in mind we do have a duty to report if there is significant danger uncovered in their histories.
b) If mild to moderate adversity exists, we can support by modelling a healthier relationship (with you or with known counsellors or therapists), by referring them on to appropriate services, and by supporting the youth by decreasing the load of adversity if possible.

ACEs 101: Part 1
An Introduction to Adverse Childhood Experiences (ACEs) in Primary Care

Presented by Dr Linda Uyeda
Facilitated by Dr Rob Lehman & Dr Shirley Sze

Question **How does one do this work (i.e. self-reflection and awareness) effectively?**

Answer In most cases you have already established a long-term provider/patient relationship with increasing rapport and trust.
This is really about learning about the powerful relationship between childhood adversity and an increase in risky behaviours/unhealthy lifestyle choices as well as the physiological effects of a chronic stress response on chronic illness and a decrease in life span.
You are doing this work when this information is added to your helping relationship in educating your patients in a gentle manner and helping them to focus on their strengths and resilience.

Be open to reflecting on our own upbringing as well as the trauma which may have been experienced by our parents and grandparents. Our own trauma and attachment histories will play a part in how we interact with our patients.

Question **When is the best time to use the ACEs questionnaire?**

Answer Again, within the context of a trauma-informed approach, if you are seeing emotional or physiological reactions that cue you to a probable history of trauma (remember 65% of us have had a least one childhood adversity on the 10 item list) the ACEs questionnaire can be a helpful adjunct to your inquiry on their history.

If one chooses to do it, it should be done in the context of a safe and trusting relationship as part of history-taking and supports need to follow if trauma is uncovered.

In terms of playing a significant preventative role, using the questionnaire during antenatal care and providing supports to parents can impact the transmission of ACEs to the next generation which we have seen in the work we do. There are clinic groups in Alberta that screen ACEs at the 2nd antenatal visit and provide supports and resources and Perinatal Services BC has done a pilot project with 5 – 6 antenatal practices in BC. All these groups noted that the patients did not experience harm with the use of the ACEs questionnaire in a setting where the reasons for doing so were explained, and patients were made aware of supportive resources.

Question **How do I use the ACEs Questionnaire?**

Answer The ACEs Questionnaire is one tool and we are not recommending that everyone **has** to use it.
I (Dr Uyeda) work in a setting where trauma scores are known to be quite high. In this setting, trauma is assumed, and we do not administer the ACEs Questionnaire. We employ trauma-informed practice with everyone and if patients are ready, we provide education on how early trauma may impact present health. Along with this education, we help patients build new skills to face current challenges.

However, if you feel comfortable with your patient and have the supports in your community to follow through, you may mention to them that there is a history-taking tool that may be helpful in understanding some of their symptoms. This may be particularly useful in situations like antenatal care where trauma-informed practice may be critical to preventing transmission of ACEs. Even still, you would need to ask permission to administer the questionnaire. *(Answer continues on next page…)*

ACEs 101: Part 1
An Introduction to Adverse Childhood Experiences (ACEs) in Primary Care

Presented by Dr Linda Uyeda
Facilitated by Dr Rob Lehman & Dr Shirley Sze

The questionnaire can be administered in various ways. Most suggest that the physician explain the rationale for taking the additional history of past trauma, ask the patient whether they are willing to compete the questionnaire with the option to decline at any time, and then the patient can do it on their own and report just the number or present the completed questionnaire to the family physician.
When patients have literacy issues, if they are interested in providing the additional history, the physician may need to work with the patient to complete the questionnaire. It is entirely up to the patient whether they want to talk about their past ACEs. The physician's role is to validate, listen, and empathize with what has happened and continue to support the patient in providing any additional assistance they may require to heal. With adult patients, what has happened is past, we cannot "fix" it. However, as physicians, we can continue to provide that supportive relationship to the patient for their healthcare needs and help them focus on resilience factors in their lives.

In Summary:

The ACEs Study gave us important information about how trauma may be carried forward with us for decades. We can employ a trauma-informed practice approach with all of our patients even without having to administer the ACEs Questionnaire.
It is also important to know how to administer the questionnaire if you choose to use it. The questionnaire is not meant to be administered verbally but in a setting where the patient may score themselves without disclosing exactly which traumas occurred.

The science of ACEs has provided us a way to understand how we can promote development in our children by helping to break transgenerational cycles of adversity. As care providers, we can use this knowledge:
1) To influence government and policy makers to encourage and facilitate prevention;
2) To address current health problems by encouraging patients to engage in self care and trauma specific healing; and
3) To break the cycle by encouraging patients to take parenting courses and individual counselling for their own healing and for the healing of their families.

Question **What are the pieces that ACEs misses?**

Answer The 10 items in the questionnaire cover a wide range of adversities. As Dr. Felitti has stated, other questions on other areas may also be asked but it was found that the results of identifying adversity and its severity were essentially the same with different questions.

The ACEs Questionnaire was a collection of the top 10 adversities obtained by the 1998 study. There are many other types of trauma not included in the questionnaire. The same experience may be traumatic for one person and not traumatic for another, so it is important to recognize what the event meant to the individual. We should also be open to taking a look at attachment theory (and insecure attachment) and what chronic emotional responses were experienced in the family of origin. Some people may have an ACE score of 0 but a history of insecure attachment which may also put them at increased risk of mental and physical health problems as well as relationship difficulties.