Screening for ACEs

ACEs hub

What is screening?

Screening for adverse childhood experiences (ACEs) refers to using a questionnaire or interview during routine healthcare appointments to gather information about a person's exposure to adversity before age 18.

The ACE Questionnaire is often used for ACEs screening, and there are many other tools that assess additional types of adversity or focus on a narrower set of experiences. All assessments have strengths and weaknesses. Importantly, many tools being used for ACEs screening were not designed to be used as screening tools, so their use for this purpose remains controversial.

How is screening used?

ACEs screening is used in two main ways.

First, practitioners may collect a patient's ACE history to help them better understand how the patient is doing, what may be contributing to their health concerns, and how to best support their well-being. For example, learning that a patient has a high ACE score could help a practitioner understand factors that may contribute to problems with substance use. Gathering an ACE history can increase practitioners' awareness of how common ACEs are and encourage the use of trauma-informed approaches with all patients. It can also increase empathy and compassion for patients with health concerns that are often stigmatized.

Second, ACEs screening has been used more deliberately to help decide what supports or referrals a patient may need. In the most extreme case, a certain ACE score may be used to decide whether a patient will receive specialized care. This practice can increase awareness of ACEs, encourage the use of trauma-informed care, and help create personalized treatment plans.

Evidence for screening

Research across different healthcare settings suggests that asking about childhood adversity is generally practical and acceptable to both patients and providers.[1]

It is important that **trauma-informed approaches** are used when asking patients about their trauma history and that screening is only used when appropriate resources and referral pathways are available.[2] However, there is limited and inconclusive evidence about whether ACEs screening improves patient outcomes or may cause harm. Several systematic reviews, which bring together findings from the available research, have concluded that the current evidence does not support routine ACEs screening.[1,3,4]

Related Resources:

- Trauma-Informed Care
- ACEs Prevalence

Arguments for screening

- ACEs are very common (60% of individuals have 1 or more ACEs)[5] and early identification may help to prevent further adversity or reduce its impacts.
- ACEs are associated with a range of poor outcomes that affect health, well-being, and quality of life, so there may be important benefits to universal screening.
- ACEs screening may support tailored and personalized care, may reduce healthcare costs, and can strengthen patient and practitioner relationships.
- ACEs screening may help interrupt cycles of adversity across generations.

Take-home message

Although asking about ACEs is generally well-received by both practitioners and patients, we do not know enough about the benefits and potential harms of universal screening. Many experts do not currently recommend ACEs screening as part of routine practice.

Practitioners are encouraged to provide trauma-informed care to everyone. This d oes not mean assuming that everyone has experienced childhood adversity or trauma. Rather, it means recognizing that everyone has a unique history that shapes their health and well-being, and creating care that is safe, respectful, and responsive to each person. It also means giving people control over what they disclose and ensuring that appropriate supports are available when someone does share experiences of adversity.

Arguments against screening

- The ACE Questionnaire was not designed to be an individual-level diagnostic tool.[6] It was designed as a public health tool to help researchers understand how childhood adversity is related to health across large groups of people, rather than to predict the health of an individual person. Studies show that ACEs are a poor indicator of later mental and physical health outcomes for any one individual.[7]
- Many measures do not consider when an adversity happened, how long it lasted, or how severe it was. Therefore, two people with the same ACE score can have very different levels of risk that an ACE score may not capture. That is, a person with a low ACE score may be experiencing more severe or ongoing stress and be in greater need of support than someone with a higher ACE score.
- Asking about traumatic experiences can be distressing or potentially re-traumatizing, especially if the practitioner is not adequately trained in trauma-informed care or if access to support services is limited.
- ACE scores could potentially lead to stigma or discrimination depending on how the information is used.

Further reading in support of screening

ACEs Aware. (2021). Why Should My Practice Screen for Adverse Childhood Experiences and Risk of Toxic Stress? Retrieved from https://acesaware.org/resources

Gordon, J., & Felitti, V. (2023). The Importance of Screening for Adverse Childhood Experiences (ACE) in all Medical Encounters. *AJPM Focus, 2*(4), 100131. https://doi.org/10.1016/j.focus.2023.100131

Further reading advising against screening

Austin, A. E., Anderson, K. N., Goodson, M., Holditch Niolon, P., Swedo, E. A., Terranella, A., & Bacon, S. (2024). Screening for adverse childhood experiences: A critical appraisal. *Pediatrics, 154*(6), e2024067307. https://doi.org/10.1542/peds.2024-067307

McLennan, J. D., MacMillan, H. L., Afifi, T. O., McTavish, J., Gonzalez, A., Waddell, C. (2019). Routine ACEs screening is NOT recommended. *Paediatrics & Child Health, 24*(4), 272-273. https://doi.org/10.1093/pch/pxz042

McLennan, J. D., Gonzalez, A., MacMillan, H. L., & Afifi, T. O. (2025). Routine screening for adverse childhood experiences (ACEs) still doesn't make sense. *Child Abuse & Neglect, 168*(1), 106708. https://doi.org/10.1016/j.chiabu.2024.106708

Sherin, K. M., Stillerman, A. J., Chandrasekar, L., Went, N. S., & Niebuhr, D. W. (2022). Recommendations for population-based applications of the Adverse Childhood Experiences Study: Position statement by the American College of Preventive Medicine. *AJPM Focus, 1*(2), Article 100039. https://doi.org/10.1016/j.focus.2022.100039

References

1. Gentry, S. V., & Paterson, B. A. (2022). Does screening or routine enquiry for adverse childhood experiences (ACEs) meet criteria for a screening programme? A rapid evidence summary. *Journal of Public Health, 44*(4), 810-822. https://doi.org/10.1093/pubmed/fdab238
2. Racine, N., Killam, T., & Madigan, S. (2020). Trauma-informed care as a universal precaution: Beyond the Adverse Childhood Experiences Questionnaire. *JAMA Pediatrics, 174*(1), 5-6. https://doi.org/10.1001/jamapediatrics.2019.3866
3. Cibralic, S., Alam, M., Mendoza Diaz, A., Woolfenden, S., Katz, I., Tzioumi, D., Murphy, E., Deering, A., McNamara, L., Raman, S., & Eapen, V. (2022). Utility of screening for adverse childhood experiences (ACE) in children and young people attending clinical and healthcare settings: A systematic review. *BMJ Open, 12*(8), e060395. https://doi.org/10.1136/bmjopen-2021-060395
4. Loveday, S., Hall, T., Constable, L., Paton, K., Sanci, L., Goldfeld, S., & Hiscock, H. (2022). Screening for adverse childhood experiences in children: A systematic review. *Pediatrics, 149*(2), e2021051884. https://doi.org/10.1542/peds.2021-051884
5. Madigan, S., Deneault, A.-A., Racine, N., Park, J., Thiemann, R., Zhu, J., Dimitropoulos, G., Williamson, T., Fearon, P., Cénat, J.M., McDonald, S., Devereux, C., & Neville, R.D. (2023). Adverse childhood experiences: A meta-analysis of prevalence and moderators among half a million adults in 206 studies. *World Psychiatry, 22*, 463-471. https://doi.org/10.1002/wps.21122
6. Anda, R. F., Porter, L. E., & Brown, D. W. (2020). Inside the adverse childhood experience score: Strengths, limitations, and misapplications. *American Journal of Preventative Medicine, 59*(2), 293-295. https://doi.org/10.1016/j.amepre.2020.01.009
7. Baldwin, J. R., Caspi, A., Meehan, A. J., Ambler, A., Arseneault, L., Fisher, H. L., Harrignton, H., Matthews, T., Odgers, C. L., Poulton, R., Ramrakha, S., Moffitt, T. E., & Danese, A. (2021). Population vs individual prediction of poor health from results of adverse childhood experiences screening. *JAMA Pediatrics, 175*(4), 385-393. https://doi.org/10.1001/jamapediatrics.2020.5602

ACEs hub

aceshub.org