DRAFT for External Review:

Adverse Childhood Experiences (ACEs) and Trauma-Informed Practice

Link to online survey: https://survey.health.gov.bc.ca/ACES

Scope

This guideline provides recommendations to primary care practitioners providing care to patients of all ages impacted by adverse childhood experiences (ACEs). It offers three strategies to address ACEs in primary care: trauma-informed practice, directed history-taking, and use of the ACEs Questionnaire as a history taking tool. It offers strategies to provide support and help patients build resilience. Trauma-specific diagnosis and treatment (e.g. assessment and management of post-traumatic stress disorder) are out of scope.

Key Recommendations

- Use universal precautions by recognizing and respecting the high prevalence of trauma and the many ways that trauma can be experienced.
- Prepare for the needs of a traumatized person by approaching all patients with compassion and understanding.
- Use “I” statements and emotional language to validate patients’ feelings.
- Identify patients’ strengths and build on them.
- Consider integrating the ACEs questionnaire as part of comprehensive history taking. It is not a screening tool.
- Ask questions about traumatic experiences strategically and transparently.

Definitions

- **Adverse childhood experiences (ACEs) questionnaire**: a questionnaire asking about ten specific experiences of emotional, physical, or sexual abuse and neglect, and household dysfunction before age 18 (Appendix A): emotional, physical and sexual abuse; having one’s mother treated violently, substance abuse and mental illness at home, parental separation or divorce, having an incarcerated household member, emotional neglect, and physical neglect. One point is assigned to each question answered “yes” and the total represents an individual’s ACE score.

- **Trauma**: In this guideline, trauma refers to the psychological effects of a life event that is out of an individual’s control and overwhelms an individual’s capacity to cope. Trauma has serious long term mental, emotional, spiritual, physical and behavioural impacts. There are several types of trauma. This guideline will focus on developmental trauma (trauma that occurs while the brain is still developing), which includes ACEs.

- **Trauma-informed practice**: a strengths-based approach to interactions with patients that acknowledges the conscious and unconscious impacts of trauma on health and functioning, and emphasizes safety, choice, collaboration and trust. Challenging behaviours are recognized as previously adaptive coping strategies to survive past and current stress, and may now interfere with healthy functioning.

- **Resilience**: the ability to cope, heal and thrive despite adversity.

Background

Adverse childhood experiences (ACEs) including childhood abuse, neglect, and household dysfunction are risk factors for many of the leading causes of disease, death, disability, poor health, and other social problems in adults. The relationship between ACEs and adult health was first established in a landmark study that assessed ACEs using a
questionnaire.

People who experience ACEs without adequate support develop patterns of adaptive and physiological disruptions that interfere with neurodevelopment, impede executive function, self-regulation and healthy attachment, and compromise health over the lifespan. When the developing brain experiences chronic and pervasive stress over time, cortisol dysregulation can lead to adaptive physiological responses including impaired stress reactivity, impaired brain development (structure and circuitry), impaired immune function, infection, hypertension, cardiovascular disease, and other chronic diseases. Refer to Appendix B: Developmental Impact of ACEs for more information.

The ACE score has an independent, cumulative, dose-response relationship with chronic disease, mental health conditions, problematic substance use, health-risk behaviours, and frequent medical visits. ACEs are common among all demographic and socioeconomic groups. Two-thirds of people report at least one ACE. One in ten people report ≥4 ACEs. They are also highly interrelated: exposure to one ACE increases the probability of exposure to a 2nd ACE by 87%. As the number of ACEs in a person’s history increases, so does the risk for the following causes of death and poor health:

Table 1. Adult negative health outcomes associated with having a history of adverse childhood experiences (ACEs)

<table>
<thead>
<tr>
<th>Health problems</th>
<th>Social problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic heart disease</td>
<td>Depression</td>
</tr>
<tr>
<td>Respiratory disease, e.g. Chronic obstructive pulmonary disease</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Cancer</td>
<td>Suicide attempts</td>
</tr>
<tr>
<td>Gastrointestinal disease</td>
<td>Concurrent mental health conditions and substance use disorders</td>
</tr>
<tr>
<td>Headaches</td>
<td>Substance use disorders: alcohol, tobacco, stimulants, opioids</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>Obstetrical complications (refer to p. 5)</td>
<td>Borderline personality disorder</td>
</tr>
<tr>
<td>Fracture</td>
<td>Challenges at work and school</td>
</tr>
<tr>
<td>Somatic pain</td>
<td>Intimate partner violence</td>
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<tr>
<td></td>
<td>Sexual violence</td>
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<td></td>
<td>Unintended pregnancy</td>
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<td></td>
<td>Poor quality of life</td>
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<tr>
<td></td>
<td>Psychological distress</td>
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<tr>
<td></td>
<td>Being a victim of violence</td>
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<td></td>
<td>Low socioeconomic status</td>
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</tbody>
</table>

Other causes of developmental trauma

ACEs are not the only source of developmental trauma. Many other experiences of psychological, spiritual, physical, social and emotional trauma (both commission and omission) can significantly impact health and wellbeing, e.g. family separation, being in foster care or having a child in foster care, racism, colonisation and cultural dislocation, war, and torture. An event that one person experiences as traumatic may not be traumatic for another. The impact of the event depends on the individual’s resilience, support system, and available resources.

Problematic substance use is a very common response to trauma, as an attempt to cope with stress and numb negative emotions.

Benefits of addressing ACEs and other developmental trauma in primary care

Traumatic experiences impact the health, wellbeing and functioning of many patients who present to primary care. Addressing sources of mental and physical stress is important in preventing negative health outcomes. Addressing ACEs in the primary care setting can:

- provide a supportive and healing longitudinal relationship for safe attachment
- improve the quality of patient interactions
- help practitioners and patients gain a better understanding of underlying causes of physical and mental health problems and develop more effective treatment plans
- reduce stigma, by demonstrating that the practice is a safe and non-judgmental environment
- address suffering
Primary care practitioners who demonstrate that they are comfortable and willing to acknowledge difficult topics, and believe in their patient’s ability to make positive changes, are better able to support their patients to improve their well-being, address past experiences, and give hope for the future.21

**Asking, listening, and accepting is itself an intervention that can support patient health outcomes and promote healing and recovery.**10,22,23 Primary care providers are ideally suited to addressing ACEs in practice because of the longitudinal, supportive, therapeutic relationship inherent to primary care practice.

## How to address ACEs in primary care

The following strategies have been developed to support all patients seen in primary care practice. Three core approaches to addressing ACEs in primary care are:

- trauma-informed practice,
- directed history-taking, and
- use of a standardized questionnaire to determine a summary (de-identified) score.20

### Trauma-informed practice

Trauma-informed approaches are not based on disclosure of traumatic experiences.24 The aim is to build a relationship of trust between patient and provider where the patient feels safe to rebuild a sense of control and empowerment. This approach benefits all patients regardless of their trauma history and should be offered as a universal precaution. Trauma-informed practice should be adopted consistently by all staff who interact with patients. Without this approach, patients may experience healthcare encounters as retraumatizing and triggering.6

**To adopt a trauma-informed approach:**

- Focus on empathetic listening, rather than problem solving.
- Be mindful of body language.
- Connect before you redirect.
- Emphasize choice and collaboration.
- Identify patients’ strengths and build on them.
- Provide brief education about the relationship between life and physical and mental health.20
- Reframe perceptions of challenging behaviours (reactivity, intense emotion, irritability). They are often rooted in adaptive but unhealthy coping strategies,10,24,25 represent attempts to regain choice and control, and indicate that there is a communication problem that needs to be addressed.
- Use motivational interviewing techniques, such as active listening, validation, compassion, acceptance and evocation as a means to address any discord in communication between care provider and patient.
- Ask permission before physical exams. Explain what will happen in advance.25,26

Refer to Appendix C (Practitioner Resources) and Appendix D (Avoiding Practice Traps) for further support.

### Directed history-taking

“Because abuse and violence are common and can affect a person’s health, I make a point to ask patients if they have ever had these experiences.”

Incorporate direct, open-ended questions about trauma into routine history taking.20,27 Understanding the patient’s trauma history can help the practitioner understand how trauma may impact the patient’s life.24 Understanding the connection between trauma and health can help the patient understand how trauma may impact their own life.

1. Ask permission, open a brief conversation and explain why you are asking. You can also inquire about specific experiences by asking about some or all of the ten ACEs (or other experiences) verbally. A detailed history is not
required. Consider keeping a mental tally of the ACE score as the patient discloses. More information may come out over time.

2. Validate and acknowledge past trauma by asking and using “I” statements. Ask questions about how this may impact the present. The responses may help identify the support the patient needs. Do not minimize or compare traumas or give trite solutions. Refer to Appendix E: Validating and Invalidating Statements and Curious Questions for conversation scripts.

- Collect a summary (de-identified) ACE score

Purpose and considerations:

The ACEs Questionnaire (Appendix A) should be viewed as a history-taking tool for understanding how past experiences may impact an individual’s health. Understanding ACEs can empower patients to make changes for themselves, their children, and their families. Use a trauma-informed approach to all conversations about ACEs.

Routine, universal assessment of ACEs is acceptable to most patients regardless of their trauma history.28–32 Generally, in adults, ACEs history taking only needs to happen once. Use clinical judgment to choose whether to approach the questions once a relationship has been built. Patients who are reluctant to disclose at first may be more forthcoming over time. Asking the question(s) shows your interest and may encourage the patient to disclose in future. Remember that patients with an ACE score of zero may still have experienced significant traumatic experiences (refer to Other Causes of Developmental Trauma on page 2).

Consider introducing the ACEs questionnaire with patients in the following encounters:

- preventative health visits: immunization, sexual health care
- follow-up for chronic disease management (physical or mental health conditions, substance use disorders)
- prenatal care
- any time comprehensive history taking is performed

ACEs history taking should not take place during acute visits.

Steps to follow when you introduce the ACEs questionnaire:

1. Before providing the questionnaire, explain the purpose of ACEs assessment and ask permission: e.g. “I have some questions of a sensitive nature. May I have your permission to ask them today?” Let the patient know they do not have to answer questions they are not comfortable with, and their responses will be kept confidential.

2. The ACEs questionnaire takes about 2-5 minutes to complete. The practitioner can administer it in the following ways:
   - give to patient to complete in private after they are brought into the exam room
   - give to patient to complete at home and bring to their visit

Example of an “I” statement and curious question:

“I can understand that must have been really hard. How do you think what happened to you back then may be affecting your life now?”

Adverse Childhood Experiences Questionnaire

Refer to Appendix A for printable handout.

Prior to your 18th birthday:

Did a parent or other adult in the household, often or very often:

1. Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?
2. Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

Did an adult or person at least 5 years older than you ever:

3. Touch or fondle you or have you touch their body in a sexual way? or attempt or actually have oral, anal, or vaginal intercourse with you?

Did you often or very often feel that:

4. No one in your family loved you or thought you were important or special? Or, did your family didn’t look out for each other, feel close to each other, or support each other?
5. You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Was your mother or stepmother:

6. Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
7. Were your parents ever separated or divorced?
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
10. Did a household member go to prison?
3. The patient then provides their total (de-identified) ACE score. A “de-identified score” is the total score. The practitioner does not need to know the answer to each question. It is not necessary to know history/details of the experiences, unless patient indicates an interest in discussing further. The patient’s ACE score is the total number of “yes” responses. Acknowledge the score, provide brief education, validate and acknowledge past trauma, ask “how is this affecting you now?” and offer support (Appendices B and C).

4. The questionnaire can be retained in the patient’s chart or sent home with the patient.

5. Incorporate the ACE score and your understanding of its impact into your ongoing care of the patient.

How to Support Patients Who Have Experienced ACEs

Asking, listening, and accepting is itself an intervention that can support patient health outcomes, and promote healing and recovery.\textsuperscript{22,23,33} The majority of patients will not need specialist referral but would benefit from an ongoing supportive relationship with their primary health care provider.

Identify patients’ strengths and build on them: Consider offering a resilience questionnaire (Refer to Appendix F) and/or building a personalized resource list (Appendix G). Refer to \textit{Adult Mental Health Cognitive Behavioural Interpersonal Skills Tools}.

Employ motivational interviewing techniques to support patients in making changes that improve their own personal sense of well-being.

Pediatric Considerations

Most children seen in family practice will experience, have already experienced, or are still facing ACEs. Caring relationships with supportive adults can build resilience and decrease the impact of toxic stress.\textsuperscript{34}

- Primary care practitioners can support optimal development and health throughout a person’s life course by:

1. Incorporating trauma informed practice and ACEs history taking into pediatric care
   - Using the ACEs questionnaire to obtain a summary score may be more feasible than directed history taking when the whole family is being seen together.
   - An ACEs Self-Report Questionnaire adapted for teenagers is provided in Appendix H
   - As an alternative to the questionnaire, consider asking: “Has anything scary or upsetting happened to your child or your family since the last time I saw you?”\textsuperscript{35,36}

2. Providing support
   - Reinforce what parents are doing well\textsuperscript{34}
   - Identify the child and family’s strengths, especially supportive relationships, and how they can build on them
   - Provide child- and family-friendly brief resources: refer to Appendix E
   - Encourage regular household routines e.g. bedtime, meal times
   - Educate about positive parenting strategies\textsuperscript{34}
   - Be aware of the resources for children and families in your local community such as early years programs, peer-support, and parenting programs\textsuperscript{34} (refer to Appendix C on page 9)
   - When in doubt, consult with the local pediatrics service, COMPASS Line, or RACE Line (Appendix C).

- ACEs are associated with negative health outcomes across all developmental stages:
  - In infancy, ACEs have been associated with growth delay, cognitive delay and sleep disruption.
  - In the school-aged child, there is an increased risk of asthma, infections, ADHD, behavioural difficulties and emotional dysregulation.\textsuperscript{37}
  - In adolescence, there are higher rates of obesity, bullying, violence, substance use and early initiation of
sexual activity.

- ACEs in children are also associated with mental health conditions such as anxiety and depression, developmental and educational delays, poor school engagement, attention and oppositional defiant disorder, and somatic complaints (e.g. headaches, tiredness, stomach problems)

Some items may require additional investigation that may identify details that are reportable.


**Maternity Care Considerations**

Pregnancy is an optimal time to support women to build resilience and improve their health. All new parents can benefit from support and resources to reduce stress and build resilience (refer to Appendix G).

Consider inquiring about trauma and/or discussing ACEs with pregnant patients. Some practitioners have found that this conversation fits well into the workflow of the 18-20 week visit.

Discussing ACEs with pregnant patients and their partners, and providing support, is an opportunity to decrease maternal stress, support preventive health care, and interrupt cycles of intergenerational trauma.

ACEs are associated with prenatal and postpartum depression, excessive weight gain, obstetric complications, preterm birth, intimate partner violence, substance use, avoidance of prenatal care, and psychosocial difficulties including hypervigilance toward the mother’s own health and the health of the baby.
Appendix A: Adverse Childhood Experiences (ACEs) Questionnaire

Self-rating: PLEASE CHECK ALL THAT APPLY USING CIRCLES BELOW

While I was growing up, before I turned 18:

1. A parent or other adult in the household would often swear at me, insult me, put me down, humiliate me, or act in a way that made me fear I would be physically hurt.

2. A parent or other adult in the household would often push, grab, slap, or throw something at me or would hit me so hard that I had marks or was injured.

3. An adult or person at least 5 years older than me touched or fondled me or had me touch their body in a sexual way or tried to or actually had oral, anal, or vaginal sex with me.

4. I often felt that no one in my family loved me or thought I was important or special or that my family didn’t feel close or support or look out for each other.

5. I often felt that I didn’t have enough to eat, had to wear dirty clothes, and had no one to protect me or that my parents were too drunk or high to take care of me or take me to the doctor if I needed to go.

6. I experienced a parental death, separation, or divorce.

7. My mother was often pushed, grabbed, slapped, or had something thrown at her or sometimes kicked, bitten, hit with a fist or something hard, or ever repeatedly hit over at least a few minutes or threatened with a gun or knife.

8. I lived with someone who was a problem drinker or alcoholic or who used street drugs.

9. A household member was depressed or mentally ill or attempted suicide.

10. A household member went to prison.

Write the total number of YES answers: ______________________
Appendix B: Developmental impact of ACEs

ACEs increase the risk of biomedical disease in four ways:

- **Chronic stress impacts development (allostatic load):** Chronic toxic stress in early childhood is mediated by chronic hypercortisolemia and proinflammatory cytokines. This is associated with long term changes in multiple brain circuits and systems, particularly those that affect mood control, social attachment, anxiety, executive function, memory and learning. Therefore, ACEs can negatively health and wellbeing even without the presence of health risk behaviours.

- **Health-risk behaviours as coping strategies:** Behaviours such as problematic substance use and over-eating can provide immediate pharmacological and/or psychological benefit when people are faced with stress and adversity. Over time, chronic “self-medicating” behaviours increase the risk of disease later in life. For example, ACEs --> depression or anxiety --> overeating --> type 2 diabetes --> coronary artery disease.

- **Harmful risk environments:** The environments where people grow up can affect the likelihood and impact of ACEs. Examples include: poverty, stigma, intimate partner violence, colonisation and social marginalization.

- **Intergenerational transmission:** Toxic stress caused by ACEs can influence heritable epigenetic changes, and parenting practices can also be influenced by the parent own ACE history.

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**Figure source:** Trauma-informed – The Trauma Toolkit, Second Edition, 2013 – Klinic Community Health Centre
Appendix C: Practitioner Resources

Rapid Consultation Services

- **RACE (Rapid Access to Consultative Expertise):**
  Provides primary care practitioners with rapid access via phone or app to a wide range of specialist services for patient consults. Calls are returned within 2 hours.

- **Compass:** 1-855-702-7272 available Monday to Friday, 9am to 5pm
  Phone and telehealth consultations for practitioners working with children and youth living with mental health and substance use concerns. The Compass multidisciplinary team can help with diagnostic clarification, medication recommendations, treatment planning, consultation around cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), substance use counselling, behavioural challenges, family challenges, trauma treatment, and general support when things aren't going well. You will receive a written record of all consultation recommendations for the patient's chart.

Continuing Professional Development

- Practice Support Program ACEs module: for small group learning and individual support
- Alberta Youth and Family Wellness: The Brain Story Certification: [https://www.albertafamilywellness.org/training](https://www.albertafamilywellness.org/training)
- ACES Connection: [https://www.acesconnection.com/](https://www.acesconnection.com/)

Pediatrics

- Collaborative Toolbox: a ‘one-stop-shop’ of resources created and curated by members of the BC Child and Youth Mental Health and Substance Use Collaborative: [http://www.collaborativetoolbox.ca/](http://www.collaborativetoolbox.ca/)
- Touchpoints: [https://www.brazeltontouchpoints.org/](https://www.brazeltontouchpoints.org/)
- Stress Health - practical resources for parents to build resilience: [stresshealth.org/what-can-i-do/mindfulness/](https://stresshealth.org/what-can-i-do/mindfulness/)

Trauma-Informed Practice

- Cognitive Behavioural Interpersonal Skills (CBIS) - Indigenous: [pspexchangebc.ca/course/view.php?id=70&section=4](http://pspexchangebc.ca/course/view.php?id=70&section=4)
- BC Trauma-Informed Practice Guide: [bccewh.bc.ca/2014/02/trauma-informed-practice-guide](http://bccewh.bc.ca/2014/02/trauma-informed-practice-guide)
- EQUIP Trauma and Violence Informed Care Workshop and Resources: [https://equiphealthcare.ca/tvic-workshop/](https://equiphealthcare.ca/tvic-workshop/)
- Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services: [samhsa.gov/samhsanewsletter/Volume_22_Number_2/trauma_tip](http://samhsa.gov/samhsanewsletter/Volume_22_Number_2/trauma_tip)
- Complex Trauma Resources for Clinicians: [https://www.complexttuma.ca/clinicians/](http://www.complexttuma.ca/clinicians/)

Indigenous Cultural Safety

- San'yas Indigenous Cultural Safety Training from the Provincial Health Services Authority: [sanyas.ca](http://sanyas.ca)
## Appendix D: Avoiding Practice Traps

<table>
<thead>
<tr>
<th>Practice Trap*</th>
<th>When you identify the practice trap, change it to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixing and wanting to be helpful to the point of inadvertently disempowering the patient and taking over</td>
<td>Offer choice</td>
</tr>
<tr>
<td>Becoming the expert and losing collaboration, which is sometimes triggered by time pressures and the perceived necessity to provide ALL of the information</td>
<td>Listening</td>
</tr>
</tbody>
</table>
| Feeling overwhelmed can result from feeling pushed, especially when the patient’s situation is so complex that it is hard to know where to start | Focus on being in the moment. Practice and teach relaxation techniques.  
  • Demonstrating a breathing exercise (e.g. box breathing, or taking a few deep breaths together) at the start of a visit to establish a calm tone and model a simple way to self-soothe.  
  Set boundaries by explaining the length of the visit, choose a priority to work on together, and schedule a follow up.  
  Use an incremental/longitudinal approach – small steps over time  
  • Set agendas for more frequent, shorter visits for complex medical issues  
  • Involve other care providers on the team  
  Consider reaching out to a colleague for support. |
| Rigidly: belief that there is only one way for patients to recover             | Flexibility                                                                                                        |
| Believing that information alone can cause change: reflected in statements like “you would think knowing that drinking only makes it worse would make them stop.” | Appeal to the emotional instead of the rational (connect to heart).  
  Refer to Appendix: Validating and Invalidating Statements and Curious Questions. |
| Losing awareness of body language and facial expression can result in expressions of excessive sympathy or shock that can have an unintended impact on the conversation | Register your intention, clarify, and move on.                                                                   |

Appendix E: Validating and Invalidating Statements and Curious Questions†

Remember not to focus on what happened; focus on how the patient feels about the situation.
To address feelings, you must use emotional language, not rational or judgmental language.

- **Examples of validating statements that address feelings**

  “I can see that you are very (upset, sad, frightened, scared)”
  “Here’s what I’m hearing you say” *(Summarize with fact checking.)*
  “I can see how hard you are working.”
  “Wow, that (she/he/they) must have made you feel really angry/sad, etc.”
  “I can see this is important to you.”
  “It makes sense you would be so upset about that.”
  “I can see you’re overwhelmed. Can we talk?”
  “I know you’re scared. It’s going to be hard... and I know you will figure it out.”

- **Examples of curious questions**

  “Can I ask some questions?”
  “Tell me more.”
  “What are you feeling?”
  “What am I not getting?”
  “Can you give me a stress #? 1 = I’m OK, 10 = I’m drowning!!”
  “Are you safe?”
  “I’m worried about where this will go.”
  “I’m thinking I might have a feeling of what you’re going through.”
  “Do you want to know what I think?”
  “I need time to think about it/talk to a colleague about it. I will get back to you.”

- **Examples of invalidating statements**

  “I hated it when that happened to me.” *(Make it about you.)*
  “You should feel lucky, thankful...” “What’s the big deal?” *(Tell them how they should feel.)*
  “What you really should do is...” *(Try to give advice.)*
  “Well, life’s not fair...” *(Make “life” statements.)*
  “What you did was wrong/bad...good/great...” *(Make judgmental statements.)*
  “I bet they were just...” *(Rationalize another person’s behavior.)*

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† Adapted from: [www.borderlinepersonalitydisorder.com](http://www.borderlinepersonalitydisorder.com)
Appendix F: Resilience Questionnaire‡

Devereux Adult Resilience Survey (DARS)
by Mary Mackrain

Take time to reflect and complete each item on the survey below. There are no right answers. Once you have finished, reflect on your strengths and then start small and plan for one or two things that you feel are important to improve. For fun and practical ideas on how to strengthen your protective factors, use the chapters in this book. For a free copy of the DARS visit www.centerforresilientchildren.org.

<table>
<thead>
<tr>
<th>Items</th>
<th>Yes</th>
<th>Sometimes</th>
<th>Not Yet</th>
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<tbody>
<tr>
<td><strong>Relationships</strong></td>
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<tr>
<td>1. I have good friends who support me.</td>
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<td>2. I have a mentor or someone who shows me the way.</td>
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<td>3. I provide support to others.</td>
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<td>4. I am empathetic to others.</td>
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<td>5. I trust my close friends.</td>
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<td><strong>Internal Beliefs</strong></td>
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<tr>
<td>1. My role as a caregiver is important.</td>
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<td>2. I have personal strengths.</td>
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<td>3. I am creative.</td>
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<td>4. I have strong beliefs.</td>
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<td>5. I am hopeful about the future.</td>
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<td>6. I am lovable.</td>
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<td><strong>Initiative</strong></td>
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<td>1. I communicate effectively with those around me.</td>
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<td>2. I try many different ways to solve a problem.</td>
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<td>3. I have a hobby that I engage in.</td>
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<tr>
<td>4. I seek out new knowledge.</td>
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<td>5. I am open to new ideas.</td>
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<td>6. I laugh often.</td>
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<td>7. I am able to say no.</td>
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<tr>
<td>8. I can ask for help.</td>
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<tr>
<td><strong>Self-Control</strong></td>
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<tr>
<td>1. I express my emotions.</td>
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<tr>
<td>2. I set limits for myself.</td>
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<tr>
<td>3. I am flexible.</td>
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<tr>
<td>4. I can calm myself down.</td>
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Appendix G: Patient, Family, and Caregiver Resources

- **Support for parents and caregivers**
  - **Confident Parents Thriving Kids**: A telephone-based coaching service for parents proven effective in reducing mild to moderate behavioural problems in children ages 3–12. Offered at no cost to BC parents and caregivers through referral from a family doctor or pediatrician.

- **Public Health Prenatal Registries and Programs**: Pregnant women and girls can be referred to public health as early in pregnancy as possible by phone, fax or on-line as available. *Women can also self-refer.* Public health can offer women with social complexities more intensive follow-up and enhanced support services and will support women to make the healthiest choices possible including accessing community resources.

- **Nurse-Family Partnership (NFP)**: NFP offers support for pregnant women and girls who are having their first baby and are facing disadvantages such as low income. A public health nurse will provide home visits starting in pregnancy and continuing until the baby turns two. Eligible women and girls can be referred to the program through prenatal registries or directly by contacting public health in your health authority.

  Weekly education program for parents and caregivers to improve parent-child attachment. The program assists parents to better understand and respond to their child's needs, and improve confidence in parenting skills. Childcare provided.

- **Supports for teens and young adults**
  - **Foundry**: integrated health and social service centres for young people age 12-24 including mental health care, substance use services, primary care, social services and youth and family peer supports.

- **Support for adults**
  - **Bounce Back®**: an evidence-based CBT program designed to assist primary care practitioners in working with patients (age 15+) experiencing mild to moderate depression or anxiety. Participants learn CBT skills to help them improve problems such as low mood, reduced activity, unhelpful thinking, worry, and avoidance.
Appendix H: Teen Self-Report Adverse Childhood Experiences (ACEs) Questionnaire

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

To be completed by Patient

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)

CYW ACE-Q Teen SR (13-19 yo) © Center for Youth Wellness 2015

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Source: Centre for Youth Wellness: https://centerforyouthwellness.org/cyw-aceq/
References


24. Saari, Carol-Ann. Trauma Informed Practice (TIP) makes perfect (or at least it is a good start) [Internet]. This Changed My Practice. 2018 [cited 2019 Sep 6]. Available from: https://thischangedmypractice.com/trauma-informed-practice/


May;139(5).


This draft guideline is based on scientific evidence current as of September 2019.

The draft guideline was developed by the Guidelines and Protocols Advisory Committee.

The principles of the Guidelines and Protocols Advisory Committee are to:

- encourage appropriate responses to common medical situations
- recommend actions that are sufficient and efficient, neither excessive nor deficient
- permit exceptions when justified by clinical circumstances.

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Disclaimer

These draft Clinical Practice Guidelines (the guidelines) have been developed by the guidelines and Protocols Advisory Committee on behalf of the Medical Services Commission. The guidelines are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. The guidelines are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of clinical problem. We cannot respond to patients or patient advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a health care professional.