

Improving the identification of Adverse Childhood Experiences in developmental clinics

Does it make a difference?

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Introduction

Child abuse and/or neglect (CAN) is a major public problem and an important cause of death in childhood. Adverse childhood experiences (ACE), including CAN have medium and long-term consequences for children's health and development. Studies have shown that children with disabilities have greater risks of CAN and there is evidence that less than 30% of abuse of children with disabilities is reported.¹ Families with children with disabilities experience more stress which amplifies their child abuse potential.

Given the evidence that children with disability are at increased risk of harm, it is likely that children attending child development (CD) clinics have significant exposure to ACE and CAN. There is no data on early identification of this population at risk of abuse and neglect attending CD clinics in Australia.

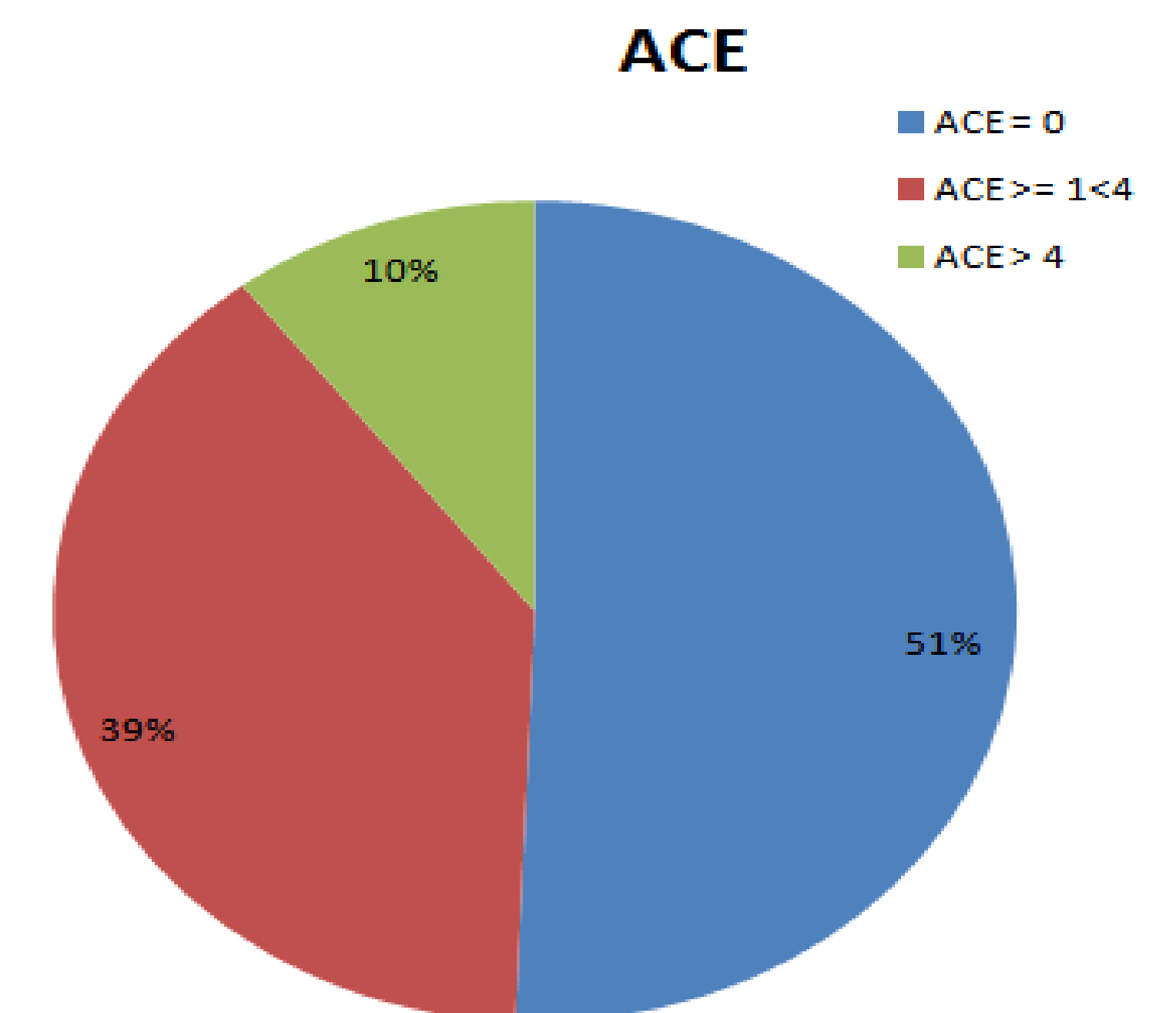
South Western Sydney (SWS) is the most populous and ethnically diverse health region in NSW, Australia. The Department of Community Paediatrics runs a range of multi-disciplinary CD clinics across SWS. Previous audits of Community Paediatric clinics have demonstrated that children at social and environmental risk have higher rates of physical health problems, poorer developmental outcomes and mental health needs than children not exposed to these risks.² Identifying children who are at risk in CD clinics during the assessment process is critical to promoting their health and wellbeing.



Investigating Adverse Childhood Exposures in Developmental Disabilities.
Paediatrician Checklist

Name	DOB	Sex	Visit Date	Cultural Background	Preferred Language	Clinic	Name of Examiner	MRN	Blue Book Available
Diagnoses:									
ACE Checklist									
ACE Category	Identified								
1 Physical Abuse									
2 Emotional Abuse									
3 Child Sexual Abuse									
4 Neglect									
5 Parental Drug Abuse									
6 Parental incarceration									
7 Parental Mental Health Issues									
8 One or no parents, Parental separation or Divorced									
9 Domestic violence									
10 Housing Instability									
11 Foster care system (History or Current)									
12 Intrauterine Drug Exposure/ Neonatal Abstinence Syndrome									
13 Child Protection Services (CS/DoCS) Involvement									
14 Exposure to Traumatic event in the past or (eg: fire,)									

Distribution of ACE Scores in Children attending CD Clinics

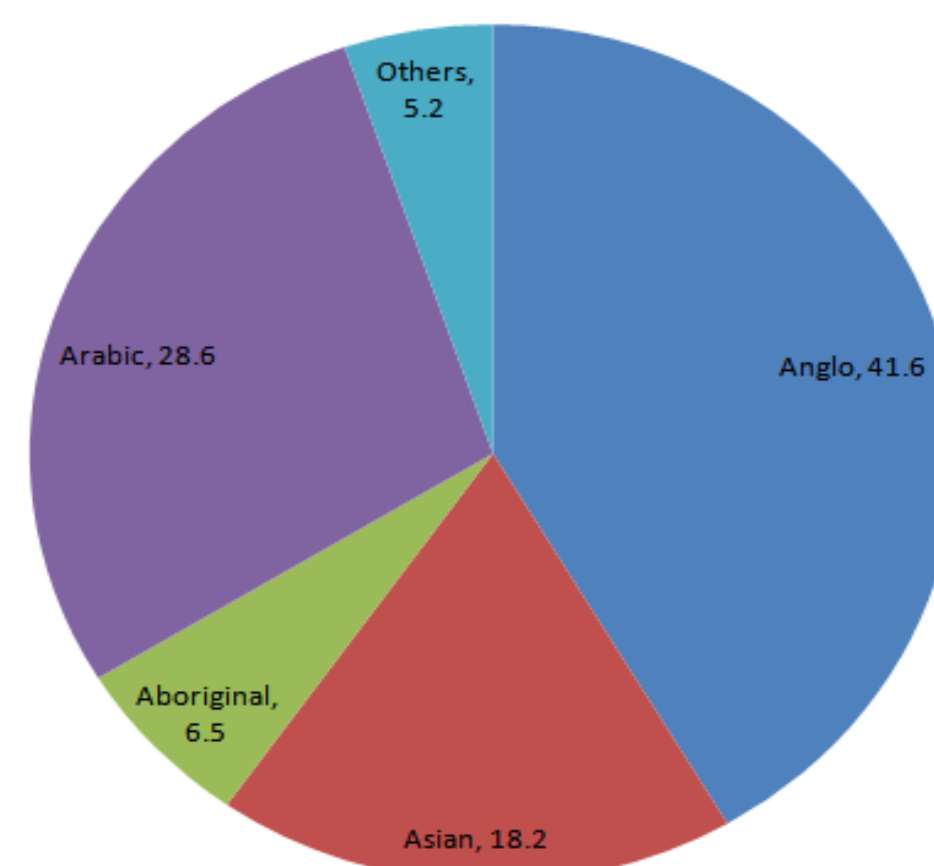


Key Findings:

- Most of the children with ACE scores ≥ 4 were in **foster care**.
- 50% of children with ACE scores ≥ 4 had documented **Neglect**.
- Community Services (**child protection**) involvement was present in the majority of children (63%) with ACE scores ≥ 4 .
- 29% of all children had a **personal health record** available during their consultation.
 - Most of the children with ACE scores ≥ 4 did not have a personal health record available.
- Children with ACE scores ≥ 4 were significantly more likely to have Community Services involvement, have abuse and neglect identified and be in foster care ($p < 0.00$).
- There was a trend towards children with high ACE scores being older, likely to be Aboriginal, less likely to be from non-English speaking backgrounds, have behaviour disorders (these did not reach statistical significance).
- Clinicians found the checklist easy to use and strongly recommended using the tool in clinics.

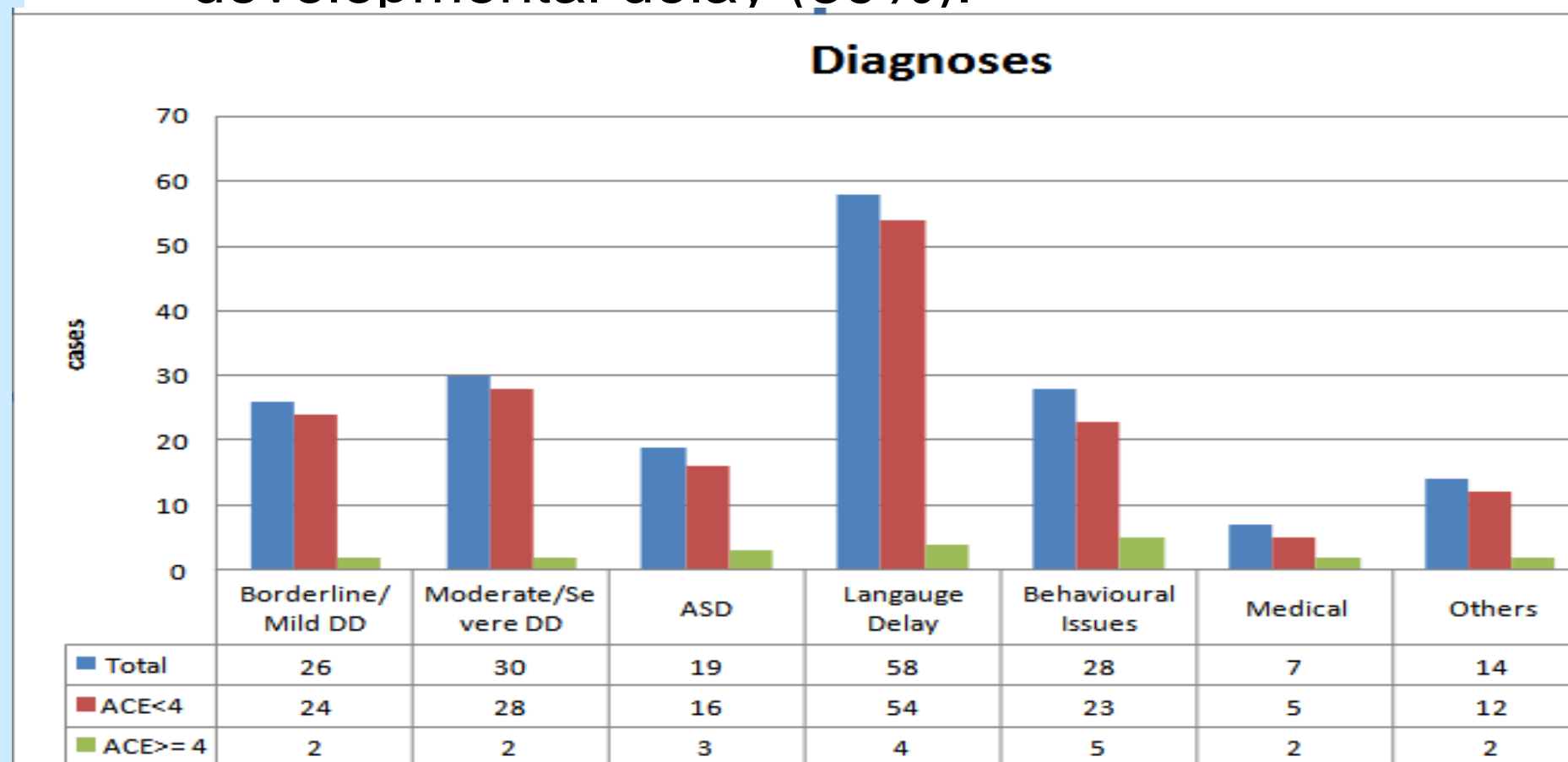
Results

- Seventy-seven children attended CD clinics in six months, 80% were males.
- Average age of children presenting to CD clinics was 4.7 years.

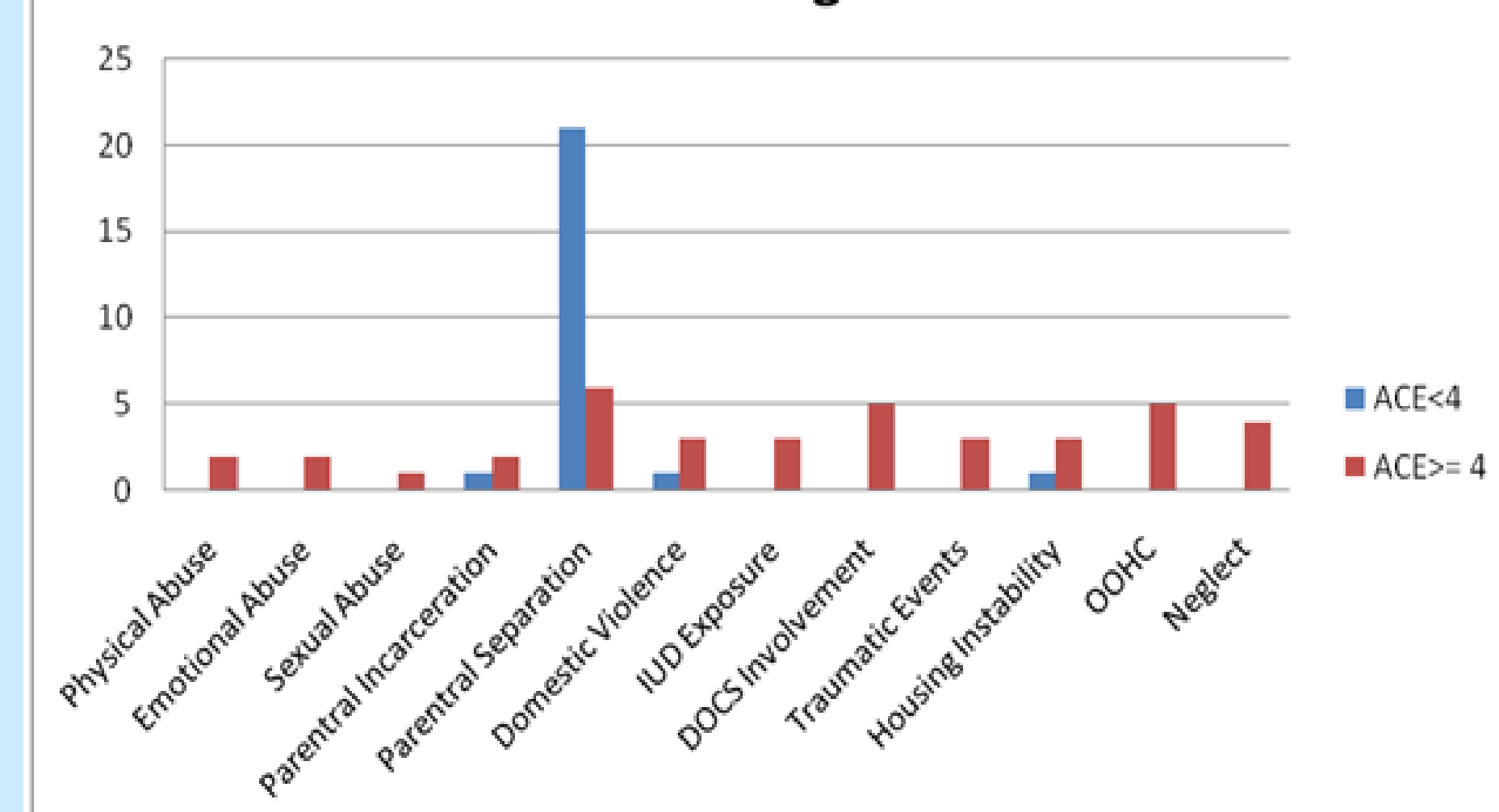


Cultural background of children attending CD clinics

- Most of the children had at least 3 diagnoses, language delay/disorder was the most frequent diagnosis (75%), followed by moderate to severe developmental delay (39%).

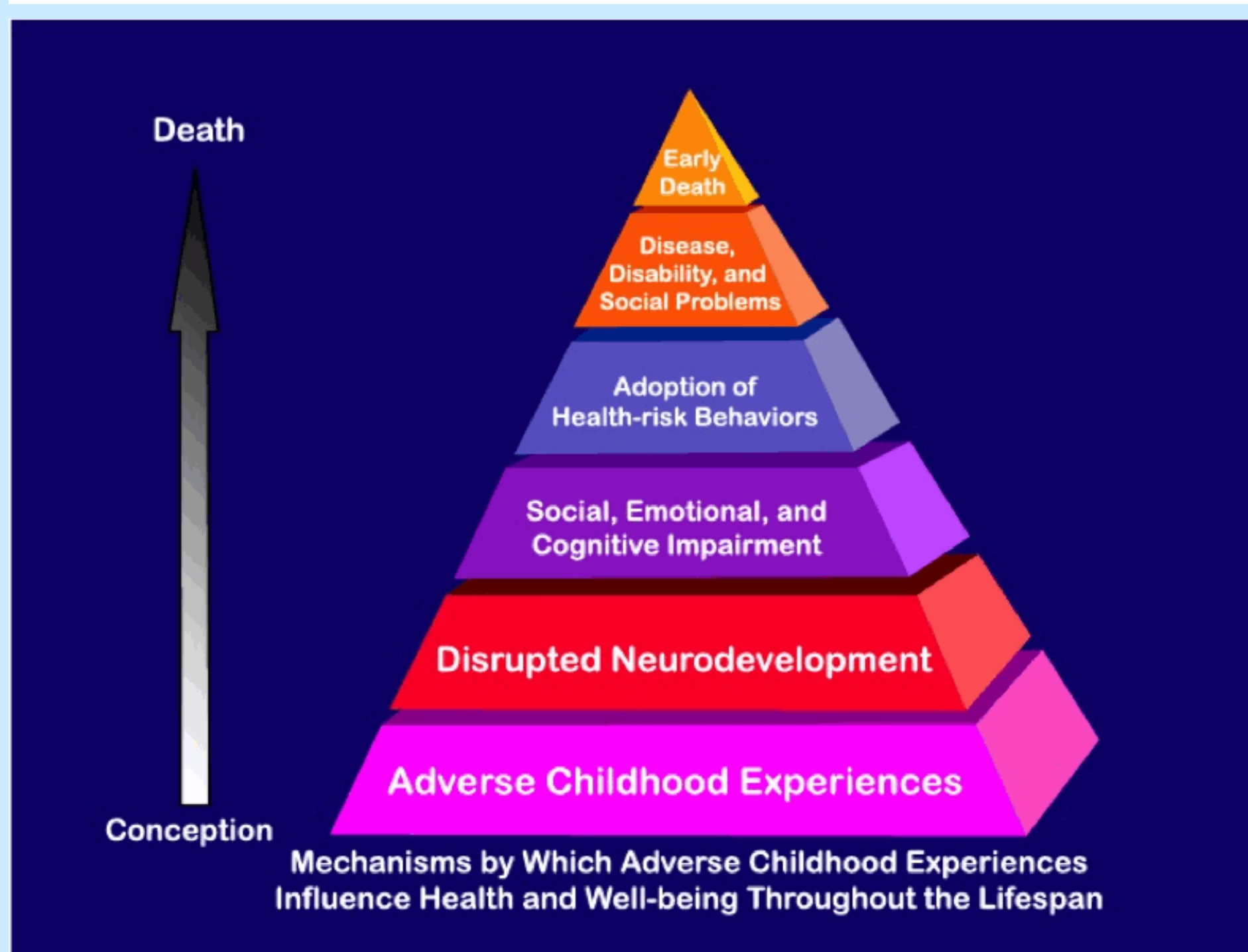


ACE Categories



Profile of ACE categories in children attending CD clinics

- Parental separation was the commonest ACE category, identified in 35% of all children.
- Most of the children (75%) with ACE scores ≥ 4 had parental separation identified.



Aims

- To identify children who are at risk of abuse or exposed to ACE in the population attending CD clinics in South Western Sydney
- To estimate the prevalence of CAN and ACE in this population.
- To determine if use of a checklist improves clinicians' identification and support of vulnerable children in CD clinics.

Methods

Clinicians filled in a one-page ACE checklist modified from an existing checklist,³ for all children attending CD clinics between October 2012 and May 2013. Demographic information, clinical diagnoses and ACE risks were entered into an Excel database. Qualitative interviews were conducted with clinicians about use of the tool. Descriptive analysis and cross tabulations on the quantitative data were done using SPSS V21, children with ACE scores < 4 and ACE ≥ 4 were compared.

Conclusions

- Half the children attending developmental clinics in metropolitan Sydney have ACE identified, 10% have significant burden of early life adversities.
- Children with ACE scores ≥ 4 are more likely to be exposed to abuse and neglect, have child protection service involvement and be in foster care.
- Utilisation of the personal health record is generally poor, and needs to be promoted particularly for children with high ACE scores.
- The ACE checklist may be a valuable adjunct to developmental and paediatric clinics, to improve identification and support for socially at-risk children.

References

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