

Thoughts and Concerns about H.762 and its Impact on People

By Gerri Oppedisano, PhD
Licensed Psychologist – Doctorate

Main Points

- **The ACE Study results have already provided a service and can be used to inform professionals about the link between adverse experiences and health so as to train sensitive care providers that are considering these issues. The questionnaire should not be used to invade patients' privacy or compromise their dignity.**
- **Having a questionnaire such as the ACE that screens for traumatic experiences will be re-traumatizing to patients and has potential to cause serious clinical harm.**
- **Specifying Medicaid as a specific withholder of funds targets one group of people unfairly, namely, the lowest income population, with likely the most environmental pressures on them already.**
- **Tying reimbursement to use of specific tools is coercive and limited.**
- **Conditions in research are very different from direct patient care, thus use of research criteria in direct patient care can not be assumed effective, is not good science and poses ethical problems. Competent direct patient care considers triage, cost/benefit ratios and do no harm. Mandatory screenings are not voluntary or anonymous.**

Accolades

The ACE Questionnaire identifies well 10 areas of “adverse experiences” based in the literature on trauma. It’s use so far in identifying the association between adverse childhood experiences and chronic health conditions validates what professionals in the behavioral health field have known and worked with for years and serves as a good informational tool for training professionals, but not necessarily as a tool to be used in actual patient care.

Often in Prevention, education is intervention enough. Knowing these correlates/potential predictors serves a purpose without need to use the ACE as an assessment tool on a specific individual basis.

The Nature of Trauma and the Impact of Mandating the ACE

Conditions of childhood adversity – trauma, neglect, family mental illness - are experiences shrouded with shame. Interpersonal traumas are particularly

horrifying in terms of the level of shame left upon those who have had to endure it. The nature of trauma itself is coercive and invasive and anything remotely reminiscent of those two characteristics are immediate and salient triggers for people who have been traumatized. The specific traumatic experiences of childhood abuse and neglect are almost always accompanied by threats to one's safety if the trauma were revealed or spoken about. The predictable and understandable response to the triggers of coercion and the intrusion of exposure are overwhelm and avoidance, and sometimes decompensation that pose as immediate risks to one's safety (e.g., self harm as a means of emotion regulation or attempt to end it all). The practice of requiring an ACE screening at a large health care clinic is likely to lead to patients who may decompensate and/or not return to treatment, leaving their conditions to mount secretly only to return when medical conditions are emergent (most expensive and highest risk).

While the ACE questionnaire is incredibly useful and may be predictive of high risk, its content is highly triggering and delicate. Asking a trauma survivor about such highly personal experience in such detail is not something that should happen in the context of a large clinic with a generic professional/case manager. These intimate experiences are most safely managed in the context of a therapeutic relationship where there is sufficient trust, the assurance of confidentiality and ideally with the control of information shared in the hands of the patient.

Use of Research Based measures in Health Care Clinics

In research, participants are voluntary, are informed of risks and benefits when providing consent to participation and are assured confidentiality through anonymity of their responses when responses are stored. When a measure is given as part of direct care, their responses become part of their medical record and not anonymous. This is even more compromised in a large clinic or health care home environment when records can potentially fall into the hands of many other than the direct care providers.

Participants in research are in a much more powerful position, having volunteered, than a patient is in a clinic. Often patients are in a position of vulnerability and may feel limited in their options. If there are pressures on providers via payment contingencies, these pressures are passed onto patients creating an even more vulnerable position for the patient to be in.

My understanding is that research to date has not used the ACE in the way that is being suggested by this bill, but rather as an anonymous questionnaire on a volunteer basis, or when used in a clinic setting with vulnerable populations has been altered to remove the most sensitive questions regarding abuse and neglect with families already identified with adversity through other means. By the guidelines of competent science and ethical behavior, one does not misapply or alter research tools or assume their efficacy in a general population.

Mandating Measures and/or Treatments

There is no measure or treatment out there that is %100 full proof. These cannot be mandated. Those treatments and measures deemed as having adequate empirical support are best thrown onto a list of most useful options to choose from when planning treatment. This is why we have trained experts. Professionals in the field are highly trained to assess and use informed clinical judgments when working with people as well as interpreting and applying research. Mandating specific strategies or measures threatens to *decrease* effectiveness and accuracy, rather than increase. Please respect the vast majority of trained experts to behave ethically and with competence while working in recommended guidelines rather than dictated mandates.

Tying reimbursement to treatments or measures poses many ethical dilemmas, not the least of which is the coercion it imposes on both practitioners and patients. Furthermore, specifying Medicaid as a specific withholder of funds targets one group of people unfairly, namely, the lowest income population, with likely the most environmental pressures on them already.