Written evidence submitted by NSPCC (EYI0034)

Executive Summary

- The NSPCC recognises the role that the Adverse Childhood Experiences (ACEs) research can play in bringing awareness of the negative impact of early disadvantage into the design and delivery of public services and beyond.
- The strength of the concept is that it highlights ACEs as a matter of public health with significant consequences for children and for wider society.
- There is strong evidence that ACEs represent a major risk factor for numerous physical and mental health problems and that this impact is cumulative such that greater numbers of ACEs are associated with more severe outcomes. Although we must not underestimate the negative impact that even one ACE, such as abuse, can have on child development.
- While exposure to ACEs represents a risk factor for negative outcomes, this link is not deterministic. Not all individuals facing the same experiences will have the same outcomes. Individual resilience, wider support networks and access to evidence based interventions can help to break the link.
- The NSPCC also advocates that all future UK-based ACE research and practice include reference to neglect given it is the most prevalent form of maltreatment across the four nations of the UK.
- Government should focus on investment in the prevention of ACEs and trauma-informed service development.
Introduction

The NSPCC is the leading children’s charity fighting to end child abuse in the UK and Channel Islands. We help children who have been abused to rebuild their lives, protect those at risk, and find the best ways of preventing abuse from ever happening. To achieve our vision, we:

- Create and deliver services for children which are innovative, distinctive, and demonstrate how to enhance child protection;
- Provide advice and support to ensure that every child is listened to;
- Campaign for changes to legislation, policy, and practice to ensure the best protection for children;
- Inform and educate the public to change attitudes and behaviours.

Long-term negative outcomes associated with Adverse Childhood Experiences

1. Adverse Childhood Experiences (ACEs) is a broad term which encompasses both direct and indirect harm to the child (Hughes et al., 2017). Traditionally, these harms have covered ten different domains:
   a. Abuse: physical, emotional and sexual abuse
   b. Neglect: physical and emotional
   c. Family dysfunctions: mental illness in the household, incarceration in the household, mother subject to physical abuse, substance abuse and divorce.

   When we use the term ‘ACEs concept’ we mean the long-term harm which is associated with experience of any of these childhood adversities.

2. When deployed as a screening tool, the ACEs questionnaire applied to England and Wales has confirmed the outcomes of the studies in the USA. The application of the questionnaire has highlighted that a
significant minority of the English and Welsh resident populations have grown up with multiple disadvantages with almost half of the general population in England and Wales reporting at least one ACE and over 8 per cent in England and 14 per cent in Wales reporting four or more (M. A. Bellis, Hughes, Leckenby, Perkins, & Lowey, 2014)(Public Health Wales, 2015).

3. Evidence indicates that abuse and neglect can have a profound adverse impact on brain development leading to both physical and behavioural changes as the child tries to adapt to environmental stress factors. If trauma occurs over a prolonged period, it can impact on the regulation of the child’s internal stress system which then contributes to physical and mental health problems over the life course (Kalmakis & Chandler, 2015). Even in cases where mental health problems haven’t yet emerged, there is now evidence to suggest that some children who have been maltreated have a latent vulnerability for developing future mental health problems meaning they are at elevated risk (McCrary & Vising, 2015).

4. There is strong evidence from a global meta-analysis of all published research on ACEs, that early adversity is a major risk factor for numerous physical and mental health problems, such as obesity, diabetes, cancer, heart disease, respiratory disease, substance misuse, depression and self-harm. There is a cumulative impact of ACEs, with those who report four or more at greatest risk; individuals who had at least four ACEs are more than twice as likely to be current smokers or heavy drinkers, and almost six times as likely to drink problematically as those with no ACEs (Hughes et al., 2017). It is critical to note that should these individuals have children; their problems will represent the ACEs of future generations with the risk of establishing an intergenerational cycle.

5. The negative health outcomes associated with ACEs contribute to significantly greater use of public health services, specifically, primary, emergence and inpatient care. Analysis from Wales reveals a cumulative impact of ACEs on levels of use: those who
had experienced four or more ACEs had the highest usage, with this pattern holding through ages 18-59. It is notable that the impact of ACEs on health care use has already begun while the individual is still in adolescence, such that 18-29 year olds with four or more ACEs were three times as likely to have used GP services in the past year as those who had no ACEs (M. Bellis et al., 2017).

Application of ACEs concept in the UK

6. The NSPCC recognises the role that the ACEs concept can play to bring the negative impact of early disadvantage into the design and delivery of public services and beyond.

7. This approach enables practitioners and policy makers to look at a child’s experiences in the whole - highlighting that one form of maltreatment is often accompanied by another form of victimisation or psychosocial adversity - and in doing so, generates a common reference framework for all staff working with children who are disadvantaged.

8. It is also useful when working with parents, to better understand the challenges they face and the kind of parenting support that they need. From our work in Blackpool and Wales (please see intervention section) we know that the use of this concept in frontline delivery has improved communication between staff from different agencies and of different disciplines, and has led to better care planning. This is to be welcomed.

9. There are, however, a number of considerations which we would like to raise which must be addressed. Much of this UK research on ACEs has excluded reference to neglect. This is a significant omission given that neglect is the most prevalent form of maltreatment across the four nations of the UK, with one in six children experiencing it (Radford, Corral, Bradley, & Fisher, 2013), as well as being the most common category for children in need who were the subject of child protection plan (Department for
It is also the primary reasons to contact our NSPCC Helpline for support; with over 19,000 contacts about neglect in 2016/17 alone. A failure to include neglect as the tenth ACE reduces the concept’s reliability and validity.

10. Similarly, while a greater number of ACEs is associated with more severe outcomes, we caution against underestimating the potentially significant detrimental effect of a single ACE on child development and psychosocial functioning. Experience of even one form of maltreatment (physical, sexual or emotional abuse and neglect) can be traumatic for a child and lead to numerous physical and mental health problems if early support is not provided. Experience of childhood maltreatment doubles an individual’s risk of depression (Nanni et al. 2012), and for those who are sexually abused as children, lifetime contact with public mental health services is three times as high as their peers (Cutajar et al., 2010). A low ACE score can inadvertently mask the depth of trauma endured; one continuously present and severe ACE may be as detrimental as the presence of four co-occurring ACEs which occur over a short period of time.

11. Furthermore, we are mindful that within ‘ACE-speak’, one form of abuse is described simply as one ‘type’ of ACE. However, both in policy and practice any form of abuse encompasses a very wide spectrum of abusive incidents and experiences, involving a very wide range of relationships between victims and perpetrators, occurring in many different contexts, of different durations, and whose impact on each individual is mediated by a range of factors. The sexual abuse ACE category may be ticked in a screening process, but what that actually means in terms of what an individual has experienced and how it has affected them will vary massive. As such, ACEs terminology i.e. ‘a single ACE’ can inadvertently encourage a reductionist view of very complex experiences which we caution against.
12. With this in mind, we have concerns about the roll out of the ACEs checklist as a screening tool in primary care. We are particularly concerned that this tool, which was devised as a retrospective questionnaire for adults, would be used with children without appropriate staff training or oversight given its highly sensitive nature. The ACEs tool is still in its infancy and without proper oversight and evaluation, translating this research into practice prematurely may lead to unintended harm. Harm could be caused through the process of being screened (with or without a paper questionnaire) causing distress which is then not monitored, through the harm caused if mental health needs are subsequently identified but appropriate care services are not provided, or by alerting abusing parents that questions about abuse and neglect are being asked to their child. Even where therapy is offered there will be a risk of unintended harm which also needs to be recognised and managed (Parry & Duggan, 2016). If the ACEs tool is intended to be used in the primary care setting, to minimise these risks, it should be subject to the national guidelines on the use of screening tools and fully evaluated before being recommended for practice. Even if this does meet this standard, it will still not be appropriate for many groups, such as pre-verbal children, and clinicians must be mindful of this. Where use of the tool does detect potential need, it should lead to a comprehensive physical and mental health assessment, deploying a wider range of measures, which then informs evidence-based support.

**Evidence-based Early Years Interventions**

13. There is a significant ethical implication associated with detecting need through use of the ACEs concept and not having the infrastructure in place to adequately address that need (Finkelhor, 1994).

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1 For further information, please see: [https://www.gov.uk/government/groups/uk-national-screening-committee-uk-nsc](https://www.gov.uk/government/groups/uk-national-screening-committee-uk-nsc)
If the ACEs concept is to be widely adopted within the UK, whether as a screening tool or as a concept embedded in practice, investment in evidence-based support will need to be scaled up. This investment must be twofold: in the first instance, investment in preventative interventions should be prioritised to ensure that the intergenerational cycle of ACEs is brought to a halt; secondly, where ACEs have already occurred, trauma-informed support must be in place to ensure that if need is identified, it can be appropriately met.

To this end, the NSPCC is part of the Blackpool Better Start partnership. This partnership is one of five National Lottery funded programmes aimed at improving outcomes for 0-4s in three key areas; diet and nutrition, speech, language and communication and social and emotional development. At the heart of Blackpool Better Start is the Centre for Early Child Development, the ‘engine room’ of the partnership, driving the partnership in systems change, workforce development and a range of new research areas and developments. Underpinning all of the evidence-based work and supporting the theory of change to reduce critical stressors and increase parental capacity, is a trauma informed care strategy which will transform the workforce over the lifetime of the programme and beyond. The Centre is piloting the use of the ACEs questions, delivered in a trauma informed way and utilising a more therapeutic approach, through the Health Visiting service, as part of the wider Health Visiting transformation. Through co-designing the pilot alongside Health Visitors themselves, and community members, the Centre will be generating learning in relation to the impact of ACEs on the workforce and quality of assessments. This new approach is also informing the newly developing supervision models incorporated as part of the new HV model.

Similarly, the NSPCC has been supporting the development an ACE informed workforce and practice, particularly in early intervention services, in Wales. We are part of a Police Innovation Funded
project involving South Wales Police, Police and Crime Commissioner South Wales, Public Health Wales, and Bridgend Council. The project is using Public Health Wales research to develop ACE informed approaches including vulnerability training and early intervention collaboration between Neighbourhood Policing Teams and statutory social care early to help police officers and partners. The aim is to break the generational cycle of crime through achieving systemic change in policing vulnerability. Police Transformation Funding has now been secured to enable this approach to be further developed across the four Wales Police Force areas. Our Senior Consultant in Wales has been seconded to the project.

16. Aside from these specific ACE partnerships, the NSPCC is developing a range of preventative programmes which can reduce the likelihood of children growing up with adversity developing poor health outcomes in the first instance. It is critical that government champions support during the perinatal and early infancy period as the necessary first step in risk mitigation. Maternal antenatal depression is recognised as an important link between childhood maltreatment and subsequent psychiatric diagnosis; not only does maternal depression increase the risk of maltreatment taking place in first instance, but it also increases risk of child mental health problems when maltreatment has taken place (Pawlby, 2011).

17. A recently published systematic review of the evidence which was commissioned by the NSPCC found that two scales: the Kessler Psychological Distress Scale and Self-Report Questionnaire – were considered the most promising measures for examining the mental health of men and women with children aged between 0 and five years of age (Webb, 2017). These screening tools should be deployed in primary care during the perinatal and infancy period to ensure that any emergent mental health problems can be detected and addressed. Pregnant women and those with a baby should then have priority access to IAPT services, with access to Mother and
Baby Units for overnight stays. At minimum every area should have access to a specialist community perinatal mental health team (Hogg, 2013). Ensuring that parents are supported at this stage will greatly reduce risk of intergenerational transmission of ACEs.

18. Aligned to this, the NSPCC is running a new intervention in Glasgow and London - the Infant and Family Team (GIFT and LIFT) - to improve outcomes for looked after children 0-5 and promote infant mental health by working with both birth and foster parents. Based on the US New Orleans Intervention Model, the intervention is two-part, entailing an extensive attachment-based, relational mental health assessment with the child, their foster carers and birth parents, followed by a prolonged intervention with the child and their birth parents. These services are innovative because they follow a truly collaboration partnership model using multiple agencies such as health (NHS), social care (local authority), and third sector (NSPCC), as well as the judiciary (family courts). This UK-based work is currently subject to a randomised control trial. The results from the American trial suggest it is effective for reducing repeat maltreatment when the child returns home and leads to a lower risk of harm for subsequent children in the family (Zeanah et al., 2001).

19. The National Institute for Health and Care Excellence (NICE) has endorsed the NSPCC’s Parents Under Pressure programme that works with parents who have substance abuse problems - a recognised ACE - to minimise the risk of child abuse and neglect (NICE, 2017). The programme focuses on helping parents build a bond with their children and develops their parenting skills. It is currently being evaluated by Warwick University via a randomised control trial with findings due to be published in March 2018.

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3 For further information, please see: https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/parents-under-pressure/parents-
20. Finally, the NSPCC is mindful that children who have experienced adversity, such as abuse or neglect, need focused attention and support, and as such we provide a number of trauma-informed response services, as well as the preventative programmes detailed above. To give one example, *Letting the Future In* is a support service for 4-17 year olds who have been sexual abused which is premised on a strong therapeutic relationship, drawing on a wide range of approaches such as play therapy and attachment work.\(^4\) It also has been recommended by the 2017 NICE guidelines on child abuse and neglect (NICE, 2017).

**Recommendations**

1. A return to the original ACEs concept which includes neglect when applying it in the UK, with general recognition that this is not an exhaustive list - other non-specified experiences, such as growing up in the care or asylum system, can also exert a significant negative impact on child wellbeing.

2. Before being recommended for practice, the ACEs tool should be subject to the national guidelines on the use of screening tools and fully evaluated before being disseminated.

3. Any dissemination of the tool should be accompanied by comprehensive staff training on its strengths and weakness. Specifically staff must be alert to the fact that ACEs are not *determinants* of poor outcomes.

4. Awareness of the ACE concept should also lead to an expansion of preventative activities; some ACEs can be averted with the right early years support. This should begin during the perinatal period and then span the duration of childhood to mitigate risk factors.

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which might occur at any point during the critical development years of childhood and adolescence.

5. If ACEs do occur and where need is identified, individuals must have access to appropriate support. This means ensuring that all primary care settings have capacity to deliver a trauma-informed service for both children and adults. Effective trauma-informed services necessitate innovative ways of multi-agency working, as exemplified by the NSPCC’s GIFT and LIFT services detailed above.

6. Finally, ACE research is on-going and therefore everyone using the research to inform policy making and practice should explicitly recognise that new learning on ACEs may necessitate a change in practice requiring flexibility. Learning from ACEs is important and significant but should not be seen as an overall panacea or "silver bullet".

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Bibliography


https://www.nice.org.uk/guidance/ng76

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