Written evidence submitted by the International Centre for Lifecourse Studies in Society and Health (EYI0043)

Who we are
This response was prepared by:

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All authors are members of the Economic and Social Research Council’s (ESRC) International Centre for Lifecourse Studies in Society and Health (ICLS, http://www.ucl.ac.uk/icls). ICLS is a multi-disciplinary research group designed to bridge the social and biological sciences in order to understand development, health and ageing over the life course. One of ICLS’ activities is research into how early life circumstances affect health. Dr Lacey, Prof Kelly and Prof Bartley have all conducted a wide range of studies investigating the life course health consequences of adverse childhood experiences using UK longitudinal data.1–8

1. Introduction

Childhood adversities are common in the UK. The NSPCC estimate that around 1 in 4 children will have experienced family or domestic violence by the time they are 18 years old, and more than 1 in 6 11–17 year olds will have experienced severe maltreatment.9 There is a large body of evidence that shows that adverse childhood experiences can have lifelong health and social consequences. The types of childhood adversities typically included in these studies are abuse (psychological, physical and sexual), domestic conflict, parental substance misuse, parental mental illness and parental imprisonment. Adverse childhood experiences are costly to the UK economy. The direct and indirect economic costs of domestic abuse, for example, were estimated at £15.7 billion in 2008, including costs to the NHS, social services and the wider economy.10 Also non-fatal child maltreatment costs the an estimated £89,390 per victim and £940,758 per fatal child maltreatment victim.11 Childhood adversities place high demands on public services and third sector organisations. For instance, the number of referrals to social services for child protection concerns has increased significantly in recent years.12

We therefore welcome this inquiry into childhood adversities and the recognition that they can have lifelong consequences. Our response focuses on three main points:

- The quality of the existing evidence base and gaps in knowledge
- How the quality of the existing evidence base affects the planning of interventions
- Our recommendations for the committee

2. Question 1: The evidence-base for the link between adverse childhood experiences and long-term negative outcomes, and any gaps in that evidence base, as well as data on which specific adverse childhood experiences produce greatest adverse impact

2.1 The evidence base for the link between adverse childhood experiences and long-term health
There is a large body of evidence that shows that adverse childhood experiences can have lifelong consequences for health. For instance, Felitti and colleagues showed that the number of childhood adversities experienced increased the likelihood of health damaging behaviours, and accordingly also the risk of heart disease, cancer, lung disease, depression, attempted suicide, obesity and liver disease. In our own work we showed that the number of childhood adversities experienced increases the risk of cancer and early death. Fahy and colleagues have also recently shown that adverse childhood experiences increase the likelihood of work disablement and early exit from the labour force among people in their 50s. In all of these studies, the number of adversities reported was important; the more adversities the person reported, the greater their risk of poor health.

2.2 Limitations and gaps in knowledge in the evidence base

There are three main problems with the current evidence base that we would like to highlight. Firstly, many studies have asked participants about their experience of childhood adversities when they were adults (‘retrospective reporting’). This approach relies on accurate recall and is known to be affected by current stressful life circumstances, such as stress at home or work and by depression. In the UK, we have a world-renowned series of birth cohort studies which allow us to measure childhood adversities closer to the time at which they occurred (‘prospective reporting’). This approach is more reliable and accurate however there are few studies which have been able to use this approach. A second related issue is that the reporting of childhood adversities also depends on who you ask. For example children may report differently than parents, and parents than teachers or other professionals. As far as we are aware there are no longitudinal studies which collect information on childhood adversities using a multi-informant design across childhood. The third issue involves the lack of recognition that different childhood adversities are likely to have differing implications for health and other outcomes. For example, although both physical abuse and parental separation and divorce are regarded as adversities, the effects are likely to be different. Linked to this there has been little recognition that childhood adversities tend to co-occur and academic work that has acknowledged this has tended to add together adversities reported into an Adverse Childhood Experiences (ACE) score. For instance, Felitti and colleagues reported the co-occurrence of childhood adversities in their study; of their participants reporting psychological abuse, 52% also reported physical abuse, 47% sexual abuse, 51% parental substance misuse, 50% parental mental illness and 39% reported domestic conflict. The ACE score approach is highly limited in being able to inform interventions as it’s unclear which adversities produce the most negative impacts upon health and how this occurs. The limitations of the ACE score approach are becoming more widely acknowledged in this field of research but little work has been done so far to explore alternative approaches. We are starting work on an ESRC research grant to explore the extent to which childhood adversities co-occur in the UK. We will also be investigating how different childhood adversities affect different health outcomes in a way that is more informative for developing interventions. More information on this grant can be found here: http://gtr.rcuk.ac.uk/projects?ref=ES%2FP010229%2F1

3. Our recommendations for the committee

- The importance of adverse childhood experiences for intractable problems in terms of physical health, mental health and employment in adult life is beginning to be recognised in the health professions, but this needs to be more widely considered.
- Failure to do so is resulting in futile interventions that are not cost effective.
- We would welcome the recognition that childhood adversities are likely to co-occur and that ACE scores limit the ability to inform the planning of interventions.
In order for studies of ACEs to be scientifically robust, longitudinal studies starting at birth or in early childhood are indispensable. Other study designs rely on memory which may be distorted or unreliable.

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References


