Executive Summary

- Some evidence exists to demonstrate an association between ACEs and negative outcomes for children and young people. However, not all of the existing evidence is robust. Consolidation of existing literature should be conducted prior to further research.
- Rates of reported mental health problems in children are rising and increasing evidence points towards ACEs as contributing to the development of mental health disorders later in life.
- Research should focus on the influence of ACEs upon the resilience of children and young people.
- Little robust research currently exists to claim there is a sufficient evidence-base for specific interventions.
- Government policies have confounded negative outcomes for children and young people. As funding and resources have been cut, effective preventative interventions are neither sufficiently available or appropriately adequate.
- Research, especially on testing interventions to prevent and ameliorate adverse childhood experiences should be supported through collaboration with key stakeholders engaged in the field, backed by sufficient incentives and funding mechanisms to develop and test interventions that support early childhood development.

1. Introduction

1.1. The Royal College of Paediatrics and Child Health (RCPCH) is responsible for training and examining paediatricians. The College also sets standards for professional postgraduate education. The College has over 18,000 members in the UK and internationally. We work to transform child health through knowledge, research and expertise, to improve the health and wellbeing of infants, children and young people across the world.

1.2. The RCPCH are well placed to provide comment to this inquiry given our unique position to influence the work and role of paediatricians, ultimately improving the care of children and young people. We have argued elsewhere that ‘children of all ages must be protected from adverse childhood experiences and given support to develop the resilience to thrive in today and tomorrow’s society’.

1.3. The response provided in this document was drafted after careful consultation with paediatricians working in the key areas of health promotion and child protection, with valued support from the British Association for Child & Adolescent Public Health (BACAPH).

1.3. Adverse Childhood Experiences will be referred to as ACEs throughout this document.

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2. Evidence linking ACEs with long-term negative outcomes

2.1. A large amount of research has been produced on the topic of ACEs, initiated by the release of Felitti and colleague’s 1998 study\(^2\). Many of the studies have suggested a link between ACEs and long-term negative outcomes for the physical and mental health of children, having both human and economic consequences. ACEs are considered to have detrimental implications on the development of children, impacting upon their physical health, resilience and wellbeing.

2.2. Published research has demonstrated that retrospective reports of ACEs are associated with negative outcomes relating to: education, criminality and physical and mental health\(^3\). In terms of mental health, ACEs are thought to contribute to anxiety, depression, self-harm, suicide, eating disorders, psychoses\(^4\) and PTSD\(^5\). Prospective approaches have not proven associations with all of these outcomes; raising doubts over specific ACE measures, but not on the association between family stress and later mental health problems\(^6\).

2.3. In considering the association between ACEs and long-term negative impacts, the inquiry should consider the definition of ACEs provided. ACEs are thought to represent traumatic childhood experiences. The RCPCH advises that while parental maltreatment is an important cause of negative childhood experiences, it is not the sole factor, moreover that the causes of the causes are important, and can be prevented. Indeed, ACEs may not always be easily deducible to one factor. Furthermore, not all children experiencing trauma will present with ill health. For example, one Australian study found that of 16% of maltreated children within one jurisdiction, there was no clear link of negative outcomes – a wide range of between 8 and 46% of children went on to become convicted for youth offences\(^7\). Therefore, caution should be held in offering widespread claims to this regard.

2.4. Rates of mental ill health amongst children in the UK are thought to be rising. While there is not sufficient evidence for the RCPCH to support an explicit causal relationship between this and the prevalence of ACEs, evidence exists that suggests that experience of maltreatment in childhood contributes to the development of a range of mental health disorders and risky behaviours\(^8\). It has

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\(^8\) NSPCC (2017) *Transforming the mental health services for children who have been abused: A review of local*
been acknowledged that half of all people who experience mental health distress in the UK will experience initial symptoms before they are 14 years of age\(^9\). Furthermore, 1 in 10 children aged 5-16 years old have been diagnosed with a mental illness\(^10\). Clearly, adverse childhood experiences and mental ill health are both areas for concern and it is important to act against any factors that are contributing to the rise in these problems.

2.6 Evidence has highlighted that one form of maltreatment often co-occurs with other problematic exposures, including other forms of maltreatment, household substance use and parental criminality. A retrospective study of over 17,000 persons showed that experience of childhood sexual abuse increased the likelihood of experiencing another adverse experience by three-fold for women and two-fold for men compared to peers with no history of sexual abuse in childhood\(^11\). Other studies have also inferred a cumulative effect of ACEs related to worse outcomes\(^12,13,14\).

2.7. A national survey of ACEs in Wales interviewed 2,000 people aged 18-69 about their experience of childhood trauma and found that 14% had suffered from four or more ACEs\(^15,16\). Findings suggest that children who have experienced traumatic events may be more likely to engage in risky behaviours. Of those who experienced four or more ACEs, they were four times more likely to be a high-risk drinker, six times more likely to smoke e-cigarettes or tobacco, 14 times more likely to have been a victim of violence (within the last 12 months) and 16 times more likely to have used crack cocaine or heroin.

2.8. The RCPCH’s *State of Child Health* found that certain family and social environment indicators impact upon children’s health, namely child poverty and being in the child protection system\(^17\). Currently, 1 in 5 children in the UK live in conditions of poverty and this figure is projected to rise\(^18,19\).

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\(^19\) Joseph Rowntree Foundation (2017) *UK Poverty 2017: A comprehensive analysis of poverty trends and
Research demonstrates that poverty is associated with adverse health, developmental, educational and long-term social outcomes\(^{20}\). Furthermore, children in the child protection system are more likely to experience physical and mental health issues. Counselling sessions by Childline revealed that nearly half of all contacts made related to children who were worried about unhappiness, bullying and family relationships. These findings suggest that adverse experiences during childhood can contribute to negative outcomes for children.

3. Evidence gaps within the literature

3.1. Many of the research studies on interventions have been conducted within US and Canadian settings. Though specific UK studies have been conducted\(^{21}\), RCPCH calls for further investigation with UK children, testing policy and practice interventions in this setting.

3.2. Due to the nature of the topic, much of the data has been collected retrospectively—relying upon individuals to recall experiences within their childhood. Retrospective methodologies are naturally open to bias and confounding. A smaller number of studies have utilised a prospective methodology, whereby individuals are followed over time to observe the prevalence of negative outcomes and have gone some way to mitigate fears of recall bias\(^{22,23}\). However, in these studies, the evidence that ACEs lead to long-term negative health outcomes has been mixed. Therefore, RCPCH suggests caution in interpreting the results of studies and calls for more prospective research to be conducted.

3.3. Literature has commonly overlooked the role of parental distress impacting upon unborn and new-born children—studies have mostly considered young people at older ages. Maternal function during the perinatal period is vital for the long-term health of the child. Many parental predicaments do not present as obvious clinical disorders but may lead to consequences, such as: antenatal anxiety, maternal eating disorders, obesity, postnatal depression, and the insecurity of being the victim of violence or intimidation\(^{24}\). These are not all ICD diagnoses that fulfil criteria for randomised control trial research. RCPCH calls for more research in this area. There is a responsibility for health and social work professionals to better recognise these vulnerabilities and take action before the child’s development is impacted.

3.4. There is a major gap in research relating to child maltreatment; it has not been determined which ACEs or the quantity of experiences that result in negative outcomes\(^{25}\); though it has been


conjectured that domestic abuse, loss and social isolation are key factors. Screening tools using ACEs have been used, but are not sensitive or specific to child maltreatment. It is also not known what the differential impact of different forms and intensities of maltreatment are on mental and physical health.

3.5. RCPCH suggests shifting the focus of research away from whether ACEs determine negative outcomes and toward the influence upon the resilience of children and young people, and towards developing and testing interventions that support resilience and promote healthy childhood experiences. Individual resilience is known to be affected by temperament, self-esteem, emotional regulation, self-compassion, trauma appraisal and peer relationships (at home and school). Resilience is also related to familial support, neighbourhood cohesion and social capital. Therefore, there are structural barriers that must be addressed, such as poverty, unemployment and poor housing conditions. Future research should endeavour to explore how these resilience factors can both implicate or prevent the development of ACEs.

4. Evidence-base for interventions

4.1. Interventions are either directed towards reducing the incidence of ACEs that take place in the UK and/or reducing the negative impacts of ACEs once they have taken place. The impact of interventions aiming to reduce long-term negative outcomes is dependent on the type of trauma the individual has experienced. At present, little robust research exists on the impact of interventions upon children who suffered from different ACEs. Such research is made difficult as tools for early identification are not sufficiently strong.

4.2. There are evidence-informed interventions for children and young people who can be identified as being at risk for poor outcomes, which has been detailed in the NICE Child Abuse and Neglect guideline[26]. One randomised controlled trial demonstrated the effectiveness of trauma-focused cognitive behavioural therapy in survivors of child sexual abuse[27].

4.3. Caspi et al. (2016) have found negative implications of ACEs to be intergenerational; their study of adolescents with post-traumatic stress disorder (PTSD) found that parents also have high ACE scores, leading to low levels of emotional attachment and connection with their infants[28]. This suggests that halting transmission of ACEs may be a useful therapeutic avenue, however, it does not demonstrate the truth of this.

4.4. There is some evidence that programmes designed to improve social skills of parents (e.g. Triple-P Positive Parenting Program) are ineffective for vulnerable families. Randomised control trials should be conducted that compare social learning parental programmes with programmes designed for parental emotional attachment (e.g. Tuning in To Kids). Trials should compare therapeutic interventions against each other and not compare to interventions with families on a waiting list, as social equipoise is ethically an important consideration in mounting such trials.

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4.5. The Washington State Department of Health – in the US - have suggested that building a community capacity would be effective in reducing ACEs. They define community capacity as a ‘cross-system infrastructure, integrated service delivery system and protective community living environments’. Within a UK context, this would translate to integrated commissioning of services, robust housing standards, and local leadership and accountability of children’s services. RCPCH recommends that action is taken to support development in these areas.

5. Is evidence being used effectively within government policies?

5.1. Currently, the existing evidence is not being used effectively within government policies.

5.2. Lack of funding and investment have led to cuts within children’s services and centres across the UK. Health visitors and school nurses have been subject to reduced funding allocation at a time when voluntary services are also stretched. Funding has shifted from early intervention to late interventions, in direct contradiction to the evidence on effectiveness and cost-effectiveness\(^29\). Funding cuts have caused a decrease in community capacity to provide care and support for children who may be at risk of ACEs. There is evidence to suggest that these cuts have led to an increase in maltreatment cases. There should be greater governmental recognition of the impact of funding cuts within vital areas, which implicate upon the negative outcomes for children.

5.3. Mental health services in the UK are under resourced and are therefore unable to provide early intervention programmes. Within the current model, children must present with symptoms of ill health before they are eligible to receive treatment or care. As such, preventative strategies are not usually pursued and typically become the responsibility of stretched community paediatricians, social care workers and/or the voluntary sector. This system has resulted in many children not getting care that they require – for example, 70% of children experiencing mental health frailties in the UK have not received appropriate interventions\(^30\).

5.4. The need for early identification of children in vulnerable families is embedded in the 0-19 Healthy Child Programme. Also, the Department for Education’s Working Together to Safeguard Children advocates for local provision of enhanced universal services; including the need to promote and provide ‘early help’ through offering social support with parenting capacity and coping strategies. Furthermore, former MP Graham Allen has outlined effective early intervention programmes and policies\(^31\), which have been broadened to provide local early intervention strategies\(^32\).

5.5. The impact of ACEs on mental health in is also considered in the recent government Green Paper on transforming children and young people’s mental health provision. Acknowledgement is given for secure attachment as a protective factor for children and young people’s mental health, and the


Written evidence submitted by the Royal College of Paediatrics and Child Health (EYI0054)

recommendations give a commitment to commissioning further research into interventions, to reduce the impact of ACEs and support parents and carers to improve attachment with their babies.

5.6. Effective healthcare for children and families should centre around multi-disciplinary working and integrated decision-making to advise, support and treat individuals. Kraemer (2015) argues for the presence of a ‘regular multi-disciplinary team in every large maternity centre to detect any risk of parental distress, disorder or disability that may impact on the child’s subsequent development’.

6. How can research in this area be supported?

6.1. Research should be supported through collaboration with a wide range of organisations, ensuring all necessary voices are considered. The RCPCH should be represented as a necessary organisation for inclusion. A roundtable of organisations should consult and consider funding for viable research opportunities. Research should be supported and funded by the Medical Research Council (MRC) and the National Institute for Health Research (NIHR). The RCPCH would be willing to host roundtable events, providing funding was made available.

6.2. A literature review should be conducted to collate the vast and varied literature on ACEs in a systematic way. NICE could facilitate with drawing together the existing evidence-base and suggesting areas for recommendation. Where literature is lacking, systematic reviews and/or cohort studies/randomised control trials should be funded. It would be useful to thematically order the literature under the following headings:

- Should professionals enquire about ACEs at every new contact?
- Should professionals enquire about ACEs opportunistically?
- Can ACEs or components of ACEs be used as a ‘screening tool’ to identify those who require early intervention?
- If so, which components have the best psychometric properties?
- What are the most effective interventions for those children and families identified as being at risk for adverse outcomes?

6.3. Future research should seek to examine evidence gaps, as outlined above, focusing on development and evaluation of individual and population level interventions in practice and policy, and translation of knowledge to action. It is vital that population level determinants such as the relationship between social and financial disadvantage and children’s health features centrally, as the link between poverty and adverse childhood experiences are clear, avoidable and ameliorable.

6.4. Lancashire NHS Foundation Trust are currently conducting routine questioning about ACEs at each health or social care contact through the Routine Enquiry about Adversity in Childhood (REACH) project, which has been funded by the Department of Health and NHS England with support from the Royal College of Psychiatrists. Results show that 82% of psychiatric inpatients disclosed trauma when questioned, compared to 8% of individuals voluntarily disclosing. Such strategies are effective methods to collect data, however, they should only be conducted where there are effective interventions and support systems in place for those who do choose to disclose information.

7. Recommendations for action

7.1. The existing literature on ACEs should be reviewed, organised and appropriately interpreted. Evidence that ACEs lead to negative outcomes and that intervention strategies are effective in mitigating consequences should be outlined, understood and implemented.

7.2. A cross-governmental summit should be held to provide a platform for discussion and engagement with necessary stakeholders. The summit should include the Department of Health, NHS England, Public Health England, Health Education England, Department for Education, the Home Office, Royal Colleges and academics working in this field. The RCPCH would be willing to host the summit, providing funding was made available.

7.3. Early-help services should be supported and funded with adequate provision. Funding should provide investment for a well-trained multi-disciplinary workforce to appropriately respond to children and families at risk of or who are experiencing harm. Furthermore, the availability of therapeutic support should be increased for children and young people who have suffered adversity in all forms.

7.4. UK governments should follow recommendations outlined in the RCPCH State of Child Health report and introduce comprehensive programmes to reduce child poverty\(^\text{37}\). Governments should ensure that universal early years’ public health services are prioritised and supported, with targeted support for children and families experiencing poverty.

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