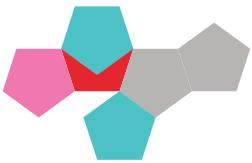











The Little Book of ADVERSE CHILDHOOD EXPERIENCES

Siobhan Collingwood, Andy Knox, Heather Fowler, Sam Harding, Sue Irwin and Sandra Quinney



Editor of this Little Book:

Dr Claire Coulton
ImaginationLancaster, Lancaster University

With design by Michael Stead and Roger Whitham
ImaginationLancaster, Lancaster University

Lancaster University

The Little Book of ADVERSE CHILDHOOD EXPERIENCES

Siobhan Collingwood, Andy Knox, Heather Fowler, Sam Harding, Sue Irwin and Sandra Quinney

The Authors

Siobhan Collingwood
Siobhan Collingwood is a Headteacher at Morecambe Bay Community Primary School, a school well known for its work to support Children and their families. She is also a representative on the Lancashire Safeguarding Children's Board for whom she is currently seconded to address the challenges of multi-agency working.

Dr Andy Knox
Andy is Executive Lead GP for Morecambe Bay CCG and Director of Population Health for Bay Health and Care Partners.

Heather Fowler
Heather Fowler is the Designated Lead for Safeguarding and SEMH at Westgate Primary School. She has 15 years experience working in both mainstream and special settings with children and families with complex needs. Heather has recently provided support for other schools across the north west in developing inclusive practices and sits on the management committee for the safeguarding charity Kidsafe UK.

Sam Harding
Sam is a qualified social worker with a background in Child and Adolescent Mental Health Practice. She is currently a Primary Mental Health worker at Lancaster and Morecambe CAMHS where her role is to advise and educate the community of professionals to feel comfortable supporting young people's mental health.

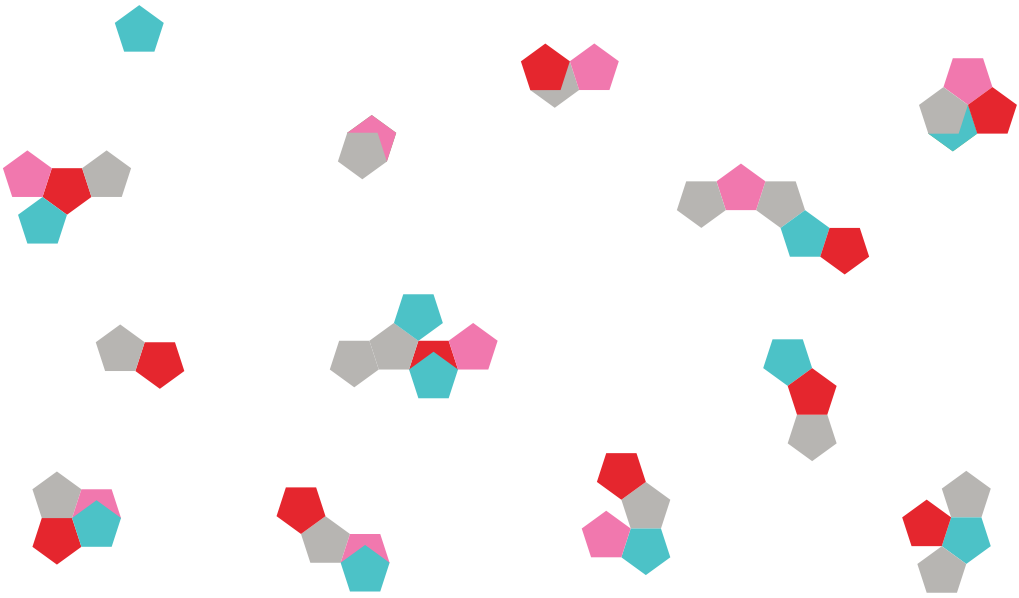
Sue Irwin
Sue Irwin is a very experienced consultant, with over 23 years in education and learning. As a national lead on Adverse Childhood Experiences (ACEs) and founder of EmBRACE, Sue effectively leads other professionals to reflect and develop their practice, provide change management through an ACE lens and build trauma-informed cultures.

Sandra Quinney
Sandra works as a learning mentor and family support worker at Morecambe Bay Community Primary School. Part of her role is to support children and families who have experienced Adverse Childhood Experiences.

Contents

What this little book tells you

This little book has been written by a small group of front line practitioners who have extensive experience in supporting children who are living with trauma and/or experiencing traumatic events. We are all based in the North West of England and work in the education sector and the NHS. We have written this Little Book to inform other practitioners about what ACEs are, what their immediate effects are and how they can affect children both in the short-term and throughout their lives. We offer the reader some case study examples, and also discuss a number of different ways that have been developed to manage the effects of ACEs and to prevent them occurring in the first place.



Introduction

A societal change is happening – across the world and the United Kingdom, people are becoming ACE aware. ACEs stands for Adverse Childhood Experiences, and the term is used to describe stressful situations that children may experience; this includes domestic violence, drug and/or alcohol abuse, familial mental health issues, physical abuse, emotional abuse, sexual abuse, neglect, separation, loss and incarceration of a family member.

Surveys show that ACEs are very common, with between half and two thirds of respondents having experienced one or more ACE. The more we have found out about this subject the more it has resonated with our own lives and daily experiences. As parents, friends, teachers and people who have experienced some ACEs within our own early years, our increased awareness of this subject has helped us to make sense of behaviours that can be seen as frustrating and bewildering within a school environment.

So why does this matter? Current research and collected evidence clearly demonstrate the effects of cumulative and prolonged stress in a child's body and brain, profoundly altering the development of their brains, immune systems and resistance to disease, so much so that a child with exposure to multiple ACEs may have a 20 year shorter life expectancy and is much more susceptible to risk taking or criminalised behaviour. Even worse, they are very likely to pass these traits on to the next generation.

The good news is that these outcomes can be improved and ACEs can be prevented. Early action and prevention can have a profoundly positive impact upon health, educational and criminal outcomes, improving the long-term outcomes for individuals and families, but also increasing the nation's cultural, societal and financial capital.

As practitioners, we have found that increased understanding of ACEs has helped us to be more tolerant and kinder to ourselves and others. Improved understanding of these issues has fostered such practices as kind listening and unconditional positive regard. This helps healing and minimises

damage, while building resilience in families, groups and individuals. We believe that with simple kindness, having better knowledge and access to appropriate support, it is possible to prevent ACEs from blighting the lives of people and reduce the intolerable strains that their effects put upon society. But we can only do this if we are ACE aware and ACE alert, only if everyone; teachers, doctors, nurses, police officers, bar staff, volunteers, teenage friends, and parents know what they are and how they affect so many people.

Over half of the people you will meet today have lived with and been affected by ACEs. How would it alter the way you interact with them and your expectations of them, if you saw them through this lens? That is why this Little Book matters. The toxic effects of ACEs will not be mitigated by a visit to a professional alone; appropriate support services will only be effective if they are complimented by the daily interactions that we all have with each other. This cannot be left to an anonymous professional to deal with, we all need to be aware and ready to play our part in healing the effects of so many silent and hidden cuts to people's sense of self, health and prospects.

In the next section, we will look more closely at some of the research that has been carried out into ACEs and discuss how, as a society, we can begin to support those who need our help to heal and move on from their early traumatic experiences.

What are ACEs?

Adverse Childhood Experiences (ACEs) describe a wide range of stressful or traumatic experiences that may occur as a child is growing up. As we have discussed above, this can include;

- domestic violence
- drugs and/or alcohol abuse
- familial mental health issues
- physical abuse
- emotional abuse
- sexual abuse
- neglect
- loss due to separation or divorce of parents
- loss due to bereavement
- incarceration of a family member

People started to study the effects of ACEs in the United States in the 1990s. This early study found that the more a person experienced ACEs in their childhood, the more likely they were to experience a range of health conditions in adulthood. Further studies have been carried out in England and Wales that have found similar things.

ACEs can directly harm a child; for example, if they experience physical, emotional, sexual, verbal abuse or neglect. ACEs can also indirectly cause harm, due to the effects of the environment in which the child is living; this includes things like experiencing bullying, parental separation and divorce, witnessing domestic violence, experiencing parental mental illness, and living with someone who has an alcohol or drug addiction. Other ACEs that cause harm include the death of a parent or sibling, the incarceration

of someone living with them or entering foster care or the care system.

Unfortunately, ACEs are extremely prevalent. In 2014 an ACE Study by Bellis et al found that nearly 50% of all people living in the UK have experienced at least one ACE – and 9% have experienced four or more.

This is the equivalent to three children in every class of 30.

Further studies have also found that the more ACEs you have experienced, the worse your physical, mental and social outcomes will be (See Larkin, Felitti, & Anda, 2014; Skehan, Larkin, & Read, 2012; Varese, et al., 2012; Kessler & et al, 2010 for further information.) and ACEs don't occur in isolation – if you experience one ACE there is an 87% chance that you will experience two or more. From this, we can see that ACEs can cause devastating long-term harm, but what is it about ACEs that cause damage and ultimately affect life outcomes?

How do ACEs affect us?

When we are exposed to stress our adrenal system's 'fight, flight or freeze' response kicks in to protect us and get us out of danger. This is a normal and protective response which subsides once we are out of the stressful situation. When we are continually exposed to increased or prolonged states of stress we stay in this heightened state of alert and are unable to relax and recover. This could be described as a toxic state of stress. ACEs cause toxic stress and research has shown that toxic stress in childhood adversely affects the structure and functioning of a child's developing brain. This has the effect that children experiencing ACEs are often unable to think rationally and interact with others and it is physiologically impossible for them to learn, leading to low academic achievement.

There is a lot of evidence that ACEs also affect short- and long-term health outcomes, and can even impact every part of the body. This can lead to lifelong conditions by disrupting the brain and organs and damaging the body's defence against disease, leading to autoimmune and chronic diseases, such as arthritis, type II diabetes, chronic pulmonary disease as well as heart disease, breast cancer, lung cancer and a range of mental health problems - it can even alter how our DNA functions, and that can be passed on from generation to generation. Research has also shown that

exposure to ACEs is linked to increased levels of violence.

We have seen that exposure to ACEs in childhood has a negative effect on educational achievement and health, both in the short term and also in the long term. However, there is also an effect on behaviour - compared with people who experience no ACEs, people who experience four or more ACEs have a two and a half times increased risk of acquiring a sexually transmitted infections, a five times increased risk of illicit drug use, a seven times increased risk of alcohol addiction and a 12 times increased risk of attempted suicide. The risk also increases with the increase in ACEs, people who experience six or more ACEs have a 46 times increased risk of intravenous drug abuse, 35 times increased risk of suicide and are at risk of their lifespan being shortened by 20 years.

Even with experiencing less than four ACEs people have increased risks of health harming behaviours. They are;

- two times more likely to binge drink and have a poor diet
- three times more likely to smoke
- five times more likely to have underage sex
- six times more likely to cause or have an unplanned teenage pregnancy
- seven times more likely to be involved in violence
- 11 times more likely to use intravenous drugs and go to prison.

In comparison, if there were no ACEs, there would be the following reductions. It is estimated that we would see 22.9% fewer mood disorders, 31% less anxiety disorders, 41.6% less behavioural disorders, 27.5% less substance-related disorders, 29.8% less mental health diagnoses overall and 33% less diagnoses of psychosis.

But we believe that ACEs can also be prevented. Stable and nurturing relationships and environments help children to build the skills and resilience needed to thrive as adults. By encouraging these stable and nurturing relationships – even in difficult circumstances – ACEs can be prevented. It is crucial we support children as they grow and develop. It is also possible to minimise the impact ACEs have with the right support – for children and adults.

In the next section, Heather Fowler summarises an approach that she commonly uses to explain to professionals and families the effects of our early experiences on our development. In it she demonstrates very clearly the crucial role that the first 1,000 days of a child's life has on the way in which they engage with the world, inside and outside of their families. She then goes on to show how the subsequent culmination of stress in a child's life adds to these issues and prevents them from thriving.

Adverse Childhood Experiences: Pennies in the Bank

Research tells us that children's development is affected by their experiences, not just in the early years, but even before that, throughout pregnancy in the womb. To explain how these experiences affect children, we can compare the point of conception to being a bit like opening a bank account; a wellbeing bank account.

Following conception, every time a pregnant mother experiences her needs being met, care from her partner, family or friends, access to appropriate medical care, and positivity and inclusion from the community around her, a penny is put in that child's wellbeing bank account. Over time, throughout pregnancy, these pennies add up.

Following birth and during the crucial first 1000 days of a child's life, every time they experience connection with their care-giver through having their needs met, more pennies are deposited in the wellbeing bank account which accrues positive interest on their social and emotional health.

Occasionally, there might be times when withdrawals are made, perhaps when a parent is experiencing stress and is less available to their child, but there are enough funds already in the bank to cover this withdrawal without making too much of a dent in the total balance. The child has already built up a resilient bank balance in their wellbeing savings account. This translates to the child having a good credit rating which is shown through how they are able to interact with the world and this increases their chances of good physical health.

However, for some children who have grown in the womb experiencing toxic stress through adverse childhood experiences, they may be born without that many pennies in the bank. Perhaps they might even already be overdrawn.

These children will encounter some positive experiences and subsequent deposits being made into that bank account, but it's not quite enough to recover the deficit. If there are further adverse experiences, there will be further withdrawals. The deficit will impact on their wellbeing credit rating, meaning they might find it difficult to see the world as a safe place and increase their chances of risky behaviours and chronic health conditions.

It's stressful being overdrawn and having a negative bank balance. This can affect the way children behave and as a result of this the world around them often perceives these children with huge deficits in their wellbeing bank account as 'difficult' and 'challenging' and 'hard to engage'. These children often experience harsh sanctions and as adults they are more likely to enter the criminal justice system. These attitudes and actions act as red letters, reminding people of the negative balance in their wellbeing account.

Our job as a society is to make as many deposits as we can into people's wellbeing bank accounts. We can do this through unconditional positive regard and kindness. As with any deficit, it might take a while to pay off, but it is possible to get there with the support of a community. We need to be providing pennies in the bank, not more red letters. Healing happens in communities and healing helps communities. It's never too late. In the following three case studies, we give real-life examples of young people and their families experiencing ACEs and some of the steps taken to help. Please note that we have changed the names and any other identifying features to preserve their privacy and anonymity.

Case Study: Simon

Simon lived alone with his mother. When Simon was in Year Six, school staff visited his home unannounced due to concerns about his attendance. Staff found Simon living in very poor home conditions, with dog faeces engrained on his bedding and his mother unable to speak coherently due to substance misuse.

Children's Social Care and the police were called and Simon was removed and put in the care of an extended family member. He was allowed no unsupervised contact with his mother.

A few days later, Simon had his 11th birthday. He was distressed in school because he couldn't see his mother and he got into a fight and damaged school property. To address this, the Head Teacher contacted the social worker and asked if school could facilitate and supervise contact between Simon and his mother. This was agreed and arrangements were made for Simon and his mother to have some time together. School supplied a birthday cake and candles.

Afterwards, Simon's mother spoke to the Head and disclosed adverse childhood experiences of her own. The Head helped her to find the right support to address these issues.

Six months later Simon was able to return home. His mother engaged with support and said she felt that she had been heard and helped by staff in school.

Five years later Simon returned to his primary school and asked to speak to the Head. He told the Head it was his 16th birthday and he remembered his 11th birthday and wanted to thank her. Simon's mum had continued to make changes with support and Simon was no longer experiencing adverse childhood experiences.

Case Study: Thomas

Sarah and Paul are the parents of Thomas who is in the Early Years Foundation Stage in school. They have been in a relationship for six years. The family were experiencing some difficulties and sought support from local

agencies around issues of debt and supporting Sarah to attend appointments for her mental health diagnosis of bipolar.

During this time, Sarah disclosed that she was drinking a bottle of vodka a day and that she was experiencing abuse from Paul. Following a particularly significant disclosure from Thomas in school about witnessing his dad hurt his mum, Children's Social Care became involved.

Staff in school had always been concerned about Thomas's presentation and his attendance, but following this disclosure staff were concerned about how withdrawn he was and his reluctance to speak to staff.

Through the statutory involvement of Children's Social Care there was a multi-agency decision to make Thomas subject to a Child Protection Plan. The plan focused on Sarah reducing her drinking and support from domestic abuse services for both Sarah and Paul.

Sarah and Paul had both experienced adverse childhood experiences in their own childhood. Sarah had been sexually abused by a family friend and Paul had grown up in an environment where he had experienced his mother being hurt by his father.

The support from agencies focused mainly on the symptoms of the adversity Sarah and Paul had experienced – alcohol misuse, mental health and violent behaviour, rather than the cause – trauma in childhood. After 12 months on a child protection plan, Thomas was removed from his parents' care and placed in foster care.

Case Study: Sam

Sam is 10. He lives with his mum, his older sister, Claire (12), and his younger sister, Chloe (3).

Sam, his siblings and his mum have all experienced multiple ACEs. His mum witnessed domestic violence in her childhood and lived with a parent who suffered from severe mental health issues.

Sam and Claire witnessed domestic abuse in their early years at home. Their mum has also suffered from long term severe mental health issues. Sam's dad has been to prison. During Sam's formative years a lot of his care was provided by his sister who was only two years older than him.

Several agencies were involved in supporting the family over a number of years and the family made a lot of progress. Mum had another baby with a new partner and for a while things were positive.

In recent years Claire has become a school refuser, been excluded, become involved in criminal behaviour, been vulnerable to sexual exploitation, is violent within the family home and is again open to several agencies trying to support her.

Sam and Chloe are witness to this on a daily basis. Events are impacting on Sam's mum's mental health which in turn is impacting on her ability to parent effectively.

Sam is now displaying behaviours similar to Claire – there have been lots of incidents in school where he is unable to regulate his behaviour and he has been spending lots of unsupervised time out in the community. He appears to be depressed and staff now worry about his mental health.

His younger sister, Chloe, aged only three, is becoming very challenging in her nursery setting.

The whole family are once again now open to multi-agency support.

Once our eyes are open to the reality of ACEs and the effects that they have on ourselves and those around us, the next question is - how do we make a difference? What do we need to do to interact in a trauma informed manner?

This is where the challenge really sets in. We believe that to avoid further trauma for young people we should:

- prioritise safety
- establish trust while maintaining boundaries
- support autonomy for the individual.

In order to do this, we are going to have to become the instruments of a societal change. We will have to learn, help others to understand, create physically and emotionally safe environments, promote collaboration across sectors and organisations, encourage resilience and ensure support for survivors of trauma to access.

How can ACEs be managed?

So far, we have discussed what ACEs are, how they impact on people's lives, both in the short term and in the long term, and we have provided real-life examples of three young people living with exposure to multiple ACEs. However, we have also noted that we believe that the impact of ACEs can be managed and prevented. In this next section, we discuss three different approaches to management and prevention, these are:

1. EmBRACE: An educational Approach
2. Population Health Approach
3. Asset based Approach – Scotland, a nationwide approach.

1. **EmBRACE** (**Em**otionally and **B**rain **R**esilient to **A**dverse **C**hildhood **E**xperiences)

Sue Irwin, a recognised authority on the identification and management of ACEs, has worked with schools in Blackburn, Burnley and Skelmersdale, to develop a systems based approach to the management of ACEs within schools called EmBRACE. In this section, Sue explains this approach in detail and offers ways in which professionals can reflect and adapt their practice through an ACE lens.

Taking a Trauma-Informed Approach within the Classroom and Beyond

Background

In response to the emerging evidence on adverse childhood experiences (ACEs), a new and dynamic cultural change and leadership programme has been developed. This was funded in the beginning by Lancashire Constabulary when they became aware of the research carried out by Public Health at Blackburn with Darwen Council, and felt that an approach through local schools would be beneficial.

So, initially focussed within an educational setting, the programme has evolved to enable multi-agency programmes to adopt the approach and become Trauma-Informed. The cultural change programme is called 'Emotionally and Brain Resilient to Adverse Childhood Experiences', or EmBRACE for short. It was founded and developed by Sue Irwin, an experienced Educational Trainer, who acknowledged the relationship between academic success in childhood and the number of ACEs.

Blackburn with Darwen Borough Council, the first area in the UK to undertake a population-based ACE survey, found similar results to those found within America, which was poor health and social outcomes in adulthood which was related to childhood adversity.[1] Given the links with education, criminal justice and health, the approach taken in the Borough was holistic in its vision and, across all partners and within all communities. Blackburn with Darwen Borough Council strives to be the first Borough to be ACE-Informed and recognises the importance of both communities and organisations to becoming trauma and ACE informed. EmBRACE supports this vision and contributes to enabling organisations and communities to become Trauma-Informed.

EmBRACE was based on the pioneering work of Jim Sporleder when he was principal at Lincoln High School, Walla Walla, in America. A documentary, 'Paper Tigers', by James Redford follows six students at the school during the implementation of a truama aware programme.[2] Under Sporleder's

[1] For example see work by Bellis et al (2014) and Felitti (1991).

[2] More information on the film, Paper Tigers, can be found here: https://kpjrfilms.co/paper-tigers/

leadership, the school gained national attention over a four-year period due to the dramatic drop in out-of-school suspensions, increased graduation rates and number of students going on to post-secondary education.

EmBRACE recognises that individuals impacted by trauma operate at a continually high level of stress which results in them living in survival mode every day; the 'fight, fright or freeze' mode. Consequently, children under such adversity live every day in fear, reactively and in failure. It is, therefore, important to understand that students are entering classrooms in this already heightened state of stress. Given that ACEs are so common and endemic, EmBRACE takes a universal approach and focuses on ensuring that young people have at least one positive relationship with a trusted adult to provide the resilience that they require, and as Sporleder states, 'the underlying principle for a trauma-informed school is relationships first, then discipline'.

EmBRACE is a vehicle to change culture, focusing on relationships, the development of the brain during stressful environments and shifting policy/practice to a relationship-based culture. Whilst this takes time, energy and real commitment, EmBRACE provides such a framework for the necessary change management processes within a school (or any environment) to take place and to become trauma-informed.

Taking the nuances of each educational setting, EmBRACE provides a whole-school improvement approach where staff are supported in their thinking and developing practice to make the cultural shift. EmBRACE is not a prescribed set of policies, nor is it a neat package of lesson plans and resources; EmBRACE is a reflective tool that enables each setting to review current practice, identify what needs to change and begin the process of implementing that change. Firm and fair structures with compassion and empathy are part of the building blocks for becoming a trauma-informed school. Whilst the ACE journey differs within each school, because of different starting points, and each facing different challenges and opportunities, the vision remains the same: to become trauma-informed, provide the best opportunity for children and young people to flourish through a nurturing and supportive environment where the consequences of ACEs are reduced and, ultimately, to contribute to the reduction in ACE prevalence.

Case Study: Witton Park Academy (WPA)

EmBRACE was initially undertaken at Witton Park Academy[3] (WPA) in Blackburn, where Behaviour Manager, Steve Archer, was the ACE Champion supported by Sue Irwin. The implementation at Witton Park provided the opportunity to take theory and put it into practice, to refine what worked well within an educational setting, to assess whether the desired impact was being achieved and to have the opportunity to capacity build to enable sustainability and to expand into other settings.

After Trauma-Informed strategies were implemented it became apparent to staff that this was helping students feel safe and helping them to self-regulate, thereby putting them in a calming state which ultimately enabled them to learn.

Taking this approach with students who were impacted by trauma were effective strategies for all, leading the school to build capacity and sustainability, and it also increased awareness and understanding for the students themselves and helped them to seek help themselves but also identified a few undisclosed safeguarding issues.

Providing students opportunities to unlock their barriers and talk to a caring and trusting adult was a positive strategy in supporting students who had experienced trauma. What was fundamental to this change was the language used, focusing on 'What's happened to you?' rather than 'What's wrong with you?'

By taking an ACE-informed approach, using new language and a shift in thinking, the school has provided new opportunities to engage their students, and their staff, so that increased support has been provided with little resource investment; it has shifted the thinking and provision. Students who have been supported and nurtured through the interactive sessions have improved their academic achievements, as evidenced within the school's reflection report.

All staff received the ACE awareness training and, therefore,

[3] Witton Park Academy is a high school with academy status for children aged between 11-16 in Blackburn, Lancashire.

they have been able to consider their own experience of ACEs and the impact that it has had on their lives.

This has gone some way to reducing staff sickness levels, which is not surprising given Sporleder highlights, 'When an adult is not able to stay regulated when approaching a student who is dysregulated, the outcome will be to escalate the student to their breaking point'. Both staff and students had the opportunity to understand about the brain and its trigger points, and ultimately support new relationships to de-escalate potential challenges, thus improving health.

In relation to sustainability, Witton Park has built capacity for working in a trauma-informed way and is now enabling ACE-awareness and ACE-informed practice to be brought into feeder primary schools, as well as transition for students going into college and apprenticeships. One of its key successes is demonstrated when senior leaders include EmBRACE within their organisational development plans, self-evaluation processes and recognise the impact it has on individual's wellbeing, attendance and academic success. The EmBRACE cultural change model has been adopted across primary and secondary schools and within other settings, i.e. Substance Misuse Services; Transforming Lives (Troubled Families Blackburn with Darwen).

2. Applying a Population Health Approach to Adverse Childhood Experiences

In this section, Dr Andy Knox, explains how a population health approach can help to lessen the impact of ACEs on a whole population.

Here in Morecambe Bay, we have developed a way of thinking about Population Health in what we call our 'Pentagon Approach'. It can be applied to ACEs as a helpful framework for thinking about how we begin to turn this tide and cut out the harm caused by ACEs from our society. This is an area of great complexity with several contributing factors and will take significant partnership across all levels of government, public bodies, organisations and communities to bring about a lasting change. There are things we can do

immediately and things that will take longer, but with a growing awareness of just what a significant impact ACEs are having on our society, we must act together to do something now.

As detailed in Figure 1 below, the Pentagon Approach is made up of five actions; Prevent, Detect, Protect, Manage and Recover. These actions do not come in a defined order, rather, they should be thought of as happening simultaneously and should be on-going.

Figure 1. Diagram of the Pentagram Approach to managing Population Health developed by Morecambe Bay CCG.

Prevent

We believe that prevention will entail a mixture of community grass-roots initiatives, changes in policy and a re-prioritisation of commissioning decisions for us to make a difference together. Here are some practical suggestions:

- The first step is most certainly to break down the taboo of the subject and continue to raise awareness of just how common ACEs are and how utterly devastating they are for human flourishing.
- Introduce parenting classes at High Schools in Personal and Social Education Classes to help the next generation think about what it would mean to be a good parent. To be most effective, these should also form an important part of antenatal and postnatal care, with further classes available in the community for each stage of a child's development. Extra support is needed for the parents of children with special developmental or educational needs due to the increased stress levels involved.
- There needs to be a particular focus on fatherhood and encouraging young men to think about what it means to father children. Recent papers have demonstrated just how important the role of a father can be (positive or negative) in a child's life and it is not acceptable for the parenting role to fall solely to the mother.[4]
- We have much to learn from the 'recovery community' about how to work effectively with families caught in cycles of addiction from alcohol or drugs. We must find a more positive approach to keeping families together whilst helping those caught in addictive behaviour to take responsibility for their parenting, and helping to build support and resilience for the children involved is really important.
- We need a social services that is sufficiently resourced to provide continuity and consistency of the people working with any given family, especially around the area of mental health. Relationships are absolutely key in bringing supportive change and we must breathe this back into our welfare state.

[4] See the following for further information regarding to role of fathers in the family: www.eani.org.uk/_resources/assets/attachment/full/0/55028.pdf

- Hilary Cottam writes powerfully in her book, Radical Help[5] that we must foster the capabilities of local communities, making local connections and "above all, relationships". The welfare state is incapable of 'fixing' this, but it has an important role to play. It can catch us when we fall, but as Cottam asserts, it cannot give us flight.
- Sex education in schools needs to be more open and honest about the realities of paedophilia and developing sexual desire. Elizabeth Letourneau argues powerfully that paedophilia is preventable not inevitable. We must break open this taboo and start talking to our teenagers about it.[6]

Detect

If we want to make a real difference to ACEs and their impact on society, we need to be willing to talk about them. We can't detect something we're not looking for. Therefore, as our awareness levels rise of the pandemic reality of ACEs, we need to develop ways of asking questions that will enable children or people to 'tell their story' and uncover things which may be happening to them or may have happened to them which may be deeply painful or they may even have memories which are difficult to access. Again, our approach needs to be multi-level across many areas of expertise. We need to be willing to think the unthinkable and create environments in which children or adults can talk about their reality. For children in particular, this may need to involve the use of play or art therapy.

- School teachers and teaching assistants need to be given specific training, as part of their 'safeguarding' development, about how to recognise when a child may be experiencing an ACE and how to enable them to talk about it in a non-coercive, non-judgmental way.

[5] See Radical Help: How We Can Remake the Relationships Between Us and Revolutionise the Welfare State by Hilary Cottam.

[6] We recommend Prof. Elizabeth Letourneau's talk at TEDMED 2016 as a starting point for further information. This is available at the following link: https://www.tedmed.com/talks/show?id=620399&utm_source=rss&utm_medium=rss

- Police and social services need training in recognising the signs of ACEs in any home they go into. For example, in the case of a drug-related death, how much consideration is currently given to the children of the family involved, and how much information is shared with the child's school so that a proactive, pastoral approach can be taken. There are good examples around England where this is now beginning to happen.[7]
- Clinical staff working in healthcare need to be given REACh training (routine enquiry about adverse childhood experiences) as part of their ongoing Continuous Professional Development (CPD). In busy clinics, it is easier to focus on the symptoms a person has, rather than do a deeper dive into what might be the cause of the symptoms being experienced. A wise man once said to me, "You have to deal with the root and not the fruit". Learning to ask open questions like "tell me a bit about what has happened to you" rather than "what is wrong with you", can open up the opportunity for people to share difficult things about their childhood, which may be profoundly affecting their physical or mental health well into adulthood. There is a concern that opening up such a conversation might lead to much more work on the part of the clinician, but studies have shown that simply by giving someone space to talk about ACEs they have experienced, they will subsequently reduce their use of GPs by over 30% and their use of the emergency department (ED) by 11%.[8]
- We can ask each other. This issue is too far reaching to be left to professionals. If simply by talking about our past experiences, we can realise that we are not alone, we are not freaks and we do not have to become 'abusers' ourselves, then we can learn to help to heal one another in society. Caring enough to have a cup of tea with a friend and really learn about each other's life story can be an utterly healing and transformational experience. When we are listened to by someone with a kind and fascinated, compassionate eye, we can find incredible healing and restoration.

[7] See Paterson, B. (2017) for further details.

[8] See Larkin, Felitti and Anda (2014) for more information.

Protect

When a child is caught in a situation in which they are experiencing one or more ACEs, we must be vigilant and act on their behalf to intervene and bring them and their family help. When an adult has disclosed that they have been through one or more ACE as a child, we must enable them to be able to process this and not let them feel any sense of shame or judgement.

- Staff in trauma-aware schools are more naturally prone to thinking that 'naughty' or 'difficult' children are actually highly likely to be in a state of hyper vigilance due to stressful things they are experiencing at home. Expecting them to 'focus, behave and get on with it', they acknowledge is not only unrealistic, it's actually unkind. Equally, children who are incredibly shy and easily go unnoticed must not be ignored. Simply recognising that kids might be having a really hard time, giving them space to talk about it with someone skilled, teaching them some resilience and finding a way to work with their parents or carers via the school nurse or social worker could make a lifetime of difference. It is far more important that our kids leave school knowing they are loved, with a real sense of self-esteem and belonging than with good SATS scores or GCSEs. The academic stuff can come later if necessary and we need to get far better at accepting this. A child's health and wellbeing carries far more importance than any academic outcomes and Ofsted needs to find a way to recognise this officially. In other words, we need to create compassionate schools and try to ensure that school itself does not become an adverse childhood experience for those already living in the midst of trauma.
- In North Lancashire, we have created a hub and spoke model to enable schools to be supportive of one another and offer advice when complex safeguarding issues are arising. So that when a teacher knows that they need to get a child some help, they can access timely advice with a real sense of support as they act to ensure a child is safe. These hubs are connected to a multidisciplinary team, who can help them act in accordance with best safeguarding practice. This multidisciplinary team incorporates the police, social services, the local health centre (for whichever member of staff is most appropriate) and the child and adolescent mental health team.

- For adults who disclose that they have experienced an ACE, appropriate initial follow-up should be offered and a suicide risk assessment should be carried out.

Manage

The management will depend on the age of the child and must be tailored according to a) the level of risk involved and b) the needs of the child/young person involved. Some of the options include:

- In severe cases the child or young person must be removed from the dangerous situation and brought under the care of the state, until it is clear who would be the best person to look after them.
- Adopting the whole family into a fostering scenario, to help the parents learn appropriate skills whilst keeping the family together, where possible.
- EmBRACE training for safeguarding leads and head teachers in each school, enabling children and young people to learn emotional resilience in the context of difficult circumstances.
- Art/play therapy to enable the child to process the difficulties they have been facing.

For adults who disclose that they have experienced ACEs, many will find that simply by talking about them, they are able to process the trauma and find significant healing in this process alone. However, some will need more help, depending on the physical or mental health consequences of the trauma experienced. This may include:

- Psychological support in dealing with the physical symptoms of trauma
- Targeted psychological therapies, e.g. CBT or EMDR to help with the consequences of things like PTSD[9]
- Medication to help alleviate what can be debilitating symptoms, e.g. anti-depressants

[9] See The Body Keeps the Score, by Dr Bessel van der Kolk.

- Targeted lifestyle changes around relaxation, sleep, eating well and being active
- Help with any addictive behaviours, e.g. alcohol, drugs, pornography, food (suicide risk increases by eight times after bariatric surgery).

Recover

Again, this will follow on from whatever management is needed in the 'healing phase' to enable more long term recovery. There are many things which may be needed, especially as the process of recovery is not always straightforward. These may include:

- The 12 step programme, or something similar in walking free from any addiction.
- Revisiting psychological or other therapeutic support
- Walking through a process of forgiveness
- We may need to help children go through development phases, which they have missed, at a later stage than usual, e.g. some children will need much more holding, cuddling and eye contact if they have been victims of significant neglect.
- Compassionate school environments to help children and young people catch-up on any work missed, in a way they can cope with and reintegrate into the classroom setting where possible, but with head teacher discretion around sitting exams.

To complete the cycle, those who have walked through a journey of recovery are then able, if they would like, to help others and form part of the growing network of people involved in this holistic approach to how we tackle ACEs in our society.

3. The case for asset based approaches to reducing the impact of ACEs

In the final section of this Little Book, Siobhan Collingwood, Head Teacher of Morecambe Bay Primary School, explores how focusing upon positives in our young people and their families will allow us to build resilience to trauma and allow victims to lead happier, healthier and more fulfilled lives. She argues that the findings of a report into the Scottish asset based approach to service practice,[10] shows how important it is to have institutional practice that is backed by clearly supportive local and national policy.

It is clear that the experience of moving towards a united, service-based approach to the handling of trauma and ACEs in Scotland has many learning points for those of us that wish to make a positive difference in this field. If we are to begin to narrow the inequalities in society, the research argues that a fundamental shift in thinking is needed from what makes us ill to what keeps us well. It is clear that a societal shift and service shift needs to occur, to promote and strengthen the factors that make our lives healthier and more fruitful. This approach promotes the power of the individual and builds on what resources are already there.

The Scottish research argues that such a model fundamentally incentivises the workforce as it is at the heart of what first attracts many public sector employees into their roles. Belief that people are fundamentally good and have the power within them to create healthy fulfilling lives, if supported by services that help, guide and empower; exists as a fundamental value set in truly optimistic public services. Working at the opposite end of this scale leads to pessimism, disillusionment and defensive practice.

The report however, is clear that such an approach cannot replace but must compliment national policy that truly seeks to understand and address the root causes of inequality, poverty and dysfunction. This opinion repeats the findings of the 2010 Marmot Review that stated:-

[10] See McLean, McNeice and Mitchell (2017) Asset-based approaches: Striking a balance. Report available at the following link: https://www.gcph.co.uk/assets/0000/6049/Asset_based_approaches_in_service_settings.pdf

> As with health inequalities, reducing educational inequalities involves understanding the interaction between the social determinants of educational outcomes, including family background, neighbourhood and relationships with peers, as well as what goes on in schools. Indeed, evidence on the most important factors influencing educational attainment suggests that it is families, rather than schools, that have the most influence. Closer links between schools, the family, and the local community are needed.[11]

This is reinforced further, by Pamela Cantor[12] in which she makes a strong case that if we are to truly narrow the attainment gap for our nation's children, an aim that has been a huge national focus for many years, then we must look wider than curriculum content and ever tougher metrics. She is clear that schools dealing with the highest levels of poverty and adversity need the highest level of trust, emotional warmth and focus upon self-awareness and emotional health. This is why it is so vital that policy drivers within organisations and sectors do not drive practice that is counterproductive to Trauma informed care.

In Pamela Cantor's film, she clearly explains why the children seek out hugs and personal contact with school staff, and how Cortisol build up due to stress can be counteracted by an oxytocin response to affirming relationships of trust . She argues that if schools are safe environments, that provide rich, nurturing relationships of trust and allow time for children to learn about emotions and emotional responses, they will become much more successful in unlocking the potential of all children to learn.

In the Scottish report on the impact of asset based approaches to ACE management (see footnote 10) one of the case studies that they present focuses upon the value of Nurture Groups and whole school Nurture approaches.

[11] See the Marmot Review (2010) Fair Society, Healthy Lives: strategic review of health inequalities in England post-2010. Available at the following link: https://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

[12] See Turnaround for Children's short film, The science of adversity presented by Dr Pamela Cantor. This is available to watch online at the following link: https://www.turnaroundusa.org/video/the-science-of-adversity/

This is an approach that is truly asset based, that persistently starts from what is good about the child, helps them to discover these qualities and teaches them how to build on them for sustained and wide reaching success. I know this to be a vital part of managing the effects of trauma in children's lives and has been used to great effect at Morecambe Bay Primary. I have seen children change from being angry, non-compliant, fierce and unteachable, or from sad, withdrawn and near mute to enthusiastic, warm, positive and happy young learners.

This approach works because it starts from the child's baseline, it goes on to find out what is good and strong about them and builds on these attributes. At the same time it provides, calm, consistent, and high expectations of conduct and provides many opportunities for young people to reflect on how well they have met these expectations. When they have struggled and feel that they have failed or taken a backward step, time and space will always be given to make amends, they know that they will meet unconditional positive regard from the adults working with them, who may not always love their actions but will always love them. They are given the space to focus on healing and self-discovery, without the pressure of academic targets or strict disciplinary policies built upon fear and sanctions. Fear of academic failure, feelings of shame or angry adults will only send stressed brains further into a cortisol response and shut off a child's capacity to learn or develop. How different is this from the climate being promoted in some schools, to rigorously enforce behavioural expectations, in an environment that names and shames and scares pupils into compliance in the pursuit of academic rigour?

I believe that we would secure long-term positive outcomes in educational, health and societal terms, that could have a transformative impact upon our nation as a whole, if we can accomplish the following:

- Nurture the best in children
- Establish support mechanisms that nurture the best in parents and families
- Continue to promote an understanding of the long term toxic effects of trauma
- Promote self-esteem and emotional health in children, young people, parents and staff.

It is time for our public services to embrace positivity and focus upon asset based approaches that allow people to see and grow the best in themselves.

Conclusion

This little book is not a definitive guide to the issues and challenges that exist around Adverse Childhood Experiences. Through publishing this book we hope to raise awareness, prompt debate and encourage conversations between and across agencies: we hope that it can play a part in raising awareness, to lead towards an ACE informed society that promotes effective trauma informed care for all of us.

In the Lancaster and Morecambe area we have a well established multi-agency Mental Health Champions' Network, supported by Sam Harding and her colleagues in CAMHs. This group will continue to offer training and support on the subject of ACEs for practitioners across all sectors that are working to support the mental health of children and young people. Further support and training will be offered through a safeguarding network that will become established during the latter half of 2018, this group will catalogue resources and agencies that can offer support and provide training. In addition it will implement the EmBRACE approach into 12 local schools that will be able to share their growing expertise with a further 50 local schools, ensuring that all schools in the Lancaster and Morecambe area are offered training and support in this field.

The Lancashire Safeguarding Children's Board and Lancashire County Council have identified becoming ACE aware as a key target for developing appropriate family support services and the Lancashire Police are about to launch a joint project called Operation Encompass with schools to ensure that all children who are living with domestic abuse are identified and supported appropriately.

We are starting to work together so that we can really see those who need support through an ACE lens and to develop wholesome, trauma informed practice across every aspect of our society. We hope that after reading this book, you want to get on board and be part of the change that needs to happen across society in order to end the effects of ACEs.

References

Bellis, M., Lowey, H., Leckenby, N., Hughes, K., & Harrison, D. (2014). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. Journal of Public Health, 36(1), 81-91.

Cottam, H. (2018). Radical Help: How we can remake the relationships between us and revolutionise the welfare state. London: Virago.

Felitti, V. (1991). Long-term medical consequences of incest, rape, and molestation. Southern Medical Journal, 84(3), 328-331.

Kessler, R., & et al. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. British Journal of Psychiatry, 197(5), 378-385.

Larkin, H., Felitti, V., & Anda, R. (2014). Social Work and Adverse Childhood Experiences Research: Implications for Practice and Health Policy. Social Work in Public Health, 29(1), 1-16.

Marmot, M. (2010). Fair society, health lives: The Marmot review: Strategic review of health inequalities in England post-2010. Department for International Development. Retrieved June 26, 2018, from https://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

McLean, J., McNeice, V., & Mitchell, C. (March 2017). Asset-based approaches in service settings: striking a balance. Glasgow: Glasgow Centre for Population Health. Retrieved June 25, 2018, from https://www.gcph.co.uk/assets/0000/6049/Asset_based_approaches_in_service_settings.pdf

Paterson, B. (2017). Adverse Childhood Experiences (ACE): Safer communities through strong partnerships (PowerPoint Presentation). Public Health England. Retrieved June 25, 2018, from https://www.eelga.gov.uk/documents/conferences/2017/20%20march%202017%20safer%20communities/barbara_paterson_ppt.pdf

Skehan, D., Larkin, W., & Read, J. (2012). Childhood adversity and psychosis: A literature review with clinical and societal implications. Psychoanalysis, Culture and Society, 17(4), 373-391.

The Science of Adversity by Turnaround for Children (n.d.). [Motion Picture]. Retrieved June 25 2018, from https://www.turnaroundusa.org/videos/

van der Kolk, B. (2015). The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma. Penguin Books.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Bentall, R. (2012). Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective- and cross-sectional cohort studies. Schizophrenia Bulletin, 38(4), 661-671.