1. Strategic Statement on ACEs

Our aim is to strengthen and coordinate responsiveness to ACEs in Liverpool to build an ACE resilient city where children are less likely to experience ACEs, where children and families have support and resilience through adversity and where adults are supported to mitigate the potential impact of their own ACEs on their own health and wellbeing and that of their families. Ultimately our aim is for children and families to have longer, healthier and happier lives.

2. Purpose

This purpose of this Strategic Statement is to set out the collective commitment of all key partners across Liverpool to recognise and respond to the critical importance of Adverse Childhood Experiences in determining the current and future health and wellbeing of the population. A prevention based framework is proposed with the aim of establishing key opportunities to prevent children being impacted by ACEs, to ensure children have support and resilience through adversity and to ensure adults have support and resilience against the potential impacts of their ACEs. Capitalising on these opportunities requires responsiveness to ACEs and participation in this strategic approach from a range of key stakeholders from commissioners and planners through to front line professionals from a range of disciplines as well as from communities.

This strategic statement is driven by the intent to improve the education, employment, health and emotional wellbeing outcomes of Liverpool children, young people and families and is informed by Liverpool's Children and Young People's Plan, Health and Wellbeing Strategy and within the context of Liverpool's ambition to be a 'Child Friendly City'.

This statement:

- Sets out the critical importance of a coordinated and collaborative strategic response to ACEs;
- Uses life course approach operating across levels of prevention;
- Forms the foundation of a city wide ACEs action plan to operationalise the required response based on the following **key recommendations**:
  - The approach must be collaborative and multi-agency across key stakeholders working with children and families (including the parent or future parent cohort within adult services) and include the perspective of local communities
  - Commissioners and local leaders need to work jointly to create the conditions for evidence based, collaborative/multi-agency working around ACEs

- The landscape of providers responding separately to ACEs need to be explored and a better aligned and defined ACEs approach should be developed
- Communities and professionals need to be supported to understand the importance and impact of ACEs and the ways in which they can be survived and overcome
- Development of stakeholder workforces is an essential element.

3. National and Local Policy Context:

Possibly the most developed UK ACEs policy exists in Scotland where there is real commitment to addressing all types of childhood adversity, to reducing the negative impacts of ACEs where they occur and to supporting the resilience of children, families and adults in overcoming adversity. The work is brought together under the national approach 'Getting it right for every child' and 'The Scottish Programme for Government 2018 to 2019'.

The Scottish government are taking forward action in four key areas:

1. Providing inter-generational support for parents, families and children to prevent ACEs
2. Reducing the negative impact of ACEs for children and young people
3. Developing adversity and trauma-informed workforce and services
4. Increasing societal awareness and supporting action across communities

The approach builds on existing policies, including:

- Providing more support for children and families in the very earliest years by sustaining and developing the universal Health Visiting service;
- Achieving equity in education through the Scottish Attainment Challenge and, in combination with the Pupil Equity Fund, allocating funding directly to schools to close the poverty-related attainment gap;
- Putting children's wellbeing first through the Child Protection Improvement Programme, keeping them safe from abuse and neglect by ensuring effective child protection procedures are in place.

The approach also includes initiatives to better support adults who have been through adversity and trauma, including:

- Investment in a national trauma training programme to help Scotland's current and future workforce develop skills and services that respond appropriately to people's adverse childhood experiences and other traumatic experiences.
- Ensuring that ACEs inform the development of national policy. For example, the Justice in Scotland: Vision and Priorities 2017 to 2020 identified ACEs as a key issue and includes a range of actions to reduce their impact e.g. measures to reduce parental incarceration by moving to a presumption against short prison sentences.

- Working with the Scottish ACEs Hub to raise awareness and understanding about ACEs and progress national action. For example, by organising a national conference with partners in Education on addressing childhood adversity to support children's learning and wellbeing.

In late 2018 the UK Government Early Intervention Foundation (EIF) published the results of their inquiry into evidence supporting adversity-targeted early intervention as an effective strategy to address childhood adversity and trauma which included their assessment of the extent to which this evidence base was informing early intervention practice across England.

The report sets recommendations for what the Government should do nationally, and what local authorities should do locally, to ensure that every child has access to adversity targeted evidence-based early intervention if they need it. These recommendations:

- Identify that important research questions regarding childhood adversity and early intervention remain;
- Call for a fundamental shift in the Government's approach to early intervention targeting childhood adversity and trauma, matching the ambition of the Scottish and Welsh Governments, building on the example set by certain English councils and set out in a clear, new national strategy to empower and encourage local authorities to deliver;
- Maintain that the Healthy Child Programme is the only mechanism through which all children in England receive early years practitioner support before the age of five, and is therefore critical for identifying ACEs and other child development issues early and that the Government should review and strengthen the current provision of the Healthy Child Programme across England;
- Recognised the value of the original vision for Sure Start Children's Centres to provide or co-ordinate a variety of early years services (such as education, childcare, health services, social services and information, advice and training) whilst calling for national oversight to inform a more detailed core purpose, better evaluation and more focused delivery to those most in need;
- Call for Government to recognise the importance of child development and the impact of adversity in the early years, and ensure that it adopts 'transformative' ambitions and policies for pre-school aged children alongside its work targeting schools and colleges;
- Call for policy for primary and secondary schools that seeks to promote wellbeing as well as improving the early identification of, and support for, emerging problems;
- Acknowledge that there are a variety of programmes beyond the Healthy Child Programme that reach children who are experiencing or have experienced adversity and trauma (e.g. childcare providers) where evidence-based early intervention programmes should be initiated that specifically target these children and prioritise preventing ACEs or mitigating their effect;
- Declare the strength of evidence supporting long-term savings associated with effective early intervention as something that cannot be ignored on the basis of financial constraint especially given the savings that can be delivered for local authorities, particularly in the long-term, and given the positive impact on the life chances of children;
- Advocate strongly against financial strategies that favour maintenance of statutory duties alongside total disinvestment in well evidenced preventive programmes or investment in cheaper non-proven or one-off intervention programmes outside of a defined needs assessment and evidence based, sustainable strategy that is subject to proper evaluation;

- Call for Government to devise policy and also for Local Authorities to innovate to overcome challenges associated with the collection, sharing and analysis of appropriate data to track infant development, health and wellbeing outcomes to identify families that could benefit from adversity-targeted early intervention initiatives, to monitor their impact and to inform further improvements;
- Call for accreditation criteria for social workers to include knowledge of child development science, the impact of adversity and methods for addressing this, as well as good practice in collecting and using data;
- Call for improved awareness across the full range of professions that engage with young children or their families and that could either: help to identify those who would benefit from adversity-targeted early intervention; or would play a role in delivering early intervention services, in particular for those in leadership positions and inclusive of the following principles:
    - The importance of early years experiences on child development
    - The impact of childhood adversity or trauma and what can be done to remedy this
    - How to identify families that could benefit from early intervention
    - How to access and use relevant, up-to-date scientific evidence
    - How to make best use of data in offering, delivering and evaluating the effectiveness of early intervention services
- Call for local authorities to ensure that there is sufficient accredited, ongoing, specialist supervision from qualified supervisors for the workforce delivering adversity-targeted early intervention;
- Promote the opportunity presented by the Apprenticeship Levy as a source of funding for training early years practitioners.

4. Liverpool ACEs Delivery Group

An ACEs delivery group has been established in Liverpool with the aim of developing and coordinating a strategic response to ACEs. A range of stakeholders representing CCG, Local Authority Children's Services, CAMHS, Public Health, Children's Health Services, Education, Merseyside police, Higher Education/Research have come together with agreed Terms of Reference to review local intelligence/insight and evidence base (including good practice) to inform the approach.

The group is inspired by the strength of evidence surrounding ACEs and their impact as well as the potential protective and preventative scope of a coordinated strategic response across a range of outcomes. A significant driver has also been the voice and lobby of Children and Young People in Liverpool who have identified and demonstrated that ACEs represent their number one priority for improving health and wellbeing in Liverpool. This was powerfully demonstrated by the direct challenge vibrantly offered by Liverpool's Children and Young People during the 2019 NOW festival of children and young people's mental health and emotional wellbeing. The voice of children, families and adults impacted by ACEs will need to continue to be represented across this programme of work and co-production should feature centrally.

Group Terms of Reference

Rationale:

To bring focus and pace to the coordination and delivery of ACE and trauma informed practice including awareness and training across all partners agencies in Liverpool (child and adult).

Purpose:

a) To develop a Strategic Statement to guide the approach to embedding ACE and trauma informed practice across the city including raising awareness and understanding in this area.
b) To review and refresh the Training Needs Analysis to ensure it captures the requirements of all core settings (i.e. schools) and partner organisations
c) To influence the development of ACES awareness and training materials to ensure they reflect the different needs across settings and partner agencies
d) To coordinate the commissioning of ACES training across the city
e) To explore opportunities to develop and implement programmes/interventions which support ACE and trauma informed practice to guide the strategic approach
f) To encourage a learning environment between each other and also through best practice and evidence base
g) To ensure all developments are in line with local, regional and national policy guidance.

Schedule and Administration of Meetings:

- Meetings will be planned for a 12 month duration (see meeting schedule below)
- Administration of meetings will be through the local authority
- If a member is unable to attend a meeting apologies should be directed through the individual administrating the board prior to the meeting.
- An agenda and any relevant documentation will be distributed to all members before the meeting
- Brief discussion notes and actions will be circulated after each meeting.

Accountability:

The T&F group will be accountable to the Children's Mental Health and Emotional Wellbeing Partnership Board.

Membership:

- Gail Porter – Programme Director (chair), LCC
- Lisa Nolan – Programme Manager Mental Health- CYP, LCCG
- Jane Roberts – GP lead for Mental Health, CCG
- Jayne Cook/Kerry Taylor– Public Health, LCC
- Damian Hart – Merseyside Youth Association (MYA)
- Wendy Moss – Strategic Workforce Lead, LCC
- Elaine Rees – CEO, Liverpool Learning Partnership
- Carolyn Lawler – Virtual Head, School Improvement Liverpool
- Andy Kerr –Programme Manager Mental Health, LCCG
- Tom Fairclough – Programme Lead (Mental Health and Learning Disabilities for CYP) Liverpool CCG
- Gina Perigo – Joint Commissioning Programme Manager, LCCG/LCC
- Sue Renwick –Programme Manager, Long Term Conditions, LCCG
- Colette Williams/Kimberley Suart Done – Merseyside Police
- Zara Quigg – LJMU
- Jill Summers - Merseyside VRU (PT secondment)

- Paul Millet – ACES Coordinator, LCC

5. Strategic Aims

- To build an ACE responsive city: to prevent children being impacted by ACEs, to ensure children and their families have support and resilience through adversity and to ensure adults have support and resilience against the potential impacts of their ACEs.
- To communicate the critical importance of this approach and to gain support with reference to evidence surrounding the impact of ACEs locally on people and on the delivery and future sustainability of public services.
- To identify and influence existing local partnerships and services that are essential to this approach and have responsibility to respond to ACEs.
- To use evidence, intelligence and insight to inform a strategic plan that results in measurable responsiveness to ACEs across a range of settings (services, workplaces, education, communities, police, local authority, NHS, third sector etc.).

6. What are ACEs?

Childhood experiences have a huge impact throughout life, shaping who we are and how we respond to events in our lives. Adverse Childhood Experiences (ACEs) not only have a significantly negative impact on the health, wellbeing, quality of life and development of children but are also associated with a range of negative health and social consequences extending into adulthood and often creating intergenerational cycles of childhood adversity and poor outcomes in adulthood.

The ten widely recognised ACEs are:

Abuse:

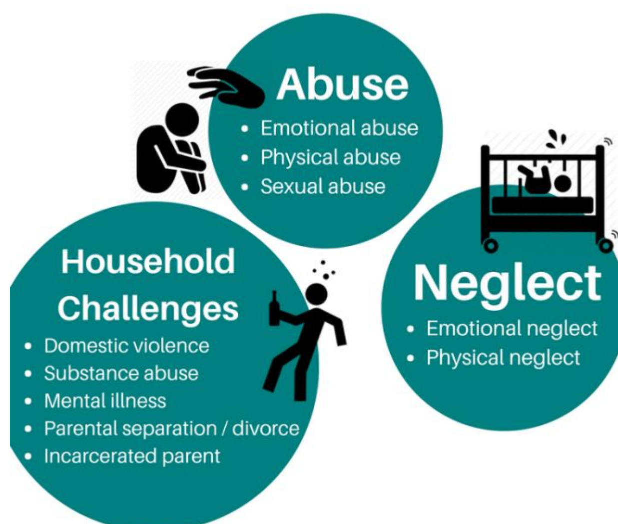
- Physical
- Sexual
- Verbal

Neglect:

- Emotional
- Physical

Growing up in a household where:

- There are adults misusing alcohol/drugs



- There are adults with mental health problems
- There is domestic violence
- There are adults who have spent time in prison
- Parents have separated

As well as these 10 ACEs, there are a range of other types of childhood adversity that can have similar negative long term effects. These include bereavement, bullying, poverty and community adversities such as living in a deprived area, neighbourhood violence, etc.

Children commonly exist within a family unit and ACEs often impact across families. The adverse childhood experience of parents can determine not only their wellbeing and their prospects but also their parenting in ways that can create ACEs for their children. Supporting adults to acknowledge and address their ACEs can prevent or significantly mitigate intergenerational impact of ACEs.

Preventing adverse childhood experiences where possible and tackling their impact where they do happen is therefore crucial to thinking about how to improve the lives of children and young people, to support better transitions into adulthood, and achieve good outcomes for all adults.

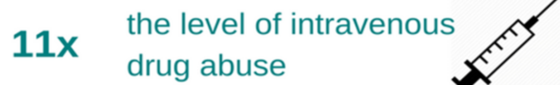
7. Summary of Key Research Findings:

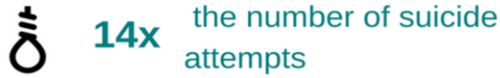
The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study conducted in America is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and wellbeing and is widely regarded as ‘the original ACEs study’.

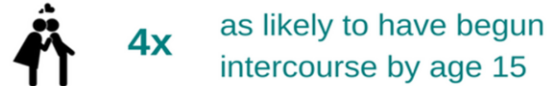
The study was conducted from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organisation members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviours. The ACE score is the total sum of the different categories of ACEs reported by participants. Study findings show a graded dose-response relationship between ACEs and negative health and wellbeing outcomes. In other words, as the number of ACEs increases so does the risk for negative outcomes.

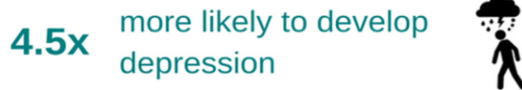
A significant proportion of the subsequent literature surrounding ACEs is based on the understanding that those who experience 4 or more ACEs face the most significant risk of poor outcomes. However the most recent findings indicate that although the ‘greater dose: greater response’ effect of ACEs is well tested, trauma is also individual, affects people differently and that ‘adding up’ individual ACEs as a measure of risk doesn’t account for the equally significant impact of regular exposure to a single ACE or the impact of low exposure in less resilient individuals.

4 or more ACEs









www.70-30.org.uk

- Adverse Childhood Experiences are unfortunately common yet rarely asked about in routine practice (Felitti et al., 1998; Read et al 2007; McGee et al 2015);
- In the English National ACE study, nearly half (47%) of individuals experienced at least one ACE with 9% of the population having 4+ ACES (Bellis et al 2014.);
- There is a strong and proportionate (dose-response) relationship between ACE and the risk of developing poor physical health, mental health and social outcomes (Bellis et al 2014).
  (Skehan et al 2008; Kessler et al, 2010; Varese et al 2013; Felitti & Anda, 2014.);
- ACEs increase the risk of adult onset chronic diseases, such as cancer and heart disease, as well as increasing the risk of mental illness, violence and becoming a victim of violence (Bellis et al 2014);
- ACEs are associated with a large proportion of absenteeism from work, costs in health care, emergency response, mental health and criminal justice involvement (Bellis et al 2014, 2017; Hughes et al 2016).

7.1 Health Impact:

Childhood adversity creates harmful levels of stress which impact healthy brain development. This can result in long-term effects on learning, behaviour and health. Evidence from ACE surveys in the US, UK and elsewhere demonstrates that ACEs can exert a significant influence throughout people's life. ACEs have been found to be associated with a range of poorer health and social outcomes in adulthood and these risks increase as the number of ACEs increase.

Toxic stress caused by ACEs affects short- and long-term health, and can impact every part of the body, leading to autoimmune diseases, such as arthritis, as well as heart disease, breast cancer, lung cancer and a range of mental health problems.

Over any 12 month period, people with 4 or more ACES (compared to those with none) are:

- 2x as likely to frequently attend the GP
- 3x more likely to have attended A&E

- 3X more likely to have stayed overnight in hospital
- 4x more likely to develop type 2 diabetes
- 3x more likely to develop heart disease
- 3x more likely to develop respiratory disease (England and Wales ACEs Surveys)

The mechanisms by which childhood adversity impacts health are not fully understood and it is not possible or appropriate to conclude that people who experienced 4 or more ACEs will experience poor health outcomes or to target services accordingly. People with 4 or more ACEs can and do avoid negative health outcomes and equally people with fewer ACEs can experience associated poor health impact. The key finding is that ACEs increase risk of poor health in adulthood both directly and as a function of negative health behaviours that can result from the developmental and psychological impact of ACEs.

Research from Wales found that people who reported experiencing four or more ACES are:

- 4x more likely to be a high-risk drinker
- 16x more likely to have used crack cocaine or heroin
- 6x increased risk of never or rarely feeling optimistic
- 3x increased risk of heart disease, respiratory disease and type 2 diabetes
- 15x more likely to have committed violence
- 14x more likely to have been victim of violence in the last 12 months
- 20x more likely to have been in prison at any point in their life

Across England, adults reporting four or more ACEs are (Bellis et al, 2014):

- 2x more likely to be a binge drinker or have a poor diet
- 4x more likely to report low life satisfaction and low mental well-being
- 6x more likely to have ever used cannabis or had an unplanned teenage pregnancy
- 7x more likely to have committed violence or to have been victim of violence in the last 12 months
- 11x more likely to have been in prison at any point in their life, or to have ever use crack cocaine or heroin

7.2 Prevalence Amongst Children:

- 1 in 10 children will experience 4 or more ACEs
- Children with 4 + ACEs are 32x increased risk of behavioural & learning problems at school
- 1 in 20 children have been sexually abused
- 1 in 14 children have been physically abused
- 1 in 5 children have been exposed to Domestic Abuse

- 1 in 10 children will experience neglect
- 1 in 3 children have experienced cyber-bullying

7.3 Childhood impact of ACEs:

Childhood and adolescence are key periods for development, growth and education, and are of critical importance in shaping adulthood. It is widely recognised that just as supportive, nurturing, safe and happy childhoods are necessary for later health and wellbeing, children growing up exposed to adverse conditions can experience negative short and long-term effects, including for health.

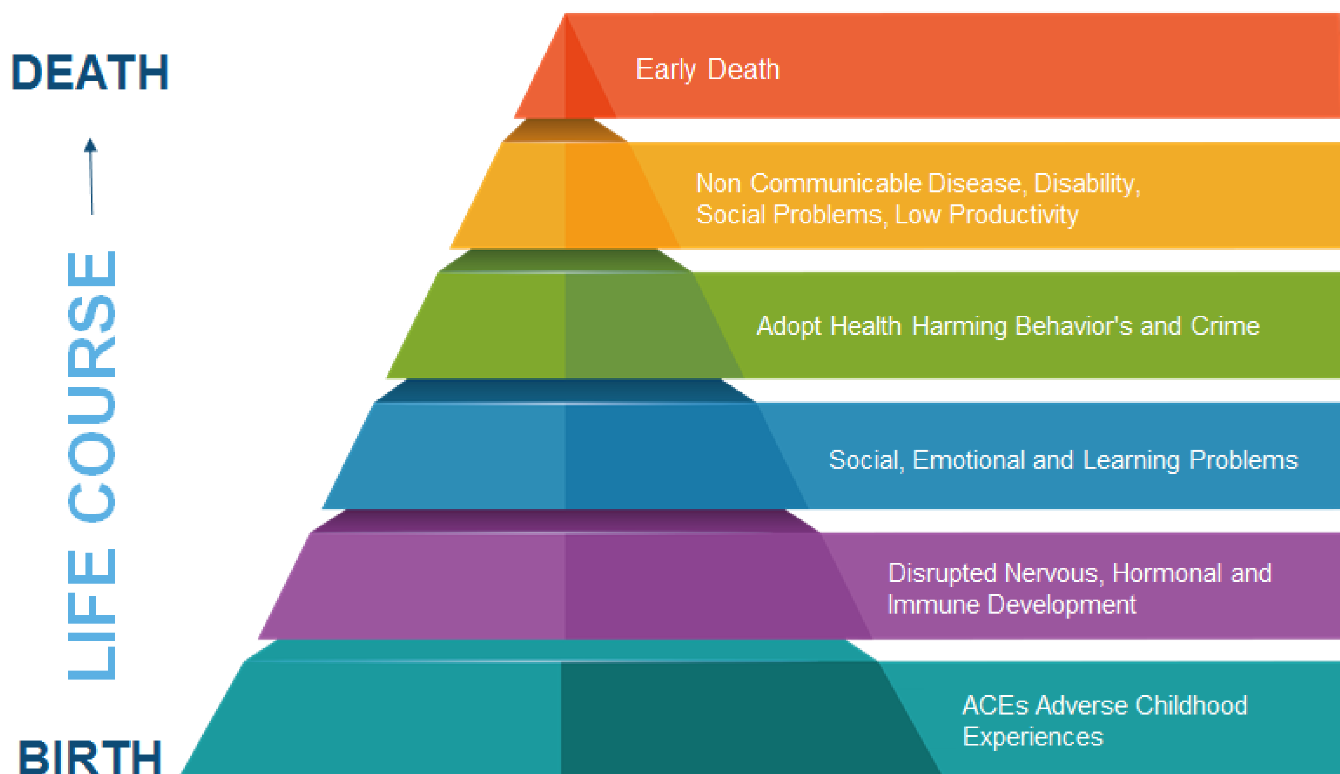
The impact of ACEs can begin to imprint even before birth. Maternal stress and lifestyle choices (e.g. exposure to smoke, alcohol and illicit substances) in pregnancy are known to adversely affect the structure and functioning of an unborn child's developing brain as well as their physiology and levels of resilience leading to adverse impact on lifelong outcomes.

At their most extreme, the presence of ACEs is associated with death through infant mortality, homicide or suicide during childhood and adolescence as well as with risk of self-harm mental illness or a low level of mental wellbeing, including low self-esteem, depression and relationship difficulties.

The presence of ACEs in childhood is also associated with increased risk of unplanned teenage pregnancy and violence perpetration. The adoption of these behaviours can be seen in the short term (mostly during adolescence but sometimes before) and persisting into adulthood. They impact on health directly, through an increased likelihood of disease, accidents or violence, and, in some cases (for example, criminality), impact on the wider conditions in which people live.

There is significant evidence linking ACEs with poor educational outcomes including specific evidence that verbal abuse impacts development of language skills and that abused and neglected children achieve lower grades, lower educational attendance and are more likely to be placed in special education provision.

The diagram below illustrates the impact of ACEs on the brain development of children which disrupts abilities in adopting healthy behaviours, seeking comfort and solving problems which in turn influences the choices and experiences of children exposed to ACEs as they grow up, ultimately leading to negative impacts across the life course.



Bellis 2016 Developed from Felitti et al. 1998

8. Local Intelligence on ACEs:

8.1 Data

In the absence of a recognised ACEs intelligence set, the following represent a collection of available relevant indicators:

- Liverpool's percentage of children in need due to abuse, neglect or family dysfunction (82.2%) is higher than the English average (67.3%) and 4th highest in the North West region;
- In Liverpool, 10.2% of all families are lone parent families and 10.8% of all new births are registered by one parent only, the latter is the highest in the region;
- The rate of children in need due to abuse or neglect in Liverpool is 270.9 (per 10,000), which is considerably higher than the national average (181.4);
- In Liverpool, the proportion of children being looked after because of family stress, dysfunction or absent parenting (11.2 per 10,000) is amongst the higher rates in the North West;

- Though latest estimates are somewhat out of date, in 2011/12 there were around 200 Liverpool children whose parents were in alcohol treatment and approximately 285 whose parents were in drug treatment services. As rates, both these measures are comparatively high, but the drug indicator is considerably so;

- It is estimated that 10.4% of Liverpool's children aged 5-16 suffer from mental health disorders. This is amongst the highest prevalence in the country, the highest observed nationally being 11.0%;
- In Liverpool, 378.7 (per 100,000) children aged 10-14 are admitted to hospital for self-harm, this increases to 660.5 for children aged 15-19;
- Data for 2016/17 shows Liverpool schools to have one of the worst rates of pupil absence seen in the country – 5.4% compared to 5.7% for the worst performing area nationally.

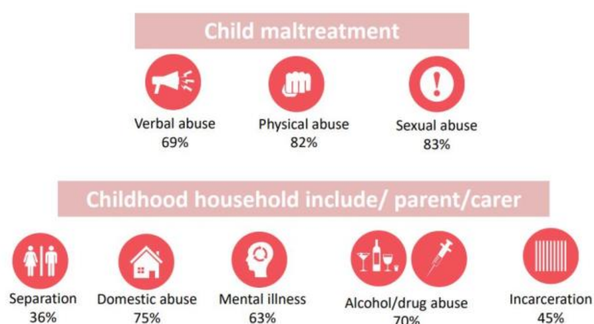
8.2 ACE perception Survey

In 2018, Merseyside Youth Association undertook a Liverpool ACEs Perception Survey designed to understand perceptions of ACEs across children & young people's workforce. The aim was to generate local insight to enable partners to take an informed approach to ensuring ACE & childhood trauma are identified and understood. There were 450 participants in total including teachers, social/youth workers, mental health practitioners, etc.

The findings can be summarised as follows:

- Overall there is good awareness of the impact of ACEs on behaviours (e.g. violence), education and employment but not on physical health (e.g. cancer, heart disease);
- Good understanding of the functions of attachment and trauma;
- Lower understanding of the concept of toxic stress and impact of ACEs on brain development;
- Lower familiarity (45% of those surveyed) with trauma informed approaches;
- 60% of those surveyed don't tools or resources to identify if children have or are living with ACEs;
- Over half (55%) would be confident to ask an adult about their ACEs;
- Slightly less than half (48%) would like support with self-care when dealing with CYP distress;

Knowledge of where to signpost for support:



Understanding aspects of resilience building:

In addition, the perception survey indicated that:

- Professionals in Liverpool would like to access professional development surrounding ACE awareness and building CYP resilience (training, workshops, online materials);
- Commissioners and providers in Liverpool should support the delivery of ACE awareness raising, training and workforce development (in assessing and responding to ACEs), in particular support for schools and specifically acknowledge the requirement for multi-agency working.

9 Conclusions from Research Evidence and Local Intelligence/Insight:

- ACEs are a cross cutting priority that influence a range of outcomes across the life course and these outcomes are the focus of input from a broad range of services and professionals;
- Children and families in Liverpool are exposed to relatively high levels of ACEs based on comparison with North West and National rates;
- There may be more local data on ACEs within existing local databases (e.g. CAMHS, Families Programme, Healthy Child Programme, Children's Centres etc.) that could inform a deeper understanding of local needs;
- There is little evidence to indicate that services are utilising data systems to track infant development, health and wellbeing outcomes, to identify families that could benefit from adversity-targeted early intervention initiatives and/or to monitor impact;
- Awareness of the wider impact of ACEs in Liverpool is mixed/partial;
- Awareness of the function of protective factors (e.g. attachment, resilience) is fair/good;
- Most professionals working with children in Liverpool are aware of where to signpost to services that respond to individual ACEs but don't formally ask about ACEs or offer any other evidence based response (e.g. trauma informed)

10 Building a Strategic Response to ACEs

Strategic responses to ACEs generally focus on 5 main approaches (discussed and extended below):

a) Support for Parents, Families and Children to Prevent Intergenerational Recurrence of ACEs
b) Reducing the negative impact of ACEs for children and young people
c) Creating resilience in adults and children

d) Developing trauma-informed workforces and services

e) Increasing societal awareness and supporting action across communities, changing culture

Crucially these approaches apply universally to public provision and services (including the voluntary and community sector) working with, encountering or impacting upon the lives, circumstances and environments surrounding children, families and all adults, especially parents, who may have been affected by ACEs.

a) Support for Parents, Families and Children to Prevent Intergenerational Recurrence of ACEs:

The intergenerational effects of adverse childhood experiences relate to those risk factors passed on through family generations. Children who experience adverse conditions are more likely to have a parent who has also experienced childhood adversity.

'Chronic toxic stress' can have a lasting effect on physical and mental health from birth to adulthood and these effects can be passed on to further generations sometimes resulting in intergenerational harm. Some of the mechanisms by which this occurs are covered below. Intergenerational effects add to the considerable human and societal costs of adverse childhood experiences for individuals, families, communities and services.

i. Environmental Circumstances and Inequality

There is a developing case for including material or social context for example, living in extreme poverty or deprivation as an adverse childhood experience. These conditions are linked to ACE prevalence and tackling material inequality and the negative circumstances that result is therefore an essential element of efforts to reduce the impact of ACEs, as well as reducing inequalities in childhood development and experiences more generally. ACEs must be seen as one part of a range of circumstances, experiences and contexts which impact on families and which must be considered holistically in order to be tackled successfully.

A clear inequalities gradient for adverse childhood experiences exists. While adverse childhood experiences occur across the whole population, the majority of risk factors for adversity are clustered in areas of socio-economic deprivation whilst people living in more deprived circumstances may experience worse outcomes due to an increased stress response and vulnerability to adversity.

The risk factors associated with increased likelihood of experiencing abuse, trauma and stress in childhood are varied and include the social context in which families live, parenting and family structure, and household factors. One of the ways in which ACEs can operate across generations is through persistent environmental and community adversity, added to experience of adversity at an individual level, sometimes described as a 'Pair of ACEs'. This perpetuation of disadvantage, from one generation to the next, contributes to societal inequalities as it places an extra burden on those children who come from disadvantaged backgrounds, reducing social mobility and increasing the risk of ACEs across generations.

It is important to always note that ACEs and their impact should not be seen as inevitable. The evidence and the premise for this strategy indicates that there is much that can be done to build resilience and positive futures for children, young people and adults who have experienced adversity in early life.

Drawing conclusions about risk of childhood adversity based on a person's socio-economic circumstances requires careful thought as it has the potential to stigmatise those living in areas of deprivation, perpetuate social injustice and increase risk. However where adversity is common and persists across generations for entire communities, it is especially important to ensure that individuals, families and communities have the skills, resources and necessary support to address their ACEs and to create and support resilience. This strategy to address ACEs should also seek to make clear the function of ACEs within the wider context of efforts to tackle societal inequalities.

ii. Genetics

Mothers with multiple adverse childhood experiences or who experience toxic stress during pregnancy are more likely to experience low birth weight, premature birth, and postnatal depression. Their babies are also more likely to have poorer physical and emotional health at the age of 18 months than mothers with no adverse childhood experiences.

In addition, changes in the way genes are expressed can be passed on to future generations, so that even though one person may not have directly experienced the stress and trauma that the previous generation of their family suffered, they may inherit genetic predisposition to ill health due to factors that affected their forbearers. Long term consequences of this type of genetic change have been extensively studied in communities which have large groups of people who all experienced the same trauma with reliable links established to poorer physical and mental health outcomes.

These findings resonate with those related to inequalities above and strengthen the view that communities exposed to adversities require particular attention when it comes to devising adversity-targeted early intervention and resilience building initiatives. In addition the impact of stress in pregnancy adds to the strong and growing evidence base to support radical upgrade to support offered pre-conceptually and in pregnancy when it comes to influencing key outcomes in Liverpool including infant mortality, special educational needs and disabilities (SEND) and childhood adversity.

Case Study – 1001 Critical Days Strategic Network

The 1001 Critical Days manifesto highlights the importance of intervening early in the 1001 critical days between conception to age 2 to enhance outcomes for children across the life course. The upward trend in infant mortality and downward trend in school readiness in Liverpool indicate where the focus needs to be. A local framework to inform the process of identifying priorities has been devised based on a UNICEF global report on early childhood development.

The network is overseen by a 1001 Critical Days strategic group representing senior leadership across the local health economy. Partnership sub-groups are progressing action plans associated to three key themes 'Infant Nutrition and Health', 'Protection from Adversity in Infancy' and 'Parent Infant Wellbeing and Development'. This includes a specific programme of work aiming to influence known modifiable risk factors related to infant mortality (e.g. parental smoking, obesity, substance/alcohol misuse, violence, mental ill health and failure to engage with services in pregnancy and early infancy).

This programme has informed the development and delivery of a number of initiatives linked to promoting health, wellbeing and resilience in pregnancy and the very years, an example of which is the Baby Steps intervention:

Baby steps

Baby steps is an information based partnership between public health and maternity services. During the different stages of pregnancy pregnant women are provided with information and advice about achievable actions they can take to ensure they remain as healthy as possible during pregnancy. This includes information about improving wellbeing and avoiding stress, stopping smoking, not drinking, eating a healthy diet and regular exercise. This information is then inserted into the woman's hand held notes to refer to throughout the pregnancy. For those women who require additional support referrals are made to a range of support services including smoking cessation.

iii. Parenting

The impact of ACEs on future parenting is well evidenced, parents who experienced ACEs are more likely to have children who are exposed to ACEs. Intergenerational transmission of ACEs has been demonstrated in relation to child abuse, mental ill health and substance misuse. Children exposed to domestic violence and other forms of violence are more likely to become both a victim and perpetrator of violence in later life.

Parenting style and capability have been linked to the prevalence of ACEs which may in part be due to children modelling the behaviour of their parents when they grow up added to the disadvantage of lacking positive parenting experiences and role models to learn from and replicate. Similarly parents who maltreat their children tend to be more isolated, lonelier and have less social support than those who don't and therefore inhibited in their parenting practices as a function of both the distress of social isolation added to lack of positive parenting role models and lack of pressure from others to conform to positive parenting behaviours.

It is important to acknowledge that experiencing ACEs does not determine that an individual is destined to perpetuate these conditions in relation to their own children. Most people who are maltreated or who are exposed to violence do not go on to expose their own children to similar adversities. More research is needed on the factors

that enable these people to 'break the cycle' although it appears that achieving socioeconomic progression is a key factor.

Parental social networks and universal parenting programmes that teach about good parenting have a hugely protective nature and can defend against poor outcomes for children, increase the amount of positive interactions mothers have with their children and provide diverse social networks that help to reduce parental isolation and stress, generate shared understanding of parenting and a buffer to the challenges of parenting.

b) Reducing the Negative Impact of ACEs for Children and Young People:

Where risk of childhood adversity is high or when ACEs occur, there is good evidence to indicate that the response of services to vulnerable families can greatly reduce negative impact. This might include sensitive approaches to very critical circumstances such as police and law enforcement agencies taking additional precautions to understand and mitigate the immediate adverse and traumatising impact of investigating or arresting a parent on the rest of the family as well as ensuring that efforts are made to reduce ongoing childhood adversity through sensitive family orientated policies surrounding trial proceedings and imprisonment.

This element of a strategic response should equally include adversity-targeted early intervention initiatives that are more broadly available to a range of families at risk such as strengthened early years support to vulnerable families, family parenting programmes on overcoming ACEs and their impact, effective collaborative systems for identifying and responding appropriately to Early Help with emphasis on understanding and responding to ACEs and helping children experiencing ACEs to access and sustain activity that creates resilience including remaining in and being supported through school.

A programme of targeted action is required to develop the profile of and response to ACEs across the working practices of broad range of services who are in the position to influence and mitigate the impact of exposure to ACEs in children and young people and/or to create and nurture resilience where this occurs. A first step in achieving this change may be to map and understand these opportunities.

c) Creating Resilience:

The Welsh Adverse Childhood Experience (ACE) and Resilience Study interviewed approximately 2,500 adults (aged 18-69 years) across Wales in 2017. The results indicate the critical function of building resilience universally in adults and children as well as targeted resilience programmes to mitigate the impact of ACEs. For example the risk of mental illness amongst those with 4 or more ACEs was more than halved by the protective impact of:

- Building resilience in children including trusted adult relationships and participation;
- Building resilience in adults including community engagement and perceived financial stability.

There is a strong evidence base to support a range of approaches to creating resilience universally in both children and adults as well for families together:

- Universal and targeted family support;
- Parenting interventions/Positive parenting skills;
- Group/peer activities – connectedness & relationship building;
- Exercise – especially with others;
- Expressive writing;
- Mindfulness meditation;
- 5 ways to wellbeing;
- Dietary advice and education about nutrition;
- Advice and education about the benefits of good quality sleep and how to achieve it.

There are also a number of known protective factors associated with better resilience through adversity:

- Supporting and strengthening safe stable nurturing relationships including an always available trusted adult for children at risk of or experiencing ACEs;
- Holistic and integrated support for whole families in times of need;
- Parental resilience programmes;
- Building children's social and emotional skills;
- ACE aware supportive communities, services and social systems;
- Trauma-focused therapies, (e.g. trauma focused CBT, Eye Movement Desensitisation Reprogramming, bereavement counselling).

There is a need to coordinate local initiatives to build resilience both universally and targeted at children and families at risk of or experiencing ACEs. Liverpool CAMHS have devised a resilience framework that is used in individually targeted work but could potentially be translated to support a coordinated locality level approach to building resilience for families, groups and communities.

d) Developing trauma-informed workforces and services:

Trauma informed describes a broadly applicable model of service delivery that is grounded in understanding of how trauma affects neurological, biological, psychological and social development and behaviour. The approach calls for a move away from the process of assessing needs and offering solutions to current problems towards a more collaborative and reflective process of enquiry and listening when it comes to ACEs.

This approach can be commonly confused with 'trauma focussed'/'trauma specific' which are generally considered to describe specialist therapeutic approaches to the direct treatment of trauma, its impact and associated distress. Trauma informed responses **can include** direct provision of or signposting to specialist trauma focussed/specific therapies where required, but the trauma informed approaches alone can also result in successful outcomes.

Commonly, the term 'trauma informed care' is used which can unhelpfully focus total responsibility on health and care services whereas trauma informed ways of working have much broader relevance and can enable a range of

services and people in a position to converse with those who have experienced ACEs to alleviate their impact and support recovery.

i. *Case for trauma informed work across a range of services/settings:*

- The prevalence and impact of ACEs demonstrates that a system wide shift of approach is needed;
- An effective response to ACEs is associated with significant system wide financial return on investment;
- Many ACE creating 'symptoms' and 'behaviours' in adults/parents (e.g. drug and alcohol misuse) are mechanisms of coping with their own childhood trauma, removing them without providing routes to a positive replacement can **increase** risk and vulnerability in families;
- 'Fixing' symptoms and behaviours without a strengths based approach can lead to learned helplessness and fear of asking for help.

ii. *Key Challenges:*

- Services don't ask routinely about life experiences, especially ACEs;
- Some ACEs (e.g. domestic abuse) are more commonly discussed than others meaning that other ACEs are more likely to go unaddressed;
- Professionals can be uncomfortable enquiring how a person is coping with parenting;
- Adults are often viewed in isolation – rarely in the context of the whole family;
- Focus is often on the 'symptoms' or 'behaviours' presented by adults and children as opposed to the underlying trauma – this is ineffective for trauma based difficulties and therefore inefficient;

iii. *Summary Principles of Trauma Informed Work:*

- Identifying people as survivors of trauma and paying attention to their associated needs;
- Avoiding further disempowerment and re-traumatisation;
- Promoting a sense of safety;
- Taking an holistic perspective;
- Offering education about trauma and its impact;
- Helping clients to identify triggers/cues;
- Encouraging clients to develop helpful soothing and coping skills;
- Encouraging access to activities that support resilience and wellbeing;
- Discussing and supporting action to increase exposure to protective factors and opportunities to create resilience;
- **Routine enquiry** (see below) is included as a hugely helpful approach in its own right;
- Direct provision of or signposting to specialist trauma focussed/trauma specific treatments where required.

Trauma informed responses can be summarised as providing people with:

- Choice
- Control
- A chance to talk
- An opportunity to be believed
- Validation of the experience and the impact it has had
- Access to further support if needed.

iv. Routine Enquiry as Part of Trauma Informed Work:

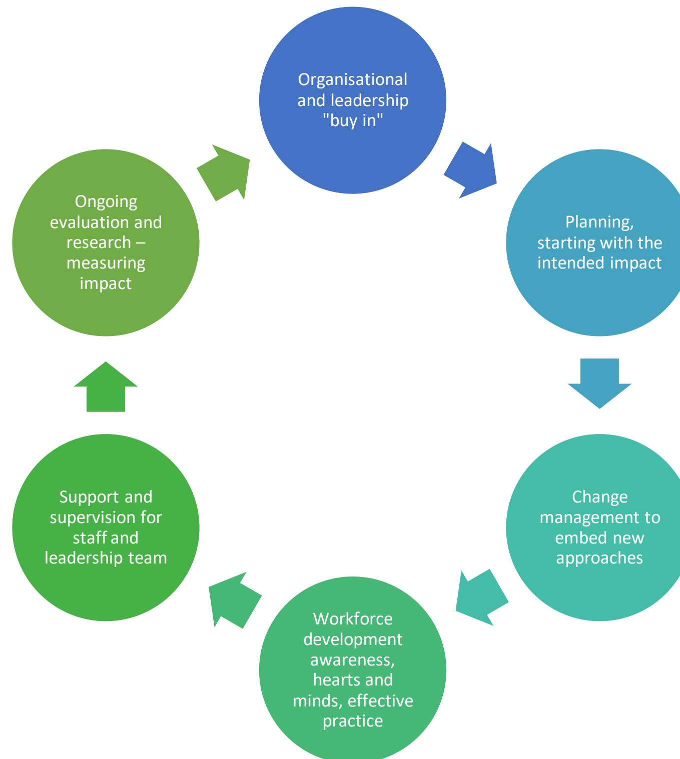
Most trauma informed work includes universal and routine enquiry and discussion of trauma and the principle of universal precaution – treating all as if affected by trauma. The process of enquiring about ACEs and listening provides transformative process for those affected by ACEs. As a result, they are able to understand and reflect on their own adverse childhood experiences, without experiencing judgement, within the context of their current challenges and therefore relate their current circumstances more closely to the impact of the adversity they were exposed to, as opposed to simply a feature of their own present needs and perceived deficits. This opens up possibilities and optimism for the individual about the potential for achieving self-directed positive change by building resilience in the present as opposed to focusing on what can often be learned beliefs about perceived hopelessness and helplessness linked to continued focus on the provision of services and support to identify, accommodate and attempt to 'fix' shortfalls in their own present abilities.

Why is universal routine enquiry important?

- People commonly do not disclose their experience of trauma unprompted (e.g. most victims of childhood abuse never disclose their experience unprompted, and those that do wait from between 9 and 16 years);
- Children experiencing trauma rarely talk about it and professionals working with children tend towards focus on observable behaviour as opposed to underlying trauma;
- Failure to discuss leaves children and adults isolated and vulnerable to the mental and physical impact of their trauma;
- Most people who are asked about trauma willingly disclose their experience (e.g. 82% of psychiatric patients were found to disclose their childhood trauma when asked compared to only 8% who voluntarily disclosed);
- People who are simply asked about their ACEs become more resilient (e.g. a study that routinely enquired about ACEs in standard assessment of 130,00 patients found a direct reduction of 35% in GP visits, an 11% reduction in A&E attendance and a 51% reduction in overall service use across the following year);
- The act of asking, listening and accepting an individual's experience of ACEs is in and of itself a powerfully therapeutic form of doing/supporting;
- Enables people to reformat their understanding of their challenges, from caused by disease or personal flaws, to being resultant from the impact of their past experience on their current circumstances;
- Provides people the experience of sharing 'shameful secrets' with a respected/trusted other and yet still feeling accepted (not rejected);
- Empowers people to feel less guilt/shame and helplessness more able to change their circumstances;
- Alleviates the independent health risk associated with keeping 'shameful secrets' – part of the ACEs problem is the relationship between suppressing emotions, thoughts and actions and impaired immune function, cardio-vascular health and neurochemistry which is largely reversed by the act of safe disclosure;

- Can open individuals' ability to effectively engage with existing support and initiatives that create resilience.

v. Factors for Successful Implementation of Trauma Informed Work:



vi. ACE Workforce Development:

Developing workforces and services towards principles such as trauma informed work and adversity-targeted early intervention, will likely form a key principle of any effective ACEs strategy. However, evaluation of such programmes has identified 2 key challenges:

- Workforce training in and of itself is enlightening but often difficult to translate into practice;
- Many staff encountering workforce development may have experienced trauma/ACEs themselves and require support accordingly.

In response, some key principles have been devised to describe the training model that needs to be in place across the system, and it is preferable to ensure the first three of these recommendations before training is delivered:

1. Support for staff including occupational health and supervision;
2. Consultation and co-production with those who will access training;
3. Organise and communicate clear pathways for signposting individuals as part of trauma informed work (e.g. to community programmes that support wellbeing and resilience);

4. Identification and delivery of effective, evidence-based training programmes tailored to individual needs/service constraints;
5. Continued evaluation at every stage.

In addition, it can help to prioritise workforce development initially to focus on services that support priority/vulnerable cohorts. Some level of more detailed needs assessment linked to ACEs in Liverpool should inform the process of prioritisation. Examples from programmes elsewhere included groups of people:

- Homeless;
- Children on the edge of care/exclusion/exploitation;
- CYP involved/at risk of knife crime;
- Care leavers.

e) Increasing societal awareness and supporting action across communities, changing culture

The adoption of ACE informed new ways of working within services is greatly enhanced when communities are also provided with increased awareness of ACEs and their impact. Where this happens, people who have experienced ACEs are more likely to open up and be offered support by their trusted peers; access to support in services is improved by the powerful impact of word of mouth; people who share experience of ACEs can support one another and reduce burdensome feelings of isolation and shame; and parents who experienced ACEs can share in positive role modelling to reduce the intergenerational impact of ACEs.

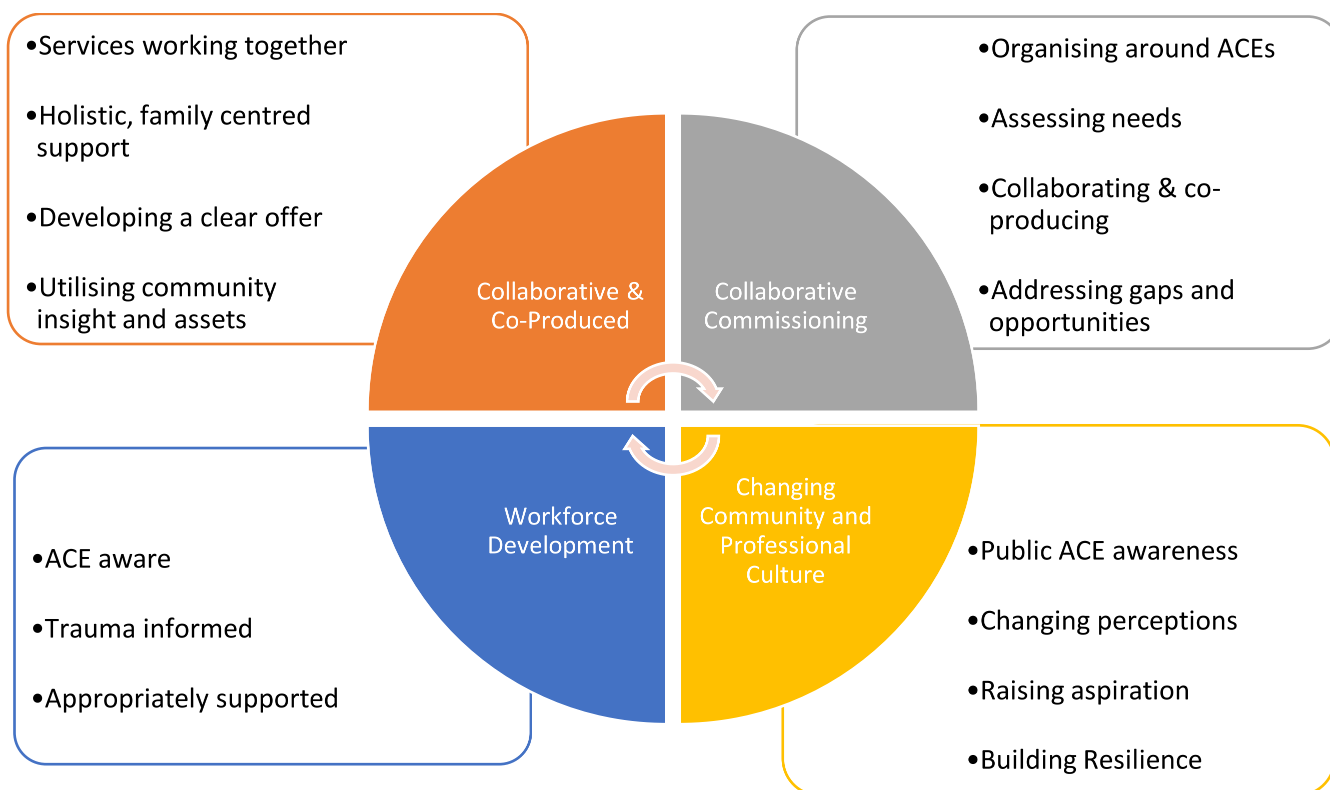
Behavioural science and community insight should be used in order to encourage wider awareness and understanding about ACEs and their impact on health and behaviour. This approach generates detailed intelligence about how ACEs are impacting on individuals and communities in Liverpool and can therefore inform assessment of community needs and assets as well as ensuring the direct involvement of local people and communities in the co-design of adversity-targeted early intervention.

11. Recommendations

The insight and evidence above indicate some key principles that should incorporate a strategic approach for Liverpool:

- The approach must be collaborative and multi-agency across key stakeholders working with children and families (including the parent or future parent cohort within adult services) and include the perspective of local communities;

- Commissioners and local leaders need to work jointly to create the conditions for evidence based, collaborative/multi-agency working around ACEs;
- The landscape of providers responding separately to ACEs need to be explored and a better aligned and defined ACEs approach should be developed;
- Communities and professionals need to be supported to understand the importance and impact of ACEs and the ways in which they can be survived and overcome;
- Development of stakeholder workforces is an essential element.



The desired impact of establishing these principles can be envisaged as follows:

- The system realises the widespread impact of ACEs and understand the potential for recovery;
- The system of support recognises the signs of trauma in those they support;
- The system of support responds by fully integrating knowledge about trauma into policy, procedure and practice;
- The systems is committed to actively improving outcomes for those affected by ACEs, preventing the occurrence of ACEs and bringing an end to “re-traumatisation” (the impact on a person affected by ACEs encountering people/professionals/services who does not understand their trauma and focuses on fixing, punishing or regulating them).

More specifically an associated action plan will be required to provide detail on the approach to be taken according to these principles and collaboratively across key stakeholders. The action plan should draw from the policy and evidence covered across this strategy and should potentially be informed by a detailed local needs assessment. The priority headings for this action plan, indicated by the evidence summarised above should be considered as follows:

1. Understand local needs:

- Devise a deeper assessment/understanding of local needs in relation to ACEs (e.g. explore data within CAMHS, Families Programme, Healthy Child Programme, Children's Centres etc.);
- Strengthen data systems to track infant development, health and wellbeing outcomes to identify families that could benefit from adversity-targeted early intervention initiatives, to monitor their impact and to inform further improvements.

2. Support for Parents, Families and Children to Prevent Intergenerational Recurrence of ACEs

- Develop the function and profile of ACEs within the wider context of efforts to tackle societal inequalities;
- Target initiatives to address ACEs and build resilience towards those experiencing inequality;
- Contribute to radical upgrade in support offered pre-conceptually and in pregnancy to increase protective factors and reduce exposure to risk;
- Develop parental social networks and universal parenting programmes that reduce parental isolation and stress, teach positive parenting, increase positive parent/child interactions and provide diverse social/supportive networks of parents.

3. Reducing the negative impact of ACEs for children and young people

- Map services that are in a position to influence and mitigate the impact of exposure to ACEs in children and young people and/or to create and nurture resilience where this occurs;
- Support services to develop their response to ACEs within their working practices.

4. Creating resilience in adults and children

- Coordinate local initiatives to build resilience both universally and targeted at children and families at risk of or experiencing ACEs;
- Develop or utilise existing resilience frameworks (e.g. the Liverpool CAMHS resilience framework) to support a coordinated locality level approach to building resilience for families, groups and communities.

5. Developing trauma-informed workforces and services

- Develop the following key principles when constructing the training model required across the system:

a. Support professionals from abroad range of backgrounds to understand:

- The prevalence of ACEs in Liverpool;
- The voice of young people in Liverpool and the priority they attach to ACEs;
- The impact of ACEs both within individuals and families and across a their health and social outcomes;
- The basic principles of responding to ACEs (asking, listening, supporting resilience, signposting, self-care);
- The value of a conversation about ACEs, that asking and listening is a worthwhile and powerful form of doing;
- The need to raise their own expectations and support others to do the same - helping stakeholders to understand why and how they should go further in implementing an ACE response.

b. Provide professionals with:
   - Knowledge and skills to support them in implementing an ACE response;
   - Provision of resources and information on local services/pathways to support them in implementing an ACE response;

c. Prioritise workforce development to focus on services that support priority/vulnerable cohorts informed by needs assessment linked to ACEs in Liverpool.

d. Develop a graduated workforce offer that meets the balance between responding to organisational challenges in accessing workforce development (e.g. capacity, time) whilst ensuring that services are responding appropriately to their responsibilities around ACEs and contributing adequately to a system wide approach to addressing ACEs.

6. Increasing societal awareness and supporting action across communities, changing culture

Engage with the public health behavioural insight team with the aim of taking an insight led approach to:

- Encouraging wider awareness and understanding about ACEs and their impact on health and behaviour;
- Generating detailed intelligence about how ACEs are impacting on individuals and communities in Liverpool;
- Informing assessment of community needs and assets;
- Ensuring the direct involvement of local people and communities in the co-design of adversity-targeted early intervention.