



Lambeth Early Action Partnership



Adverse Childhood Experiences (ACEs)

An Evidence Review for Lambeth (Summary)

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June 2019

Acknowledgements

I would like to thank all the Lambeth stakeholders who agreed to a telephone interview. I would also like to thank key informants from Scotland, Wales and Manchester. Angharad Lewis, Laura McFarlane, Shaffique Prabatani and Abdu Mohiddin for their support. Katrina McCormick who helped me with the literature search and synthesis of the literature. I would like to thank the mothers who attended the Parents Focus Group and the young people who attended the Young People's Focus Group for their insightful contributions.

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Summary on ACEs

Background

Research on ACEs has generated a lot of positive interest in Lambeth including:

1. The prevalence of childhood trauma including Adverse Childhood Experiences (ACEs).
2. Their impact on an individual's health and other life outcomes.
3. The applicability of a trauma informed approach as an appropriate response.

This interest is exemplified by various ACEs related activity including a recent borough-wide screening of the film 'Resilience', followed by a debate on ACEs, the Lambeth Children's Safeguarding Board Conference on 8th November which was focused on ACEs and ongoing work on the local Youth Violence strategy. Work on ACEs is also clearly aligned with the vision set out in the Lambeth Children and Young People's Plan 2018-2022, that the borough should be one of the best places in the world for children and young people to grow up (1). Work in Wales, Scotland and in some areas of England has begun to address the issues raised by ACEs through a number of interventions, including policy and strategy development, ACE awareness training, adopting trauma-informed approaches, routine enquiry, and work in schools and the criminal justice system. To further explore ACEs, trauma informed approaches and their generalisability to Lambeth, LEAP commissioned a scoping review of the literature and a stakeholder consultation.

Numerous studies have found a strong association linking ACEs to severe negative health and social outcomes across the life course. This evidence came initially from large population studies in the US (2), and has been replicated in studies in many different countries all over the world, including England (8) and Wales (9,10).

ACEs are traumatic events occurring before the age of 18. There are ten ACEs - five which relate directly to children including physical abuse, sexual abuse, emotional abuse, physical neglect and emotional neglect and five that relate to parents/household environment, including mother treated violently, household substance abuse, household mental illness, parental separation or divorce and an incarcerated household member.

Evidence shows that ACEs can increase an individual's risk of developing health-harming behaviours (9). These behaviours such as high-risk drinking, smoking, under age sexual activity, and drug abuse can lead to an increased risk of poor physical and mental health later in life including cancer, heart disease, diabetes, depression and anxiety, as well as negative social outcomes, such as domestic violence, low levels of education, incarceration, and ultimately early death. Research has found there is a dose response relationship with experiencing ACEs - those who experience four or more ACEs are more likely to engage in associated harming behaviour, thus worse health, and social outcomes (8).

ACEs are found across the whole population however there is more risk of experiencing ACEs in areas of higher deprivation (14).

Not everyone who experiences ACEs experience the same harmful outcomes. Children and adults who function adequately despite experiencing ACEs demonstrate resilience. Resilience is described as the ability to overcome serious hardships such as those presented by ACEs (10). Resilience is often described as supporting young people's ability to 'bounce back' (21). It has also been described as converting 'toxic stress' into tolerable stress by supporting young people to achieve favourable outcomes. Resilience is not, and should not, be viewed as an issue of individual

resources and capabilities. Scaffolding child development by supporting families, building healthy and happy school environments and communities, and addressing social inequalities in access to resources is crucial (23). Research shows that providing stable, responsive, nurturing relationships in the earliest years of life can prevent or even reverse the damaging effects of early life stress. Where this is not available, early intervention can prevent the consequences of adversity (21).

Resources and guides are available to support the development of resilience at both an individual and community level.

Defining trauma

Early experiences influence the developing brain. In the first years of life, the brain undergoes rapid development. Chronic or extreme adversity can interrupt normal brain development. When strong, frequent, or prolonged adverse experiences such as extreme poverty or repeated abuse are experienced without adult support, stress becomes toxic, as excessive cortisol disrupts developing brain circuits (18). Children and young people who experience adversity in childhood may experience such toxic stress as traumatic events (33). What makes an experience traumatic is the individual's reaction to the event rather than the event itself. The terminology around different types of trauma can often be complex and overlapping. Prolonged trauma, particularly in childhood, can also cause difficulties over the longer term by limiting cognitive, social and emotional development and opportunities for learning. This type of trauma is also known as developmental trauma. Traumatic circumstances that are ongoing and repeated are most commonly experienced in the context of relationships: parents, carers and responsible adults for children (in relation to, for example, childhood abuse or neglect), and partners for adults (domestic abuse). The experience of interpersonal trauma, or sometimes termed relational trauma, particularly in childhood, can disrupt the ability to form and maintain healthy and supportive relationships with others (31).

Trauma-informed approaches

Being aware of the possible consequences of such adversity in childhood is one of the key elements of an organisation having a trauma-informed approach. A trauma-informed approach has been described as one which:

'Realises the widespread impact of (psychological) trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatisation. A trauma -informed approach seeks to avoid the potential for people to exclude themselves from services as a result of trauma related distress triggered by any aspect of contact with staff and services. Trauma informed services change the question from 'What is wrong with you?' to 'What has happened to you?' (36).

Addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment.

A trauma-informed approach can be implemented in any type of organisation or service setting and can be distinct from trauma-focused interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing. The five key principles of a trauma-informed approach have been defined as, trust, control, safety, empowerment and collaboration (36).

Building workforce capacity

NHS Education for Scotland has published a *Transforming Psychological Trauma: A knowledge and Skills Framework for the Scottish Workforce*. The Framework describes in detail the expected knowledge, skills, and behaviours specific to a worker's role in relation to trauma-informed or trauma-specific practice. Four levels are described, the trauma-informed practice level; trauma-informed skilled practice level. Trauma-enhanced practice level and the trauma-specialist practice level. The framework does not aim to specify which staff roles correspond to which practice level. The expectation instead is that workers and their employers will take responsibility for ensuring that they relevantly interpret and apply the content and aspirations of the framework (36).

Yet, there is little robust evidence on the outcomes for clients as a result of a trauma informed intervention (39).

Trauma-informed approaches in education

Reviews of the literature have not identified existing programmes and activities based around ACEs and trauma-informed practice that result in positive educational outcomes. However, it is acknowledged that despite the limitations of the evidence, a better understanding of what impact ACEs have on children's behaviour, social and emotional development, and physical and mental health can help people working with children in an educational context to address challenges appropriately and lead to more positive educational outcomes (40).

Scotland has developed a 'nurturing approach' in schools and is now linking this with ACE awareness and a trauma-informed approach (41). The Welsh ACE Support Hub has developed a suite of information to support primary schools to develop an ACE informed approach. The ACE Informed information slides provide school staff with the confidence in identifying ACEs and how to employ skills using an ACE informed approach. It also considers the steps that schools can take to help pupils build resilience (42). In Islington, Trauma Informed Practice in Schools (TIPS) works to develop and embed whole-school trauma approaches to provide a stable, safe space and to improve pupils' ability to regulate and increase their learning potential. It has been piloted in five primary schools and a pupil referral unit and will be expanded to 6 more primary schools and two comprehensive schools (43).

Routine enquiry

As a means of responding to experiencing of adversity or trauma, national reports such as *The Future in Mind* and *The Tackling Child Sexual Exploitation* recommend that professionals use routine enquiry into child abuse in services such as mental health, sexual health and substance abuse. A leading proponent of the use of routine enquiry is Dr Warren Larkin who has developed the Routine enquiry into Adversity in Childhood-REACH programme. Its aim is to raise professional awareness about the impact of ACEs and to embed REACH within client assessments. The rationale for REACH is to encourage disclosure of ACEs and support practitioners to respond effectively (48). Routine Enquiry can help individuals to understand the impact of early trauma on their life, which can aid their recovery. It is argued that it can lead parents to reflect on their parenting style, thereby potentially reducing the risk of intergenerational transmission of ACEs (45).

Evidence on the impact and implementation of routine enquiry in the UK is still developing. The REACH model has been piloted in North West England for a number of years, initially across five organisations in 2015. More recently, the Department of Health (DoH) has piloted a pathfinder project in CAMHS, drug and alcohol and sexual violence support service. The DoH published its independent evaluation of the REACH approach this year (50). This pathfinder project comprised

a standalone implementation pack (rather than a comprehensive package of training and support) which was trialled across three pilot sites in North West England, a Child and Adolescent Mental Health Service (CAMHS), a drug and alcohol service, and a sexual violence support service. Overall, the report highlights the limitations of the REACH approach as a standalone off-the-shelf training package and the need for suitable levels of expertise and support during and beyond implementation. It also emphasises the crucial importance of organisational readiness. The DoH opted for a standalone toolkit for cost reasons. A more comprehensive package, the report notes, may limit the scalability of the approach.

In terms of its impact, the findings are limited due to the sample size and the early stage that all the sites were evaluated - only two of the three sites had started routine enquiry, and none of them had embedded it.

A recent paper by the Scottish government on routine enquiry identified seven principles of best practice (51). These are:

- It is essential that an organisation is ready to implement routine enquiry before training is delivered.
- Explain the rationale for routine enquiry to practitioners before implementation.
- Ensure there is adequate staff subject knowledge of ACEs and routine enquiry before, during and after implementation.
- Routine enquiry should be tailored to individuals – taking into account their age, competency, current circumstances, appropriate timing of enquiry etc.
- Routine enquiry should be the start of a conversation not a tick-box exercise (e.g. 'tell me about your life...').
- Ensure that there is adequate support should a service user (or member of staff) require additional support or treatment following a disclosure.
- It is essential to establish rapport before asking someone about ACEs.

National initiatives

The National Institute of Clinical Excellence published guidelines on Child Abuse and Neglect (NG76) in 2017 aimed at a wide range of practitioners whose work bring them into contact with children and young people (52).

The House of Commons Science and Technology Committee on evidence based early years intervention sought to examine the strength of the evidence linking ACEs with long-term negative outcomes, the evidence base for related interventions, whether evidence is being used effectively in policy-making, and the support and oversight for research into this area. Its report was published in November 2018 (55). It heard oral evidence from a wide range of individuals and organisations both in support of and critiquing the concept of ACEs. Professor Rosalind Edwards from Southampton University and colleagues submitted evidence that was critical of the ACEs approach (53). In their view the evidence of and cure for ACEs is unresolved and still contested and they question the notion that ACEs are a solution to complex problems. Their views were echoed by other academics. The Children's Commissioner for Wales published a policy paper outlining similar concerns (54). Common to all was the concern that there was too great a focus on individuals rather than the need to change social conditions such as poverty, poor housing, discrimination and lack of prospects for the future. Despite these criticisms, the Select Committee and the Welsh Children's Commissioner acknowledged that the focus on ACEs is valuable in helping to attract attention to childhood developmental processes and that being ACE aware could improve outcomes for children and young people.

In its report, the House of Commons Science and Technology Committee on evidence based early year's intervention called on the government to draw up a national strategy for early intervention approaches to address childhood adversity and trauma. The Committee recommended that the national strategy should contain the following components:

- Define and train the early years workforce.
- Make use of 'implementation science'.
- Support for Local Authorities.
- Better use of data.
- Funding.

Lambeth context

Lambeth is a vibrant, densely populated, ethnically diverse inner London borough. There are 67,900 children and young people aged 0-19 years old in the borough (58) and 85.6% of school children are from black and minority ethnic communities (65). Lambeth remains one of the most deprived areas of the country, it is 44th out of 326 most deprived local authorities in England and 9th most deprived local authority in London (58). Inequality remains high in Lambeth with a high level of child poverty. It is estimated that 27.3% of children under 16 years of age (14,700 children) are living in poverty (defined nationally as less than 60 per cent of the median household income) (58). That is worse than the London and England average. The rate of family homelessness is worse than the England average (58).

Prevalence of ACEs in Lambeth

An ACEs survey to estimate prevalence has not taken place in Lambeth. Thus to get an estimate of the number of adults that have experienced ACEs, the prevalence rates of ACEs found in the English survey can be applied. In the English survey, 23% of those aged 18-69 had experienced one ACE (8). Applying this rate to the Lambeth 2017 ONS mid-year population estimate of 18-69 year olds (64) suggests that 55,984 adults may have experienced one ACE. Applying the English rate of 9% who had experienced four or more ACEs. The estimate for Lambeth is 21,907 adults. However as indicated by the Philadelphia study, rates may be higher in Lambeth due to its ethnic diversity and deprivation.

Stakeholder consultation and views

A wide range of stakeholders (24) were consulted from Early Help, Troubled Families, SLAM, CAMHS, Primary Care, Paediatrician, Health Visiting, GPs, Midwifery, Police, YOT, Young Lambeth Co-op and the Voluntary Sector. Two focus groups were also held with a group of six mothers and a small group of young people.

A summary of key themes from the local stakeholder consultations are outlined below:

<p>What is the level of understanding and/or experience of working with ACE's in your service in Lambeth?</p>	<p>All of the stakeholders had knowledge and experience of working with adversity and how it affects individuals and families who are in contact with their service. However, for the majority of participants they were not using the language of ACEs to describe the work. Some services such as FNP/ST Michaels/Well Centre/Redthread/Addictions Services are more explicit about asking about ACEs (but not all ACEs) in their assessments of and discussions about service users.</p> <p><i>"We don't know it as ACEs, however it is something we are dealing with regularly we are not using that terminology."</i></p> <p><i>"We occasionally use ACE scoring to reflect on in discussion of our parents. Within our service we have considered thoughtfully if /how it could be used."</i></p>
<p>Are there any additional ACEs that should be considered given the Lambeth context?</p>	<p>The following issues were raised as important to the Lambeth context: poverty, deprivation, poor housing, overcrowding, homelessness, the impact of austerity, racism, refugee status, gang affiliation, youth violence, witnessing violence. Other issues which were raised were - bullying in schools including online bullying, learning disability/learning difficulties especially if undiagnosed, parents who have been looked after themselves, transient families, parental relationships/low level conflict and LGBT/homophobia.</p> <p><i>"Struggle with terminology around ACEs. Doesn't take account of community adversity, poverty, deprivation, racial issues."</i></p> <p><i>"Young People we work with disproportionately young black boys – they are throughout the system; more exclusions from schools/police services and then Youth Offending Services (YOS). Because of race and gender more likely to be in YOS system."</i></p>
<p>What is your view on routine screening/ enquiry about ACEs? How does it fit with other screening/ routine enquiry that you do?</p>	<p>There were no respondents undertaking routine enquiry about all the 10 ACEs. All respondents ask their users/patients about their background and family situation and for some this included some ACEs. All using different methods to get this information.</p> <p><i>"Do routine screening for mental health/domestic violence; Midwives have gut feeling for other ACEs/professional practice helps them consider them."</i></p> <p><i>"Another screening tool would fill me with horror! Laying another tool could be very frustrating for the patient group. These things ACEs, many of them come out. But not everyone wants to discuss them."</i></p>

<p>Are you doing this already? What do your patients/clients think about it/acceptable/intrusive/too personal?</p>	<p>All services endorsed the importance of getting information on adverse life events from their patient/service user. Some thought that routine enquiry/ screening would be an appropriate method to achieve this. However, the majority had concerns about routine enquiry for ACES, these included the need to develop a good relationship and rapport with clients; those asking the questions needed training; the necessity for follow up to be in place to pick up ACES; respect for those who did not wish to disclose /discuss ACES. And issues around increase of stigma and parents blaming.</p> <p><i>"Routine enquiry itself not a bad thing – but need to build a relationship to ask questions. Can use routine enquiry to get a score but need relationship to understand 'why'."</i></p> <p><i>"I think it's essential that whole picture is considered. Many young people we work with 4 ACES or more. Need to be robust about this: how we ask the question: Are there resources to meet the needs?"</i></p>
<p>Have you had training on routine enquiry/ screening for ACES?</p>	<p>Only one service had some limited training on routine enquiry/screening for ACES. GPs are used to asking questions and it is expected of them. Others said that they would like to have this training.</p>
<p>Would you say that your service takes a trauma informed approach (TIA) in its work?</p>	<p>All services answered this question positively. Some services were very clear that they were taking a TIA approach in their work and one service had TIA training. Other services were more aspirational and would like to take this approach. The importance of training for TIA was voiced.</p> <p><i>"The way we work is consistent with a TIA – but not all staff trained in TIA, we would take advantage of it when it comes along, we all know elements of TIA."</i></p>
<p>Do you receive supervision?</p>	<p>All but one service said that some level of supervision is offered to staff. For many services it involved clinical supervision as well as line management supervision. Although supervision was offered for some services due to workload, they did not have time to access it.</p> <p><i>"Everyone gets supervision, gets reflective practice, we have pathways and have staff training on managing emotional difficulties."</i></p> <p><i>"Yes some of us do. Clinical supervision being reintroduced but don't often have the time to attend. It is something that needs to be promoted."</i></p>
<p>Is there help available for workers if they have experienced trauma?</p>	<p>The majority of services had services in place to help workers if they had experienced trauma in work or outside.</p> <p><i>"They are all employed by Lambeth, all have access to telephone helpline support. Some of employed staff access services around domestic violence themselves."</i></p>

<p>How does work on ACEs fit with your current priorities?</p>	<p>For the majority of services work on ACEs is very high on their agenda and part and parcel of their daily work.</p> <p>Although there is some hesitation about adopting training for everyone on ACEs plus there is concern for staff who already feel overburdened.</p> <p><i>"It is our priority. I have worked in this field since 2003, complexity of cases has changed. Young people have more ACES. For staff who have caseload of 10/13 young people 90% of young people will have 2 and more ACEs."</i></p> <p><i>"Kind of hesitation about training everyone up in this. Staff are drowning, they have so much to do. Ideas about ACEs underpins our work but hesitant about making it more formal."</i></p>
<p>How do you think we can build more community resilience in Lambeth</p>	<p>Respondents answered this on a number of levels:</p> <ul style="list-style-type: none"> • The need for services to be more embedded in and engaged with the community. • Multi-agency working. • Use the lived experience of members of the community. • Build on work of Children Centres. • Information about services to be disseminated widely. • Services to reflect the demographic make of the community and be more inclusive. • Extension of Lambeth Made: good if scope extended to services and communities too. • Enhancing Early help and schools offering mental health and wellbeing support to pupils. <p>Other suggestions:</p> <ul style="list-style-type: none"> • Community Champions/Parent Champions. • Affordable leisure centres/activities/green spaces that the community can access. • Reduce school exclusions. <p><i>"Bringing people together police officer's have to be part of the constructive discussion around issues; problems solved symbiotically rather than in silos."</i></p> <p><i>"As GPs we are sign posters to community services; but GPs know about health but don't know much about education/social services. GPs don't know about Children Centres and are amazed at what is offered in them."</i></p>

<p>What do you currently do to build resilience with the people you work with?</p>	<p>All respondents felt that the primary way that they could build resilience with the people they worked with was through the relationship they developed with them. By listening to their story, by working with them to identify what support they need, by giving them information and choices, offering the right support so that they can find solutions for themselves. Other approaches were ensuring that young people had opportunities outside the academic curriculum to build life skills through different programmes and creative and sporting activities.</p> <p><i>"Resilience is a way of working; working with young people to find positive solutions, making them believe in themselves."</i></p> <p><i>"Empower people with information –knowledge is power these are your choices – let me know what you want to do."</i></p>
<p>Where do you think the emphasis on work on ACE's should be in Lambeth? Prevention/alleviation /treatment?</p>	<p>Everyone stated that there needed to be a focus on prevention and that it was important to work with families to stop ACEs happening, this was seen as a huge challenge and a long-term approach. There also needed to be work across all three levels.</p>
<p>Do you consider that there may be any negative impacts by taking an ACEs approach –what might they be and who might they effect?</p>	<p>Negative impacts included:</p> <ul style="list-style-type: none"> • Staff need training to ask ACEs questions so as not to re-traumatise. • Services need to be in place to pick up ACEs. • Implementation should not be a top down approach. • Language used to describe is very important. • Need to respect autonomy of the client. • Not to be used as a threshold for service. • Who will ACEs miss out? • Blame mentality/labelling of people/stigma. • What are the opportunity costs? <p><i>"Need to be very trauma-informed on how to do the assessment. Need to very careful all young people have to do is Google ACEs and they will find out what Aces are about; could have very devastating consequences."</i></p> <p><i>"Will be seen in a deterministic way."</i></p> <p><i>"Score of ACEs used to determine thresholds. Becomes top down management imposition. Implemented badly, need to have service users involvement at centre of this."</i></p>

<p>We are not starting from scratch; what assets/facilitating factors do we have already in Lambeth?</p>	<ul style="list-style-type: none"> • LEAP /Lambeth Made. • Strong vibrant community. • Children’s Centres. • Health Visitors. • The Well Centre and other voluntary sector groups. • The role of community organisations which local families access. • Experienced practitioners and their willingness to undertake partnership working. • Good links between the local authority and health. <p><i>“I think the LEAP project, is doing very creative work, best place to be driving this through community.”</i></p> <p><i>“Community in Lambeth very strong- happening place.”</i></p>
<p>What should the next steps be?</p>	<p>Nest steps included:</p> <ul style="list-style-type: none"> • Community engagement. • ACE awareness training for all. • Don’t be too restrictive to 10 ACES. • Get more partnership and joined up working. • Do a skills audit. • Consider how ACEs can be linked to other public health issues. • Take a planned approach. • Pilot approach and evaluate. • Development of care pathways. • Be aware of possible negatives. <p><i>“Need to keep talking about it. All services need to be aware, more showing of the film in children and adult sector.”</i></p> <p><i>“Needs to be a planned approach; don’t dive in, find out what else is happening in rest of the country.”</i></p> <p><i>“Definitely pilot it in a good-sized area-ward.”</i></p>

This above literature review demonstrates there is a growing evidence base about the prevalence of ACEs and the negative impacts of ACEs on the long-term health and wellbeing of populations in many countries including the UK. There is no doubt that a similar picture would be found in Lambeth as the estimate of prevalence above indicates. However, as highlighted, not everyone who is exposed to one or more ACEs experiences negative health outcomes and many function well. Childhood and adolescence are key periods for brain development when the brain can be damaged by adversity but can also grow and repair when children and adolescents are supported by caring adults, families and communities. This builds on the vision of Lambeth's Children and Young People's Plan 2018-2022 (1) and the key priority programmes which are:

- Children and young people achieve.
- Children and young people are healthy.
- Children and young people are safe.
- Children and young people are resilient.

It is imperative that the knowledge and evidence about the negative effects of adversity and ACEs on health and wellbeing are widely disseminated. It is equally important to continue to improve actions and services to better prevent ACEs occurring in the first place, to mitigate the effect of ACEs on adults and children and to build individual and community resilience. The priority programmes and core design principles of the Children and Young People's Plan are fundamental to achieving these outcomes.

However, as also demonstrated in the literature and voiced by the stakeholders there are other wider societal and economic determinants that affect the health and wellbeing of many Lambeth families including poverty, deprivation, housing, unemployment, the effects of austerity and racism. The call from stakeholders in Lambeth is that these factors must be kept at the forefront of the health and social care agenda and addressed as well as the consideration of ACEs. Other important factors highlighted were youth violence, gangs, peer violence and witnessing violence, the insecure status of those seeking refugee status and those who had no recourse to public funds, bullying in schools and also through social media, and learning and physical disability.

For the majority of services in Lambeth, ACEs and the language of ACEs is new. All services had an understanding that what happened in childhood could influence present behaviour and that getting a history from the user/patient was important. However, not all services would enquire about these childhood experiences. Many argued that these experiences would be disclosed as a rapport and a relationship with the user/patient was developed over time. If routine enquiry was to be established in Lambeth there was no consensus about which professional or at what stage of the life course it should happen. Appropriate professions suggested were GPs, midwives or at school. Many respondents highlighted the need for more ACE awareness training, training on routine enquiry and training on trauma informed approaches.

It is essential that the health and wellbeing of staff, who are dealing with adults and children who have suffered trauma and ACEs is seen as a priority. When stakeholders were asked how work on ACEs fitted in with current work priorities, for the majority, work with families and children on adversity was seen as a top priority and part of their everyday work.

As explored in the literature, not all those who experience ACEs suffer the same outcomes. Many people will suffer an adversity/adversities and go on to live a fulfilled life. Some of the literature on how to build both individual and community resilience has been explored in this paper. Findings from the stakeholder interviews reflect and build on that evidence from a Lambeth perspective. In order to build resilience at a community level there was a desire from services that they should

get closer to the communities they service, be more embedded in the community, go out to the community more rather than asking them to come to services. There was an acknowledgement that there was a tendency for services to work in silos and there was a call for more integrated working across services including health, children services, schools, adult services and the voluntary sector.

Schools were also seen as a key player in developing community and individual resilience. It was acknowledged as an asset that Lambeth schools were generally good. There was a plea that all schools had a Personal Social and Health Education (PSHE) curriculum. Reductions in the number of exclusions from schools was also cited as important both for the individual pupil's wellbeing but also for the community as these young people were seen to be at risk once out of school.

When asked where the emphasis of work on ACEs should be in Lambeth, the majority of the stakeholders said; "prevention is better than cure" and therefore work in the early years should be prioritised. It was also clearly recognised, people who had already suffered trauma required appropriate services in order to alleviate/treat the trauma and also to stop the possibility of intergenerational transference of trauma. Therefore, work across the lifecycle is needed.

As indicated in the literature review the international movement to identify and work on ACEs is not unanimously accepted. There are a number of academics who are critical of this approach. The majority of the interviewees in Lambeth were welcoming of an ACEs approach as it provides a common language to discuss adversity across sectors. Many felt they were already doing this work. The use of the 10 ACEs indicators (and any additional ACEs) could give them a framework to consider in more depth what might be happening with a family/adult/child. Despite this, they too had a number of concerns about the possible negative impacts of taking an ACEs approach. Primarily people were concerned that those asking the questions needed to be trained and skilled to undertake this task otherwise there was a risk of retraumatisation. There was also a fear that the ACEs approach was a deficit model and could lead to further labeling/blaming of families/parents and children. Therefore, the language used would be very important. There was consensus that this work needed to be undertaken through a strengths-based approach. These potential negatives need to be addressed through training and the development of work on ACEs in the borough.

The stakeholders agreed that Lambeth was in a good position to take this work forward. They identified many assets and facilitating factors that would help in the development of ACEs work in the borough. There was a degree of consistency across stakeholders concerning how work on ACEs should be taken forward. Overall, there was a view that work in this area needed to build on what services were already doing. The ACEs approach should not be seen as the magic bullet and that one approach did not fit everybody. As ACEs was a new language and concept, staff from all services and the community require a lot more awareness training sessions. The community needed to be involved in the discussion and the work should be built from the bottom up rather than a top down approach. If ACEs are to be addressed in a timely and consistent way there is a need for more integrated and partnership working. Respondents also advocated taking a planned approach, and suggested undertaking a pilot, either in an area or with a particular service and that the pilot should be evaluated before rolling out across the borough.

Parents focus group

The mothers who attended the Parents Focus Group highlighted a number of actions as a means of preventing and mitigating toxic stress in the home:

- Need groups for women to support and empower each other – e.g. a counselling group.
- Education for parents before the baby is born on how to prepare for the baby and its development, more than just about the birth, how to bring up a child, how to be a good

parent and how to prepare the child for life.

- Financial education for parents.
- A follow up group for new mothers to attend after the birth, so that they know there is somewhere they can go for support after the birth.
- A supportive group for fathers and more images of father being involved in family life e.g. pushing prams.
- Parents need support at the right time, before things get out of hand.

One clear message from the women was that the time after giving birth to a baby, can be very stressful and lonely for the mother. Health services such as the hospital, antenatal care and midwifery were seen as very important, but their focus was more on the baby rather than the mother. This could be an especially isolating time for those women who gave birth without family/friends close by or who were living in another country and could not offer support. New mothers can become isolated and afraid to ask for help. The mothers suggested that they needed a community based service which reaches out to them, offering them friendship and support.

They also suggested how to support children and young people who may be affected by ACEs

- Children and young people need a voice and needed to be listened to. Where there was abuse e.g. sexual abuse they needed to be believed
- There need to be more opportunities for them to discuss difficult /taboo subjects
- They need to be taught life skills in school

The young people's focus groups highlighted the following points as a way of supporting young people to be physically and emotionally healthy:

- Access to healthy food.
- Opportunities and spaces to encourage physical activity and community activities, clean air and less pollution.
- Easy, non stigmatising access to mental health support systems in schools
- Sessions on spotting signs of mental health issues
- Easy access to sexual health services
- Cultural norms of parents/carers may need to be challenged such as acceptability of hitting a child
- Consultation with other areas

National stakeholders

Telephone discussions were held with the ACEs Hub coordinator in Wales, with the project lead and the project manager for the Harpurhey Pilot in Manchester and information was sent by key informants in Scotland. Information from Gloucestershire was downloaded from the internet, (see appendix 3 for further details). Although these areas are all at a different stage of work on ACEs, the common feature is that they have undertaken extensive consultation with services over many months to embed the concept of ACEs and to inform ACEs training models. Such an approach echoes with the suggestions of stakeholders above.

Conclusion

ACEs are experienced by many people, reflecting key stressful events from before birth through adolescence. As explored in this report, adversity in childhood and adolescence can become traumatic and injurious to physical and mental health and wellbeing throughout the life course. The lens of ACEs prompts questions over the way we design and deliver services. As detailed in this report, adopting trauma-informed approaches and models of care can help support children, parents and adult survivors of ACEs.

In September 2018 a Task and Finish Group was convened in partnership between Lambeth Council and LEAP. It included representation from key Lambeth services including schools, police, youth offending service, public health, early help, voluntary and community organisations, community paediatrics, GPs, housing, CAMHS, midwifery and health visiting.

The aim of this group was to initiate a multi-agency discussion around ACEs and the relevance to Lambeth, and begin to consider different approaches to prevent and reduce the impact of ACEs on children and young people in the borough.

An operational working group will be created to take this work forward which will sit within the Serious Youth Violence governance structure.

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Adapted from a live illustration of conversations at Lambeth Safeguarding Children's Board Conference, 2018.



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