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Adverse childhood experiences

What we know, what we don't know, and what should happen next

1 Research into adverse childhood experiences (ACEs) has generated a powerful and accessible narrative which has helpfully increased awareness of the lifetime impact of early adversity on children's outcomes.

Research into ACEs consistently shows that a set of 10 adverse experiences in childhood are associated with an increased risk of poor health and other problems in later life. This consistent and compelling evidence has brought greater focus from a wide range of policymakers and public services on the harm caused by child abuse, neglect and other adversities. However, this ACE narrative has increasingly dominated the debate about the role of public services in preventing and responding to childhood experiences of trauma. It has resulted in several misconceptions which must be addressed as the ACE agenda is taken forward.

2 The current popularity of the ACE narrative should not lead us to ignore the limitations in the current evidence base or be allowed to create the illusion that there are quick fixes to prevent adversity or to help people overcome it.

It is essential that children's policy and services respond to the fact that understanding, measuring and assessing need is complex, as is responding effectively to complex social problems. We urge caution on the ACE agenda given that:

- **Current estimates of the prevalence of ACEs are imprecise.** Although we know that childhood adversities and vulnerabilities are prevalent, we do not know *how* prevalent. For example, people are not always able to accurately recall whether they have experienced adversities, such as abuse, in childhood.
- **Good data on the prevalence of childhood adversity and wider risk factors is lacking.** More accurate estimates are essential for understanding the scale of childhood adversity, in order to plan services and to ensure that effective interventions are available for the children and families who most need them.
- **A focus on the original 10 ACEs to the exclusion of other factors risks missing people who also need help.** Many other negative circumstances in childhood are also associated with poor adult outcomes. These circumstances include economic disadvantage, discrimination, peer victimisation, low birth weight and child disability. For example, studies show that low family income may be a stronger predictor of poor physical health outcomes than many of the original ACE categories.
- **ACEs do not occur in isolation**. While ACEs occur across society, they are far more prevalent among those who are poor, isolated or living in deprived circumstances. These social inequalities not only increase the likelihood of ACEs, but also amplify their negative impact. This means that structural inequalities must be addressed for ACE-related policies, services and interventions to have any meaningful effect.
- **The evidence raises serious concerns about the ethics of some ACE screening practices.** ACE screening (including routine enquiry) is increasingly being used to identify children with symptoms of trauma, as a result of current or recent adversity. However, a number of major questions remain. Few evaluations to date have rigorously considered whether ACE screening is an effective method for identifying vulnerable children and making treatment decisions. We do not know whether ACE screening activities could inadvertently retraumatise children or cause other forms of harm. Serious concerns have been raised about whether some ACE screening practices are ethical in the absence of referral to effective treatments. And we should also recognise that such screening tools are unlikely to be a substitute for empathetic conversations by skilled and supervised practitioners.
- **Trauma-informed care has the potential to improve the quality of practice, but caution should be used in considering it to be a sufficient response to the complex problems of childhood adversity.** Governments and public agencies have invested in trauma-informed care as a way of increasing practitioner awareness of the effects of early trauma. However, what constitutes trauma-informed care is not well defined and current practice is highly varied across different settings. There is also limited robust UK evidence that demonstrates it improves outcomes for children. Further specification and testing are needed to fully understand its benefits for children who have experienced adversity.

3 The current enthusiasm for tackling ACEs should be channelled into creating comprehensive public health approaches in local communities, built on the evidence of what works to improve outcomes for children.

The original ACE study concluded that comprehensive strategies, involving universal, selected and targeted interventions were necessary to prevent and reduce ACEs. We agree with this position, but believe this must be part of a wider, whole-system approach. This means:

- **Tackling the conditions in which ACEs are more prevalent.**
- **Improving the strength of national and local systems** for preventing childhood adversity and providing support to the families and children who are the most vulnerable.
- **Providing evidence-based interventions**, universal and targeted, in response to population needs.