**Adverse Childhood Experiences:**

**Learning from Research for Better Policy and Practice in Scotland**

Tuesday, 19 June 2018 (Edinburgh)

**Introduction**

Evidence shows that adversity and trauma in childhood can impact on a wide range of education, health, justice and social outcomes[[1]](#footnote-1).

The Scottish ACEs Hub, in collaboration with the Scottish Government, hosted a seminar on research and evidence on childhood adversity and trauma and its implications for policy and practice. It was attended by approximately 100 people from a range of backgrounds and disciplines (see [**Annex C**](#annex_c)).

The Scottish Government and partners are keen to learn from the best available evidence and practice in order to develop the most effective policy responses to addressing and preventing adverse childhood experiences (ACEs).

NHS Health Scotland and the Scottish Government have published a number of reports on ACEs which have highlighted the importance of evidence in developing policy and services that are fit for purpose:

The Scottish Public Health Network produced the “[Polishing the Diamonds: Addressing Adverse Childhood Experiences in Scotland](https://www.scotphn.net/projects/adverse-childhood-experiences/introduction/)” report in May 2016. This summarised the compelling research on the links between adverse events occurring up to the age of 18 and later health and life outcomes. It emphasised the importance of preventing the repeated cycle of intergenerational transmission by offering evidence-based targeted family programmes and called for policy to cover all aspects of household adversity. It identified existing policy areas that ACEs should be an integral part of and called for further research to explore how best to ensure that the longer term consequences of ACEs are effectively managed. The Scottish ACEs Hub was established by NHS Health Scotland in order to help inform and shape the actions outlined in this report.

NHS Health Scotland’s report “[Reducing the attainment gap – the role of health and wellbeing interventions in schools](http://www.healthscotland.scot/media/1693/evidence-summary-reducing-the-attainment-gap-the-role-of-health-and-wellbeing-interventions-in-schools.pdf)”, published in December 2017, aimed to identify and review health and wellbeing interventions in school settings that could have a potential impact on inequalities in educational outcomes. Looking at a number of relevant studies in the UK and Ireland the report identified the lack of evidence on the matter. In order to better support the development of evidence-informed programmes in the future it called for more research in this area.

The “[Reducing Offending, Reducing Inequalities](http://www.healthscotland.scot/publications/reducing-offending-reducing-inequality)” report, published by NHS Health Scotland in August 2017, collates the health and social determinants of offending in the context of reducing health inequalities in Scotland. It aligns to the ambitions of the National Community Justice Strategy and implementation of the Community Justice (Scotland) Act 2016. It identifies opportunities for earlier intervention, mitigation of the negative impact that offending and sentencing have and introduces ways of building resilience and sustaining change. It calls for a partnership approach and proposes a range of actions to reduce offending and health inequalities across Scotland.

Justice Analytical Services in the Scottish Government published the “[Understanding childhood adversity, resilience and crime](https://beta.gov.scot/publications/understanding-childhood-adversity-resilience-crime/)“ evidence summary in May 2018. This sets out a summary of the evidence on the links between childhood adversity and criminality and victimisation in adulthood. It makes a strong case for preventing crime by intervening at the earliest stage possible and targeting those most at risk of experiencing adversity in childhood as well as supporting those already in the Justice system. It emphasises that resilience is built at an individual, family and community level. It identifies the need for further research on the incidence and effect of childhood trauma on male offenders and victims and also highlights the need to adopt a collaborative approach and build evidence on ‘what works’ in relation to a trauma-informed justice system.

For more information on the work of the Scottish Government and NHS Health Scotland on ACEs & Resilience please visit:

* [SG ACEs webpage](https://beta.gov.scot/publications/adverse-childhood-experiences/) &
* [NHS Scotland ACEs webpage](http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences)

**This report provides an overview of the presentations (see also the presentation slides and videos), and the main themes of the group discussions and questions from the floor.**

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| **The aims of the day were to:**   * Share multi-disciplinary research findings on childhood adversity to inform policy and practice in Scotland; * Identify priorities for future research; * Develop a network to share evidence and contribute to future ACEs events. |

**Summary of Presentations**

We heard from a range of researchers with an interest in child and adult trauma and adversity (see **Annexes A** **& B** – [programme](#annex_a) and [speaker bios](#annex_b)). There was opportunity for delegates to ask questions and discuss implications for policy and practice.

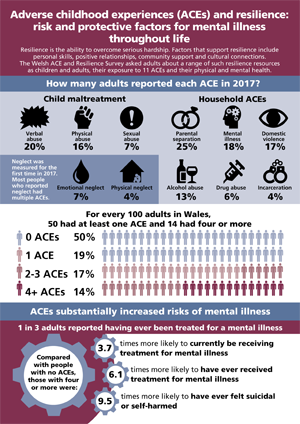
The workshop was kindly chaired by Dr Fiona Cuthill who is a Lecturer in Nursing Studies and Academic Director of the Centre for Homelessness and Inclusion Health, University of Edinburgh.

**Dr Cuthill** opened the event by talking about the common language that the ACEs research and evidence provides across a wide range of services. Her opening remarks highlighted the shifting emphasis from treating symptoms to treating causes which underpins trauma-informed approaches. Dr Cuthill described an exciting time in Scotland, the contribution by the Scottish ACEs Hub, and from many sectors which are implementing trauma-informed services. She finished by highlighting the need to embed an understanding of ACEs in communities and not just in professional services.

**Presentation 1:**  **ACEs in Wales and preliminary findings from a review into routine enquiry**

[Dr Kat Ford](https://www.bangor.ac.uk/health-sciences/staff/kat-ford/en), Bangor University

Dr Ford began by summarizing the Welsh ACEs population surveys which have been published over the past few years. These studies have analysed ACEs prevalence in the general population in relation to health harming behaviours, chronic illness, mental health and resilience.

[](http://www.wales.nhs.uk/sitesplus/888/opendoc/319093)She described how the studies have had a huge impact on public health policy in Wales. ACEs are now embedded in national strategy with an emphasis on breaking intergenerational cycles, building resilience in the whole population and supporting those who have experienced ACEs.

She then described some ongoing research that she is currently undertaking –

* prevalence study to measure the rate of ACEs in the offender population and their children.
* an evaluation of a pilot study of routine enquiry of ACES in GP practices in the UK. Looking at feasibility of this in health visiting in Wales.

**Systematic review of routine enquiry (RE)**

* Dr Ford has conducted a systematic review of peer reviewed studies of routine enquiry of ACEs (1997-2018) – not yet published.
* It covers 5 published pilots of routine enquiry (all from the US), 3 of which were in primary care settings with adults.

As the findings are yet to be published we are unable to share with you what Dr Ford presented at the seminar. We will share following publication.

C:\Program Files\Microsoft Office\MEDIA\CAGCAT10\j0293236.wmfWant to know more about Routine Enquiry?

Take a look at the workshops we held last year on the [NHS Health Scotland ACEs webpage](http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences).

**Presentation 2: Adverse Childhood Experience and homelessness in adulthood: what do we know about the links?**

[Prof. Sarah Johnsen](https://researchportal.hw.ac.uk/en/persons/sarah-johnsen), Institute for Social Policy, Housing and Equalities Research (I-SPHERE), Herriot Watt University

Prof. Johnsen’s presentation began by discussing the multifarious problems that people who experience multiple exclusion homelessness (MEH) live with and how, despite considerable support, no-one has found a solution that breaks the cycle of repeat homelessness.

She talked about how MEH people can be difficult to work with, reluctant to engage with support, and sometimes, abusive. ACEs – which many people in this group experience – can create barriers to recovery and drive a cycle of rejection which continues as people behave in an undesirable way and are then excluded from services. Trauma-informed approaches can promote a way of working that avoids re-traumatisation. Prof. Johnsen was also keen to point out that there is a danger of pathologising homelessness through the ACEs lens and ignoring the structural drivers of homelessness e.g. poverty.

Prof. Johnsen described how there is lots of research on the causes of homelessness but less on childhood factors, and then provided an overview of ongoing PhD research being undertaken by Nikoletta Theodorou at Heriott Watt University which explores the relationship between ACEs and MEH.

* Nikoletta has done 30+ in-depth interviews with MEH population which included the ACE questionnaire.
* ACEs exposure in this small sample was very high – 27 of the 30 had experienced 3 or more. 2 of the 30 had experienced all 10 experiences from the ACE questionnaire.

**Best practice – what works for multiple exclusion homelessness**

* Mainstream approaches tend to focus on ‘fixing’ the person first whilst housing them in temporary accommodation and then, conditional on improvement, providing permanent housing – with a clear termination point. This approach often doesn’t work with people who experience MEH.
* An example was given of the Housing First approach in New York which Prof. Johnsen has reviewed. It works differently and has been shown to be highly effective (with most people still in housing after 2 years). Under this scheme, people are placed in permanent housing first whilst receiving ongoing support.
* The approach has been piloted in Glasgow and was evaluated by Prof. Johnsen. There are 4 critical ingredients – support is not time limited, long-term security of tenure, provides a stable platform to address other issue and provides flexible support (intensity can fluctuate depending on needs/ability to engage).
* This approach leads to better relationships between the individual and their practitioner. It also provides ‘stickability’ – unlike traditional time-limited services support stays even if someone relapses/’fails’. This facilitates trust, honesty and receptivity to support.
* The environment is also key in providing a sense of normality – housing is not delivered in homeless settings and support is delivered in the home and the community which helps mitigates against stigma.

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| **Policy implications:** Prof. Johnsen’s presentation closed with a call for more preventative work for people at risk of homelessness and the need to avoid excluding MEH people from services, many of whom have experienced ACEs. |

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[Homelessness and Rough Sleeping Action Group](https://beta.gov.scot/groups/homelessness-and-rough-sleeping-action-group/)

[Health & Homelessness Inequality Briefing](http://www.healthscotland.scot/media/1251/health-and-homelessness_nov2016_english.pdf)

**Presentation 3: Prevalence of Adverse Childhood Experiences in the general population of Scottish Children**

[Dr Louise Marryat](http://www.scphrp.ac.uk/about/people/louise-marryat/), University of Edinburgh

Dr Marryat described the ‘Scottish ACEs Study’ which explores the prevalence of ACEs in Scotland using data from the [Growing up in Scotland](https://growingupinscotland.org.uk/) (GUS) survey which is a longitudinal research study, tracking the lives of thousands of children & their families from the early years, through childhood and beyond. Two papers have been produced, both of which are still under review.

Dr Marryat began by discussing the possibility that ACEs prevalence is higher in Scotland due to high levels of poor health in Scotland compared with England and Wales. She then described two studies that she is involved in.

**Study 1** – Analysis of prospective data on cohort of Scottish children up to age 8 (n=3,500). Purpose was to ascertain which factors best predict ACEs in children.

* Prevalence levels were similar to the Welsh and Felitti ACEs studies – with some figures lower (which one would expect given the age of the sample).
* 35% had no ACEs compared with half of adults who had no ACEs in the Felitti studies.
* Two thirds of children have one or more ACE by age 8.
* The most common ACEs are **parental mental health** and parental separation.
* The main risk factors for ACEs were being male (these findings contrast with adult studies which tend to show higher female rates – maybe due to girls acquiring ACEs later on), **household income** (strongest predictor), having a young mother and living in an urban area.
* The researchers were struck by disparity by income as ACE literature tends not to acknowledge poverty fully enough. They found that ACEs are clustered in areas of deprivation. 1 in 2 children in most affluent areas had no ACEs compared with 1 in 10 children in most deprived areas. They tested the influence of poverty and found that one fifth of 3+ ACEs cases can be attributed to poverty.

**Study 2** - PhD student’s work using the same sample (ongoing). Purpose is to investigate the role of community in moderating the effects of ACEs in deprived areas e.g. stable housing, transportation, breast feeding counselling (as a proxy measure for post-natal support), childcare services, local park availability.

* The only significant mediator was **transportation** – analysis estimates that transportation could eliminate 21% of inequality in ACEs.
* The analysis also linked GUS data with routine health data (e.g. A&E attendance).
* ACEs were associated with fair/poor health rating, disability, unintentional injury and obesity.
* Other factors associated with ACEs are social and behavioural measures e.g. conduct difficulties, contact with the Children’s Reporter and lower parental aspirations.

**Limitations of GUS data**

* Important to note however that correlation is not causation.
* Discussed the strengths and weaknesses of the study e.g. social desirability bias (parents reporting on their child’s ACEs).
* GUS holds data on 7 (of the 10 most commonly measured) ACEs – there are none on emotional abuse and neglect or sexual abuse.
* But there are also issues with retrospective data (which most ACEs studies rely on) – people rate their ACEs differently depending on their mental health. Childhood trauma can impact on memory; some ACEs may not be known to individuals (e.g. imprisonment of household member)

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| **Policy implications**   * Could better transport help support low-income families avoid ACEs? * ACEs should be seen within the context of wider structural factors such as poverty. |

C:\Program Files\Microsoft Office\MEDIA\CAGCAT10\j0293236.wmfWant to know more about what aspects of a place supports health, wellbeing and quality of life?

Take a look at The Place Standard Tool on the [NHS Health Scotland](http://www.healthscotland.scot/tools-and-resources/the-place-standard-tool)

[webpages](http://www.healthscotland.scot/tools-and-resources/the-place-standard-tool)

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| **Future research** – Dr Marryat finished by describing plans for future analysis.   * Is it ACEs or other things that are driving these outcomes? Future research will explore the linked data further, using the next sweep of GUS data. The analysis will investigate influence of trusted adult/attachment on ACEs and outcomes. * The researchers are bidding for collecting data on parental ACEs in future GUS surveys to investigate impact of ACEs on parenting and intergenerational transmission of ACEs. * The research will continue to look at prospective ACEs up to age 18. |

**Presentation 4: Loss and adversity in childhood: how adversity, gender and the justice system can interact**

[Dr Nina Vaswani](http://www.cycj.org.uk/about-us/meet-the-team/nina-vaswani/), Centre for Youth and Criminal Justice, University of Strathclyde

Dr Vaswani’s presentation covered research that she has undertaken at the IVY Project which works with very vulnerable young people (aged 12-18).

* Based on a review of case files, only 7% of the sample (n=111) had one ACE. 59% had experienced 4+ ACEs.
* The most common experiences were parental separation (81%), domestic violence (61%), emotional neglect (50%), and family incarceration (25%).
* Unlike other ACEs studies there was not a dose response relationship – likely due to skewed, small sample.
* Highlighted some of the **limitations of ACEs research** – the evidence provides a powerful public health message but there are issues such as labelling, recall problems, missing ACEs, simplistic measure (e.g. parental separation can be positive), score alone is not enough.

Dr Vaswani then went on to talk about her interest in **bereavement:**

* Loss and bereavement are key issues in ACEs work – many of the ACEs are about loss (or absence) of parental support/attachment.
* Children are more likely to lose a father (higher mortality rates) – is there something about the loss of same gender parent?
* Her research looked at 252 case files of young offenders – 59% had experienced a bereavement (which is not vastly different from the general population). But their bereavements were multiple and traumatic - 1 in 5 had lost a parent compared with 3-5% in general population.
* Bereavement research of men under 21 in Polmont YOI found that the risk of negative outcomes increases at 4 bereavements.

And in **gender**:

* There are inconsistent but small gender differences in ACEs studies; sexual abuse is higher for girls. Risk of under-disclosure of some ACEs for men, particularly sexual abuse.
* In studies of vulnerable populations (Kibble, prisons) – females are more vulnerable and victimised than their male counterparts.
* Females present with higher level of vulnerability when they come into contact with the Justice system.
* Males come into contact with the justice system at a lower adversity level than females (Shilling et al, 2007).

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| **Policy (and research) implications**   * Seek the views of children and young people on what they think ACEs are e.g. bullying? Being in care? * Should we dismiss parental separation as an ACE because it’s such a common experience? * Are there gender differences in ACEs exposure? * Are there gender differences in ways people respond to ACEs? Study in Queensland found that 30% men would not seek help, compared with 6% females. * Are there gender differences in the symptoms/expression of trauma? Females tend to internalise, males externalise (e.g. aggression & violence) which provokes different services (authoritarian/behavioural response for males; emotional/wellbeing approaches for female). * Does the justice system respond differently to males and females affected by ACEs? Is this why we have such a high proportion of males and such vulnerable group of females in justice system? * What about other intersections (e.g. ethnicity, poverty)? |

**Presentation 5: ACEs in forensic populations in Scotland: The importance of CPTSD and directions for future research**

[Prof. Thanos Karatzias](https://www.napier.ac.uk/people/thanos-karatzias), Director of Research in the School of Health & Social Care at Edinburgh Napier University, UK and Clinical & Health Psychologist at the Rivers Centre for Traumatic Stress, Edinburgh

Prof. Karatzias’ presentation covered a wide range of research that he has conducted on complex post-traumatic stress disorder (CPTSD), which is a new condition to be included in the forthcoming ICD-11. It is predominantly associated with childhood, interpersonal and multiple traumatisation.

**ACEs and trauma**

* Psychological interventions play a key role in helping people address the mechanism that explain the effect of traumatic life events (e.g. by changing people’s perspectives of the world as an unsafe place).
* Highlighted **links between childhood and adult trauma** which tend to co-occur - childhood trauma creates an environment for later traumatic experiences.
* Childhood trauma is more serious – **all mental health conditions are associated with childhood trauma**. If we eradicated ACEs there would be 1/3 less diagnosable mental health conditions.
* This is because ACEs impact on all psychological schema. Impact of ACEs is idiosyncratic – it varies by individual.
* His research has shown ACEs are associated with earlier offending, more serious offending, self-harm in prison, and violent offending associated with drug use.
* 80% people in a secure unit in Scotland had experienced childhood trauma – associated with suicidal tendencies and self-harm, drug use, and offending in adulthood.
* ACEs are also associated with chronic pain (medically unexplained symptoms).
* People who experience ACEs have more complex symptoms including symptoms associated with CPTSD.

**Diagnosis and treatment of CPTSD**

* Diagnosis of traumatic distress is key to identifying the right treatment.
* Prof. Karatzias has conducted work on distinguishing between PTSD and CPTSD which will be added to the next ICD-11 – covers symptoms like hyper-arousal.
* He conducted the first study on CPTSD in Scotland –– all ACES are more highly correlated with CPTSD than simple PTSD. CPTSD is common and associated with depression and disassociation.
* He has developed an instrument to measure CPTSD which includes a 12 item version about to be released in the literature. This will be free to use, and is already used in 29 countries inc. US and Australia.
* Treatment of CPTSD is at an early stage. He recommends a phased approach – stabilisation (e.g. survive and thrive) followed by trauma-focused work (UKPTS Guideline 2017).
* Completed analysis of 51 studies of treatments of CPTSD – ACEs moderate negative outcome of treatment i.e. people with ACEs do worse in treatments compared to those without ACEs. Need to do more work on this e.g. routine screening of CPTSD.

**Presentation 6: Bearing witness to trauma among offenders: harnessing the Adverse Childhood Experiences evidence for better outcomes.**

[Jane Mulcahy](https://www.researchgate.net/profile/Jane_Mulcahy3), University College Cork

The final speaker was Jane Mulchahy who is conducting her PhD research with people in prison in Ireland. She made an impassioned case for more trauma-informed justice systems which recognise the significant ‘overdose’ of trauma in forensic populations.

**Family and intergenerational transmission of ACEs**

* Trauma is intergenerational – need to intervene when children are small.
* Support should be focused on primary care givers and children – referenced the family pathways project in US (experienced mothers visit at risk mothers for 18 months to help them build good attachment with their children).
* It all begins with the family (early attachment is crucial) and how we choose to support them or not – our ambition should be to help people become a ‘good enough’ parent.

*“Hurt people hurt other people” “Recovery is through connections with people”*

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| **Practice reflections**   * Just having people listen about your trauma can be therapeutic. * Services need to be not just trauma-informed but **trauma-responsive** – relationships are vital and reflective practice. * Diagnosing mental health conditions of people in prison can be problematic – maybe it’s trauma? * Argued that it is **unethical to not ask about ACEs** – we need to challenge the fear of practitioners to ask about ACEs. * Calls for **strengths-based** practice in prisons where staff ask prisoners what they are interested in/good at (e.g. boxing, sports, art in prison). Opposition behaviour is often driven by fear – release from prison can be frightening. * Drew links between Maslow’s hierarchy of needs and the ACEs pyramid – if physiological and safety needs are not met then no way of progressing. It’s important to meet these needs first. * Not suggesting that we can cure people and make them safe to be around by just doing an ACE questionnaire. But if we don’t intervene in ways that makes sense to people they will continue to do harmful acts. * Practitioners need to understand the fight/flight/freeze response e.g. someone awaiting sentence. You can choose to escalate or reduce the risk of conflict. We may need to unlearn some of our own behaviour and responses to threat, but staff need support to do this. * One thing to do differently – try to look comfortable in the presence of the most challenging people. |

**Key themes from the day and panel questions**

**Are all ACEs equal?**

* This is a common question that researchers grapple with particularly parental separation which is such a common ACE. The cumulative aspect is key – parental separation in and of itself might not be an ACE if it takes place in a supportive family environment but if combined with other ACEs then it can have negative impacts (as less support available).
* ACEs tend to co-occur e.g. drug and alcohol use in the home.
* Some ACEs are more extreme than others e.g. sexual abuse – this one ACE could have a significant impact. Need more research on weighting of ACEs and which ACEs predict others.
* It depends on severity and frequency of ACEs. Combination of adversity in childhood AND adulthood can drive really extreme forms of exclusion.
* In America some primary care settings (e.g. Nadine Burke-Harris’ centre) focus on the ACEs score rather than what the individual ACEs are. Dr Ford’s review of Routine Enquiry has found that response rate is higher for score-based items and that this approach identified higher prevalence of ACEs.
* There are other adversities not covered by the standard 10 e.g. discrimination, bullying and community violence.
* May never be able to say one ACE is more important than another – it’s how the child/person responds, their level of stress, fear etc. The ACE research has been useful as a population health survey to give an indicator of the cumulative impact of early adversity. It does not tell us what the individual experience has been like.
* Important to look at a person’s resilience factors not just ACEs – at family and community level – look wider than just the child/person. Need to do RE in conjunction with an understanding of resilience.

**Asking about ACEs (Routine Enquiry)**

* Explore role of RE in maternity services as there is an association between history of sexual abuse and poor attachment. Disclosure must be accompanied by appropriate response e.g. extra appointments, extra care to talk through what to expect – not necessarily specialist services.
* Need to challenge culture of fear about asking about ACEs – costs us more money in the long run if we don’t.
* Needs to be part of a trauma-informed reform in services – there was a view that we should invest in universal screening at GP practices, trauma-informed schools and prisons that support people.
* Does it open a can of worms? There’s no such thing as thing as a can of worms that isn’t there already. It’s a matter of choice whether you want to do anything about it. Perhaps it is more difficult for the practitioner to ask the question than the individual to answer it. It’s a question of readiness depending on where they are on their recovery journey.
* Is there a good way to ask about ACEs, including child sexual abuse? (see reference to Reed’s article in the final presentation about how to ask about sexual abuse in psychiatric setting).
* Mixed views on whether to do it at first assessment (assuming the person is stable enough) or whether to wait until rapport is established. Concern that if you wait too long you put it off. Important to make it part of what you do (routine).
* Suggestion that it is phrased as part of a conversation e.g. ‘tell me about yourself’, ‘tell me about your life’.
* Most people won’t need specialist help but it’s important to have it available if needed.
* Provide a basic level of trauma training which covers which language to use. Need a basic level of rapport with the individual first. They need to know why you are collecting the information.
* See the NHS Education for Scotland ([NES) Trauma training framework and animation](https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx).
* Sometimes an impersonal questionnaire as part of assessment is safer – it is then up to individual if they are ready to complete it or not, but need to follow up responses/provide future opportunities to disclose.

**Trauma-informed approaches**

* In relation to the justice system – it is important for judges to understand the psychology of addiction, consider what supports are available and understand the impact of a sentencing decision on a person.
* Also need to think about how to support victims of crime in a trauma-informed way.
* Important to keep women who are primary care givers out of prison.
* Focus on what outcomes you want to achieve and what is the best way to achieve those.
* Language is important. Consider changing the language of justice to more welfare-based language. This could help move the conversation forward. Acknowledged that language takes time to change.
* Need to maximise the opportunity that prison can provide to help people.

**Key messages, sharing evidence and research gaps**

Delegates were asked to reflect in groups on 3 questions:

1. What are the key messages for policy and practice that you’ve heard today?

2. What are the most effective ways to share research findings and evidence for practice?

3. Where do you think the research gaps are?

**1. Key messages for policy and practice**

**Trauma-informed policy and practice – key messages**

* The development of a trauma-informed workforce is essential and there are certain elements that should be taken into account:
  + the level of organisational readiness should be carefully considered,
  + raising awareness around ACEs should be an integral part of training,
  + involvement of people with lived experiences,
  + trauma-informed leaders training: senior management should be on board,
  + practitioners training & ongoing support,
  + we need to be aware that we are talking about a cultural shift and the implications that this might have.
* It is important for professionals to be properly trained so that disclosure becomes a therapeutic process and re-traumatisation is avoided. At the same time, professionals themselves need protected from secondary traumatisation.
* Intervention should be introduced as early as possible and needs to be based on multi-agency partnerships. Every individual is different. Flexibility is important to build a consistent relationship and allow long-term support.

**Messages for education and early years**

* Schools can be used as a place to inform a whole population cohort about ACEs and human development.
* The curriculum needs to include information on adversity and its future impacts as well as help-seeking resources in order to inform and equip children.
* **Attachment** is of great importance and the Scottish Government should address this. It is believed that the political focus on attainment has shifted the attention away from attachment. The current childcare policy and parental leave could be ameliorated to demonstrate a better understanding of attachment and reflect the needs of children and their parents.

**Building awareness in communities and wider society to prevent ACEs**

* Need to find ways to build resilience within **communities** so that they are equipped to understand and engage with individuals even when they manifest violent or intimidating behaviour.
* Consider a **public education campaign** on ACEs and stress and their impact on brain development to raise awareness amongst the general population.
* Senior politicians should educate the public regarding ACEs and take destructive mainstream press practices to task.
* Need to inform everyone about ACEs in order to build empathy.
* Build relationships with the media. The film ‘Resilience’ is a helpful way to reach ordinary people.
* Launching a **nation-wide campaign on attachment** was identified as a way to reach out to every parent on good parenting practices without stigmatising anyone.
* The baby box was identified as a possible medium of communicating information on post-natal & infant mental health.

**Challenges and Barriers**

* The right intervention at the right time can lead to prevention, however, it was acknowledged that the reality of delivering person-centred care can be difficult given the expectations in times of austerity and the impact of austerity on families.
* Services are under pressure and need more time, funding and staff to work flexibly with people in an effective way: relationships matter.
* Need to be careful not to blame or stigmatise people because that would reduce the likelihood of seeking help.

**General points**

* Policy and research should be integrated into practice and trauma-informed resources should be made widely available.
* Shared language is needed across services to achieve shared understanding.
* It is important to look at the lessons learned from existing evidence and how they can be transferred (e.g. use the lessons learned from the Routine Enquiry on Gender Based Violence and use these to inform future implementation).
* It is important to look at wider issues such as housing, benefits and transport related solutions to support people that struggle.
* How to prevent ACEs from occurring: focus on adult mental health and the structural factors that impact on communities, families and children, especially parents, to prevent intergenerational ACEs.

**2. Suggestions on how to share research findings and evidence for practice**

* Research needs to be translated into practice and embedded into workforce training.
* **Gather and share evidence** from practices and pilots that have been already implemented and tested.
* Address the gap in communicating and sharing the work each organisation/ service carries out through collaboration and multi-disciplinary approaches.
* Hosting more workshops and seminars like this was encouraged.
* **Summarise research findings** and share them in the form of headlines and graphics that are easily readable (the infographics from the Welsh ACEs report were given as an example).
* The Scottish ACEs Hub needs to find ways of disseminating research findings and information to the wider public and make links with colleagues from all disciplines (health, criminal justice, police, education, 3rd sector etc.).
* Need to enhance representation from all sectors and bring them all together in the same room.
* It is important to invite people from all organisational levels: practitioners, managers, leaders.
* Networking was identified as a useful channel for different organisations or disciplines to discuss research findings and share their knowledge and views.

**3. Suggested research gaps and questions for policy and practice**

* Scottish data on the prevalence of ACEs amongst the adult population.
* What does it feel like to have experienced ACEs?
* Are there other adversities that should be considered?
* What do we offer people once they have disclosed experience of ACEs?
* How do we build resilience in education & communities?
* Attachment is a vital component which can be missed within ACEs.
* How is effectiveness of treatment on people measured & what interventions make the biggest differences to people’s lives?
* How can the economic costs and benefits of early intervention be measured?
* How is the impact of relationships and the building of trust measured?
* Lack of evidence on the prejudice towards people who have experienced multiple ACEs and experience adverse social and health outcomes as a result.
* There is a need for better understanding of the impacts on neurodevelopment in order to start working with people at the stage they are at.
* Mapping of interagency communication to promote effective person-centred care.
* Need to be aware that being there for people is a difficult outcome to demonstrate and measure but one that is easily achieved and appreciated.

If you are aware of any research on adverse childhood experiences that you would like to share with us please email: [nhs.Healthscotland-ChildhoodAdversity@nhs.net](mailto:nhs.Healthscotland-ChildhoodAdversity@nhs.net)

**Next Steps**

Colleagues working across NHS Health Scotland and the Scottish Government will review the learning from this workshop and issues raised, and consider the next steps.

We would like to explore if a Scottish ACEs research network would be of value and to organise future research and learning events. If you have any suggestions for future events/topics please get in touch.

If you have any queries or suggestions, or would like please contact: [aces@gov.scot](mailto:aces@gov.scot) or [nhs.Healthscotland-ChildhoodAdversity@nhs.net](mailto:nhs.Healthscotland-ChildhoodAdversity@nhs.net)

**Follow the conversation on Twitter** #ACEsEvidence #ACEsScot

**Organisers**

**Katy Hetherington,** Organisational Lead - Child and Adolescent Public Health, NHS Health Scotland

**Tamsyn Wilson**, Policy Manager – ACEs and Resilience Team, Scottish Government

With thanks to Adam Burley for his help in securing our fantastic speakers, colleagues in NHS Health Scotland and Scottish Government in ensuring the day ran smoothly, and COSLA for providing a super venue.

**Annex A**

**Scottish Adverse Childhood Experiences Hub**

**Adverse Childhood Experiences: Learning from Research for Better Policy and Practice in Scotland**

**19th June 2018, COSLA**

The Scottish ACEs Hub, in collaboration with the Scottish Government, is hosting a seminar on research and evidence on childhood adversity and trauma and its implications for policy and practice.

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| The aims of the day are to:   * Share multi-disciplinary research findings on childhood adversity to inform policy and practice in Scotland; * Identify priorities for future research; * Develop a network to share evidence and contribute to future ACEs events. |

You will hear from academic professionals with a diverse range of research interests. This is a rare opportunity to bring evidence together and discuss how we can use this research to inform policy and practice aimed at preventing and mitigating ACEs in Scotland.

|  |  |
| --- | --- |
| **Time** | **Programme** |
| 9.30-10.00 | **Arrival and tea/coffee** |
| 10.00-10.10 | **Chair’s welcome** Dr Fiona Cuthill, Lecturer in Nursing Studies and Academic Director, Centre for Homelessness and Inclusion Health, University of Edinburgh |
| 10.10-10.35 | **ACEs in Wales and preliminary findings from a review into routine enquiry**  Dr Kat Ford, Bangor University |
| 10.35-11.00 | **Adverse Childhood Experience and homelessness in adulthood: what do we know about the links?**  Prof. Sarah Johnsen, Herriot Watt University |
| 11.00-11.15 | **Coffee Break** |
| 11.20-11.45 | **Prevalence of Adverse Childhood Experiences in the general population of Scottish Children**  Dr Louise Marryat, University of Edinburgh |
| 11.45-12.10 | **Questions for morning speakers**  All |
| 12.10-12.30 | **Table discussions** |
| 12.30-1.15 | **Lunch** |
| 1.15-2.15 | **Loss and adversity in childhood: how adversity, gender and the justice system can interact**  Dr Nina Vaswani, Centre for Youth and Criminal Justice, University of Strathclyde  **ACEs in forensic populations in Scotland: The importance of CPTSD and directions for future research**  Prof. Thanos Karatzias, Edinburgh Napier University & NHS Lothian Rivers Centre for Traumatic Stress  **Bearing witness to trauma among offenders: harnessing the Adverse Childhood Experiences evidence for better outcomes.**  Jane Mulcahy, University College Cork |
| 2.15-2.25 | **Comfort break** |
| 2.25-2.45 | **Questions for afternoon speakers**  **All** |
| 2.45-3.15 | **Table discussions** |
| 3.15-3.30 | Chair’s closing remarks |
| 3.30 | **Close** |

**Annex B**

**Speaker Biographies**

**Scottish Adverse Childhood Experiences Hub**

**Adverse Childhood Experiences: Learning from Research for Better Policy and Practice in Scotland**

**19th June 2018, COSLA**

**Dr Fiona Cuthill, Lecturer in Nursing Studies and Academic Director, Centre for Homelessness and Inclusion Health, University of Edinburgh (Chair)**

Having worked for several years as a Registered Adult Nurse and community nurse for people seeking asylum and refugees in the North East of England, Fiona has worked as a lecturer in Nursing Studies at the University of Edinburgh (UoE) since 2014. Her teaching and research interests are around health inequalities, gender-based violence, homelessness and refugee health. She is the Programme Director for the MSc in Advancing Nursing Practice and Academic Director for the new Centre for Homeless and Inclusion Health (UoE). She is particularly interested in qualitative research methodologies that work with peer participatory researchers as part of the research process. Fiona is a founding member and current trustee of Justice First, a charity working in the Tees Valley with people who find themselves destitute following the asylum process in the UK.

**Dr Kat Ford, Bangor University**

Dr Kat Ford is a public health Research Officer at the Hot House, Bangor University. Kat’s research interests include violence prevention, specifically research which focusses on Adverse Childhood Experiences (ACEs), the misuse of alcohol and management of the night-time economy. Kat has worked on a number of ACE studies, including most recently the Welsh ACE and resilience study and is currently running the first study in the UK exploring the prevalence of ACEs in an offender population.

Kat previously worked in the Policy, Research and International Development Directorate at Public Health Wales, where she was the research lead on the Police Innovation funded, Early Intervention and Prevention project. In post, Kat led a team of researchers who conducted a large scale research study into the response to vulnerability and risk by South Wales Police (SWP) and other agencies. This included a large analysis of safeguarding referral data held by SWP and social services, and an evaluation of ACE-informed training delivered to South Wales Police.

Twitter handle @Katharineford

**Prof. Sarah Johnsen, Herriot Watt University**

Professor Sarah Johnsen is a Professorial Fellow in the Institute for Social Policy, Housing and Equalities Research (I-SPHERE) at [Heriot-Watt University](http://www.sbe.hw.ac.uk/staff-directory/sarah-johnsen.htm).  She has previously worked for Queen Mary University of London, the University of York, and The Salvation Army (UK & Ireland).  Much of Sarah’s work focuses on homelessness, addiction, and related forms of street culture (e.g. begging and street drinking).  She has particular expertise in welfare provision for people with complex support needs, and ongoing interest in the practice and ethics of research involving vulnerable people.

**Nikoletta Theodorou, Herriot Watt University**

Nikoletta Theodorou is a PhD student in the Institute for Social Policy, Housing and Equalities Research (I-SPHERE) at [Heriot-Watt University](http://www.sbe.hw.ac.uk/staff-directory/sarah-johnsen.htm). Her doctoral study focusses on the impact of trauma, including adverse childhood experience, on the attachment styles and service use of homeless people affected by severe and multiple disadvantage. Her study will assess the implications for the delivery of services for homeless people with complex needs. Prior to commencing her study Nikoletta worked as a frontline support worker in homelessness services and has completed her professional qualification as a counsellor.

**Dr Louise Marryat, University of Edinburgh**

Dr Louise Marryat is a Research Fellow in natural experiments at the Farr Institute Scotland and SCPHRP, at the University of Edinburgh. She also holds honorary posts at the University of Glasgow and the Gillberg Neuropsychiatry Centre, Sweden. Louise has a BA (Hons) in Politics and Sociology, a MA in Research Methods and a Ph.D. in Psychological Medicine.  Before returning to academia, Louise worked for several years at NatCen Social Research, working on the Growing Up in Scotland study, as well as the Scottish Health Survey and several public health interventions. She has held postdoctoral positions in the University of Glasgow, in the Institute of Health and Wellbeing, and the School of Mathematics and Statistics. Louise works primarily with longitudinal secondary data, particularly administrative data, and has a specific interest in early child development. She currently manages the Scottish ACE Study, which explores the prevalence and impact of ACEs in the Scottish population.

**Dr Nina Vaswani, Centre for Youth and Criminal Justice, University of Strathclyde**

Nina joined the Centre for Youth and Criminal Justice (CYCJ) in October 2013.  CYCJ is an independent centre hosted by the University of Strathclyde.  Prior to joining CYCJ she worked at Glasgow City Council, helping to develop the city’s evidence-based approach to youth justice policy, practice and service development and also managing the Youth Justice Research and Development Team. Nina’s role at CYCJ is Research Fellow.  Her key research interests are the experiences and impact of bereavement and loss in young people as well as the vulnerability of young men.  Recent projects include: conducting the CYCJ stakeholder survey; an evaluation of a Systemic Family Practice Course; an exploration of the changes in the way that young people and crime are reported in the media; an implementation of Multi-dimensional Treatment Foster Care in the West of Scotland; and the piloting of an assessment and monitoring tool for vulnerable young women.

Find out more about CYCJ at [www.cycj.org.uk](http://www.cycj.org.uk/)

**Prof. Thanos Karatzias, Edinburgh Napier University & NHS Lothian Rivers Centre for Traumatic Stress**

Professor Karatzias, is the Director of Research in the School of Health & Social Care at Edinburgh Napier University, UK and Clinical & Health Psychologist at the Rivers Centre for Traumatic Stress, Edinburgh, UK. He is the former Chair of the British Psychological Society Scotland Working Party for Adult Survivors of Sexual Abuse (BPSSS) and he is a current member of the Committee of the British Psychological Society (BPS) Crisis, Disaster & Trauma Section and UK Psychological Trauma Society (UKPTS) Board. He has spent his entire clinical and academic career working in the field of psychological trauma, particualry on interpersonal psychological taruma. In collaboration with national and international research partners he has developed a special interest in the effects and treatment of psychological trauma on physical and mental health; on prison populations; and on people with learning disabilities. Prof. Karatzias has published widely in these areas.

In 2016, Prof. Karatzias published the first study in the world providing evidence on Complex Post Traumatic Stress Disorder (CPTSD), a new condition to be included in the forthcoming ICD-11 which predominantly associated with childhood, interpersonal and multiple traumatisation. In the same year he published the first study on the standardisation of the International Trauma Questionnaire (ITQ), a new scale that assesses PTSD and CPTSD as per ICD-11 criteria. With over 35 international peer reviewed journal articles dedicated to the area of CPTSD area alone, the work of Prof. Karatzias made a significant contribution to understanding the concept of complex trauma. His current work is utilising this knowledge to better understand recognition and treatment of this debilitating and prevalent disorder in the absence of any definitive guidelines from health related bodies.

**Jane Mulcahy, University College Cork**

Jane (Twitter: @janehmul) is a PhD candidate in law at University College Cork in Ireland. Her research is entitled “Connected Corrections and Connected Corrections: Post-Release Supervision of Long Sentence Male Prisoners.” She is an Irish Research Council scholar under the employment based PhD scheme, co-funded by the Probation Service and the Cork Alliance Centre, a desistance project in Cork, is Jane’s employment partner. Jane has worked as a researcher in the area of criminal justice, penal policy and social justice since 2005. As an independent research consultant she wrote the research report on *The Practice of Pre-trial detention in Ireland* (2016) for the Irish Penal Reform Trust (IPRT) as part of an EU Commission funded project facilitated by Fair Trials International. Between 2010 and 2013 she worked as Research and Policy Officer at IPRT. Previously she was senior legal researcher on the Codification of the Criminal Law project at University College Dublin. Prior to that Jane worked on the law of homicide at the Irish Law Reform Commission, writing the Consultation Paper on Involuntary Manslaughter (2007) and the Report on Homicide: Murder and Involuntary Manslaughter (2008). Aside from criminal justice, penal policy and human rights research and advocacy, Jane is passionate about the arts, especially theatre. She has written, directed and acted in several plays. She began hosting a new radio show/podcast in conjunction with the UCC Law Department and UCC 98.3fm called Law and Justice in September 2017. Many recent features have addressed the subject of Adverse Childhood Experiences, how trauma is embodied and the devastating lifelong impact on individuals and society.

**Annex C**

**Delegate List**

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| --- | --- | --- |
| **First Name** | **Surname** | **Organisation** |
| Camilla | Barnett | Scottish Government |
| Stuart | Baxter | Scottish Government |
| Vikki | Binnie | Dumfries and Galloway Council |
| Catherine | Bisset | Scottish Government |
| Louisa | Brown | Scottish Government |
| Nicky | Brown | The City of Edinburgh Council |
| Nicola | Bruce | Midlothian Council |
| Adam | Burley | NHS Lothian |
| Marie Therese | Cain | North Ayrshire Council |
| Tony | Cain | ALACHO |
| Allison | Calder | Rock Trust |
| Kirsty | Campbell | Justice Analytical Services, Scottish Government |
| Sam | Campbell | NHS Highland |
| James | Carnie | Scottish Prison Service |
| Jan | Clarke | FFSA |
| Morag | Coleman | Families First St Andrews |
| Clare | Collin | Scottish Government |
| Louise | Cook | DWP |
| Katie | Cosgrove | NHS Health Scotland |
| Mamie | Couper | City of Edinburgh council |
| Fiona | Crawford | NHS GG&C |
| Kellie | Cunningham | Clyde Valley High School, North Lanarkshire |
| Fiona | Cuthill | University of Edinburgh |
| David | Dickson | Scottish Sentencing Council |
| Sara | Dodds | Scottish Government |
| George | Dodds | NHS Health Scotland |
| Edward | Doyle | Scottish Government |
| Susan | Dunn | Gowrie Care |
| Catherine | Elder | Dumfries and Galloway Council |
| Laura | Falconer | Barnardo’s |
| Marian | Flynn | CELCIS |
| Kat | Ford | Bangor University |
| Ann | Forsyth | NHS GG&C, GCHSCP |
| Hamish | Fraser | Midlothian Council |
| Kirstie | Freeman | Fife Council |
| David | Gaughan | Ypeople |
| Kenneth | Gilroy | Police Scotland |
| Ashley | Goodfellow | NHS Lanarkshire |
| Caroline | Greenshields | South Lanarkshire Council |
| Andy | Hardie | Venture Trust |
| Helen | Harpe | Scottish Government |
| Neil | Hastie | Scottish Government |
| Claire | Hendry | NHS Health Scotland |
| Katy | Hetherington | NHS Health Scotland |
| Laura | Hoskins | Community Justice Scotland |
| Sarah | Johnsen | Herriot Watt University |
| Wendy | Johnson | University of Edinburgh |
| Marta | Kanafa | Scottish Government |
| Thanos | Karatzias | Edinburgh Napier University |
| Nicola | Kelly | South Lanarkshire Council |
| William | Kennedy | East Dunbartonshire Council |
| Caroline | Kerr | City of Edinburgh Council |
| Rachel | King | NHS Lothian, East Lothian H&SC |
| Tamasin | Knight | NHS Tayside |
| Joanna | Kozyra | The Junction |
| Stacey | Kyle | Children and Families Dumfries and Galloway Council |
| Tom | Lamplugh | Scottish Government |
| Jenny | Leishman | Scottish Government |
| Michelle | Lloyd | Cyrenians |
| Joanne | Logan | Police Scotland |
| Rachel | Love | NSPCC Scotland |
| Pauline | Lunn | Ypeople |
| Kathleen | Mackenzie | Families First St Andrews |
| Franca | Macleod | Scottish Government |
| Rachel | Macpherson | Scottish Government |
| Fiona | Malcolm | Scottish Government |
| Louise | Marryat | University of Edinburgh |
| Jane | Marshall | Boroughloch Medical Practice |
| Charlie | Martin | The Wise Group |
| Leah | McCabe | Scottish Sentencing Council |
| Jan | McClory | University of Edinburgh |
| Avril | McIvor | University of Edinburgh |
| Crina | Mihet | Dumfries and Galloway Council SW Youth Justice |
| Alison | Miller | Families First St Andrews |
| ganka | Mueller | Scottish Government |
| Jane | Mulcahy | University College Cork |
| Lucy | Mulvagh | Health and Social Care Alliance Scotland (The ALLIANCE) |
| Alex | O'Donnell | CJ Social Work |
| Stefania | Oikonomou | Scottish Government |
| Maggie | Page | Scottish Government |
| Elaine | Paterson | NHS Health Scotland |
| William | Penrice | Fife Council |
| Lisel | Porch | Scottish Government |
| Chloe | Riddell | Children 1st |
| Gill | Robinson | SPS |
| Daniel | Rowley | Children and families |
| John | Scott | Capital Defence Lawyers |
| Holly | Scott | Scottish Government |
| Tia | Simanovic | University of Strathclyde |
| Tricia | Spacey | Fife Council |
| Emma | Stokes-King | Dumfries and Galloway Council |
| Mhairi | Struthers | NHS Health Scotland |
| Felicity | Sung | Scottish Government |
| Kathleen | Symington |  |
| Clea | Thompson | NHS Fife |
| Kevin | Toshney | Aberdeen City Health & Social Care Partnership |
| Nina | Vaswani | University of Strathclyde |
| Val | Vertigans | Aberdeen City Council |
| Nicole | Walsh | Scottish Government |
| David | Walsh | Glasgow Centre for Population Health |
| Ann | Wardlaw | Inverclyde HSCP |
| Kimberley | Wharton | Heathery Knowe Primary School |
| Jane | White | NHS Health Scotland |
| Kerima | Whiteford | South Lanarkshire Council |
| Tamsyn | Wilson | Scottish Government |
| Mike | Wright | Cyrenians |

1. <https://www.scotphn.net/projects/adverse-childhood-experiences/introduction/>

   [↑](#footnote-ref-1)