**Recognising and Responding to**

**Adverse Child Experiences and Trauma Workshop**

Thursday 30 November 2017 (9:30-16:00), Edinburgh

**Introduction**

Evidence shows that adversity and trauma in childhood can impact on a wide range of education, health, justice and other outcomes[[1]](#endnote-1). This report provides an overview of the workshop which took place on the 30th November 2017 to discuss ‘Recognising and responding to adverse childhood experiences and trauma’. The workshop was organised by the Scottish Government in conjunction with NHS Education for Scotland and NHS Health Scotland; three organisations which all have a collective interest in preventing and addressing adversity and trauma:

* The Scottish Government has set out its commitment to addressing adverse childhood experiences (ACEs) in the 2017-18 Programme for Government[[2]](#endnote-2).
* The Scottish Government also, as part of the Survivor Scotland Strategic Outcomes and Priorities 2015-2017[[3]](#endnote-3), commissioned NHS Education Scotland to support work on the planning and delivery of training for the Scottish workforce who have contact with those who have experienced adversity and trauma. NHS Education Scotland published the resulting National Trauma Training Framework[[4]](#endnote-4) in May 2017. The Framework seeks to improve workforce capacity to recognise and respond to the individual needs of people with ACEs and adult experiences of trauma, including enabling workers to have a conversation with the people they work with about what has happened to them in order to better respond. NHS Education Scotland is currently developing an implementation plan.
* NHS Health Scotland set up a Scottish Adverse Childhood Experiences (ACEs) Hub in 2016 following on from the publication of the Scottish Public Health Network report ‘Polishing the Diamonds: Addressing Adverse Childhood Experiences in Scotland’[[5]](#endnote-5) (May 2016). The Hub was established to shape and progress the actions identified in this report, and consider further actions to better prevent and mitigate ACEs. As part of their role in hosting and supporting the Hub and improving population health, NHS Health Scotland have an interest in increasing understanding of and sharing learning about routine enquiry of ACEs. In June 2017 the Scottish ACE Hub hosted a seminar exploring the evidence about routine enquiry of ACEs in health service settings[[6]](#endnote-6). Delegates heard from Dr Warren Larkin about the REACh (Routine Enquiry on adverse childhood experiences) model he developed in England and from other speakers who discussed relevant work underway in Scotland.

This workshop held in November 2017 was intended to build-on the seminar hosted by the Hub in June 2017 and consider whether and how routine enquiry and response about ACEs, as well as adult adversity and trauma, could be introduced and linked to the implementation of the National Trauma Training Framework.

There were three key objectives for the workshop to:

1. Introduce the National Trauma Training Framework and share learning from the REACh model
2. Consider the learning from current approaches and how that can inform further development of ACE-informed and trauma-informed services
3. Discuss the potential to implement routine enquiry and response as part of existing services and identify potential pilots.

A range of presentations were provided at the workshop on work in Scotland and England (see Annex A for programme) and there was plenty of opportunity for workshop participants (see Annex B) to ask questions and discuss the implications for policy and practice. The workshop was chaired by Fiona Crawford who is a Consultant in Public Health who works in a joint role between NHS Greater Glasgow and Clyde Public Health Directorate and the Glasgow Centre for Population Health. This report provides an overview of the presentations (see also the presentation slides), the main messages from discussion at the workshop, and the issues covered in group discussions which focused on services relating to: early years, children and young people, adults, and the whole life-course.

**Presentation 1:**  **National Trauma Training Framework principles and approach**

Sandra Ferguson and Sharon Doherty (NHS Education Scotland)

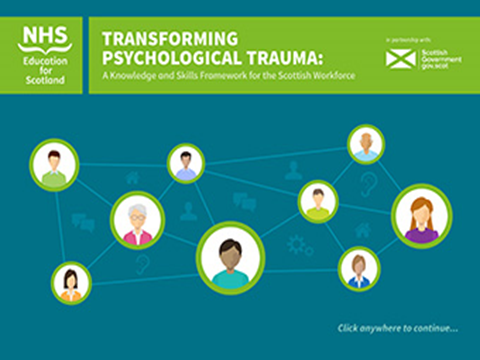


**Adversity and trauma:**

* ACEs and on-going adversity /trauma in adulthood present huge risks for negative physical and mental health outcomes and contact with the justice system.
* However, adversity is not destiny and there are a whole range of complex factors which influence outcome and potentially resilience. Evidence suggests that availability of safe and supportive relationships can be a key factor in this.
* We need to recognise the complexity of human growth, whilst understanding the significant impact that adversity and trauma can have on people’s lives and the negative outcomes revealed in ACE studies. It prompts us to think how do we respond in a trauma informed and holistic way? How do we provide services which avoid retraumatisation and are designed in a way which enable people to access and use the services they need?
* The language can be complicated as a range of terms are used. It can be useful to think of adversity and trauma along a continuum of stressors, with some experiences being so stressful they count as traumatic.
* Trauma informed practice should emphasise: collaboration, empowerment, safety, control and trust.

**National Trauma Training Framework**

* The aim of the NHS Education of the Framework is for all in the Scottish workforce to have the knowledge and skills to recognise and respond to adversity and trauma.



* The Framework is informed by a process of data gathering and engagement, including:
  + surveys to understand what the workforce already knows and what they need (there was a clear identified need for trauma training)
  + Literature reviews and qualitative research with people affected by trauma (findings from both of these overlapped and are reflected in the Framework)
* The key intended outcome of the workforce skills and training is that people affected by trauma feel safe and protected from harm; that they are feeling emotionally safe to make sense of the trauma, and have a future focus on what they want to achieve.
* The Framework splits the workforce into four main levels, it is not hierarchical or profession specific but instead articulates the different knowledge and skills which workers require to respond effectively to people affected by trauma in the context of their job role and service remit:
  1. **Trauma informed** (knowledge and skills for the whole workforce)

**Trauma skilled** (knowledge and skills for those workers who are regularly coming into contact with people affected by trauma {where trauma may not be known about} and in contexts where trauma informed adjustments to practice can be helpful)

**Trauma enhanced** (knowledge and skills for workers who have a role in directly providing services for people affected by trauma {support, care and interventions})

* 1. **Trauma Specialist** (knowledge and skills for workers who have a role in providing specialist interventions for people affected by trauma who have complex difficulties)

**Framework implementation**

* This year NES is working on a national strategy and trauma training plan (to be published March 2018), and Sharon Doherty is leading on strategy development. The aim of the strategy is to clarify what training would be useful for staff at different practice levels, what good quality training looks like and the knowledge and skills required of trainers, to help organizations access and where needed commission training.
* Next year to support the implementation of the Transforming Psychological Trauma framework, NES will be developing and piloting some specific training packages.

**Routine enquiry**

* It is useful to think about the implications for the spectrum of needs that might emerge if we start to routinely enquire about ACEs and adult adversity and trauma so long as there is organizational support in place.
* Routine enquiry is something that may be introduced in practice level 2 (‘trauma skilled’) for members of the workforce who have a lot of contact with members of the public, many of whom will have undisclosed history of adversity and trauma.
* Routine enquiry requires necessary workforce training and support, and the Framework articulates the knowledge and skills workers require to respond to disclosures in trauma-informed way.
* Routine enquiry is one component of a multi-faceted way of responding to people affected by adversity and trauma. It is important that services and organisations use trauma-informed principles to inform the service as a whole.
* Leaders’ commitment and buy-in is important so that staff are enabled to carry out routine enquiry in trauma-informed way.
* Evaluation of outcomes is also important to, because if routine enquiry is going to be implemented we need to know whether it is making a meaningful difference to people’s lives.

**Presentation 2: Routine Enquiry about Adversity in Childhood - Implementation**

Warren Larkin (Clinical Lead, Department of Health, Adverse Childhood Experiences Programme and Director Warren Larkin Associates Ltd)



**Evidence base:**

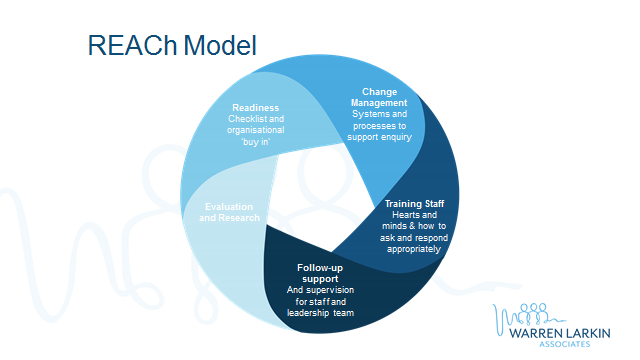
* Huge impacts of ACEs across the life-course including mental health, use of A&E, absenteeism at work, criminal behaviour etc. ACEs don’t occur in isolation need to look broadly at co-occurring adversity.
* Science of adversity shows impact of ACEs in terms of toxic stress and allostatic load from in-utero throughout child development, and into adulthood (Australian Government report ‘First Thousand Days’ is a good summary of the research).
* Resilience science shows that people can make great recoveries. Many resilience factors are important including: access to psychological therapies, opportunities for safe stable relationships, and trauma-sensitive schools, hospitals and prisons.

**The case for routine enquiry:**

* The conceptual model held by organisations determines what questions are asked. If a professional doesn’t think adversity and trauma are relevant to their work they won’t ask about it (e.g. if a psychiatrist believes psychosis is primarily a brain disease, they are unlikely to ask about childhood adversity and subsequent trauma, instead focusing their attention on diagnosing and treating the symptoms of that disease; yet evidence shows there is a causal relationship between childhood trauma and psychosis).
* Waiting to be told doesn’t work, many professionals think relying on clinical intuition or professional judgement to decide when to assess someone for adversity and trauma, but this is not a reliable way do it (e.g. Read & Fraser[[7]](#endnote-7) (1998) study found 8% people spontaneously disclosed lifetime physical or sexual abuse and this increased to 82% with routine enquiry).
* If routine enquiry is implemented well it supports the resilience of the workforce by supporting staff to address their own personal issues and staff (e.g., REVA study[[8]](#endnote-8), 2015).
* Research has found that routine enquiry is considered acceptable and desirable by survivors of trauma.
* Introducing routine enquiry can help reduce, rather than increase, demand on services (e.g. Anda & Felitti[[9]](#endnote-9) found that in a cohort study of 130,000 patients, in the year following being asked about adversity as part of an overall health assessment, people visited the doctor 35% less and visited A&E 11% less).
* Routine enquiry with parents can facilitate reflection on their parenting and prevent inter-generational transmission of ACEs; the optimal window is 6 weeks after the enquiry where parents are motivated to get help.
* Talking about ACEs, encouraged by routine enquiry, can help facilitate a more empathic and understanding community. It’s important for people / communities to understand that what happened in the past can be driving current health and risky behaviours.

**REACh Model:**

* In Lancashire, Warren Larkin developed the REACh Model (routine enquiry of adversity in childhood). The model, informed by implementation science, has shown that training is important to support practice change but the preceding stage of organizational readiness is critical, as is follow-up support and supervision of staff. See diagram of the model:



* It is important to train workers on what good practice looks like and give them consistent and reliable ways to ask questions and enable people to give consistent and clear answers. It’s important for staff to know the best time to ask questions - service entry is the best time but the exact point needs to be decided based on the service context. If the REACh methodology and training steps are done correctly, staff will feel confident in using what they have learned effectively.
* There is often practitioner and organizational fear that routine enquiry “opens a can of worms” that will be difficult to deal with. Although a service will need referral pathways in place for those that require additional support, in most cases a person can be supported sensitively by their worker to make sense of what happened to them and to address questions (e.g. was it my fault?). Disclosure can be handled by most workers if they have access to appropriate training and supervision.
* Supervision and follow-up support for staff and the leadership team is important. In most cases the day job is already hard and people can get compassion fatigue. Confidence in practicing routine enquiry of ACEs is predicted by management support.

*“Lifeline embedded the use of Routine Enquiry into Adverse Childhood Experiences within holistic assessment as part of a pilot project. This was following effective training for staff, to support them through this process. The team found that REACh enabled young people to disclose and receive support at an earlier opportunity. Practitioners felt supported throughout and felt they were better able to support young people whilst understanding the complexities within their lives.”*

Zoe Gatland, Manager – Lifeline – Young Person’s Drug & Alcohol Service

**Presentation 3: Reflections and learning from implementing Routine Enquiry on Gender Based Violence**

Katie Cosgrove (Organisational Lead – Gender-based Violence, NHS Health Scotland)

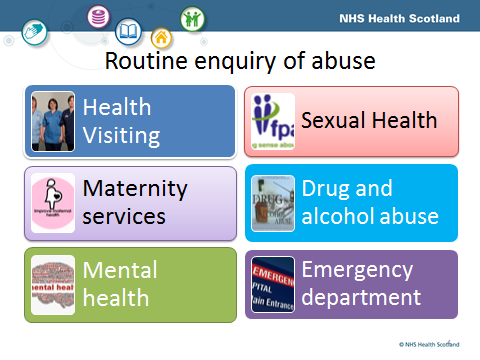


**Background**

* NHS Health Scotland policy on gender-based violence is to adopt a systems approach to ensure that the NHS recognised and met its responsibilities on gender-based violence as a service provider, employer and partner agency.
* It introduced routine enquiry on gender based violence as it was not being done - if you don’t know people’s life experiences then likelihood that the intervention will be partial at best.
* Previously the onus was on individuals to disclose even though that is very difficult for them and they don’t always make the connections.
* There is a debate about the traditional public health screening model which is about a population health intervention. Routine enquiry is not about screening, it’s about understanding and working with people to discuss what will help them.

**Implementation**

* The intention wasn’t that woman should be assessed when they come in contact with every service, rather that routine enquiry should be done by key services that are more likely come into contact with women who have experienced abuse.



* Before implementing training, the team worked with Health Boards to encourage them to consider how to introduce routine enquiry effectively. Some services were in a better position to implement it than others, and those that are aligned to a medical model can find it harder to shift.
* Routine enquiry training was mandatory.
* Change is difficult. Some of the issues that were raised included lack of time, lack of expertise, opening can of worms, what we going to do, child protection concerns.
* Staff resistance is understandable as services are under pressure. Staff can be fearful of talking about abuse.
* Many NHS employees will have experienced abuse themselves – in every training session at least one member of staff disclosed abuse, reinforcing the need to take care of our staff.
* Leadership is incredibly important, both nationally from the Scottish Government and at a local level.
* There wasn’t a script for workers to follow; instead they were trained and supported on how to have the conversation. It’s not about asking ‘are you experiencing domestic abuse?’, rather ‘are you living in fear? are you being harmed?’ etc.
* Not all people recognise their experiences as abuse. They may need help to piece it all together and recognise it as abuse, and information to help them make informed decisions – their narrative is important as they’re the expert on their lives not services/workers.
* Not everyone will need counselling.
* Educating communities is important (above and beyond routine enquiry) as it helps people to reflect on their own lives and seek help where needed.

**Presentation 4: Experiences of Implementation and Recommendations from East Lancashire**

Rob Dickinson, Business Development Lead – North of England at The Children’s Society (Formerly Service Manager for Early Support Services at Child Action North West)



**Background:**

* Introduced routine enquiry of ACEs (REACh model) in a third sector family support service, Familywise, operating in East Lancashire, England.
* Concentration of deprivation in small wards and communities often means they are impenetrable to services (high levels of distrust of services in the communities) and geo-political boundaries mean services can take a long time to catch up if families move post code.
* East Lancashire has a very young population (30% under 20 years) and people from a wide range of different ethnic communities, including a large population of asylum seekers and refugees.
* Familywise set out to address number of referrals to Children’s Services and inability to meet demand – the Family Wise service Rob managed was a buffer in-between families and Children’s Services.
* Familywise is a holistic model of solution focused interventions and assessment, with

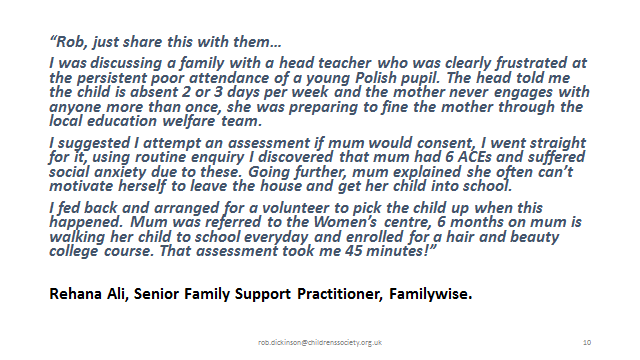
A multi-skilled and diverse team of social workers, youth workers, therapeutic practitioners, parenting practitioners and family group conferencing co-ordinators.

**Implementation of REACh:**

* Familywise service was working well and had made a range of improvements, but introduced REACh because interventions were lengthy and re-referrals and sibling referrals were common.
* Lancashire Care Foundation Trust Pilot programme involved Familywise, a School Nurse cluster and a Health Visitor neighbourhood team.
* REACh was a way of identifying presenting issues and required resources much sooner.
* Initial staff concerns included: disclosures of abuse/exploitation and a lack of time to discuss it, lack of resources for counselling, potential reactions from people from different cultural and religious backgrounds, and issues for staff themselves.
* The team were educated on ACEs and trained in routine enquiry and how to use the new assessment.
* Initial hesitations of staff were a challenge but reduced quickly with the right support and effective/reflective supervision.
* Managerial level buy-in was crucial for sustainability and completion rates.

**Experience of REACh:**

* Involved a service shift from solution-focused to allowing the family to set the agenda on what they think is important to change e.g. an enquiry of ACEs might be followed by a phone call the next day to say “can we talk again about that question you asked me”.
* Most service users were happy to engage in the conversation (hesitation or disengagement was less than 5%).
* The team found that enquiring about ACEs shortened the assessment stage and brought about a different conversation and reduced misunderstandings and unhelpful sanctions.
* Resulting action plans were clear, focused and with relevant referrals to partner agencies where necessary (see reported practitioner experience below).
* Case files moved quicker and n time, re-referral rates dropped.
* Inter-generational challenges seemed to be disrupted too but there is a question of how long can that can be tracked by data.
* Overall routine enquiry achieved great results for Familywise and is now being widely used across Lancashire. They are now looking to implement it across The Children’s Society’s services.

****

**Discussion Points**

**Understanding routine enquiry**

* Need to be clear this is about routine enquiry in settings where people are already seeking help and NOT screening
* Just because a questionnaire is used as part of routine enquiry doesn’t mean it’s a tick box exercise – found that questionnaires get higher rates of disclosure, but practitioners need to explain why they are doing it, what the benefits are and that it is part of a holistic assessment.
* If you are going to do routine enquiry you need to do it right - always need to think about a good outcome, support for the person and how to do that in safe way.
* Routine enquiry needs to be appropriate to age and stage of person (i.e. not for children but effective with adults, parents, young people)
* Routine enquiry needs to encompass broad approach to adversity not just the original 10 ACEs. It’s not just about what happened in the past but also the impact of ACEs and whether they are relevant to their lives today.
* Can’t just focus on past experiences, there is a need to address what is needed now in terms of system response and support.
* This debate highlights a need for longer-term workforce planning with trauma informed care in mind (the NES Trauma Training Framework represents an important foundation for such an approach)

**Links to wider relationship-informed approaches**

* Shouldn’t compartmentalize routine enquiry, it is part of wider consideration of trauma-informed systems and services (or psychologically-informed approaches) about how to build trust and enable people to access support which address their individual needs.
* NES Framework is helpful as it’s about having the key knowledge andskills required to have a conversation effectively with someone around adversity and trauma.
* Routine enquiry is part of shift of to ‘what happened to you? rather than ‘what’s wrong with you?
* Diagnoses that lead to a conclusion of what’s wrong with somebody can be helpful and a relief, but can’t just manage symptoms which may be an attempt to manage/cope with experiences and underlying issues.
* Once we know things have happened to a person it changes your position and relationship - trauma-informed relationships are healing. Need to be careful not to be ‘mothering’ and balance enquiry of ACEs with focus on resilience and protective factors.
* There are a range of opportunities to increase understanding of ACEs in general practice (e.g. link worker role presents opportunities) and use routine enquiry of ACEs in mental health services.

**Organisations and Workforce**

* If we’re going to engage our workforce there is a need for clarity about what routine enquiry is and to be clear about what we’re going to do.
* The workforce wants to work well and make a difference, but in many places feels overwhelmed; it is important not to confuse the workforce.
* Organisational culture is important (i.e. if already going through organisational change, the workforce won’t be ready for introduction of routine enquiry or any kind of practice change/ development due to the lack of psychological safety and uncertainty)
* Need to assess organizational readiness before implementing routine enquiry - part of assessing readiness is whether the workforce has existing, adequate supervision.
* Need to support a resilient workforce with restorative supervision and informed by improved understanding of impact of trauma. It’s emerging in the NHS but what models exist in other sectors?
* Some people/organisations in Scotland are using screenings of ‘Resilience’ documentary and/or Alberta ‘growing brains’ animation to open a dialogue on ACEs with agencies and partners.
* There are differences between statutory and voluntary sector training requirements which need to be considered.

**Getting it right for every child (GIRFEC)**

* GIRFEC provides us with a common use of language we can use across agencies; need to consider routine enquiry in this context and the [SHANNARI wellbeing indicators](http://www.gov.scot/Topics/People/Young-People/gettingitright/wellbeing).
* Need to think how routine enquiry fits with role of named person.
* Community GIRFEC management groups could do routine enquiry and report back to children’s commission manager.
* GIRFEC and ACEs lens helps us to understand the environment in which children are raised and the need for integrating services (e.g. domestic abuse referral need to think about and support children rather than solely focus on abused partner)
* Not one size fits all in terms of adversity, need to think about different experiences children have, including inside and outside family home(s).

**Parents**

* Risk that increasing understanding of ACES leads us to a position where there are child protection interventions much earlier, but need to combine knowledge of childhood adversity with parenting support - can use information to help people be better parents so the child is not removed.
* About having a nuanced approach to disclosure within a supportive environment.
* REACh experience found predictable pattern that when asked about their own adversity, parents’ motivation increased and they became more willing to accept help to be better parents.
* What improvements in parental capacity can we get from routine enquiry? What's our state of knowledge in helping parents to parent?
* Need to remember fundamental drivers of family adversity and challenge of increasing poverty. Alongside an understanding ACEs, we need to make sure people have access to benefits they need.
* Important not to focus so much on parents to the extent that we overlook the development of the baby and growing child, and also supporting resilience of children – good science showing us that we need to focus on strengthening and bolstering stable relationships for children.

**Education/Schools**

* Should not ask all children about ACEs in schools, rather help teachers be more confident in asking distressed children how they are. Trauma-sensitive schools create the environment and opportunity for children to seek help.
* There is impressive work going on in Scotland on ACE-informed and trauma-informed schools – it’s about looking at what we are doing well and doing it in a more systematic way.
* ACEs are not a thing on their own, they underpin struggles, but need to ensure children and young people are given knowledge and power (e.g. why isn’t learning about own brain development part of the curriculum?)

**Society, Places and Communities**

* There is also a need for increasing public awareness and community understanding of adversity and trauma and the impacts of this across the life-course.
* Routine enquiry is an approach to be considered alongside others which are about having place-based approaches to ACEs and psychologically-informed communities.
* To change culture communities need to be engaged and involved in work on ACEs.

**Specific Service Considerations Across Life-Course**

**Early Years**

* How does routine enquiry fit with early years? Early years’ workforce crowded with other things to do, so need to think about what would be required if thinking about doing routine enquiry with parents.
* Need to look at issues of supervision. E.g. health visitors’ supervision is currently only on a 6 month basis.
* Routine enquiry is a big ask if workforce not being cared for – important to retain our workforce and look after them.
* Some people suggested that there would be value in a small-scale pilot with dedicated resource and project management, others questioned whether routine enquiry is the best use of resources in early years.
* There are other ways to develop resilient children and support parents other than routine enquiry in early years’ sector (e.g. Psychology of Parenting approach and supporting evidence base). However, it is not necessarily about a choice between the two and routine enquiry has been found to support parenting programmes.

**Children & Young People**

* Services working with children and young people is probably the most complex area to think about routine enquiry.
* Questions about whether it is appropriate to use routine enquiry with children and from what age it is appropriate to ask direct questions.
* Generally not appropriate for young children unless within a specialist service (e.g. child protection).Other approaches more appropriate and effective for this age group (e.g. play therapy, drama therapy).
* It may work with young people/adolescents as it could help build relationships but need to seek views of young people on this and make sure any approach adopted used right language.
* Important to think of children’s rights in the context of ACEs and how we mirror the language used in the UNCRC.

**Adults**

* Routine enquiry very valuable in adult life-stage for organisations to adapt practice to respond effectively to address coping strategies (e.g. alcohol and drugs), people with reoccurring needs, and those using emergency services (e.g. police, ambulance, A&E, often providing mental health support).
* Understanding of trauma and its impact is needed within adult support and protection.
* How can wider services (third sector, DWP, housing) adopt this approach?
* There is currently a focus on ACEs in justice and how the justice system could respond more effectively (e.g. systems focus on offender behaviours – how to reframe understanding of some offenders as trauma survivors, issues of risk management).
* How to develop routine enquiry for a forensic population e.g. men who are survivors and perpetrators of harm. Need a balance between competing roles and pressures (courts, community, clients). Supporting adults is important for building resilience in children.

**Older People**

* Important not to forget about older people in ACEs context, sometimes people don’t disclose until their older years (70+)
* Is there a need to develop a routine enquiry approach (prototype) for older people?
* Often focus is on older people’s physical ability, mobility and ability to stay in their home and not on emotional / social wellbeing.
* Emotional wellbeing and addressing of ACEs for older people has broad knock-on implications for wider family members, younger generations and role of older people as grandparents (often taking on lot of childcare) – about a compassionate approach to whole family.
* Relevant to work of ‘last 1,000 days’.
* Important implications for palliative work and links between pain and distress.

**Issues to consider**

Workshop participants suggested a range of issues that need considering in any development of plans for routine enquiry on ACEs.

**Definition and understanding:**

* Do we have an operational definition of routine enquiry? There are some in Scotland doing this already but different models exist.
* Is routine enquiry for everyone who comes into contact with a service regardless of how they present?
* There is still work to do to increase awareness and understanding of ACEs and energy may need to be put into this before implementing routine enquiry.

**Resourcing:**

* Need to have the right leadership, right training and support to make it manageable for the workforce (e.g. is the Scottish Government going to provide resources for training and support?)
* Is there a need for a national implementation team as there was for the implementation of routine enquiry on gender-based violence?
* NES are developing the STILT approach- Scottish Training Informed Leadership Training and this might be a useful model to support organizational change/readiness alongside staff support.

**Working across systems and services:**

* Across how many agencies and organisations do you introduce routine enquiry – how many points in life will be asked?
* How to avoid people in crisis being asked again and again. People may want to review / amend their ACE score, if for example they don’t feel able to disclose they have experienced ACEs the first time they are asked, they may later want to be asked again so they can ‘review’ their answers.
* How to share information between services and agencies? Can you pass it on?
* If ACEs scores are recorded in case notes how can we ensure this doesn’t lead to discrimination due to high ACE score?
* Do case notes need to be shared so that if a person previously declined routine enquiry services don’t keep on asking? Could encourage individuals to have confidence to state they’ve been asked before and they don’t want to talk about it.
* One approach is to inform individuals concerned of the boundaries of information sharing and then they make a decision about what they disclose and remind them of the boundaries of confidentiality.
* Possible to have one integrated assessment as part of a whole systems approach? But this assumes adversity finished or impacts don’t change when actually might need to ask again.
* Within each local area there are so many services (statutory and third sector) - how to know what’s going on and get all services to take it on board? Recommendation to identify key services and work with them.
* Consider co-producing routine enquiry across Scotland with people who have experienced multiple ACEs

**Policy/practice landscape:**

* How does routine enquiry fit with existing commitments/policy e.g. GIRFEC, Equalities Act, Health visiting universal pathway, educational attainment, Nursing 2020 Vision. There is a need to join up the dots.

**Evidence base:**

* Can more information be shared about the theory and evidence base behind routine enquiry? Why does asking lead to better outcomes, what is it about routine enquiry that makes the difference? There is existing evidence – can this be further developed and tested in Scotland?

**Potential pilots**

Some workshop participants were interested in developing small pilots or early adopter projects as tests of change on implementation of routine enquiry of ACEs and outcomes. For example, it was suggested that the new GP contract could provide a timely opportunity for looking at routine enquiry in the context of primary care. The potential to pilot routine enquiry within community justice settings was also raised.

Participants emphasised that any pilots or early adopter projects would require: leadership buy-in, dedicated resource, project management and evaluation of the difference it has made.

If you are aware of routine enquiry of ACEs developments underway in your local area or service setting, or you would like to explore the possibility of developing a routine enquiry project, please email: tamsyn.wilson@gov.scot.

**Next Steps**

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

If you have any queries or suggestions, or would like to discuss potential implementation of routine enquiry please contact: [tamsyn.wilson@gov.scot](mailto:tamsyn.wilson@gov.scot).

**Organisers**

**Julie Crawford,** Survivor Support Team, Scottish Government

**Sara Dodds,** Adviser on Adverse Childhood Experiences, Scottish Government

**Sandra Ferguson**, Associate Director for Psychology, NHS Education for Scotland

**Sharon Doherty**, Principal Educator, NHS Education for Scotland

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

**Vikki Milne,** Survivor Policy, Scottish Government

**REFERENCES**

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

   [↑](#endnote-ref-1)
2. <http://www.gov.scot/Publications/2017/09/8468> [↑](#endnote-ref-2)
3. <http://www.gov.scot/Publications/2015/10/3487> [↑](#endnote-ref-3)
4. <http://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf> [↑](#endnote-ref-4)
5. <https://www.communityfoodandhealth.org.uk/2016/polishing-diamonds-addressing-adverse-childhood-experiences-scotland/> [↑](#endnote-ref-5)
6. <http://www.healthscotland.scot/events/2017/june/aces-routine-enquiry-seminar> [↑](#endnote-ref-6)
7. <https://www.ncbi.nlm.nih.gov/pubmed/9525796> [↑](#endnote-ref-7)
8. <http://www.londonmet.ac.uk/research/centres/child-and-woman-abuse-studies-unit/projects/reva-project/> [↑](#endnote-ref-8)
9. <https://www.ncbi.nlm.nih.gov/pubmed/9635069>

   **Annex A – Workshop Programme**

   **9:30-9:45 Registration**

   **9:45-10:00 Introductions/ Objectives for the day**

   Chair

   **10-10:30 National Trauma Training Framework principles and approach**

   Sandra Ferguson (NHS Education Scotland)

   **10:30-11:15 Learning from REACh approach**

   Warren Larkin (Clinical Lead, Department of Health, Adverse Childhood Experiences Programme and Director Warren Larkin Associates Ltd)

   **11:15-11:45 Q&A and Discussion**

   **11:45-12:00 Reflections and learning from implementing Routine Enquiry on Gender Based Violence**

   Katie Cosgrove (NHS Health Scotland)

   **12:00-13:00 lunch**

   **13:00-13:30 Experiences of Implementation and Recommendations from East Lancashire**

   Rob Dickson, Children’s Society (former manager of Child Action North West)

   **13:30-2:00 Group Discussions**

   **2:00-2:30 Plenary Discussion**

   **2:30-2:45 Break**

   **2:45-3:30 Breakout groups of service areas** to consider implications and self-assess readiness for potentially piloting routine enquiry of ACEs and trauma

   **3:30-4:00 Close**

   **Annex B – Workshop Participants**

   |  |  |
   | --- | --- |
   | **Name** | **Organisation** |
   | Vikki Milne | Scottish Government - Survivor Policy |
   | Sinead Power | Scottish Government |
   | Lesley Weir | Family Nurse Partnership |
   | Lesley O'Donnell | Family Nurse Partnership |
   | Marion McPhillips | Family Nurse Partnership |
   | Tracey Tilley | The Rivers Centre |
   | Roslyn Taylor | The Rivers Centre |
   | Katie Cosgrove | NHS Health Scotland |
   | Sandra Ferguson | NHS Education for Scotland |
   | Brenda Renz | NHS Education for Scotland |
   | Margaret Clark | NHS Lanarkshire |
   | Tamasin Knight | NHS Tayside |
   | Kathleen Winter | NHS Ayrshire & Arran |
   | Carol Chamberlain | NHS Lanarkshire |
   | Samantha Campbell | NHS Highland |
   | Brian Reid | NHS Highland |
   | Sally Amor | NHS Highland |
   | John Anderson | Scottish ACE Hub |
   | Adam Burley | Scottish ACE Hub |
   | Lesley Taylor | Clackmannanshire Council |
   | Katy Hetherington | Scottish ACE Hub |
   | Sara Dodds | Scottish Government - Scottish ACE Hub |
   | Chris Gilbert | Scottish Government - Scottish ACE Hub |
   | Sarah Fletcher | Dalkeith Social Work Centre |
   | Lesley Fraser | NHS Lothian |
   | Jenny Gutry | NHS Lothian |
   | Lynsey Voy | East Lothian Council |
   | Kirsten Kidd | East Lothian Council |
   | Lisel Porch | Scottish Government - Substance Misuse |
   | Neil Hunter | Scottish Children's Reporter |
   | Rowan Anderson | Corra Foundation |
   | Carrie-Anne Logan | Family Addiction Support Services (PASS) |
   | Anna Mitchell | City of Edinburgh Council |
   | Vikki Kerr | Community Justice Domestic Abuse Services Edinburgh |
   | Mark Mungavin | City of Edinburgh Council |
   | Duncan Gourlay | Criminal Justice Group Work Services Edinburgh |
   | David Cotterell | Scottish Government - Youth Justice |
   | Diane Artis | Edinburgh Women's Aid |
   | Fiona Fraser | Scottish Government - Mental Heath |
   | Fiona Malcolm | Scottish Government - Local Government and Communities |
   | Lynne Mooney | City of Edinburgh Council |
   | Fiona Crawford | NHS GGC - CHAIR |
   | Jenny Leishman | Scottish Government - Justice Analytical Services |
   | Warren Larkin | Clinical Lead, Department of Health, Adverse Childhood Experiences Programme  and Director Warren Larkin Associates Ltd |
   | Rob Dickinson | Children’s Society |

   [↑](#endnote-ref-9)