Editorials

Addressing adverse childhood experiences:

implications for professional practice

INTRODUCTION

It has been over 20 years since the publication of seminal research by Felitti *et al*, highlighting the powerful relationship between adverse childhood experiences (ACEs) and a wide range of health and wellbeing outcomes.[1]

Since the landmark ACE study was published, a compelling body of research has accumulated confirming the strong and proportionate relationship between experiences of childhood adversity and the manifestation of detrimental health and social outcomes later in life.[2,3] We have learnt that ACEs are relatively common and are amenable to detection. We have an evolving understanding of the neurodevelopmental links between adversity and poor mental and physical health outcomes. We have evidence that the negative effects of ACEs can be mitigated through psychosocial and resilience building interventions.[4] However, despite this growing awareness, it is not obvious that ACEs have yet been approached as a significant public health problem in the UK.

ACE enquiry is becoming more common in the US primary care system and in paediatric medicine, with emerging evidence of significant human and financial payoff.[2] In the UK there is a growing interest in routine or targeted ACE enquiry, with early indications that this might offer opportunities for GPs to alleviate suffering via therapeutic relationships.[5] Nonetheless, it is still relatively rare for healthcare professionals in the UK to routinely enquire about these experiences and their impact on a patient's health. In this editorial we hope to explore some of the enablers and barriers related to implementing ACE enquiry in a UK primary care context.

WHAT ARE ADVERSE CHILDHOOD EXPERIENCES?

The ACEs concept most often refers to a list of ten categories of abuse, neglect, and household dysfunction, experienced before the age of 18 years. These are: parental mental illness; parental substance misuse; parental alcoholism; living with a parent or adult who went to prison or youth offending institution; parental divorce or separation; being exposed to domestic abuse; experiencing emotional, sexual or physical abuse; and significant neglect.

Of course, adverse life experiences are not confined to childhood and there are many adverse experiences and circumstances that can negatively impact a person's wellbeing.

> *"Enquiring sensitively, with a questionnaire-based tool, when followed up with a compassionate response, is acceptable to patients and fosters insight into the social and psychological determinants of many presenting problems."*

For example, we know that poverty is positively correlated with many of the ACEs on this list,[6] and living in an area lacking social cohesion or having high levels of crime and violence can have a similarly negative impact on emotional wellbeing and health outcomes.

UK national ACE studies[7,8] reveal that around 50% of the UK population experiences ≥1 ACE, with one in ten people experiencing ≥4. At a population level, greater numbers of ACEs are associated with dramatically and proportionately increased risk of poor outcomes. Outcomes affected include: educational and employment status; low mental wellbeing and life satisfaction; significantly increased risk of substance misuse; and increased risk of developing some of the leading 'biomedical' causes of disease and death, such as cancer and heart disease. According to the Centers for Disease Control, an ACE score of ≥6 has been found to reduce life expectancy by 20 years.[9]

RESILIENCE

Having greater exposure to 'toxic stress' (a term coined by the Harvard Centre on the Developing Child) in childhood, such as witnessing violence or not having a consistent caregiver, is clearly not an optimal start in life. However, exposure to ACEs or toxic stress does not mean that a person's outcomes are set in stone.

The antidote to ACEs is 'resilience'. Resilience means having resources that can help a person cope and retain emotional and psychological balance in the face of adversity, such as being able to confide in a trusted adult, and can be acquired across the life course.

In a recent study examining resilience and ACEs, people with ≥4 ACEs who reported more childhood resilience assets were around two-thirds less likely to experience poor childhood health compared with people who had ≥4 ACEs but no resilience assets.[10]

WE CAN'T KEEP DOING THE SAME THINGS AND EXPECT DIFFERENT OUTCOMES

ACE enquiry offers new opportunities to mitigate the health impact of adversity by addressing the source of the distress. This is potentially significant as traditional approaches to helping patients experiencing the consequences of adversity often have low success. For example, commissioners of drug treatment services cite success rates as low as 10% in helping people give up their addiction to heroin as class leading.

WHAT IS REALISTIC IN PRIMARY CARE?

We should consider enquiring more frequently about ACEs.

Research suggests that disclosure of ACEs can positively impact recovery, promote resilience, and improve a person's perception of themselves. In contrast, keeping burdensome secrets, like childhood adversity or subsequent trauma, can be damaging to health and wellbeing.[11]

Evidence suggests that if people are not asked directly, it can take many years for an adult to disclose a history of abuse.[11] With disclosure, people can begin to create meaning through telling their story, which can help them to make sense of their experiences. This empowering experience can be a catalyst for meaningful change.

WHY ARE SERVICES NOT ALREADY ASKING?

Survivors of ACEs can often be reluctant to disclose voluntarily due in part to feelings of shame, guilt, and anxiety about their experiences and the act or consequences of disclosure.[12] Furthermore, health and social care practitioners often describe discomfort about the idea of having to ask people about childhood adversity and trauma, and worry about upsetting clients. In practice, such anxieties tend to fade once training is provided and professionals have the opportunity to

experience ACE enquiry. Crucially, a recent evaluation indicates that service users appreciate being asked and the majority report that their appointment was improved as a result.[5]

In San Diego, Kaiser Permanente conducted an analysis of 135 000 patients taking part in their programme intake health assessment. They found that after adding an ACE questionnaire, with follow-up in the exam room, they observed a 35% reduction in outpatient visits and an 11% reduction in emergency department visits over the following year compared with that group's prior year utilisation.[2]

WHAT ABOUT IN THE UK?

In England, routine or targeted ACE enquiry using the 'REACh' model has been shown to be feasible and acceptable to both staff and service users across a range of settings, including encouraging pathfinder work in GP practices.[5] Similar findings have been demonstrated in Wales in various settings, including GP practices, and can be found on the RSPH website.[13]

ACE enquiry is also currently being piloted and evaluated by NHS Health Scotland. Our experience, although limited to date, echoes that found elsewhere; it is acceptable to patients and has, in some instances, been transformative in helping make sense of an individual's life course. We are using a modified version of the original ACEs questionnaire, which includes some broader questions around experiences of adversity, as well as exploring resilience factors.

We have found it more helpful so far to simply explore the clinical relevance of any reported ACEs, as opposed to counting the number of ACEs disclosed (an ACE 'score'), acknowledging that individuals may experience similar traumas very differently.

Our ACE enquiry has been at its most impactful where there is a good relationship between practitioner and patient, where there is a little extra time (for example, 15-minute appointments), and where the practice is able to utilise other trusted local services, such as counselling or third-sector support (for example, wellbeing groups). Therefore, there is some crossover between our work piloting ACE enquiry in vulnerable groups and our NHS Scotland Pilots of Community Link Working.

This approach speaks to a place-based relational model of care, which runs counter to the current pressure to deconstruct primary care. However, it may limit any potential system impact of enquiring more broadly or systematically around ACEs in a wider population, for example, asking all new patients registering with a practice.

To date, our ACE enquiry has also tended to be limited to GP-led consultations, where the presenting issue is often mental health or substance misuse related. However, research elsewhere has shown the importance of ACEs in the aetiology of conditions like asthma and obesity.[14] Therefore, ideally we would also be able to expand our ACE enquiry to include chronic disease settings, practice nurse clinics, and even conceivably linking with secondary care colleagues around an ACEs agenda.

CONCLUSION

Research indicates that the majority of people that seek our help as healthcare professionals will have experienced ACEs and trauma. This should be considered when designing and commissioning services, particularly for vulnerable patient groups. Enquiring sensitively, with a questionnaire-based tool, when followed up with a compassionate response, is acceptable to patients and fosters insight into the social and psychological determinants of many presenting problems. For some, the disclosure experience will have inherent therapeutic value and for others there are effective interventions that can contribute to building resilience. Perhaps the main risk for primary care and for many patients is to not ask and to still expect them to get better.

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Competing interests
Warren Larkin is a director of Warren Larkin Associates Ltd. Warren Larkin developed the REACh approach and offers consultation and training to services and professionals who want to deliver routine or targeted ACE enquiry in clinical practice. Warren Larkin is involved in testing approaches to ACE enquiry with GPs in Scotland. Peter Cairns is one of the GPs testing ACE enquiry in their Edinburgh Deep End practice as part of an NHS Health Scotland pilot.

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