Edinburgh Research Explorer

Adverse childhood experiences

OPEN ACCESS

Adverse Childhood Experiences: Beyond Signs of Safety; reimagining the organisation and practice of social work with children and families

*Trevor Spratt
Professor in Childhood Research
Trinity Research in Childhood Centre
Trinity College Dublin

John Devaney
Centenary Professor and Head of Social Work
School of Social and Political Science
University of Edinburgh

John Frederick
Visiting Scholar Social Work
School of Social and Political Science
University of Edinburgh

*Correspondence should be sent to:
Trinity Research in Childhood Centre
30 Anglesea Street
Dublin DO2 T253
Ireland
Email: sprattt@tcd.ie
Phone: 00353 1 8963790

Adverse Childhood Experiences: Beyond Signs of Safety; reimagining the organisation and practice of social work with children and families

ABSTRACT

While an ACE informed approach to child protection and welfare has become influential in the United States, it has had markedly less influence in the UK, this despite growth in adoption of ACE research as a basis for understanding population needs and aligning service delivery amongst policy makers and other professional groups. In this paper we note the development of ACE research and draw out implications for social work with children and families. We argue that current organisational and practice preoccupations, drawing on the example of the *Signs of Safety* programme, together with antipathy to ACEs in some quarters of the social work academy, have the effect of reifying a short term and occluded view of the developing child's needs so as to obstruct the systemic analysis and changes necessary to ensure that the child welfare system is redesigned to meet such needs. This suggests that post Kempe era child welfare services are no longer conceptually or systemically adequate to protect children beyond immediate safety outcomes and consequently we need to reimagine their future.

Introduction

David Finkelhor has argued that 'Adverse Childhood Experiences (ACEs) research has quickly grown into the lodestar in the United States for much policy discussion in the child maltreatment field.' (2017, p. 1). He identifies two associated reasons for this; the original ACE study, being run by a medical team, was effective in highlighting for policy makers associations between child maltreatment and health outcomes, who then realised there was potential to reduce health care costs by early intervention. Whilst associations between experience of child abuse and

neglect and later outcomes have been known for decades, outcomes studied tended to concentrate on mental health and psychological functioning, with associated social functioning (Davidson *et al.,* 2010). Adding physical health outcomes into the equation and employing advances in biology, genetics and neuroscience to better understand the embodiment of early adverse experiences was to prove influential in the development of models charting interactions between the physical, psychological and behavioural aspects of development (Davidson et al., 2010). It is not, however, the complexity of such models, demonstrating as they do linkages between the stimuli of experience and effects which may only be realised and measured, in some cases decades later, that has proved compelling in the growth of influence of ACE research. Rather, it is the simplicity of the ACE concepts that have proved persuasive. The idea that when bad things happen to us this increases the probability of detrimental effects, which are beyond the immediate, reflects common experience. The notion that the more bad things that happen, so we experience reduction in our ability to resist their effects and so increases probability of undesired outcomes, feels intuitively right. Precisely naming the bad things and neatly packaging them in a self-completing questionnaire which gives the individual an immediate score offers information which is potentially of use to service providers and professionals in the therapeutic milieu seeking to design effective interventions. ACEs have also provided an important bridge between professions in relation to the development of a shared conceptual framework, which locates the antecedents of later social, health and economic life outcomes in childhood, maps the interrelated mechanisms of transmission and promotes interventions across the life-course.

A central purpose of this paper is to trace the development of ACE research, outlining its uptake by social work researchers and identifying its influence on social policy development across the UK nations. In doing so we further seek to outline the implications of these developments for child and family social work services, including the identification of current preoccupations within these services, which challenge the adoption of an ACE informed model, both conceptually and practically.

The development of ACE research

The original ACE study was carried out at the Kaiser Permanante Appraisal Clinic in San Diego, California in collaboration with the US Centres for Disease Control and Prevention (Felitti *et al.*, 1998). The original focus of the work was on the apparent inability of patients to sustain weight loss in programmes. In interviewing patients about why this might be, a recurring theme was the long-term impact of having experienced significant adversity in early life. The staff at Kaiser Permanante developed a 10-item questionnaire, based on items from the Conflicts Tactics Scale (Straus and Gelles, 1990) combining five indicators of child abuse (psychological, physical and sexual) and neglect (physical and emotional), for example; *did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?* With a further five signalling family incapacities (loss of parent, parental imprisonment, violence against mother, parental substance abuse and parental mental illness), for example; *was a household member depressed or mentally ill, or did a household member attempt suicide?* The answers were dichotomous (Yes/No), and by adding together the 'Yes' scores an individual's ACE score is calculated. These retrospective scores were found to be associated with risky health behaviours, such as smoking, drug taking and over-eating, which in turn predicted increased probability of contracting non-infectious illness, such as heart disease, diabetes and cancer. ACE scores indicated a so-called 'dose effect', with the higher the score the greater the risk to an individual (Felitti *et al.*, 1998). With further research, the same relationship was found with associations between higher ACE scores and mental illness and to a whole raft of problematic social circumstances, ranging from youth offending (Fox *et al.*, 2015) to homelessness (Roos *et al.*, 2013).

ACEs are cumulative and feature cluster effects or co-occurrence; for example, the majority of children who experience domestic violence are also likely to experience abuse or neglect (Hamby *et al.*, 2010; McGavock and Spratt, 2017). Whilst ACE research has demonstrated conclusively that there is a graded

relationship between score and probability of health, social and economic outcomes, the pathways or trajectories between ACEs and outcomes are less well understood. The models that have been proposed all have the commonality of combining biological, psychological and social elements. ACEs are regarded as stressors, and exposure to chronic stress, as Bellis and colleagues note, 'can impact on the neurological, immunological and hormonal development of children. Repercussions of such impacts include substantive increases in risk of adopting anti-social and health-harming behaviours, accelerated development of chronic disease and early death.' (2018, p. 1). In recent research there have been attempts to better understand the factors that promote resilience (achieving good outcomes despite having an elevated ACE score). Bellis and colleagues observe that, 'Sources of resilience can include, but are not limited to, cultural engagement, community support, opportunity to control one's personal circumstances and access to a trusted individual throughout childhood who provide a sanctuary from the chronic stress of ACEs.' (2018, p. 2). Resilience research is closely associated with more recent research to identify the types of interventions likely to be successful in either preventing the occurrence of ACEs or the amelioration of detrimental effects of ACEs (Pachter *et al.*, 2017).

With high lifetime economic costs associated with ACEs (Spratt, 2012), policymakers in the US have been quick to seize on ACE research to help drive services toward ACE reduction in the population as a way to reduce health care costs. ACE research, however, has challenged models of intervention which target changes to what were previously considered *maladaptive* behaviours on the part of individuals. As Larkin and colleagues note, 'the ACE researchers propose that substance abuse and other health risk behaviours may actually be attempts at coping when other more adequate supports are unavailable. In this paradoxical way, public health *problems* are also seen as attempted personal *solutions* to problems buried in time and protected by shame and secrecy.' (2014, p. 3). Recognition of this has tended to upstream intervention towards early and preventative service provision, with Finkelhor noting that, 'there are many proven behavioral health interventions from parenting education, family therapy, and individual treatment that have been shown to help children and families facing

adversities and adults suffering from the effects of adverse childhoods.' (2017, p. 4).

Another strand of ACE research has featured a raft of national studies examining prevalence. This has enabled studies comparing ACE *footprints*, with the particular profile of countries differing, mainly due to the combination effects of socio economic conditions and cultural traditions (Bellis *et al.*, 2014). For example, whilst ACE studies in western industrialised countries indicate that around 15% of the population have an ACE score of four or more (a level, which is rather arbitrarily regarded as clinical), Saudi Arabia has 29% of its population at this level (Almuneef *et al.*, 2017). How ACE national profile scores are comprised also features significant variation, with for example, much higher numbers of citizens in the US receiving prison sentences than is the case in European countries (Bellis *et al.*, 2014). Such studies indicate that prioritisation in direction of service provision alone would be unlikely to achieve impact on both ACE prevalence scores and their composition in the absence of more fundamental economic and cultural changes taking place, to address aspects of social and economic inequality which provide the conditions for creating and sustaining ACEs (Marmot, 2017).

ACE informed policy and practice in the UK

There has been considerable interest amongst UK national governments in developing ACE informed policies. This has been largely driven by Public Health research (particularly in Wales), together with strong interest amongst non-governmental organisations (Davidson *et al.*, 2012). The Scottish Government have embedded initiatives to address ACEs in their *Programme for Government 2017/18,* with specific reference to family and child care services in *Getting it Right for Every Child* (Scottish Government, 2018). Both the Scottish and Welsh Governments have recently set up *Adverse Childhood Experience Hubs* with a remit to coordinate and promote ACE related training and services (Hughes et al., 2018). In Northern Ireland an ACE focus on practice with children and families is being taken forward by the Safeguarding Board for Northern Ireland (Health and Social

Care Board, 2017). In England the House of Commons Science and Technology Select Committee Inquiry into the evidence-base for early years intervention has focussed on the potential for ACE research to inform such interventions (National Mental Health Intelligence Network, 2017). As such, the language and rhetoric of ACE are now mainstream, although in turn this has resulted in a closer scrutiny and critique of both the concept and the way that policy and practice are being influenced.

ACE research and social work

Within social work there has been significant interest in ACEs in the US. Larkin and colleagues (2014) argue that the biopsychosocial model underpinning ACE research reflects the broad conceptual perspective of social work and that the common childhood antecedents of poor life outcomes are well understood by social workers. The ACE scale, including as it does items related to parental difficulties and family circumstances, has challenged the prioritisation within policy circles of child abuse and neglect as the received set of adversities that the State should respond to. With the introduction of the World Health Organisation's *Ace International Questionnaire*, the scale has been increased from 10 to 12, to include two new extra items measuring exposure to bullying and community violence. This is a reminder that the ten/twelve ACEs typically referred to, are in some ways arbitrary. While they all have a strong research base to indicate the negative impact they have on the lives of individuals, the list of ACE factors could easily be expanded to include further research-evidenced adversities. However, the central premise holds true – adversity is generally not a good thing, particularly in childhood, and especially not in multiples.

Whilst the idea that risks are cumulative is not new to social work (Spratt, 2012), the effect of the ACE model has been to influence researchers to expand the range of harms experienced, together with outcomes considered. Whilst once research in the field was characterised by seeking to identify and measure associations between one form of abuse or neglect and a specific later life outcome (what we might term *one thing begets one thing studies*), these came to be

superseded by studies considering a range of adversities with specific outcomes (*more than one thing begets one thing studies*) (Davidson, *et al.*, 2010). Contemporary ACE influenced research, however, considers both a broad range of adversities and a broad range of outcomes (*more than one thing begets more than one thing*) (Devaney *et al.*, 2014). If we were to conceptualise such research as a shape, it would look like an *inverted egg timer*, with the sands of experience being filtered through the individual and expressed diversely and sometimes in multiple ways across a range of outcome domains.

Most ACE studies exploring implications for social work emanate in the US, with few examples being from the UK. The Multiple Adverse Childhood Experiences research group at Queen's University Belfast has, however, been active in exploring the possible utility of ACE research for social work policy and practice, working with both service providers in the statutory and voluntary sectors to develop a raft of empirical studies and service initiatives. They found that applying an ACE lens to a diverse range of issues, ranging from teen suicides (Devaney *et al.*, 2014) to young carers (Spratt *et al.*, 2018), offered new ways of conceptualising needs so as to inform assessment processes and stimulate bespoke service provision (Bunting, Webb and Shannon, 2017). The research also raised questions as to how local authority social workers currently conceptualise and respond to referrals. For example, McGavock and Spratt (2017), in a university population ACE survey, found that the experience of witnessing domestic violence was the strongest predictor of a high ACE score, with 80% of respondents who indicated having this experience recording ACE scores in the four plus range. This signal of elevated risk is largely reversed in local authority practice in the UK, where Stanley and colleagues observe that for cases referred because of domestic violence, 'In total, 83 per cent of notifications received either a letter or no further action.' (2010, p. 180).

Barriers to adoption of ACE informed practices in social work in the UK

Whilst policy makers and other professional groups in the UK have taken up an ACE informed approach with varying degrees of enthusiasm, the rather lacklustre

and patchy level of interest amongst social work researchers and practitioners raises an important question. If the central focus of social work in the UK has been largely concerned with questions of how best to recognise and respond to child abuse and neglect, why does research, which has these concerns at its core, not prove of compelling interest? To answer this question we have to consider something of the history of child and family social work. Child and family social work in the UK has, over the course of its existence, displayed something of a Janus face. Alternatively drawn to helping families with needs so as to make the lives of their children better and policing them so as to ensure child safety. In times of rising public concern with regard to family dangerousness the policing side has demonstrated a tendency to win out (Spratt, 2001). In such circumstances the concept of immediate risk trumps future risk, especially those realised in adulthood. This need to manage immediate threats has led to a concentration on ways to triage referred families so as to share and manage the risks in the most efficient and practical ways possible, with a nod to human rights via initiatives encouraging participation and partnership. In her review of the child protection system in England, Eileen Munro (2011) articulated eight core principles, which underpin an effective child protection system. This attempted to recalibrate the system and professional practice to one centred on developing caring and supportive relationships with children and families earlier rather than later, tailoring help to individual circumstances and needs, a requirement for practise and policy to be informed by a strong knowledge and research base, and a move away from believing that practitioners and agencies can both predict and remove all risks that children may be facing. In the wake of Munro's review there has been a swing towards developing and utilising a range of interventions and approaches to practice that are rooted in systemic and solution focused practice, such as *Signs of Safety*.

Signs of Safety

Signs of Safety was developed in the 1990s in Western Australia as an approach to working with children and their families whenever there were child protection

concerns (Turnell and Edwards, 1999). The original approach has evolved and been refined, gaining support and adoption in other jurisdictions, including the UK. Reekers and colleagues (2018) state that *Signs of Safety* draws upon techniques from solution focused brief therapy and has two core principles: establishing a working relationship with parents, referred to as a cooperative partnership, with the aim of parental empowerment, while also focusing on the need for child safety at all times. Proponents argue that it is superior to traditional approaches to child protection in that it seeks to more explicitly find ways to engage meaningfully with parents, and that direct work with children is central to the success of professional intervention (Baginsky *et al.,* 2017). There is a growing literature in the UK about the initial implementation and reflections on the potential usefulness of the approach (e.g. Baginsky *et al.*, 2017, Hayes *et al.*, 2014), and an embryonic evidence base about whether the approach leads to improved outcomes for children and families, compared to usual approaches (Reekers et al. 2018). However, Sheehan and colleagues (2018) observe in their systematic review of the approach, that while Signs of Safety is currently widely used, there is little evidence to date of positive impact.

What has been interesting is the alacrity with which *Signs of Safety* has been taken up in the UK. In part this has been due to the perceived 'fit' between the values underpinning the approach, such as focussing on future safety, parental competence, including parents in decision-making processes, and core social work values (Keddell, 2014). However, this must also be seen within the temporal context of organisations, in particular those perceived as 'in trouble' and required to undertake significant step changes in what they do and how they do it (Hayes et al., 2012). In this context, the introduction of *Signs of Safety* can be seen as a means of helping the current system operate better in identifying the immediate risk to children, and in facilitating parents and professionals to collaborate to reduce this risk, without challenging the fundamental basis of the child protection system (Keddell, 2014). Whilst *Signs of Safety* may have a reinvigorating effect on the current system, this could have the effect of reifying short-term inventions which not are not calibrated to meet the needs of children whose circumstances

require a longer gaze to future outcomes and services designed to meet their needs over extended periods of time.

Concerns regarding ACEs

If *Signs of Safety* is indicative of a pragmatic response to the everyday reality of social work in the UK, the views on ACE research held by some members of the social work academy, as portrayed in submissions made to the House of Commons Science and Technology Select Committee Inquiry into the evidence-base for early years intervention, offer insight into an ideological barrier to this alternative approach gaining traction. The Inquiry had indicated that they were open to considering submissions by those who were critical of the ACE approach. Subsequently Edwards and colleagues (2017) made a submission entitled *The Problem with 'ACEs'* which was largely supported in an appended response from a number of academics, including some with backgrounds in social work, entitled *Discussing the Problem with 'ACEs'* (Edwards *et al.*, 2017). It is worth considering this submission in some detail as it offers insight into the arguments employed by those who take a critical approach to ACE research and the implications for policy and practice.

They critique ACEs on a number of grounds, which fall into two distinct categories; first a questioning of the validity of ACE research and second a concern as to how ACE research is used to inform policy and practice – in particular, early preventative interventions. With respect to validity, the authors assert that ACE research employs *skewed evidence*, claiming that biological risks 'tend to extrapolate from research on clinical populations and highly controlled experiments in animal laboratories.' (Edwards *et al.*, 2017, p. 3). In fact, while clinical populations and laboratory based research are certainly an important part of ACE research, this is complemented by a large body of prospective and retrospective studies that point to the same conclusion: having adverse experiences in childhood increases the probability of poor outcomes across the life course – with some of the indicators and the mechanisms for transmission being biological in nature (Hughes *et al.*, 2017). It is interesting to note that in some areas traditionally dominated by biological research, such as psychosis, an

opposite effect may be discerned, with Read and colleagues (2009) arguing for an abandonment of the biological model of psychosis in a favour of one that incorporates epigenetics and psychology in explaining the pathway from early adverse experiences to disease onset. Edwards and colleagues also raise concerns with regard to recall of childhood experiences – 'a notoriously inaccurate way of establishing causation not least because such recollections are subjective and unverifiable.' (p. 3). A review of the evidence on reports of ACEs (including those considering verifiable evidence) undertaken by Hardt and Rutter concluded that, 'It is clear that the blanket rejection of retrospective recall is unwarranted. The available evidence on abuse and neglect indicates that when abuse or neglect is retrospectively reported to have taken place these positive reports are likely to be correct. The main concern over validity stems from the universal finding that, even with well-documented cases of serious abuse or neglect, about a third of individuals do not report its occurrence when specifically asked about it in adult life.' (2004, p. 270). While ACEs may be underreported, this does not affect the prevailing pattern evident in such research, where, as Appleyard and colleagues note, the pattern is always the same; 'the accumulation of risk factors, independent of the presence or absence of particular risk factors, impacts developmental outcomes, such that the greater the number of risk factors, the greater the prevalence of clinical problems.' (2005, p. 235).

We have some sympathy with the view that widespread adoption of ACE research may lead to the adoption of 'simplistic 'new' solutions' (Edwards *et al*., 2017, p. 6), resulting in the labelling of already marginalised and disempowered populations, who then have services foisted upon them when the evidence base for the efficacy of such services may remain in question. History teaches us that new ways of looking at age old phenomena, usually involving a raising of consciousness with respect to both the scope of its prevalence and the severity of its effect, can lead to widespread public concern and changes in patterns of professional practice – not always in ways helpful to those experiencing the particular issue. In this regard Edwards and colleagues are particularly exercised with regard to *early* interventions, arguing that 'The ACEs approach is not a neutral, evidence-based diagnosis. Rather it reflects certain presumptions and is

driven by particular agendas and interest groups…The ACEs approach, as with other attempts to diagnose and label sections of the population as deficient, has the potential for damaging consequences for children and adults who are said to possess such deficiencies.' (2017, p. 1). Explicit motivation to reduce the harms associated with adverse childhood experiences is, of course, not *neutral* in the sense that it has a clear and explicit purpose. And *interest groups* have driven the research, but these are very diverse in nature, ranging from epidemiologists, professions, NGOs working with children and adult services, through to policy makers. They are broad-based and multinational in scope, making it impossible for any one interest group to *own* the research. It is therefore important not to conflate the validity of the research with its appropriation and use by any particular group. The most serious assertion is the notion that there is a *lack of evidence base* to support the claim that ACEs are influential for life outcomes. Employed to underpin the view that the ACE thesis is an attempt to *label sections of the population as deficient* serves to create the impression that it is a pejorative labelling theory devoid of an empirical basis and potentially harmful. We agree that nothing in either the natural or social sciences is value free. Michael Marmot has argued, however, that as social scientists we need to make ideology explicit and that 'evidence-based policies should be presented in a spirit of social justice' (2017, p. 1). The ideological motivation behind ACE research is to better understand the processes and mechanisms via which ACEs come to influence later life outcomes within an explicit position that it would be better if ACE scores in the population were reduced. Regarding the claim that ACEs are not evidence-based leaves us agreeing with Marmot who notes that 'If so-called 'critical theory' leads to a post-modern questioning of the very possibility of objective truth, then in an age …where there are facts and 'alternative facts'…we are in grave danger… evidence really matters' (Marmot, 2017, p. 4). It is interesting to note that in recent presentations on his work on the social determinants of health, Marmot draws attention to ACEs as a way of examining the interplay between social and individual level determinants (Marmot, 2018). The ACE thesis is that probability of poor outcomes increases exponentially with the ACE score – with transmission being detectable via biological, psychological and social indicators. The evidence supporting this thesis reflects research undertaken over some two decades and is

both consistent and overwhelming in nature (Hughes *et al.*, 2017). Evidence does indeed *matter.*

ACEs and child and family social work in the UK

A recurring question for the child protection and welfare system in the UK is at what point does the state identify harm as reaching a level of significance to mandate intervention? This threshold is often constructed around an incident of child physical/sexual/emotional abuse or state of neglect where the focus is essentially to prevent its reoccurrence via a mix of measures to both provide support for the family to ameliorate conditions seen as associated with abuse/neglect, together with multi agency surveillance measures to monitor compliance. The intervention is mandated on the basis that occurrence increases probability of reoccurrence. Intervention strategies targeted at families where the parents have high ACE scores would not have the same mandate. While we know that children in such families are at increased risk of experiencing childhood adversity via intergenerational transmission (Kinner and Borschmann, 2017), the threshold for state intervention remains sensitive to more immediate danger. Considering those children with high ACE scores drawn into the existing child protection system, such scores do not merit prioritisation as the broader range of poor outcomes predicted over the life-course lie far beyond agency remit. There is also the question as to how high scores at assessment would inform service response? Social workers might rightly be wary of deterministic labels, but the poor conceptual fit for ACEs with the menu of categorisations within the present system should stimulate further consideration as to how social work might adapt to develop services better aligned to the needs of children and/or parents with high ACE scores.

Services and interventions

This raises fundamental questions regarding the mandate for state intervention and what type of services should be provided? The literature in this area provides some indication as to how services might become ACE sensitive in design.

The prevention of early adversity and its ramifications for children, their families and the wider community necessitates a broad process involving 'all-of-society' (Metzler *et al.*, 2017, p.146). Such processes can be incorporated into government legislation as, for example, the Well-Being and Future Generations Act (Wales) 2015, which legitimates communal action directed at the prevention of ACEs (Ashton *et al.*, 2016). The Government in Scotland has also committed to a focus on both the prevention of ACEs and assistance of children and adults to overcome childhood adversity. This applies throughout the public service (involving health, education, justice and social work), with these initiatives being tied to the Children and Young People's (Scotland) Act (2014) and the Getting it Right For Every Child (GIRFEC) practice model (Winter and Iqbal, 2018).

Accumulated evidence indicates that multiple agencies in the community can work in an integrated way to assist with both the prevention of ACEs and the amelioration of their effects (Hughes *et al.*, 2018). Indeed, the concept of ACEs supplies a framework to enable the development of connections among the many service and community organisations that at present 'work in silos', based on specific types of problems, categories of services or geographical limits (Pachter *et al.*, 2017, p.130). As an example, the Philadelphia ACE Task Force is based on the ACE framework so as to bridge disciplinary and institutional restrictions through a community-based effort to reduce adversity and its consequences (Pachter *et al.*, 2017).

Interventions to tackle ACEs need to be comprehensive rather than narrow in order to address the range of 'social-relational-cultural factors' involved (Ford, 2017, pp. 9-10). According to Hall and colleagues, to deliver impact on ACE reduction at community level, interventions need to be 'multidisciplinary, multilevel, and multiyear', with '"silo-ed" interventions' focused on a single issue or group of problems unable to deliver such effects (2012, p. 333). Further, 'direct-service interventions' are 'necessary but not sufficient' and only reach a small percentage of the people affected by the wide range of problems generated by ACEs (Porter, *et al.*, 2017, p. 22). In order to resolve complex problems,

organisations involved in community care have to collaborate by removing service duplication, pooling resources, and providing more cohesive and comprehensive systems (Hargreaves *et al.*, 2017). ACE-informed practice does not necessarily mean that completely new approaches or interventions have to be developed, but rather requires evaluation of how agencies may cooperate, and current services improved (Ford *et al.*, 2016). Further, practice that is ACE-informed, such as teaching problem solving and coping strategies, can be carried out in a wide variety of services such as schools, youth justice facilities and social care agencies, being adapted to the particular requirements of the clients (Hughes *et al.*, 2018).

In ACE interventions, the complexity of the interaction between factors at the individual, family, community, and larger societal structural level, makes the socio-ecological model a suitable conceptual framework to provide guidance, with strategies required at every level (Oral *et al.*, 2016). At primary prevention level approaches are needed, such as greater provision of mental health and substance misuse services, to help make children less vulnerable to adversity, and less likely they will have children of their own who are exposed to adversity. Secondary prevention involves strategies that occur soon after an adverse experience to diminish the immediate effects, for example, psychological first aid (PFA), which can be implemented in schools and health services, to identify negatively impacted children early and improve their recovery and resiliency. Early tertiary prevention requires methods to address and limit the long-term consequences of adverse experiences, for instance, Trauma-Informed Care (TIC), which can be integrated into educational, health, justice and child welfare services (Oral *et al.*, 2016). Dube (2018, p. 3) emphasises that the intergenerational nature of adverse childhood experiences necessitates a 'paradigm shift', whereby amelioration in adults (late tertiary prevention) has to be seen as a vital step to primary and secondary prevention of exposure for children.

Reimagining the organisation and practice of social work

Local authority social work in the UK largely seeks to manage the needs of children and their families via a system that treats difficulties presented as short term and amenable to intervention in ways which prioritise the immediate safety of children, but does little to address the 'causes of the causes' (Marmot, 2018), nor cast a concerned eye to their future prospects. The present situation is analogous to the development of a health service that featured heavy investment in accident and emergency services, but paid little attention to the aetiology of disease – treating symptom presentation as an occurrence and not a signal of deeper ills. As with the health service, most cases seen by social workers are better conceptualised as representing chronic conditions than they are wounds. This misreading is not the fault of service providers, who on the whole recognise the misalignment between the complex and enduring nature of presenting issues and limitations of response. As Finkelhor has observed in the US context; 'service provision through the child welfare system referral has not shown to be reliable or evidence-based. It is also not clear that these child welfare system services actually reduce abuse.' (2017, p. 3).

A starting point for a new engagement of social work with ACE research might be to reverse the two tendencies noted above, first to reconsider the utility and durability of short-term triage arrangements such as *Signs of Safety* in providing sufficient remedy for enduring and complex problems. Such reconsideration may be better informed by emergent research on the efficacy of *Signs of Safety*. However, for now, it is apparent that while such interventions have their place, making good sense of the day-to-day experience of social workers and the tasks before them, they may represent a temporary dressing obscuring the greater wound. While immediate safety interventions will continue to be necessary, there exists potential for services to be informed by an understanding of the impact of multiple adversities, and to create common purpose amongst professional groups and service providers, within which social work might reimagine its role in having the lead responsibility for child abuse and neglect. To realise this potential, however, some serious consideration will need to be given to our particular ideological predispositions, which may act as barriers to recognition and ownership. If this can be done, child and family social work in the

UK may yet take its place in the vanguard of those seeking to influence political will towards the development of new and bespoke interventions designed to meet the needs of those children and young people whose circumstances indicate the probability of unhappy futures.

References

Almuneef, M., ElChoueiry, N., Saleheen, H. and Al-Eissa, M. (2017) 'The impact of Adverse Childhood Experiences on social determinants among Saudi adults', *Journal of Public Health*, published advance access, 27 December 2017.

Appleyard, K., Egeland, B., van Dulmen, M. and Sroufe, A. (2005) 'When more is not better: The role of cumulative risk in child behaviour outcomes', *Journal of Child Psychology and Psychiatry*, **46**(3), pp. 235–45.

Ashton, K., Bellis, M, Hughes, K. (2016) 'Adverse childhood experiences and their association with health-harming behaviours and mental wellbeing in the Welsh adult population: a national cross-sectional survey', *The Lancet*, Meeting Abstracts, Published Online November 25, 2016, p. 21.

Baginsky, M., Moriarty, J., Manthorpe, J., Beecham, J., & Hickman, B. (2017) *Evaluation of signs of safety in 10 pilots*, London, Department for Education.

Bellis, M. A., Hughes, K., Ford, K., Hardcastle, K. A., Sharp, C. A., Wood, S., Homolova, L. and Davies, A. (2018) 'Adverse childhood experiences and sources of childhood resilience: a retrospective study of their combined relationships with child health and educational attendance', *BMC Public Health*, **18**(792), pp. 1-12.

Bellis, M. A., Hughes, K., Leckenby, N., Jones, L., Baban, A., Kachaeva, M., Povilaitis, R., Pudule, I., Qirjako, G., Ulukol, B., Raleva, M., Terzic, N. (2014) 'Adverse childhood experiences and associations with health-harming behaviours in young adults in eight eastern European countries', Bulll World Health Organ, **92**(9), pp. 641-655.

Bunting, L., Webb, M. A., and Shannon, R. (2017) 'Looking again at troubled families: parents' perspectives on multiple adversities', *Child & Family Social Work*, **22**, pp. 31-40.

Davidson, G., Bunting, L. and Webb, M. A. (2012) *Families experiencing multiple adversities: A review of the international literature*, Belfast, Barnardo's Northern Ireland.

Davidson, G., Devaney, J. and Spratt, T. (2010) 'The impact of adversity in childhood on outcomes in adulthood: research lessons and limitations', *Journal of Social Work,* **10**(4), pp. 369-390.

Devaney, J., Lazenbatt, A., Bunting, L., Davidson, G., Hayes, D., Spratt, T. (2014) 'The

Relationship Between Cumulative Adversity in Childhood and Adolescent Suicide and Accidental Death', *Developing Practice*, accepted for publication August 2014.

Dube, S. R. (2018) 'Continuing conversations about adverse childhood experiences (ACEs) screening: A public health perspective', *Child Abuse & Neglect*, pp. 1-5, advance access online, 7th March 2018.

Edwards, R., Gilles, V., Lee, E., M, J., White, S. and Wastell, D. (2017) *The Problem with 'ACEs'',* EY10039 submission to the House of Commons Science and Technology Select Committee Inquiry into the evidence-base for early years intervention,

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Marks, J. S. (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine,* **14**(4), pp. 245-258.

Finkelhor, D. (2017) 'Screening for adverse childhood experiences (ACEs): Cautions and suggestions', *Child Abuse & Neglect*, pp. 1-6, advance access online, 16th July 2017.

Ford, D. E. (2017) 'The Community and Public Well-being Model: A New Framework and Graduate Curriculum for Addressing Adverse Childhood Experiences', *Academic Pediatrics*, **17**, pp. 9–S11.

Ford, K., Butler, N., Hughes, K. E., Quigg, Z., Bellis, M. (2016) 'Adverse Childhood Experiences (ACEs) in Hertfordshire, Luton and Northamptonshire', Centre for Public Health (CPH), Faculty of Education, Health and Community, Liverpool John Moores University, Henry Cotton Campus, 15-21 Webster Street, Liverpool, L3 2ET, May 2016.

Fox, B. H., Perez, N., Cass, E., Baglivio, M. T. and Epps, N. (2015) 'Trauma changes everything: Examining the relationship between adverse childhood experiences and serious violent and chronic juvenile offenders, *Child Abuse & Neglect*, 46, pp. 163-173.

Hall, J., Porter, L., Longhi, D., Becker-Green, J., Dreyfus, S. (2012) 'Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings', *Journal of Prevention & Intervention in the Community*, **40**, pp. 325–334.

Hamby, S., Finkelhor, D., Turner, H. and Ormrod, R. (2010) 'The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth', *Child Abuse & Neglect*, 34, pp. 734-741.

Hargreaves, M. B., Verbitsky-Savitz, N., Coffee-Borden, B., Perreras, L., White, C. R., Pecora, P. J., Morgan, G. B., Barila, T., Ervin, A., Case, L., Hunter, R., Adams, K. (2017) 'Advancing the measurement of collective community capacity to address adverse

childhood experiences and resilience', *Children and Youth Services Review*, **76**, pp. 142–153.

Hardt, J. and Rutter, M. (2004) 'Validity of adult retrospective reports of adverse childhood experiences: review of evidence', *Journal of Child Psychology and Psychiatry*, **45**(2), pp. 260 – 273.

Hayes, D., McGuigan, K., Pinkerton, J. and Devaney, J. (2014) *Safety in Partnership Evaluation: Phase Two report – perspectives on practice,* Belfast, Queen's University Belfast.

Hayes, D., Pinkerton, J. and Devaney, J. (2012) *Safety in Partnership Evaluation: Phase One report – first impressions,* Belfast, Queen's University Belfast.

Houston, S., Spratt, T. and Devaney, J. (2011) 'Mandated prevention in child welfare: Considerations from a framework shaping ethical inquiry', *Journal of Social Work*, **11**(3), pp. 287-305.

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L. and Dunne, P. (2017) 'The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis', *The Lancet*, **2**(8), pp. 356-366.

Hughes, K., Ford, K., Davies, A.R., Homolova, L. and Bellis, M.A (2018) *Sources of resilience and their moderating relationships with harms from adverse childhood experiences*, Bangor, Public Health Wales and Bangor University.

Health and Social Care Board (2017) *Regional Adverse Childhood Experiences (ACEs) Conference Report*, Belfast, Health and Social Care Board.

Keddell, E. (2014) 'Theorising the signs of safety approach to child protection social work: Positioning, codes and power', *Children and Youth Services Review*, **47**, pp. 70-77.

Kinner, S. A., Borschmann, R. (2017) 'Inequality and intergenerational transmission of complex adversity', *The Lancet*, **2**(18), pp. 324-343.

Larkin, H., Felitti, V. J. and Anda, R. F. (2014) 'Social Work and Adverse Childhood Experiences Research: Implications for Practice and Health Policy', *Social Work in Public Health*, **29**(1), pp. 1-16.

Marmot, M. (2017) 'Social justice, epidemiology and health inequalities', *European Journal of Epidemiology*, pp. 1-10, advance access online, 3rd August 2017.

Marmot, M. (2018) *Austerity, Health and Children*, Trinity Research in Childhood Centre Inaugural Annual Lecture, Trinity College Dublin, 5 February, 2018, http://www.tcd.ie/tricc/events/lecture.php/

Metzler, M., Merrick, M. T., Klevens, J., Ports, K. A., Ford, D.C. (2017) 'Adverse childhood experiences and life opportunities: Shifting the narrative', *Children and Youth Services Review*, **72**, pp. 141–149.

McGavock, L. and Spratt, T. (2014) 'Prevalence of Adverse Childhood Experiences in a University Population: Associations with Use of Social Services', *British Journal of Social Work*, **44**(3), pp. 657-674.

McGavock, L. and Spratt, T., (2017) 'Children Exposed to Domestic Violence: Using Adverse Childhood Experience Scores to Inform Service Response', *British Journal of Social Work*, **47**(4), 1128 – 1146.

Munro, E. (2011) *The Munro Review of Child Protection: Final Report. A child-centred system,* London, Department for Education.

National Mental Health Intelligence Network (2017) *Better mental health: JSNA toolkit*, London, Public Health England.

Oral, R., Ramirez, M., Coohey, C., Nakada, S., Walz, A., Kuntz, A., Benoit, J., Peek-Asa, C. (2016) 'Adverse childhood experiences and trauma informed care: The future of health care', *Pediatric Research*, **79** (1), pp. 227-233.

Pachter, L. M., Lieberman, L., Bloom, S. L., Fein, J. A. (2017) 'Developing a community-wide initiative to address childhood adversity and toxic stress: a case study of the Philadelphia ACE task force'**,** *Acad Pediatr,* **17**(51), pp. 130-135.

Porter, L., Martin, K., Anda, R. (2017) 'Culture Matters: Direct Service Programs Cannot Solve Widespread, Complex, Intergenerational Social Problems. Culture Change Can,' *Academic Paediatrics*, **17**, pp. 22–23.

Read, J., Bentall, R. P and Fosse, R. (2009) 'Time to abandon the bio-bio-bio model of psychosis: exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms', *Epidemiol Psichiatr Soc*, **18**, pp. 299–310.

Reekers, S. E., Dijkstra, S., Stams, G. J. J., Asscher, J. J., and Creemers, H. E. (2018) 'Signs of effectiveness of signs of safety?–A pilot study', *Children and Youth Services Review,* **91**, pp. 177-184.

Roos, L. E., Mota, N., O Afifi, T., Katz, L. Y., Distasio, J. and Sareen, J. (2013) 'Relationship Between Adverse Childhood Experiences and Homelessness and the Impact of Axis I and II Disorders', *American Journal of Public Health*, **103**(2), pp. 275-281.

Scottish Government (2018) *Delivering for today, investing for tomorrow: the Government's programme for Scotland 2018-2019*, Edinburgh, Scottish Government.

Sheehan, L., Forrester, D., Kemp, A., O'Donnell, C., Addis, S., Nurmatov, U., Brand, S.L. and El-Banna, A. (2018) *Signs of Safety: Findings from a mixed-methods systematic review focussed on reducing the need for children to be in care*, Cardiff, What Works Centre for Children's Social Care, Cardiff.

Spratt, T. (2001) 'The Influence of Child Protection Practice Orientation on Child Welfare Practice', *British Journal of Social Work*, **31**(6), pp. 933-954.

Spratt, T. (2009) 'Identifying families with multiple problems: Possible responses from child and family social work to current policy developments', *British Journal of Social Work*, **39**(3), pp. 435-450.

Spratt, T. (2011) 'Families with multiple problems: Some challenges in identifying and providing services to those experiencing adversities across the life course', *Journal of Social Work*, **11**(4), pp. 343-357.

Spratt, T. (2012) 'Why Multiples Matter: Reconceptualising the Population Referred to Child and Family Social Workers', *British Journal of Social Work*, **42**(8), pp. 1574-1591.

Spratt, T. and Devaney, J. (2009) 'Identifying families with multiple problems: Perspectives of practitioners and managers in three nations', *British Journal of Social Work*, **39**(3), pp. 418-434.

Spratt, T., McGibbon, M. and Davidson, G. (2018) 'Using Adverse Childhood Experience Scores to Better Understand the Needs of Young Carers', *British Journal of Social Work*, published on advance access, 5 March 2018.
Stanley, N., Miller, P., Richardson Foster, H. and Tomson, G. (2010) *Children and Families Experiencing Domestic Violence: Police and Children's Social Services' Responses*, London, NSPCC and University of Central Lancashire.

Straus, M. and Gelles, R. J. (1990) *Physical violence in American families: risk factors and adaptations to violence in 8,145 families,* Transaction Press, New Brunswick.

Turnell, A. and Edwards, S. (1999) *Signs of Safety: A solution and safety oriented approach to child protection casework,* New York, W.W. Norton & Company.

Winter, K., and Iqbal, A. (2018) 'The State of Child Health: Adversity is not Destiny: Population Lens on Adverse Childhood Experiences', Ayrshire and Arran NHS Board, Paper 8, 1 March, 2018.