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New understandings in childhood research and their implications for child and family services

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Abstract

In recent times the production of research linking childhood experiences with later life outcomes has had the effect of producing new understandings of child development, with increased attribution given to this stage in the life cycle as being foundational for future outcomes. In turn, this has generated the development of models which combine physiological, psychological and social impacts of adversity to challenge services to deliver interventions which are trauma aware and consequently designed to either prevent the occurrence, or ameliorate the effects, of childhood adversities. In this article we examine the implications of these developments for services delivered at community, familial and individual levels. While there have been attempts to incorporate advances in research with respect to what is harmful to children, the space for action remains limited both by structural constraints and the lag in the development of an evidential base supportive of interventions designed to make a positive difference in the lives of children.

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Introduction

What goals do we want to achieve in the provision of social services for children and families and how should we go about achieving them? Since the emergence of national child welfare systems in the aftermath of the second world war, these questions have become increasingly prescient. On the one hand they are driven by a moral imperative, fuelled by public/media/political concerns, to *do something* for those children whose circumstances are most egregious. On the other, they reflect an awareness of the larger number of children whose lives are impacted by social forces and familial circumstances to negatively impact their health and development and detrimentally influence their future lives (Parton et al., 1997).

The answers to such questions have been, to some degree, prescribed by the philosophical parameters within which family troubles are understood by politicians, policy makers and wider society. These are often presented as an axis between those welfare regimes wherein such troubles, and to some extent their solutions, are primarily located within the domain of the family, in contrast to societies where the problems of the private milieu are understood to sit within structural contexts, wherein remedies may lie. Gilbert and colleagues (2011) have classified these perspectives as *child protection* and *child welfare orientations*. In the former, favoured by societies where the individual is seen as primarily responsible for their own actions and outcomes in life, the focus is on the child subject to maltreatment via parental culpability, resulting in a legalistic response, so as to ensure that there are no further repetitions of abusive actions. In child welfare orientated societies, by contrast, there is a greater appreciation of context, to mitigate the responsibilities of parents in the understanding that social conditions may, in part, help create sets of circumstances detrimental to children. Such orientations are, however, not fixed polar positions, as in both there is considerable recognition that, on one hand social circumstances are influential in making the occurrence of child maltreatment more or less likely and, on the other, that some families present dangers to their children to an extent to make consideration of mitigating social circumstances nugatory.

The disruptive force to any philosophical or moral position is to be found in the nature of evidence. The idea of family circumstances being understood, and interventions mandated and delivered within an evidence-based paradigm, is a relatively recent concept which has been slow to influence organisational service design and delivery (Aarons & Palinkas, 2007) and individual practice (Coulter et al., 2020). Evidence informing system adaptation has often, rather, been of the in-house variety, relying on system output data; a poor proxy for outcomes for children and families receiving services (Kislov et al., 2019). While there is an increasing acceptance that evidence should inform how services are constructed and delivered, there is resistance from some who argue that family circumstances and dynamics cannot be captured by standardised

measures and that research evidence remains a poor cousin to the gathered experience of practitioners in informing professional and organisational decision making (Nevo & Slonim-Nevo, 2011; Webb, 2001).

In this article we argue that there are answers available to the questions posed as to what constitutes good goals for child welfare services, alongside indications as to how these might be achieved. We take the view that even where the evidence is of a provisional nature, there are sufficient indications as to where we should look and how we might look, so as to make the foundations of child and family service design more secure and practice more effective.

The changing nature of evidence

Contemporary answers to the question as to what might constitute an effective intervention in a service users' life, when there are concerns about their well-being, are characterised by reference to two key concepts: the interrelated biological, psychological, and social nature of harm, and measures of the expression of such harm being considered over time and across personal and social dimensions (Bolton & Gillett, 2019).

Taking a broad overview of research conducted in the area of child welfare, a migratory trajectory is evident. The landscape was previously dominated by studies concerned with the short to medium term impact of, usually singular, adverse events, often employing qualitative methodologies concerned with measuring effects within narrowly prescribed domains; for example, links between the experience of physical abuse and depression (Davidson et al., 2010). Alongside such studies, and often employing both quantitative and qualitative methods within cross sectional designs, were investigations into the effects of social conditions on a range of life outcomes. For example, the limitations put upon education and employment opportunities by being from a working-class family (Smyth, 2016). More recent research differs in how child development is understood, the range of negative impacts conceptualised, and possible links between causes and effects measured (Spratt et al., 2019). Essentially, the interplay between the biological and psychological reactions to stimuli emanating from the social domain are now better understood, mainly as a result of more sophisticated measures becoming available, particularly with regard to neuroimaging and advances in DNA research. Such biological and psychological impact is, in turn, seen to express itself in the social world, where conditions serve to reinforce or diminish the effects of earlier experiences of adversity (Asmussen et al., 2020)

There have been two methodological pillars supporting such research. One has been large scale longitudinal cohort studies, enabling identification of previously occluded connections between early circumstances and later outcomes, together with studies eschewing homogenous in favour of heterogenous measures in establishing potential links between causes and effects (Spratt et al., 2019). The other has been large population cross sectional studies which link self-reported early life experiences with later life outcomes, with perhaps the best known of these being the Adverse Childhood Experiences (ACEs) study (Felitti et al., 1998), which has established that there is a dose like relationship between numbers of adverse experiences in childhood and increased probability of

encountering poor later life outcomes across health and social domains (Spratt, 2012). Such studies have influenced a movement to reconceptualise the impact of childhood adversity as *traumatic* in nature, wherein elevated stress levels serve to degrade biological and neurological systems, leading in turn to psychological symptoms and problematic behaviours which may endure across the life-course (Leitch, 2017). Alongside this research there have been a raft of studies concerned with better understanding the social determinants of life outcomes. These have demonstrated an enduring negative relationship between poverty (Marmot, 2017), particularly income disparity (Pickett & Wilkinson, 2009), and a range of problematic life outcomes, such as domestic abuse (Skafida et al., 2021). The messages from this type of research have more recently been reinforced in public consciousness via a constant information stream centred on the stratified impact of the Covid-19 pandemic, especially regarding heightened vulnerability associated with poverty and being a member of a minority ethnic group (Taylor-Robinson et al., 2021).

What do the changes in the nature of evidence suggest?

Perhaps the singular most important impact of new understandings in childhood research has been to reinforce notions of what happens in childhood being foundational for later life outcomes. At the structural level this has resulted in calls for more equal distribution of resources to ensure opportunities are as fair as they can be (Marmot et al., 2020). Regarding the more proximal influences of community and family, there is concern to both reduce social ills, for example parental drug and alcohol dependency, to tackle the conditions associated with childhood adversity (Cleaver et al., 2011), and to provide services to mitigate, compensate and remediate where adversities have already been experienced. As has been demonstrated by research, both poverty and family can impact upon outcomes for children, sometimes in interrelated (interdependent) ways and sometimes singular (independent) ways (Walsh et al., 2019). It is, of course, important to address the structural determinants of inequality and poverty. It would be better, for example, to construct a society on the Swedish model, because it redistributes resources more equitably, than it would be to emulate the USA, where more unequal distribution contributes to social ills, including higher rates of maltreatment of children (Pickett & Wilkinson, 2009). However, while service providers may be keenly aware as to the negative impact of such determinants in the everyday lives of the families they work with, their sites of intervention are necessarily restricted by mandates to either prevent children experiencing adversity, where this is likely to occur, or to protect against reoccurrence and ameliorate effects, where the child has already been impacted.

It is with regard to the sites of intervention open to providers of child and family services that the aforementioned ACE studies have had particular influence on policy and practice. All four UK nations have promoted initiatives founded on an understanding as to how the experience of multiple adversities in childhood has the potential to have lasting impact on children; in recognition that whilst all adversities are not necessarily traumatic in their effects, they may still have deleterious impact for individuals. Location of sites for intervention, has either been on the basis of targeting reductions

in singular adversities or identifying those children who have experienced greater numbers of adversities, so increasing the probability of poor outcomes, and prioritising them for interventions (Spratt & Kennedy, 2020). However, knowing *where* to intervene does not necessary imply knowledge of *how* to intervene. To help better understand the evidential basis for interventions it is necessary to interrogate the extant research.

Interventions

While the nature of interventions in child and family services may vary across jurisdictions, most tend to have three key features; the investigation and management thereafter of possible child maltreatment, state care provision for children no longer able to live with their families, and provision of support to families whose circumstances indicate heightened potential for poor outcomes for their children. With rising numbers of referrals being a feature for agencies in recent times, there is an interest in promoting community-based services, which are conceived of as preventative in nature, so as to reduce numbers of referrals (Local Government Association, 2020). For families who have been referred, there is a marked tendency to promote remedies which include community-based services via, for example, differential response initiatives (Hughes et al., 2013). For those families who find themselves in the ambit of social work services, the priority has been to develop responses which prevent, where possible, reception of children into state care via cessation of maltreatment and amelioration of the effects of adversities already experienced (Spratt et al., 2019). To what extent are such endeavours informed by evidence? To address this question, we examine the current evidence with respect to addressing ACEs at structural, community, familial/individual and therapeutic levels.

The structural context of agency interventions

While the polarity of either/or arguments with respect to economic and familial level determinants of childhood adversity may be unhelpful in conceptualising responses, the relative weight of these positions needs to be considered in mapping the scope for agency interventions. In the UK context the work of Paul Bywaters and colleagues (2016) has been particularly important in highlighting the presence of a social gradient with respect to the increase in chances that children from the poorest communities will be received into care. Similar studies across the globe attest to the fact that children drawn to the attention of child welfare agencies are disproportionately drawn from the most socially disadvantaged communities (Stokes & Schmidt, 2011). The greater the number of families in poverty, especially in societies where income disparity is most acute, the greater the number of children coming to the attention of welfare authorities. The fact that children from such communities tend to have higher ACE scores further suggests that their exposure to the pernicious social ills that contribute to such scores might be reduced with the introduction of economic and social policies designed to lift their families out of poverty (Walsh et al., 2019). For example, research in Canada has demonstrated correlations between poverty levels and levels of child abuse and neglect (Lefebvre et al., 2017). Such findings are often aligned to models of causation that

view increases of stress within families, such as having inadequate income, as being visited on the children in the form of poor parenting (Wekerle et al., 2007).

While service providers may receive political and legal mandates to intervene early so as to provide services preventative of adversities occurring, this remains restricted in reach and limited in effect in the absence of wider social and economic policies designed to reduce numbers of children in poverty. As Coles has observed; 'unless national government addresses the wider societal determinants of family distress, we cannot make sustained improvements in the lives of children.' (2021: 4). Economic conditions, however, are not always predictive of social gradients in a straightforward way. Mason and colleagues (2020) have sought explanations for the paradoxical situation pertaining in Northern Ireland, whereby it is the country with the highest levels of economic deprivation in the UK, but also has the lowest numbers of children in care. They speculate that, 'social work systems and practices, early help systems and structures, communities and families may combine to provide a counterweight against the effects of deprivation.' (2020: 1). This suggests that optimal conditions for children at a structural level are not straightforwardly determined by economic and social policy, but that these forces may be mitigated by culture and community in ways which effect both how services are delivered by professionals and understood by those in receipt of them. It is also the case that tackling the social conditions wherein ACEs levels are at their highest will not eliminate ACEs. In an important review by Lester and colleagues of the evidence concerning service needs of young people who have experienced ACEs (2019), they quote research by Bellis and colleagues (2015) that 'indicate[s] that the proportion of people experiencing four or more ACEs is almost three times as high in the most deprived quintile of neighbourhoods as in the least deprived, although it should be borne in mind that there is also substantial prevalence in middle and higher quintiles, and most people exposed to multiple ACEs are not in the most deprived segment.' (Lester et al., 2019: 6). Lester and colleagues also note that their 'findings highlight the importance of focussing on wider social factors to encourage meaningful engagement with services.' (Lester et al., 2020: 1).

What is the evidence that community level interventions work?

Since the turn of the millennium there has been a conceptual and political shift from new public management as the answer to the challenges faced by modern societies, to a focus on an approach that promotes the widening of the stakeholder net, emphasising collaboration between a diverse range of potential beneficiaries, which includes co-collaborators as well as citizens (Connolly & Van Der Zwet, 2021). This is focused on the growing call for place-based policies, that seek to meet needs where they are, and in ways that allow services to break free of the restraint of linear management structures (Beer et al., 2020).

However, although there is strong interest in wishing to tackle ACEs at the community level and build communities that are resilient and trauma-aware, at present there is a shortage of empirical evidence regarding effective approaches to achieving these goals, in terms of mitigation, compensation and remediation strategies (Matlin et al., 2019). A recent comprehensive review of effectiveness data regarding interventions for those

who have experienced ACEs shows that most evidence for the efficacy of interventions is for psychological interventions seeking to improve resilience for individuals, rather than for interventions at a service or community level (Lorenc et al., 2020).

There is considerable variation among communities regarding the extent and degree of problems they confront, as well as of the resources available to contend with these challenges (Hall et al., 2012). Many problems emanating from ACEs are complex and inter-related, for example, child abuse, intimate partner violence, out-of-home care, school failure, and substance abuse, and are problematic to tackle at the community level because of varied issues including long-standing, intergenerational issues, complicated funding arrangements, and restricted capacity to implement comprehensive approaches across agency and sector boundaries (Hall et al., 2012; Hargreaves et al., 2017). In fact, community approaches to preventing or reducing ACEs are difficult and expensive to implement, and require amounts of time, expertise, and dedication not always readily available in many community systems (Asmussen et al., 2019).

Problems resulting from ACEs span the boundaries of agencies and service sectors necessitating integrated, collaborative approaches across agencies and sectors (Hall et al., 2012). Such community collaboration requires a high level of coordination, management, and organisation to work at the 'scope and scale' required to have impact at the community level (Hargreaves et al., 2017: S8). A significant challenge for the implementation of cross sector interventions is that organisations need to commit to significant structural adjustments, with changes required at a range of different levels (Matlin et al., 2019). Organisational and system issues, such as staff capacity and processes for interagency referral, determine the amount of time practitioners have available to work with service users affected by ACEs (Asmussen et al., 2019). For instance, individual members of systems may make changes to their practice, but without organisation and system level supports, including funding and policy changes, maintaining sustained change is less likely (Matlin et al., 2019). Therefore, community organisations require assistance to enable them to put in place the structural changes required, with financial support considered crucial (Matlin et al., 2019).

It has been suggested that long-term, comprehensive public investment is required to establish and enable the complex requirements of multi-agency collaborative working and governance arrangements, the training and development of staff, as well as the sustainable funding of programs (Asmussen et al., 2019; Local Government Association, 2020). However, maintaining public funding over sufficient time can be problematic. As an example, a well-known and successful community approach to tackling the harmful effects of ACEs in the USA was in Washington State, which had been developing responses to childhood social problems through legislation since 1989, via localised Community Networks, overseen by a Family Policy Council (Clary, 2017). However, despite the successes the Family Policy Council and Networks had achieved, in 2011 the legislature discontinued the Family Policy Council's funding, with reasons including: the economic fallout of a recession; political tensions and turf wars with other programs; shifting political priorities, and a move towards a public-private partnership approach (Clary, 2017). Accordingly, even successful programs can be vulnerable and government funding may not be able to be counted on for long-term support for community ACEs interventions (Clary, 2017).

Research shows that implementing and maintaining programs in 'real world settings' is a complex, long-term process with comparatively few interventions able to be sustained over time, despite achievements during initial periods (Durlak & DuPre, 2008: 327–328). Nevertheless, success is possible, however it requires the following essential components: detailed planning in advance; multiple stakeholder involvement, including funders and policy makers, researchers and local practitioners; clear processes of accountability; and high-quality implementation (Durlak, 2013). An example of a community approach to addressing ACEs, which offers a prospective road map for how such a process may be built and sustained, is provided by the Pottstown Trauma-Informed Community Connection (PTICC) located near Philadelphia in the USA. The key lessons offered here are firstly, to build from a small, dedicated core group with a shared vision; secondly, for that core group to have leverage in the community; thirdly, that financial support for is available; and, fourthly, that continuous learning and evaluation occurs (Matlin et al., 2019).

What is the evidence that familial/individual level interventions work?

An important means of ascertaining the service needs of people affected by ACEs is to ask them directly about what they need and thereby develop a more complete understanding of what might be helpful (Whitehead et al., 2019). Children's views are especially valuable as they can draw attention to needs and concerns of which adults may be unaware (Lester et al., 2020). In an extensive review of multiple qualitative research study consultations with young people across a broad range of ACEs, Lester and colleagues (2020) found that young people appreciate both emotional and practical support, together with supportive relationships with trusted adults. This finding regarding supportive relationships with trusted adults is reinforced in another systematic review by Whitehead and colleagues (2019) who reported that young people consistently see the role of trusted adults as helpful and one that leads to positive outcomes, such as attaining better educational results, developing improved confidence, and decreasing their symptoms of anxiety and depression. In addition, Bellis and colleagues have found that access to a trusted adult mitigated the risk of adopting health harming behaviours and having lower mental well-being (2017) and was connected to improved health and social outcomes among people with higher levels of ACEs (Bellis et al., 2018). Further, Hughes and colleagues (2018) report strong relationships between the presence of a trusted adult relationship in the lives of children affected by ACEs and better mental health outcomes. Indeed, because of the emotional stresses that ACEs produce in young people's lives and the social isolation that can result, young people have expressed a clear wish for supportive relationships from services (Lester et al., 2020). However, interventions that are provided in community or clinical settings are often delivered by practitioners that the young person does not know (Lester et al., 2020).

According to Brown and Shillington (2017), because young people who experience multiple ACEs are also liable to have harmful primary caregiving relationships, the

role of non-parental adults and their potential mentoring support assumes great import-
ance. Sulimani-Aidan and colleagues (2019) report that young people in cares' relation-
ships with supportive adult mentors can offset problematic parental relationships, such as
those involving poor attachment or neglect. A variety of situations have been identified
where supportive relationships between trusted adults and young people can be devel-
oped including at their school, with relevant agencies and services, as well as in the com-
munity more generally (Whitehead et al., 2019). Helpful relationships can be built with
adults connected to formal services, such as foster carers, social workers, healthcare pro-
fessionals and teachers, as well as with extended family members and neighbours (Lester
et al., 2019). Trusted adults can be of assistance in various ways, such as helping a child at
school, supporting adolescents in care, and providing mentoring for young people
affected by violence (Whitehead et al., 2019).

 However, it is vital that the supportive role of the trusted adult is well understood and
properly implemented or there is a risk that young people may find themselves involved
in a superficial and ineffective relationship (Whitehead et al., 2019). This is particularly
the case for many young people who have had previous experiences of being let down by
adults; therefore, these relationships need to be dependable and longer-term if they are to
lead to improved outcomes (Whitehead et al., 2019). Qualities in adults that facilitate
trusted relationships for these young people include genuineness and empathy, as well
as being accessible, reliable, pro-active, non-judgemental, and active listeners
(Sulimani-Aidan, 2018; Whitehead et al., 2019; Lester et al., 2020). It is also most
important that structures are in place that facilitate consistent, long-term engagement
(Whitehead et al., 2019), with length of time of being linked to the success of the relation-
ship (Sulimani-Aidan, 2018).

What is the evidence that therapeutic interventions work?

While there have been a number of translational routes proposed between the experiences
of adversity in childhood and the later expression of these in terms of detrimental health
and social circumstance outcomes, the dominant explanatory theoretical schema has
come to be encapsulated in the so-called *toxic stress model*. Drawing on recent advances
in neuroscience, it is postulated the prolonged exposure to stress in childhood can create
heightened arousal to stimuli which manifests itself over the life course, sometimes in
ways disassociated from the original triggers (Franke, 2014). Whilst there is a consider-
able science on the understanding of trauma, knowledge as to what might constitute suc-
cessful intervention is still in the developmental phase, especially as not all the effects of
adversity are not necessarily traumatic but may nevertheless be problematic.

 The types of services developed to address the needs indicated by assessments have
become collectively known as *trauma-informed care* (TIC) (Sweeney et al., 2016).
While TIC covers a heterogenous range of therapies, there are a number of key principles
governing the approach, these include sharing with service user's information on the
causes and presentation of trauma and adopting strengths-based approaches to help
reframe symptoms as adaptations while working in partnership to develop new and
effective services (Sweeney & Taggart, 2018). However, a key issue here is that while

less rigorous evaluations, often based on qualitative research, indicate that TIC services are well received, the findings from more rigorous investigations, for example RCTs, are rather less positive in terms of outcomes for children and families. As Asmussen and colleagues observe, current models of TIC need to 'clearly specify how each practice component will contribute to reduced symptoms of trauma within a well-articulated theory of change… More rigorous evaluations of the impact of TIC on child outcomes are also required before TIC can be considered a proportionate and evidence-based response to childhood trauma and adversity.' (2020: 78–79). Such observations have begun to fuel research that focuses not so much on how the effects of early experiences of adversity may be understood in terms of concepts or principles, although these may be incorporated into their framework of reference, but rather pragmatically on measures of change in the functioning of those children and families using services. For example, Spratt and Kennedy (2021) have measured changes in individual health and interfamilial relationships for children and their families referred to family centres where the work is described as *trauma informed*. Using established standardised measures is one way to compare the efficacy of programmes thus described with services using other approaches and helps identify where, if not how, changes may be occurring. This more systematic and pragmatic approach to measuring the impact of services can go some way to allaying the concerns that have been expressed regarding the widespread uptake of trauma informed approaches which may lack a clear understanding that trauma is not simply a product of *exposure* but must be accompanied by *reaction*. Consequently, any rush to provide trauma informed services must be tempered by the twin imperatives to accurately assess for the presence or otherwise of trauma at point of referral and develop measures of the efficacy of any interventions provided (Spratt and Kennedy, 2021).

Concerns have also been raised regarding the possible pejorative effects of ACEs informed perspectives. Essentially these involve the potential for high ACEs scores to be read as determinative (rather than probabilistic) of poor future outcomes. Lacey and Minnis caution that: 'If the ACE-aware movement gains momentum and the language of ACEs becomes current in society, there could be unintended negative effects on children if, say, a ten-year-old child with a history of multiple adversities comes to feel stigmatised and doomed to poor physical and mental health. It is crucial that alongside public discussion of ACEs there is at least as much emphasis on resilience and potential for change towards more positive trajectories.' (2019: 122).

To help establish what might influence such positive trajectories, attempts have been made to identify helpful experiences in the life of children that may serve as buffers against the effects of adverse experiences, these have become known as Positive Childhood Experiences.

Positive childhood experiences

One of the conundrums of the literature on ACEs is why a large proportion of those with high numbers of ACEs appear to get on with life without any significant detrimental impact in the longer term. It is recognised that children's lives are rarely all good or all bad, and that the interplay between adverse and positive experiences and

circumstances warrants further attention. Adding weight to our earlier argument, 'positive' or 'protective' childhood experiences (PCEs) frequently have their roots in developmental psychology, and particularly, attachment theory. Attachment theory purports that early relationships with the primary caregiver, as well as others such as teachers or extended family members, provide the basis for a positive sense of self and help to model positive future relationships. Several scales purporting to measure PCEs have been developed or adapted for this purpose (for example, Narayan et al., 2018; Slopen et al., 2017). Studies seeking to explore the relationship between ACEs and PCEs have concluded that, for some conditions, such as depression and/or poor mental health, the proactive promotion of PCEs for children may reduce risk for later adult poor mental health and promote adult relational health (Bethell et al., 2019). However, a more recent national birth cohort longitudinal study has highlighted by the age of 12 in Scotland, most children have experienced at least one ACE (76.5%). The majority (98.4%) experienced at least one PCE. Higher levels of ACEs were associated with being male, lower household income, and higher levels of area deprivation. Higher levels of PCEs were associated with being female. Results suggested no statistically significant correlation between ACEs and PCEs, indicating that PCE are not simply the reverse of ACEs and warrant further investigation.

Discussion and conclusion

In reimagining what interventions might look like if more fully informed by evidence, it is important to recognise that contemporary systems of service delivery have largely evolved within environments where accountability rested more on preventing the worst of outcomes rather than on achieving the best of outcomes. Historical preoccupations with preventing the occurrence or reoccurrence of child abuse and neglect have resulted in a default to agency output data as measures of the system's efficiency and effectiveness. As we have observed, more recent developments in our understanding of an expanded range of harms to children, together with the translational mechanisms to creation of potential lifelong effects, has served to subvert traditional narrow conceptualisations of abuse and neglect as the most pressing signifiers of need.

The evidential landscape painted by current research would suggest that major initiatives in social and economic policy designed to reduce income inequality and redirect resources to those most in need would be effective in decreasing stresses on families who are currently impacted by poverty, and so lower the prevalence of adverse experiences for their children. But such redistributive policies will not float all boats. Childhood adversities are endemic and will continue to require initiatives and interventions at community, family and individual levels. As we have seen, the evidence for what works at these levels is, at best, equivocal. And, as is sometimes the case, research has provided a more significant evidential basis for diagnosing the problems than it has for suggesting the remedies. But this is not to suggest that significant clues have not emerged in relation to where future evidential investigations may prove fruitful.

With regard to community level interventions, the legion of problems identified above makes it tempting to think that there is no workable model. However, we can identify three key areas of concern; these are, lack of shared understanding as to what ACEs are and how they impact upon the person, difficulties in creating and sustaining 'joined up' interagency services, and lack of long-term funding commitments. While it is tempting to conclude that community services may not work this would represent a conflation, as the identified problems are really structural in nature and are potentially solvable. As noted earlier, also, success at the community level can be achieved but the challenge should not be underestimated, requiring thorough planning, multiple committed stakeholders, and high-quality implementation (Durlak, 2013).

The idea that *one trusted adult* may act as an important mitigation factor, reducing the impact of ACEs, appears to be a meta-theme with respect to what works at familial/individual level. It is particularly noteworthy that the evidence of the young person's voice is in harmony with the research findings in attesting to the centrality of this factor. The fact that such relationships may be potentially sourced in both community and professional environs provides challenges in establishing continuity of contact with a known individual where current organisational structures are more aligned to discrete service domains than to the imperative of relational support.

With regard to therapeutic interventions, the alignment between principles derived in Trauma Informed Care and the evidence base for interventions is perhaps most attenuated. Such lags in testability of concepts in real world settings are common, and it will be interesting to see how this research lacuna is filled. There are already promising signs that research that focuses on specific outcomes for service users, together with identification and promotion of the range of positive childhood experiences will provide promising avenues for future investigations.

In this article we have sought to provide a broad overview of services in transition as the weight of accumulated evidence serves both to inform and to change how services to children and their families are both conceptualised and delivered. The process is neither linear nor entirely rational, but it is evident.

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