EARLY
INTERVENTION
FOUNDATION

Adverse childhood experiences

Building consensus on what should happen next

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Dr Kirsten Asmussen and Tom McBride

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About EIF

The Early Intervention Foundation (EIF) is an independent charity established in 2013 to champion and support the use of effective early intervention to improve the lives of children and young people at risk of experiencing poor outcomes.

Effective early intervention works to prevent problems occurring, or to tackle them head-on when they do, before problems get worse. It also helps to foster a whole set of personal strengths and skills that prepare a child for adult life.

EIF is a research charity, focused on promoting and enabling an evidence-based approach to early intervention. Our work focuses on the developmental issues that can arise during a child's life, from birth to the age of 18, including their physical, cognitive, behavioural and social and emotional development. As a result, our work covers a wide range of policy and service areas, including health, education, families and policing.

Early Intervention Foundation
10 Salamanca Place
London SE1 7HB

W: www.EIF.org.uk
E: info@eif.org.uk
T: @TheEIFoundation
P: +44 (0)20 3542 2481

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Contents

Introduction

Background

In February 2020, we published a comprehensive review of the adverse childhood experiences (ACEs) evidence entitled *Adverse childhood experiences: What we know, what we don't know and what should happen next*.[1] We observed that while ACEs pose a clear threat to children's wellbeing at all points of their development, many popular claims about ACEs are not supported by the best evidence, and many ACE-related practices have yet to be rigorously evaluated. The report concluded with a set of nine recommendations about how the ACEs evidence could be improved, and outlined what an 'evidence-based' public health response to ACEs might be.

While the review and its conclusions were positively received by a wide range of audiences, it was clear that more work was needed to understand how its key messages were perceived and if they were influencing their work with families and children. We therefore commissioned RAND Europe, a not-for-profit research institute, to conduct a consensus-building exercise on our behalf to better understand our audience's views about the research evidence, and how they think it might best be taken forward to improve policy and practice.

Our study was successful in engaging 70 practitioners, policymakers, academics and children's charities who have a shared interest in improving children's lives. These individuals achieved consensus on 41 statements regarding the quality of the ACEs evidence and how it might best be used to help vulnerable children.

This report provides a high-level overview of the findings of this exercise, highlighting the areas where consensus was achieved and how this consensus aligns with the most robust research evidence. A more detailed analysis of our findings is also available in the technical annex[2] and a useful discussion of the methodology is provided by RAND Europe on their website.[3]

Adverse childhood experiences: the evidence and associated controversies

Scientific evidence does not speak for itself. It requires analysis, explanation and interpretation – and it is not uncommon for experts to disagree about the implications of evidence for policy and practice decisions. This is particularly true when it comes to the evidence stemming from the ACEs research, which has been controversial since the first study was published 23 years ago. ACEs are traditionally defined as 10 categories of child maltreatment and family dysfunction that are psychologically traumatic for most children (see box below). Findings from a landmark 1998 survey conducted retrospectively with adults observed that experiencing four or more ACEs before the age of 18 significantly predicted the onset of many life-threatening diseases, including heart failure, diabetes and cancer. The study concluded that the impact of four or more ACEs on poor adult health was 'strong and cumulative'.[4]

1 Asmussen at al., 2020. Available at: https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

2 Available at: https://www.eif.org.uk/report/aces-building-consensus-on-what-should-happen-next

3 See https://www.rand.org/randeurope.html

4 Felitti et al., 1998

What are the 10 ACEs?

The 10 'traditional' ACEs are:

- experiencing physical abuse
- experiencing verbal abuse
- experiencing sexual abuse
- experiencing physical neglect
- experiencing emotional neglect
- having a parent who's an alcoholic
- having a mother who's a victim of domestic violence
- having a family member in jail
- having a family member diagnosed with a mental illness
- experiencing the disappearance of a parent through divorce, death or abandonment

These findings have since been replicated multiple times, all verifying the same graded relationship between ACEs and poor physical and mental adult health.[5] The consistency of these findings, coupled with preliminary evidence suggesting that traumatic events may disrupt the immune system, has led some to speculate that four or more ACEs may be a leading cause of early death.

This speculation has resulted in practices aimed at increasing practitioners' awareness of ACEs and identifying those who have experienced many, so that they can receive further help. Common practices include universal ACE screening, whereby individuals receive an ACE score based on their response to the original ACE-study questionnaire. 'Trauma-informed' activities are now also widely implemented to increase practitioners' awareness of the negative impact of ACEs and change practices that have the potential to retraumatise vulnerable individuals.[6]

Despite this enthusiasm, the ACEs evidence has been widely criticised.[7] Much of this criticism involves the adequacy of the ACE study methodology for supporting causal assumptions about children's development.[8] In particular, researchers note that retrospective surveys with adults are never appropriate for confirming causal conclusions. Criticism has also been levelled at the ACE categories themselves, with many observing that most ACE studies have not adequately considered other factors, such as economic disadvantage that could also explain the relationship between childhood adversities and poor adult outcomes.[9]

Ethical concerns have also been raised about many of the common responses to ACEs. In particular, studies show that individuals with a history of multiple ACEs are often uncomfortable disclosing information about childhood abuse, and concerns have been raised that answering the ACE questions could be traumatising for some individuals.[10]

5 Hughes et al., 2017; Bellis et al., 2015; Bellis et al., 2014; Bellis et al., 2013
6 Loudenback, 2019; Quigg et al., 2020
7 Kelly-Irving & Delpierre, 2019
8 Baldwin et al., 2019; Reuben et al., 2016
9 White et al., 2019
10 Skar et al., 2019; Mersky et al., 2019

Many have also questioned whether asking the ACE questions may be unethical in the absence of clear protocols leading to evidence-based treatments.[11]

Trauma-informed care has similarly been criticised on account of its lack of specificity and the extent to which it can directly prevent or reduce the impact of ACEs.[12] Although some studies have observed improvements in service users' self-reported satisfaction and mood, evaluation studies have yet to rigorously verify whether trauma-informed practices have the potential to stop, prevent or reduce ACEs.[13] Given that many trauma-informed care activities are expensive, investing in them in comparison to interventions with known evidence of stopping or reducing ACEs has recently been questioned.[14]

EIF's 2020 report on adverse childhood experiences

The lack of evidence underpinning many ACE-related activities has resulted in a growing number of prominent public health bodies speaking out against many common responses to ACEs, such as universal ACE screening and trauma-informed care.[15] Nevertheless, these activities continue to have broad and growing appeal.

In 2018, the House of Commons Science and Technology Committee conducted an inquiry to better understand the nature of these concerns and the strength of evidence underpinning ACEs and ACE-related activities. The inquiry solicited the views of a wide range of experts, including academics, practitioners, policymakers and representatives from third-sector organisations. The inquiry concluded that while there was clear agreement that ACEs were harmful and associated with poor adult outcomes, there was also a notable lack of consensus regarding the precise nature of this relationship.

The inquiry additionally noted that many common responses to ACEs were not evidence based, nor were they aligned with best practice and when this was the case, 'vulnerable children were being failed'.[16] The inquiry then went on to identify us as having a key role in promoting the use of evidence-based responses to ACEs and partnering with the government to develop and implement a robust national strategy.

In response to this challenge, we published a comprehensive review of the ACEs evidence in 2020.[17] Our review not only considered the quality of the evidence underpinning the original ACE study and those that followed, but also the evidence underpinning many common responses including universal ACE screening and trauma-informed care. We concluded that while ACE studies have helpfully increased awareness about the negative impact of childhood adversities on adult outcomes, the potential causal nature of this relationship remains unclear. Additionally, the review observed that the evidence underpinning many ACE-related policies and practices was weak and some practices had the potential to do harm. The report then identified the components of an evidence-based response to ACEs, which included interventions and activities with robust evidence of reducing ACEs and the factors that contribute to them. A full list of the report's conclusions and recommendations is provided in table 1 in the 'Findings' chapter of this report.

11 McLennan et al., 2019

12 Bargeman et al., 2020; Hanson & Lang, 2016

13 Bailey et al., 2019; Bendall et al., 2020; Bunting et al., 2019

14 Racine et al., 2020

15 Finkelhor, 2018; McLennan et al., 2019

16 See https://publications.parliament.uk/pa/cm201719/cmselect/cmsctech/506/50609.htm

17 Asmussen at al., 2020. Available at: https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

Aims of this work

From our perspective, the current lack of consensus about how to best respond to ACEs risks hampering progress in reducing them and could lead to the proliferation of potentially harmful practices. **Therefore the primary aim of this study was to identify areas within current practice where there is consensus that is also consistent with the best evidence, as well as areas where there remains a lack of agreement.**

A variety of methods exist to help audiences with a shared interest gain consensus about important policy and practice issues. Examples of common consensus-building activities include professional consultations, calls for evidence, expert round tables and Delphi surveys. Delphi surveys in particular are viewed by many as an 'evidence-based' method for gaining consensus on policy and practice decisions, as well as identifying priorities for future work.[18]

A Delphi survey typically convenes a group of experts (ranging anywhere between 10 to 1,000) who anonymously reply to questionnaires which are used to both define the problem and gain consensus through multiple survey rounds. The goal is to start with a wide range of statements or recommendations generated by the participants, and then reduce them to a smaller set of statements where there is strong agreement through at least two subsequent rounds. Agreement does not need to be unanimous and 70% agreement is typically set as the benchmark for consensus being achieved. A key advantage of this methodology is that it facilitates participation from divergent groups by providing a neutral platform through which ideas can be shared and agreed.[19]

The RAND Corporation is credited with inventing the Delphi method and is widely regarded as the leading expert in conducting consensus-building exercises.[20] We commissioned RAND Europe and their subcontractor Accent to work with us to design and conduct a three-round modified Delphi survey with two primary objectives:

1. Understand how the EIF ACEs report was viewed by EIF's key audiences and identify areas of agreement and disagreement.
2. Achieve consensus on a set of next steps for taking ACEs' research, policy and practice forward that are well aligned with the best evidence.

Methods

We recruited 70 experts from a representative cross-section of our policy and practice audiences. Further details about the characteristics of these individuals and their level of participation are provided in the full report.

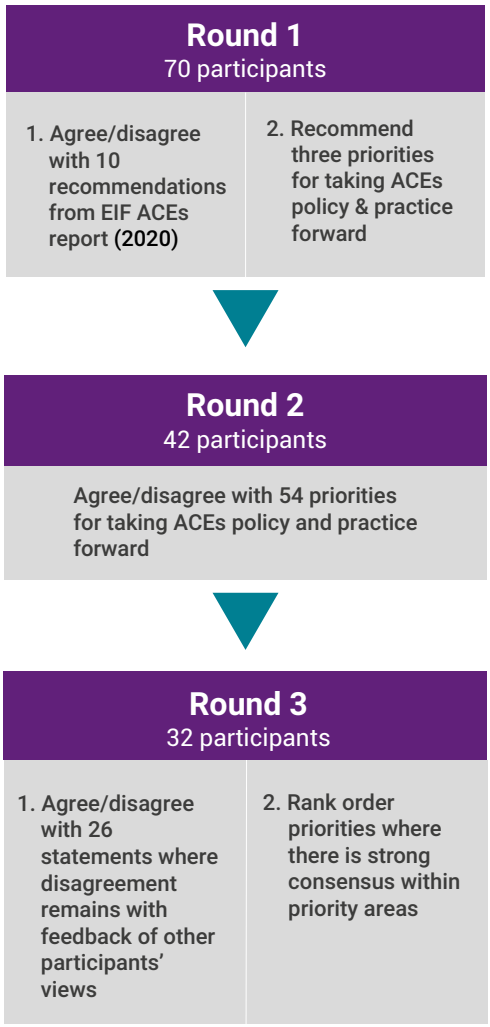
We achieved strong engagement from 50 of these individuals who participated in at least two of the three survey rounds. Figure 1 below provides an overview of the numbers of participants for each survey round and the tasks they were asked to complete.

18 Rowe & Wright, 1999

19 Lokker et al., 2015

20 Sackman, 1974

FIGURE 1
Content and participation in the three Delphi survey rounds



The three Delphi survey rounds

Round one

The first survey asked participants to read the summary of our 2020 ACEs report. Participants were then asked to:

1. provide their general impressions of the report and the extent to which they found the knowledge to be useful through free-text boxes and a series of four-point Likert-type rating scales[21]
2. rank their agreement (strongly agree, agree, disagree, strongly disagree) on a four-point Likert scale with 10 recommendations and conclusions from the report
3. make three suggestions for taking the evidence forward.

The complete survey used for round one can be found in appendix A of the technical annex.[22]

21 A Likert-type scale is a set of consecutive numbers (typically no less than three and no more than 10) that allows respondents to specify their level of agreement or disagreement with a statement in a questionnaire.

22 Available at: https://www.eif.org.uk/report/aces-building-consensus-on-what-should-happen-next

Round two

Respondents to survey one provided over 200 suggestions for taking ACE-related policies and practices forward. There was a fair degree of overlap amongst the suggestions, so they were condensed into 54 statements using thematic techniques. The original language and conceptual framing used by participants was retained wherever possible, although small adjustments were made to ensure that the statements were clear and unambiguous.

These 54 statements were then sent to participants as part of the second round of the Delphi survey, so that they could see what the others had suggested and rank their agreement or disagreement with each statement. Survey two can be found in appendix B of the technical annex.[23]

Round three

The findings from round two revealed a high degree of consensus for 26 suggestions, where over 90% of the participants either agreed or strongly agreed. In round three, participants were asked to prioritise these statements for further action.

For the remaining 28 suggestions where a lack of consensus remained, participants were provided information about the other participants' responses and asked to reconsider their agreement in light of this knowledge.[24] Survey three can be found in appendix C of the technical annex.[25]

23 Available at: https://www.eif.org.uk/report/aces-building-consensus-on-what-should-happen-next

24 Rank their agreement (strongly agree, agree, disagree, strongly disagree) on a four-point Likert scale.

25 Available at: https://www.eif.org.uk/report/aces-building-consensus-on-what-should-happen-next

Findings

Participants' perceptions of EIF's 2020 ACEs report

A primary objective of round one of the Delphi survey was to understand the participants' perceptions of our 2020 ACEs report[26] and the extent to which they agreed with its conclusions and recommendations. **Participants were strongly enthusiastic about the report and its messages.** Seventy-five per cent said it increased their knowledge and understanding of ACEs and 87% agreed that it had helped them understand, or be aware of, some of the existing gaps in the ACEs evidence. As one of the participants described in the free-text response:

> *I think* [the report] *draws a balanced view of a practical useful and personally and intuitively meaningful concept. And starts to get us all clear on the strengths and weaknesses* [of the evidence] *and where it needs to go next in policy, research and practice. And it does need to move further.*

The participants endorsed all the report's conclusions and recommendations, with each statement receiving 80% agreement or higher by the final round. Table 1 shows the level of agreement with the conclusions and recommendations from our original report.

TABLE 1
Level of agreement with conclusions and recommendations from EIF's 2020 ACEs report

		Conclusions & recommendations from the report	Percentage agreement
Conclusions	1	Research into adverse childhood experiences (ACEs) has generated a powerful and accessible narrative which has helpfully increased awareness of the lifetime impact of early adversity on children's outcomes. However, it has resulted in several misconceptions which must be addressed as the ACEs agenda is taken forward.	87%
	2	The current popularity of the ACEs narrative should not lead us to ignore the limitations in the current evidence base, or be allowed to create the illusion that there are quick fixes to prevent adversity or to help people overcome it.	81%
	3	The current enthusiasm for tackling ACEs should be channelled into creating comprehensive public health approaches in local communities, built on the evidence of what works to improve outcomes for children.	90%

26 Asmussen at al., 2020. Available at: https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

		Conclusions & recommendations from the report	Percentage agreement
Recommendations	1	We need to improve our estimates of the prevalence of ACEs, so we know who the most vulnerable children are and can make interventions available to them as and when needed.	81%
	2	A focus on the original 10 ACEs to the exclusion of other factors risks missing people who also need help. We must therefore look beyond the original ACE categories to understand children's needs in a more holistic way.	93%
	3	We need to increase the availability of interventions with known evidence of stopping and reducing the social processes contributing to ACEs, while investigations into the neurobiological basis of ACEs continue.	90%
	4	We currently know very little about the effectiveness of ACE screening and routine enquiry. We therefore recommend that further research is necessary to investigate the safety and accuracy of ACE screening before it is used more widely.	82%
	5	Increased specification and further rigorous testing is necessary before the potential of trauma-informed care for reducing symptoms of trauma can be fully understood.	84%
	6	Many ACEs could be prevented or substantially reduced if more evidence-based interventions were made available through a comprehensive public health strategy aimed at improving the lives of vulnerable children.	90%

Statements achieving high levels of consensus

In round two, participants were asked to rank their agreement with 54 suggestions generated in round one which we grouped into eight thematic areas. Five of these themes are closely aligned with the conclusions and recommendations made in our 2020 report, whereas three of them are new, reflecting recent changes in policy and practice. By the end of round 3, consensus was reached on 41 statements, as described below.

Statements achieving consensus of 70% or higher

Statements in bold are particularly well aligned with five of the recommendations made in our 2020 report. The extent to which they are supported by the evidence is described in greater detail in the next section.

Statements grouped by themes that correspond to recommendations in EIF's ACEs report (2020)

1. The prevalence of ACEs and other childhood adversities

- **There should be increased investment in sustainable data collection and monitoring activities that will provide a more robust understanding of the prevalence of ACEs and their impact on child and adult wellbeing.**
- **Data linkage approaches should be investigated and improved so that data collected through the ACE prevalence surveys can be joined up with data that is routinely collected on children and families. For example, birth records, health records, etc.**
- **Data on the prevalence of ACEs in the UK child population should be collected on a regular basis.**

- **A digital 'red book' should be established for each child as a first step in coordinating information on children's development and adversities and providing high-quality, evidence-based services that are specific to each child's needs.**

2. The limitations of the ACE categories for understanding the impact of structural inequalities on children's development

- **The ACEs framework should be expanded to consider the impact of structural inequalities such as poverty and racism on children's development.**

3. ACE screening

- **The routine enquiry of ACEs should be evaluated to determine whether it is effective or appropriate for making decisions about children's access to treatment.**
- **ACEs screening should not be used unless it leads to access to interventions with evidence of reducing symptoms of trauma and improving child and family outcomes.**
- **The effectiveness of ACE screening for identifying children at risk of poor life outcomes should undergo rigorous evaluation before it is widely implemented.**
- All children attending court should be screened for trauma.
- Regular mental health check-ups should be provided to all children in schools.

4. Trauma-informed care

- Multi-agency training should be made available across the entire children's services system to ensure that all partners are trauma informed.
- All children's services should understand how their activities can be more child-focused and promote children's strengths.
- **The effectiveness of trauma-informed care for stopping and reducing children's experience of trauma requires further evaluation so that examples of good practice can be identified and shared across children's services.**
- All frontline practitioners should be trained to ask children and families 'what happened to you?' instead of 'what is wrong with you?'
- Public services and environments need to be made more welcoming and family friendly, so that they do not inadvertently retraumatise children and adults.

5. A public health response to ACEs

- **The UK government should adopt a public health approach which explicitly aims to prevent child maltreatment from conception to age 18.**
- **Funding should be made available to local areas to design a sustainable whole-system strategy to prevent and reduce ACEs at the population level.**
- Whole-systems action is required to prevent childhood adversity at the community level. This means working with community leaders, children and parents to design services and approaches.
- Ensure ACEs work on prevention and early intervention is joined up with other policy agendas such as adolescent mental health, reducing parental conflict, early years and maternity, which would include better data-sharing systems.
- Government should invest in new ways of working to provide a mixture of services that support positive child and parent relationships in the early years.

- **Evidence-informed parenting support should be made available at the universal, targeted and indicated level as a first step in a population-wide strategy for preventing and reducing ACEs.**
- Every local authority should be required to develop a child health and wellbeing strategy to increase accountability for supporting vulnerable children and young people.
- It should be common practice for local responses to ACEs to be codesigned by practitioners, academics and those with lived experience.

Statements grouped by new themes

6. National guidance and language

- A review should be conducted to consider how ACEs research is currently informing UK policy. Findings gathered from this review alongside other evidence, should be used to produce a guidance document on how the ACEs framework can be used to inform local responses in order to promote good practice that is holistic and child-centred.
- A common language about ACEs should be agreed and adopted nationally. Currently, there is too much confusion about what is meant by ACEs/trauma/evidence-based models, etc. – leaving it to local areas to develop their own interpretation.

7. ACE-awareness training

- All frontline staff in schools, social services, the police, probation and judicial settings should undergo ACE-awareness training.
- The findings of the EIF report could be used to create continuing professional development (CPD) material for professionals.
- All frontline practitioners should receive training about children's biological needs for healthy brain development. This includes knowledge of the importance of sleep, physical exercise and diet.
- All parents should be given information about the biological processes underpinning children's physical health and brain development. This includes knowledge of the importance of sleep, physical exercise and diet.
- Parenting classes should be made widely available for first-time parents, to make them aware of the importance of this period for early brain development and to provide them with strategies for supporting their child's needs.

8. Enhancing current provision

- Children's centres/family hubs should be reinvigorated across England to 'join-up' practice and provide locally tailored services.
- The current health visiting service should be strengthened to provide support to all children, proportionate to their need, regardless of where they live.
- Services which potentially cause ACEs and trauma (such as, policing practices and school exclusions) should be identified and changes should be introduced to reform these practices.
- Policies should be implemented to discourage schools from using exclusions as a method of managing difficult pupil behaviour.
- We should increase the size of the early years workforce and specify new training routes to attract people from a range of professions and backgrounds.

- Families should be made better aware of community resources that might prevent or reduce ACEs.
- Children's residential care homes should be redesigned so that they are less institutional and more warm and inviting.
- The Troubled Families programme should be expanded to make better use of the ACEs evidence and adopt a more trauma-informed approach.
- The quality of the children's social care workforce should be strengthened through better pay, supervision and development.
- Resources should be made available to improve the standard of current housing provision.
- The government should commission a national review of the children's social care workforce followed by additional investment in training and recruitment.

Suggestions consistent with the evidence

The findings from this exercise confirmed that there is widespread enthusiasm for comprehensive measures to prevent childhood adversities from occurring in the first place and reduce their negative impact when they do occur. Some of these suggestions involve activities that have already been proposed at the national level, such as the reinvigoration of family hubs and the introduction of a digital red book for all children starting at birth. Others go well beyond the ACEs evidence, calling for reforms to housing provision, practices to discourage school exclusions and the introduction of mental health check-ups at schools.

While each of these suggestions warrants further consideration, we highlight 12 that are particularly well aligned with five of the recommendations made in our 2020 report. These statements are highlighted in bold in the list above, and the extent to which they are supported by the evidence is described in greater detail below.

Prevalence of ACEs and other childhood adversities

» **EIF ACEs report (2020) recommendation:**
We need to improve our estimates of the prevalence of ACEs, so we know who the most vulnerable children are and can make interventions available to them as and when needed.

Eighty-one per cent of the participants agreed with this recommendation, and consensus was reached on three suggestions that are consistent with recommendations made in our 2020 report:

» ***There should be increased investment in sustainable data collection and monitoring activities that will provide a more robust understanding of the prevalence of ACEs and their impact on child and adult wellbeing.***

» ***Data linkage approaches should be investigated and improved so that data collected through the ACE prevalence surveys can be joined up with data that is routinely collected on children and families. For example, birth records, health records, etc.***

» ***Data on the prevalence of ACEs in the UK child population should be collected on a regular basis.***

These suggestions are also consistent with work currently being conducted by NatCen Social Research on behalf of the Office for National Statistics (ONS), to consider the feasibility of a national prevalence study on child maltreatment.[27] It is anticipated that the scope of this study will be similar in magnitude to the 2011 NSPCC study of child maltreatment, providing valuable information about the number of the children who have experienced abuse and the risks associated with it.

The fourth suggestion endorses the need for a digital 'red book' (or Personal Child Health Record) that would be established for each child at birth as a means for coordinating information on the child's development.

» ***A digital 'red book' should be established for each child as a first step in coordinating information on children's development and adversities and providing high-quality, evidence-based services that are specific to each child's needs.***

We also view this suggestion as 'evidence based' as it is consistent with recommendations made in the fifth edition of *Health for All Children* which was informed by a careful examination of the most recent evidence involving children's early development.[28] The need for a digital red book has also been identified by the Department of Health and Social Care in *The best start for life: a vision for the 1,001 critical days* as essential for providing children and parents faster access to effective treatments. We concur that a digital red book will not only be useful for helping practitioners share information about individual children, but also help parents monitor their children's development.

Next steps: Improve our understanding of prevalence of childhood adversities through the collection, linking and sharing of data

When used for the purposes of population surveillance, asking questions about childhood adversities can provide reliable information about their frequency and the circumstances in which they occur. This knowledge is highly valuable for planning purposes, as well as monitoring changes in population risk over time. Work for the ONS exploring the feasibility of a new national prevalence study on child abuse and neglect is an opportunity to improve our understanding of maltreatment through a validated questionnaire that is digitally administered to a representative cross-section of the child population at regular intervals (for example, every two years).

We also think there is merit in investigating the extent to which the data collected by Health Behaviour in School-aged Children (HBSC) survey can be anonymously linked to national health and education records in England, as is already the case in Wales. The survey is currently conducted every four years with a nationally representative sample of secondary school children, and provides the Welsh government with important information about the health and wellbeing of young people.[29]

The negative impact of structural inequalities on children's development

» **EIF ACEs report (2020) recommendation:**
A focus on the original 10 ACEs to the exclusion of other factors risks missing people who also need help. We must therefore look beyond the original ACE categories to understand children's needs in a more holistic way.

27 Sharrock et al., 2019

28 Emond, 2020

29 Brooks et al., 2018

Ninety-three per cent of participants agreed with this recommendation and consensus was reached on one suggestion that is consistent with recommendations made in our 2020 report:

» ***The ACEs framework should be expanded to consider the impact of structural inequalities such as poverty and racism on children's development.***

We strongly agree that the impact of structural inequalities on children's development requires further investigation. As we describe in our 2020 report, other negative circumstances considered by many to be structural inequalities also predict poor adult outcomes. These inequalities include economic disadvantage, racial discrimination, community crime and poor birth outcomes. Many studies now show that these inequalities are often better predictors of poor child outcomes than many of the original ACE categories.[30]

It is clear, however, that specifying these inequalities as an additional ACE is not likely to be beneficial. This is because of the general limitations of the ACEs framework (see the technical report for a full description[31]), as well as the complex relationship between ACEs and these inequalities.[32] We therefore advocate for research which robustly compares the impact of ACEs to known inequalities on poor child outcomes. This knowledge is essential for understanding how and when to intervene, as well as which activities will have the greatest impact.

Next steps: Tackle structural inequalities through national policies

ACEs are consistently underpinned by a set of structural inequalities that are strongly associated with poor child outcomes. While effective support can help mitigate the effects of poverty and disadvantage, it is not sufficient to prevent poor outcomes on its own. To ensure the best outcomes for children and young people, policy to address poverty must be a focus of government.

Universal ACE screening

» **EIF ACEs report (2020) recommendation:**
We currently know very little about the effectiveness of ACE screening and routine enquiry. We therefore recommend that further research is necessary to investigate the safety and accuracy of ACE screening before it is used more widely.

Eighty-two per cent of participants agreed with this recommendation, although it was also clear that ACE screening practices (including routine enquiry) were highly controversial. While some participants viewed these activities as beneficial, others were strongly opposed to any form of enquiry, viewing it as potentially harmful and unethical if conducted in the absence of clear referral routes or safeguarding protocols.

Five recommendations achieved consensus at 70% or higher, three of which were consistent with the recommendations made in our 2020 report:

» ***The routine enquiry of ACEs should be evaluated to determine whether it is effective or appropriate for making decisions about children's access to treatment.***

30 Finkelhor et al., 2015; Lacey et al., 2020; Turner et al., 2020

31 Available at: https://www.eif.org.uk/report/aces-building-consensus-on-what-should-happen-next

32 Straatmann et al., 2020

- ***ACEs screening should not be used unless it leads to access to interventions with evidence of reducing symptoms of trauma and improving child and family outcomes.***
- ***The effectiveness of ACE screening for identifying children at risk of poor life outcomes should undergo rigorous evaluation before it is widely implemented.***

While we agree that ACE screening practices should be evaluated, we now feel strongly that all universal ACE screening activities including routine enquiry should be stopped entirely, until a validated measure of childhood adversity has been developed and there is clear evidence of it leading to effective treatment. There is new and robust evidence showing that the original ACEs questionnaire has 'poor accuracy', meaning that it is an ineffective means for understanding whether children are at risk of poor outcomes, and is an inappropriate method for informing treatment decisions.[33]

There is also emerging evidence showing that many vulnerable individuals do not like answering the ACE questions and are less likely to answer them truthfully.[34] This evidence is consistent with findings from several recent systematic reviews which show that most child maltreatment questionnaires have limited validity and therefore should not be used until their accuracy can be verified through the following three levels of testing:[35]

1. **Derivation** involves identifying the extent to which all items on the measure can predict the events and behaviours they aim to measure. As we described in our original ACEs report, the predictive properties of all the ACEs have not been established, nor has their relationship to other outcomes which may be more predictive of individual risk.
2. **Validation** means verifying that a tool is accurate – in other words, can accurately measure childhood adverse experiences and is specific and sensitive enough to identify those who are experiencing difficulties and would most benefit from treatments.
3. **Impact analysis** encompasses evidence showing that the use of the tool changes clinician behaviour in a way that leads to children and families receiving effective services.

To date, no ACE screening tool has sufficiently met these three criteria, resulting in the World Health Organization (WHO) stating that there is currently 'no evidence to support universal screening or routine enquiry of child abuse and neglect.'[36]

The WHO furthermore advises that any enquiry into childhood abuse and neglect should only be conducted by qualified professionals with a clear mandate to ask such questions and with sufficient training to ask them. Such enquiry should also only occur within the context of safeguarding protocols which clearly lead to effective interventions or service response.

It is also worth noting that Robert Anda, one of the original ACE study's authors, has recently advised against ACE screening with the questionnaire used in the original study:

33 Baldwin et al., 2021; Gentry & Paterson, 2021

34 Mersky et al., 2019; Skar et al., 2019

35 McTavish et al., 2020

36 WHO mhGAP, 2015

> *Given the limitations of the ACE score and its lack of standardization in combination with a list of health outcomes with widely varying aetiologies,* [it's use] *will inherently lead to both over- and underestimation of individual risk. Although there are potential benefits for clients in the intent of this initiative, in its current form, the* [tool] *may stigmatize or lead to discrimination based upon an ACE score, generate client anxiety about toxic stress physiology, or misclassify individual risk, which could result in the withholding of useful, necessary services or, alternatively, steer clients toward unnecessary services.*[37]

Next steps: Halt all frontline ACE screening practices until validated measures and protocols have been tested and developed

In our view all ACE universal screening activities should be stopped until robust testing and validation takes place. Additionally, practitioners should recognise that it is unlikely that ACE scores will ever represent an appropriate way of measuring individual risk or making treatment decisions. This means that ACE scores should never be used as a basis for treatment referral and, given the emerging evidence showing that many vulnerable individuals are less likely to answer ACE questionnaires truthfully, probably should not be used to initiate conversations with children and adults about difficult childhood histories.

Trauma-informed care

» **EIF ACEs report (2020) recommendation:**
Increased specification and further rigorous testing is necessary before the potential of trauma-informed care for reducing symptoms of trauma can be fully understood.

Eighty-four per cent of participants agreed with this recommendation and consensus was achieved for five related suggestions, as we describe in the full technical report.[38] We highlight one of these suggestions here as it is particularly well supported by the research evidence.

» ***The effectiveness of trauma-informed care for stopping and reducing children's experience of trauma requires further evaluation, so that examples of good practice can be identified and shared across children's services.***

As described in our 2020 ACEs report, we strongly agree with the need to better define trauma-informed care and evaluate its impact across a range of settings, including health visiting, schools and the police. While the principles underpinning trauma-informed care may be beneficial for improving practice, we are concerned that most trauma-informed activities have yet to be robustly evaluated. We also believe more needs to be known about how these activities will add value over current practice.

We are currently investigating what is known about the benefits of trauma-informed activities in children's social care and will share the findings from this study later this year. From our work to date, it appears that trauma-informed care often does not lead to dramatic changes to service delivery, and in some cases represents no more than a rebranding of standard practice. Further work is therefore necessary to understand how trauma-informed care is defined and can improve practice within different sectors.

Next steps: Rigorously evaluate the training outcomes of trauma-informed care

While it is clear that many practice audiences believe that trauma-informed care adds significant value, our work with children's social care teams shows that there is a high

37 Anda et al., 2020

38 Available at: https://www.eif.org.uk/report/aces-building-consensus-on-what-should-happen-next

degree of variation in how it is being used and in perceptions of how it improves frontline practices. This level of diversity creates challenges in identifying examples of best practice and in rigorously evaluating them. We therefore recommend that government should fund a series of national evaluations aimed at investigating the benefits of trauma-informed care training for the frontline practitioners who are receiving it, including social workers, teachers, health visitors and the police. These evaluations should measure both service outcomes involving increased practitioner knowledge and public health outcomes involving child and family wellbeing.

A public health approach to prevent and reduce child maltreatment

» **EIF ACEs report (2020) recommendation:**
Many ACEs could be prevented or substantially reduced if more evidence-based interventions were made available through a comprehensive public health strategy aimed at improving the lives of vulnerable children.

Ninety per cent of participants agreed with this recommendation and consensus was achieved for eight related suggestions made by the participants, as described in the full technical report.[39] Three of these suggestions are particularly well supported by scientific evidence, as we describe below.

» ***The UK government should adopt a public health approach which explicitly aims to prevent child maltreatment from conception to age 18.***

We agree that targeting child maltreatment is the logical place to start when it comes to reducing ACEs and ACE-related trauma. Although many of the survey participants also endorsed the idea of a broader 'good childhood strategy', recent evidence tells us that a specific focus on preventing child maltreatment is the most effective method of ensuring that the needs of the most vulnerable children are met.[40] For example, new evidence emerging from the Family First Preventive Services Act in the United States suggests that specifically targeting child maltreatment may be a particularly effective way of improving the lives of vulnerable children, including those who have experienced multiple ACEs.[41]

» ***Funding should be made available to local areas to design a sustainable whole-system strategy to prevent and reduce ACEs at the population level.***

We agree that resources should be made available to local areas to help them focus on tackling child maltreatment and associated ACEs, as well as other adversities also known to contribute to poor child outcomes through their early help service planning. However, the evidence is clear that support offered to local areas must go beyond funding to include clear guidance and advice.[42] Examples of guidance that has been shown to help local areas develop effective strategies include:

- clear guidance that can be accessed through easy-to-navigate websites and documents
- bespoke advice from consultants, evaluators and public health experts
- simple to use software programs that can capture important monitoring data, including dashboards and access to relevant data banks
- ongoing training.[43]

39 Available at: https://www.eif.org.uk/report/aces-building-consensus-on-what-should-happen-next
40 Jones Harden et al., 2020; Feely et al., 2020
41 Waid & Choy-Brown, 2021
42 Slack & Berger, 2020; Greenberg et al., 2007
43 Johnson et al., 2013

» ***Evidence-based parenting support should be made available at the universal, targeted and indicated level as a first step in a population-wide strategy for preventing and reducing ACEs.***

There is clear evidence that parenting support should be a key element of any initiative aimed at reducing child maltreatment.[44] As described in our 2020 report, a wide variety of effective universal, targeted and selected parenting interventions are available in the UK. Each of these programmes have strong evidence of increasing parental sensitivity and improving child wellbeing when they are implemented to a high standard and are delivered by qualified and trained professionals. Although we know that evidence-based parenting interventions are currently being delivered in many areas, we are also aware that these interventions are not always implemented to a high standard or are not reaching the families who most need them. It is also clear that some areas often prefer locally developed approaches that have often not yet been evaluated to approaches which have been developed elsewhere.

Next steps: Support local areas in preventing and reducing child maltreatment

Our exercise revealed strong enthusiasm for comprehensive public health measures aimed at reducing child maltreatment and its associated risks. There are a range of government programmes which are currently considering how to develop a strengthened family support offer in local communities, including: the current independent review of children's social care services led by Josh MacAlister; the Department for Education's work on Family Hubs; as well as the Ministry of Housing, Communities and Local Government (MHCLG) Strengthening Families programme. Forward policy should include a focus on how these initiatives can be used to deliver targeted evidence-based interventions to vulnerable families with a focus on preventing child maltreatment and other poor outcomes. Central government also has a strong role to play in building the evidence base by funding evaluations for interventions that show promise in reducing serious problems known to contribute to child maltreatment, including parental substance misuse and domestic violence.

Additionally, we believe that government could do more to incentivise the use of evidenced approaches by making funding contingent upon the delivery of evidence-based models. For example, the Family First Prevention Services Act in the United States only funds parenting interventions that are listed on the Prevention Services Clearinghouse website.[45]

44 Van der Put et al., 2018; Chen & Chan, 2016

45 See https://www.childrensdefense.org/wp-content/uploads/2020/07/FFPSA-Guide.pdf

Conclusions

Using a Delphi approach to build consensus

Our primary aim in conducting this work was to build on our 2020 ACEs report and identify areas within research and practice where there is strong consensus, and agree practical next steps for taking the ACEs research forward. We were successful in this, engaging a representative group of policymakers, practitioners and researchers with strong expertise in supporting vulnerable children and families. Our study confirmed that our report was both well received by the majority of these experts and increased their understanding of the ACEs evidence and its current limitations. More specifically, this research also achieved its two primary objectives:

1. To understand the extent to which our experts agreed with the conclusions and recommendations in our 2020 ACEs report, and identify areas of agreement and disagreement.
2. To achieve consensus on a set of next steps for taking ACEs research, policy and practice forward that are well aligned with the best evidence.

Objective 1: understanding the views of the EIF report and identifying areas of agreement and disagreement

Participants strongly endorsed our report's key messages. All nine of the conclusions and recommendations were endorsed by at least 80% of the participants, with four endorsed by 90% or more. Enthusiasm was particularly high for recommendations calling for comprehensive public health measures aimed at preventing and reducing ACEs, as well as the need to consider the impact of structural inequalities on poor child outcomes.

However, our study also revealed strong differences of opinion concerning the usefulness of universal ACE screening practice, including routine enquiry. While some felt these activities were useful for initiating conversations with service users and encouraging them to seek treatment, others felt that asking these questions was unethical in the absence of validated measures and evaluated treatment protocols.

We believe that these debates have the potential to hamper progress in preventing and reducing ACEs and could result in ineffective and harmful practices being developed. While our work has identified many areas of agreement, it is clear that more work is needed to build consensus in some areas.

Objective 2: achieving consensus on next steps for ACEs' research, policy and practice

We convened a group of diverse experts who reached a high level of consensus on many of the themes in our report, as well as several new areas involving national guidance and practice. The level of consensus we achieved was high in comparison to other Delphi exercises, especially given that we recruited such a diverse group of participants. In the end, this group achieved consensus on 42 suggestions for taking the ACEs evidence forward. In this report, we have identified 12 statements where consensus was reached which are also consistent with the current best evidence.

The way forward

There is no question that adverse childhood experiences represent a significant threat to children's development. In this study, we have gathered the views of individuals with expertise in childhood adversity and have reached agreement on some next steps for preventing maltreatment and better supporting those who experience it.

At EIF we are committed to using the best available evidence to help achieve better outcomes for children and families, and we will continue to work with central and local government to make sure that evidence is used in the most appropriate way. This will include continuing to raise our concerns about the use of ACE screening for identifying children at risk, and seeking ways to generate much-needed evidence on the impacts of trauma-informed care.

However, we know our efforts will not be sufficient to prevent childhood adversity. The causes of child maltreatment are complex and multi-faceted and so are the solutions. Tackling this endemic problem needs a coordinated and dedicated long-term programme of activity between central and local government. The next steps identified in this report would, in our view, represent an ambitious and comprehensive approach to preventing childhood adversity and supporting those who have experienced it. We therefore call on government, and in particular the Department for Education, the Department of Health and Social Care and the Ministry of Housing and Communities to work together with local government to take forward these steps and deliver a lasting improvement for the country's most vulnerable children.

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