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# Addressing Adversity

## Prioritising adversity and trauma-informed care for children and young people in England

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# 18. Enquiring about childhood adversity and trauma

**Dr Warren Larkin** and **Dr Graham Simpson-Adkins**

## 1. The Impact of Experiencing Adversity and Trauma in Childhood

There is now a vast and compelling body of research demonstrating the link between experiences of childhood adversity and trauma and the development of detrimental health and social outcomes later in life. Research on Adverse Childhood Experiences (ACEs) over the last two decades has accelerated and has led to important developments in our understanding of these links[1]. ACEs refer to some of the most commonly occurring, toxically stressful experiences that take place during the first 18 years of life. These experiences include multiple forms of abuse and neglect, as well as various household adversities, such as witnessing violence between parents or caregivers.

There have been a number of large scale population based studies that collectively provide powerful evidence confirming that ACEs are causally and proportionately linked to poor physical, emotional and mental health outcomes. Put simply, the more ACEs an individual experiences, the worse their outcomes. Recent UK regional and national ACEs studies[2] revealed that around 50% of the UK population experience at least 1ACE, with around 12% experiencing 4or more. Greater numbers of ACEs are associated with dramatically increased risk of poor educational and employment outcomes, low mental wellbeing and life satisfaction, alongside the development of some of the leading causes of disease and death.

Furthermore, abuse, trauma and other adverse experiences have been found to often co-occur. For instance, if a person experiences one type of abuse or adversity, they are 87% more likely to experience other types of abuse and adversity; the more types of abuse and adversity a person experiences, the higher the risk of harmful health and social outcomes later in life[3].

These findings indicate a public health imperative to prevent and respond more appropriately to experiences of adversity in our society. Health and social care services have an opportunity at the point of initial contact to routinely ask service-users about childhood adversity and trauma. The *Future in Mind* report[4] outlined the impact of experiencing or witnessing adversity and trauma and set out a specific recommendation for the development of routine enquiry procedures as a means of responding to these concerns. Furthermore, the *Tackling Child Sexual Exploitation* report[5], which set out how the Government is dealing with child sexual exploitation in the UK, signalled a commitment from government to introduce routine enquiry. The introduction of such procedures would enable services to offer, and the public to access, more targeted support and would aim to prevent the continuation of abuse and adversity in future generations.

## 2. Why are services not already asking?

Research and practice have both demonstrated a number of barriers to hearing disclosures of childhood adversity and trauma. For instance, survivors of such experiences can often be reluctant to disclose voluntarily[6], due in part to feelings of shame, guilt and anxiety about their experiences and the act or consequences of disclosure[7]. However, survivors have suggested that these issues can either be exacerbated or alleviated by the responses of the person listening to their disclosure[8].

Furthermore, health and social care practitioners have described an unwillingness or discomfort with the idea of having to ask people about childhood adversity and trauma[9]. Young and colleagues[10] identified professional anxiety as a major cause of such reluctance, particularly due to a perceived risk of upsetting the service-user, fears of the process being upsetting for them as professionals and concerns related to the development of false memories. Consequently, both service-users and professionals have described a need for professionals to be trained to ask routinely; helping professionals to feel more confident to ask, in order to support service-users to feel more comfortable to talk about their experiences.

## 3. What do we know about impact of disclosures?

Research has regularly shown that, although people rarely disclose voluntarily, people often expect to be asked about these experiences by health and social care practitioners. Furthermore, disclosure can have the opposite effect to

what professionals often think: it can actually reduce distress. Disclosures can positively impact recovery, promote resilience and improve a person's perceptions of themselves[11]. However, delaying a disclosure or never having the opportunity to make a disclosure is associated with more negative outcomes.

Evidence suggests that, if people are not asked directly, it can take between nine to 16 years for an adult to disclose a history of abuse or adversity[12]. We have received practice examples where a service-user has accessed a service intermittently for many years, but when a professional invited that person to discuss whether they had experienced childhood adversity or trauma, the service-user disclosed a number of adverse experiences, which had not been previously known to the service. When professionals asked people why they had never disclosed this information before, the reply was often, "you never asked".

Asking enables people to move on from their current situation. This conversation can support people to understand the impact of their experiences in the context of their current circumstances, helping them to find new solutions. People begin to create meaning through telling their story, which can help them to make sense of the experiences with that professional. This empowering experience can be a catalyst for meaningful change. Making links between their past adversity and present difficulties can facilitate a greater potential for self-compassion and helps people re-frame their current situation as an understandable reaction to extremely challenging circumstances.



## 4. Recognising a need to change

As outlined, experiencing adversity and trauma early in life increases one's risk of developing negative health and social outcomes, including poor mental health and wellbeing. Consequently, the Government, in response to a recognition of such high prevalence, have called for services to do more to routinely identify and provide support for those who experience early life adversity, so that health and social care service providers can offer appropriate interventions to support positive recovery.

To support this need, the Routine Enquiry about Adversity in Childhood (REACh) model was developed.





### a. Development of REACh

In 2013, Dr Warren Larkin and a small team from Lancashire developed the REACh model; a training programme designed to develop the skills and confidence of professionals to routinely ask about childhood adversity and trauma. This programme was developed to offer a clear practical framework for change and to support professionals to feel confident enough to routinely ask service-users about early adverse life experiences.

The REACh approach began when the lead author used the ACE literature as a compelling case for the introduction of routine enquiry about abuse and traumatic experience within a first episode psychosis (FEP) service. As a result of positive engagement and support at team development sessions it was agreed that routine enquiry should be introduced within the service, given the excess of abuse and trauma reported by people with psychosis[13]. Almost 100 practitioners in the FEP service were trained and this experience provided valuable insight into the essential ingredients required to implement and embed routine enquiry.

Funding was secured from a range of sources between 2013 and 2015, and partnerships with local authority, public health, charitable and voluntary sector organisations were formed. REACh was successfully implemented across a range of services, including health visiting, substance misuse, domestic abuse, young people's services, early help and family intervention and prevention. These organisations are still routinely enquiring three years post training. Partners report that this approach has enabled organisational and cultural change as well as improved engagement and outcomes for service-users. Services are better able to provide targeted support for people, resulting in improved outcomes for services and service-users.

### b. The REACh model

REACh aims to raise awareness among professionals and the public about long-term outcomes of childhood adversity and trauma. This is achieved by establishing and supporting organisational practice and culture change by embedding REACh within every appropriate assessment.

REACh involves, as part of the model of delivery, one or 2-day training on why, when and how to enquire safely and sensitively, alongside organisational support, helping teams to navigate potential risks and challenges and to ensure

appropriate staff support is in place. The model has five key elements.

- **Stage 1** is a co-produced audit and evaluation of an organisation's readiness to engage in routine enquiry. This helps to identify any potential systemic barriers and supports organisational buy-in.
- **Stage 2** involves consideration of change management processes and a review or design of an organisation's specific systems and processes required to support effective and safe enquiry.
- **Stage 3** is the delivery of REACh training, which is tailored to the organisations specific needs, in terms of content and delivery methods.
- **Stage 4–** the REACh team offer time-limited follow-up support to the organisation, including consultation and supervision for staff and leadership teams, to ensure effective implementation.
- **Stage 5–** the team support the organisation to evaluate the implementation of REACh, to assess practice change and the impact on their service and service-users.



Figure 1: The REACh Model






## c. The Evidence

In 2014, evaluation of the experiences and insights of staff trained in REACh revealed a number of positive impacts on professional practice and client outcomes[14]. For instance, REACh training inspired practitioners to develop a trauma-informed understanding of clients' experiences, resulting in clinical practice changes, which, in turn, facilitated more lasting change for clients. It was found that enquiries encouraged clients to make links between their past and their present situation, enabling them to accurately identify the right support for them, at the right time. The research findings also suggested that not all clients required, or wanted, referrals for psychological or other practical support in relation to their disclosure. In the majority of cases, therapeutic conversations with practitioners seemed to be sufficient to encourage meaningful change.

In 2015, an independent evaluation of the REACh programme[15] found that REACh training equips practitioners with the knowledge and tools to conduct routine enquiry effectively with the people they support. All practitioners who attended the training reported that it was useful, enjoyable and increased their knowledge and awareness of childhood adversity and trauma, including its widespread impacts. REACh was found to initiate earlier intervention, as a result of speedier disclosures. Importantly, practitioners reported no issues with implementing REACh in their practice and reported no increase in service need following the enquiries made. Participants and managers felt that they were able to create with the individual a more appropriate intervention plan if they have enquired about previous experiences, dealing with the root cause of presenting issues rather than the 'symptom'.

The most recent evaluation in 2016 qualitatively explored the impact of REACh on parents accessing an early help family support team[16]. Results demonstrated that all parents agreed to engage in enquiries. Although the process of disclosure was emotive, parents' post-disclosure reflections resulted in a process in which they re-evaluated their parental goals, roles and priorities. This re-evaluation appeared to initiate a drive to parent differently, propelled by their desire to give their child a better start in life. These results demonstrated that, without any post REACh intervention, parents appeared to engage in a self-determined process of post-disclosure behaviour change, alongside a number of positive impacts, such as increased mentalizing capacity[17] and experiences comparable to post-traumatic growth[18]. These impacts resulted in reports of improved relationships between parents and their children.

## d. Current projects

The *Tackling Child Sexual Exploitation* report[19], reported failings across the wider care system to respond to or protect children and young people from child sexual abuse (CSA) and Childhood Sexual Exploitation (CSE). As a response the Government made a commitment to introducing routine enquiry about such abuses in some targeted NHS commissioned services. Services such as Mental Health and Substance Misuse teams will be supported to routinely ask those over 14 years old who present to their services about their experiences of adversity. In 2016, as a result of the success of the REACh model, the Department of Health commissioned the REACh team to develop a method of improving the skills and confidence of services to routinely ask about CSA, nationally. The objective of this training package is to provide the materials, tools and evidence to enable the Department of Health, NHS England and Public Health England to progress wider roll-out of routine enquiry; a key deliverable in the *Tackling Child Sexual Exploitation* strategy.

The REACh team have utilised learning from their work to devise procedures and training for enquiring specifically about various forms of CSA, in the context of other childhood adversities, using the broader framework of ACEs. This has also involved adapting an approach initially designed to work with adults, to support sensitive enquiries with children and young people. This has provided evidence that the REACh model can be extended to enquiries about various forms of adversity and can support enquiry with children and young people. The Department of Health pilot will initially be trialled with professionals in targeted services, including children's mental health, sexual health and substance misuse services.

The team have also commenced work on a number of other pathfinder projects to further develop the REACh approach in various settings. For instance, REACh is currently being adapted and evaluated for use in GP practices. In collaboration with Blackburn with Darwen local authority Children in Our Care Virtual Head-Teacher, the team have also begun work on developing a trauma-sensitive school model and have also commenced work with a local safeguarding children board to devise trauma-informed procedures to support the missing from home pathway. The team have recently developed an online training module to improve awareness of childhood adversity and trauma-informed approaches. This online module has been developed by and is currently being utilised within Lancashire Care NHS Foundation Trust and will also form part of the resource package designed for the Department of Health project described above.







## 5. Next steps

Firstly, we hope to continue to improve community awareness about the impact of childhood adversity and trauma and to support the development of approaches to address this widespread public health issue. We hope that on-going research and evaluation of REACh will help to provide a better understanding of methods for harm reduction and broader prevention strategies in relation to experiences of childhood adversity and trauma. From the work we are currently doing, we also hope to identify and quantify the impact of practice change produced by REACh in terms of improved outcomes for services and service-users, alongside highlighting any resulting cost avoidance and service utilisation as result of implementing routine enquiry in standard practice. More broadly, the information collected from enquiries in the Department of Health pathfinder project and subsequent roll out will hopefully enable earlier identification of abuse and adversity at local and national level. Providing prevalence data for local commissioners and services should enable more appropriate service provision, earlier offers of meaningful, tailored support and support widespread cultural and practice change.

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"It is the experiences we find hardest to talk about in our society that have a lasting impact on the mental health and wellbeing of children and young people. Be it bereavement, domestic violence, caring for a parent, or sexual abuse, we must ensure that all services are better able to identify childhood adversity and help to resolve the trauma related to it."

Sarah Brennan OBE Chief Executive of YoungMinds

With 1 in 3 adult mental health conditions related directly to adverse childhood experiences, it is vital that we understand the impact that adversity and trauma can have on the mental health and wellbeing of young people, and how we can strengthen resilience and support recovery.

*Addressing Adversity* presents evidence, insight, direction and case studies for commissioners, providers and practitioners in order to stimulate further growth in adversity and trauma-informed care, and spark innovation and good practice across England.

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