Addressing Adversity

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

Edited by Dr Marc Bush

Foreword by Sarah Brennan OBE

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Foreword

Sarah Brennan OBE

> "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."

YoungMinds has compiled this collection to raise awareness about the impact of adversity and trauma on the mental health of children and young people.

1in3
diagnosed mental health conditions in adulthood are known to directly relate to adverse childhood experiences

We know that one in three adult mental health conditions relate directly to adverse childhood experiences, and that young people's mental health and wellbeing can be significantly compromised by adverse environments, and the experience of trauma.

Experience of adversity and trauma in childhood can significantly increase the risk of mental and physical ill health in adolescence and adulthood, and result in these young people dying earlier than their peers later in life.

Yet too often services become fixated on what they see as challenging or risky behaviour. These services can quickly stigmatise or criminalise young people's normal responses to adversity and trauma.

Uninformed services, interventions and professionals unnecessarily escalate young people's mental distress, put them off asking for, or engaging in, support,

and ultimately have a profound impact on their social, psychological and emotional development.

It is, therefore, 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.

In Addressing Adversity, we bring together contributions from leading academics, clinicians, commissioners and frontline professionals who all share a passion for ensuring that services and support for children and young people in England is both adversity and trauma-informed.

The papers present evidence, insight, direction and case studies for commissioners, providers and practitioners. We hope that this collection will stimulate further growth in adversity and trauma-informed care, and spark innovation and good practice across England.

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Sarah Brennan OBE
Chief Executive of YoungMinds

Authors and illustrators

Lord Victor Adebowale CBE is Chief Executive of the leading health and social care charity Turning Point. He is a Cross-bench Life Peer in the House of Lords, and a Visiting Professor and Chancellor at the University of Lincoln. Lord Adebowale is President of the International Association of Philosophy and Psychiatry, President of the Community Practitioners and Health Visitors Association, a commissioner for the UK Commission for Employment and Skills, sits on the National Quality Board and is the incoming Chair of Social Enterprise UK. He is an associate of the Cambridge University Judge Business School, and Birmingham University Centre for Health Service Management.

Dr Rebecca Adlington is a Clinical Psychologist and Manager of the Bereavement, Trauma and Crises Response Services at CHUMS. She has worked at CHUMS since 2014 as a clinician in the Trauma Service and the Emotional Wellbeing Service. Before this, she worked in adult Community Mental Health and Clinical Health Psychology settings in Bedfordshire. Rebecca completed her Doctorate in Clinical Psychology at the University of Hertfordshire in 2012, during which time she published several articles in the area of Problem Based Learning (PBL) and presented her thesis at the Paediatric Psychology Network UK Conference on the Narratives of Adolescents with Cystic Fibrosis. Rebecca completed a doctorate by research in 2009 looking at category-specificity in people with Alzheimer's Dementia.

Matilda Allen is a Public Health Consultant Trainee. She previously worked at the UCL Institute of Health Equity as a senior researcher where she wrote a number of publications relating to the social determinants of health and how to improve them.

Associate Professor Mario Alvarez-Jimenez is Head of e-health at Orygen, The National Centre of Excellence in Youth Mental Health. Associate Professor Alvarez-Jimenez leads a multidisciplinary team of 40 professionals focused on bringing about long-term psychosocial recovery in youth mental health through online social media-based interventions and new models of psychotherapy. Since 2010, Mario has attracted 24 competitive grants (12 as principal investigator), totalling $13.8 million in competitive research funding (over $5 million as principal investigator). In 2012, he was awarded the CR Roper Fellowship by the University of Melbourne, as well as the International Early Psychosis Association Young Investigator Award. In 2014, Mario was awarded the Rising Star Award by the Society for Mental Health Research.

Agnes Aynsley works within Addaction's Kent Young Person's drug and alcohol services as the Specialist Treatment Team Leader. She oversees one to one interventions with young people involved in substance use. Agnes has an additional specialism around wellbeing with a focus on nutrition and is the Child Sexual Exploitation (CSE) champion for the team.

Andy Bell is the Deputy Chief Executive at the Centre For Mental Health and recently won the President's Medal for outstanding services for all with mental health conditions from The Royal College of Psychiatrists. He is a member of the Mental Health Policy Group and was Chair of the Mental Health Alliance between 2006 and 2008. Andy has carried out research on the implementation of national mental health policies, on local mental health needs assessments and writes a regular blog on mental health policy for the Huffington Post.

Dr Sarah Bendall is a clinical psychologist and senior research fellow at Orygen: The National Centre of Excellence in Youth Mental Health, and the Centre for Youth Mental Health at the University of Melbourne, Australia. She has practiced as a clinical psychologist for over 20 years in a variety of settings including adult and adolescent outpatient mental health. She leads research into trauma in youth mental health and the development and trialing of new psychological therapies for recovery in youth mental health. She is the author of over 50 publications in these areas, including two psychological treatment manuals. She regularly trains mental health professionals in responding to trauma in early psychosis.

Dr Lucy Bowes is a Leverhulme Early Career Research Fellow at the Department of Experimental Psychology, University of Oxford. Lucy's research focuses on the impact of early life stress on psychological and behavioural development. In particular, Lucy has focused on the effects of victimisation on young people's adjustment and wellbeing. Her research integrates methods from social epidemiology, developmental psychology and behavioural genetics in order to understand the complex influences that promote resilience to victimisation and early life stress. The aim of her research is to guide interventions by identifying protective factors that promote positive outcomes among vulnerable children.

Rick Bradley is the Operations Manager of the Addaction Mind and Body programme which works with young people around self harming behaviours. He is a passionate advocate of early intervention support for young people, encouraging open discussion of issues before they become more problematic. Rick also leads Addaction's work around new psychoactive substances,

including so-called 'legal highs' and sits on the national clinical group that monitors these substances. He was part of the Education and Prevention sub group which informed the expert panel's advice to the UK Government on how to respond to New Psychoactive Substances trends, and also helped to develop the Home Office resource pack for educators.

Sarah Brennan OBE is the Chief Executive of YoungMinds and has worked with vulnerable young people and families for over 30 years. She has acted as an independent advisor on children and young people's mental health to successive governments, and recently served as co-Chair of the Vulnerable Group and Inequalities task group of Future in Mind. Sarah currently Chairs the London and South East CAMHS Collaborative, and serves the Mental Health Independent Advisory and Oversight Group, which oversees the implementation of NHS England's Five Year Forward View for Mental Health.

Lindsay Buchanan is the Addaction Mind and Body Coordinator for Cornwall's 'YZUP' addiction service. She is a qualified youth worker and sociologist with a keen interest in mental health issues and domestic abuse.

Naomi Burrows is the Team Leader at Young Addaction Lancashire. She is experienced in managing both substance misuse and mental health services, and currently oversees the therapeutic and pharmacological substance misuse team, local Mind and Body delivery and the CYP IAPT team. Naomi's work looks to reduce stigma associated with mental health conditions and aims to educate and empower people to look after their own wellbeing.

Dr Marc Bush is the Chief Policy Advisor at YoungMinds, and a Visiting Professor in Public Health at the University of Northampton. He has an extensive background in research, policy, and practice in the fields of disability, health, mental health, psychotraumatology, and childhood adversity. Marc is the editor of this collection, and authored YoungMinds' Beyond Adversity report.

Dr Carmen Chan is a clinical psychologist and Service Lead for Horizon, a specialist CAMHS team working alongside professionals to support young people and families affected by sexual harm. She is also a Visiting Tutor at the Oxford Institute of Clinical Psychology Training, University of Oxford. She has specialised in working with interpersonal trauma and PTSD across the lifespan and she has extensive experience training professionals in this area. Her areas of research includes PTSD, trauma, shame, self-criticism and children's experiences and disclosure of sexual abuse.

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Dr Sarah Clement (PhD CPsychol) is a research psychologist and health services researcher. She has worked as an academic researcher and lecturer since 1993, and is now freelance. Her research on trauma and on mental health is informed by her lived experiences.

Jan Cooper is a qualified counsellor specialising in bereavement work and currently sits on the advisory panel for the Childhood Bereavement Network and also co-chairs the Hertfordshire and Bedfordshire Bereavement Alliance. She volunteered for CHUMS for several years before joining the staff team in 2009, coordinating referrals for bereaved children and families in Bedfordshire. Jan managed the child bereavement service at CHUMS, and more recently has taken on the role of bereavement and neonatal specialist. Jan provides individual and family pre-bereavement and bereavement support and works with families where a baby has died. She regularly facilitates workshops and monthly ongoing groups for parents and carers, delivers training to local professionals and facilitates training and supervision for bereavement volunteers.

Betsy de Thierry (MA Psychotherapy and Counselling, B.Ed (hons)) has been a qualified teacher and psychotherapist for over 20 years, and founded the Trauma Recovery Centre (www.trc-uk.org) which has therapy centres and alternative education centres in four cities across the UK. She has authored Teaching the child on the trauma continuum (Grosvenor Publishing) and also The Simple Guide To Child Trauma, published by Jessica Kingsley. She founded the Therapeutic Mentoring Rooms which are within schools across the UK. She delivers training across the UK and is a consultant to many organisations, schools, Pupil Referral Units, virtual schools, therapy centres etc about the impact of trauma on a child.

Dr Angela Donkin is the Joint Deputy Director of The Institute of Health Equity (IHE), leading their programmes to improve and disseminate evidence, evaluate, monitor and provide strategic policy advice. Angela has worked in applied social research for 25 years and is an expert on early years, health inequalities, improving work and income for health, and sits on a number of advisory and steering groups in this capacity. Before joining IHE Angela was a civil servant in ONS, DWP and the Cabinet Office. Towards the end of her civil service career Angela managed the delivery of key government reports on Early Intervention and Health Work and Wellbeing and maintains research interests in sustainable international development and food and poverty.

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Beth Filson (BA, MFA) is a US-based nationally recognised writer and trainer in Trauma-Informed Approaches (TIA). She works with diverse groups to integrate TIA in policy and practice, and co-authored Engaging Women in Trauma-Informed Peer Support. She also contributes to the development of Intentional Peer Support and peer support alternatives to the psychiatric system. Her early experience of multiple hospitalisations informs her work.

Professor Peter Fonagy is a Professor of Contemporary Psychoanalysis and Developmental Science and Head of the Research Department of Clinical, Educational and Health Psychology at UCL, Chief Executive of the Anna Freud National Centre for Children and Families, London, Consultant to the Child and Family Program at the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine, Houston and holds visiting professorships at Yale and Harvard Medical Schools.

Steve Haines has been working in healthcare for over 25 years and as a bodyworker since 1998. Understanding the science of pain and trauma has transformed his approach to healing. He has studied Yoga, Shiatsu, Biodynamic Craniosacral Therapy and Trauma Releasing Exercises (TRE). He is a UK-registered chiropractor and teaches TRE and cranial work all over the world.

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Corinne Harvey is a public health consultant at PHE Yorkshire and the Humber, specialising in reducing health inequalities and improving health and wellbeing. She has experience of working across the health system in a variety of operational and strategic roles and continues to be a registered mental health nurse.

Dawn Hewitt worked as a manager in the NHS for 11 years, and is responsible for developing CHUMS' Child Bereavement Service as a countywide service. In 2009 she was instrumental in setting up the charity Friends of CHUMS to raise money to deliver a Trauma Service. Dawn led CHUMS through the Department of Health's Right to Request programme to become a social enterprise in 2011. As CEO of a social enterprise her focus changed from clinical delivery to business development. With support from a committed team the service grew rapidly and now receives approximately 3000 referrals annually. Dawn trained as a RGN (registered nurse) and later as a District Nurse. She has an MSc in Leadership, as well as qualifications in management, reflective practice, counselling and bereavement.

Dr Kristine Hickle is a Senior Lecturer in Social Work at the University of Sussex. She received her PhD from Arizona State University in the United States, where she was a practicing clinical social worker. Her social work practice was primarily in the voluntary sector, working with sexually exploited young people and adults through the use of trauma-focused group interventions. Her research interests include child sexual exploitation and sex trafficking, developing and testing interventions that reduce trauma symptoms among victims of exploitation and trafficking, group-work and group-based interventions. She has written extensively about the experiences of adults and young people affected by sexual violence and trauma.

Dr Nick Hindley is clinical lead for the Thames Valley Young People's Forensic Service, part of the Oxford Health NHS FT CAMHS provision, and specialises in working with young people about whom there are concerns about risk of harm to others or who have particularly complex needs. The service includes the forensic CAMHS Thames Valley-wide, the Child and Adolescent Harmful Behaviour Service (CAHBS) which covers Oxon and Bucks, the Young People's Liaison and Diversion Service for Oxon and the HORIZON Team which works with young people who have experienced sexual abuse in Oxfordshire. Dr Hindley is involved locally and nationally in the development of support for, and meeting the needs of, high risk young people and those with complex needs. He has experience of working in a number of custodial, secure and community settings, and is the NHS England clinical lead for the national implementation of community forensic CAMHS.

Dr Russell Hurn is a Consultant Counselling Psychologist and Clinical Director. Russell spent 11 years working for CAMHS in Hertfordshire before leaving the NHS to join the Traumatic Bereavement Service at CHUMS. He is the former Chair of the Child and Adolescent Section of EMDR UK and Ireland. Russell has specialised in the treatment of trauma since 2005. His recent roles have been to act as Clinical lead for the implementation of the CYP IAPT programme within the service and form closer working links with the local CAMHS teams. Russell has also been developing the trauma service over the last couple of years to widen its focus to the treatment of children and young people presenting with non-bereavement trauma.

Professor Henry Jackson is Emeritus Professor in the Melbourne School of Psychological Sciences at the University of Melbourne. Henry's research expertise is in clinical psychology with regards to youth mental health and severe mental illness, especially in the fields of early psychosis and personality disorders. He has authored or co-authored 203 papers in refereed journals,

20 book chapters and co-edited three books. Henry is a clinical psychologist who worked as a full-time public practice clinician for 13 years before entering academia in 1991. From 2005–2007 Henry served as Head of the School of Behavioural Science (now renamed Psychological Sciences). In 2009, Henry was made a Fellow of the Academy of Social Sciences in Australia.

Dr Angela Kennedy (DClinPsych) is a clinical psychologist who has worked in the NHS since 1990. She is a trauma therapist and board member of the European Society for Trauma and Dissociation. Her focus is applying clinical knowledge towards system-wide change, including compassion focused cultures and leadership.

Professor Eóin Killackey is Head, Functional Recovery Research in Youth Mental Health at Orygen, The National Centre of Excellence in Youth Mental Health and the Centre for Youth Mental Health at The University of Melbourne. He completed his doctorate at Deakin University in 2000. He has worked as a clinical psychologist in adolescent and adult public mental health settings. His research interests are functional recovery for young people with mental illness, evidence-based interventions in mental health and barriers to their implementation.

Dr Pooky Knightsmith is the Director of the Children, Young People and Schools Programme at the Charlie Waller Memorial Trust. She is also the Vice Chair of the Children and Young People's Coalition.

Almudena Lara joined the NSPCC in February 2017 as the Head of Policy and Public Affairs. Prior to this, she worked at the Department for Education where she held a variety of roles, including leading the social work reform agenda, setting up the Innovation Programme and leading the children in care portfolio. Before joining the Department, Almudena worked at the Cabinet Office and at the Prime Minister's Strategy Unit leading the social investment and social action agenda. Almudena started her career as an economic consultant at Frontier Economics, where she worked for eight years.

Dr Warren Larkin is a Consultant Clinical Psychologist and Visiting Professor at Sunderland University. He is also the Clinical Lead for the Department of Health Adverse Childhood Experiences programme and a Director at Warren Larkin Associates Ltd. He has a long-standing interest in the relationships between childhood adversity and outcomes later in life. He has spent most of his career working in specialist early intervention services with service users who are experiencing psychosis. He has published numerous research articles

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on the topic of trauma and psychosis and published an edited book with Tony Morrison in 2006 (now commissioned for a second edition) exploring this theme. Warren led one of the two national IAPT (Increasing Access to Psychological Therapies) demonstration sites for Psychosis and was a member of the Children and Young People's Mental Health Services National Task Force. Warren also developed the REACh approach (Routine Enquiry about Adversity in Childhood) as a way of assisting organisations to become more trauma-informed and to support professionals to ask routinely about adversity in their everyday practice.

Georgie Lowry is a graphic designer working in the north of England. A background in mathematics and statistics combined with a natural creative flair led her to set up GS Lowry Design in 2012. She now works almost exclusively in non-profit and education sectors, fulfilling infographic and editorial design needs for many national charities and organisations.

Rob McCabe is the strategic lead for the Birmingham SEMH Pathfinder. His experience includes 16 years as a senior education social worker and manager in the Criminal Justice System, based in Birmingham. Rob has extensive frontline and strategic social work experience and has built up specialist knowledge of young people and families with multiple complex needs. He also has substantial experience of multi-agency working with the many professionals and agencies involved in such complex cases. Rob has undertaken research and development work for Birmingham Local Authority to understand the profile and systemic processes of multiple and complex needs cohorts in Birmingham. He is also working with the West Midlands Combined Authority to inform the complex needs strand of Public Services Reforms.

Lisa McCrindle was Policy Manager at the NSPCC before joining the Centre of Expertise for child Sexual Abuse in the summer of 2017. She is an experienced public policy manager, researcher and evaluator with over 14 years' experience working in public policy across the children and young people's agenda. Lisa's career has focused on the issues affecting, and the provision of services and support to, women, families, children and young people. She has a particular focus on those from disadvantaged and vulnerable groups.

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Rosie Powell-Davies began her career at the NSPCC as a Charityworks fellow in September 2016. Since completing the 12-month programme she has continued to work in the Policy and Public Affairs team as the Policy and Public Affairs Assistant. Prior to this, Rosie was studying at the University of Oxford for undergraduate and postgraduate qualifications.

Jo Prestidge is a project manager at Homeless Link, the national membership body for the single homelessness and supported housing sectors in England. She works on a portfolio of projects to bring innovation and improve practice across the homelessness sector. Before joining Homeless Link, Jo worked in frontline homelessness services for several years, mostly with street homeless people with multiple and complex needs. In 2014 Jo participated in a transatlantic practice exchange and spent time in the US learning about trauma-informed practices. Having learned about trauma and the principles of trauma-informed care, Jo was quickly able to change her own practice and see an impact with the people she supported. Since then Jo has become a strong advocate for the approach, developing and delivering training and speaking at a number of events.

Kathryn Pugh MBE works at NHS England as the Deputy Head of Mental Health, and leads the Children and Young People's Mental Health Programme which contributes to NHS England's implementation of Future in Mind and the Five Year Forward View for Mental Health. Past roles include work in primary care, commissioning primary, secondary and specialist care in both acute and mental health and a role as Head of Policy and Innovation at YoungMinds. She led the programmes to implement the children and young people's amendments to the Mental Health Act, and to improve transition for the National CAMHS Support Service and National Mental Health Development Unit, as well as the development of the CYP IAPT programme.

Claire Robson is an experienced public health specialist in Public Health England's national Health Improvement Directorate. Claire's experience spans local health improvement delivery, national and regional programme management, policy development and organisational design gained from working in a variety of roles across the NHS, the private sector and in regional and national government.

Katharine Sacks-Jones is the inaugural Director of Agenda, the lliance forwomen and girls at risk. She has 15 years' experience working across policy, campaigns, public affairs and parliament. She is an expert in social policy and has a track record of influencing the policy, political and media agendas and

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bringing about policy change for marginalised groups including securing new primary legislation to protect private tenants whose landlords are repossessed; funding for homelessness services and programmes and the prevention of specific benefit cuts. Before joining Agenda, Katharine led the Policy and Campaign team at Crisis. She has written extensively on issues around social exclusion including for the Guardian, Telegraph and New Statesman.

Lucas Shelemy is a PhD Researcher at the University of Reading, specialising in child and adolescent mental health.

Dr Graham Simpson-Adkins is a clinical psychologist in a specialist community learning disability team in Mersey Care NHS Foundation Trust. Graham previously acted as the subject area expert in Adverse Childhood Experiences for Lancashire Care NHS Foundation Trust and project development lead and co-developer of the Department of Health's national programme to implement Routine Enquiry about Adverse Childhood Experiences, Sexual Abuse and Sexual Exploitation – an approach designed to assist organisations across the UK to become more trauma-informed and to support professionals to ask routinely about adversity in their everyday practice. Graham has published articles and research on the topic of trauma, mental health and clinical practice approaches and has a long-standing interest in the impact of trauma and adversity.

Sophie Standing is a London-based illustrator. Her interest in human anatomy often inspires her work, including the popular comics Trauma is Really Strange and Pain is Really Strange.

Dr Angela Sweeney (MA Hons (Cantab) PhD) is a trauma survivor and researcher. She's worked in mental health research since 2001 on a variety of predominantly health services research studies. She has a particular interest in perinatal mental health and trauma-informed approaches. Her current research is aimed at understanding and improving assessment processes for talking therapies.

Matthew Todd was editor of the UK's best selling gay magazine, Attitude, from 2008-2016 where he was the recipient of 3British Society of Magazine Editor Awards and the Stonewall Journalist of the Year Award 2011. His play, Blowing Whistles, has played in London, Australia and America. His first book, Straight Jacket: How to be gay and happy, was published by Bantam Press in June 2016 and has been described by readers as "game changing and life changing", as "utterly brilliant" by Owen Jones in The Guardian and as "an essential read for every gay person on the planet" by Sir Elton John.

Sanjana Verghese is a student at King's College London, and was a Policy and Parliamentary Engagement Intern at YoungMinds in 2017. Her interests include public health, the environment and policy development.

Clare Wightman is Chief Executive of Grapevine Coventry and Warwickshire. She is an Associate of Lankelly Chase Foundation, advising and coaching on systems change within the Pathfinder. She co-leads Ignite, a system change programme in Coventry, and Causes not Consequences, a social movement-inspired community for change in local public services.

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Abbreviations

Wherever possible the contributors to this collection have avoided using abbreviations. There are some papers where the use of abbreviations makes the content easier to read. We have included a short list of the most frequently used here, so the reader has a place to refer back to if they need clarity.

ACEs	Adverse Childhood Experiences
ASD	Acute Stress Disorder
BAME	Black and Minority Ethnic (sometimes expressed as Black, Asian or Arab and Minority Ethnic)
BESD	Behavioural, emotional and social difficulties – recently renamed 'social, emotional and mental health difficulties'
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Groups
CSE	Child Sexual Exploitation
DSM – 5	Diagnostic and Statistical Manual of Mental Disorders (fifth edition)
DTD	Developmental Trauma Disorder
EHCP	Education, Health and Care Plan
ICD 10	International Classification of Diseases (10th revision)
LGBT+	Lesbian, Gay, Bisexual and Transgender and the wider queer, questioning, non-binary and intersex communities
LTPs	Local Transformation Plans
MHPs	Mental Health Professionals
NHS	National Health Service (in England)
PTSD	Post Traumatic Stress Disorder
SDH	Social Determinants of Health
SEND	Special Educational Needs and Disability
STPs	Sustainability and Transformation Plans
TIC	Trauma-Informed Care (also used to refer to adversity and trauma-informed care)

Addressing childhood adversity and trauma

WHAT IS ADVERSITY?

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence

It can be a single event, or prolonged threats to, and breaches of, a young person's safety, security, trust or bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation.

Adaptations are children and young people's attempts to:

Survive in their immediate environment

Find ways of mitigating or tolerating the adversity by using available resources

Establish a sense of safety or control

Make sense of the experiences they have had

WHAT KINDS OF EXPERIENCES ARE ADVERSE?

Forms of ACEs include:

Maltreatment
i.e. abuse or neglect

Violence & coercion
i.e. domestic abuse, gang membership, being a victim of crime

Adjustment
i.e. migration, asylum or ending relationships

Prejudice
i.e. LGBT+ prejudice, sexism, racism or disablism

Household or family adversity
i.e. substances misuse, intergenerational trauma destitution, or deprivation

Inhumane treatment
i.e. torture, forced imprisonment or institutionalisation

Adult responsibilities
i.e. being a young carer or involvement in child labour

Bereavement & survivorship
i.e.traumatic deaths, surviving an illness or accident

HOW COMMON ARE ACES?

Around half of all adults

living in England have experienced at least one
form of adversity in their childhood or adolescence

Of all children and young people:

52% experienced 0 ACEs
23% experienced 1 ACE
16% experienced 2-3 ACEs
9% experienced 4+ ACEs

HOW DOES IT IMPACT THE LIVES OF YOUNG PEOPLE?

ACEs impact a child's development, their relationships with others,
and increase the risk of engaging in health-harming behaviours, and
experiencing poorer mental and physical health outcomes in adulthood.

Compared with people with no ACEs, those with 4+ ACEs are:

2x more likely to binge drink and have a poor diet

3x more likely to be a current smoker

4x more likely to have low levels of mental wellbeing & life satisfaction

5x more likely to have had underage sex

6x more likely to have an unplanned teenage pregnancy

7x more likely to have been involved in violence

11x more likely to have used illicit drugs

11x more likely to have been incarcerated

WHAT PROTECTS YOUNG PEOPLE FROM ACES?

Not all young people who face childhood adversity or trauma go on to develop a mental health problem.

There are personal, structural and environmental factors that can protect against adverse outcomes, as shown in the protection wheel opposite.

Positive and supportive family environments

Trauma-informed policies & systems that address bullying, harassment or victimisation

Safe and mutual relationships with peers

Early intervention from support, therapeutic or safeguarding services

Access to a wider supportive and understanding community

Compassionate, attuned and supportive responses from professionals

Aquisition of practical problem-solving skills

Ability to regulate emotions and manage emotional distress

WHAT CAN WE DO ABOUT IT?

Commissioners can address childhood adversity and trauma by:

Making childhood adversity and trauma a local commissioning priority — **1**

Creating a common identification and enquiry framework for identifying need — **2**

Investing in adversity and trauma-informed models of care — **3**

Adversity and trauma-informed models of commissioning and care are always:

Prepared

ensures addressing ACEs is a strategic priority, analyses the available data and anticipates need in local commissioning and service pathways.

"When you notice, or I tell you that I need help, you should already know what the next step is"

Aware

understands childhood adversity and trauma, has a common framework for identification and routine enquiry, and responds appropriately to the cultural and personal characterises of the young person and their communities.

"Recognise all of my needs"

"Don't label me with the experiences I've had"

"Understand my behaviour"

Flexible

provides services that young people can easily access, does not rely on a formal psychiatric diagnosis, and targets children who live in adverse and traumatic environments.

Safe and responsible

intervenes early, avoids re-traumatising or stigmatising young people, and ensures staff are knowledgable, qualified, trustworthy and well-trained.

Collaborative and enhancing

involves young people in decisions about their care and the design of services, adopts a strengths-based approach, and ensures services recognise and harness community assets.

Integrated

co-commissions services, and ensures smooth transitions and communications between partners.

"Shape your support around me"

"Find a way that we can both understand each other"

"The way you treat me matters"

"Know where I'm coming from"

"Keep me safe and don't betray my trust"

"Include me in decisions about my life"

"I want to talk to someone who has been through the same thing"

"I've survived this long"

"Don't pass me from person to person"

"Stop asking me to repeat myself"

WHERE IS THE EMERGING GOOD PRACTICE?

- Enquiring about childhood adversity and trauma **(Lancashire)**
- Family-based interventions from an ACE perspective **(Birmingham)**
- Specialist and liaison services **(Oxfordshire)**
- Youth-led approaches to tackling adversity **(London)**
- Embedding a trauma-informed approach in the community and voluntary sector **(Sussex and Surrey)**
- Education and alternative approaches **(Bath)**
- Trauma-informed approaches in substance misuse **(Cornwall)**

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Sources:

Bellis MA, Hughes K, Leckenby N, Perkins C and Lowey H. (2014) 'National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England' BMC Medicine 2:72.

Hughes, K., Lowey, H., Quigg, Z. and Bellis, M. A. (2016) 'Relationships between adverse childhood experiences and adult mental well-being: results from an English national household survey' BMC Public Health 16:222.

You can read the full text of these articles in the Annexes of this collection, republished with the permission of BioMed Central.

1. Childhood adversity and trauma: an introduction

Dr Marc Bush

1. Introduction

Addressing Adversity aims to raise awareness about the impact of childhood adversity and trauma on the mental health of children and young people in England. It contains papers from leading academics, clinicians, commissioners and frontline professionals who all share a passion for ensuring that services and support for children and young people are adversity and trauma-informed.

In this introductory paper, we have provided an introduction to childhood adversity and trauma, drawn out some of the key debates and focused on the impacts it has on the lifelong health outcomes of children and young people in England. This introduction builds upon the *Beyond Adversity* report[1] published by YoungMinds in 2016.

→ **Navigation boxes**

We have included navigation boxes so the reader knows where in the collection they can go for further detail and examples of good practice – just look out for this symbol.

2. Childhood adversity

We all face emotionally challenging situations during our childhood and adolescence. It is a normal part of growing up, and this emotional distress can come from moving to a new area, feeling stressed revising for exams, falling out with friends or forming and experimenting with our identities and sexualities.

That said, many children and young people grow up in environments, or have experiences, that are more than emotionally distressing or difficult. These environments and experiences are adverse, and have a potentially traumatic and long-lasting impact on our development, health and way of life.

Adverse Childhood Experiences (ACEs) are more common than you might think.

> Almost half of all adults living in England have experienced at least one form of adversity in their childhood or adolescence[2].

This broadly reflects the picture of childhood adversity in other developed countries[3]. These adversities can include experiences of neglect, abuse and/or violence within the home or local community, the unexpected loss of a caregiver or a sibling and taking on adult responsibilities[4].

These ACEs are exacerbated by wider social conditions and circumstances that create inequalities in the ways that children and young people live, and are treated by those around them[5]. These inequalities include levels of material deprivation or child poverty[6] and institutional prejudice in state and support services.

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For more on:

- the Social Determinants of Health see Paper 3.
- institutional prejudice see Papers 14 and 15.

The term Adverse Childhood Experiences was popularised through US studies exploring the impact of adversity on people's health and behaviours across the lifecourse[7]. Since the original study, researchers have used various definitions[8] and measurement frameworks[9] to describe what an ACEs is, and the impact it can have on young people's mental health, behaviours and wellbeing.

Inevitably, the papers in this collection draw on varying traditions and definitions of childhood adversity. By way of bringing together all of these important contributions, YoungMinds builds on Dr Katie McLaughlin's proposed definition[10] and recent developments that aim to expand the more restrictive conventional definition[11].

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. It can be single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation.

Adaptations represent children and young people's attempts to: survive in their immediate environment (including family, peer group, schools and local community), finding ways of mitigating or tolerating the adversity by using the environmental, social and psychological resources available to them, establishing a sense of safety or control, making sense of the experiences they have had, the community or family that they are growing up in and the identity they are forming.

To make this definition more tangible, we have listed below different experiences that constitute childhood adversity under this definition. These examples draw on the feedback YoungMinds received from the publication of Beyond Adversity, and the clinical summit we held in the Winter of 2017.

Examples of Adverse Childhood Experiences (ACEs)

Maltreatment: including physical, sexual, emotional and financial abuse and neglect.

Violence and coercion: including experiencing, or directly witnessing, domestic abuse, assault, harassment or violence, sexual exploitation, sexually harmful behaviour, being the victim of crime or terrorism, experience of armed conflict, gang or cult membership and bullying.

Inhumane treatment: including torture, forcible imprisonment, confinement or institutionalisation or confinement, non-consensual and coercive scarification and genital mutilation.

Prejudice: discrimination, victimisation, hate incidents and crime, other attitudes, chronic exposure to behaviours and institutional processes driven by LGBT+ prejudice, sexism, racism or disablism.

Household or family adversity: including living in a household with adults or adolescents who misuse substances, engage in criminal activities, are not supported to manage their mental ill health, making sense of intergenerational trauma (such as experiences of genocide). It also includes living in poverty, destitution or facing significant social, material and emotional deprivation. It also include being looked-after, leaving care, being detained in a secure children's service (i.e. young offenders institution) and family or placement breakdown.

Adjustment: including moving to a new area where there are no social bonds, migrating, seeking and gaining refuge or asylum and the ending of a socially significant, or emotionally important relationship.

Adult responsibilities: including being the primary carer of adults or siblings in the family, taking on financial responsibility for adults in the household and engaging in child labour.

Bereavement and survivorship: including death of care giver or sibling (including through suicide or homicide), miscarriage, acquiring or surviving an illness or injury and surviving a natural disaster, terrorism or accident.

→ Sections 2 and 3 of this collection consider the specific mental health needs arising from many of these forms of adversity.

In reality there is significant overlap in children's experiences of these adversities. One study from England shows 16% of adults experience two or three ACEs, and almost one in 10 experience four or more[12]. This means that many children experience the **cumulative impact**[13] from different forms of ACEs on their health and wellbeing outcomes in adolescence and adulthood[14].

Illustrating this, a recent report of the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*[15] found that the "circumstances that lead to suicide in young people often appear to follow a pattern of cumulative risk". The cumulative risk pattern involves a) traumatic experiences in early life, b) a build up of adversity and high risk behaviours (as a response) in adolescence and early adulthood, and an adverse event (which may be seemingly insignificant, but hold significance and importance for the young person) precipitating the suicidal behaviour.

When children and young people are exposed to these adversities across their childhood and/or adolescence we can think of it as being developmental – in that it will have an impact on the ways in which the young person grows up, experiences their environment, explores their identity, and not to mention the delays and alterations it can cause in the way that they think and behave.

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→ For more statistics about ACEs in England see Paper 2.

3. The impact of childhood adversity

A major US study[16] uncovered a strong relationship between ACEs and risk factors for ill health and poor wellbeing. Research in England[17], Wales[18] and Scotland[19] replicated these findings and suggest that ACEs are strongly associated with adverse behavioural, health and social outcomes in childhood, adolescence, adulthood and later life.

All these studies were based on an evidence-based, conceptual framework for thinking about the impact of ACEs on a child over the course of their life[20]. This model demonstrates that there is a progression of outcomes. Below is an adapted version of the ACEs framework, which we developed from our Beyond Adversity report[21].

Figure 1: ACEs Framework

Conception

Experience of adversity and trauma

Disrupted neurodevelopment

Aquiring / exhibiting social, emotional and cognitive problems

Adoption of risky and challenging behaviours

Increased morbidity*

Premature mortality**

* living with physical and / or mental ill health

** dying earlier than would otherwise be expected

Death
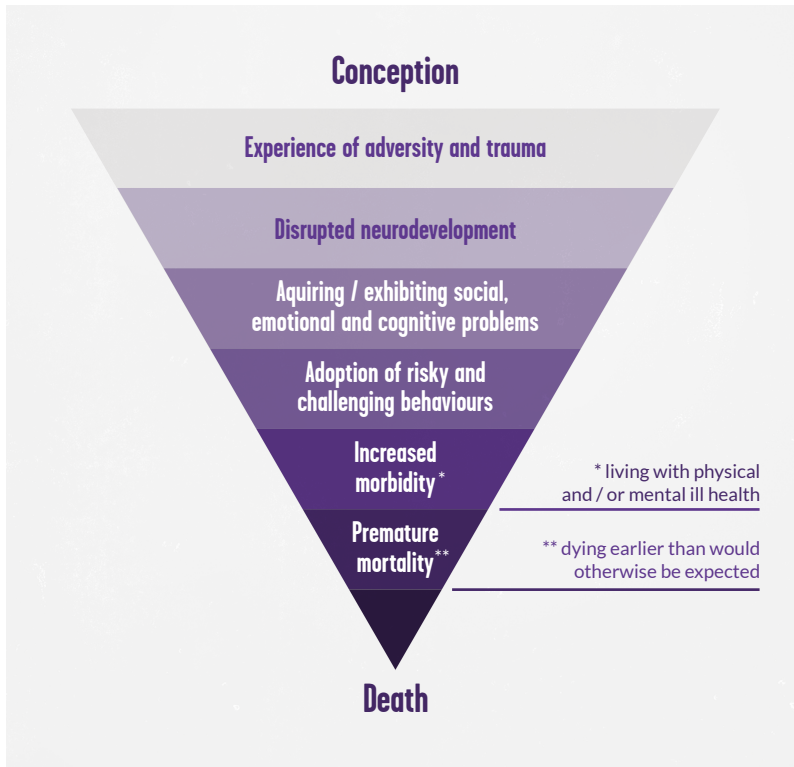
Source: adapted from the CDC-Kaiser ACE Study [1998]

Research has clearly shown that experiencing adversity in childhood has a substantive impact across the lifecourse[22]. These experiences increase the risk of poorer physical[23] and mental health outcomes in adulthood[24].

Furthermore, ACEs also result in higher rates of avoidable death[25] from natural causes [26], including from the leading causes of early adult deaths (such as heart disease, respiratory disease and cancer)[27]. Women who had experienced one adversity had a 66% increased risk of premature death, and those who had experienced two or more adversities had a 80% increased risk compared to their peers. In contrast, men who had faced two or more adversities in childhood have a 57% increased risk of early death[28] compared to their peers.

Additionally, ACEs are associated with a significantly higher risk of suicidality in adolescence[29], adulthood[30] and later life[31]. Sadly, these young people are also more likely to die from non-natural causes[32] than would otherwise be expected[33].

→ For more on the impact of childhood adversity across the lifecourse see 2, 3, 9 and 10.

4. Childhood adversity and mental ill health

Around one in 10 children and young people have a diagnosable mental health condition[34]. Many young people do not have a clinical diagnosis, but experience a period of mental ill health or emotional distress during their childhood or adolescence. The Government's own measures of children's wellbeing found that almost one in four showed some evidence of mental ill health (including anxiety and depression)[35].

It has been suggested that over the last decade there has been an increase in the number of children who are presenting with mental ill health[36], and whose needs are being identified by professionals[37]. It is hard, however, to say for certain whether or not the actual number of children experiencing mental ill health is increasing, or whether there has been an increase in identification and diagnosis.

It is vital that we identify adversities that children and young people face as early as possible to ensure we can mitigate the impact of this additional complexity and prevent further escalation of emotional distress and mental ill health. The majority of enduring mental health problems manifest in teenage and young adulthood, and it is estimated that half of all mental health problems manifest before the age of 14 years, with one in four enduring mental health conditions being present by the age of 24 years[38].

Research suggests that **at least one in three diagnosed mental health conditions in adulthood are known to directly relate to adverse childhood experiences** that have subsequently impacted on their psychological development and wellbeing[39]. Furthermore, childhood adversity is accompanied by lower levels of mental wellbeing and life satisfaction in

adolescence and adulthood[40], as well as an increased risk of enduring mental health problems (including experiencing psychosis)[41]. Subsequently, children who have faced adversity are more likely to use psychiatric medicines that have an additional adverse impact on their physical health in the longer term[42].

1in3

diagnosed mental health conditions in adulthood are known to directly relate to adverse childhood experiences

By way of illustration, we can clearly see increased emotional distress and mental ill health among children and young people who have faced one or more of the forms of adversity described previously.

Examples of the mental health consequences of ACEs

Bereavement: over three in 100 young people experience the death of a parent, primary care giver (such as a carer or grandparent) or sibling[43] before the age of 16 years[44]. Bereaved children are 1.5 times more likely than their peers to be diagnosed with a mental health condition[45], and have three times the risk of experiencing depression than their peers (irrespective of the cause of death)[46]. Within this group, children who lose their parents or carers when they are very young, or to death from external causes (such as suicide, accident or homicide), are at a higher risk of depression in childhood and adolescence[47]. Understandably, children who experienced more than one death, or consecutive death, of a close family member or friend have increased depressive symptoms as a result of the adversity they have faced[48].

Violence: it has been suggested that around two in five victims of Child Sexual Exploitation (CSE) experience mental health problems and are 17 times more likely to experience a psychotic episode than their peers[49]. An enquiry held by the Children's Commissioner for England found that around one in four children were exhibiting mental health problems, with almost a third having self-harmed as a result of their experience, rising to over three quarters of those they interviewed directly[50].

Household and family adversity: just under one in 100 children are looked after by the State, and are living in care[51]. Research suggests that children who are looked-after (including those who are fostered[52]), are around four times more likely to have a diagnosable mental health condition than their peers[53]. The higher risk of poor mental health can be seen in the two in five looked after children that have a diagnosed behavioural condition[54] and the three in five more that have some form of emotional and mental health problem[55]. As a consequence of their experiences, and the lack of support they frequently face during life transitions, looked-after children and care leavers are between four and five times more likely to attempt suicide in adulthood[56].

5. Neurobiological and neurocognitive changes

Experiencing childhood adversity fundamentally alters the course of a child or young person's development. Recent studies have found that these experiences are 'likely to influence fundamental biological processes and engrave long-lasting epigenetic marks, leading to adverse health outcomes in adulthood'[57]. In other words, experiencing ACEs can trigger genetic predispositions towards mental ill health[58].

For example, witnessing domestic violence is the most frequently reported form of childhood adversity[59]. Research using neuroimaging has shown that experiences of domestic violence in childhood can change brain structures and increase the risk of mental ill health, in a way that is akin to soldiers who have trauma following armed conflict[60].

Experiencing adversity during childhood impacts our autonomic nervous system. These experiences can alter our neuroception, which is our automatic detection of whether or not there is a threat in our external environment[61]. This means that these children and young people spend a significant amount of time in a state of hyperarousal, facing significant emotional distress, which adversely changes a young person's ability to regulate their emotions (also known as affect dysregulation)[62].

Experiencing psychological trauma can also create a hypervigilance, in which the young person is continually looking to identify and detect threats on their

environment[63]. This is associated with problems with sleeping[64] as the child grows older. As such, many children who experience trauma find it difficult to calm themselves, and return to a "window of tolerance", which represents a safe and optimum level of arousal[65].

An alternative response to trauma is disassociation, by which a child might try to separate their emotions from the overwhelming feelings of distress they experienced at the time of the adversity. These children may feel unconnected with their body or a specific body region or area associated with the trauma. They may also feel an emotional numbness and significant cognitive fatigue if they try to recall or remember[66] anything related to the experience –this is also known as being in a state of hypoarousal. Sometimes it seems as if the child has spaced out or is emotionally absent[67]. Some of these young people consequently are unable to experience pleasure as a result of activities that would usually be pleasurable, such as music, social interaction or sexual encounters (also called anhedonia)[68].

Repeated adversity and trauma in childhood results in the overstimulation of hormones (cortisol) that are intended to help mitigate stress. Over-exposure to these stress hormones can suppress the response of the hippocampus (affecting both memory and behavioural responses) and significantly impact the areas of a child's brain that are still developing[69].

This includes impairing the prefrontal cortex, which continues to develop during childhood and adolescence, and is responsible for making sense of executive thought and cognition[70]. As such, children who experience adversity and trauma create new neural pathways in the brain that are highly sensitive to threats and heighten children's arousal.

As a result of trauma, children who face adversity and complexity are unable to effectively engage in important learning experiences that help to shape child development[71]. For example, they may not feel safe enough to play with their peers, might feel ambivalent towards family, friends and siblings, or may be mistrustful of, and distressed by, authority figures in formal education. Dr Katie McLaughlin and colleagues found different alterations depending on whether the adversity was threat or deprivation related[72].

6. Childhood adversity and traumatic stress

There is significant overlap between the terms 'Adverse Childhood Experiences' and 'childhood trauma'. The Substance Abuse and Mental Health Services Administration (SAMHSA)[73], for example, defines trauma as 'a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional or spiritual wellbeing'.

Perhaps the greatest difference in the use of the terms is that while ACEs describe the events or situations that children and young people face that lead to mental health problems (including traumatic stress), childhood trauma describes experiences directly relating to traumatic stress. That said, in reality many clinicians, policy makers and commissioners use the terms interchangeably. As such children and young people who experience mental ill health as a consequence of adversity (whether or not it manifests as traumatic stress) should be kept in mind when designing commissioning strategies and service interventions.

While all children and young people will experience some form of emotional distress, and neurobiological, neuroceptive and neurocognitive changes as a result of the trauma and adversity, not all of these will result in enduring mental health conditions, nor will they necessarily lead to a trauma-related diagnosis. The majority of children and young people find ways of overcoming the adversity they have faced by drawing on the internal or external resources and support available to them, and it does not have a substantive nor long term impact on their everyday life, relationships with others or social functioning. However, around one in three children and young people who have a traumatic experience will go on to develop symptoms that could lead to a traumatic stress-related psychiatric diagnosis[74].

Existing psychiatric diagnoses recognise the traumatic stress related to children's mental health and emotional wellbeing. The most well known is Post Traumatic Stress Disorder (PTSD), which originates from exposure to adverse and traumatic events, and results in significant distress in recalling the traumatic event(s), accompanied by behaviours and ways of thinking that avoids confronting the trauma, are self-destructive, or affect the mood of the young person.

The latest version (fifth edition) of the Diagnostic and Statistical Manual of

Mental Disorders (DSM-5) describes the symptoms and suggested treatment for PTSD and includes a consideration of manifestations of PTSD in children who are six years old, or younger[75]. There is also a new 'dissociative subtype' of PTSD, which focuses on feelings of disconnectedness and detachment from one's body or experiences[76]. Furthermore, it notes that many young people who experience PTSD will have at least another co-occurring diagnosable mental health condition related to the adverse experiences they have had. This might include anxiety, eating disorders, adjustment disorders, conduct and personality disorders, somatic disorders or the problematic misuse of substances.

Similarly, the International Classification of Diseases (ICD 10) contains a specific classification of PTSD (with a similar aetiology and symptomology as the diagnosis in the DSM-5) and also references a second classification that refers to a 'transition to an enduring personality change'[77]. The ICD 10 is currently in the process of being revised for an eleventh time and it has been suggested that this associated classification be renamed 'complex PTSD'[78], which has a higher threshold of adversity, including experience of disaster, prolonged possibility of death and exposure to life threatening situations.

The DSM-5 also includes the diagnosis of Acute Stress Disorder (ASD), which is seen as within a normal range of response to adversity. The symptoms of traumatic stress usually develop within a month of a single adverse event or situation. This can involve a wide range of trauma-related responses including intrusive memories or thoughts, nightmares, flashbacks, psychological distress when play resembles the traumatic event, a persistent negative mood, disassociation, problems sleeping or concentrating, unprovoked aggressive behaviour, or continuous scanning for threats in the immediate environment. The main difference between ASD and PTSD is that you need to be experiencing fewer symptoms to get an ASD diagnosis, and they tend to subside after a month, whereas in PTSD they persist for a much longer period of time.

In both situations the psychiatric symptoms of traumatic stress can be delayed or missed. This is especially true in situations where children or young people remain in an adverse environment. For example, Professor Eamon McCrory and colleagues have found common neurocognitive alterations in adults who have experienced adversity (whether or not they have a diagnosed mental health condition), and that they can be used to predict future psychiatric symptoms and mental ill health[79]. As a result, they propose the idea of 'latent vulnerability', arguing that more attention needs to be given to pre and sub-

clinical symptoms of mental ill health resulting from adversity[80]. They call for an indexing of latent vulnerability, which would include early indicators of altered neurocognitive functioning, such as changes in threat and reward processing, and to autobiographical memory.

Despite relative clinical agreement about the nature and presentations of traumatic stress, there are many children and young people who have experienced significant adversity and trauma, however their need is not recognised as ASD or PTSD. As such, they do not always receive access to the mental health and support services they may require. It is estimated that around one in six children and adolescents develop PTSD after being exposed to a traumatic event (as defined in DSM-5)[81]. This means that the higher proportion who experience pre- or sub-clinical traumatic stress symptoms do not get a clinical diagnosis, or are left being misdiagnosed – primarily as their presenting symptoms are not seen in the context of wider adverse experiences in childhood[82]. For example, adversity and trauma-related hospital admission should act as a flag for further enquiry and intervention, however a recent study demonstrated that this is frequently missed[83].

In response to these concerns, Dr Bessel van der Kolk and colleagues have proposed the introduction of a new classification of 'Developmental Trauma Disorder' (DTD), which would specifically recognise trauma resulting from Adverse Childhood Experiences[84]. Despite being considered for the most recent revision of the DSM-5[85], and significant support from practitioners working with children who faced childhood adversity, it was not included as a new classification[86].

While we agree with Dr Bessel van der Kolk's proposal of DTD, we do not advocate in this paper either for or against introducing new clinical diagnoses. However, we do think that there is an important need to recognise the traumatic stress and changes at a neurobiological and neurocognitive level that result from ACEs. Furthermore, following Professor Eamon McCrory we believe there is an urgent need to acknowledge that children and young people are experiencing pre- or sub-clinical symptoms of traumatic stress that are not being otherwise identified, or are being misdiagnosed. This is an important part of ensuring that the care these children and young people receive is both adversity and trauma-informed.

7. Behaviours seen as risky and challenging

In the face of significant adversity and complexity, many children and young people adopt risky or challenging behaviours, for example highly sexualised behaviour and substance misuse. For example, the study of ACEs in England found that those adults who had experienced four or more adversities in their childhood, were twice more likely to binge drink, and 11 times more likely to have gone on to use crack cocaine or heroin[87]. The chances of developing a dependence on substances doubles if a child has also experienced sexual abuse[88] or other forms of violence[89].

→ For more on childhood adversity and substance misuse see Paper 24.

These behaviours can quickly become labelled as problematic by professionals and families. Some are seen as signs of being 'anti-social', having a problem with one's 'conduct', and being oppositional, defiant or disruptive towards a carer or authority figure (i.e. a parent, teacher, doctor or social worker)[90].

By way of illustration, there are just over 169,000 students in England with an identified Special Educational Need or Disability (SEND) relating primarily to their social, emotional or mental health[91]. This represents one in six of students known to have a SEND[92], and equates to 2% of the total student population of primary and secondary schools, including alternative provision (i.e. special schools and Pupil Referral Units)[93].

Not all children who experience mental ill health, or social or emotional difficulties, will be identified as having a Special Educational Need, as they do not meet the definition and threshold for additional support[94]. Furthermore, some children who experience social, emotional or mental health problems will not have this classified as their 'primary' SEND need, and, as such, more children in need are hidden within other 'primary need' classifications, for example children with 'speech, language and communication needs''.

There is, however, a wider population of students who require support. It has been estimated that around three children in every classroom in the country have a diagnosable mental health condition[95], with many teachers suggesting that at least a quarter of their students are experiencing mental health problems[96]. These children face disruptions and/or difficulties in their learning because of the impact that adverse experiences have on their development[97].

The highest rate for permanent school exclusions is for students with an identified SEND, but ineligible for support (58.8%), compared to those with support (6.7%) and those with no known SEND (34.5%)[98]. Worryingly, students with identified Behavioural, Emotional and Social Difficulties (BESD) are significantly more likely than other SEND groups to be excluded from school, with one in five students with identified BESD being excluded for at least one fixed period of time, and one in 100 being permanently excluded[99].

→ For more on the role of alternative education see Paper 21.

In our schools and colleges, health services, and youth justice institutions we continue to misunderstand the behaviours and emotions that children and young people present with. Many of the pre- and sub-clinical symptoms of traumatic stress are misinterpreted as behavioural problems or are based on prejudicial views about the morality or characteristics of the child or young person. Ultimately the problem is seen as being the child's, and much of the attention is focused on correcting their behaviours, rather than identifying the cause of it. Echoing this, the Royal College of Psychiatrists recently found that antipsychotics are being routinely prescribed for people who have behaviours that challenge, but with no record of having an enduring mental illness[100]. The rate of prescription increased if the young person had a learning disability.

Worryingly, there is a correlation between the specific form of adversity that a child has experienced, and the kind of harmful behaviour they are more likely engage in adulthood[101]. For example, children who had lived with someone who was suicidal were more likely to have tried to end their life; if they were sexually abused, they were more likely to engage in risky or underage sex and if they lived in households with significant substance misuse[102], they were more likely to misuse substances themselves[103].

→ For more on intergenerational trauma and cycles of violence see Papers 3, 16, 18, 24, 26.

Clinical research suggests that it is common for children and young people who have experienced adversity and trauma to 'act out' – exhibiting self-destructive, conduct disordered behaviours. These are attempts by the child to make sense of their experiences[104] and cope with trauma they have acquired

and is a way of communicating something that is not yet conscious, or that perhaps cannot yet be verbalised[105]. Other behavioural responses might include children attempting to self-calm and self-soothe, but in a self-harming or regressive way[106]. This might include violent rocking, chanting, scratching their face or body or biting themselves, or banging their hands against walls or objects.

While sometimes difficult for others to watch, challenging behaviour acts as a method of reducing tension, and can play a role in the child attempting to protect themselves from, or avoid, what they perceive to be a threat or a continuation of the trauma[107]. Presentations of anti-social behaviour in relation to ACEs are more prominent among boys and young men[108], possibly because of gendered ideas about displaying emotions[109].

For example, victims of Child Sexual Exploitation also exhibit increased risk-taking behaviour and criminality as a way of making sense of the adversity they have faced. Around two in five children develop a substance (drug and alcohol) problem and girls who have experienced CSE are 2.5 times more likely to have a criminal record, because their behaviour is criminalised rather than being seen as an indicator of additional need[110].

Similarly, many young people who have experienced or witnessed domestic violence do not engage in violence themselves[111]. Research shows that domestic violence is strongly associated with offending and anti-social behaviour[112]. Some respond to the distress of experiencing domestic violence by exhibiting these behaviours with others in the family, or later on in their young adult relationships. Finally, domestic violence is a shared risk factor for poor mental health and gang-affiliation[113].

Children who engage in significant risk-taking should be seen as both finding ways to make sense of adversity and trauma they have experienced, as well as avoiding the need to address and resolve the trauma. Such children are at additional risk of being labelled as having a clinical disorder (such as 'oppositional / defiant disorder' and 'conduct disorder'), rather than having the adversity identified[114]. Additionally, these children are more likely to be known to the authorities, because they are engaging in anti-social or criminal behaviour[115].

When we look at the needs of young people who offend there are clear mental health needs and childhood adversity that are not being addressed. The Chief Medical Officer noted that two in five children and young people

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on Community Orders have emotional and mental health needs and approximately the same proportion have experienced neglect or abuse been homeless – and around half have been a victim of crime[116].

In the context of gang membership an evidence review for the Ministry of Justice noted that a 'social value of violence' was established among membership in terms of utilising a history of family violence and to help maintain a bond between young members[117]. As such, the aggressive behaviour seen in gang initiation and gang membership may be an acting out of gang loyalty, as much using the experience of violence as a template to establish a bond with peers.

This sentiment is recognised in an evidence review for the Home Office, which notes that young people who become involved in gangs or violent lifestyles are some of the most vulnerable young people in our society and may have experienced adversity from a very young age. They should be seen and treated first and foremost as children and young people in need of support'[118].

It is vital to understand the meaning of both challenging and risk-taking behaviours, as for many children they will represent a response to the adversity, complexity and trauma they have experienced in childhood. Moreover, being further labelled, stigmatised and confronted by professionals who are unaware of their adversity, can trigger memories and emotions relating the trauma they have experienced. This can have the effect of escalating their behaviour and emotional distress, and risks re-traumatising the young person or sustaining a secondary trauma[119].

8. Adversity and trauma-informed care

It is clear from the above discussion that the experience of adversity and trauma in childhood or adolescence increases our risk of poorer social, emotional and health outcomes in adulthood. Some children and young people, as we have seen, will go on to adopt behaviours and coping strategies that may mitigate the impacts of these adversities, but they also have a long-term effect on their emotional wellbeing, social functioning and psychological development.

These behaviours and ways of thinking should be regarded as creative adaptations and creative adjustments that the young person is using to survive

in an adverse environment and make sense of their experiences. It is very difficult to predict what a child or young person's response to adversity and trauma might be (reflected in the wide range of trauma-stress symptoms for example), and whether the behaviours and ways of thinking that they adopt will successfully mitigate the impact of the adversity they face.

a. building resilience

Interacting with the risk factors discussed above are protective factors that reduce the likelihood of long-term mental ill health and emotional distress. Lucas Shelemy and Dr Pooky Knightsmith (see Paper 6) identify four core protective factors that increase the resilience of children and young people in relation to adversity and trauma, including the relationship with nurturing care givers[120] (if they are not the origin of the adversity) and social connectedness with a supportive peer group. The ability to problem solve and communicate can moderate risk factors, and an interest, hobby or skill that the child or young person highly values in themselves.

→ For more on resilience and protective factors see Papers 5, 6 and 13.

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The Center on the Developing Child at Harvard University describes resilience as a 'positive, adaptive response in the face of adversity'[121]. In direct contrast to the health-harming and risk-related adaptations, resiliency mitigates the full impact of adversity, and transforms potentially traumatic stress into tolerable stress, which can be subsumed into a young people's life and enables them to grow and develop as would have been otherwise expected.

At an individual level, building resilience allows the children to protect the developing brain and body from adverse neurobiological and neurocognitive changes. At a social level, it ensures the young person can re-establish the safety, connection and support they will require to recover from the adverse experience(s), and to mitigate the feelings of isolation, hopelessness and meaninglessness that can arise from adversity and trauma.

Professor Peter Fonagy (see Paper 13) proposes that we see this resilience as an 'outcome of the quality of the social network surrounding the child and the child's capacity to access that network', rather than a quality or characteristic of the individual child. From this standpoint, he makes a compelling case to

focus on the 'systems of care' in the social environment around the child, as well as providing the specialist support a young person will need to make sense of their trauma.

b. adversity and trauma-informed care

Both Dr Judith Herman and Dr Sandra Bloom[122] have been influential, and successful, in advocating for models of care that move beyond a purely diagnostic model of trauma, and instead place greater emphasis on creating safe environments and practices, building individual resources and wider resiliency, as well as restoring connection to supportive and safe communities. Reflecting this, the Center on the Developing Child[123] notes that learning to cope with manageable threats to our physical and social wellbeing (and practices of self-regulation) are critical for the development of resilience, and enhance recovery.

Similarly, Dr Bessel van der Kolk suggests that these models of care can powerfully demonstrate to the child or young person (as well as the family or community they live with), that a) relationships can heal, b) through therapy and connection with others we can create meaning out of our experiences, c) we can learn to regulate our own physiology and take greater care of ourselves, and finally d) it is possible to create conditions and environments where these young people can thrive and receive the care they need.

Increasingly, these models of care are being described as adversity or trauma-informed care. These models of care aim to mitigate the impact of adversity on people's lives, and to address the mental health and/or traumatic stress resulting from these experiences. Importantly instilling trauma-informed care is now being seen as a priority public health concern throughout the UK[124].

> → More detailed discussions of adversity and trauma-informed care are available in Section 2, with local good practice examples set out in Section 3.

The Provincial Mental Health and Substance Use Planning Council of British Colombia in Canada differentiates between trauma-informed and trauma-specific services[125]. Trauma-specific services are described as being delivered in a trauma-informed environment and focus on treating trauma through

therapeutic interventions, involving professionals with specialist training and skills. These services and interventions are based on detailed assessments of the trauma and adversity that a young person has faced, and co-creates with them an integrated treatment plan to address identified symptoms.

In contrast, trauma-informed care can be delivered by all organisations and professionals. Its core principles include building awareness of adversity and trauma (understanding of cultural, gender and sexuality contexts) into service protocols and staff culture in order to avoid re-traumatisation. Establishing and maintaining safety is at the heart of all adversity and trauma-informed models of care. Furthermore, these models focus on increasing levels of trustworthiness by being transparent with clients and investing in greater collaboration, shared decision making, and mutuality between the people who are using the services and receiving them.

The papers included in Addressing Adversity will provide you with greater clarity and insight into what adversity and trauma-informed care looks like in practice, how it can benefit children and young people who have experienced different forms of adversity, and finally some of the challenges and successes from local areas across England.

The first section of this collection considers evidence and analysis of the impact that adverse childhood experiences and trauma have on children and young people's mental health and wider outcomes across the lifecourse. Building on this foundational analysis, section two provides insight into areas for priority focus from leading policy makers, national organisations and clinicians who work with children and young people who have experienced different forms of adversity and trauma. In section 3, we explore case studies and working examples of adversity and trauma-informed service models to identify emerging good practice from across England. Finally, the collection ends with an agenda for change, calling on all commissioners and providers to make adversity and trauma-informed care a priority in their locality.

For more on:
- the principles of adversity and trauma-informed care see Papers 7, 8 and 9.
- adopting an LGBT+ affirmative commissioning and service models see Paper 14.

- adopting culturally sensitive trauma-informed models of care see Paper 15.
- ensuring commissioning and services is gender-informed see Paper 17.

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Understanding adversity, trauma and resilience

2. Adverse Childhood Experiences, health outcomes and risk factors

Matilda Allen and **Dr Angela Donkin**

This extract is from *'The impact of adverse experiences in the home on the health of children and young people, and inequalities in prevalence and effects'* report and has been re-used under the Open Government Licence v2.0 with the permission of the authors.

1. Adverse Childhood Experiences

Childhood and adolescence are key periods for development, growth and education, and are of critical importance in shaping adulthood. It is widely recognised that just as supportive, nurturing, safe and happy childhoods are necessary for later health and wellbeing, if individuals live in damaging circumstances, or are exposed to adverse conditions early in life, this can have negative short- and long-term effects, including for health.

The term 'Adverse Childhood Experiences' was originally coined in an American study on the impact of adversities across the lifecourse[1]. Adverse childhood experiences have since been defined as: 'intra-familial events or conditions causing chronic stress responses in the child's immediate environment. These include notions of maltreatment and deviation from societal norms'[2].

> When we refer to Adverse Childhood Experiences, or adverse experiences, within this paper, we are referring to:
>
> *Maltreatment:*
> - Physical abuse
> - Emotional abuse
> - Sexual abuse
> - Neglect

Household adversity:

- **Domestic violence** (this... encompasses physical, psychological, sexual, financial and emotional abuse and includes controlling and coercive behaviours)

- **Substance misuse** (there are adults within the home with drug misuse or addiction problems, including alcoholism)

- **Mental ill health** (there are parents or other adults within the home with diagnosed or undiagnosed mental illness)

- **Criminality** (parents or others who usually live in the home are either in prison or on probation)

- **Separation** (parents are separated or divorced, or one or both parents are dead)

- **Living in care** (children are looked after by the state in a care setting or elsewhere – sometimes referred to as 'looked-after children and young people')

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2. ACEs and Social Determinants of Health (SDH)

The term 'social determinants of health' (SDH) refers to the conditions and circumstances in which we are born, grow, live, work and age. These conditions are shaped by inequalities in power, money and resources and therefore are unequal in their distribution[3]. This inequality in the social determinants of health contributes to inequalities in health outcomes. In England, between the most and least deprived local areas there is a difference of 17 years in the number of years that people live in good health.

Fair Society Healthy Lives (known as the Marmot Review)[4], set out the evidence of inequalities in health and the social determinants of health in England, and proposed six high level policy objectives in order to take action on the social determinants of health. These were:

1. Give every child the best start in life

2. Enable all children, young people and adults to maximise their capabilities and have control over their lives

3. Create fair employment and good work for all

4. Ensure a healthy standard of living for all

5. Create and develop healthy and sustainable places and communities

6. Strengthen the role and impact of ill health prevention

These relate to ACEs and health in three ways. Firstly, tackling the presence and impacts of ACEs is an important component of some of these policy objectives – such as giving children the best start in life and maximising capabilities and control. Secondly, inequalities in the SDH could be contributing to inequalities in the prevalence of ACEs. Deprived areas and families living in poverty (who do not have a healthy standard of living) are likely, on average, to have a higher prevalence of ACEs. Thirdly, the presence of ACEs could impact on the SDH, so that children and young people who are exposed to ACEs are more likely than those who are not to grow up to live in conditions (such as in poverty, or with damaging employment) that have a negative impact on their health.

The conceptual framework (opposite) provides an outline of the topic areas that are discussed in this paper and how they relate to each other. The arrows represent correlations, connections or possible pathways, but do not show evidenced causation, because in many areas the current evidence is suggestive of causation but it is not proven.

3. Associations between ACEs and health

Not everyone who is exposed to one or more ACEs will experience negative health outcomes: a review of children and young people who had experienced ACEs found that a "large proportion do appear to be functioning adequately or well"[5]. The type of ACEs, the number of ACEs experienced, and the length of time over which they are experienced, can impact on the risk of negative health outcomes.

In addition, contextual factors can increase resilience – the ability to 'bounce back' from adverse experiences. Supportive peer relationships, the impact of schools, potentially family wealth and a range of other factors can reduce

Figure 1: ACE conceptual framework
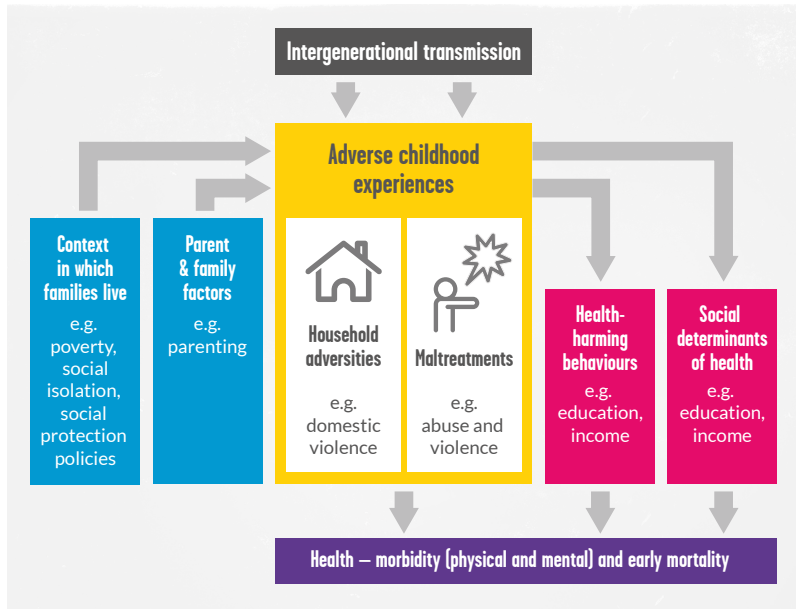
vulnerability of children to poor health and wellbeing outcomes as a result of adversity[6]. However, although protective factors can increase resilience, this does not make children and young people 'invulnerable' or impervious to harm – experiencing severe or multiple adverse experiences is likely to be damaging to children and young people regardless of how high their resilience levels are[7].

One UK-based study has found that those who experience neglect at an older age are likely to experience worse outcomes compared with their younger counterparts[8]. This is supported by American evidence, which finds that maltreatment experienced during adolescence had a "stronger and more pervasive effect on later adjustment", including in areas such as criminality, substance misuse and other health damaging behaviour[9].

a. Injury and death during childhood

At their most extreme, the presence of ACEs can result in death during childhood. In 2012/13, there were 69 homicides of children aged 0–15 across

the UK[10]. The presence of ACEs can also increase self-harm and suicide among children and young people. There were 170 suicides of 15–19 year olds in the UK in 2013, 135 of which were in England and Wales. This was split into 112 male and 23 female[11]. Self-harm, suicide and injury rates among children and young people are likely to reflect, in part, the presence of ACEs. However there is a lack of clear data on this relationship.

b. Premature mortality and suicide

A British study published in 2013 used longitudinal data of a set of over 15,000 individuals born in 1958 to determine mortality rates by 50. The authors found that: "in men the risk of death was 57% higher among those who had experienced two or more ACEs compared to those with none. Women with one ACE had a 66% increased risk of death and those with two or more ACEs had an 80% increased risk versus those with no ACEs"[12]. The definition of ACEs used included maltreatment, living in care and some household adversity measures (offenders, parental separation, mental illness or alcohol abuse in the home). Figure 2 shows these rates, for men and for women. Although the overall proportions are small, the relationships between mortality and prevalence of ACEs are clear.

Figure 2: All-cause mortality rate by age 50 according to prevalence of adverse childhood experiences, British men and women, 2008
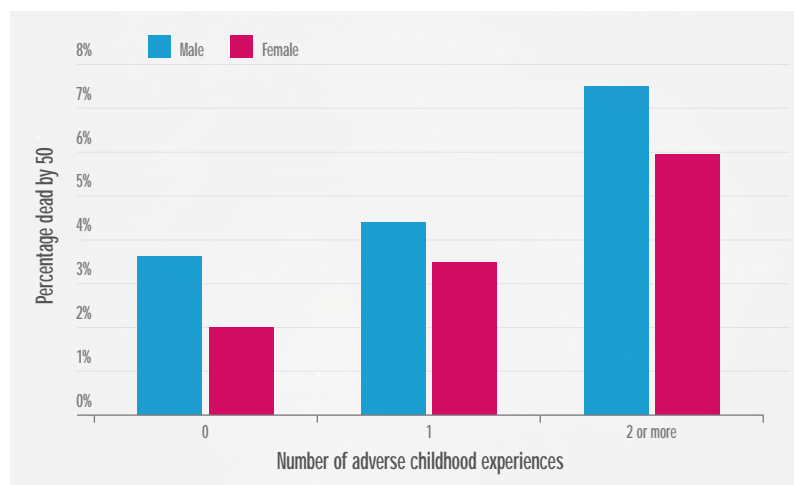
A different study of the same birth cohort (1958), examined what risk factors were present at age seven that predicted later suicide. The authors found that emotional adversities such as parental death or separation and living in care had an association with risk of suicide. This risk was graded: "the highest was for persons with three or more adversities"[13]. Surveys conducted from 2010–2013 in eight Eastern European countries found that respondents who reported at least four ACEs had increased odds of 49 for attempting suicide[14]. This is a particularly high figure, which may not be reflected in the English context – but it does demonstrate the potentially disastrous impacts of ACEs.

c. Disease and illness

The US ACEs study found a relationship between the number of ACEs and the presence of diseases in adulthood, including ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease. Other studies have also found relationships with a risk of stroke, and the development of cancer, hypertension, diabetes, asthma, arthritis, angina pectoris and osteoporosis. US research has also found a three-fold increased risk of lung cancer for those with six or more ACEs and found that this cohort were roughly 13 years younger on average when first detecting symptoms than those without ACEs.

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A 2013 survey of 4,000 English adults found increased odds of developing a range of diseases, and particularly high risks associated with experience of four or more ACEs. Moreover, the study shows that those with more ACEs have a higher rate of diagnosis of a major disease at a younger age. By the age of 69, among those who experienced four or more adversities during childhood, only approximately two in 10 people have not been diagnosed with a major disease.

d. Mental ill health

Research has shown that the presence of ACEs can increase the chances of children and young people experiencing mental illness or a low level of mental wellbeing, including low self-esteem, depression and relationship difficulties[15]. In addition, WHO Euro reports that post-traumatic stress disorder has been reported in as many as a quarter of abused children[16]. Not only can experience of ACEs impact on childhood, but also there can be a lasting impact on adult mental health. The WHO World Mental Health Surveys estimate that 30% of adult mental illness in 21 countries could be attributed to physical abuse in childhood or other adverse childhood experiences[17].

Some groups are more at risk of adverse mental health impacts than others: for example, a British cohort study found that looked-after children and young people were significantly more likely to be depressed, dissatisfied with life and have low self-efficacy (which relates to feelings of control over one's life)[18]. After adjusting for family socioeconomic status, residential care was associated with an increased odds ratio of four for depression[19].

A study of the 1958 British birth cohort study estimated the impact of childhood adversities on psychopathology across the lifecourse[20]. This is one of the few studies that focus on older children rather than the 0–5 age range. Figure 3 summarises some of the results related to adversity in the home. The graph shows varying impacts of different ACEs over time. For example some ACEs, such as divorce of parents and being looked-after, have a higher impact on mental illness at younger ages, which then declines over time.

Figure 3: Increased odds ratio of psychopathology associated with various types of ACE, by age, UK, 2008
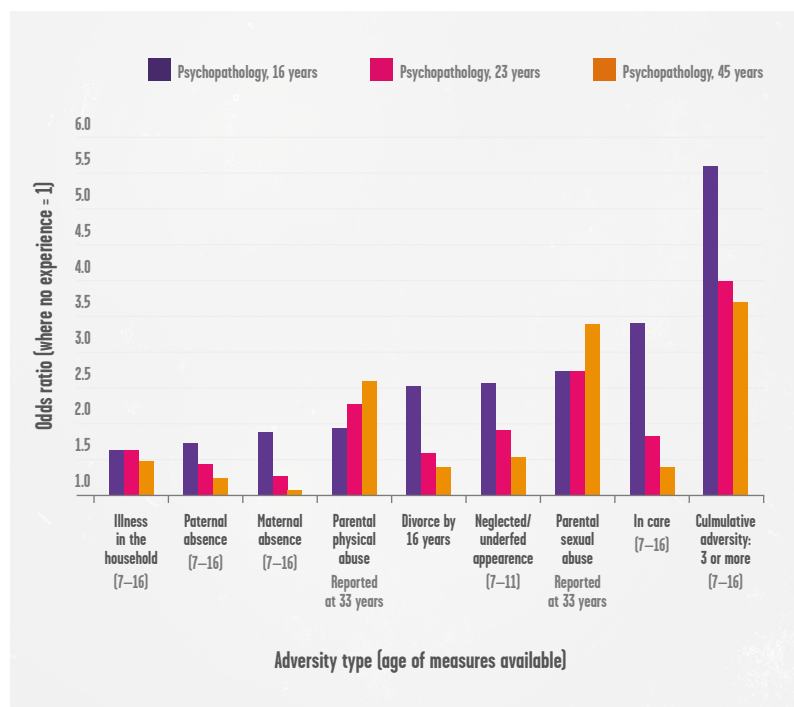
4. Link from ACEs to health-harming behaviours

It is possible that exposure to ACEs during childhood and adolescence increases the likelihood of an individual later adopting health-harming behaviours, including substance misuse, alcohol misuse, smoking, sexual risk behaviour, violence and criminality or behaviours leading to obesity.

An English study published in 2014 found a correlation between the number of ACEs experienced and health-harming behaviours. The increased odds ratios associated with four or more ACEs varied from two for poor diet to 11 for incarceration. Heroin or crack cocaine use also showed a significantly increased odds ratio of 11. The authors conclude that, "resistance to commercial, cultural, and other environmental pressures to adopt health-harming behaviours appears to be related to childhood stressors, with nurturing, ACE-free childhoods increasing personal resilience"[21].

Results from the US ACE study[22] have shown the association between ACEs and later smoking: for example, 16% of smokers reported verbal abuse in childhood compared with 8% of non-smokers, and 14% reported physical abuse compared with 7% of non-smokers[23]. English evidence supports these US findings[24]: for example, those with four or more ACEs have been found to have odds ratios of three for smoking[25].

A study using longitudinal data from the 1970 British Cohort Study also found that those who were looked-after as children were significantly more likely to smoke and have criminal convictions Generally, admission to care at a later age tends to result in increased risk of negative outcomes – for example, admission to care after the age of 10 was associated with an increased odds ratio of three for smoking and six for adult criminal convictions[26].

Studies of the association between ACEs and obesity in the 1958 British birth cohort show that, "the risk of obesity increased by 20% to 50% for several adversities"[27]. English evidence has also showed adjusted odds ratios of six for unintended teenage pregnancy among those who experienced four or more ACEs (compared with those who experienced none), and eight for violence perpetration[28].

The adoption of these behaviours can be seen in the short term (mostly during adolescence but sometimes before) and in the longer term, during adulthood. They impact on health directly, through an increased likelihood of disease, accidents or violence, and, in some cases (for example, criminality), impact on

the wider conditions in which people live – the social determinants of health.

5. Link from ACEs to the social determinants of health

The social determinants of health (SDH) are the conditions in which we are born, grow, live, work and age, and the impact that these conditions have on our health. Experiencing ACEs may have an impact on three key social determinants of health: educational attainment, employment and income. For example, a US study found lower rates of success in employment and education among those who were maltreated in childhood. Of men in the sample maltreated as children[29], 45% graduated from high school compared with 65% of non-maltreated men; for women this was 52% compared with 71%. There is evidence that ACEs can impact on future employment and earning potential[30]. Evidence also shows that maltreated children are more likely to have menial or semi-skilled jobs as young adults and are more likely to be unemployed than their non-maltreated peers[31].

There is significant evidence linking childhood maltreatment with poor educational outcomes[32]. This includes evidence that verbal abuse contributes to lower language test scores for 10 year olds[33], and that abused children have lower grades, lower educational attendance and more placements in special education programmes[34]. Evidence has also shown that maltreated children, particularly those who were neglected, had lower test scores and grades in reading and maths[35]. Other studies have shown an impact of household adversities on the SDH – for example, data from the 1970 British Cohort Study has shown a clear association between maternal mental health and children's educational attainment and future household income[36].

Evaluating the full impact of the pathway from ACEs to health via the social determinants is complex, as many studies of the impact of ACE control for educational attainment, socioeconomic status or other SDH, which therefore makes it harder to isolate these as pathways. In general, a greater relationship can be seen between ACE and health outcomes when these factors are included (often as 'unadjusted figures'). However, this may be due to common causes – for example, family poverty in childhood can increase the chances of experiencing ACEs and increase the chances of being unemployed later on in life.

6. Neurobiological and genetic pathways

There may also be a link between ACEs and health that occurs through the direct impact of ACE on neurobiological and genetic functioning. Studies have suggested a relation between trauma (which can result from maltreatment), other ACEs, and brain dysfunction or neurobiological impacts that can affect later health[37]. It is likely that part of this link is due to increases in damaging responses to stress[38]. These alterations to stress-responsive neurobiological systems can impact emotional regulation, somatic signal processing, substance abuse, sexuality, memory, arousal and aggression[39].

The areas of genetics and epigenetics also may provide links between ACEs and health. It has been suggested that, "exposure to prolonged activation of physiological stress responses due to events chronically unsupported by positive and secure relationships causes deleterious modifications to biological systems (neuroendocrine, inflammatory, immune) involving epigenetic modifications, that may or may not be reversible"[40]. This then increases morbidity and early mortality as individuals are less able to adapt to negative exposures and more likely to engage in damaging health behaviours.

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7. The intergenerational transmission of ACEs

In general, those children who experience ACEs are more likely to have a parent who has also experienced ACEs. This perpetuation of disadvantage, from one generation to the next, contributes to societal inequalities as it places an extra burden on those children who come from disadvantaged backgrounds, increasing the risk of ACEs across generations.

This 'intergenerational transmission' of adversity has been reported in relation to child abuse[41], mental ill health[42] and substance misuse[43]. Exposure to domestic violence and other forms of violence increases the risk of becoming both a victim and perpetrator of violence in adolescence and later life[44], sometimes called the 'cycle of violence'[45]. One study has suggested that approximately a third of parents who were maltreated in childhood will maltreat their own children[46]. In part this may be due to children modelling the behaviour of their parents when they grow up and not having a 'positive' experience to learn from and replicate. Parenting programmes that teach about good parenting could help to break this cycle[47].

A 2015 US study examined the pathways by which ACEs experienced in childhood increase the risk of intimate partner aggression in adulthood[48]. The study found that among men, post-traumatic stress disorder mediated the relationship between sexual abuse and intimate partner aggression, and substance abuse mediated the relationship in men and women. It concluded that, "programs geared towards aggressors should address abuse (sexual, physical and psychological), which occurred during childhood and recent substance abuse and PTSD (post-traumatic stress disorder). These programmes should be implemented for men and women"[49].

However, experiencing one or more ACEs in childhood or adolescence is not fate – it does not mean that the individual is destined to perpetuate these conditions in relation to their own children. Most people who are maltreated do not go on to maltreat their own children and most of those who were exposed to violence do not go on to perpetrate or be a victim of violence. More research is needed on the factors that enable these people to 'break the cycle' – although it appears that having a higher socioeconomic status and sufficient economic resources may help. For example, English evidence has found that father's mental illness ceased to have an impact on their children's attainment and development where the family had higher socioeconomic resources[50].

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8. Risk factors of ACEs

a. the context in which families live

Difficult and challenging social, economic and cultural factors impact on families and increase the stress on parents and families. All of these will likely increase the risk and likelihood of ACEs.

i. poverty, low socioeconomic status and disadvantage

Most parents who live in poverty, are disadvantaged or have low socioeconomic status do not maltreat their children. However there is evidence that low economic status and having insufficient economic resources can act as a risk factor for child maltreatment[51].

For example, there is evidence that women from poorer childhood homes were twice as likely to have suffered from abuse or neglect and three times as likely to have suffered from more than one form of abuse than those from more affluent childhood homes[52]. US research has found that children in households with an annual income below $15,000 (in 1993) were 22 times more likely to experience harm as a result of maltreatment compared with those in families with incomes over $30,000[53].

More recent US research has also found a clear relationship between material factors and child maltreatment[54]. This includes a random-assignment study where a gain in income resulted in a reduction in child abuse and neglect, compared with a control group[55]. While random-assignment is rare, other studies have shown a correlation between reductions in income and increases in child maltreatment[56].

UK longitudinal research has found that an indicator of deprivation (derived from measures of paternal unemployment, overcrowding, living in rented or council accommodation and not having access to a car) had the strongest association with child maltreatment out of all the risk factors included in the study[57]. The majority of parents who live in poverty, disadvantage, or are of low socioeconomic status, do not mistreat their children[58]. However, UK research has found that being in a lower socioeconomic group is associated with a more significant level of abuse[59] and data from England and Wales from the 1980s and 90s showed a steep social class gradient in intentional injury among children and young people: for example, the homicide rate for children aged 0-15 in the lowest social class was 17 times that for those in the highest social class[60]. A Scottish study found that 82% of families with higher incomes (over £33,571) had no instances of poor maternal mental health, while this dropped to 54% for families in the lowest quintile (under £8,410)[61].

The association between poverty and maltreatment is most commonly explained by stress factors linked to unemployment, low income and depleted resilience, including social isolation, mental ill health, domestic abuse and substance misuse[62]. For example, parents with a low income are four times more likely to feel 'chronically stressed' than parents with higher incomes[63]. The NSPCC states, in relation to social status and child maltreatment, "the most common explanation centres on the stress factors that are associated with unemployment and low income, such as social isolation and mental ill health. Poverty can also erode parents' resilience to deal with these stress factors"[64].

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ii. unemployment

Studies that find a relationship between ACEs and unemployment rarely control for income, in order to ascertain the effect that unemployment might have over and above, or separate from, the increased risk of low income. However, some studies do mention unemployment specifically as a risk factor[65], and it may be the case that unemployment increases the chances of children experiencing ACEs, perhaps due to increased stress in the home.

iii. deprived communities

The WHO states that, "maltreatment tends to be more common in families in deprived communities. These areas can lack 'social capital' – the institutions, relationship and norms that shape a society's social interaction – and may have many alcohol outlets"[66].

The impact of local deprivation has also been seen in UK studies[67]: children who live in the most deprived 10% of neighbourhoods have a 10 times greater chance of being on a child protection plan and an 11 times greater chance of being taken into care than children in the least deprived 10%. This may have an impact separate from the likely lower incomes and increased poverty of families in this area – in part through a lack of local services or community conditions which increase stress for families and do not provide sufficient social support. There is also evidence linking violent neighbourhoods to an increased risk of child maltreatment[68].

iv. social isolation

There is some evidence that parents who maltreat their children are more isolated, more lonely and have less social support than those who don't[69]. This may be in part because social isolation increases stress, and those who are isolated have a lack of positive parenting role models, or a lack of pressure from others to conform to positive parenting behaviours[70].

Evidence on the protective nature of parental social networks has found that they protect against poor outcomes for children[71] and increase the amount of positive interactions mothers have with their children[72]. Social networks provide a shared understanding of parenting[73] and a buffer to the challenges of parenting[74].

b. parental and family factors

i. parenting

There is some evidence that links parenting style with child maltreatment. For example, a retrospective study in the UK found that incompetent parenting by mothers (such as being impatient, irritable or giving too little time and attention) was associated with their offspring reporting maltreatment during childhood[75]. Parents who maltreat their children are also more likely to use harsh discipline strategies, less likely to use positive parenting strategies, and more likely to respond to negative but not positive behaviours[76].

One element of knowledgeable parenting is having appropriate expectations and accurate understanding of children's development. Some studies have found links between higher (unsuitable) expectations of children and lower understanding of developmental processes, and child maltreatment[77].

While some of these findings refer specifically to younger children, it is likely that damaging parental relationships with children over the age of 5, and some parenting practices, may be related to ACEs. One study also found that poor parenting was a background factor for adolescent physical abuse[78]. However, in some cases, parental behaviours that may have been abusive or neglectful for a younger child are not so damaging for older children[79].

There is some evidence that younger parents may be more likely to maltreat their children than older parents[80]. For example, a longitudinal study of British parents found that parents who were younger than 20 had a three times greater risk of having a child placed on the child protection register before the child's 6th birthday[81]. It may be the case that younger parents are more likely to be exposed to other risk factors – such as poverty and unemployment – compared with their older counterparts, and that this increases the risk of child maltreatment[82] and likelihood of poor parenting.

ii. family structure

Children living in single parent families have been shown to be at increased risk of maltreatment[83]. A UK cohort study of more than 14,000 individuals also found a relationship between family structure and child maltreatment

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– single parent and reordered (with step-parent) families both had a higher risk of children becoming placed on local child protection registers. The odds ratio was three times higher in these families. However, the authors report that this odds ratio drops substantially when other factors are controlled for, suggesting that, "while important, the effects of family structure are modified by the confounding roles of parental background and socioeconomic environment"[84]. Having larger numbers of children in the household has also been linked to an increase risk of neglect[85].

It is not clear whether living with only one parent is the actual risk factor for child maltreatment, or whether this is indicative of poverty or low socioeconomic status (since one-parent families are more common lower down the social gradient), which are also risk factors. In some cases, for example in which there is domestic violence or other conflict in the home, separation may be beneficial for the child and reduce the chances of maltreatment. In addition, while factors such as family structure can increase the risk of child maltreatment, the absolute risk is still low: for example, in the UK longitudinal study cited above, only 3.5% of all single mothers had children registered for child abuse or neglect[86].

c. household adversity

In England, an examination of the household conditions present in cases of child death or serious injury shows the presence of domestic violence in more than 60% of cases, parental mental illness in 60% of cases, and parental substance misuse in 42% of cases[87]. However, deaths and serious injuries represent a very small fraction of all child protection cases – there are many less serious or immediate impacts, which also reveal household adversity as a risk factor. For example, further research shows that more than 34% of under-18s who have lived with domestic violence have been abused or neglected by a parent or guardian[88], and parental abuse of drugs or alcohol, or both, has been detected in more than half of parents who neglect their children[89]. US research supports these findings: parental substance abuse has been found to be a contributing factor for between 30 and 60% of maltreated children in the welfare system and children whose parents abused alcohol were approximately three times likelier to be abused and over four times more likely to be neglected when compared with those whose parents were not substance misusers[90].

Child maltreatment, particularly sexual abuse, in institutional care settings has

received much publicity recently. Overall prevalence across the population is not possible to ascertain with certainty but one study from 1992 found that out of 1,000 children in institutionalised care in the UK, 158 reported that they had been sexually abused[91]. This figure is now out of date, however, and prevalence may have changed significantly since then. A 2013 National Crime Agency report found that children cared for by institutions were more vulnerable to abuse due to the structure and status of institutions and the power of the adults working in them[92].

9. Taking action to address ACEs risk factors

Taking preventive action to reduce the prevalence of ACEs, and thereby improve population health, therefore requires acting on the risk factors identified. Some current policies, for example the Troubled Families Programme[93], aim to do this. However this and many other interventions are only available for those with the very highest levels of need.

It may be the case that many children who are exposed to ACEs, but are not identified by local safeguarding systems, would benefit from a 'proportionate universalism' approach – universal in scope, but recognising the increased burden faced by those lower down the social gradient. This could act on the three risk factors as follows:

- Improving the context in which families live – local programmes that tackle social isolation, increase community coordination and mitigate the negative impact of poverty, the recession and austerity measures on families may help to reduce stress, increase resilience and therefore reduce ACEs prevalence.

- Tackling parental and family risk factors – parenting programmes have a range of benefits, and some have been found to reduce child maltreatment[94]. Making these available to a wider range of parents, and implementing them with the involvement of a range of sectors, could reduce ACEs prevalence.

- Reducing household adversity – local organisations and practitioners can work in multi-agency teams to provide integrated responses that recognise multiple needs and adversities, and act holistically and flexibly to better detect and respond to those facing adversity at home.

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In addition, all policies could usefully incorporate the principles of early intervention and prevention, integrated working and proportionate universalism. Integrated working, for example, can help both to detect and respond to the risk factors for ACEs. This should include a range of partners including criminal justice, health, education and other services and staff who work with families.

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3. Trauma is really strange

Steve Haines and **Sophie Standing** (illustrator)

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Learn more about Steve and Sophie's work at:
www.traumaisreallystrange.com and www.sophiestanding.com
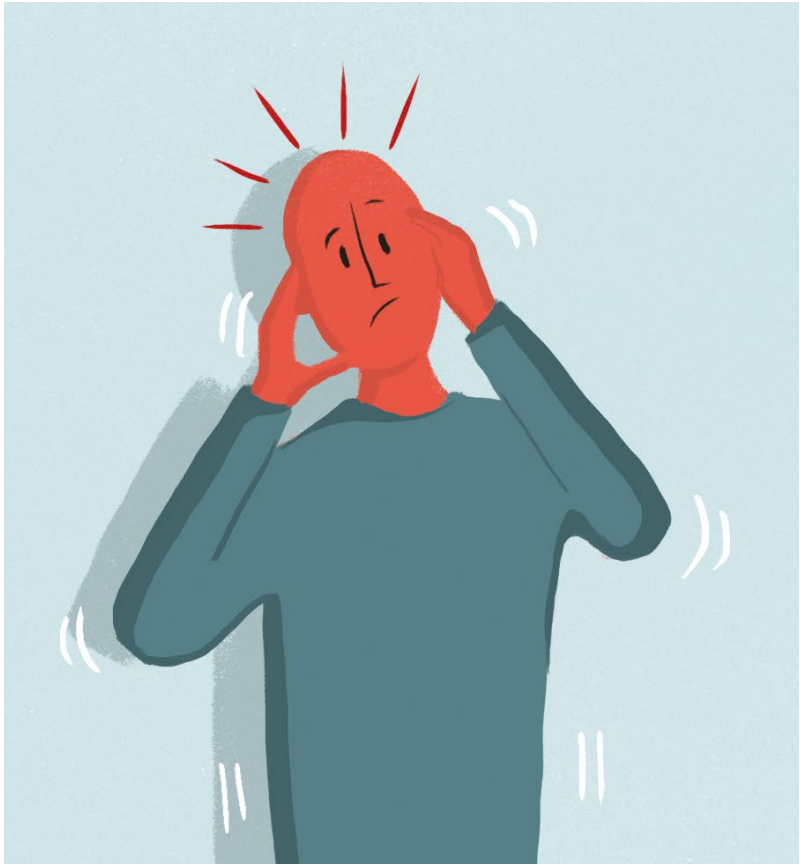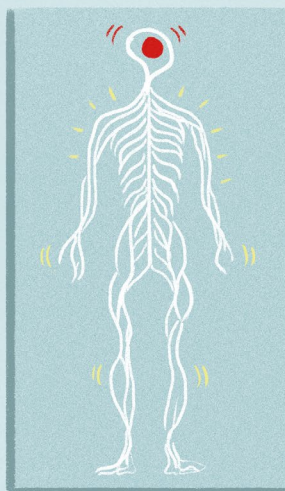
THE GOAL OF THIS BOOK IS TO BE A NON-SCARY INTRODUCTION TO TRAUMA. FOR MANY PEOPLE, UNDERSTANDING WHAT THE BRAIN IS TRYING TO DO TO PROTECT THEM HELPS HEALING.

MOST OF THE BITS OF THE BRAIN THAT DEAL WITH OVERWHELMING EVENTS ARE VERY OLD. SOME OF THE REFLEXES WE USE TO RESPOND TO DANGER ORIGINATED IN REPTILES.

IN FIGHT-OR-FLIGHT, RESOURCES SUCH AS OXYGEN, BLOOD AND SUGAR ARE DIVERTED TO THE BIG MUSCLES AND THE BRAIN. PRIMITIVE REFLEXES TAKE OVER.

'GET ME OUT OF HERE NOW!'
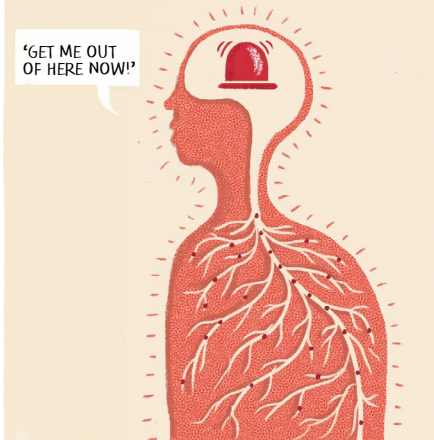
FIGHT-OR-FLIGHT OR DISSOCIATION SWITCH ON REALLY REALLY REALLY QUICKLY. UNLESS THEY ARE DISCHARGED, THE BRAIN CAN DEFAULT TO THESE LIFE AND DEATH SCENARIOS LONG AFTER THE DANGER HAS PASSED.

THIS IS THE BIG PROBLEM OF TRAUMA.

ON
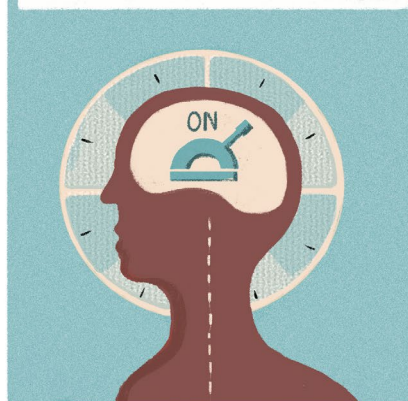
THE EXCITING NEWS IS THAT THEY CAN ALSO SWITCH OFF REALLY QUICKLY - EVEN IF THEY HAVE BEEN STUCK IN PLACE FOR YEARS.

OFF

WE ALL HAVE WITHIN US THE ABILITY TO ENDURE, RECOVER AND LEARN FROM OVERWHELMING EVENTS.

A common response is contracting to make ourselves small, ultimately into an immobile, fetal position. We are left bracing ourselves against life, disconnected from our internal and external worlds. 'Trauma occurs when an event creates an unresolved impact on an organism' (Levine 1997).

Running away from a lion is life or death. All non-essential activity is switched off, there is no need for digestion, libido and reproduction, immune systems or growth and repair (Sapolsky 2004). Health can dramatically improve when the 'defense cascade' is reset (Kozlowska et al 2015).

83
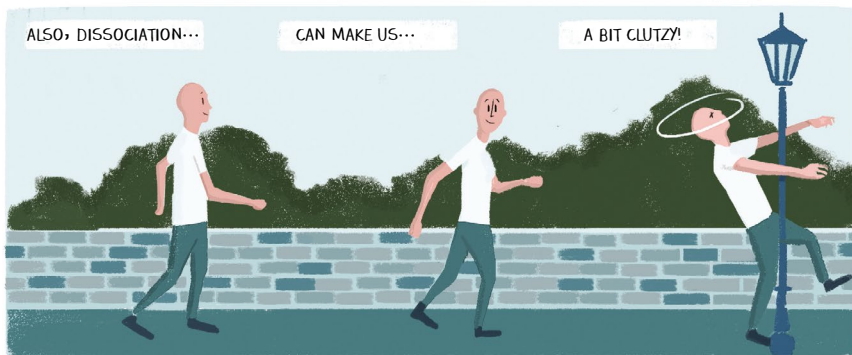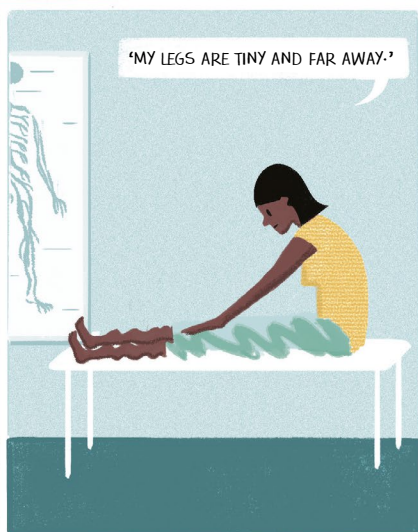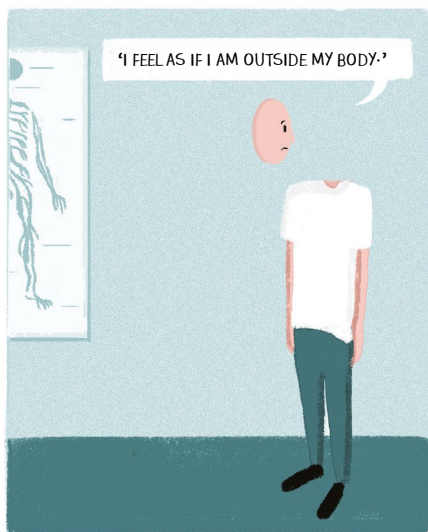
WE LOSE CONNECTION WITH OUR BODY OR PARTS OF OUR BODY. IT IS HARD TO STAY PRESENT AND GROUNDED.
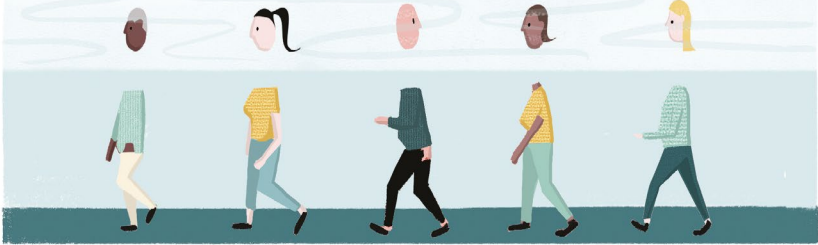
DISSOCIATION CAN BE TERRIFYING, BUT IT CAN ALSO BE VERY HARD TO SPOT. THE CENTRAL FEATURE IS THAT BRAIN IS IN THE HABIT OF NOT FEELING.

FEEL ME
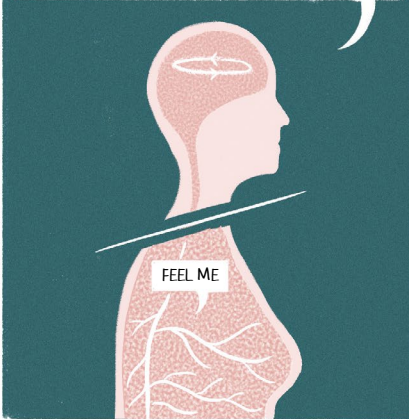
DISSOCIATION IS DIFFICULT TO IDENTIFY AS 'WE DON'T KNOW WHAT WE DON'T KNOW.' OLD PARTS OF THE BRAIN ARE TRYING TO STOP US SENSING, DISTANCING US FROM THE BODY AND LIMITING OUR PERCEPTION.

85

PEOPLE CAN RELY ON THINKING AND FUNCTION PRETTY WELL, BUT OFTEN REPORT THEY FEEL CUT OFF, LIKE AN OBSERVER.
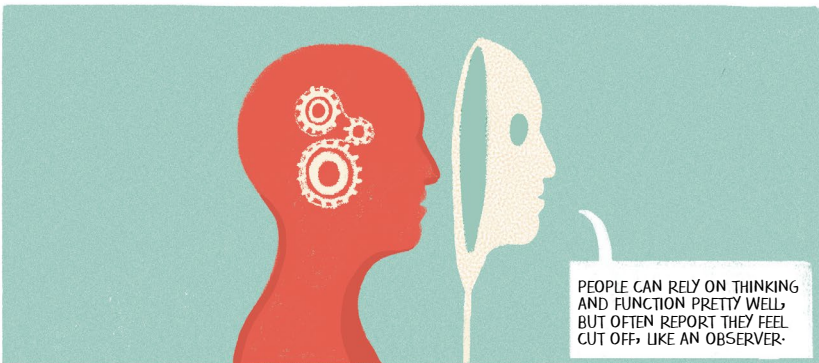
'I CAN'T GET ENOUGH AIR IN.'
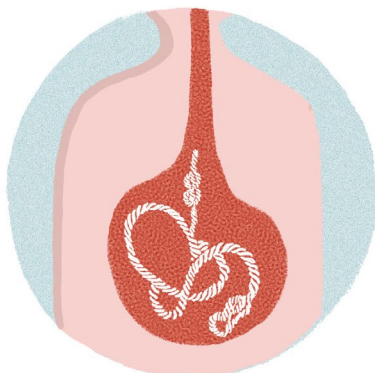
'THERE IS A KNOT OF ANXIETY IN MY BELLY.'
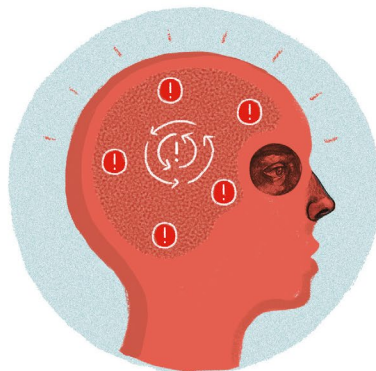
'THOUGHTS KEEP INVADING ME, IT'S AN OBSESSION I CANNOT LET GO OF.'

'I CAN'T KEEP STILL, MY MIND IS RACING.'

THESE STATEMENTS DESCRIBE BEING STUCK IN THE GO QUICK, FIGHT-OR-FLIGHT MODE.

THE BODY FEELS AS THOUGH EVERYTHING IS GEARED UP FOR ACTION, ALL THE TIME, NON-STOP. PANIC ATTACKS AND/OR RAGE ARE THE LAST STOPS ON THIS ROUTE.

Classic post-traumatic stress disorder (PTSD) symptoms include involuntarily re-experiencing aspects of the traumatic event in a very vivid and distressing way, avoidance behaviour hyperarousal, and emotional numbing (NICE 2005).

Being stuck in fast forward can be very productive. There are many successful executives whose internal state drives them forward. But the imperative from the body is ultimately very draining and frequently associated with massive anxiety.

'I'M SHAKING, IS THIS NORMAL?'

SHAKING AFTER A DRAMATIC EVENT IS OFTEN ASSOCIATED WITH FEAR. SHAKING UNCONTROLLABLY FEELS BIZARRE AND TOO MUCH.

LETTING OURSELVES SHAKE CAN BE A VERY POWERFUL TOOL AND CAN BE USED LIKE A SAFETY VALVE TO CLEAR EXCESS ENERGY. WE CAN LEARN TO INTERACT WITH SHAKING, RATHER THAN TRYING TO DAMPEN IT DOWN ALL THE TIME. SHAKING CAN BE UNCOUPLED FROM EMOTIONAL INTENSITY.

RESTLESS LEGS AND TENSION SHAKES ARE VERY COMMON WHEN WE ARE OVERWHELMED.

87

SHAKING IS BEST UNDERSTOOD AS A WAY OF EXTINGUISHING FEAR AND DISCHARGING ALL THE ENERGY MOBILIZED FOR FIGHT-OR-FLIGHT.

(MORE ON THE STRANGENESS OF SHAKING LATER.)

The 'I'm shaking, is this normal?' quote is from a young girl after watching her first deer being killed. Her dad does an amazing job of reassuring her and helping her discharge, check YouTube: 'Savannah's first deer hunt'.

The amount of people who experience restless leg syndrome (RLS) is surprisingly high: 'RLS affects 5%–10% of adults in the general population and is associated with various chronic conditions' (Li et al 2013).

WE CAN USE THREE STATEMENTS TO HELP UNDERSTAND WORKING WITH AND OVERCOMING TRAUMA.

1. 'THERE IS TRAUMA.' TERRIBLE THINGS HAPPEN TO HUMAN BEINGS.

TUSNAMI

WAR

88

2. 'WE CAN OVERCOME TRAUMA.'

WE ARE 'WIRED TO SURVIVE'. WE WOULD NOT BE HERE AS A HUMAN SPECIES UNLESS WE HAD EVOLVED WAYS OF RECOVERING FROM THAT LION ATTACK (OR SUDDEN LOSS OF A LOVED ONE, OR BEING ABUSED, OR BEING IN AN ACCIDENT...).
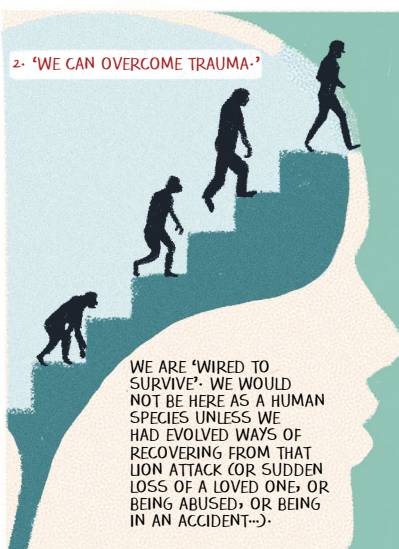
3. 'HEALING TRAUMA IS ABOUT MEETING THE BODY.' IN TRAUMA, OLD PARTS OF THE BRAIN CHANGE HOW THE BODY WORKS. BY PAYING ATTENTION TO FEELINGS IN THE BODY AND LEARNING TO SELF-REGULATE WE CAN REBOOT THE BRAIN.

REBOOT
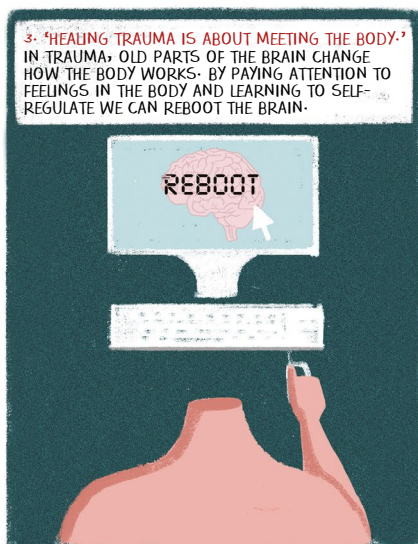
'As I learned more about how people manaage to withstand extremely aversive events, it became all the more apparent to me that humans are wired to survive. Not everybody manages well, but most of us do' (Bonanno 2010)

These three statements are drawn from the work of Dr David Berceli, creator of Trauma Releasing Exercises (TRE). The body is central to healing, as often 'there are no words to describe the depth of human experience the trauma survivor has been plunged into' (Berceli 2008a).

4. Childhood adversity and lifetime resilience

Dr Lucy Bowes

Summary

Childhood adversity increases children's risk of poor educational, social, mental and health outcomes. However, many children display 'resilience' in the face of adversity, and function at least as well as the average non-exposed child. A great deal of research has focused on the role of children's individual characteristics such as cognitive appraisal and coping strategies. However resilience is not, and should not, be viewed as an issue of individual resources and capabilities.

Resilience arises through children's interactions with their social and physical ecologies, from families through to schools, and neighbourhoods. Scaffolding child development by supporting families, building healthy and happy school environments and communities, and addressing social inequalities in access to resources is crucial for enabling vulnerable children exposed to adversity to navigate their way to success. Resilience therefore depends on the structures and social policies that determine availability and access to resources.

Adverse childhood experiences, including child maltreatment, bullying (including bullying by siblings), and other forms of violence and victimisation in the home or community place children at increased risk for a broad range of mental health, social and educational difficulties[1]. Despite this increased risk, there is plenty of evidence to suggest that many children function at least as well as the average, non-exposed child. Some researchers have gone on to suggest that 'resilience' – or the process by which children maintain or regain normative functioning following exposure to significant adversity – is the norm, not the exception[2]. Research on resilience has progressed from an early focus on the particular characteristics of 'invulnerable youth' to an understanding that resilience is a dynamic process involving a complex interplay between individuals and their particular life circumstances[3].

1. Individual characteristics that foster resilience

Much research has focused on the individual-level factors that help determine whether an experience is associated with severe symptoms or recovery. The 'kindling hypothesis' describes how early adverse experiences may sensitise children to subsequent life stress, increasing vulnerability to psychological disorders such as depression and anxiety[4]. However, exposure to stress early in life is not always a source of risk; studies of 'stress inoculation' or 'steeling effects' point to the beneficial effects of exposure to mild forms of stress[5]. It is thought that the experience of successfully coping with milder forms of stress may give children an opportunity to develop adaptive strategies that can be utilised to change future stressful situations where possible or modify their emotional response[6]. In a recent study of 1,584 teenagers in the Netherlands, it was found that for some adolescents, the experience of childhood adversity was associated with a lower probability of later depression under stressful situations compared to adolescents without a history of adversity[7]. It is thought that such individuals become more 'adapted' to stressful environments than teenagers without a history of childhood adversity. However, this may come at a cost – the same adolescents may display an overall lower sensitivity to all environmental experiences, meaning they may also benefit less from more positive environments.

The way we attend to stimuli in our environment, and how we process information, is thought to play an important role in risk and resilience to psychological disorders. In the cognitive model of psychological disorders, a complex interaction between one's genetic make up and early life experiences are thought to give rise to particular cognitive schemas – dysfunctional cognitive attitudes that, when activated by stressful life events, serve to bias our attention towards negative stimuli, to cause us to interpret ambiguous stimuli negatively, and biases our memory towards more negative events[8]. While research originally focused on the impact of significant life events such as the death of a loved one or loss of a job, more recent research has emphasised that relatively milder forms of stress may precipitate depression in those with cognitive vulnerability. For example, students who showed evidence of cognitive vulnerability in terms of negative attitudes and biases about the self were more likely to become depressed following negative outcomes on college applications compared to students without such cognitive vulnerability[9].

The cognitive model has given rise to one of the most effective forms of treatment for the psychological difficulties associated with childhood

adversity – cognitive behaviour therapy (CBT)[10]. There are numerous different models and treatments that build on the core principles of CBT; CBT-based treatments for post-traumatic stress disorder, social anxiety, obsessive compulsive disorder and depression to name but a few. The key process remains consistent across treatments: identifying and challenging patterns of negative thinking and avoidance behaviours. Though CBT-based approaches are not the only form of psychological therapy, they are among the most effective, particularly for the treatment of depression and anxiety[11].

2. The social ecology of resilience

Resilience in the face of adversity is not – and should not – be considered an issue in terms of individual resources and capabilities however. While cognitive vulnerability and other individual-level characteristics may be a predisposing factor to psychological difficulties, one must also consider protective factors at the family and social level, the wider school and community-level resources in place and how these are shaped by national policies and practices. It has been argued that resilience is better construed as "The capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of wellbeing, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways"[12]. Thus the onus moves away from the individual, but rather acknowledges the responsibility of society to support vulnerable individuals and build the resources necessary to enable individuals who have experienced adversity to navigate their way towards wellbeing. Practically, what might that entail?

3. Strengthening social support for vulnerable children

Availability and access to social support – both in terms of supportive relationships with family members, but also with friends and peers beyond the family – are an important source of resilience in at-risk youth[13]. The importance of forming positive attachments, particularly for children exposed to abuse and maltreatment, has underpinned much of the recent changes in the child welfare system.

There has been an overall decline in the use of residential care for children in

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high-income countries since the 1980s, in large part due to concerns about the lack of attachment in young children, and the risk of abuse[14]. In 2005, 68% of children in care were fostered[15]. However, a survey by Fostering for the Future[16] found that five out of seven councils had difficulties finding suitable matches between child and carers. As a consequence, out of area placements for children are not reducing, and placement stability may even be worsening[17]. Such instability reduces the opportunities for vulnerable youth to build and maintain positive relationships with supportive adults, and thus reduces opportunities to promote resilience. Strong sibling bonds have also been shown repeatedly to be associated with greater resilience to stressors such as maltreatment and bullying[18]. The importance of keeping siblings together during foster care or adoption has been well-documented in research[19]. Increasing availability of foster carers able to care for sibling groups and providing enhanced support is likely to be of great benefit. Likewise, the importance of school ties – both in terms of peer friendships and positive teacher-student relationships – plays an important role in children's resilience to adversity[20]. Too often, looked-after children are forced to move schools, disrupting these ties and reducing the likelihood of resilience.

Access to social support is not just important for children exposed to maltreatment, but rather promotes resilience to multiple forms of adversity. Increasing opportunities for socially isolated youths to develop support systems is one way to maximise opportunities for resilience. While the risks associated with online social networks is often highlighted[21], online resources to support health and social care are becoming increasingly popular. Online support groups and forums have potential to provide an important source of protection, with studies suggesting beneficial effects in terms of increased emotional support, self-disclosure, reduced social anxiety and belongingness[22].

4. The school environment

Children spend some fifteen thousand hours at school from the start of school until GCSEs[23]. In addition to supporting children's educational outcomes, the physical, social and cultural environment in which staff and students spend so much of their time may impact profoundly on their wellbeing, mental health and their opportunities to choose healthy lifestyles[24]. A systematic review of school-based interventions that promote student social and emotional development and mental health also promote better attainment[25]. However, schools may also impart risk for child mental health and wellbeing.

There is a substantial body of evidence that school-based bullying is a key risk factor for the development of psychological disorders including depression, anxiety and self-harm. School bullying may also exert long-term effects on children's educational and social outcomes[26]. Systematic reviews provide evidence that there are effective interventions that serve to reduce bullying, particularly those that target the whole school[27]. Recent research highlights the importance of changing bystander responses – shifting attitudes and actions away from providing implicit support for bullying behaviours such as through laughing or sharing online messages towards a discouraging stance[28].

By UK law, all state schools (not private schools) must have a behaviour policy in place that includes measures to prevent all forms of bullying among pupils. However, policies are decided by schools, and there is great variation in policy content and implementation[29]. Increasing awareness on best practices for tackling bullying and provision for schools to implement evidence-based anti-bullying programmes is greatly needed. Finland provides an excellent example here. The evidence-based whole-school intervention program 'KiVa' developed in Finland has now been adopted as the national anti-bullying programme, with over 90% of schools registered as implementing the KiVa programme[30]. A similar approach in the UK would help reduce the prevalence of a key risk factor for children and young people's mental health and wellbeing.

The rise in cyberbullying presents a new challenge for families, schools and society. While evidence may suggest that cyberbullying may represent a new tool through which bullying can take place rather than a new phenomena per se[31], the very fact that the bullying does not take place within school grounds, and that the bullies may remain unknown, means existing anti-bullying interventions will need to be modified to address cyberbullying at the very least. New interventions are being developed, many utilising effective components from traditional anti-bullying interventions such as psycho-education and changing bystander behaviour[32]. However as yet, systematic evidence of their efficacy is lacking.

5. Addressing the adverse experiences in the round

Bullying also provides an example of the silos in which we conduct research and improve practice. Children's experiences of trauma and victimisation in the home are closely connected with their experiences with their peers outside of the home environment. Children who are maltreated are twice as likely

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to be bullied at school for example[33]; more than half of children victimised by their siblings also report being bullied by their peers[34]. This is not to say that all bullied children have experienced some form of maltreatment at home – far from it – but rather raises the point that victimisation experiences tend to co-occur. Research and practice often neglects the fact that children who experience one form of victimisation are at significantly greater risk of experiencing other forms of violence[35]. In a survey of children's victimisation experiences in the home, school and wider community, the average number of victimisation experiences reported was 3[36]. Children who experience multiple forms of adverse experiences are particularly vulnerable to developing psychological difficulties[37].

Exposure to multiple types of adversity substantially decreases the chances of children and young people navigating their way to resilience[38]. Unfortunately, most interventions are designed to target specific forms of adversity: family nurse partnership programmes and other parenting programmes are designed to support parents at risk of harsh parenting practices; bullying interventions are almost wholly confined to the school domain, despite strong evidence of an overlap between experiences at home and at school[39]. This separation of research and intervention misses the chance to provide better, integrated support for children exposed to multiple forms of adversity. Protective factors at the family level including parental warmth, positive sibling relationships and a supportive home environment have the power to promote resilience to bullying, yet such family factors are often overlooked in school-based anti-bullying interventions[40].

Schools too may play an important role in supporting children exposed to family maltreatment, with evidence that school education programmes increase child self-protective skills and knowledge[41]. A better integration of family and school services and interventions is likely to be of great benefit in reducing risk and promoting resilience. Alongside this, there is strong evidence that when adolescents are able to access mental health services, they are better able to manage their mental ill health, and make sense of the trauma and adversity they have faced[42].

6. An integrated view of resilience

Resilience encompasses children's individual strengths and capabilities as well as their social and physical environments. Protective factors range from proximal, individual characteristics of children and their families to broader, distal (remote) factors that together promote successful development under adversity. Resilience is not an individual trait, or something that children are born with. Rather, children's interactions with their social and physical environments build resilience. Resilience is therefore dependent on the structures and social policies that help scaffold children and make resources available.

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5. Building resilience in the face of adversity

Lucas Shelemy and **Dr Pooky Knightsmith**

Introduction

In reviewing what the academic and practice literature says about how children and young people build resilience in the face of adversity, several themes emerged as key factors in protecting and promoting children and young people's resilience – what we call the '4Ps':

- **Parents** – a nurturing, caring, rule-enforcing relationship with a parent, carer or adult figure

- **Peers** – social connectedness with a supportive peer group

- **Problem solving** – ability to problem solve and communicate can moderate risk factors

- **Passion** – an interest, hobby or skill that the child highly values in themselves

In this paper we explore each of these 'Ps' in turn and consider their practical application in the current context.

Figure 1: Key factors that protect and promote resilience in children and young people in the face of adversity and trauma
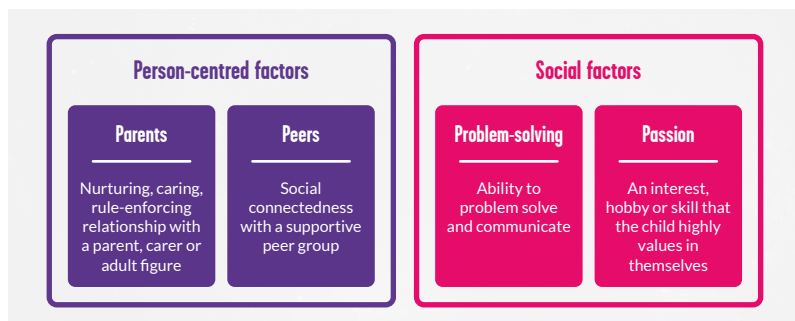
1. Parents

The role of early attachment and a strong, nurturing relationship with a parent or carer is highlighted by much of the literature. The fulfilment of this role by a trusted adult away from the home environment such as a teacher can also boost resilience. All children benefit from at least one stable caring relationship from a supporting adult. Where there is no existing relationship at home or school, the allocation of an adult mentor may be beneficial.

In order to build the resilience of a vulnerable child, the supporting adult can[1]:

- Offer a warm and nurturing environment

- Spend quality time with the young person

- Provide clear guidance, structure and rule-setting

- Encourage and support participation in leisure activities

- Act as a role model that the young person can look up to

- Incite goals and inspire ambition

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For children and young people who experience adversity, one of the most effective protective factors that can enhance resilience is having a stable and caring parental person in their life. Parents can protect and 'buffer' children from some of the worst effects of environmental adversity and can also nurture the characteristics in children that help them to cope with problems.

Previous studies have highlighted the importance of a supportive and nurturing relationship between the young person and a parent to improve resilience in adverse circumstances[2]. Traumatised children are more likely to recover when in a "healthy, nurturing, consistent, repetitive, rewarding, persevering, emotionally literate relationship"[3].

A supportive, stable and consistent family environment provides a strong basis for increased resilience. De Haan found that children aged 10 with supportive mothers were more resilient to everyday stressors than to those with less supportive mothers[4], while La Fromboise and colleagues found that in the face of prejudice and violence, American-Indian adolescents' resilience was

greatly enhanced by having a "warm and supportive mother"[5]. The quality of the relationship between parents or carers greatly affects the resilience of the child[6] and the presence of a compassionate and active father can also improve resilience in children who may be facing trauma[7].

This effect extends beyond emotional health: children are more protected from crime and drugs when parents or carers are more affectionate and supportive, regardless of other external factors such as neighbourhood[8]. In one Australian study it was found that children from disadvantaged areas view their parents as central to helping them do well when met with a "tough life"[9].

As well as creating a nurturing relationship, parents also have an important role in the creation and maintenance of community support factors for the young person. In some communities, strong extended family connections can heavily influence young people's sense of resilience and coping strategies (e.g. African-American families[10]). When met with illness-related trauma, children showed improved coping in families with close and constructive relationships[11].

Where there is an absence of a home-based attachment figure in the form of a parent or carer, the ability to form a trusting relationship with at least one adult outside of the home environment is also a factor that can boost resilience when met with trauma or risk[12]. These trusted, supporting adults may be from a school or other community environment; the allocation of an adult 'mentor' for a child has been demonstrated to be beneficial in boosting resilience[13]. Resilience is improved if the adult mentor is caring and supportive, and incites goals and ambition in the child[14]. For some children, a faith community can provide that relationship that may not be found at home[15].

For younger children, it is usually the parent or carer that is best placed to provide such a relationship. As adolescents grow older, the tendency to rely more on peer relationships is an important one in helping foster resilience.

2. Peers

Peer relationships become increasingly important as children grow older, or where there is an absence of a positive relationship with a parent. Positive peer relationships describe those where the young person:

- Feels a sense of belonging and acceptance

- Identifies with a group, sharing likes, dislikes and opinions

- Feels supported and respected and reciprocates these feelings

- Has a few high-quality friendships rather than many superficial friendships

A group of supportive peers and friends around a young person can play an important role in boosting resilience[16]. This is the case especially in late adolescence, where support from adults is replaced by those of a similar age. Good peer relationships can improve the wellbeing, social skills and problem-solving ability of young people[17]. A friendship group enables protection from negative risk factors and the opportunity to 'escape' from high-risk environments[18].

In one study of over 1000 adolescents, it was found that peer acceptance was a significant protective factor for young people with low closeness with parents[19]. Support from the social environment and social attachment are the highest predictors of emotional recovery following child sexual assault[20]. Graber and colleagues studied adolescents from a low socio-economic area in Britain and found that psychological resilience was positively correlated with the quality of friendships[21]. One study found that good peer relationships moderated the negative effects caused by parental separation[22].

3. Problem-Solving

When discussing resilient families, Walsh writes that the ability for a family to communicate and problem-solve together is vital to ensuring protective factors to resilience[23]. Children show improved coping with domestic abuse when they are part of the decision-making process and are informed about what is happening around them (e.g. whether to leave home)[24].

In fact, intelligence and the ability to problem-solve has been consistently indicated as a protective factor for children facing trauma and adversity with studies indicating that more resilient children have higher intelligence and problem-solving ability compared to peers, despite being surrounded by

the same high-risk adversity environment[25]. For example, in a longitudinal study of New Zealand adolescents it was found that resilient teenagers had significantly higher IQ scores than their peers[26]. Flouri and colleagues analysed data from over 16,000 children in the UK, studying the relationship between family risk factors and emotional outcomes[27]. They found that higher general intelligence by age five was a significant protective factor. Children in adverse conditions with high intelligence were less likely to experience behavioural and emotional problems compared to those with lower intelligence. Perhaps most relevant of all is Kwok and colleagues' study of adolescents living in China which concluded that rational problem-solving ability was a significant moderator in suicidal ideation following physical abuse in females[28].

Improvements in intelligence can be gained through an encouraging family and school environment[29]. Likewise, schools are an ideal environment to teach problem-solving skills from an early age and throughout adolescence discretely through timetabled Personal, Social, Health and Economic (PSHE) education lessons, or across the curriculum, as part of an embedded, developmental curriculum.

4. Passion

Young people who have a passion or hobby that interests them and which gives them a feeling of belonging, self-efficacy, self-worth and self-esteem may have greater resilience than their peers. A young person's perceived efficacy in 'something' can moderate risk factors, regardless of whether that 'something' is creative, physical, academic, social etc. This is true of children from high risk as well as low risk environments[30] both in the short term and in the longer term; a young person succeeding in something that they value highly has a positive effect on future psychological resilience when faced with childhood trauma[31].

The ability for children to participate in activities in their local area is correlated with improved self-esteem and self-efficacy[32]. Self-belief (the confidence that one is good at something) and self-efficacy (an understanding of one's own strengths and limitations) may be crucial factors for improving self-esteem and subsequently resilience.

Robbie Gilligan writes about a series of case studies in which resilience is greatly enhanced in young people following attention to cultural and sporting

activities[33]. The engagement with mentors through these activities could be an effective way of helping a young person form a positive relationship with parents or peers and can expedite and enhance the development of a protective social network within which the child identifies.

One case study described by Gilligan showing the power of strong interests as a protective factor is of a boy in foster care. His strong interest in dancing and performance enabled him to become resistant to "sexist mockery". Following a performance, he felt much more self-confident and positive about his future. The encouragement of young people to find interests and activities is one of the most effective means in boosting their self-esteem and resilience.

Schools are an ideal environment to offer development in skills and hobbies. Likewise, parents or carers are effective in sparking an interest in the child that helps divert attention away from negative life events[34] and in many cases, passionate engagement with an activity or hobby will also support the development of other resilience boosting skills such as problem-solving, intelligence and communication.

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5. Practical implications

The literature we have reviewed suggests a role for our '4Ps' (parents, peers, problem-solving and passion) in the development of resilience in children and young people protecting them from the effects of trauma and adverse events, indicating a role for both person-centred and social factors.

The most important takeaway is that it appears that it is possible for us to support children and young people in developing resilience and the ability to cope both before and after the onset of trauma or adverse effects and that there are a wide range of means that may be effective – and possibly more so in combination as there are clear interactions between the four Ps.

In simple terms, the literature indicates that for every child or young person who is faced with adversity we should ask the following questions:

- Does this child have a supportive relationship with a trusted adult?

- Does this child have quality relationships with a group of friends?

- Does this child have good problem-solving skills?

- Does this child have an interest, hobby or skill?

Where we answer no to one or more of these questions, there is a clear indication of practical steps we might take in order to support the growth, and development of their resilience.

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Section 2

Addressing childhood adversity and trauma

(a national view)

6. Moving Beyond Adversity

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In this paper we propose three urgent actions that local commissioners could take to begin to address childhood adversity and trauma in their local area. These actions include:

1. making childhood adversity and trauma a **local commissioning priority**

2. creating a **common identification and enquiry framework** for identifying need

3. investing in **adversity and trauma-informed models of care.**

Sections 2 and 3 of *Addressing Adversity* provide additional ideas on how to put these three actions into practice, and give insight and case studies about how this has been achieved across different local areas in England.

1. Make childhood adversity and trauma a local priority

YoungMinds was part of the Government's independent taskforce, which made important recommendations about the transformation of children and young people's mental health through the *Future in Mind* report[1]. The recommendations were accepted by government and subsequently embedded in the NHS England Five Year Forward View for Mental Health[2], NHS planning guidance[3] for 2016/17 – 2020/21 and guidance for Local Transformation Plans (LTPs)[4].

Most local areas have captured their priorities for the transformation of children and young people's mental health in their LTPs, which have been developed by Clinical Commissioning Groups (CCGs) in partnership with local agencies. However, within these there remains discrepancies in the recognition and identification of children who face adversity and trauma. Moreover, the scale of the transformation challenge facing local areas, has resulted in significant variation across the country.

For example, analysis of LTPs by the NSPCC in 2016 found that a third contained no recognition that children and young people who have been abused or neglected present a very high risk of developing mental health issues, or gave any detail about the provision of services to meet their needs[5]. Just one in three of these plans were seen by the NSPCC as containing an adequate needs assessment for the mental health needs arising from experience of childhood abuse and neglect.

This is contra to the guidance to local areas from NHS England, which states that "the scope of Local Transformation Plans should cover the full spectrum of service provision and address the needs of all children and young people including the most vulnerable, making it easier for them to access the support they need when and where they need it"[6]. Clearly more needs to be done at a national level to support local areas to prioritise a transformation agenda, which is adversity and trauma-informed.

> For more on the NSPCC analysis of Local Transformation Plans see Paper 17.

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While Local Transformation Plans are the focal planning document for the transformation of children and young people's mental health services, they are located within a larger NHS geographical footprint of the Sustainability and Transformation Plans (STP)[7]. The 44 larger plans describe the transformation strategy for the implementation of the NHS Five Year Forward View across the wider sub-regional health economies in England, and for all areas of health.

We believe that all STPs and LTPs must include a priority committed to ensuring that all new and transformed local services supporting children and young people should be adversity and trauma-informed. This could easily be incorporated into existing commitments or be included as a new strategy priority through the annual refreshing of the LTPs.

The refreshed LTPs should include addressing pre- and sub-clinical symptoms of (post) traumatic stress within the design and implementation of a local, generic children and young people mental health pathway. This is recognised within Public Health England's Prevention Concordat for Better Mental Health, which places a renewed focus on the wider determinants of mental ill health (including experiences of adversity and trauma) within psychosocial pathways[8]. Additionally, the adversity and trauma-informed models of

care should be embedded within crisis care pathways and local Crisis Care Concordats[9] (where these arrangements are in place). Furthermore, a number of local areas have already put this in practice through their response to tragic incidents, and in anticipation of future need arising from these experiences.

The London Incident Support Pathway for Children and Young People

The London Incident Support Pathway for Children and Young People[10] was developed in response to the London Bridge terrorist incident in June 2017. The pathway built upon the existing transformation and crisis care plans[11] for children and young people, the NICE guidance on PTSD[12], and the THRIVE model[13] developed by The Anna Freud Centre and The Tavistock and Portman NHS Foundation Trust. The NHS Healthy London Partnership also created a pathways for adults[14].

The pathway for children and young people provides clarity on the support that local agencies have made available to those children and young people who have been exposed to the distressing terrorist incidents (including those who have acquired an injury and/or experienced bereavement). Importantly, it recognises that some children and young people may have a delayed distress response, and describes pre- and sub-clinical behaviours and ways of thinking that would be considered normative responses to trauma.

At the heart of the key principles of the pathway is adversity and trauma-informed care. The principles for the models of care offered within the pathway are to:

- Acknowledge the importance of anticipated reactions (stress response) to a major incident.

- Support children and young people to develop and sustain their ability to cope (including the wider role of care givers and community resources).

- Utilise a multi-agency stepped model of care that provides a continuum of care that is holistic.

- Ensure approaches are evidence-based and proportional, flexible and timely to respond to the needs of the children and young people affected.

- Provide clear and consistent messages and communication to partners, children, young people and families.

- Ensure professional practitioners and staff providing support have access to training, consultation and supervision relating to adversity and trauma.

The continuity of care offered through the multi-agency stepped model, first offers universal advice and resilience building, using familial and community resources. If symptoms escalate or persist the child or young person can access targeted psychosocial support and mental healthcare (if required).

CYP will be identified following specialist consultation with either the referrer (professional) or family. Specialist consultation will also identify CYP with additional risk factors (pre-existing history of trauma, co-existing mental health needs and secondary stresses).

Finally, the offer is extended for those children and young people who are experiencing moderate-severe needs where the symptoms are persistent or increasing, which is having an impact on their day-to-day living, and in situations where they lack familial or a network of emotional and social support. This focuses on more incentive provision of mental healthcare being led by, and with input from, a specialist clinical team.

These targeted and specialist services (the latter via additional consultation) have been made available for those children and young people who have a 'pre-existing greater risk, or complexity' relating to trauma and who have co-existing mental health needs. Within the THRIVE model, these children are located in the 'Getting More Help' and 'Getting Risk Support' domains.

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2. Create a common identification and enquiry framework

Creating and sustaining a local transformation priority of adversity and trauma-informed care requires us to bring together the different ways in which local agencies recognise and identify adversity, trauma and related mental health needs. The wider variation in terminology and clarification even within forms of service creates confusion about populations that are being supported, and can unwittingly fail to recognise forms of adversity that can have a significant impact on a young person's mental health and wellbeing. For example, an analysis by the Children's Society of 36 specialist child and adolescent mental health (CAMHS) providers, found significant inconsistencies in the way that providers described and identified 'vulnerable' children and young people[15].

These inconsistencies are replicated at a local level through the legislative focus of different statutory agents. At present, local authority safeguarding teams in England focus on identifying and assessing the needs of children and young adults who are at risk of, or experiencing, abuse, maltreatment or harm. They also are responsible for coordinating inter-agency working (including education) to promote the welfare for children[16] and young (vulnerable) adults[17]. These responsibilities are enhanced by the recent passing[18] of the Children and Social Work Act 2017, and there is additional statutory guidance for children who experience specific forms of abuse, including Child Sexual Exploitation.

Local authorities also have a broader responsibility to identify and assess 'children in need', including those who are at risk of poor mental health and emotional development[19]. Likewise, tools are used by local authorities to identify the mental health and emotional wellbeing of specific groups, including looked-after children, through the use of a Strengths and Difficulties Questionnaire (SDQ)[20].

A similar approach is taken in youth offending, with teams specifically considering the risk of serious harm[21] and mental ill health, where an adverse childhood experience has been identified as a contributing factor, and would increase the likelihood, of poor outcomes[22]. In areas where there is a known social problem in the community, both local authorities and Youth Offending Teams have programmes of work to identify those children who are at risk of a prevalent childhood adversity or additional complexity in their community, for example gang membership or substance misuse.

The Children Act of 2004 requires local authorities to make arrangements to promote cooperation between local statutory partners to identify, assess and meet the needs of children who require additional support. As part of the implementation of the Children Act of 2004 and the former Every Child Matters policy[23], local authorities adopted a Common Assessment Framework[24], which standardised processes across agencies so that they could identify the needs of children, including those who faced additional risk and adversity in their lives. A core intention of the new assessment framework was to give local agencies a common language to identify and describe the needs of these children. This is why many local authorities (despite the financial implications[25]), and their partners, have continued to use Common Assessment Frameworks beyond the lifespan of the Every Child Matters policy, and the end of a national pilot to collate local data[26].

Common Assessment Frameworks are now frequently used by local authorities as a tool for identifying the needs of children and families who would benefit from "early help"[27] as set out by the revised statutory guidance for safeguarding children[28] and requirements in the Ofsted inspection framework[29]. Ofsted's definition of early help is targeted at "those children and young people at risk of harm (but who have not yet reached the 'significant harm' threshold (as set out in the statute) and for whom a preventative service would reduce the likelihood of that risk or harm escalating)"[30].

Similarly, the Education, Health and Care Plans (EHCP)[31] introduced as part of the Children and Families Act[32] of 2014, put an emphasis on multi-agency identification and coordination of services to meet the needs of children who have a SEND. Beyond this, children who have a level of need that is not deemed eligible for an EHCP, are meant to be given access to a local offer that enables their families to navigate the support that is available for them in the local community. This should include signposting to relevant children's mental health services, if a need has been identified.

More recently, local authorities have been incentivised by central government to focus on the needs of children living in families who experience significant complexity. The national Troubled Families Programme[33] aims to support families who meet three of the following criteria[34]: 1) contain a child involved in youth crime or anti-social behaviour; 2) have children who are regularly truanting or not in school; 3) have an adult on out of work benefits; 4) cause high costs[35] to the taxpayer (because of the complexity of their need or interaction with services).

Over 117,910 families have been identified in this way and all receive multi-agency interventions to support their needs[36]. Within this group of families are children who will have faced multiple adverse childhood experiences, which is further compounded by the complexity of their family life and interactions with local services. Moreover, the criteria used for the programme focuses on presenting factors or symptoms of underlying adverse childhood experiences[37].

In contrast Directors of Public Health can take a more broader perspective, considering the social and environmental factors that contribute to higher risk of mental ill health and determinants of premature mortality. Reflecting this, both the Public Health Outcomes Framework[38] and the Children and Young People's Mental Health and Wellbeing Profiling Tool[39] created by Public Health England contain proxy measures relating to childhood adversity. The latter has been updated to include three domains that enable local areas to explore data relating to childhood adversity, vulnerability and protective factors.

Building on the reforms of the Health and Social Care Act of 2012, most areas now hold a shared profile of children's health and care needs in their area[40]. These are usually contained or summarised within their Joint Strategic Needs Assessment or Health and Wellbeing Plans, many of which derive from data compiled by Public Health England in their annual Child Health Profiles[41]. Some Clinical Commissioning Groups (CCGs) and NHS mental health providers specifically target groups of children who are at additional risk, such as those involved in gangs, those who have life-limiting health conditions or those with learning disabilities.

More recently, health commissioners and providers have followed the lead of Blackburn with Darwen Local Authority and Lancashire Care NHS Foundation Trust by embedding a routine enquiry about childhood adversity into service models and assessment processes. This follows measures taken by the devolved nations, including the Scottish Government's early adoption as part of its National Domestic Abuse Delivery Plan for Children and Young People[42]. While routine enquiry is still in its infancy, and requires further development, it is beginning to signal the need for a common way of describing and enquiring about childhood adversity within non-specialist services. Furthermore, it offers a form of enquiry that can be used in relation to pre- and sub-clinical symptoms of traumatic stress, as well as acting as a basis for identifying adverse situations and circumstances in the child or young person's life.

Future in Mind recognised the value of routine enquiry. NHS England has subsequently been supportive of its roll-out, and the government has incorporated it into measures to tackle sexual exploitation, domestic violence and abuse of young people aged over 16 years[43]. Routine enquiry is now being extended into child and adult mental health, sexual health and adult substance misuse services[44].

→ For more on identification of need and routine enquiry see Papers 10, 11, 12, 19, 20, 24, 25, 27.

3. Invest in adversity and trauma-informed models of care

Finally, in order to commission and deliver adversity and trauma-informed care for children across England, we need a common set of guiding principles.

→ Throughout sections 2 and 3 of this collection, you will find a number of proposed principles that provide a clear direction of travel for the transformation of services (in particular we recommend reading those set out in Paper 9).

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Here, we have set out the guiding principles from *Future in Mind*[45] that would enable local services to be commissioned and provided in a more adversity and trauma-informed way, which we identified in our *Beyond Adversity* report[46]. These principles are based on the work of a Vulnerable Groups and Inequalities Task and Finish Group[47], and have been subsequently refined with insight and reflections from the clinical summits YoungMinds held in 2017, and the contributions we have included in *Addressing Adversity*. The principles are summarised in short-form on the next two pages.

Table 1: The Six Principles of Adversity and Trauma-informed Care

Adversity and trauma-informed models of commissioning and care should be:	
1. Prepared	• creates and maintains a priority in addressing the causes and mental health consequences of childhood adversity and trauma. This includes having this priority embedded in local commissioning, service and transformation plans. • analyses available data on prevalence, and possible local need, at both a pre- / sub-clinical and clinical level. • anticipates mental health needs arising from childhood adversity and trauma, by embedding knowledge, expertise and informed interventions in local commissioning and service pathways.
2. Aware	• ensures local agencies and partners have a good understanding of childhood adversity and trauma, and the associated symptoms and responses. • has a common framework for identification and routine enquiry about adversity and trauma in childhood and adolescence. • understands and responds to the cultural, identity and gendered contexts of the young people and the community in which they live – including situations where a child continues to live in adverse circumstances.
3. Flexible	• provides stepped support to children and young people who face adversity or trauma at both a pre- / sub-clinical and clinical level. • provides models of care that enable alternative and more flexible forms of access and engagement (i.e. through street triage). • provides targeted models of care to excluded groups of children and young people who live in adverse and traumatic environments.
4. Safe and responsible*	• intervenes early to prevent an escalation of need and avoid preventable exposure to additional adversity and trauma in children and young people's lives. • puts in place policies, practices and safeguarding arrangements that avoids re-traumatising the young people and stigmatising their behavioural or emotional response to trauma.

Adversity and trauma-informed models of commissioning and care should be:	
4. Safe and responsible* *(continued)*	• ensures that safeguarding procedures are in place, are seen as part of interventions in childhood adversity, and work in a way that supports the child or young person to recover from the adversity or trauma they have faced. • ensures that children and young people receive coordinated support from knowledgable, qualified, trustworthy and well-trained professionals who have suitable supervision and workforce support that can address vicarious or secondary trauma that may occur.
5. Collaborative and enhancing	• meaningfully engages and involves children and young people who have faced adversity and trauma in decisions about their treatment, care and the design of interventions. • adopts a strengths-based approach, recognising the resources and resilience that children and young people have drawn upon in the past, and creating positive and additional strategies for symptom mitigation and recovery – including self-soothing, emotional and regulation and the promotion of self-care. • ensures models of care recognise and harness (where possible) families, care-giving, peer and community assets as part of treatment and recovery.
6. Integrated	• enables effective communication and data-sharing between agencies to ensure that the whole of the child's needs are identified and met. • co-commissioned (possibly with a lead agency) to ensure that there is a continuity of care and consistency of pathways across, and within, the services and interventions that children and young people will receive. • ensuring smooth transitions between stepped care models, providing timely referral and treatment to specialist services, and proving access to enhanced mental health, adversity and trauma knowledge and expertise when required (i.e. through outreach and liaison models of care).

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* We would recommend readers consult NHS Education for Scotland's framework for core components of the required knowledge and skills-base. NHS EfS / Scottish Government (2017) Transforming Psychological Trauma: A skills and knowledge framework for the Scottish workforce: *http://www.nes.scot.nhs.uk/media/3983113/NationalTraumaTrainingFramework-execsummary-web.pdf*

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7. Young people's principles for adversity and trauma-informed care

During 2016 and 2017 YoungMinds worked with a small group of children and young people to explore their experiences of care and support during and following adversity and trauma. We supported them to co-create their own principles for adversity and trauma-informed care.

Table 1: The Six Principles of Adversity and Trauma-informed Care

Adversity and trauma-informed models of commissioning and care should be:	
1. Prepared	"When you notice, or I tell you that I need help, you should already know what the next step is" – sometimes I feel like people are making it up as they go along.
2. Aware	"Don't label me with the experiences I've had" – I'm not a label, I am me. Everyone's experiences are different, and it doesn't define who I am. "Recognise all of my needs" – I don't think of my life as school, family, medication, all of the different parts of my life are connected, see me as a whole person. "Understand my behaviour" – when I'm shouting, crying, hiding, stealing, hitting out at myself or others I'm just trying to make sense of everything I've gone through. I'm not 'wrong', 'damaged', 'mad' or 'bad'.
3. Flexible	"Find a way that we can both understand each other"- we might communicate in different ways, make sure you use a way that works for me. "Shape your support around me" – getting care is already hard work, so don't make it harder by giving me the wrong person, in a place I don't feel comfortable in, or at a time that doesn't work for me.

Continued...

Adversity and trauma-informed models of commissioning and care should be:	
4. Safe and responsible	"Keep me safe and don't betray my trust" – tell me what you will need to do next and who you will be talking to, and make sure you include me in the process and keep me updated.
	"Know where I'm coming from" – I may not be or feel safe back where I live. If people know about what is going on, they could use it against me.
	"The way you treat me matters" – to recover I need you to treat me with respect and understand why I'm behaving this way. Make sure I'm not in the care of someone who will make things worse. I want someone who is on my side.
5. Collaborative and enhancing	• "Include me in decisions about my life" – ask me what I want to happen, I have the right to be involved in decisions about my life.
	• "I've survived this long" – build on my strength and help me find new ways to recover.
	• "I want to talk to someone who has been through the same thing" – it helps me make sense of what I've experienced and shows me I am not alone.
6. Integrated	• "Stop asking me to repeat myself" – it's a hard thing for me to talk about, and if it's going to help me I'd rather you told the right professional so that I don't have to.
	• "Don't pass me from person to person" – I have to start from scratch each time. I don't want to be thrown between services, and it's going to screw with my recovery.

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8. Creating trauma-informed mental healthcare in the UK

Dr Angela Sweeney, **Dr Sarah Clement**, **Beth Filson** and **Dr Angela Kennedy**

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1. Re-traumatisation in the mental health system

Re-traumatisation essentially means to be traumatised again. It occurs when a person experiences something in the present that is reminiscent of a past traumatic event. This current event or trigger often evokes the same emotional and physiological responses associated with the original event. People are not always aware that their current distress is rooted in past events, nor do all people relive the original event in a logical, coherent manner[1].

The mental health system can re-traumatise survivors through its fundamental operating principles of coercion and control[2]. Re-traumatisation includes overt acts, such as restraining and forcibly medicating a rape victim, as well as less palpable re-traumatisation, such as pressure to accept medication which mimics prior experiences of powerlessness. Empirical research indicates that traumatic experiences (e.g. physical assault, seclusion, restraint) are widespread in inpatient settings[3]. Mental health services can also contribute to historical and cultural trauma by recasting responses to racism as individual pathology[4], recasting women's attempts to resist domestic control as hysteria[5] and recasting homosexuality as sexual deviance in need of corrective treatment[6].

Jennings believes that while re-traumatisation can be unintentional and unanticipated, it will remain while mental health systems fails to acknowledge the role of trauma in people's lives and their consequent need for safety, mutuality, collaboration and empowerment[7]. Current services and supports that do not take these impacts into account may inadvertently re-traumatise,

further reinforcing survivors' needs for coping strategies such as illicit drug use or self-harm.

2. The impact of re-traumatising systems on staff

The policies, procedures and practices that staff may be required to perform in "trauma-organised systems"[8] can conflict with personal and ethical codes of conduct. For example, the use of seclusion and restraint as an institutional practice erodes the very meaning of compassion and care, the primary reasons most staff enter their chosen field. Staff who experience conflicts between job duties and their moral code are under chronic stress for which they must learn to cope and adapt. Those coping strategies may include "shutting off" the ability to empathise, and viewing people receiving services as "other" thereby disqualifying their humanity and basic human rights. Pessimism – rather than enthusiasm and hope – may buffer staff from their own feelings of helplessness[9].

Staff may also engage in "power over" relationships when organisations place a higher priority on risk management than human relationships. A nurse who is required to perform a personal search may become frustrated by a service user's resistance, failing to recognise that she/he is a stranger who is placing hands on the body of another who may be a rape survivor. Organisational cultures may become corrupted, paving the way to power over relationships that reinforce people's helplessness and hopelessness. In these "corrupted cultures", the basic values of the organisation are no longer driving practice; instead, the needs of service users become secondary to the needs of staff, and restraint and coercion may be used widely even when less restrictive options are available. This and other working practices and routines (such as rigid professional hierarchies and a lack of supervision) can dehumanise both staff and service users and lead to human rights violations[10]. The National Institute for Clinical Excellence (NICE) has expressed frustration at first resort to coercive practices even where other approaches are indicated[11]. The impact of trauma-organised services on workers is analogous to the impact of trauma on survivors – it reshapes and re-constructs self-identity and can shatter individual meaning and purpose[12].

3. The principles of trauma-informed approaches

The development of Trauma-Informed Approaches (TIAs) can be traced to the USA and to Harris and Fallot's seminal text[13], Using Trauma Theory to Design Service Systems. Bloom[14], also from the USA, who developed the Sanctuary Model outlines the development of TIA from the era of moral treatment, through social psychiatry and finally the concept of the Therapeutic Community[15] which includes developments in the UK. TIAs can be defined as "a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological and social development"[16]. Consequently, TIAs are informed by neuroscience, psychology and social science as well as attachment and trauma theories, and give central prominence to the complex and pervasive impact trauma has on a person's worldview and interrelationships.

TIAs are applicable to all human services, including physical health, education and schools, forensic, housing and social care[17]. In a trauma-informed service, it is assumed that people have experienced trauma and may consequently find it difficult to develop trusting relationships with providers and feel safe within services. Accordingly, services are structured, organised and delivered in ways that engender safety and trust and do not re-traumatise. Thus, trauma-informed services can be distinguished from trauma-specific services which aim to treat the impacts of trauma using specific therapies and other approaches. The key principles underlying TIAs can be found in Table 1, adapted from SAMHSA[18], Elliot and colleagues[19] and Bloom[20].

While it may seem that principles such as safety and collaboration define any good service for any service user, Elliot and colleagues[21] have argued that if these principles are not adhered to, trauma survivors may be unable to use services. It is striking that these general principles have strong resonance with the values that psychiatric survivors have historically called for, and underpin much peer support practice[22].

4. What are the potential benefits of TIAs?

The potential benefits of TIAs to survivors are myriad, including hope, empowerment, support that does not re-traumatise and access to trauma-specific services. Moreover, the medicalisation of human suffering has created a divide between people receiving services and those offering support; this

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divide can create tenuous bonds that are inadequate, at times, to protect the human and civil rights of people viewed as other[23]. But trauma is something that many of us experience, and indeed, a small number of studies suggest that workers in human services have a high prevalence of ACEs scores[24]. In recognising trauma as a shared event, healing too becomes something we do together.

Table 1: The key principles of trauma-informed approaches

1. Recognition	Recognise the prevalence, signs and impacts of trauma. This is sometimes referred to as having a trauma lens. This should include routine enquiry about trauma, sensitively asked and appropriately timed. For individual survivors, recognition can create feelings of validation, safety and hope.
2. Resist retraumatisation	Understand that operational practices, power differentials between staff and survivors, and many other features of psychiatric care can re-traumatise survivors (and staff). Take steps to eliminate re-traumatisation.
3. Cultural, historical and gender contexts	Acknowledge community-specific trauma and its impacts. Ensure services are culturally and gender appropriate. Recognise the impact of intersectionalities, and the healing potential of communities and relationships.
4. Trustworthiness and transparency	Services should ensure decisions taken (organisational and individual) are open and transparent, with the aim of building trust. This is essential to building relationships with trauma survivors who may have experienced secrecy and betrayal.
5. Collaboration and mutuality	Understand the inherent power imbalance between staff and survivors, and ensure that relationships are based on mutuality, respect, trust, connection and hope. These are critical because abuse of power is typically at the heart of trauma experiences, often leading to feelings of disconnection and hopelessness, and because it is through relationships that healing can occur.
6. Empowerment, choice and control	Adopt strengths based approaches, with survivors supported to take control of their lives and develop self-advocacy. This is vital as trauma experiences are often characterised by a lack of control with long-term feelings of disempowerment.

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7. Safety	Trauma engenders feelings of danger. Give priority to ensuring that everyone within a service feels, and is, emotionally and physically safe. This includes the feelings of safety engendered through choice and control, and cultural and gender awareness. Environments must be physically, psychologically, socially, morally and culturally safe.
8. Survivor partnerships	Understand that peer support and the coproduction of services are integral to trauma-informed organisations. This is because the relationships involved in peer support and coproduction are based on mutuality and collaboration.
9. Pathways to trauma-specific care	Survivors should be supported to access appropriate trauma-specific care, where this is desired. Such services should be provided by mental health services and be well resourced.

Because TIAs are premised on the understanding that most of the people who come into contact with mental health services have been impacted by trauma, training, supervision and support for staff are seen as essential. This attention to staff support has the potential to decrease burnout and reduce staff turnover. For example, research suggests that supervisors who feel that their organisation values them and cares about their wellbeing are more likely to be supportive towards the people they are responsible for[25].

There are complex interactions between service users, practitioners and organisations that can come to mirror one another through "parallel processes"[26]. Trauma survivors' lives may be organised around the trauma experience, just as systems can come to be organised around models that are inadequate for responding to survivors. This means that, for example, in trauma-organised systems, survivors may feel and be unsafe, leading to aggression towards staff. Experiencing aggression from survivors may cause staff to become wary and hostile, with organisations responding with greater punitive and risk-averse measures. This increases survivors' sense of unsafety and aggression. Becoming trauma-informed has the potential to break these negative parallel processes and create positive interactions.

Trauma carries a heavy economic cost. Dolezal and colleagues[27] have reviewed US research evidence on the economic impacts of violence and abuse and estimate a cost of between 17 and 37.5% of the total spend on healthcare. They believe that a compassionate healthcare system that understands the impacts of violence and abuse and offers appropriate support may avoid many

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of these costs. In the UK, the Department of Health has estimated that: "costs include the costs of providing public services for victims, the lost economic output of women and the human and emotional costs of violence for victims. An indicative figure for the minimum cost of violence against women and children is £36.7 billion"[28]. There is also some evidence that a reduction in seclusion and restraint has large cost savings (e.g. a 92% reduction in the costs linked to restraint[29]).

5. Applying trauma-informed principles to mental health

Trauma-informed mental health services are strengths based: they reframe complex behaviour in terms of its function in helping survival and as a response to situational or relational triggers. Reframing refers to looking at, presenting, and thinking about a phenomenon in a new and different way, and replaces traditional individual/medical model approaches to madness and distress with a social perspective, somewhat akin to the Social Model of Disability[30]. Reframing behaviour as meaningful allows providers to address underlying needs and utilise less intrusive strategies. We have fictionalised a trauma-informed response to a woman who self-harms in the box below.

> ### *Jenny's Story*
>
> Jenny has had numerous hospital admissions over four years, usually through self-harming events, including swallowing foreign objects and cutting her arms. Previously, some staff described Jenny as "attention-seeking" and "manipulative", and responded by trying to control or stop the behaviour. This included ignoring Jenny, giving PRN ('when required') medication or forcibly medicating her. This has changed since the organisation began training its staff on trauma and trauma-informed approaches. Now, when Jenny tells staff she wants to hurt herself, staff respond to Jenny's pain, recognising that past strategies added to Jenny's sense of powerlessness. While Jenny's safety is no less important, validating Jenny's pain and her attempt to cope with it, along with using harm reduction strategies around her self-injury, has greatly helped her. Jenny is now using art to bring voice to her experiences, and her treatment team have referred Jenny to a therapist who will work with her on the issues arising from her experiences of abuse.

In a trauma-informed mental health service, all staff – clinical and non-clinical – understand the impact of trauma on a person's ability to survive in the present moment. Crucially, this entails a shift from thinking "what is wrong with you?" to "what happened to you?"[31]. The critical roles of racism, sexism, homophobia, ageism, poverty and their intersectionalities are recognised. Survivors in crisis are not viewed as manipulative, attention-seeking or destructive, but as trying to cope in the present moment using any available resource.

Providers do not fear asking about trauma, yet do so in ways that are respectful of potential re-traumatisation; the power of telling one's story but also the impotence of telling it where nothing changes[32]; the need to move at the survivor's pace; the need to truly listen and the need for post-disclosure support. Survivors are forewarned about trauma questions, and can choose not to answer. Trauma information is integrated into treatment plans so that people can be referred to trauma-specific services (if wanted)[33].

The basic safety of environments is prioritised – physical, psychological, social and moral – with organisations making a commitment to non-violence[34]. Staff receive support to help them focus on trauma, and steps are taken to build a sense of community and shared responsibility between staff and survivors. This means that services prioritise building trusting, mutual relationships between staff and survivors. When relationships are prioritised, policies and procedures (such as time limited sessions with a therapist) can be re-evaluated in light of whether or not they support TIAs.

TIAs in mental health aim to reduce or eradicate coercion and control, including medication as restraint, verbal coercion, threats of enforced detention, withholding information, restrictive risk-aversive practices, disrespectful and infantilising interactions and Community Treatment Orders[35]. Clinicians understand the re-victimisation that "power over" relationships reinforce. Training and supervision provide staff with the tools to attend to potential relational and situational triggers and to use trust-based, collaborative relationships to support people.

Survivors often encounter numerous human services across their lives. To be trauma-informed, each service within and beyond the local mental health system should operate according to TIA principles. This includes primary care, A&E, talking therapies, mental health teams, crisis care, the police, social services and voluntary sector services (such as trauma-specific service providers).

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6. TIAs in the UK

One of us, (AK), has played a key role in introducing TIAs to Tees, Esk and Wear Valleys NHS Foundation Trust, and describes her experiences in the box below.

Case study: introducing TIA to an NHS Trust

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) is a large mental health provider in the North of England which serves a population of 1.6 million people and employs over 5,000 staff. TEWV is embarking on a programme to develop trauma-informed services throughout its adult division. Its TIA has been to develop a pathway of care and to train staff to implement this pathway. Training is undertaken as a team and it has been well received with staff reporting it relevant to their work and increasing their confidence afterwards. The resource set incorporates a number of elements: it has a variety of information leaflets for clients; resource links and summaries for staff; a treatment algorithm; service skills matrix; good practice guidance for managing trauma disclosures; information on screening for dissociation and how to manage it; a section on staff wellbeing and a framework for understanding risk issues.

The pilot project on an acute adult mental health ward included all staff from senior medics to health care assistants. They found that three quarters of the people admitted could directly link trauma with their current difficulties. In total, 80% had substance misuse issues, and the same proportion self-harmed. In total, 40% were experiencing some psychosis. Ward staff felt empowered to have meaningful discussions about trauma and used this to inform formulation based care plans. They were able to implement some core skills in grounding and emotion regulation, which resulted in a reduction in the use of PRN medication. It was important that local trauma champions in each team facilitated supervision, management and implementation of the guidance. Staff could also call on external complex case consultation for trauma, which was evaluated as being extremely helpful.

Follow-up training plans were then developed to respond to specific areas of need as requested and so far this has been dominated by

dissociation. TEWV has promoted experts by experience to deliver much of this. Finally, trauma specific supervision groups are supporting therapists to respond to issues of complex trauma.

It is clear that TIAs are beginning to reach the UK, although often in settings beyond mental health. However, the two conferences on trauma-informed mental healthcare in 2014 – with speakers from psychology, mental health nursing, psychiatry and the survivor movement – indicate the beginnings of a sea-change. Scotland's Mental Health Strategy 2012-2015 includes psychological trauma as a key priority[36]. The strategy states that "General Services should be Trauma Aware", and aims to improve recognition and awareness of trauma in Primary Care and Mental Health Services, encourage staff to make appropriate referrals for trauma survivors, and roll out trauma training. Although TIAs are not named, this is nevertheless a welcome development.

Similarly, the National Mental Health Development Unit[37] and the Department of Health (DH)[38] have released strategy documents on gender sensitive services that include trauma awareness. The DH published recommendations regarding routine enquiry of abuse in mental health settings over a decade ago[39] and a programme of work was undertaken to train staff, which demonstrated changes in skill[40]. This focused on changing the emphasis from "What is wrong with this person?" to "What has happened to this person?". Asking the basic question: "Have you ever experienced physical, sexual or emotional abuse at any time in your life?" has now become mandatory for UK services. However, current evidence that staff do this in practice is scant and this suggests that good practice that goes beyond this question is not widespread[41]. One significant change that may prompt responses from services is the inclusion of trauma in some NICE guidelines, for example, the recently updated guidance for the management of schizophrenia[42]. Some early intervention services for psychosis, in particular, are attempting to be more trauma-informed. Toner and colleague[43] showed that having a formulation-driven approach to understanding psychosis was more important in creating staff that were empowered to address trauma than having the ability to enquire about it. There is something very important about the model of mental health that staff bring with them to the role.

7. What are the barriers to implementing TIAs in the UK?

We have identified a number of potential explanations for the slow implementation of TIAs in the UK, although our list is not exhaustive. Many of these implementation barriers are applicable to settings beyond the UK. First, despite compelling evidence, there remains strong resistance to the notion that trauma and childhood abuse plays a causal role in psychosis and mental distress. Historically, such claims have been seen as "family blaming", and have been vehemently opposed, e.g. historic opposition to Freud and Laing. Instead there is a focus on the biological basis of mental distress, with genes and neurology seen as causal and trauma relegated to a trigger at best[44]. Thus, mental distress is understood as a scientific, medical and pharmacological problem, rather than a human, familial or social issue.

Second, Western societies have strongly resisted notions of historical and cultural violence and their consequent trauma legacies. Jackson[45], an African American survivor and therapist, has produced a powerful research account of scientific racism, slavery and colonialism and the impact this has had on survivors generationally and today. Focussing on the social and systemic causes of trauma places practitioners in opposition to powerful groups and consequently is often avoided[46].

Third, Coles[47] has described "horror" as a barrier to practitioners embracing notions of trauma: "to stand as witness to the extent and horror of people's accounts of pain and suffering is to encounter and experience fear, despair, loss and rage".

Fourth, UK public services face continuous change and upheaval, making many wary and weary of new initiatives. Consequently, introducing new conceptualisations of care can be challenging, and this is particularly acute with TIAs because the role and prevalence of trauma is disputed (e.g. the DH and NICE focus on diagnostic categories, rarely referring to trauma). Compounding this, UK austerity means that resources are scarcer and morale lower. This context makes it harder to engage with new initiatives.

Fifth, TIAs are a relatively complex and involved approach to service provision, and are easily confused with trauma-specific services. Muskett (2014) has described how mental health nurses in Australia struggle to translate TIA principles into their everyday practice beyond reducing seclusion and restraint.

Sixth, there have been a number of initiatives aimed at improving mental health services and relationships between service providers and users. For example, in the UK, Star Wards aims to support excellence on inpatient psychiatric wards[48], Safewards aims to reduce conflict and containment and increase safety on inpatient mental health wards[49] and Compassion in Practice centralises the 6Cs of nursing and midwifery (care, compassion, competence, communication, courage and commitment). While such initiatives are compatible with TIA, they are nonetheless another way to conceptualise and implement care for providers to grapple with.

Seventh, many UK mental health staff have no access to regular structured supervision, and this is a serious barrier to the implementation of TIA. In our case study (see the box below) we cite trauma-specific supervision groups as a way of supporting therapists to respond to issues of complex trauma.

Case study: key factors in successfully implementing TIA

The experience gained by TEWV in implementing the Clinical Link Pathway for Trauma has generated some insights. It has taken a lot of planning, patience and determination to keep it on the agenda in spite of organisational changes, mergers and competing priorities. There are, however, a few key factors that have facilitated the ambitious scope and success so far: first, it was important to sell the concept to senior leaders in the organisation using language that connected with its change processes and aims. The TIA was then sponsored by the medical director. TEWV uses "Lean" methodology, which looks for ways to reduce inefficiencies in its delivery of care. Unidentified trauma was demonstrated using local statistics and service user stories as one way that a person's journey could stall, be misguided or be less than optimal. The TIA needed to demonstrate how it fitted with the organisation's key objectives both strategically and in practise with individual clients. By engaging senior support, the approach has maintained high level support in spite of competing demands.

Second, it helped to use the methodology for system change that the Trust already employed. TEWV uses 'pathways' to describe the structures, management systems and clinical decision making necessary to support the needs of a specific client group. Pathways aim to deliver

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care which adds value to the client's health outcome. Most pathways are diagnostic. However, the Trauma Informed Service pathway describes care for anyone showing the effects of trauma regardless of their diagnosis.

Third, change is facilitated when staff are empowered by it rather than burdened. This pathway does not dictate what must be done nor is it strictly governed. The process of becoming trauma- informed has become embedded when it is owned by staff and this has had to be gradual over time as awareness deepened. It helped to have emphasis on flexibility of response, to enhance skills and confidence, and to keep data collection to a minimum.

Fourth, it helped the pathway lead to understand theory relating to organisational functioning as well as individual trauma work and consider what leadership behaviours others would follow. Empathic engagement with other staff was needed to create alliances and fit the pathway to their clinical needs. Staff needed to be shown the difference it could make to clients and to their own work. They needed opportunity to develop skills, to embed the value of TIA into their own motivational system and to see TIA as a group that they want to belong to. And finally, the personal voices and experiences of service users have been vital in showing the way.

Finally, once a concept starts to take hold it can gain momentum. Debate, training opportunities, champions, mentors and networking all perpetuate thinking and practice. Our mapping work suggests that despite evidence of increasing interest in TIAs in the UK, we have not yet achieved the critical mass needed for frontline TIA implementation.

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9. Adverse Childhood Experiences: a public health concern

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Summary

A public health approach is essential if we are to prevent many of the poor health, social and economic problems experienced by individuals and communities. Using our understanding of risks and assets, enables us to invest more effectively in prevention of poor health, maximise positive outcomes across every stage of the lifecourse and empower individuals to realise their full potential. The skills that lie at the core of public health are powerful tools in our endeavours to work together to affect change and reduce inequalities.

1. A public health approach to addressing childhood adversity

The term Adverse Childhood Experiences (ACEs) is used to describe a wide range of stressful or traumatic experiences that children can be exposed to while growing up[1]. ACEs include direct experiences such as suffering physical, verbal or sexual abuse, and physical or emotional neglect and indirect experiences affected by the environment in which a child grows up. Examples include parental separation, domestic violence, mental illness, alcohol abuse, drug use or incarceration. As the number of ACEs increases[2], so does the risk of poor health outcomes[3]. As such, early childhood experiences are recognised within public health as a wider determinant of subsequent lifelong health and are an important area of focus given the potential to prevent and to mitigate the adverse consequences.

This chapter sets out the contribution that a public health approach can make in helping prevent and mitigate the impact of adversity in the lives of children, families and their wider community. It references the work of Public Health England (PHE) in providing national systems leadership for protecting

and improving the nation's health and in working through regional and local centres to support local authorities in fulfilling their public health functions. The chapter also highlights PHE's role in providing information directly to the public. The chapter starts by setting out the defining features of a public health approach – its aim and some of the key areas of public health practice. It describes the wider determinants of health and the significance of this as a conceptual basis for public health actions that seek to affect change at an individual, community and wider societal level. It then focuses in more detail on key aspects of public health practice to improve outcomes for children, young people and families, highlighting links to helping prevent and mitigate the impact of ACEs.

2. Defining features of a public health approach

Public health aims to promote and protect health and wellbeing, prevent ill-health and prolong life. The World Health Organisation describes health not only as the absence of disease and infirmity, but a state of complete physical, mental and social wellbeing[4].

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A public health approach aims to intervene early across the life stages and domains of people's lives, to reduce and avoid escalation of risks and to enhance protective factors for health, wellbeing and build resilience[5]. Public health emphasises a collective responsibility for health and wellbeing and engages with a wide range of partners to champion macro/whole systems level change focussing on both universal and targeted population interventions. It draws on data, evidence and insights into the expressed needs of the population as a means of identifying need, highlighting inequalities and prioritising opportunities for action at both a policy and practice level. A public health approach also seeks to build skills among the health and wider workforce as facilitators of change. It draws on local implementation expertise, behavioural insights, social marketing and other technical expertise to influence action for health improvement.

A public health approach recognises that there are a range of risk and protective factors which operate across different domains of people's lives and that the determinants of health and wellbeing result from the interplay of genetics, lifestyle, health care and wider physical, social, economic and environmental factors, as depicted in Whitehead and Dahlgren's model[6].

Figure 1: The Determinants of Health – Dahlgren-Whitehead model

Source: Dahlgren and Whitehead, 1991

3. Improving outcomes for children, young people and families

A lifecourse approach to public health recognises that there are key stages in people's lives that have a particular relevance for their health and wellbeing. It acknowledges that an individual's, a population cohort's or a generation's life experiences shape current and future patterns of health and disease. These in turn are shaped by the wider social, economic and cultural determinants of health[7].

There are critical periods of growth during maternity, early years, childhood and adolescence when environmental exposures do more damage to health and long-term health potential than they would at other times[8]. There are also sensitive developmental stages in childhood and adolescence when social and cognitive skills, habits, coping strategies, attitudes and values are more easily acquired than at later ages. These strongly influence lifecourse trajectories with implications for health in later life. Furthermore, health-damaging

exposures or health-enhancing opportunities are socially patterned and those living in adverse childhood social circumstances are more likely to be of low birth weight, and be exposed to poor diet, childhood infections and passive smoking.

Each stage of the lifecourse provides an opportunity to bring an integrated approach to an otherwise potentially fragmented focus on typical public health priorities spanning conventional risk factors such as smoking, drinking alcohol, drug misuse, mental health, teenage pregnancy and obesity. It allows for bespoke actions to be taken according to the stage of the lifecourse and the potential to deliver an integrated child and family-centric approach to health improvement. It also provides an opportunity for considering how best to coordinate delivery of associated government policy priorities including mental health, child sexual exploitation and abuse, and social justice. The lifecourse approach thus provides a useful framework through which to acknowledge the importance of ACEs, to customise appropriate approaches to prevention, identification and early intervention at each life stage and to secure better outcomes for children, young people and their families.

At each stage of the lifecourse across the ages 0–24 years, PHE has examined the evidence of the main risks and assets to good health and wellbeing. Some health issues span all our lives, including good mental health and the prevention of mental health problems[9]. Maternity provides an important lifecourse stage for public health interventions to help to realise positive outcomes for mother and baby. It has been estimated that the cost to the public sector of perinatal mental health problems is 5times the cost of improving the services. Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother[10], associated with long-term consequences of disordered early attachment. Examples of work that PHE is leading to address this include working with local NHS and local government to lead the prevention workstream within the Maternity Transformation Programme, developing a multi-disciplinary perinatal competency framework with Health Education England and using its social marketing expertise to develop mental health content of the Start4Life Information Service for Parents[11].

The Early Years (0–5) part of the lifecourse is particularly crucial for laying the foundations for healthy development and protecting against adverse experiences[12]. Promoting early attachment and positive parenting at this stage builds resilience and physical, mental and socio-economic outcomes in childhood and later life. The economic case for investment during the

early years is also strong – for example the cumulative fiscal cost of acute services for a child with Speech, Language and Communications problems can be over £150,000 by the age of 16 once custodial costs are included, compared to a cumulative cost of £42,000 to provide speech, language and communication support throughout childhood[13]. As part of the public health grant, local authorities are required to deliver 5universal health reviews to all children under-5, as part of the Healthy Child Programme[14]. One of PHE's national priorities is to ensure every child is given the best start in life[15] and we are working closely with other sectors on a national programme, with specific workstreams to promote speech and language and secure attachment, improve oral health, and reduce unintentional injuries – all of which have a strong social gradient, with children from the poorest areas doing less well than their peers from more affluent areas.

PHE is also focussing its efforts at this stage of the lifecourse to provide extra support for families most at risk, including supporting teenage parents and addressing co-morbidities such as children with alcohol dependent parents or living in families where there is domestic abuse.

Data indicates there may be around one in three children in an average school class with a clinically diagnosed mental disorder at any one point during childhood and that 50% of mental health disorders arise by the age of 14 rising to 75% by the age of 25[16]. The latest Health Behaviour in School Age Children Survey for England reported more than one in five fifteen year olds to have self harmed[17] and surveys in Further Education and the University sector report significant increases in the number of students with mental health difficulties[18].

Economic analyses have identified school based programmes to prevent bullying and school based social and emotional learning programmes delivered as part of PSHE to be cost effective prevention activities[19]. PHE is working with local authorities to improve the effectiveness of school health services as part of the Healthy Child Programme, including a focus on developing resilience and emotional wellbeing as a high impact area of focus for the school nursing service[20]. School nurses provide an important role through a universal, non-stigmatised, confidential service that is trusted by children and young people. It can help bridge the interface between schools, families and specialist services, helping to navigate referral systems and pathways. PHE is also actively supporting education settings from nurseries, to schools, Further Education colleges and universities to be aware of, and to put into practice evidence based principles for whole school/system approaches to mental health and wellbeing[21].

However some young people face a disproportionately greater risk of adverse experiences that warrants a more targeted, focused approach to addressing need. A report from the Children's Commissioner[22] has identified 32 categories of very diverse forms of vulnerability. These range from the direct experience of slavery or trafficking to risk factors like having a parent with a mental health condition, being in a low income household, being taken into care or being a member of a gang. For these groups of children the risks and difficulties they carry makes it much harder for them to succeed in life, to be happy and healthy and have a chance at a good future.

PHE's specialist substance misuse services records seventeen vulnerability items for young people accessing specialist substance misuse services, including mental health problems, being 'looked after', NEET (Not in Education, Employment, or Training), offending, self-harming, experiencing sexual exploitation or domestic abuse, and being exposed to another's substance misuse. Eighty three per cent of young people who entered treatment in 2015–16 reported having two or more vulnerabilities and 38% reported having four or more. This highlights the need for specialist substance misuse services as well as other children, young people and families workforce to be able to work with a range of presenting needs in a multi-agency way to ensure that all needs of a young person are met.

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4. Assets based approaches

Evidence and data support a case for building resilience at an individual level, within families and at an organisational level to help manage adversity. Figure 2 is taken from our recent report on the mental health of children and young people in England, and describes some of the important building blocks of resilience[23].

PHE has published wider data and infographics which help define protective factors that young people say contribute to positive health and wellbeing outcomes[24]. These protective factors include:

Within the context of family life:

- "important issues being regularly spoken about in my family"

- "someone listens to me"

At a school level:

- personal and social skills being covered well in PSHE

- feelings of belonging

- perceptions of safety within school

- the quality of relationships with their teachers and peers

At a community level:

- "feeling safe in the area in which I live"

- "having good places to spend your free time"

- "being able to trust people around here"

PHE has published a framework for a public health approach to resilience[25] and through its Centre teams has led local events to promote resilience in public health practice. PHE's social marketing expertise has also helped to develop Rise Above[26] – a peer led digital platform for 11-16s which uses relevant content in creative ways, tapping into inspirational video from vloggers and YouTubers to get young people talking about the things that matter to them. The campaign helps young people to develop resilience skills for dealing with diverse life challenges such as cyberbullying, exam stress, body image and self-harm.

5. An intelligence driven approach to understanding need

Understanding and quantifying the impact of ACEs is a key element in the public health approach to reduce and prevent harm at an individual and population level[27]. Through its knowledge and intelligence service, PHE collates and analyses a wide range of publicly available data on: prevalence, protective factors, primary prevention (adversity and vulnerability) and finance. It also provides commissioners, service providers, clinicians, service users and their families with the means to benchmark their area against similar populations and gain intelligence about what works.

Figure 2: Building resilience (the ability to cope with adversity and adapt to change)

FAMILY

Effective caregiving & parenting

Effective teachers and schools

Positive friends or romantic partners

COMMUNITY

Positive relations with caring adults

Beliefs that life has meaning

Faith, hope, spirituality

Achievement motivation

INDIVIDUAL

Perceived efficacy and control

Self regulation skills

Intelligence & problem solving skills

Resilience is important for emotional wellbeing. Correlates of resilience in young people include:

Source: PHE (2016)

The Child and Maternal Health tools[28], the perinatal mental health profile[29] and the Children and Young People's Mental Health and Wellbeing Profile[30] are available through PHE's Local Knowledge and Intelligence Service and will be particularly useful to those wanting to quantify the scale of ACEs within the local population. The Child and Maternal Health tools can be viewed by lifecourse stage or theme[31].

As well as supporting the application of data, a further valued and important public health function is to promote application of evidence and cost-effectiveness data in a timely way so as to helpfully inform policy and practice,

and to highlight where there are gaps in the evidence. PHE has published evidence papers relevant to addressing the issue of ACEs. For example a framework for local authorities for prevention and intervention of child sexual exploitation (CSE), produced jointly by PHE, the Office of the Children's Commissioner and the Association of Directors of Public Health[32].

6. Engagement with community and young people

Listening to, engaging, empowering and responding to the views of young people is critical in increasing our understanding of need and what works. The communities within which they live, social support and social networks are all essential aspects of effective population based public health interventions. You're Welcome quality standards for young people-friendly health services are a helpful tool designed to help commissioners and service providers to improve the suitability, accessibility, quality and safety of health services for young people[33]. NICE guidance on community engagement[34] and PHE and NHS England's guide to community-centred approaches for health and wellbeing can also be used to support local public health practice[35].

7. Tackling wider determinants and taking a multi-sectoral approach to addressing inequalities

Improving outcomes and addressing the causes of inequality requires multi-sectoral collaboration. Public health advocacy and leadership, the sharing of robust evidence and the facilitation of learning and exchange of best practice can drive this effectively.

Across the country, PHE's nine Centres report an increasing interest in partnership working across health, social care and community safety systems to promote ACEs awareness and respond in addressing needs. Public health teams are leading collaborative work to inform stakeholders, including local elected members and representatives across the health, social care and criminal justice system, of the evidence of the impact of ACEs. This work includes sharing information about how to embed Routine Enquiry into Adverse Childhood Experiences (REACh)[36] as part of an assessment process to help then plan more focussed interventions. It also includes working with

providers to ensure emerging evidence is part of workforce development and training.

For more on routine enquiry see Paper 19.

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10. What works in addressing childhood adversity

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1. Introduction

We know that adverse childhood experiences can have a deep and lasting impact on people's lives. Its effects are complex and vary for each person depending on a range of factors including genetics, family environment, the child's age and the type of maltreatment. However, some things are common across different types of maltreatment or adverse experience: maltreatment is a source of stress, so can have a harmful effect on the developing brain, and some forms (sexual and physical abuse, exposure to violence between parents or carers) are traumatic. Neglect and emotional and physical abuse are often associated with disorganised attachment.

Although we know many of the common effects of maltreatment and adverse experiences, we cannot with any certainty predict when they will surface. Some children do not experience the negative consequences of maltreatment until later in their lives, and so the support networks surrounding children and young people must be ready to support them at the right time. Those support networks are different for each person, but we have an opportunity – in driving better commissioning and service design across the country – to support children and young people who are struggling with the effects of adverse childhood experiences in school, at home, when they start work, when they go to university and, of course, when they need help with their mental health.

2. What is NHS England doing to drive change?

Future in Mind[1], the key strategic driver behind children and young people's mental health transformation in England, set out a clear and powerful consensus about how to make it easier for children and young people to access high quality mental health care when they need it. Not only did it set a national vision for change; it set in train improvements at a local level across

the country. Across England, each CCG and Local Authority is now party to a joint agency Children and Young People's Mental Health Local Transformation Plan (LTP)[2], setting out not just core information and baselines but also the components of a local offer to children, young people, parents and carers and referrers, including how the needs of the most complex and vulnerable groups would be met.

The publication of *Future in Mind* coincided with an announcement of a further £1.25 million available[3] to improve access to evidence based interventions, with the goal of seeing an extra 70,000 children and young people per year by 2020. The Five Year Forward View for Mental Health[4] reiterated the NHS commitment to *Future in Mind*, and Local Transformation Plans contribute to the whole system Sustainability and Transformation Plans.

NHS England, with other 'arms-length bodies' such as Public Health England, Health Education England and the Care Quality Commission, the Departments of Health and Education, and the Youth Justice Board have developed work programmes to support commissioners and services to reshape the way services for children and young people with mental health needs are delivered. Both nationally and locally we are looking to make some real changes right across the whole system, thinking together about prevention and moving investment opportunities upstream to build resilience in our children and young people, address adverse childhood experiences, promote good mental health and intervene early when problems first arise.

An important force in realising this change, and one that has been rolled out to services covering 90% of England, is the Children and Young People's Improving Access to Psychological Therapies transformation programme (CYP IAPT)[5] – this is different to the adult IAPT programme, which delivers standalone services for anxiety and depression. CYP IAPT has sought to re-orientate and modernise community services to make them more responsive and accessible. The programme works through partnerships across universities, CCGs, local authorities, and providers to embed evidence-based, outcomes-focused interventions across the statutory and voluntary sectors, with full collaboration with children, young people and their parents and carers.

Under CYP IAPT, CYPMH staff from the statutory and voluntary sectors and non-clinical staff can access training in evidence-based interventions to post graduate diploma level. Courses offered include CBT, Family Therapy and Parent Training, counselling, interventions for ages 0-5, learning disability

and autistic spectrum disorder, the combination of pharmacological and psychological interventions. It also includes whole team training for inpatient services and community eating disorder services, and specialist therapies for eating disorder treatments. As well as directly developing the expertise of those on training, these courses create service management, supervision and outreach training to services for staff across the statutory and voluntary sectors to support their colleagues with consultation and advice.

As well as supporting the CYPMH workforce to deliver evidence-based care, we need to help services understand and cater for the particular needs of children and young people who have an extra vulnerability to developing a mental health problem, and who face barriers in accessing the support they need. This is especially important for children and young people who have experienced maltreatment or adverse childhood experiences, and who may find it difficult to find the help they need at the right time.

One group we know will be highly likely to have experienced trauma or adverse childhood experiences is children and young people in care, adopted children and care leavers. The Departments for Education and Health have commissioned an expert working group to develop a care pathway to guide local services in what to do to support the mental health and wellbeing needs of this group. We are also piloting integrated personal budgets for looked-after children, adopted children and care leavers with joint partnerships of CCGs, local authorities and voluntary sector organisations. The drive behind both of these initiatives is, above all, choice and control – and through this work we are building replicable models so that more areas across the country are able to make this offer to looked-after children, adopted children and care leavers. Choice and control supports this group of children and young people to develop their own sense of agency. These initiatives are intended to bring their voice into every element of service design – from guidance for commissioners through the MH and wellbeing care pathway, to a clear mechanism for joint decision making through personal budgets.

3. Ways we are working together

Both providers and commissioners have a role in creating trauma-informed services which cater for the needs of vulnerable groups. The platform to achieve the interagency working required to deliver services is the Local Transformation Plan. Our thematic review[6] of LTPs in July 2016 showed that

areas were at varying stages in terms of developing models and approaches, which included:

- developing CSE/CSA care pathways to ensure there is age appropriate provision at all stages of the care journey

- case management by a dedicated CSE coordinator

- increasing awareness among professionals and the public, as with Bury's It's Not Okay campaign

- whole school approaches, providing advice and support to schools or holding forums where schools can discuss concerns and seek advice

- a small number of areas highlighted the Think Family approach that seeks to improve joint working between services from the police to ambulance services, to youth workers, voluntary organisations and schools

- sensitive enquiry into neglect, abuse and violence, with some areas investing in CSE/CSA training for staff

- using outreach and non-conventional settings rather than clinics or offices, such as CSE/CSA hubs or child houses

- one-to-one relationships with an individual worker or single point of access and

- robust, evidence-based specialist therapeutic interventions.

In addition to ensuring that early identification is in place, some areas were using or developing indicators and risk-assessment tools to assist in the identification of CSE/CSA. There are also regional responses, such as the pan-London establishment of CSA hubs and child houses, which will act as integrated centres of support to deal with CSA, CSE and female genital mutation (FGM).

Commissioners and providers need to build on these initiatives and replicate successful models to ensure that they can offer children and young people across the country appropriate and trauma-informed services at the right time.

4. What can commissioners and providers do to support these children and young people?

In terms of systemic responsibilities, the NHS, public health, voluntary and community, local authority children's services, education and youth justice sectors need to work together to:

- place the emphasis on building resilience, promoting good mental health and wellbeing, prevention and early intervention

- deliver a step change in how care is provided – moving away from a system defined in terms of the services organisations provide towards one built around the needs of children, young people and their families

- improve access so that children and young people have easy access to the right support from the right service at the right time and as close to home as possible. This includes implementing clear evidence based pathways for community based care to avoid unnecessary admissions to inpatient care

- deliver a clear joined up approach: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable

- sustain a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience

- improve transparency and accountability across the whole system – being clear about how resources are being used in each area and providing evidence to support collaborative decision making.

- ensure that data is captured locally and nationally. For example, NHS commissioned services should ensure the Mental Health Services Minimum Data Set reflects accurately the status and interventions with children and young people – for example ensuring the complexity tool is completed so we have a record of factors which will impact on a child or young person.

Building on this, there are some core principles for good practice in building services to address mental health need arising from adversity:

- Involve children and young people, and where appropriate their families and carers, at every level, from service design to commissioning, recruitment and crucially decisions about their own care

- Engage closely with local communities to create services that are racially, ethnically and culturally sensitive

- Build services that support those with extra vulnerabilities (either in terms of developing a mental health problem, or who face barriers in accessing services), such as those with a learning difficulty, children and young people in gangs, or looked-after children.

- Aligning with the principles of CYP IAPT, ensure routine outcomes measurement is embedded in services as standard practice

- Engage across service boundaries – schools, the police, children's services – so that children and young people are supported across the system with trauma-informed support

- Work to reduce stigma and prejudice – this is a key part of ensuring that children and young people seek the help they need, when they need it.

Commissioners can enact these principles with some practical steps, such as:

- Embedding these principles into Local Transformation Plans. There needs to be a clear strategic vision locally for how services will work in a trauma-informed way, and this needs to feed down to practitioner level so that frontline staff feel empowered to implement that vision and children, young people, their families and carers are able to hold their commissioners to account for implementing it.

- Ensuring there is strong communication across agencies working with children and young people who might be affected. There are myriad ways this could be achieved locally, from co-location, to joint working groups, to collaborative and pooled commissioning. Frontline staff

across universal and targeted services need to feel comfortable liaising across service boundaries to raise concerns and intervene at the right time for the child or young person. Again, this needs to be built into LTPs. Commissioners and providers might find the Schools Pilot evaluation a helpful touchstone for examples of cross-agency working.

Supporting frontline staff in delivering trauma-informed care. This is about the practical steps leaders and managers can take to ensure staff are properly trained and confident having trauma-informed conversations. To ensure that they know what the next steps are, and the appropriate local pathways, and routes for safeguarding escalation, following disclosures.In addition that they know where to find support for themselves, if they are affected by these disclosures.

There is encouraging work taking place across the country to support children and young people who have experienced trauma, and we shouldn't lose sight of the successes so far. But nor should we overlook the needs of these vulnerable groups. We need to build on those successes and work jointly to embed lasting networks of support across the system so that children and young people can reach the help they need, when they need it.

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References

1   DH / NHS England (2015) Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing: https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

2   For more information on Local Transformation Plans see: https://www.england.nhs.uk/mental-health/cyp/transformation/

3   This is over the five year period from 2015-16 to 2020-21.

4   Independent Mental Health Taskforce (2016) The Five Year Forward View on Mental Health: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

5   For more information on Children and Young People's Improving Access to Psychological Therapies transformation programme (CYP IAPT) see: https://www.england.nhs.uk/mental-health/cyp/iapt/

6   NHS England (2016) Children and Young People's Mental Health Local Transformation Plans: a summary of key themes: https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/08/cyp-mh-ltp.pdf

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11. Trauma-informed care for children with complex needs in the youth justice system

Caroline Twichett and **Sue Sylvester**
(on behalf of NHS England)

1. Unique and diverse needs

Many of the children who are close to, or come into contact with, the Youth Justice System have missed opportunities for early identification and interventions of their health needs due to a variety of reasons. They are more likely than their peers to have a mental health or neurodisability problem. They may often have more than one mental health problem in combination with a range of additional vulnerabilities from adverse childhood experiences. A common feature of this cohort is that they do not always fit into clear diagnostic categories, and as a result, some of their mental health needs are not being met.

It is important to also appreciate that the individuals in this cohort may have multiple interactions with current services commissioned by different organisations. This presents challenges around continuity of care, data sharing, the creation of a holistic picture of the individual, consistency of approach and management of transfers. It is therefore vital to ensure that each child entering the secure estate has a full health screen and assessment to use the period of detention to understand the health needs of this group of children and to improve their health and wellbeing outcomes.

2. Health and Justice current context and developments

A nationwide transformation programme is underway to improve mental health outcomes for children and young people – the Children and Young People's Mental Health Services Transformation Programme. Within this programme is the Health and Justice and Specialised Commissioning Children and Young People's Mental Health Services Transformation Workstream. They look at how to improve the commissioning of services which can meet the specific needs of some children and young people who are considered especially at risk.

This workstream aims to address some of the commonly identified gaps in mental health provision for children and young people held within, and transitioning into or out of, the Children and Young People's Secure Estate (CYPSE) either on youth justice or welfare grounds. It also targets improved service provision for children and young people coming into contact with other elements of the health and justice pathway, such as Liaison and Diversion, Sexual Assault Referral Centres or crisis care related to police custody. Additionally, it has a focus on those individuals receiving specialist mental health services (specifically high risk young people with complex needs). A core objective of the workstream is to promote greater collaboration between the various commissioners of services for those children and young people who come into the NHS England Health and Justice pathway. This includes services for children with complex needs in the CYPSE as well as in the community. However, it also refers to those children and young people within the NHS England Health and Justice pathway whose mental health needs may not meet traditional service thresholds, but for whom the aggregated impact of multiple health and social issues presents not only an immediate risk, but also one which may escalate to the point of crisis if left unaddressed.

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3. Health and Justice commissioning responsibilities

The number of children who are now held in custody is much smaller than in recent years (down from 3,500 to around 1000) but now consists of a concentrated group of children with complex and challenging needs and a wide range of vulnerabilities. This cohort of children are over represented in terms of their physical, mental, neurodisability and substance misuse needs, often demonstrating co-morbidity.

The commissioning of health services in these settings is carried out by local Health and Justice commissioning teams, of which there are currently 10 across England. All NHS England Health and Justice Commissioners work closely with individual establishments within the Children and Young People's Secure Estate. The CYPSE provides a national service, in which children may be placed anywhere in the estate, and not necessarily within, or close to, their originating locality.

The CYPSE is the collective term for three types of residential placements where 10–17 year olds sentenced or remanded to custody can be placed by

the Youth Justice Board (YJB):

- Secure Children's Homes (SCHs)

- Secure Training Centres (STCs)

- Young Offender Institutions (YOIs)

The CYPSE currently consists of four YOIs holding under-18s, three STCs (one of which, Oakhill, is not currently within NHS England Regulations) and 14 SCHs, six of which are 'welfare only.' SCHs may provide care and accommodation for young people placed by local authorities under a Secure Welfare Order for the protection of themselves and/or others (welfare placements), under Section 25 of the Children Act 1989. It is important to remember that these children are not offenders. Some SCHs are 'welfare only' while others take a mixture of these children and those placed by the Youth Custody Service.

Health and Justice Commissioners also have commissioning responsibilities for children and young people who:

- Receive specialist child and adolescent mental health services (specifically high risk young people with complex needs). Not all of these children and young people are in the NHS England Health and Justice pathway, since some may be in mainstream mental health pathways

- Interact with Liaison and Diversion services

- Present at Sexual Assault Referral Centres

- Are in crisis relating to police custody

4. Holistic health assessment and Healthcare Standards

All children placed in the CYPSE are screened and have a holistic health assessment using the Comprehensive Health Assessment Tool (CHAT), an evidenced based tool designed specifically for children placed in the Children

and Young People's Secure Estate. The tool has five parts: Part 1: Reception Screen; Part 2: Health Screen; Part 3: Substance Misuse; Part 4: Mental Health; and Part 5: Neurodisability.

On completion of the CHAT a Care Plan is completed for all children, setting out the needs and provision of health services while in the CYPSE. Where needs relate to mental health or neuro disability, all sites have access to the full range of Comprehensive Children and Young People's Mental Health provision, including, for example, Child and Forensic Child Psychiatrists, Clinical Child Psychologists, specialist nurses, Occupational Therapists and Speech and Language Therapists.

NHS England commissions health services to consistent standards set out in Healthcare Standards for Children and Young People in Secure Settings by the Royal College of Paediatrics and Child Health and others in 2013, and to core specifications developed specifically for the CYPSE. The standards take a pathway approach, following the young person's journey through a secure setting to aid multi-professional working.

The standards and specifications cover mental health in detail.

Health and Justice commissioners work closely within individual establishments within the CYPSE, to commission and procure healthcare providers a range of high quality services which fully meet the needs of the cohort of children identified.

All healthcare commissioners, governors/directors/managers and healthcare providers continuously monitor and review performance and quality. Partnership working through established governance systems enable appropriate and timely access to healthcare provision within the CYPSE, ensuring their safety and providing the best possible care.

Commissioners are required to undertake regular Health and Wellbeing Needs Assessments to ensure service planning and commissioning is responsive to the needs of children in the secure setting. The views of children and of their parents/carers, should be sought and taken into account in commissioning, delivering and improving health services in the secure setting. Health and Justice and Specialised Commissioning Children and Young People Mental Health.

5. Transformation Workstream projects

A core objective of the Health and Justice and Specialised Commissioning Children and Young People Mental Health Transformation workstream is to promote greater collaboration between the various commissioners of services for those children and young people who come into the NHS England Health and Justice pathway. The workstream has three projects, each of which focuses on a different area of care for this cohort. These workstream projects include specialist CAMHS for High Risk Young People with Complex Needs, development of a framework for integrated care for the Children and Young People's Secure Estate (known as SECURE STAIRS) and Collaborative Commissioning Networks.

- **Workstream project 1:** Specialist Child and Adolescent Mental Health Services for High Risk Young People with Complex Needs.

- **Workstream project 2:** Development of a framework for integrated care for the CYPSE (SECURE STAIRS).

- **Workstream project 3:** Collaborative Commissioning Networks.

Each workstream project has a focus on a different part of the overall commissioning landscape for this cohort of children and young people.

Workstream project 1 focuses on high risk young people with complex needs, who exist in a range of settings, both within the youth justice system and in the community. It recognises that the skills which have been historically developed in Forensic CAMHS teams are applicable to these high risk young people, and those with complex needs in situations where specialist expertise beyond that available in local Children and Young People Mental Health Services and other provision for children and young people is required. While pockets of such capability may exist across England currently, the opportunity now exists to extend this nationally and thereby ensure greater continuity of care (for example between secure and community settings) for these young people between the many settings in which they find themselves and the multiple professionals with whom they may come into contact.

Workstream project 2 looks specifically at children and young people who may:

a. Have needs which are multiple (i.e. not just in one domain, such as mental health), persistent (i.e. long-term rather than transient), and severe (i.e. not responding to standard interventions).

b. Exhibit high-risk behaviours (to self, to others and from others) and present with complex management difficulties.

c. This needs to be filled in or deleted.

d. Struggle to respond to or maintain progress with traditional regime and interventions.

e. Have common histories of early onset anti-social and / or high-risk behaviours, often supplemented with complex mental health needs and experiences of trauma and attachment disruption.

f. Be at increased risk of being diagnosed with personality disorder in adulthood.

g. Be at risk of being diagnosed with personality disorder in the present, frequently resulting in managed moves.

6. Implementation timescales and intended outcomes

The aim of the workstream project is to roll out the SECURE STAIRS Framework of Integrated Care across all of the CYPSE, this will be phased in from April 2017. Ultimately, the SECURE STAIRS framework is intended to ensure that children and young people receive the same type of care irrespective of location in England, built on an evidence-informed approach.

The SECURE STAIRS framework is based on two core elements, the 'SECURE' element emphasises the importance of consistency in the day to day care of the young people by front line staff who understand the needs from an attachment/trauma perspective. The 'STAIRS' element emphasises the importance of a co-ordinated, multi-disciplinary, formulation approach to intervention.

S	to have a staff team with the necessary **skill set** to meet the needs of the young people effectively
E	to have **emotionally resilient** staff who are able to respond in the child's best interest at all times (and reduce their own sickness and sick leave)
C	to have staff that feel **cared for** to enable them to provide the most helpful therapeutic environment for these complex young people
U	to have staff with the **understanding** of psychological theory and the ability to apply this to practice (via training and supervision) to enable young people to reach their full potential
R	to have **reflective systems** which enable an improved unit environment – less risky behaviours in units, improved consistency and communication
E	to ensure **'every interaction matters'** and is positive
S	to ensure **sufficient scoping** is done for each young person to ensure comprehensive assessment
T	**targets** for stay are collaboratively developed for each young person
A	**activators** for behaviours are identified as part of a comprehensive psychological formulation
I	**informed** by the formulation, ensure the interventions that are offered are evidence-based and developed with the aim of delivering sustained change post discharge
R	progress towards targets/interventions efficacy is **reviewed and revised** regularly
S	**sustainability of change** post-discharge remains a key consideration throughout stay in CYPSE, with the aim of long-term improvement of life chances (specifically through reduced likelihood of reoffending, more stability of placements, better health education, housing and employment opportunities, more effective therapeutic pathways into adulthood and/ or community based provision)

Workstream project 3 is intended to bring together the various partners that are involved in the commissioning of services for very vulnerable children and young people, to deliver full clinical pathway consideration for all children and young people who have received services delivered via NHS England Health and Justice directly commissioned provision. This is intended to address some of the challenges that exist in this sphere currently, such as missed opportunities for assessments, lack of continuity of care when individuals pass from one organisation to another, and silo working that prevents a holistic approach to care delivery.

The three workstream projects will all contribute to the same workstream objective, by focusing on different parts of the overall cohort of children and young people in question, at different points on their pathways. The approach recognises that these children and young people have some of the most complex needs and yet historically this complexity has been a barrier to the successful provision of care. While any individual may only ever receive services from a small part of the larger system, their potential pathway may be hard to anticipate, meaning all these components must contribute to a functioning whole.

As these workstream projects focus on different parts of the system the development of early intervention and prevention for children and young people being diverted away from the youth justice system is important as numbers in the CYPSE reduce. Further information about the development of Liaison and Diversion is detailed below.

7. Liaison and Diversion – early intervention and prevention

In the year 2016/17, 9,027 children and young people engaged with liaison and diversion services, 77% of which were male and 21% female, 80% of the 9,027 were aged 15–18. All age liaison and diversion services are currently accessible to 68% of the population in England, with plans in place to deliver full coverage by 2021. This service provides early intervention, screening and assessments for vulnerable young people as they come to the attention of the youth justice system and provides a prompt response to concerns raised by the police, youth offending teams or courts staff. The service provides critical information to decision makers in the justice system, in real time, to inform effective participation, diversion, charging and sentencing. It also involves referral and assertive follow up to ensure children and young people access,

and are supported to attend, treatment and rehabilitation appointments. Without Liaison and Diversion services, children and young people's needs may go unidentified and untreated.

> ### Case study
>
> The following text is taken from Relative Justice: the expressions and views of family members a joint report by the Prison Reform Trust (PRT) and Partners of Prisoners Family Support Groups, published by PRT in September 2015. Those in contact with liaison and diversion services spoke highly of the support they received. Whether it was help to make sense of the situation or to understand what would happen next, the offer of practical support or ensuring referrals to local agencies, the relief at having, as one mother described it, "someone on my side" was tangible.
>
> One family member whose 15-year-old son was coping with his dad's death and had a drug addiction, said: "They [liaison and diversion] have opened the door, things I couldn't get before, I can now ... She [the liaison and diversion worker] looked and found something for us; she found out about the service, the name of the person we should talk to and the telephone number. It was so helpful; we just didn't know what to do. My son is calmer – the house is calmer. We aren't scared."

What is common in this cohort of children and young people are their often complex needs and complex relationships with care pathways, for a number of personal, social and institutional reasons. Increased service provision is not the only answer to meeting their needs. There is insufficient integration between mental health, social care, youth justice services and other relevant services for children and young people. This means that opportunities are missed to share information about an individual and build up a holistic picture of their needs. This is especially a problem where a number of relatively low level needs could be aggregated to deliver a comprehensive picture that could trigger an appropriate intervention. Staff skills need to be developed accordingly to enable integrated joint working and to underpin a whole system approach to addressing the complex needs of these children and young people.

→ For further information on the Health and Justice and Specialised Commissioning Children and Young People Mental Health Transformation workstream and associated projects please contact: england.communityfcamhs@nhs.net

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12. Meeting the mental health needs of looked-after children and care leavers

Professor Peter Fonagy

1. Introduction

The number of looked-after children (LAC) in the UK has been steadily increasing over the last eight years[1]; there were 70,440 looked-after children at 31 March 2016, an increase of 5% compared to 2012. The majority of these children (74%) are in foster care and 6% of LAC in March 2016 were unaccompanied asylum-seeking children[2]. Of LAC, 56% are male, and 44% female. The age of LAC is slightly increasing: 62% were aged over 10 years in 2016, compared to 56% in 2012.

Children who are looked-after are considerably more likely to suffer from a mental health disorder than the general population: almost half of children who are looked-after meet the criteria for a psychiatric disorder (rising to three quarters of children who are living in residential homes)[3]. This is in comparison with a prevalence rate of 10% in the general population. The most commonly diagnosed disorder among LAC is conduct disorder, which is thought to affect around 38% of LAC. About 12% of LAC are thought to suffer from internalising disorders such as anxiety or depression[4]. There are many factors implicated in the high rates of mental ill health and psychological distress in this group of young people. One particular factor at play is the experience of adversity, trauma and maltreatment before being taken into care.

2. The role of adversity

The relationship between early adversity, maltreatment and trauma, and mental health disorder is well established. The US national comorbidity survey found that childhood adversities are associated with 44.6% of all childhood-onset psychiatric disorders and 25.9 – 32% of all adult-onset disorders[5]. Early adversity in the form of abuse and neglect is the most common reason for children entering into the care system – in England in 2015, the main reason for social services first engaging with LAC was because of abuse and neglect

(61%)[6]. The majority of the rest of cases being family reasons such as a parent becoming ill or disabled. More broadly, the separation and upheaval implied by being taken into care can in itself be understood as an experience of adversity.

Perhaps of particular relevance to LAC is the fact that there appears to be a dose-response relationship between trauma and psychopathology. This was observed in the Adverse Childhood Experiences Survey, which found that 34.6% of participants who had experienced at least 2types of maltreatment also experienced significantly greater mental health disorder[7]. More recently, a study[8] of over 3,000 15-year-olds found that each additional traumatic event or loss in childhood significantly increased the likelihood of high-risk behaviour problems and/or functional impairment in adolescence by 6% to 22%. There is, in addition, a wide literature indicating the negative outcomes in terms of physical health[9] and socio-economic function associated with adversity[10]. The issue of adversity and how best to treat and support children who have a history of adversity is therefore particularly pertinent in the case of LAC.

The experience of trauma and maltreatment in the context of the attachment, caregiving relationship lies, we argue, in the distorting impact it has on the individual's capacity to access and benefit from their social environment. This disruption is an adaptive response to experiencing a formative climate of relationships that communicate to the child that mentalizing oneself or others (i.e., that it is safe, relevant and pleasurable to think about the mental states of others in a reflective and open way) is not an appropriate strategy in their social environment. Individuals who have benefited from "good enough" parenting have experienced the mind of their caregiver as interested and invested in their own mind, and have therefore learnt that it might be in their interest to be invested in what others do – to mentalize and to collaborate. A traumatic and highly adverse environment may lead the child to close down this approach to the social world around them; there are adaptive, protective reasons for adopting this stance, but it can leave the individual unable to function in relation to the social environment in a way that is ultimately beneficial. It can result in social dysfunction and instability, and an apparent "rigidity" that makes it hard to enjoy the benefits and protection that arise from the ability to interact flexibly and collaboratively with one's social environment (whether that is school, close relationships or professional, helping networks)[11].

"Resilience" is a much-vaunted notion in current debates about child mental health. It is an important concept, but we can only progress in the hope of promoting resilience in our young people if we properly understand what it

is. It is not an intrinsic factor that an individual is born predisposed to. Rather, resilience is composed of an individual's perception of their relationship to the social network that surrounds them, and how this affects the decisions they make in relation to their social environment. To put it in the language of our theoretical framework, we would describe this as the way in which the young person mentalizes – how they understand the mental states of others, and themselves in relation to their actions. The reason why adversity is implicated in vulnerability to poor mental health, as well as other long-term outcomes ranging from physical to socio-economic, we suggest lies in the fact that it has such a power shaping influence on the child's perception of the social environment they inhabit, and the most effective means of navigating it.

3. Broad approaches to help and support

Given the evidence we now have indicating the benefits of programmes of enhanced foster care, there seems to be a clear case that all children placed in foster care should be provided with such care, which will be described in more detail in the next sections. But there are broader areas in which looked-after children who have experienced adversity can be supported. In particular, ongoing experiences of the care system are a critical factor. Frequent moves between placements and a caregiving system that fails to recognise and engage with the child's mind – i.e. a non-mentalizing system – are likely to further damage a child's perhaps already vulnerable capacity to form attachments, and reinforce the child's experience of transience, loss and separation.

As argued in a recent NSPCC report on the emotional wellbeing of LAC, a whole system approach to the mental health of the child is required[12]. This involves the care system as a whole to regard the emotional wellbeing of LAC as a clear priority, backed up by regular assessments of the emotional state of LAC, and underpinned by education and understanding of mental health needs within the workforce.

Traditionally the approach towards the mental health of LAC has been a reactive rather than preventative one. Having a more preventative, less crisis-driven system depends upon a joined-up approach, in which what LAC themselves report about their emotional wellbeing is heard, foster families are more supported and schools are integrated. The presence of a school-based mental health worker who is properly trained in the identification

and assessment of mental health needs, and who is meaningfully connected to local CAMH services, could stand as a key component in ensuring that services are joined up[13]. This aspiration is in keeping with the NICE guideline on attachment in children in or on the edge of care, which suggests that such children should be provided with a key worker (envisaged in this report as a designated teacher) who has specialist training and with whom the child can maintain an ongoing and consistent relationship across their school life, as well as ensuring that all staff who may have contact with the child concerned are properly trained in understanding their needs[14].

Placement stability is another key component in the mental health of LAC. The figures for all LAC children in England as of March 2016 found that 21% had two placements and 10% had had three or more placements during the preceding year[15]. Frequent moves in and out of care, and frequent placement changes within the care system, damage children's capacity to form attachments and reinforce their experiences of transience, separation and loss. A meta-analysis and systematic review found that placement breakdown is predominantly associated with child behaviour problems, but is also increased by older age at placement, a history of residential care and more previous placements[16]. A longitudinal study[17] of nearly 600 foster children found that there were five groups of factors involved in the likelihood of placement success:

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5 groups of factors involved in the likelihood of placement success

1. In relation to the child, success is greater if the child wants to be in placement, if the child has attractive characteristics, and fewer emotional and behavioural problems.

2. In the carer: carers are more likely to be successful if rated highly as social workers for their parenting qualities; were seen to be 'child-oriented' on a questionnaire and had experience few allegations of abusive practice and few previous disruptions in previous placements. These factors remained important after taking into account the child's characteristics.

3. In the relationship: how well child and carer 'clicked', i.e., how well they felt they fitted together.

4. In the school: placements more likely to succeed if child happy at school and carer felt able to encourage them.. Contact with an educational psychologist was strongly associated with an absence of a breakdown (again, after taking other factors into account).

5. In the birth family: where there was strong evidence of prior abuse and no birth family member was forbidden contact, breakdown was three times more likely than if it was forbidden.

Placement breakdown has a mutually reinforcing relationship with mental health difficulties, particularly behavioural problems. The research findings on what contributes to the likelihood of placement instability comprehensively reinforce the key theme of best practice findings in this area: the vital importance of protective networks of help around the child and the carers.

The point of transition out of care can be a time of particular vulnerability for young people. Support can further fall away at the age of 18 as it's the age at which young people are no longer eligible for CAMHS. As the NSPCC report suggests, this risks creating a "cliff edge" for vulnerable young people at the point of transition. The NSPCC report makes a convincing case for local authorities and health services to retain a position of corporate parenting responsibilities – identifying mental health needs and providing support for care leavers up to the age of 25[18]. The House of Commons Education Committee[19], in their 2016 report on the mental health of LAC, similarly concluded that given the particular vulnerability of young care leavers, CAMHS should be available to all looked-after young people until the age of 25.

4. Focused interventions

There are several interventions that have been developed to support carers in meeting the needs of LAC. The move to enhance foster care reflects the growing awareness that the needs of children and young people who have experienced maltreatment and adversity are not simply met by removing them from their home. Further help is needed to alleviate the difficulties they may experience.

One such programme is the Attachment and Biobehavioural Catch-up (ABC) programme, which was designed to help carers work to support very young children (12-24 months) by supporting their capacity for affect regulation, helping carers to understand foster children's apparently alienating behaviour, and to override issues that may inhibit their capacity to provide nurturing care. A Randomized Control Trial (RCT) showed that as well as enhancing child attachment security, the intervention improved diurnal cortisol production, executive functioning and emotional regulation[20].

Where the focus of ABC is on attachment, there are other treatment approaches for younger children which focus on behaviour. One of these is Parent-Child Interaction Therapy (PCIT), which is for children aged two to eight years. A short-term intervention based on the social learning thinking, this seeks to help carers learn communication and behaviour management techniques to positively (through praise and attention) or negatively (through selective withdrawal of attention and techniques such as 'time-out') reinforce behaviour. This intervention has shown promise in terms of behavioural outcomes in foster children who are manifesting externalising behaviours[21].

Multidimensional Treatment Foster Care (MTFC), now known as Treatment Foster Care Oregon (TFCO) is one of the most well established enhanced fostering programmes. Based on social learning theory, it provides specialist foster carers with training and intensive continuing support. An adaptation of MTFC for preschool aged foster children – the Early Intervention Foster Care Programme (EIFC) – has been found to lead to an increase in the rate of subsequent permanency of placement (versus placement failure) for the children in increasing secure attachment and decreasing avoidant attachment organisation.

A large RCT of MTFC for the middle childhood age group found that it led to improved rates of positive placements for the children (return home, placement with extended family, or adoption), increased the foster parents' positive reinforcement of the children's behaviour and reducing the children's behaviour problems[22]. However, a recent RCT of MTFC for adolescents in England found no better outcomes over usual care, although with some indication that the intervention may have been beneficial for adolescents with antisocial behaviour[23]. However, it has been suggested that this latter finding was statistically underpowered and that further research is needed to shed light on the effectiveness of this programme.[24]

Fostering Changes, which was developed by the Adoption and Fostering

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National Team at the Maudsley Hospital, South London, in conjunction with King's College London, is another promising approach. Based on social learning and attachment theory, Fostering Changes aims to build positive relationships, encourage positive behaviour and set appropriate limits. The programme also has a practical skills-based approach along with a theoretical framework which helps carers conceptualise the underlying causes of children's social and emotional difficulties. An RCT found a significant effect size (0.99) for improvements in carer-defined problems; an ES of 0.7 for carer efficacy (carer's belief in ability to make positive changes in the lives of their foster children) and an ES of .04 for improvements in quality of attachment relationships[25].

5. Conclusion

If we conceptualise "resilience" less as a quality held by the child, and more as an outcome of the quality of the social network surrounding the child and the child's capacity to access that network, the only logical step we can take is to focus our approach on creating a mentalizing system around the child. We cannot expect children who have experienced trauma and adversity to adopt a different relationship to their social environment, if we do not as service and treatment providers, provide a social environment – in the form of systems of care – that is stable and is itself able to mentalize the child.

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13. Straight Jacket: the mental health consequences of LGBT+ prejudice

Matthew Todd

(conclusion with Dr Marc Bush)

This extract is taken from *Straight Jacket: How to be gay and happy* by Matthew Todd, published by Bantam Press. Reproduced by permission of The Random House Group Ltd. It includes a new conclusion written for this collection.

Summary

Although not widely studied or understood, there is growing awareness that prejudice and lack of support and understanding of the specific needs of LGBT+ children and young people causes emotional trauma that, in turn, leads to higher levels of addiction, depression, anxiety and suicide/ideation which is now at crisis point in the gay/bi male community. General ignorance and lack of evidence, combined with misplaced fear of sexualising young people and lack of sex and relationships education, means that young gay/bi men come out into a highly sexualised and substance heavy gay culture that results in higher levels of suicide, drug use and HIV/hepatitis C rates, among other things. A groundbreaking and thorough investigation into the experience of LGBT+ people from cradle to grave is urgently needed to adequately address these serious health inequalities that have a negative impact on NHS resources and greater human impact.

1. What is the problem?

Despite more LGBT+ people than ever before, thank goodness, leading happy, successful lives, it is becoming increasingly clear that a disproportionate number are not thriving, as we should.

Something isn't working. Disproportionately high levels of depression, self-harm and suicide[1]; not uncommon problems with emotional intimacy; people keeling

over dead in saunas; the highest rates of HIV infection[2] since the epidemic began in the 1980s and now a small but significant subculture of men who are misusing, some injecting, illicit drugs[3], which, are killing too many people.

There is a problem, which has been hiding under plain sight, which needs to be urgently addressed now. It is the subject of my book[4] *Straight Jacket: How to be gay and happy*, published by Bantam Press in 2016.

Many heterosexual people experience mental health problems, of course, and indeed, most gay people are not taking drugs, not dependent on alcohol and are neither sex addicts nor bitchy, unhappy miserabilists propping up bars in desperation over their lonely lives. The opposite is true. More and more of us are happy, thriving and leading fulfilled lives. But there are patterns that are disproportionately common. For although over the last 30 years HIV and AIDS have been considered the number-one problem, the true public health crisis of LGBT+ people is that of poor mental health, low self-esteem and the damaging ways in which we cope.

At the core of this problem is a shame that has been inflicted upon us so powerfully that those of us whom it affects often do not even realise it. It is a shame with which we were saddled as children, at school, to which we continue to be culturally subjected, and which is magnified by the pinball-machine gay scene and culture that sends some of us spinning from one extreme experience to the next. As therapist and author Joe Kort has written, what's wrong is not our sexuality itself but our experience of growing up in a society that still does not fully accept that people can be anything other than heterosexual and cisgendered (born into the physical gender you feel you are)[5].

There are more straight people than gay with these problems because there are more straight people in the world. The difficulty for LGBT people is that, because of our childhood experience of growing up in shame, we are lucky if we avoid this kind of childhood trauma.

There is a dearth of research but some studies do exist. In June 2014 Public Health England issued the first of a series of reports, which concluded that gay men were disproportionately affected by ill-health in three main areas – mental health; HIV and sexual health and the use of alcohol, drugs and tobacco[6]. Various other studies in both Britain and the USA have come to similar conclusions, pointing to higher risks of suicide, suicide ideation (seriously considering killing yourself), self-harm, substance misuse, alcohol abuse and mental disorder among LGBT people than the rest of the

population[7]. We do not know if more LGBT people actually die from suicide, though a 2013 study by Martin Plöderl and colleagues, Suicide Risk and Sexual Orientation, argues that this is the case[8].

A study (Part of the Picture, 2009–14) conducted on behalf of the LGBT Foundation in Manchester found that LGB people used drugs and alcohol at 7times the rate of the general population, and that LGB people were twice as likely to binge-drink as the general population[9]. And in 2015 the UK's leading LGBT mental health charity PACE published the results of its five-year RaRE (Risk and Resilience Explored) study, which showed, among other things, higher levels of self-harm and suicide among LGBT than other people, and a greater incidence of body disorders in gay/bi men[10].

2. Why is this the case?

All over the world leading experts on emotional trauma, both gay and straight, acknowledge that the psychological pressure on LGBT children is overwhelming. Iconic author John Bradshaw, in Healing the Shame That Binds You[11], writes that "there is no group more shamed than LGBT kids". Pia Mellody, at Arizona's world-renowned treatment centre The Meadows and author of Facing Codependence[12], says that gay people often feel "shamed by society", while in the seminal The Velvet Rage, Dr Alan Downs describes gay men being "overwhelmed by shame" and adds "[Childhood] is the start of the journey for gay men and it is by far the most difficult and damaging [part]"[13].

One of the most profound comments comes from Dr Joe Kort, who writes in his book *10 Smart Things Gay Men Can Do to Improve Their Lives* that gay children are subject to "covert, cultural child abuse"[14].

What effect does this have? I go into this in more detail in my book[15], but in effect, this constant shame leads to us perceiving ourselves as a threat to our own existence meaning we are always on guard to possible threats that our nervous system perceives as being caused by us. We see ourselves as a threat and we begin to hate ourselves. This leads to problems with anxiety disorders.

The natural state for all animals, including human beings, is one of relaxation, of being in 'at-ease mode'. But when a threat appears – such as a man coming aggressively towards us wielding a knife – our entire being springs into 'action mode', sending us into a state of hyper-awareness so that we can make the

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split-second subconscious decision either to attack or to run away: fight or flight. In other words, we are in a state of heightened anxiety. When the threat passes, the fight or flight response shuts down and we return to our normal, relaxed state.

The problem is that the fight or flight response cannot differentiate between a real physical threat and one that isn't real but is just perceived in our heads. A man coming towards us with a knife is a threat we can deal with – fight him or get away from him – and the threat passes. But what I believe happens when a child has been self-shamed (for whatever reason: bullied, abused, grown up in poverty, etc.) is that subconsciously he has perceived himself as the threat, so the threat is something from which he can never escape: he stays stuck in constant fight or flight mode.

LGBT+ kids have reason to be fearful. Many find themselves under attack and unsupported at school.

On 25 November 2012 Anthony Stubbs, a sixteen-year-old from Leyland in Lancashire, father to a one-month-old baby girl, Lily, disappeared after a row with his girlfriend. The police didn't find his body for two months. He had hung himself in a local woodland with his PlayStation cord. The media speculated that he was stressed about being a young father, but in reality Anthony had been struggling to come to terms with his sexuality and was being homophobically bullied because of it. He had taken an overdose the year before and told a nurse he was "sick to death of being bullied" .His mother Denise Machin told me she had complained to the school when she first realised Anthony was being bullied, but she didn't think anything was done about it.

"They used to slap him on the way home from school, rip his jumpers," Denise told me. "He'd go up to his room crying. The teachers said they couldn't do anything because it was outside of school."

Denise found explicit texts on Anthony's phone from men but, having gay friends herself, she told him it was OK. Towards the end, he came out as bisexual at school, saying he was "Proud of it!" But this, Denise said, just made the bullying worse.

After his death Denise found abuse on Anthony's Facebook page. "It was going 'Oh faggot' and all this," she said. "'Gay boy, gay boy, shirt lifter', all this to him."

"'Look at the state of you, you camp fuck'. They said 'How can a faggot have a baby?'"

The abuse continued even when his body had been found. "On Ask.fm it was 'Oh, your son was a little faggot, I'm glad he hung himself. One less gay in the country.' They were saying to Jodie, 'Haha, your brother's a faggot' and she was wailing."

Anthony is not alone. I believe most LGBT+ children who take their own lives remain invisible because they do not disclose the cause of their suicide. But there are many names we do know about: Dominic Crouch (may or may not have been gay but was 'accused' of it, (15 years old, 2009), Ayden Olsen (14, 2013), Elizabeth 'Lizzie' Lowe (14, 2013), Sophie Clarke (13, 2016) and many more. Although more schools have anti homo/bi/transphobic bullying policies many don't.

Paul Martin of Manchester's LGBT Foundation estimates that over half the people accessing the LGBTF's counselling services in the last year had attempted to take their own lives and he believes there is often a common underlying cause. "If you scratch the surface with a lot of these guys and girls that come to our services," he told me, "often it started at school, when people experienced their first form of rejection. That can quite often be followed up by family and then the general world."

Despite all the advances that have been made, the *Stonewall Teachers' Report* of 2014 found[16]:

Almost nine in 10 secondary-school teachers (86%) and almost half of primary-school teachers (45%) surveyed said pupils in their schools experienced homophobic bullying. The vast majority heard pupils use expressions like "That's so gay" and "You're so gay". Two thirds of secondary-school teachers and one third of primary-school teachers heard pupils use terms like "poof", "faggot", "dyke" or "queer".

More than half of secondary-school teachers (55%) and four in 10 primary school teachers (42%) said they didn't challenge homophobic language every time they heard it.

There is still no mandatory sex and relationships education in schools, which leaves LGBT pupils, in particular, even more marginalised. In March 2015 the National AIDS Trust published their *Boys Who Like Boys* report[17], which

surveyed more than a thousand fourteen- to nineteen-year-olds. It found that over a quarter (27%) did not know how HIV was passed on. Almost a third didn't know you can't get HIV from kissing. Nearly three quarters did not know about PEP treatment (a course of medication you can take up to 72 hours after exposure to HIV).

A young man called James Hanson said in his response to the survey: "I was diagnosed with HIV at the age of 18, I knew very little about HIV at that age. I remember very clearly some awful sex ed lessons at school. I was never taught of the love between 2men or 2women. I was having feelings I didn't know what to do with and I felt so isolated because it was never spoken about. Looking back now I feel let down."

There is a growing awareness that trauma at an early age leads to an increased risk of addiction – and, crucially, also, that addiction is not simply a problem in itself but rather a symptom of an underlying emotional condition; essentially that addiction is a dysfunctional way of soothing overwhelming distress.

The ACEs study[18] carried out by the Centers for Disease Control and Prevention in Atlanta and Kaiser Permanente (a care consortium based in Oakland, California), claims to have found "staggering proof of the health, social, and economic risks that result from childhood trauma". Seventeen thousand patients were studied and a strong relationship was found between severe childhood trauma and "all kinds of addictions including overeating". The research found that a child with four or more negative childhood experiences (including incest; emotional, physical or sexual abuse; having an addicted or mentally ill parent) was over 1.5 times more likely to become obese, five times more likely to become an alcoholic and 46 times more likely to become an intravenous drug user than a child with no negative experiences.

In Time magazine, one of the ACE study's founders, Dr Vincent Felitti, discussing what type of childhood trauma did the most damage, said, "I would have assumed before we looked at it that probably the most destructive problem would be incest … but the one with the slight edge, was chronic recurrent humiliation, what we termed as emotional abuse".

Chronic recurrent humiliation is how, I would argue, the majority of LGBT+ people experience childhood.

I discuss how addiction works in my book[19] but this, I am certain, is why gay men, for instance, were found, in the Crime Survey for England and Wales in

2013/14, to have used illicit drugs at three times the rates straight men did[20].

What is also problematic is that because of the mainstream's homophobic lack of interest in the wellbeing of LGBT+ lives and gay culture's fear of looking at such sensitive and painful issues, our disproportionate problems in this area have not been widely discussed or investigated. Those suffering have been left to do so on their own or are turning to generic psychological services who do not understand the problem or the connection with childhood trauma and 'gay shame' or of the specific needs of LGBT+ populations. This can be even more isolating. Young people are left to deal with these problems on their own. Young men, in particular, often then find themselves self-medicating with sex via apps such as Grindr, sometimes before the age of 16.

There is a problem. It is bigger than we currently understand. Very little has been done to investigate it let alone to address it. For instance, I myself have heard of three friends of friends who have either died of a drug overdose or from suicide in the six weeks after Christmas 2016. I believe we need a full enquiry looking at the experience of LGBT+ kids from children, through school, to education, health inequalities, high HIV and Hepatitis C infection rates, suicide rates, the experience of the gay scene and racism and body fascism, how the gay and social media is impacting the situation and more.

This problem produces a burden on the NHS but takes an even bigger human toll. This is not 'a gay issue'. LGBT+ people are, on the whole, the children of straight people. This is an issue which society must address now in the interests of all of us. It is time for the experience of young LGBT+ people and children to come out of the closet. They are there. They have been ignored. They need urgent help.

4. Conclusion: what can be done?

There is a compelling case for local services to better understand the lives of LGBT+ youth, and the mental health needs that arise from the prejudice, adversity and trauma that they have experienced. Building on the suggestions in the final section of my book ('Recovery'), and the ideas in this paper, we suggest that commissioners and providers must prioritise:

a. adopting an LGBT+ affirmative commissioning and service models

The SAMHSA (Substance Abuse and Mental Health Services Administration) in the US, describes different degrees of LGBT+ sensitivity that mental health and children's services adopt (see Annex A for a more detailed overview)[21]. They advocate for services to be commissioned on the basis of 'LGBT+ affirmation', which would ensure that services actively promote self-acceptance of an LGBT+ identity and exploration as a key part of their treatment and care model.

Misattunement to the prejudice LGBT+ youth have experienced by professionals has been shown to have a significant impact on the potential for positive outcomes in therapeutic and social services[22]. As such, LGBT+ affirmative models also aim to significantly reduce the risk of staff re-triggering and re-traumatising their clients[23]. This is achieved by ensuring professionals are better attuned to the prejudice-related adversity and trauma that the young people have experienced (including experiences of homophobia, biphobia, transphobia, hate crimes or micro-aggressions). This also involves trauma-informed supervision that supports the staff to both explore vicarious trauma arising from the young people's experiences and the staff member's own prejudicial assumptions and behaviours.

Finally, all commissioners and providers should ensure that counsellors and therapists (working in the NHS and/or under the registration of professional bodies covering counselling, psychotherapy, psychology, General Practice and psychiatry) are adhering to both the Memorandum of Understanding on Conversion Therapy in the UK[24], which regards "efforts to try to change or alter sexual orientation through psychological therapies [to be] unethical and potentially harmful", and the updated statements of ethical practice from the relevant professional bodies.

b. investing in LGBT+ trauma-informed education, training and continuing professional development within local services.

This means ensuring that staff have an adequate level of understanding about identity exploration and formation during childhood and adolescence, and the various ways in which young people identify and express their genders or sexualities. This would include a recognition that identity exploration is a core part of adolescent development, and that any LBGT+ prejudice can have a lasting impact on the psychological wellbeing of the young people.

Binaries of male and female, gay and straight are being challenged by a shift in young people's expressions and experiences of gender and sexuality. For example, over two in five young people aged 18 to 24 years self-identify as being neither exclusively homosexual or heterosexual[25], which is a contrast to the last 25 years. This includes the higher number of young men who have sex with men (MSM) and young women who have sex with women (WSW) who identify as neither gay, lesbian, nor bisexual.

Within this training and professional development, there must be a greater focus on language, which LBGT+ young people might find re-traumatising, shame-inducing, or might re-trigger memories or experiences of (for example) being coerced to gender conform. This would include awareness of the ways in which a young person wants to be described (i.e. using the pronouns he, she, they, ze, zir or describing themselves as non-binary, intersex, queer, cis, trans, etc[26]) and the increasing fluidity in the use of these terms during explorations of gender and sexuality, and identity formation.

Beyond language use, staff should understand and recognise the traumatic impact of prejudice among LGBT+ communities[27]. This should incorporate trauma relating to the increased risk, and experience, of violence, micro-aggression, hostility, intimidation, bullying and shame resulting from growing up in a heterosexist and cis-gendered society. For example the latest Stonewall School Report found that around half of all LGBT+ pupils still face bullying at school for being LGBT+ (rises to two in three trans students), with one in 10 receiving death threats because of their sexuality or gender expression or identity[28]. Similarly, four in five LGBT+ people of all ages have experienced a hate crime, with one in four having experienced a violent hate crime; one in three an online hate crime, and one in 10 exposed to sexual violence as part of a hate crime[29].

The professional training must also include how to respond in an affirmative way to disclosures of gender identity or sexuality, which is especially important if they have encountered hostility or rejection from family members, a community, peers or other professionals – i.e. A&E staff following self harming behaviour or teachers following a mental health crisis at school. Within this staff need to understand the psychological trauma and shame resulting from covering, having to gender conform, coming-out, internalised prejudice, and (for example) the heightened distress some trans young people feel during puberty, resulting from people incorrectly assuming or asserting their gender identity because of physiological changes in their body (especially if the manifestation of their secondary sex characteristics have not been delayed or suppressed through hormonal interventions).

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c. investing in trauma-informed responses to health-harming behaviours

Young people can engage in health-harming behaviours (including the misuse of substances, risky sexual behaviours, and self harm) in order to make sense of, or respond to, the adversity or trauma they have experienced. As a result, psycho-education within services need to be LGBT-informed, introducing self-care, self-soothing techniques, self-harm mitigation[30] and suicide safety measures as new mechanisms for coping with the emotional dysregulation that comes with the memories and experience of trauma[31]. This involves avoiding any judgement of existing coping mechanisms (such as exposure to sexual risk, being a victim or perpetrator of domestic violence), which could intensify or re-trigger feelings of shame, worthlessness, low self-esteem or body confidence.

Professionals must always seek to contextualise these behaviours and attitudes within the lived experiences and mechanisms for survival that a LGBT+ young person will have acquired in the face of adversity and prejudice[32]. This does not mean a young person cannot in time be supported to take responsibility for their behaviour, but rather this needs first to be located in the function that is might have played for them in the context of possible rejection, hostility and prejudice.

d. establishing safety in services and communities of support

My book explores a number of different models focused on supporting the LGBT+ community to recover from health-harming behaviours. Across all of these models there are two features that commissioners should ensure are embedded into local service offers as part of an LGBT+ affirmative approach:). establishing safety, and b). reconnecting with others[33].

The first is establishing safety for LGBT+ youth within the service environment. LGBT+ young people are more likely to be hypervigilant when interacting with services because of the micro-aggressions, hostilities and prejudice they have experienced in their relationships with others. This can lead to low levels of trust in professionals and in some cases an active rejection of offers of support because of the perceived threat of further exposure to shame, aggression or mistreatment. Therefore, in order to establish safety, LGBT+ inclusive imagery, messages, attitudes and behaviours need to be seen and felt by young people to be weaved into the very fabric of the service.

While inclusive posters, signage, inclusive options on forms, and resources go some way to demonstrating that the environment is safe for the young person, the service must also signal that exploration and discussion around issues of gender and sexuality can be met with compassion, understanding and openness[34]. This also means continually asserting that the service is LGBT+ safe through the actions and attitudes of staff. For example, professionals actively challenging incidents of peer-based homophobic, biphobic or transphobic bullying through a restorative approach (embedded in a service process or protocol) that builds greater understanding of the impact of this on young people's mental health, empathy for the difficult experiences that the LGBT+ young person has faced, as well as normalising the development, experimentation and exploration of gender and sexuality during childhood, adolescence and young adulthood[35]. This should also be the case for addressing in-group prejudices, where young people's different characteristics or identities intersect. For example, in dealing with the prejudice that many Black, Asian, Arab and Minority Ethnic (BAME) youth face within the LGBT+ community, which can deprive them of the only "remaining source of social support" in terms "inducing negative social and psychological outcomes for identity processes"[36].

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We continue exploring the intersections between childhood adversity, different forms of prejudice and trauma in the next section of this collection. Readers should refer to Responding to the traumatic impact of racial prejudice by Lord Adebowale CBE with Dr Marc Bush and Sanjana Verghese (page 199), and Investing in gender and trauma-informed services by Katharine Sacks-Jones (page 219).

Furthermore, service staff should be aware of the need to maintain confidentiality when presented with young people's disclosures of sexual orientation, gender identity or expression, unless otherwise requested by the client. The young person may be disclosing this for the first time, and may not want this to be shared with their peers in the service, their parents or their wider community – especially in situations where this may expose them to further hostility or prejudice. Staff have an obligation to respect the young person's disclosure and right to confidentiality, and therefore should not unwittingly 'out' the young person when communicating with other professionals, parents or carers in their life[37].

Once safety has been established LGBT+ young people may feel more able to talk about the prejudice they have experienced, and the impact it has had on their mental health and identity formulation. Sharing experiences, and being empathetically witnessed by others, can be a powerful way of reconnecting with peers and (re)establishing friendships based on a commonality of experience or through respecting and accepting diversity and difference.

Some services use peer-support models to achieve this, where a young person acts as a mentor, supporter, educator, friend, or empathetic listener for a peer, enabling them to share their experiences and concerns, and is able to provide low level support, encouragement, LGBT+ affirmation and (where appropriate) signposting onto other services[38]. It is vital that the peer-mentor (or equivalent) is provided with training and supervision to ensure that they do not trigger their mentee, and so that they also have the opportunity to process any social or emotional distress (or difficult memories) that are triggered through supporting a peer.

Other services use parenting groups or networks, family mediation and/or caregiver support to establish safety within the home environment and to address the non-acceptance of LGBT+ identity and expression by young people. Familial or caregiver acceptance ensures greater self-esteem, a social support network and protects against mental ill health and health-harming behaviours in LGBT+ youth[39]. Pioneering research by San Francisco State University found that parental or caregiver rejection of LGBT+ youth resulted in a very high risk of health-harming behaviours and mental ill health by the time they reach 25 years[40]. Their research suggests that highly rejected LGBT+ youth are eight times more likely to have exhibited suicidal behaviours, six times more likely to report high levels of depression, three times more likely to use illegal drugs, or be high risk for HIV and sexually transmitted diseases than accepted LGBT+ peers. Research by the Albert Kennedy Trust in the UK has shown how familial and parental rejection is also a significant factor in the risk of LGBT+ homelessness[41]. Young people have suggested that rejection of their LGBT+ experience, expression and/or identity can be traumatic, and is experienced as if they are being rejected for who they are, leading to shame, humiliation and isolation from their immediate family or caregivers[42].

The Family Acceptance Project[43] is a community research, education and intervention model that has developed evidence-based programmes that build an LGBT+ affirming environment in familial and caregiving relationships. The approach builds a new understanding between family members, and LGBT+ affirming ways of relating to one another, which constructively challenges

rejecting and prejudicial behaviours, attitudes and beliefs that caregivers, siblings and the wider family may have about the young person and their sexual orientation, gender identity or expression. The Family Acceptance Project suggests that this involves sensitivity to the wider social and cultural factors that influence familial rejection. Readers can read more about the interaction between LGBT+ and racial prejudice in Lord Victor Adebowale's paper in this collection.

Finally, some young people may find meaning and healing through using their experiences to actively change services or communities that continue to perpetuate LGBT+ prejudice and discrimination. This has been shown to be a powerful tool for re-establishing a sense of belonging within a community, as well as provide young people with positive skills that enhance post-traumatic growth and resilience[44]. To enable this, local services should have relationships with local social action, or LGBT+ community action programmes (which could include art-based organisations), that a young person could be made aware of and/or signposted onto, if requested or deemed appropriate.

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Annex A: LGBT+ Sensitivity Model – adapted and expanded from SAMHSA (2012)

Model/feature	LGBT-damaging	LGBT-unaware	LGBT-naive
Sensitivity	No LGBT+ sensitivity	Moderate level of LGBT sensitivity	No LGBT+ sensitivity
Awareness	Antagonistic toward LGBT+ youth and their experiences of prejudice and adverswity	Provider and staff do not realise or acknowledge that they have LGBT+ youth using their services, and do not recognise their of prejudice, adversity and trauma	Realisation and acknowledgement that they have LGBT+ youth using their services
Provision	Services focus exclusively on heterosexual presentations of need or concern, and excludes LGBT+ clients Services contains no specific LGBT+ treatment components or pathways	Service assumes heterosexual presentations of need or concern Services contains no specific LGBT+ treatment components or pathways	Services primarily assumes heterosexual presentations of need or concern Services contains no specific LGBT+ treatment components or pathways

LGBT-tolerant	LGBT-sensitive	LGBT-affirming	Model/ feature
Minimal LGBT+ sensitivity	Moderate level of LGBT sensitivity	Highest level of LGBT+ sensitivity	**Sensitivity**
Realisation and acknowledgement that they have LGBT+ youth using their services Awareness is usually due to a passionate LGBT+ staff member	Several clients and/ or staff are open with their LGBT+ identity, and this is welcomed and supported by the service	Service and staff understand the experience of LBGT+ youth, the impact of prejudice and trauma, and respond to disclose and identity exploration / formation with an open, positive and attuned attitude	**Awareness**
Services contains no (or tokenistic) specific LGBT+ treatment components or pathways Accepting a young person's sexual orientation or gender orientation most likely will not be directly addressed Dealing with experiences of homophobia, biphobia and transphobia (associated trauma) most likely will not be directly addressed	Service accepts a young person's sexual orientation or gender orientation, and how they want their identity and expression to be described (including use of pronouns) Service incorporates LGBT experiences of homophobia, biphobia and transphobia (associated trauma) into core service model Services contains some specific LGBT+ treatment components or pathways Signposts onto local social action programmes	Service is fully LGBT+ and trauma-informed Self-acceptance and affirmation of an LGBT+ identity or experience is a key part of the support model Signposts and partners with local social action programmes Adheres to the 'Memorandum of Understanding on Conversion Therapy in the UK'	**Provision**

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Continued...

Annex A: LGBT+ Sensitivity Model – adapted and expanded from SAMHSA (2012)

Model/ feature	LGBT-damaging	LGBT-unaware	LGBT-naive
Training	Staff training and development does not include components on LGBT+ identity and experience Staff supervision questions (or seeks to invalidate) the identity and experiences of LGBT+ youth – or is based on prejudicial or discriminatory assumptions / language use is offered to staff, but is not LGBT+ sensitive	Staff training and development does not include, or includes tokenistic components on LGBT+ identity and experience Supervision is offered to staff, but is not LGBT+ sensitive, and possibly questions (or seeks to invalidate) the identity and experiences of LGBT+ youth – or is based on prejudicial or discriminatory assumptions / language use	Staff training and development does not include, or includes tokenistic components on LGBT+ prejudice, identity and experience Supervision is offered to staff, but is not LGBT+ sensitive and unwittingly questions (or seeks to invalidate) the identity and experiences of LGBT+ youth – or is based on prejudicial or discriminatory assumptions / language use
Involvement	Staff infrequently ask young people to input into the design or improvement of the service, but make no effort engage LGBT+ young people	Staff tokenistically or infrequently ask young people to input into the design or improvement of the service, but make little or no effort engage LGBT+ young people	Staff tokenistically ask LGBT+ youth to input into the design or improvement of the service
Trauma impact	Re-traumatises LGBT+ young people, with staff using triggering and discriminatory language or behaviours, and showing prejudicial attitudes and beliefs	Likely to re-traumatises LGBT+ young people, with staff unreflectively using triggering and discriminatory language or behaviours, and showing prejudicial attitudes and beliefs	Likely to re-traumatises LGBT+ young people, with staff unreflectively using triggering and discriminatory language or behaviours, and showing prejudicial attitudes and beliefs

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LGBT-tolerant	LGBT-sensitive	LGBT-affirming	Model/feature
Staff training and development includes tokenistic or limited core components on LGBT+ prejudice, identity, experience and related-trauma Staff are offered regular supervision, that supports them to address vicarious trauma, but only offer limited support on addressing staff prejudice (beliefs, attitudes and/or behaviours)	Staff training and development includes some components on LGBT+ prejudice, identity, experience and related-trauma Staff are offered regular supervision, that supports them to address vicarious trauma and any issues that have been triggered by the young people's experiences	Staff training and development includes core components on LGBT+ prejudice, identity, experience and related-trauma – this includes and understanding of in-group prejudice experienced (for example) by BAME LGBT+ youth Staff are offered regular supervision, that supports them to address vicarious trauma and any issues that have been triggered by the young people's experiences	Training
Staff infrequently asks LGBT+ youth to input into the design or improvement of the service	Service was designed or improved with the active involvement of LGBT+ youth	Experiences and ideas of LGBT+ youth are used to shape the direction of commissioning and service improvement	Involvement
Potentially re-traumatises LGBT+ young people, with staff unreflectively using triggering and discriminatory language or behaviours, and showing prejudicial attitudes and beliefs	Less likely to re-traumatises LGBT+ young people as staff and service are more sensitive about triggering and discriminatory language or behaviours, and the impact of prejudicial attitudes and beliefs	Unlikely to to re-traumatises LGBT+ young people as staff and service are more sensitive about triggering and discriminatory language or behaviours, and the impact of prejudicial attitudes and beliefs	Trauma impact

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14. Responding to the traumatic impact of racial prejudice

Lord Adebowale CBE and **Dr Marc Bush**,
with **Sanjana Verghese**

1. Childhood adversity and racial prejudice

Racial stereotypes pervade media and public discourse surrounding people experiencing mental health problems, and even determine whether they will get access to support, and the quality of care they will receive.

Young people frequently find themselves labelled by officials and professionals as being 'hard to reach', 'marginalised' or 'radicalised'. They are told by those in authority that their attitudes and behaviours are highly 'sexualised', 'criminal' and/or 'pathological'[1]. This culminates in Black, Asian, Arab, and other minority ethnic (BAME) children and young people growing up in a climate where they regularly experience fear, prejudice and discrimination. Consequently, they are confronted with harsher responses from public services, and those whose role it is to keep them safe or support them during a time of crisis.

These labels about the perceived 'morality' of BAME youth are compounded by commonly held misperceptions amongst the public about the size of the BAME population, and the prevalence of minority faiths, in Britain today. For example, a recent survey of the British public found a misperception that 31% of the population is BAME (in fact it is 11%), and similarly that the number of people identifying as Muslim was 24% (compared to the reality of just 5% of the British population)[2].

Misrepresentations of BAME communities in the mainstream media can quickly lead to moral panics about the lives, morality, behaviours and attitudes of BAME young people[3]. We need only look at fears exposed about the welfare dependency of vulnerable children who are seeking refuge in Britain because of the conflict in Syria, or the skewed coverage of the radicalisation among British Muslim youths, without due regard to their experiences of Islamophobia, or the reported spike in hate crimes following the referendum on our membership of the European Union.

The real problem with this misrepresentation is that it stigmatises BAME young people, and deflects attention away from the true extent of the inequalities and prejudice that they face in our society[4]. Moreover, racial prejudice within society, and discrimination within services, results in the overrepresentation of BAME young people in situations where they are more likely to be exposed to different forms of adversity during their childhood.

For example, recent data from the Department for Education[5] found that students from a mixed White and Black Caribbean heritage were over two times more likely to be permanently excluded than the school population as a whole. Pupils from a Black Caribbean heritage were two times more likely to be excluded for a fixed period, and three times more likely to be permanently excluded as compared to students from all other ethnic groups.

While there has been a welcome reduction in the number of under 18 year olds being held in youth custody, children from BAME groups are similarly overrepresented in secure children's homes, training centres and young offender institutions[6]. Within these settings they are also more likely to be restrained that their White peers[7]. In youth justice proceedings, Black defendants, and those with a mixed heritage, are more likely to be remanded in custody than White defendants, despite having a higher chance of being acquitted at court[8].

There is, however, variation within BAME groups. For example, pupils of Asian ethnic groups have the lowest rates of permanent and fixed period exclusion, and are underrepresented in contacts with Youth Offending teams[9]. These differences can be partly explained by prejudicial attitudes and behaviours, with police being more likely in practice to give a reprimand or final warning to Asian young offenders, and less likely to Black and mixed heritage young offenders, compared to their White counterparts[10].

Studies in England had found no significant relationships between ethnicity and prevalence of adverse child experience[11] or poor adult mental wellbeing[12]. However, a wealth of literature has shown that the cumulative experience of racial prejudice (and continued exposure to discriminatory practices) in itself creates significant adversity, and has a lasting impact on the mental health and wellbeing outcomes of BAME young people[13].

This is compounded by the economic hardship and higher levels of deprivation faced by many BAME families. Recent analysis by the Equality and Human Rights Commission found that you are still more likely to live in poverty if you

are from a BAME family[14]. Your parent(s) or carer(s) is significantly more likely to be unemployed (12.9% compared to 6.3%), or if they are in work they will be earning less than their white colleagues. This economic disadvantage results in children from Pakistani, Bangladeshi (30.9%) and Black (26.8%) households being more likely to live in substandard and overcrowded accommodation than White families (8.3%).

Together the social and economic disadvantage that arises from discrimination, and acts of prejudice, produces an environment that is "extremely harmful" to the mental health and emotional wellbeing of young BAME children and young people[15].

Needless to say, racial prejudice is not a White on Black phenomena. There is a wealth of literature exploring the tensions and prejudices between and within BAME communities in the UK. Sometimes the complexity of racial prejudice is under-theorised because we lose sight of the fact that the categories 'Black British', 'White British', 'Asian British', etc actually represent an ethnically diverse group of people, incorporating a wide variation of ethnic heritages and traditions.

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2. Multiple adversity of asylum-seeking and refugee children

Children who migrate to the UK, take refuge here, or seek asylum may face racial prejudice for the first time, or it may trigger memories of the prejudice they have faced in their country of origin. The rise in the number of BAME looked-after children has been attributed to the increase in unaccompanied asylum-seeking children in care, with 3,440 unaccompanied asylum-seeking children entering care, and 1,980 leaving care in 2016[16].

An analysis of mental health need at Immigration Removal Centres, by the Centre for Mental Health, demonstrates that most will have already experienced multiple adversities in the country of origin, on the journey to the UK, and admission to, or detention in, the UK. As a result they will have experienced traumatic stress, and many will have acquired a mental health problem, or an existing condition will have escalated or reached a point of crisis[17].

Experts working in the area of mental health and asylum-seekers or refugees, list the following as common pre-migration and post-migration adversities (the 7D's) that can have an impact on the mental health of children and young people[18].

Table 1: Common pre- and post-migration adversities

Common pre-migration adversities	Common post-migration adversities
• War • Imprisonment • Genocide • Physical and sexual violence • Witnessing violence to others • Traumatic bereavement • Starvation • Homelessness • Lack of healthcare	• Discrimination • Detention • Dispersal • Destitution • Denial of the right to work • Denial of healthcare • Delayed decisions on asylum applications

Around three in four UK asylum applicants are from countries in conflict, and the pre-migration adversities that a child might face (i.e. witnessing or experiencing violence), are further entrenched through the experience of prejudice within British society (because of both their BAME, refugee, asylum or migrant status), and through either additional post-migration adversities (i.e. being taken into care) or the treatment of services (i.e. in Immigration Removal Centres or by children's social care).

3. Traumatic impact on young people's mental health

International systematic reviews and meta-analyses, have demonstrated that experience of racial prejudice and discrimination is a determinant of poor mental and psychical health outcomes[19]; even when controlling for other factors like age, gender and level of education[20].

The acute and chronic stress resulting from experiences of prejudice can result in common childhood mental health conditions, for example anxiety disorders or depression. It can also produce harder to identify symptoms of traumatic stress, which are the emotional responses to forms of prejudice. The exposure to trauma (resulting from racial prejudice) can take many forms. From a discrete or repeated experience that has a lasting impact on the emotional and psychological state of the young person, to more subtle and insidious micro-aggressions that are not immediately seen by the perpetrator to be prejudice[21]. This might include discriminatory treatment within schools or by social services.

A recent analysis by the Centre on Dynamics of Ethnicity at the University of Manchester, demonstrates that racial discrimination has a cumulative, and corrosive, effect on the mental health outcomes of ethnic minorities[22]. Importantly, the researchers note that the fear associated with experiencing another incident of racial prejudice had the biggest cumulative impact. This shows that the trauma of the initial incident(s) entrenches hypervigilance and produces traumatic stress responses.

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For example, in 2016 those from BAME groups were three times more likely to be stopped and searched as those who were White[23]. Shockingly, this rises to six times more likely to be stopped if you are of Black or Black British heritage[24]. The likelihood of being stopped is so much higher for Black young people, because searches of people from BAME groups fell by just 13% between 2015 and 2016, compared to 38% among people identified as White. From what we know about traumatic stress, some Black young people will be experiencing higher levels of hypervigilance resulting from both the actual experience of being stopped and searched, and the perceived threat of being subjected to this again in the future.

Children and young people experiencing racial prejudice may develop symptoms of traumatic stress, including:

- intrusive memories or flashbacks to experience(s) of racial prejudice.

- symbolic and nonverbal enactment of traumatic racial prejudice through the use of play or in relationships with significant others.

- distressing dreams and reoccurring night terrors where features of the dream relate to their experiences of prejudice.

- avoiding situations, or people in authority, who trigger memories of these traumatic experiences.

- intense feelings of detachment, disassociation or estrangement from others.

- perceiving threats from those in authority and an exaggerated suspicion about the motives or intentions of those in authority who offer support.

- becoming quickly irritable or angry towards people or objects with little provocation, and engaging in reckless or self-destructive behaviours.

Studies have demonstrated that racial prejudice acts as a catalyst for both trauma-related systems[25], and perhaps also explains the higher prevalence of Post Traumatic Stress Disorder (PTSD) amongst BAME adults, and in particular those of Black or Black British heritage (8.3% compared to 4.2% White adults)[26].

There have been lively debates over differential diagnoses of these symptoms of traumatic stress among BAME patients. Researchers from the US have, for example, created a classification of Race-Based Traumatic Stress Injury (RBTSI), which is differentiated from PTSD by a core stressor of emotional pain resulting from prejudice, rather than a threat to life[27]. Others have proposed a Developmental Trauma Disorder (DTD) to describe experience of chronic developmentally adverse traumatic events occurring in childhood and frequently within the child's caregiving system and/or immediate community life[28].

In reality children are rarely diagnosed with PTSD, and as it stands neither DTD nor RBTSI have been included in the official classification systems compiled by the American Psychiatric Association[29] nor the World Health Organisation[30]. It is estimated that around one in six children and adolescents develop PTSD after being exposed to a traumatic event[31], however many more develop mental health problems that result from experiences of traumatic stress.

4. Recognising intersectional trauma and in-group prejudice

The cumulative trauma of racial prejudice is further complicated by intersectionality, and prejudice within BAME communities. For example, we know that many Lesbian, Gay, Bisexual or Transgender (LGBT) young people of BAME heritage face both the intersectional trauma of homophobia and/or transphobia within their BAME community (on the basis of their sexuality or gender identity or expression) and racism within the LGBT community (for their BAME embodiment or identity)[32]. This complexity is reflected in the higher risk, for example, of suicide among gay Black men[33].

Similarly, coercive cultural traditions have continued to be an issue for many girls and young women of Asian heritage. In five cases handled by the Forced Marriage Unit related to the possible forced marriage of girls or young women[34], and a quarter of all cases were children and young people under the age of 18 years. By far the majority of cases related to families from Pakistan (43%) and Bangladesh (8%). Within small pockets of these communities in Britain girls face the dual adversity of experiencing racial prejudice from others outside of the community due to their ethnic heritage, and within the community discriminatory attitudes and highly coercive behaviours because of their gender.

Finally, over the last decade there has been an increase in the number of children growing up in inter-ethnic families[35]. Historically, we know that inter-ethnic couples and their mixed heritage children have faced significant prejudice and discrimination within the communities of origin. Despite increased visibility in society and the media, the prejudice continues today, with many inter-ethnic families reporting hostility, confusion or non-acceptance of children in BAME communities. Today around one in 10 couples are inter-ethnic, and (perhaps reflecting a commonality of experience) young people from mixed or multiple ethnic groups are most likely to be in an inter-ethnic relationship in adulthood (85%).

An important report by the National Children's Bureau (NCB) tracks the mental health impact of racism, discrimination and identity confusion experienced by children and young people of a mixed heritage background[36]. This can include the emotional distress that arises from confusion over ethnic identity, experiencing racism and making sense of their own enactments of racial prejudice as a mixed ethnic child.

Those facing intersectional prejudice frequently report hostility and non-acceptance from their communities. This compounded isolation can expose young people to (often contradictory) forms of direct prejudice and discrimination that reduce the availability of places of safety within the community, and increases the adversity they will face (frequently experiences of threat, violence or coercion). These experiences all heighten the symptoms of traumatic stress.

5. The cyclical impact of traumatic stress

The trauma of racial prejudice is cyclical, in that the normative responses to emotional distress are misinterpreted by those in authority as signs of noncompliance, aggression or non-engagement[37].

There is a wide body of literature[38] showing how chronic hypervigilance effects the functioning of the prefrontal cortex. This means young people's ability to focus on the cognitive tasks and decision making demanded by the school curriculum or the youth justice system will be significantly reduced. Furthermore, the hyperarousal associated with traumatic stress makes it more difficult for a young person to deescalate in a confrontation. When we add this to the general higher levels of impulsiveness during adolescence it is understandable that some of these young people will respond to their emotional distress with bursts of aggression, hostility or withdrawal[39].

We also know that if a child is met with an uncompassionate or further discriminatory attitudes by those in authority, it can heighten suspicion over the motives of professionals, or rekindle the feelings of helplessness or powerlessness they experienced in the original traumatic situation. With this in mind, we can only break the cycle of traumatic stress by correctly identifying these young people's behaviours and emotions, as expected and understandable responses to the trauma of a childhood adversity, and/or the cumulative experience of racial prejudice.

So rather than simply marking DNA (did not attend) next to the name of a young person who does not turn up for a therapy session, we should be inquiring as to whether the environment and form of therapy is appropriate for the young person. Instead of labelling a young person as being 'aggressive' or having 'challenging behaviour' we should ask what in their experience is being triggered in their interaction with us, and how we are describing and

responding to this behaviour – keeping in mind that feelings of uncontrollable anger can be a response to trauma.

6. Discrimination within mental health services

The prejudice that BAME young people face in wider society is mirrored in both children's and adult mental health services. BAME children are underrepresented in Child and Adolescent Mental Health Services (CAMHS) and overrepresented in adult mental health services[40]. Similarly, there is an overrepresentation of Black mental health patients compulsorily detained in forensic and secure services[41]. This is partly explained by the more complex pathways into psychiatric care that BAME patients face[42]. This additional complexity of pathways includes more frequent involvement of the police or criminal justice system[43], higher rates of compulsory detention, and Black patients being more likely to be secluded[44] and restrained[45] as part of their detention in psychiatric services. For example, recent analysis by the University of Sheffield[46] found that Black patients were three times more likely to be compulsorily admitted under the Mental Health Act in 2010-11.

Research from the UK has shown that patients from BAME communities were 30% to 83% more likely to access mental health services through the criminal justice system than their White peers[47]. The Sainsbury Centre for Mental Health found that patients from African Caribbean backgrounds are more likely to be "misdiagnosed and diagnosed with psychotic conditions"[48], and as a consequence treated using medication at a higher dosage than their White counterparts[49].

Similarly, a recent study of four Early Intervention Services (EIS) for psychosis found that Black patients were three times more likely to be detained and hospitalised compared to their White counterparts. This increased likelihood was related specifically to more complex pathways into care, and differences in help-seeking behaviours among BAME communities[50].

Worryingly, young Black Caribbean men are three times more likely to have been in contact with mental health services in the year before suicide, and Black African psychiatric inpatients are twice as likely to commit suicide as their White peers[51].

7. Variations in health-seeking behaviours

Many BAME families and communities have a different cultural understanding of mental ill health, and the fear of being labelled (for example) 'mad' or 'possessed', or being ostracised by the community can act as a significant barrier to seeking support from GPs or specialist mental health services. Likewise, some childhood adversities are underreported as BAME communities fear that mental health and public services do not understand the cultural significance of what we might see as complex and traumatic experiences, including Female Genital Mutilation (FGM), so-called 'honour-based' violence, scarification and forced marriage. The fear, stigma and shame associated with mental ill health and childhood adversity in some BAME communities leads parents to actively avoid interactions with mental health services to circumvent a diagnosis and possible exclusion from community life[52].

Furthermore, some families turn to faith-based organisations for support during a mental health crisis. A survey by the African Health Policy Network found that 60% of respondents would 'most likely' turn to a community group, and 50% a faith group[53]. This might be because they feel more comfortable speaking to people from their community, or because they see the symptoms as part of their supernatural or faith beliefs[54]. In some areas there remains animosity between mental health services and faith leaders, and this only frustrates early intervention for children. That said, the Government's initiatives (for example) to tackle FGM alongside community leaders is proving to ensure quicker access to specialist support[55].

Given this, concerns remain that many interpreters and translators do not have experience of working in mental health. As such, they may unwittingly use language that a family or young person would find culturally stigmatising or shaming. Likewise, families report a reluctance in relying on bilingual family or friends as this could disclose to the wider community an illness that could lead to the isolation or discrimination of the family. Furthermore, parents report that the nuances of (for example) decisions about voluntary and involuntary admission to specialist mental health wards, and the implications on parental rights, or the distance of specialist placements are frequently lost in translation.

Finally, because of the trauma of perceived and actual prejudice many BAME young people experience fear about receiving a negative response from the GPs and other health practitioners[56]. They may also fear the misreading of social behaviours by frontline mental health staff, for instance the practice of

self-soothing by talking aloud[57]. The Sainsbury Centre for Mental Health in their *Breaking the Circles of Fear* report describe how this leads to a relationship of mutual distrust and hostility between African-Caribbean patients and mental health staff[58].

Echoing this, the Lambeth Black Health and Wellbeing Commission found that experience of discrimination in the community led to local Black youth being fearful of formal CAMHS support. They highlighted the benefits of investing in more informal drop-in services that reduce the stigma of accessing support in the community, provide a more equal ground for engagement, and help to prevent the escalation of needs[59].

8. Becoming culturally sensitive and trauma-informed

In order to better identify and support the mental health needs of children and young people who face racial prejudice, mental health and public services in England must become both culturally sensitive and trauma-informed.

As a starting point we recommend that all commissioners adopt the Guidance[60] issued by the Joint Commissioning Panel for Mental Health, which is chaired by Royal College of General Practitioners (RCGP) and the Royal College of Psychiatrists (RCPsych). Included in this guidance is a welcome suggestion that commissioners invest in public mental health interventions that focus on "reducing or moderating the adverse impact of social and material adversities (including racism) on these communities".

Supplementing these, we draw on what we have learnt from the experiences of BAME young people and families, to propose below additional principles that commissioners and providers alike should adopt to help to tackle racial prejudice and address its traumatic impact.

a. Raising awareness of the traumatic impact of racial prejudice

Commissioners and providers should be aware of their existing responsibilities under the Equality Act[61] and Human Rights Act[62] in respects to non-discrimination, and that it is enshrined as a right of patients and responsibility of NHS staff in the NHS Constitution for England[63].

All public service professional working directly with children and young people should have a baseline knowledge of both racial prejudice and the adverse and traumatic impact it can have on the mental health of young people and their families. initial professional training and Continued Professional Development (CPD) must include a more detailed understanding of the impact of trauma on young people's thoughts, emotions, behaviours and embodiment. Furthermore, it should require an interrogation of professionals' own experiences of, or attitudes towards racial difference and prejudice.

Dr Janet Helms[64] and colleagues identified the interaction styles used by mental health professionals when assessing people who had faced trauma and adversity (see annex A). They describe how young people might respond to these different behaviours of mental health professionals. The researchers suggest that we need to be aware of our own prejudice in order to successfully navigate the identification and treatment of prejudice-related trauma, and to bring these encounters to a non-confrontational and supportive (progressive) approach. In this way, awareness of one's own prejudice is important as it can mitigate the potential for re-traumatising young people and further entrenching mental ill health they may experience.

Within this, prejudicial and professional assumptions need to be challenged about understandings of behaviours that are frequently labelled as hyper-sexualised, criminal, pathological. For example, professionals need to be sensitive to the paradoxical ways in which membership of a gang can create for young people a sense of safety and belonging that traumatically bonds them to their peers. Peer violence and aggression towards authority here may be more about retaining or strengthening a traumatic bond, and making sense of the prejudice they have experienced, rather than the morality of the young person or the BAME community that they are identified with.

b. Navigating cultural stigma and shame

Services and professionals need to better understand the stigma that surrounds mental ill health in some BAME communities, and how disclosure or treatment risks isolation, estrangement and victimisation within the community. Similarly, for some the adversity that is or has been faced will be a cause of significant cultural shame both within their community and wider society (i.e. child sexual exploitation or inter-ethnic violence).

On this basis interventions need to be wary of overly medicalising

interventions, and ensure that service design is culturally sensitive – including the use of non-traditional modes of delivery. For example, the Time To Change 300 Voices project[65] co-developed with young men of African and Caribbean heritage is an engagement model for mental health professionals and the police. This model aims to reduce the stigma of seeking mental health support within the African and Caribbean communities in the UK, and uses appreciative inquiry, restorative justice, storytelling and community engagement to challenge the prejudicial attitudes and behaviours of professionals.

c. Collaborating with local communities

Experience and research clearly demonstrates that mental health interventions in BAME communities are most successful when they meaningfully engage the community in the design and delivery of services and support[66]. Similarly, service design should understand the collective adversity and trauma that communities have faced, and use this to inform the delivery mechanism and the partnerships they create to build trust and confidence in the community. For example, South West London and St. George's NHS Mental Health Trust co-designed with the local Tamil community a culturally-informed model of the Improving Access to Psychological Therapies (IAPT) initiative in Wandsworth and Merton[67].

The service, named Manashanthy (mind-peace) recruited Tamil speaking cognitive behavioural therapists who provided workshops at the Wimbledon Shree Ganapathy temple (and other local community and faith centres) to the Tamil community. A community development worker and services leads ensured that the project established good working relationships with wider health services (including GPs), specialised services (including Freedom from Torture and the Tamil Welfare Organisation) and community leaders. The workshops provided information on how the community could access IAPT services, as well as giving a culturally-sensitive introduction to mindfulness techniques and importantly psycho-education about traumatic stress and PTSD. Subsequently, the community were able to access both community and specialist led trauma support.

Similarly, the Up My Street projects evaluated by Centre for Mental Health demonstrate the importance of providing culturally and psychologically-informed safe spaces encouraging aspiration, openness and positive relationships between young black men who had overcome adversity[68].

Finally, the involvement of community groups becomes especially important for those young people who are facing intersectional prejudice or adversity. This might include BAME LGBT+ youth, or girls facing coercion or violence within families.

d. Ensuring early access to specialist trauma-informed care

Where a young person or community has faced a specific adversity or trauma it is vital that they get access to specialist trauma-informed care. Those who experienced complex and enduring forms of trauma (including witnessing or being a victim of torture in their country of origin) need swift and continued access to trauma support and therapeutic services. For example, Freedom from Torture, which is a charity operating from London, Glasgow, Manchester, Newcastle and Birmingham provide a programme of structured and creative therapeutic support to children and young people, in many cases alongside existing interactions with statutory services.

Annex A

Table 2: interaction styles between Mental Health Professionals and BAME young people (adapted from Helms et al, 2012)

		Description	Mental Health Professional (MHP) behaviours	Young person reactions
Type of interaction	Parallel	MHP and young person understand the factors related to the racial or cultural trauma similarly.	MHP meets the young person on common ground, but must be careful not to collude in avoiding the details of the trauma experience.	Young person will experience the assessment environment as supportive, but may not be forthcoming with vital information if the evaluator colludes with her or him in denying the racial or cultural aspects of the situation.
	Regressive	MHP, as the person in power, ignores the racial or cultural aspects of the situation and tries to convince the victim that such factors are irrelevant to the situation.	MHP attempts to impose his or her understanding of racial or cultural events on the trauma victim, possibly because the evaluator's life experiences have been different and the victim's understanding of her or his own experiences are threatening in some way.	Young person experiences the assessment environment as unsupportive and withdraws.Typically, such assessment environments are re-traumatising and the victim may engage in some of the reactions that occurred with the original trauma.
	Crossed	MHP and young person are exact opposites in their reactions or understanding of the traumatic event and, consequently, react to one another from a combative or suspicious position.	MHP assessment and/or treatment of the young person may be punitive, perhaps not purposefully. Because he or she is opinionated with respect to the racial or cultural aspects of situations and cannot set aside those opinions, the evaluator is unable to assess the situation from the young person's perspective.	Surviving trauma victims may withdraw from the interaction, which may be manifested as not talking, avoiding contact with service providers, or increased manifestation of psychological symptoms, such as depression.
	Progressive	Supportive assessment environments characterised by efforts by the MHP to understand the young person's racial and cultural experiences of trauma even when they might not be evident to the person manifesting such symptoms or reactions.	MHP attends to person's racial/ cultural issues and attempts to create an environment conducive to discussing race and culture. The MHP is able to ask questions about racial or cultural conditions of the situation, even if the perceived antagonists in such situations are people who are racially or culturally similar to the MHP.	Young person experiences these environments as supportive, but may engage in tests to determine whether the MHP is authentic. Tests might include saying negative things about people from the MHP's ethnic group to see how they will react.

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15. Investing in gender and trauma-informed services

Katharine Sacks-Jones

1. Young women, mental health and adversity: prevalence

Mental ill health among women and especially young women is on the rise. About one in five women now have a mental health problem, compared to one in eight men[1]. Young women (16–24) are at greatest risk of poor mental health – with one in five self-harming and one in seven (13%) experiencing post-traumatic stress disorder[2]. This trend is particularly concerning as we know mental health problems, which can continue right across someone's life, are first experienced young, with 50% established by age 14 and 75% by age 24[3].

The gender disparity in rates of mental ill health between young women and men has arisen, in part, because while rates of mental ill health have remained largely stable in men, they have steadily increased in women. And while men remain more likely to die by suicide, there has been a worrying increase among women, with female suicide rates in England and UK at their highest in a decade[4].

If we don't act now to halt these worrying trends, we risk storing up substantial problems for the future.

The reasons behind mental health issues are of course complicated and individual. But there are particular risks and pressures associated with being a young woman: greater worries over body image; early sexualisation; interpersonal violence, harassment and abuse and sometimes the pressures of caring or domestic responsibilities within families.

Physical and sexual violence is however, perhaps the single most significant risk factor for girls and young women. Domestic and sexual abuse remains at extraordinarily high levels and we are only now beginning to realise the scale and extent of child sexual abuse and exploitation.

It is a sobering fact that of all women who have a common mental health disorder over half have experienced violence and abuse. For one in four that

abuse started in childhood[5]. For those with the most severe mental health problems, the links are even more pronounced.

Evidence suggests that childhood abuse is a more common experience for girls: severe maltreatment by a parent during childhood happens to 17.5% of girls and 11.6% of boys, and sexual abuse is experienced by 17.8% of girls and 5.1% of boys.[6] The sexual abuse of girls is more likely to be perpetrated by family members, to begin at an earlier age and to occur repeatedly than the sexual abuse of boys. The sexual abuse of boys is more likely to be perpetrated by non-family members, to occur later in childhood and to be a single incident.[7]

Children who experience multiple forms of victimisation are at greatest risk of developing mental health problems[8] and those who are subject to multiple adverse experiences in childhood are at particular risk of developing severe behavioural problems. There is evidence that this is particularly the case for girls.[9]

2. How mental ill health manifests

There are also clear gender differences in how girls and boys behave in response to adverse experiences and trauma. Broadly, boys are more likely to externalise problems (for example to 'act out' and engage in anti-social behaviour) by contrast girls are more likely to internalise their responses (for example to experience depression or engage in self-harming behaviours).

This can mean girls' distress is less visible than boys'. For example, it is notable that while Attention Deficit Disorder (ADHD) affects a similar proportion of men and women (approximately one in 10 of the population), men are over five times as likely as women to have been diagnosed with ADHD.[10]

Boys are more likely to be looked-after – 56% of looked-after children are male, 44% female and these proportions have varied little over recent years[11]. Boys are over three times more likely to receive a permanent exclusion and almost three times more likely to receive a fixed period exclusion than girls[12]. Boys are also at increased risk of entering the criminal justice system, making up over 80% of young people arrested[13].

It appears therefore that many girls are going 'under the radar' with an increased likelihood of further abuse and long-term mental health difficulties.[14]

Although girls may be less visible in the statistics, they are no less at risk, with girls more likely to experience violence and abuse, sexual exploitation and teenage pregnancy[15]. Girls who spend time in care for example are more likely to become teenage mothers, and have their own children taken into care[16].

All of this underlines an urgent need to understand mental health in a gendered context and to develop mental health services and support in a way which meets the needs of both young men and young women.

3. Mental health service provision and gender

At the moment however, there is very little specific provision for young women. In response to a Freedom of Information request by Agenda[17], only one of the responding mental health trusts had a women's mental health strategy. In every other trust, there was no strategy explicitly recognising women's mental health as an issue and no consideration of women's needs when planning which services to provide.

What's more, just over half of trusts had no policy on routinely asking female patients about experience of abuse, despite the fact that NICE guidelines say they should be doing so. Currently it appears that most mental health services take a gender blind approach – meaning they don't recognise young men and women's different experiences and needs. And this matters.

To take an example, recent research for Agenda[18] found the use of physical restraint against women and girls in mental health settings was widespread. Girls were more likely to be physically restrained than boys (17% compared to 13%). This is despite the links between young women's mental health problems and abuse. Because of these links, restraint can not only be a frightening and humiliating experience but it also risks re-traumatising young women and exacerbating their mental health problems in the long term, with potential additional harm as much of the restraining is done by male nurses. Young women have also told us of how, when they were at their most vulnerable in mental health hospitals on 'suicide watch', being watched over by male staff made them feel unsafe and contributed to their mental distress.

We think a new approach is needed which takes young women's particular needs into account in mental health support and services.

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We recognise the tremendous pressures facing the health service but at a time of tightened resources it is more important than ever that support is effective and targeted; and that it gets to the root of problems rather than acting as a sticking plaster as young women bounce from mental health crisis to mental health crisis, at huge cost both to them and the public purse.

There are some excellent first class services out there in both the voluntary sector and within the NHS but they are incredibly few and far between. These provide female only spaces, place an emphasis on building trusting relationships and recognise and respond to the particular pressures and challenges young women face.

4. Responding to trauma, adversity and gender

We believe commissioners need to be thinking in a gendered way about what they commission and that Clinical Commissioning Groups should prioritise the following:

a. Listen to and recognise women and girls' experiences and needs:

Women and girls' needs should be explicitly recognised in policies, strategies and services. One way of achieving this would be to develop a women's mental health strategy which reaches across children and adult services and to appoint a clinical lead for women's mental health to ensure the needs of women and girls are not overlooked.

This process should include identifying and developing an understanding of gender differences in relation to mental health conditions, pathways and treatment. Consulting with young women with experience of mental ill health on what services they need and want should be a key part of informing commissioning decisions.

Commissioners should consider commissioning dedicated specialist services to meet the particular needs of young women and girls who have experienced abuse and trauma. Invest in early interventions that are shown to have longer-term benefits for women and ensure there is consideration of and robust evaluation of gender effects within interventions.

It might also include thinking about the changes that could be made across

services to better meet the needs of women and girls which could for example be something as small as offering a choice of a female practitioner or providing an environment in which young women feel comfortable. Even small steps could make a real difference to the care young women receive.

Commissioners should also recognise the particular experiences and needs of different groups of young women including those from BAME communities.

b. Ensure mental health services take a trauma-informed approach and frontline NHS workers are trained to understand that young women's mental health, trauma and abuse are closely linked.

Health services should take a trauma and gender informed approach, understanding young women and girls in the context of the abuse and disadvantage they have suffered.

In the US a few gender sensitive, trauma-informed interventions have been implemented and substantially evaluated in a number of settings (including mental health, substance abuse and criminal justice). These include Stephanie Covington's trauma-informed approach[19]. The work of Maxine Harris and her colleagues has been a major influence on trauma-informed interventions[20] with many adopting the core values she identifies for trauma sensitive services: ensuring physical and emotional safety, maximising trust through consistency, being honest and providing clear boundaries, maximising client choice and control, collaborating and sharing power, and empowering survivors[21].

c. Introduce 'routine enquiry', within urgent and emergency care and specialist services.

This involves training professionals to sensitively ask about experiences of violence and abuse and other childhood adversity. It needs to be accompanied by proper support and pathways into therapeutic care.

d. End the restrictive practice of face-down restraint and ensure other forms of physical restraint are only used as a last resort.

The use of restraint is concerning because of the potential it has to re-

traumatise the many women and girls in mental health settings who have experienced abuse and violence. Restraint is often carried out by male nurses, which compounds the fear and trauma of those women and girls who have histories of abuse and violence at the hands of men. Female patients' dignity is also at stake. Being physically held down and clothes pulled out of place, often in front of others, can be an extremely humiliating, as well as frightening, experience. As such, the use of restraint is unlikely to improve mental wellbeing in the short or long-term – and is likely to do the opposite. This is not to mention the well-documented physical dangers of face-down restraint, which can be life-threatening. Some trusts appear to have almost eliminated physical restraint and to have stopped using face-down restraint altogether which shows that change is possible, and alternative de-escalation techniques can and do work.

e. In whole school, parental and whole family support approaches it is vital that trauma and gender are considered.

It is important targeted support to parents and care givers where children are experiencing or have experienced trauma and adversity considers the role gender plays within families.

For example, many families living in poverty which contain children facing adversity are headed by women alone. Single parent families are the group most likely to be in persistent poverty[22], and 92% of single parents with dependent children are mothers[23]. In many cases, the fathers of their children are absent, unwilling or unable to get involved in raising children, meaning that realistically many of these mothers will always be the sole engaged parent.

Where families are headed by a couple, mothers still provide the majority of childcare[24.] Evidence has shown that a mother's life experiences have a strong predictive impact on her children, for example a mother's level of education has more impact on a child's cognitive ability and the nature of their home learning environment, than a father's level of education or even than household income[25]. Their role is therefore critical in a child's formative years and putting them in a position to parent well is the best way to make sure their children have good life chances.

Sadly we know that in many of the most excluded families, women and children experience violence and coercion at the hands of fathers and step-fathers[26.] Abuse has serious negative impacts on children's life chances, but often there

is insufficient support to mothers to cope with these situations[27].
It is important therefore that support targeted at families takes a gendered approach and recognises these dynamics. In particular, targeted support to help mothers be good parents can help provide the foundation children need to support their life chances in the early years. Similarly whole school approaches to mental health must consider the role of gender and how to ensure the needs of both boys and girls are being met.

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16. Tackling child abuse in local transformation planning

Lisa McCrindle, **Almudena Lara** and **Rosie Powell Davies**

1. Childhood abuse and mental health

The NSPCC estimates that every year over half a million children in the UK are abused in the home[1]. Every child should be supported to recover from abuse. The support children receive can make the difference between them overcoming their trauma or living a life shaped by the abuse experienced.

We know that childhood experience of abuse can have a major impact on young people's mental health and wellbeing. Children who have been abused are more likely to experience depression, anxiety and symptoms of post-traumatic stress disorder, as well as self-harm and suicide[2]. In addition, it can have a devastating effect on children and young people's development, with lasting consequences for their mental, physical and emotional health – as well as for their relationships with others and education[3].

A third of Childline counselling sessions related to mental and emotional health and wellbeing issues, including self-harm and suicidal thoughts or feelings[4]. There is evidence that experience of maltreatment in childhood doubles the risk of depression, and this depression is more resistant to treatment than depression which occurs without experience of childhood maltreatment[5]. Experiencing abuse in childhood can enhance vulnerability to further adversity as a child or young adult, which can include further exposure to abuse, health-harming behaviours (such as substance misuse or self-harm), and in some cases adoption of abusive and/or sexually harmful behaviour themselves.

In addition to the impact on individuals, child abuse presents wider consequences for the economy and society. A study commissioned by the NSPCC estimated that child sexual abuse alone costed the UK £3.2 billion in 2012, arising from mental and physical health problems, drug and alcohol misuse, unemployment and criminal justice costs[6].

2. Lack of access to support

Our analysis of child and adolescent mental health services (CAMHS) shows that services are struggling to cope with demand from across England. In 2015, an NSPCC Freedom of Information request discovered that one in five children referred to CAMHS are denied a service, and the average waiting time between referral and assessment ranges from just a week in some areas to more than 26 weeks (6 months) in others – with an average waiting time of nearly two months[7]. This can be a significant proportion of a child's life to be waiting for support at a critical time and may result in significant escalation of their needs. Without early intervention, the demand for services continues to increase and thresholds for treating mental illnesses in children are pushed up and waiting lists increase.

Accessing CAMHS support is especially difficult for children who have been abused or neglected. In a NSPCC survey of child mental health professionals, 98% reported there was not enough therapeutic support for children who have been abused.[8] Children who have been abused will not meet the high clinical thresholds for access to CAMHS unless they are in crisis.[9] Even then many CAMHS workers do not support children who have been abused and neglected as their needs are considered to be specialist, resulting in many children being turned away once they reach crisis point[10].

Calls to the NSPCC's Childline also show the difficulties that children face in accessing mental health support. In 2016, there were 3,250 counselling sessions in which children and young people talked about struggling to access appropriate professional support locally, particularly for mental health problems. This represents an 87% increase on the previous year, which in turn followed a 124% increase on the year before[11].

The problem begins with identification. Many children who have been abused and neglected are simply not known to services, and even those who are referred to services cannot be sure of getting the support they need to recover, with one in five children in England who are referred to mental health support services being denied help. Many children who are abused and neglected receive no automatic entitlement to assessment or support as they do not yet reach clinical thresholds. In all too many cases children are reaching crisis point before they become eligible for support.

These problems are particularly acute for looked-after children. Over 60% of looked-after children in England and Wales are in care owing to abuse or

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neglect[12]. Looked-after children are four times more likely to have a mental health issue than their peers, yet not all of these children are having their emotional wellbeing appropriately assessed. Even where looked-after children are being assessed, these assessments are rarely undertaken by a trained mental health professional, and there are no clear pathways in place to ensure appropriate support where needs are identified.

Looked-after children can face even greater challenges when seeking support for mental health needs. Since 2015, local authorities have been required to conduct a mental health assessment for every child in care and report this data to central government. However, the most recent figures suggest that almost 30% of children who are taken into care do not receive this statutory mental health assessment. The children in care who are in greatest need of clinical mental health treatment are often also those with the most fragile placements. CAMHS will often not accept referrals of children who are likely to move location frequently, and this can directly block those who most need the service.

The NSPCC is seeking to urgently address these issues to make sure the lives of children who have experienced abuse and neglect are not derailed, and are helped to put their life back together. We are calling for every child and young person who has been abused to receive the support they need. We have urged the Government to recognise the needs of children who have experienced abuse and neglect and to increase investment in targeted therapeutic services. This alone will not solve the problem. We also need to see a clear vision for the planning, commissioning and delivery of services for children who have been abused and neglected.

3. Delivering on the ambitions of *Future in Mind*

In 2015, the Government's Children and Young People's Mental Health Task Force published *Future in Mind*[13], a landmark report setting out a new vision for children and young people's mental health in England. The Government subsequently committed to spend £1.4 billion over five years to improve children and young people's mental health services (up to 2021). CCGs were asked to produce Local Transformation Plans setting out how they would improve mental health services for children and young people in their area. The deadline for completion of the first round of plans was October 2015, with all plans due to be published locally by 31 December 2015.

Local Transformation Plans are a crucial opportunity to address the current gaps in therapeutic support for children who have been abused. Two of the main themes that underpin *Future in Mind* include "care for the most vulnerable" and "promoting resilience, prevention and early intervention". This focus particularly chimes with the needs of children who have been abused – this is a vulnerable group of children, at high risk of psychological distress, who will often benefit from early intervention to prevent mental health issues from escalating. CCGs have been instructed to refresh these plans and publish the updated versions on an annual basis.

The NSPCC carried out an analysis of the original plans to assess whether the needs of children who have been abused had been considered by the CCGs. In September 2017 we revisited this analysis using the updated plans[14].

The analysis shows a picture of the extent to which local transformation plans recognise the mental health needs of children that have experienced abuse and neglect, and the services which are targeted to meet their needs across the country. Our analysis shows that an estimated 1.2 million children who have suffered abuse live in areas with inadequate mental health plans. This is despite NHS England guidance requiring plans to address the full spectrum of needs.

According to the guidance and the ambition set out in *Future in Mind* the Local Transformation Plans should set out how areas will transform children's mental health services and ultimately address the growing mental health needs of children. Given the scale and impact of child abuse and neglect the omission of their needs in planning and commissioning of support services is a significant oversight. As a society we all strive to prevent abuse and neglect, when we fail to do so we should ensure that we are able to respond to their needs to ensure that they are supported and equipped to go on to lead healthy, happy lives.

Our analysis identified a small number of very promising plans which are seeking to close the gap in therapeutic support for abused children. Examples of good practice include:

- recognition that abuse is a major risk factor for poor mental health.

- needs assessments which were much broader than a narrow focus on clinical disorders.

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- a commitment to addressing non-diagnosable mental health concerns following traumatic life events such as abuse.

- clear and transparent information about current and planned services.

> ### *Box 1: Examples from Local Transformation Plans (LTPs)*
> Source: NSPCC 2017 analysis of LTPs
>
> **Somerset Local Transformation Plan** – this plan is an excellent example of how to make an assessment of needs in the local area and how to consider the risk factors that impact on children and young people's mental health. In order to inform its needs analysis, this plan used Somerset's Joint Strategic Needs Assessment for 2014/15, the Somerset Children and Young People's and Learners Needs Analysis (2013) and a large survey (n=9774) of young people in school years 4, 6,8,10 and 12.
>
> **Bury Local Transformation Plan** – this plan is an excellent example of how to make an assessment of needs in the local area and consider the risk factors that impact on children's mental health. The plan not only considers its own needs and service provisions, but also takes into consideration the Greater Manchester area. It acknowledges the fact that there are (good and bad) crossovers geographically and utilises integration with the neighbouring Manchester CCG in order to improve its service design. The plan recognises that children and young people's needs must always be contextualised to the local area, but also exploits the benefits of working across geographies.
>
> **Heywood, Middleton and Rochdale Local Transformation Plan** – this plan provides a good example of how to conduct a needs analysis. The plan is strongly focused on the Joint Strategic Needs Assessment. It incorporates a life course approach and bases its analysis on the risk factors for mental health. The plan makes good use of health outcomes to inform its strategy, including mortality, the prevalence of mental health problems and observed incidence.

4. NSPCC services for abused and neglected children

The NSPCC has developed a number of targeted therapeutic services to improve the mental health and emotional wellbeing of children who have experienced abuse and neglect. Some of these are delivered from our regional service centres and others have been developed into scalable services that can be used by local authorities. These provide examples of the type of interventions that can be effective in helping children and young people who have experienced abuse get back on track.

Letting the Future In

Letting the Future In (LTFI) is a service designed by the NSPCC for children aged four to 17 years who have been sexually abused. The approach helps children come to understand and move on from their past experiences through activities such as play, drawing and painting and storytelling. Parents and carers are also offered support to move on from the impact of finding out about the sexual abuse and to help their children feel safe.

LTFI is grounded in an understanding of trauma, attachment and resilience. It is largely psychodynamic in nature and emphasises the therapeutic connection of the practitioner to the child's emotional responses to abuse, which typically include betrayal, powerlessness, shame and traumatic sexualisation. The therapeutic relationship between child and practitioner is core to the programme and employs creative therapies with work on the awareness and management of feelings. It also draws on other methods including counselling and socio-educative approaches.

An NSPCC evaluation of LTFI found that at the beginning of the process almost three-quarters (73%) of children aged eight and over had severe emotional difficulties and after six months of treatment this dropped to less than half (46%). Children and parents who took part in the service reported many positive results, including improved mood, a reduction in depression and anxiety, and a reduction in guilt and shame[15].

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Face to Face

The NSPCC's Face to Face service supports children and young people in care or on the edge of care who are aged between five and 18 years. The service was designed to respond to research that showed that looked-after children would most like to access confidential face-to-face support from someone who would "listen and not judge". They wanted a service that would result in tangible changes but would not feel "too heavy". The Face to Face service offers children and young people up to eight sessions of support using a solution-focused approach. Young people are able to choose the location of the work and also how frequently they wish their sessions to take place.

The service offers therapeutic support to children who are experiencing difficulties with their mental health but who have not necessarily reached the threshold of a mental health clinical diagnosis. This type of early intervention is vital.

The NSPCC's evaluation of Face to Face found that 58% of children and young people had a clinical level of distress when they first accessed the service[16]. At their last session only 15% of the same children were still experiencing clinical levels of distress. Over two thirds of children and young people reported that Face to Face had helped them a lot in addressing the immediate concern that had been impacting on their emotional wellbeing.

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17. Up-skilling the housing and homelessness sector

Jo Prestidge

→ The editor recommends reading a complementary paper on the author's experience of learning about trauma-informed care in the US in the journal Housing, Care and Support under the title of 'Using Trauma-Informed Care to provide therapeutic support to homeless people with complex needs: a transatlantic search for an approach to engage the "non-engaging"'.

1. The explicit link between trauma and homelessness

There has been much research into the correlation between homelessness and trauma. It is understood that a person's chance of becoming homeless is exacerbated as a result of experiencing one, or many, traumas and that homelessness itself can lead to further experiences of adversity. In their paper, Goodman and colleagues[1] detail that there are three potential factors linking trauma and homelessness: (1) the experience of losing your home, (2) your experiences once homeless, especially in relation to systems that are there to offer support and (3) past experiences of trauma which increase the likelihood of you becoming homeless.

Histories of trauma have been further evidenced to be prevalent within the homeless population. In a literature review conducted at Southampton University[2], researchers found a clear link between complex trauma (beginning in early childhood) and homelessness. This has been further supported by the Hard Edges[3] large scale analysis of data relating to adults who have contact with homelessness, criminal justice and substance misuse systems. Researchers found that of those individuals in contact with all three systems, 85% reported experiencing adversity as children.

These findings have two important implications for a society which wants to end homelessness. Firstly, that it is vital to provide trauma-informed services to children and adults affected by adversity and trauma who are at risk of experiencing homelessness in the future, and secondly, that it is equally important to provide trauma-informed services to an adult homeless population who have, and continue to experience, trauma to varying degrees and who may struggle to access services as a result of this.

2. The homelessness sector's response

Despite the levels of trauma faced by most people experiencing homelessness, the majority of services provided to homeless people in England have a workforce that is unlikely to have any professional training or qualifications in working with traumatised people. In addition, many 'single' homeless people (i.e. those not owed a statutory housing duty) accessing services experience multiple and complex needs, often as a result of long histories of adversity, which presents a challenge to the services that are there to support them.

Homeless Link is working to address systems failure and improve service provision to those experiencing the highest levels of multiple disadvantage through the Making Every Adult Matter coalition and Housing First England. At an operational level, organisations have long been moving towards the provision of personalised, flexible and therapeutic support to respond to the needs of those using services.

In the last few years, there has been a growing movement to up-skill staff and, in 2012, government guidance[4] was published on the development and delivery of Psychologically Informed Environments (PIE): a framework which can be adopted by services to improve the psychological wellbeing of those accessing and working in them based on the knowledge that there is a high prevalence of trauma in the homeless population.

Feedback from those adopting the approach suggest improved outcomes for those using services, in addition to reduced incidents and decreased staff turnover as a result of burnout. Many organisations have been adopting PIE including those working with young people experiencing homelessness.

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Case Study: St Basils' psychologically informed environment

Each year, St Basils provides supported accommodation and a range of services to over 4.5 thousand homeless young people across the West Midlands. More than a third of these individuals present with multiple needs, and many have experienced adverse life experiences, including trauma and abuse.

St Basils aspires to create services that empower young people to flourish and thrive. To achieve this, they implemented and developed a Psychologically Informed Environment , utilising scientific learning, to transform their cultural framework and inform procedures, behaviours and policies across all areas of the organisation. Leaders, managers and staff appreciate that maintaining a PIE is a dynamic and ongoing process: therefore, for nearly six years, they have committed to a programme of formal training, reflective practice and access to an in-house psychologist.

Integral to a PIE approach, systematic evaluation involving ongoing reflection and outcomes measurement is conducted at different levels with assistance from researchers from the University of Birmingham. Arguably, the most important lesson learned is that the quality of staff-client interactions matters, and it takes time to break through a past history of adversity and abandonment to develop genuine trusting relationships and the conditions for positive change.

3. Trauma-informing the homelessness sector

Alongside an increasing number of organisations adopting PIE, it became apparent that the homelessness sector would benefit from specific awareness of trauma and trauma-informed approaches to delivering services. Since 2015, Homeless Link has been raising the profile of trauma-informed practice and has seen a high level of demand from organisations who wish to educate and up-skill their staff about trauma and its impact. We have developed two courses and trained over 1000 frontline workers and managers.

From the author's own experience, and from feedback we have received from those attending our courses, training on trauma enables staff to better understand the needs, presentation and engagement of people who are homeless. Following the training, workers are able to understand how relationships, support approaches and services can be delivered to create safety and empowerment and reduce re-traumatisation. Training on trauma enables staff to feel more resilient, better equipped to understand and work positively with behaviours which challenge services, and to understand the risk that they will experience vicarious trauma as a result of their work.

Case study: Porchlight's implementation of psychologically and trauma-informed practice

When implementing the Psychologically Informed Environment approach, staff at Porchlight concluded that including an understanding of trauma and its affect allowed for a better understanding of a person's psychological make-up. They knew that statistically there is a high proportion of trauma survivors among people using homelessness services and so deemed it vital to give staff the tools and knowledge around working with clients who have experienced trauma.

At Porchlight, staff are trained to be trauma-informed. This has allowed the organisation to create an environment where staff learn about the impact of trauma, the residue effects of trauma and the behaviours associated with trauma. Staff are able to review and reflect on how they communicate; enabling choice for trauma survivors who may not have experienced choice before. Staff monitor their environments to ensure clients feel safe. Being trauma-informed has also enabled staff to work with the individual and their unique experiences.

The support and safety planning in Porchlight's Youth and Family Services are based on the principles of trauma-informed care; taking into account each person's individual past and present experiences in order to plan for their future. Services are subsequently tailored around the individual's needs with innovative approaches to support and improved interagency communication and joint working. This ultimately provides environments where each person's past trauma can be dealt with effectively using a person-centred approach.

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Many local authority commissioners of supported housing services for homeless people are starting to include psychologically and trauma-informed practice into their commissioning contracts.

4. The wider housing sector

Where the homelessness and supported housing sectors have for decades provided support to address the health and wellbeing needs of people accessing services, the wider system working to provide housing to adults, young people and families it is less likely to be equipped to recognise and respond to those affected by trauma. The work of local authorities and general needs housing associations is often focused on accommodation as an end in itself without consideration of wider support needs, and staff may not be aware of how to work effectively with children and adults who have experienced adversity.

This is a concern because individuals or families who have experienced trauma, or who are more vulnerable, are those most likely to have contact with the wider housing sector. A lack of trauma-informed support provision has two consequences:

1. Staff are unable to identify the potential risk of trauma faced by individuals and families and may miss opportunities to act in ways to prevent, safeguard or respond appropriately.

2. Services and systems which do not recognise trauma or respond appropriately can exacerbate the feelings of fear and disempowerment faced by those affected by trauma, and can be wholly ineffective and harmful.

There are some examples of good practice which illustrate that a simple awareness of trauma and the principles of trauma-informed practice can change the way services are delivered.

Case study: Basingstoke and Deane Borough Council

Basingstoke and Deane Borough Council commissioned Homeless Link to deliver Trauma Informed Care training to a multi-agency social inclusion partnership of operational managers and front line workers. This included staff from local alcohol pathway health services, the Community Safety team, the police, supported housing provision, outreach and day centre services, local authority housing officers, the floating support team and creative arts services.

They took this approach to 'trauma-inform' the housing pathway from each access point with the aim of ensuring that all agencies had a shared understanding of the issues that people may be experiencing, how this can affect their response to the environment and their ability to access, engage with and trust services. This has improved coordinated planning and activity between a range of agencies with an aim of preventing re-traumatisation.

Within the council's housing team, staff have trauma and psychologically informed practices embedded into their job descriptions. The council have made changes to procedures so that individuals and families who present to the service are offered person-centred support. This includes offering people the chance to have their assessment at a convenient time and place, often away from the council offices. After the training, staff were quickly able to change some aspects of service provision, including ensuring that the initial contact someone has with the service is welcoming and creates a sense of safety, planning some changes to the physical environment, as well as considering how and where assessments can be undertaken.

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5. Growing trauma-informed practice in the homelessness and housing sector

Homelessness is both a consequence and cause of trauma. Access to a stable and safe home is vital to ensuring that trauma is both prevented in the first place, and that those who have already experienced adversity are enabled to begin recovery.

Consequently, systems and services there to prevent homelessness, or intervene once an individual (child or adult) or family is already experiencing homelessness, will deliver more effective provision if the staff of those services, including decision and policy makers, have an awareness of trauma and its impact. This knowledge allows organisations and workers to create and deliver policies and procedures which address the needs of trauma survivors and, most importantly, do not re-traumatise.

Building on emerging good practice, we would recommend that commissioners ensure:

- Decisions made at a local and national level, which determine the response to homelessness, are underpinned by the principles of trauma-informed care to prevent further traumatisation of an already traumatised population.

- Decision makers commissioning health services should consider increasing provision of trauma-focussed support to people experiencing multiple disadvantage who are often unable to access mainstream services due to their multiple and complex needs.

- Training about trauma and the principles of trauma-informed care is available, and where necessary mandatory, for staff at any organisation involved in preventing or tackling homelessness of children, families and adults; including local authorities, general and supported housing providers, and voluntary sector organisations for homeless young people and adults.

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Section 3

Emerging good practice

(a local view)

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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19. Rethinking specialist and liaison services for young people who have experienced adversity or trauma

Dr Nick Hindley and **Dr Carmen Chan**

1. Introduction

This paper describes a service model which facilitates responsiveness and maximises the influence and positive effect of specialised services working with children and young people. It provides a means whereby services with particular expertise can be used in a way that supports professionals, young people and their families. The model of provision is applicable in any situation where more specialist expertise of any kind is required to support existing services in areas about which they may feel anxious or unskilled. Furthermore, it has been used and evaluated in services specifically working with children and young people under 18 that cover catchments of differing populations and geographical area and are targeted at young people who are traditionally considered 'hard to reach', have frequently had traumatic experiences, and whose needs have been difficult to meet[1]. To be effective, it is vital that any service model incorporates trauma-informed understanding of young people's difficulties that explicitly combines application of specialist knowledge with appreciation of the needs and views of the young people in question.

2. Key principles and considerations

The development of optimal services for children and young people who have experienced adversity requires the initial creation of a set of principles or considerations that can inform any subsequent service design. While some of these considerations will be specific to the area of focus of any specific service (for example, harmful sexual behaviour or experience of sexual abuse), many such considerations are relevant to services for young people in general. A number of these principles will now be considered.

a. What is a 'specialist' service?

Frequently, when services designed to meet a specific area of need are being considered for development there follows a sometimes heated debate about the pros and cons based on commissioners' and professionals' existing experience of 'specialist provision' (see Table 1). This can lead to inertia because of strongly held views on either side of the debate, all of which may be, in some respects, valid. A specialist service could be defined simply as one "which offers skills or expertise which are not available in more routine provision". The key to developing such provision would be to maximise the benefits and minimise the potential disadvantages (as outlined in Table 1) of such an enterprise. This will be the principal focus of this paper.

Table 1: Pros and cons of specialist provision

Pros	Cons
Expertise and specialist knowledge	Can have very small caseload and be expensive for relatively small gain
High level of input in complex situations	Can be difficult to access and approach
Contain anxiety among professionals and families, and at times may need to inject anxiety and promote action	Can become divorced from local provision if aloof or covers too large a geographical area
Can identify necessary strategic developments arising from gaps in provision	May not make use of expertise outside the core team
May cover a large geographical catchment and/or large population	May have limited and rigid service responses to referrals

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b. The importance of ethos

All services working with high risk/high concern young people clearly need to have highly developed governance structures so that they, their clients and families and society in general can be reassured about safety and good practice. Such matters frequently become the principal focus of development work once a service is commissioned. Less frequently is attention paid to the

ethos of the service and, in particular, the way in which the team would wish to be perceived by others – its service users and professionals seeking advice and support.

Frequently, the 'authoritativeness' of the service (its ability to provide clear answers in relation to its area of expertise) can mean that accessibility to those who are asking for its intervention and support can become restricted. While in areas of complexity and high need it is not always possible for specialist provision to meet all expectations, service models should aspire to being both accessible and authoritative. It is also not enough for such an ethos to be evident in the circles, arrows and boxes of a service diagram or the text of a service specification, it should also be evident in the approachability and flexibility of approach of individuals within a team. Equally, the service should fit around the needs and view of the young person, rather than a young person 'fitting' around predetermined inclusion criteria.[2]

c. Building resilience in individual young people's and professional networks

A key consideration when working with young people who have experienced childhood adversity is that of not inadvertently creating greater levels of complexity or indeed harm. Frequently, the higher the concern, the more professionals are drafted in to contribute to an increasingly complex solution[3]. This can be counterproductive (as reported by young people and their families), tends to lead to multiple assessments and interventions becoming part of a professional care plan, and can lead to a young person or family (who may already be demonstrating considerable mistrust or apprehension) disengaging further from well-meaning attempts to provide help and support. Furthermore, in the cases of some young people who are known to have been subject to serious adversity or maltreatment in the past, the quest for them to 'address' this or talk about it can become the focus of a multi-agency solution when the child is in no position to do this or actively does not wish to do so. It is important first to build resilience and ensure sufficient safety (both in the young person's system and within themselves) before focusing explicitly on any trauma that they may have experienced[4].

A specialist service (supplementing existing provision for children who have experienced adversity) may frequently not to be directly involved with a child about whom there are high levels of professional concern. At the same time it is important that staff are provided with "access to high quality ... advice when and where it is needed"[5]. In many cases such a service can provide support

and advice within the construction of a cross-agency care plan focussing on identification of unmet need and general measures fostering attachment and resilience such as continuity of professional input, support for existing positive relationships and educational/occupational provision. Particularly when there are multiple professionals involved in a young person's care, it is important that it is the young person's needs rather than professional anxiety that underpin any care plan. In line with this, direct intervention with the young person should be delivered where possible by individuals already trusted by and/or engaged with them[6].

Given the above, a service should offer a consultation and liaison model to support universal services in understanding the impact of early adversity and trauma and to ensure that the appropriate level of specialist support is made available. This model should offer the possibility of direct specialist input but only when other consultative input has demonstrated that this is needed.

d. Response to concern

A specialist service working with young people who have experienced adversity and/or trauma who may be difficult to engage should understand the wide variety of complex circumstances and situations in which young people find themselves and also the range of professionals with whom they may come into contact. In such circumstances, the service should not expect an initial contact from professionals to be perfectly formed and extensively documented.

A referring professional may be highly experienced in working with and understanding young people but may not be well-versed in the language and format of making referrals (for example they may have a concern about a young person's mental health but may not be able to phrase this in diagnostic terms). Equally a service receiving written referrals from professionals working with this particular population may wish to explore further with the referrer and others involved before deciding on the best course of action. In general, even the most specialist services should be accessible by whatever means for initial contact so that they can ensure that strict criteria for processing of referrals do not discourage some professionals from contacting the service with appropriate concerns.

e. An 'ecological' and stepped approach to need

It is highly unlikely when working with young people with complex difficulties who may have experienced significant adversity, that a single intervention or agency will provide a single solution. In general, complex situations require complex solutions and good cross-agency collaboration focussed on achieving consensus is likely to have the most productive results. This requires a specialist service to recognise and consider the dynamic interplay between a young person, their family, and their social environment (see Figure 1). Such an approach is frequently referred to as 'ecological' and planning should include assessment of risks/vulnerabilities and protective factors on each level[7].

Figure 1: An ecological approach to understanding a young person's needs
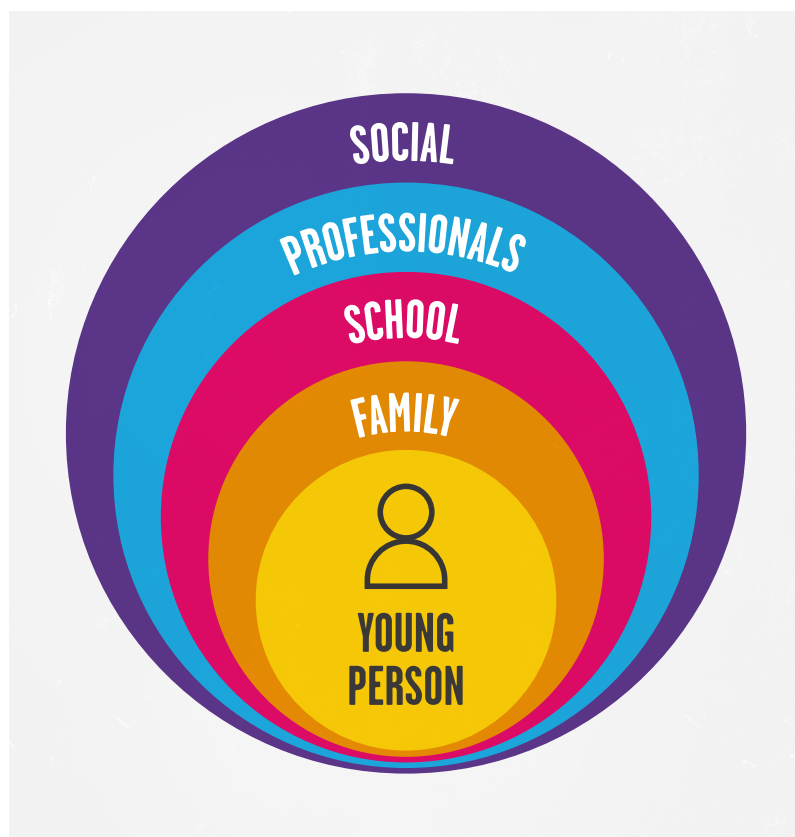
Equally, grounded in the first phase of any trauma-informed intervention with young people, should be the development of a sense of safeness and stability that clearly takes into account the child's hierarchy of need[8]. Figures 1 and 2 highlight the importance of joint consideration of ecology and hierarchy of need and underlines how important more general consideration of factors such as physiology, safety and social needs may be before more complex areas such as self-esteem and self-actualisation can be addressed.

Figure 2: Hierarchy of needs (following Maslow)
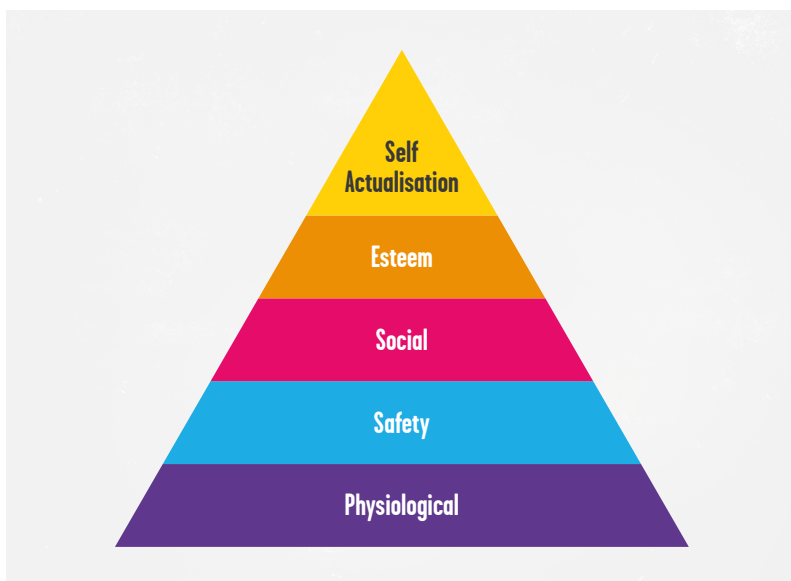
Thus, for example, in line with guidelines for working with complex trauma presentations, it is important to ensure that a young person is 'safe enough' to make use of specialist individual interventions (such as psychological therapy) before they are instigated[9]. A specialist service, in such circumstances, is thus not defined by how specialist the interventions are that it can provide, but rather, by its ability to identify and recommend what may be the most useful intervention for a child given a specific set of circumstances.

Often, such recommendations involve a focus on core needs and strengths

which can be provided by professionals already involved with the child (as long as they are reassured that a specialist service will continue to support them and will become more directly involved if needed). This is a key issue for the credibility and perceived usefulness of a specialist service: a service which provides advice and consultation alone without demonstrating a willingness to become more directly involved in cases when the need arises is unlikely to foster confidence or contain anxiety within professional systems[10].

f. Flexibility of response and knowing the catchment

Flexibility of response to requests for service involvement requires a combination of a flexible service model (discussed further later in this paper), an ethos fostering accessibility (already discussed) and good knowledge of catchment.

If a specialist service is to fulfil effectively its identified function working with young people who have experienced adversity, it is crucial that it knows its geographical catchment both in terms of the range of services available to young people and the relative strengths and limitations of those services. This kind of information is crucial for a service seeking to identify when it may need to become directly involved with a young person (rather than being involved in a more consultative way with professionals). Circumstances dictating this may not always be because of the identified needs of the young person but because of the relative lack of provision in his/her home area. The converse is also true, if there is a particular strength in service provision in a given area (such as a particularly experienced local practitioner or service) there may be less need for direct involvement by a specialist service.

g. Escalation of concern and development of relationships across agencies (in addition to protocols)

As mentioned previously, complex situations involving young people who have experienced adversity frequently mean that multiple agencies and professionals become involved in individual cases. In certain circumstances, a situation can become so difficult that it becomes stuck to the extent that professionals cannot jointly effect change or that a lack of progress leads to professional disagreement and recrimination. Such outcomes usually impact most upon the young person who then is not only aware of the adult disagreements but also fails to experience the benefits that professional

consensus can bring to their case. In such situations, protocols alone can rarely provide a meaningful solution and it is most likely that existing collaborative relationships at a senior level between agencies will provide the best means of this being achieved. Specialist services should consider it a vital part of their role to understand hierarchies within their own and other agencies and also to have established meaningful links with senior colleagues so that the possibility of escalation of concern can be undertaken quickly and lead to a return to a collaborative response to the young person in question.

2. Building a responsive service model

A working model which allows a service to adhere to the principles outlined above should have a number of particular attributes (see Box 1). The type of model which best meets these demands is a 'liaison' model which reflects practice and process traditionally used in mental health practice in general hospital environments[11]. For some reason, the application of such a model beyond such settings has rarely been described. The authors feel that it is applicable in all environments that are busy, constantly changing, frequented by multiple professionals from a range of different disciplines and are where complexity abounds and, for this reason, it fits with specialist services working with young people with complex needs.

> *Box 1: Requirements for an effective specialist service*
>
> A working model for a service working with young people with complex needs and experience of adversity should:
>
> - facilitate the maximum use of the expertise of the team
>
> - allow easy initial access to potential referrers
>
> - provide a level of service commensurate with identified need
>
> - allow 2-way ('socratic') interaction between all parties and facilitate consensus planning
>
> - be transparent and allow clear identification of responsibility

Box 2: Strategic functions of a specialist service

A working model for a specialist service should include the following strategic functions:

- raise awareness of the team and ensure that ease of initial access is understood

- provide training for professionals working with children and targeted supervision/enhanced liaison with identified services

- identification of gaps in service provision and showing leadership in development of effective means to address them

- evaluating provision and disseminating findings locally, regionally or nationally as appropriate

The key features of a liaison service model address the need for involvement in individual casework at a number of possible levels and a range of strategic functions (see box 2). The model can maximise the potential strengths and minimise or reverse the pitfalls of specialist provision. In practice, the casework model comprises a stepped approach which is based on initial accessibility and, as necessary, provision of advice, formal consultation, assessment and intervention. Such an approach enhances the flexibility of a team's response for reasons discussed above rather than relying on a more rigid 'one size fits all' response to referrals and requests for service involvement. In addition, it ensures that the skills of the team are applied as efficiently as possible. The proportional distribution of such functions within an overall caseload is outlined in Figure 3, opposite.

3. Key components of a responsive liaison model

Below we have summarised the key components of a responsive liaison model, based on our work in Oxfordshire. These can act as a guide to commissioners and providers in establishing liaison services in their local area.

Figure 3: Distribution of functions within a liaison service model
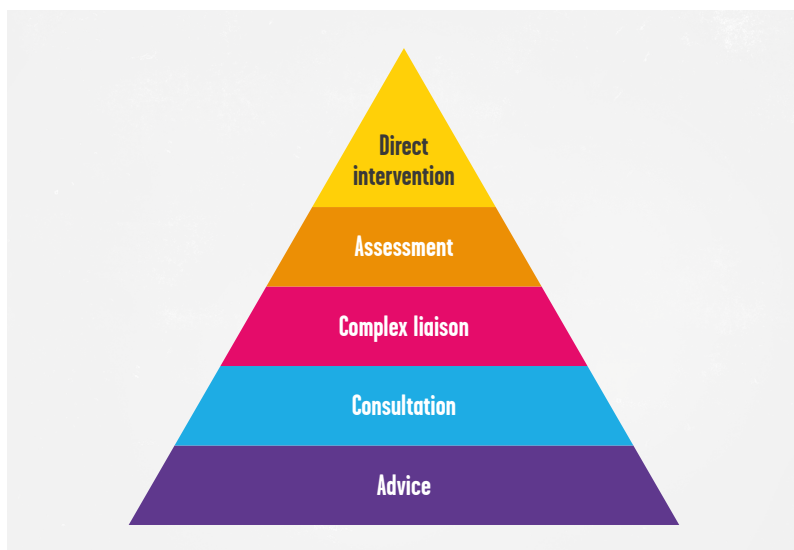
a. Initial accessibility and advice

Any service working to a particular geographical catchment needs to ensure that it is available to the patient/client group for whom it is designed. In practice this can prove difficult when working with complex young people who may be in contact with a multiplicity of agencies with differing skillsets, levels of experience, professional backgrounds and cultures. For this reason it is important that initial contact with such a service should be welcomed from any source that has a concern relating to the provision offered by the service in question; it is sufficient in such circumstances for individuals to realise that they are uncertain and that an initial point of contact is available. The service in question should welcome such contact and make this clear.

Once contact has been made the service can undertake a brief discussion with the referrer during which it will be possible to ascertain whether further, more formal input is required. If it is not, the service may be able to suggest or facilitate access elsewhere in relation to the concern in question. If formal input is considered necessary this begins via a process of formal consultation.

b. Formal consultation

Involves a more detailed case discussion led by an experienced specialist service team member. For this process, relevant background documentation should be available. The time for such a discussion should be clearly identified but it can be undertaken either face to face or by phone or videolink. The key issue in this process is that the discussion should be sufficiently detailed to satisfy both parties and to facilitate the development of a mutually agreed plan of action. This may involve the referrer taking a lead in delivering such a plan, involvement of the specialist team in further cross-agency discussion or formal process without direct involvement with the patient/client ('complex' liaison) or a decision for the team to become directly involved in assessment. Wherever possible, collaborative or joint working between parties should be prioritised and the case should remain open to the specialist team to monitor and, if necessary, revise any agreed plans. Such plans should also be confirmed in writing.

c. Assessment

A decision for the specialist service to undertake assessment should be prompted by clear identification of concern or need within the team's remit. Ongoing uncertainty following formal consultation regarding the client/patient's level of need the lack of progress of a plan needs to be agreed at the formal consultation stage. Wherever possible, assessment involving the specialist team should involve the referrer. Subjecting a child or family to serial assessments when not strictly needed should clearly be avoided.

d. Interventions

Broad interpretation of 'intervention' should accompany implementation of the service model. Thus, any of the levels of input provided by the team could be considered an intervention. This applies to case management advice and achievement of consensus within multiagency planning. Even a decision at the time of initial contact not to proceed with specialist team input falls into this category.

Specialist direct interventions for a young person will be available from a specialist service. However, the circumstances where such interventions are, for reasons already discussed, likely to be required are often less frequent

than professionals and families may consider to be the case. Thus, overall, a specialist service working with young people with complex needs may be involved more frequently in recommending simple 'generic' interventions and less frequently in providing the highly specialist interventions which they have at their disposal (see Figure 3). This does not mean that the team is shirking its responsibilities but rather that it is providing levels of support to young people, families and professionals in accordance with individual need.

4. Conclusion

This paper has outlined a set of principles and a systemically-informed model for specialist teams working with young people with complex needs who have normally experienced significant adversity or trauma. The authors have repeatedly emphasised the necessity both for flexibility of working models and ethos in such work but at the same time they would wish to emphasise that this should not be at the expense of good professional practice or the provision of authoritative opinion. A service working with high risk/high concern young people needs to be very clear about the nature of its remit and about ensuring that all concerned are aware of their particular responsibilities. Above all, teams need to work to ensure that their contribution is in the best interests of young people and their families.

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References

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20. Addressing adversity through alternative education

Betsy de Thierry

This paper includes extracts taken from the following three papers with the kind permission of the author, de Thierry. B. (2015):

- *Teaching the Child on the Trauma Continuum*, London, Grosvenor Publishing (2016);

- *The Simple Guide to Child Trauma. What it is and how to help*, London, Jessica Kingsley Publishers (2017);

- 'Understanding the impact of trauma on children in the classroom' in: D, Colley, *Emotional Development and Attachment in the Classroom: theory and practice for students and teachers*, London, Jessica Kingsley Publishers (2017).

1. Introduction

This paper explores the need to have alternative provision across the UK that is trauma-informed and focusing on the recovery from childhood trauma, and not the management of behaviour. The paper will look briefly at assessment, the framework of our provision and the key theoretical underpinnings of the work.

The primary underpinning philosophy of the Trauma Recovery Centre's (TRC) Oakside Creative Education Centre[1] and the Therapeutic Mentoring Rooms[2] is that children can recover from the impact of trauma when they are able to engage in an appropriate intervention for the level of trauma experienced, the trauma symptoms presented and the environmental capacity in their setting. When they are able to recover, their behaviour, emotions, relationships and learning can then also recover from the impact of the trauma.

Recovery from trauma involves repetitive, rewarding, nurturing, long-term relationships that facilitate co-regulation as an essential step before self-regulation and also include creative therapy that is trauma-informed.

2. The Trauma Recovery Centre and Therapeutic Mentoring Rooms

The Trauma Recovery Centre and Therapeutic Mentoring Rooms are organisations that provide trauma-informed, recovery focused provision for children and young people who have suffered trauma. The BdT Ltd organisation provides training to schools, police and organisations in trauma-informed practice and has therapeutic mentoring rooms within mainstream schools that attach a trauma-informed psychotherapist to a school to offer clinical supervision and assessment of significantly traumatised children to avoid exclusion. The TRC has therapy centres with teams of qualified art, music and play therapists in four cities and provides alternative education for excluded children which use the creative therapy spaces and also uses forests and outdoor space.

Our primary underlying ethos is that children and young people have a right to recover. However, the majority of alternative provision on offer elsewhere is 'managing' their behaviour and not facilitating recovery and this is creating significant problems long term with rising mental health issues and rising criminal justice issues.

The other primary underpinning knowledge that we hold as central is that trauma affects a child's emotions, behaviour, learning, relationships and memory. The Trauma Recovery Centre offers therapy with parenting support groups and alternative education centres in buildings that are not on school sites and include forest school spaces. This alternative setting offers a neutral, homely environment for those who need to find a safe place to recover that is not associated with schools or clinical settings.

The Therapeutic Mentoring Rooms work from the same theoretical framework as the TRC and yet work within the school setting offering a different but complementary service to prevent exclusion. The Therapeutic Mentoring Rooms do not work as intensively with the parents but can offer more frequent sessions of support from a known and specially trained staff member at school, who are clinically supervised by a trauma-informed psychotherapist and this provision requires less out of school time and less transport challenges.

3. The impact of trauma on a child and the knowledge that recovery is possible

Abuse, neglect and trauma in childhood affect a child's psychological functioning, their neurological (brain) responses, their relationships and their capacity for hope[3]. It is known that from early infancy through to adulthood, trauma can change how we perceive ourselves and the world around us, how we process information, and how we behave in response to our environment[4]. Without appropriate intervention these altered cognitive processes and behavioural responses can lead to long-term problems, such as difficulties in learning, self-regulation and/or behaviour[5]. Trauma is stored in the subconscious and the body and as such cognitive or behavioural approaches are unhelpful and ineffective and the children and young people need trauma-informed psychotherapy to process the trauma.

It is in times of great stress, or trauma, that the brain activates its deeply instinctive, 'fight, flight, or freeze' survival responses. These responses to threat are ancient, primal mechanisms that prioritise surviving over the higher functioning thinking, judging or evaluating that takes place in the prefrontal cortex (neocortex). The responses to threat or perceived threat are located in the brain stem, which is the area of the brain that is fully formed by birth. It is responsible for breathing, heart rate, body temperature and also these automated threat responses. The brain stem, on alert, immediately sends messages to an area of the brain called the amygdala that is located in the limbic area – just above the brain stem.

In our work in the Therapeutic Mentoring Rooms and at the Trauma Recovery Centre, in the context of respectful relationships towards the children for their courage to survive terror, we spend time with the children exploring how the brain is working and how the brain is processing information and stimuli from the environment. We tell the children that the amygdala is like a smoke alarm, and alerts the body to the threat (perceived threat or clear danger) and adrenaline and cortisol gets pumped around the body so that it is ready to have enough energy to react in an emergency.

When the limbic areas of the brain are fully alert and active, the consequence is that the prefrontal cortex goes 'off line'. As trained therapists, we explain to the children that when this happens, our ability to be rational, reasonable and thoughtful is hindered. We believe that this physiological response to trauma needs to be explained to the children to reduce the shame and

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shock that they often feel about their responses. Reducing shock and shame enables relationships to be built which can facilitate recovery. It is also why we recognise that interventions such as cognitive behaviour therapy can be unhelpful and frustrating for the traumatised child cannot access their pre frontal cortex to reflect or think about their behaviour or thoughts.

Too often, an adult's first reaction to an incident of high emotion, hurt or aggression in school is to say to the child "why are you doing this?" while expressing frustration or even anger. The problem here is that most children are desperately wanting to say, "I don't know, you tell me – you're the adult! I am more terrified than anyone else by what I am doing. I did not want to do this and I'm scared!" They cannot articulate this as their ability to reflect or be rational is still 'off line'. As adults, we need to wait until the 'emotional brain' has calmed and the 'thinking brain' has re-engaged before we can begin to reflect on the incident.

4. Being curious and the ability to learn

Due to the brain changes that occur in the aftermath of trauma, a child has a different physiological approach to learning. Listening with focus, remembering what was taught, following sequential instructions, remaining focused and thinking can all be challenging for children whose brains are overtaken with the primary task of surviving.

As such, when education staff expect the traumatised child to study subjects which seem irrelevant to survival, it can cause behaviour which we know to be trauma symptoms but would often be understood as defiant or naughty. We need professionals and Ofsted to understand that when a child is healthy, they learn naturally. When a child is happy they are curious and want to know about life. When the child is neurologically wired for survival due to experiencing terror and powerlessness, learning is painful and can cause significantly increased turmoil and then subsequent escalation to the trauma symptoms.

5. Trauma-informed underpinnings

Both projects are based on theories that are foundational to the work of psychotherapists and which maintain that the process of recovery includes processing the traumatic experience, which may need the help of a clinical trauma specialist.

As a teacher and a psychotherapist I know the importance of both professions working well together and the centrality of both the clinician's professional training (in understanding the subconscious where the impact of trauma resides) and the teacher's ability to build a consistent relationship and nurturing culture in the classroom. I believe that education staff are positioned to be able to focus on the importance of relationships and emotional literacy and the vital underpinning philosophy that 'behaviour is communication'. Meanwhile, the partner clinicians can unpick and unravel the subconscious aspects that may be driving behaviour and reactions because this has become stuck and muddled due to the trauma.

The other primary theories that underpin the work in both projects that I have started are those that are central to play and arts therapy such as Axline[6] and Oaklander[7] alongside contemporary research regarding neuroscience and relationships from other clinicians such as Bruce Perry[8] and the life works of Bessel Van der Kolk[9]. These clinicians offer research findings and practical frameworks for all who work with the traumatised child but offer an ideal framework for a team around the child of teacher, parent and clinician to work together with similar emphasis but differing roles. The foundational child development theories also offer a strong foundation to our work as we can then identify behaviour that is inappropriate to the child's biological age and therefore could indicate a possible conflicting emotional age of the child.

When working with complex trauma we work within the Trauma Recovery 'Complex Trauma Framework', which is a synergy of the structural dissociation theory of Van der Hart, Nijenhuis and Steele[10] along with Watkins'[11] ego state theory and the Daisy Theory of my own[12].

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6. The 'Trauma continuum'

The trauma continuum[13] (Figure 1) enables professionals to discuss how mild or severe a traumatic experience is in order to plan an appropriate intervention that can facilitate recovery rather than manage the trauma symptoms.

Figure 1: the trauma continuum

TYPE I TRAUMA
Single incident trauma

TYPE II TRAUMA
Multiple traumas

TYPE III TRAUMA
Multiple pervasive traumas from early age that continue over length of time
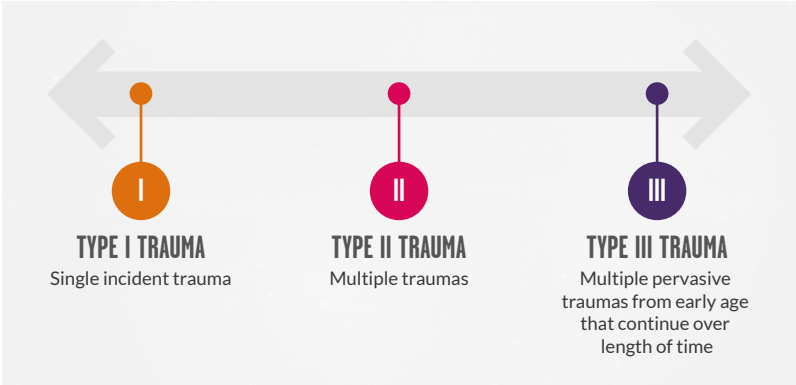
The trauma continuum needs to be considered together with the parenting or environmental capacity continuum (Figure 2), which illustrates how much resilience the child's context and environment offer them.

Figure 2: the parenting capacity continuum

WARM CARING VERBAL

BULLYING AND NO PROCESSING

FURTHER PUNISHMENT IF SPOKEN ABOUT
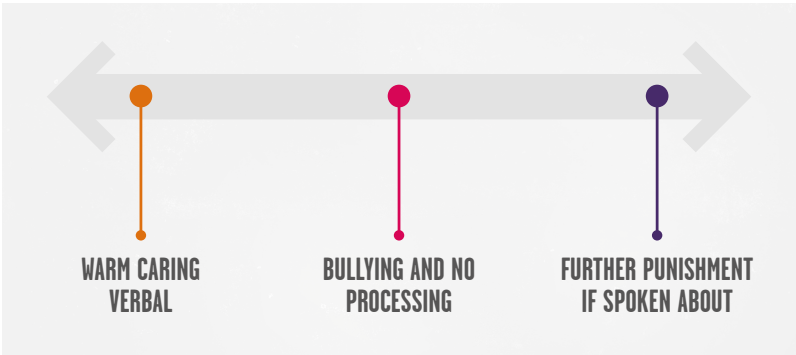
The other factors that need to be reflected upon when using the continuum are factors such as the trauma experienced; the trauma symptoms manifest; the current environment of the child (primarily the parenting capacity) and the support system including the length of time that support system has been in place. A sliding continuum enables a discussion to be had that leads to an agreed place on the line for that child at that time; thus an appropriate intervention can be put in place.

The Type I or 'simple trauma' is usually defined as a one-off traumatic incident or crisis. Simple trauma is difficult and painful and has the potential to cause injury to the child. This level of trauma, however, usually has less stigma associated with the experience and therefore other people are often responsive and supportive to those who have experienced these traumatic incidents. This results in Type I trauma being placed at the beginning of the trauma continuum; especially if this is an experience within the context of a stable family where processing difficulties is a normal cultural expectation, as this could significantly limit the damage. Examples of Type I trauma include a car accident where the emergency services are involved but there is no long-term harm, or a child who has to adapt to their parents' divorce but this was handled with care, thereby limiting the emotional damage to the child.

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The continuum progresses according to the degree of trauma experienced, the amount of different traumatic experiences and the level of social support and family attachment a child has to enable them to process and recover. Type III or complex trauma is positioned at the furthest end of the continuum, such as a child who experiences multiple abuse and/or neglect over many years, without a family setting in which the traumatic experience could be processed or spoken about in a recovery-focused manner, due to either parents' absence, neglect or inability themselves to cope with the trauma. Complex trauma usually involves interpersonal violence, violation or threat and is often longer in duration. It is almost always an experience that causes a strong sense of shame due to community stigma, which can lead to the person feeling isolated and different. For example, sexual abuse, trafficking, torture, organised abuse or severe neglect. The child or young person facing Type III trauma requires a trauma-informed clinician to lead the recovery plan for a team of professionals to enable.

The trauma continuum places the Type I, II, or III trauma along the line with reasons for the placement. It enables professionals to discuss the impact of the trauma as a natural response to any presenting behaviour that causes concern within school or home and thus should lead to appropriate recovery focused work.

7. Contrasting the approaches

As a nation we cannot afford to continue to manage children who have trauma symptoms in contexts that accentuate stress. The groups are too large, the professionals not trained to understand trauma symptoms and how to facilitate recovery and there is little expectation of recovery. The prison population is full of people with trauma histories who had no trauma recovery intervention and the mental health system is the same. Early intervention into trauma recovery is vital to save our communities. We are in a national crisis and yet the answer is relatively simple.

Currently paediatricians, educational psychologists, clinical psychologists, psychiatrists, teachers, social workers, police, health visitors and all other professionals working with children, families or adult survivors of trauma are rarely trained in the content of this short paper in their qualifying courses. Their response to such knowledge is often tearful relief yet frustration that they had not learned the vital information.

Currently most traumatised children experience the following:

- They are told off, rejected, punished and socially isolated

- They are labelled and medicated

- Education staff focus on educational outcomes rather than recovery

- Professionals are stressed and burnt out

- Therapists are not trained in trauma, use cognitive methods and usually have 6-12 weeks of sessions which don't work and cause further ruptured attachments

- The focus is on management/coping not recovery

- The emphasis is rarely on the trauma being processed from the subconscious and body

- Children are managed until adulthood when they need to access mental health services or enter the criminal justice system.

Through our alternative education children and young people are provided with:

- Adults who can offer consistent, empathetic, respectful relationships over the long term with no changes and 'new staff'

- Adults who understand the neuroscience about how such a relationship can facilitate recovery and then teach the children

- Non clinical, non judgmental homely environments, where children can go to recover and feel safe if they need to

- Therapeutic Mentors undergo a 14 day training to provide the equivalent training of nurses in the medical system to facilitate trauma recovery alongside the psychotherapists who can take the role of doctors and consultants

- Trauma trained clinical professionals who use creative psychotherapy (and not cognitive therapy that demands more on the part of the brain that is struggling to stay 'online') who take the role of doctors and consultants who can enable a child or young person to process their subconscious and body memory of the trauma to reduce the symptoms and impact of the trauma

- Homely settings which offer sensory, warm, caring places to recover, within mainstream schools and in other buildings

- Parent training support and help for them to process their trauma.

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21. Embedding a trauma-informed approach in the community and voluntary sector (YMCA)

Dr Kristine Hickle

1. Trauma-informed approaches

A 'trauma-informed approach' was conceptualised in the United States by Harris and Fallot[1] in response to a growing awareness that traumatised children, young people, and adults interact with health and human service systems that are not designed to recognise the impact of trauma in their lives. They envisioned a paradigm shift, which required stakeholders across these systems to focus on returning "a sense of control and autonomy to the [trauma] survivor"[2]. The idea developed purchase throughout the USA and in 2005 the Substance Abuse and Mental Health Services Administration (SAMHSA) created the National Centre for Trauma-Informed Care[3].

Several evidence-based models, such as Sandra Bloom's Sanctuary Model[4] were identified as best practice in adopting a trauma-informed approach (TIA). A TIA is an inherently relational and strengths-based way of working[5]. It requires practitioners to understand the ways in which a service user's present difficulties "can be understood in the context of the past trauma"[6]. An organisation that adopts a TIA should be better able to help improve survivors' ability to function and manage distress[7].

The small but growing body of research on TIA indicates positive effects such as a reduction in seclusion, improved mental and physical health, increased treatment retention and shorter inpatient stays[8]. However, TIA is still an inherently complex concept, requiring numerous interventions that make measuring change difficult.

Despite strong endorsement from SAHMSA, TIA is still not widespread in the USA or other countries where research has been conducted, such as Canada, Australia and New Zealand[9]. To date, very little evidence of TIA implementation in the UK is available[10]. Sweeney and colleagues[11] identified some of the barriers to implementing TIA in the UK (and elsewhere), including:

- widespread resistance to the notion that prior trauma has such a significant impact on current functioning;

- practitioners' own reluctance to confront the 'horror' of people's suffering;

- confusion regarding the difference between trauma-informed and trauma specific treatment services;

- a general wariness of having to take on new tasks in the face of service cuts and a strained workforce, and inconsistent access to supervision.

2. Learning from the experience of YMCA Downslink Group

The YMCA Downslink Group (DLG) serves children, young people and families across South East England, and began implementing a new agency-wide TIA in Autumn 2014. They developed a theory of change, informed by SAHMSA guidance and the Sanctuary Model[12]. Desired outcomes included:

- reduction in staff sickness and absenteeism;

- increased staff retention;

- improved communication with external partners and internal partners (i.e. across departments within the organisation);

- increased capacity among young people to engage with support;

- improved peer relationships, self-esteem and the ability to manage difficult feelings;

- reduction in harmful risk taking behaviour;

- and young people feeling an increased sense of ownership over YMCA DLG.

The agency provided all staff with 1-day TIA trainings delivered by a clinical psychologist, began implementing reflective practice supervision (RPS) groups across the organisation, and organised a 'TI development forum'

composed of management from across the organisation (e.g. including the facility maintenance department). They also employed someone part-time to coordinate the TIA agency-wide implementation.

YMCA DLG contracted with the University of Sussex to evaluate the TIA implementation in Autumn 2015. A realist evaluation methodological approach was employed (Pawson and Tilley, 1997) to capture the contexts, mechanisms and outcomes of any change across the organisation during an 18-month evaluation timeframe, from September 2015-March 2017. In keeping with a realist evaluation approach, multiple sources of quantitative and qualitative data have been collected to inform the first phase of the evaluation conducted, from October 2015-January 2016 (see Table 1).

Table 1: Data sources

Data source	Sample size and description
Staff-wide quantitative survey administered in 2015	n=95, approximately 20% of total staff population, including volunteers and paid staff
TI one-day training evaluations, primarily involving open-ended (qualitative) questions	n=75, a random sample of approximately 25% of the total 309 evaluations completed
Quarterly safeguarding and service user incident data	Quarters 1, 2 and 3 for 2015
Three staff focus groups	15 staff members: Focus group 1) 5 management level staff Focus group 2) 3 staff members Focus group 3) 7 staff members
Two service user focus groups	8 young people: Focus group 1) 4 young people Focus group 2) 4 young people

Following several careful readings of the focus group data, themes were developed deductively (i.e. from the questions asked in the focus group sessions) and inductively (themes that arose from the discussions). Basic descriptive statistics were used to analyse quantitative survey data, and

a thematic analysis of the evaluation questionnaires from TIA training workshops was also conducted.

This paper provides a reflection upon the first phase of the project, drawing upon all sources of data to identify four key points of learning, summarised as:

   i.   TIA: an organisational culture change

   ii. 'Trauma' is a tricky word

   iii. Safe people might act in unsafe ways

   iv. Safe staff are transparent, persistent and share power

Each of these key points aligns with the growing body of research on TIAs and will be discussed in detail below.

a. TIA: an organisational culture change

The first key area of learning to emerge from the evaluation project involved the importance of an agency-wide strategy for introducing TIA. This aligns with the way in which Harris and Fallot[13] initially envisioned TIA as an organisational paradigm shift, and the Sanctuary Model's understanding of a "full system approach"[14].

Feedback following the day-long TIA trainings indicated that many participants felt this approach provided an explicit framework for elucidating some of the unspoken complexities and challenges of working with trauma, and acknowledged the role that organisational culture plays in keeping both service users and staff members safe. When prompted to discuss the implementation of this new approach in focus groups, staff members described it as a more authentic and empathetic way of working, and an approach that allows them to feel unified with members in their departments and departments across the agency.

One manager involved in housing services reflected on the impact that TIA has had on service provision among his staff team:

"I do think TI has helped us. I think we were definitely doing that work anyway, but in the space of 12 months, I evicted one person from a high-

support project, and normally we average about two a quarter…it's about when you're looking at that aggressive behaviour – I think as a staff team, we are really good at not taking it personally."

Staff members also described TIA as a "broad awareness of trauma in every context" and helpful in enabling staff to be mindful, reflective, and "aware of your own reactions". They described it as helpful in maintaining professional boundaries and managing young people's expectations of them. One staff member from an alternative education setting said:

"It [TIA] helps me not only with my staff members, my client group, my students – but interactions with everybody in any walk of life, in any scenario. Because it makes me question where they're coming from…And that automatic filter goes through my brain and I think, 'okay, so why are they saying that'?"

Staff members were more ambivalent when considering how peripheral services involving maintenance, housekeeping and catering professionals can approach their work in a TI way, and several indicated that the initial 1-day trainings were not sufficiently adapted for these roles. However, they also spoke about the close contact that many of these professionals have with young people and how understanding young people's behaviours within the context of past trauma is useful for them as well. For example, a member of maintenance staff may be called to clean up something that has been broken or destroyed by a young person. A member of staff working in food service may interact daily with young people, and adopting a TIA can help them avoid emotional burnout and respond more sensitively in their interactions with young people.

Several of the young people participating in focus groups re-affirmed the need for an agency-wide approach, as they described the importance of first impressions and initial interactions with staff members not tasked with direct service provision.

One young person, Hannah (pseudonym) described interacting with a receptionist:

"One thing I get really irritated, when I first used to come in, I used to open the door and she'd [receptionist] be like: 'name, age'. All right, can you not do that? Now, she's like, 'all right, sit down'."

These first impressions of a new environment, and a continual reassessment of safety within that environment, demonstrates the way in which hypervigilance manifests in vulnerable young people accessing housing, advice and support services. For example, 'Sam' spoke about knowing if a staff member is trustworthy and safe by watching them closely:

> *"You can't really explain it but you can see if they want to be there, [or if] they're constantly looking at the clock. The ones who want to be there will make an effort to speak to you about any problems you've had or anything. The ones who don't want to be there, will be like in the kitchen making food."*

This careful observation is a necessary skill when exposed to dangerous and threatening circumstances, and continues to shape the way in which young people like Sam assess new environments intended to be safe. In Sam's case, he needs all the staff he interacts with to understand hypervigilance, and how to respond in a way that feels trustworthy and safe.

b. 'Trauma' is a tricky word

When asked in the agency-wide staff survey if they could understand what a trauma-informed organisation 'looks' like, only half of participants agreed. Approximately one-quarter of participants either disagreed (6.7%) or provided a neutral response (20%) when asked if they saw themselves as a 'trauma-informed professional'. A reluctance surrounding the word trauma may be an issue resolved through consistent messaging and a more clearly communicated vision, but may also be indicative of barriers to implementing TIA identified in research, discussed above[15].

In focus groups, ambivalence was evident in the way that participants questioned using the word 'trauma'. For example, a staff member, 'W' felt that using the word trauma could be "incredibly patronising or making assumptions of 'how dare you say I'm traumatised'?" She was not "personally comfortable with the word trauma in how others... and especially young people, could potentially perceive it." Staff member 'R' disagreed, saying that he felt the word trauma was honest:

> *"It's like, yes, really horrific shit happens, and what are you going to do? You know, pretend it isn't real? So I think it's okay to put it out there a little bit. I mean, it is true, I find it really hard, you know? It wears me out sort of looking and reading about stuff. But what's... You know, you've got to face it, haven't*

you? Yes, so I think... Well what other word are you going to use? You may as well not bother sugar coating it..."

This discussion highlights the ways in which these staff members are working through their own understanding of what a 'trauma' label might mean. As 'R' pointed out, some ambivalence in using the term may also be related to the emotional weight of confronting and acknowledging trauma. Others felt that coming to understand trauma as a 'spectrum' helped them become comfortable with the term.

When young people were asked in focus groups for their views regarding the 'trauma-informed approach' the organisation was taking, they presented with less ambivalence. Danielle said:

"There are so many different types of trauma. I've got so many different types. I've got post-traumatic stress disorder alongside loads of other things. My biggest one is attachment disorder because of childhood trauma...so I think with the staff, yes it is becoming more trauma aware, knowing that a lot of stuff that you do today is because of what's happened to you."

For Danielle, it was less important that staff knew the details of her traumatic experiences and more important that they understood the impact of these experiences on her life today. Others agreed, saying that they felt that it was important for staff members to be trained in understanding mental health and the impact of traumatic experiences even if they did not share these experiences with the staff. Greg spoke about the way in which TI staff might help normalise his experiences and make him feel less isolated:

"When I have something difficult to speak about, I think sometimes it's quite nice for someone to just say, 'it's okay to think about or see things that way' because of some of the stuff I've been through...Sometimes it's nice just to think if someone just thinks that it's okay, you've been through this, and you can move away from it."

While focus groups included a small (non-representative) sample of young people receiving services from only two YMCA DLG programmes, their views support the way in which TIA was initially defined by Harris and Fallot[16].

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c. Safe people may act in unsafe ways

A primary aim in implementing TIA is to increase service users' sense of safety and their ability to manage difficult feelings and behaviours[17], and it was acknowledged early on by service managers that as young people feel safer, staff may begin to see more difficult behaviours and become aware of additional safeguarding concerns.

Following the TIA implementation, safeguarding alerts for children under age 18 rose 8.5% in Quarter 2 and 51% in Quarter 3, primarily due to increased reports of self-harm and suicidal ideations. Safeguarding alerts for young people aged 18-25 also increased slightly (+11%) in the third quarter, also because of self-harm and suicidal ideations. This data alone is not sufficient to draw conclusions regarding the impact of the TIA on safety concerns. However, responses from young people and staff members in focus groups help provide some context for this data.

In a discussion about safety in one focus group, a young person 'Ethan' described putting on "another persona" when he feels unsafe, which is "99% of the time". He said:

"I find my other self a lot more confident than me as myself. I feel I can escape to this other person and do things that I normally wouldn't do...the [staff] would see that I'm a lot more confident and I feel a lot happier than I normally do..."

Other participants agreed with him, describing how they put up "a front" that is less open and less receptive to connecting to staff when they feel unsafe. Their descriptions align with the way staff members described young people in focus groups. Namely, that young people may appear less emotionally stable, have increased emotional outbursts and in many ways present as "less safe" when they are feeling more safe and more contained by staff members. Staff then have an opportunity to help young people begin developing self-awareness and coping strategies to better manage trauma triggers in the future.

d. Safe staff are transparent, persistent and they share power

Young people also provided insight into how staff might help them when they do experience difficult emotions or trauma triggers. They spoke about several key traits in 'safe' staff members: transparency, predictability, persistency,

authenticity, and most importantly, a willingness to share power and control. Transparency involved being honest and direct; predictable and persistent staff were physically present, reliable, and would 'go the extra mile' to check in with a young person or provide the opportunity to talk.

Authenticity was evident when staff genuinely seemed to care, and sharing power and control (most frequently identified by the young people as an indicator of safety in relationships with staff) was recognised among staff members who asked for permission before sending a referral or provided evidence for how they had taken young people's views into consideration. One young person's experience of being supported by staff through self-harming and feeling suicidal provides an example:

> "I only really just recently moved in...and I self-harmed and was suicidal. They had to follow the procedure, they called the paramedic and an ambulance turned up for me, and I think the way they relayed that to me and they helped me with my own care was by saying, 'do you want us to come with you?' While I'm getting shoved into the back of an ambulance. And going through the safeguarding form afterwards, they didn't just forget it, they didn't just say, 'we will contact you if you want us to.' It was, 'come downstairs and we'll go through a safeguarding form with you, which is how we can help you to stop this from happening again, because we care about you'. It wasn't just forgotten or left about like other places do. They just go, 'I'm sorry that's happened to you'. This one [YMCA service] was, 'we don't want this to happen again for your own safety'."

This example demonstrates a young person's acceptance of the safeguarding process staff were required to follow, and provides a helpful example of how staff can follow these processes while embodying safety through transparency, persistency, authenticity and power sharing. The ways young people defined safety here resonate with basic principles of TIA promoted by SAHMSA[18] and others[19].

3. Learning from the YMCA DLG experience

While the effectiveness of this new approach in achieving the ambitious outcomes that the YMCA DLG originally envisioned remains unknown, the first phase of the evaluation indicates that their TIA is promising in its ability to meet the needs of both staff and service users. Other organisations can learn from the YMCA DLG's innovative approach, particularly regarding their

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emphasis on a comprehensive implementation, including each department within the organisation.

Key areas for future work identified in survey and focus group data include the need to implement Reflective Practice Supervision groups more consistently across the entire organisation. Given the size and diversity of the organisation, identifying supervisors and resolving logistical barriers (e.g. time/schedule clashes) remains a difficult but necessary task as reflective supervision can provide space to support staff in embedding TIA into their professional identities, everyday interactions and routine tasks. Another key area for further development is in staff members' understanding of vicarious trauma in their own lives, as both survey and focus group data indicate a lack of understanding regarding vicarious trauma and the impact it can have on practice.

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22. A youth-led approach to tackling adversity

Andy Bell

1. Introduction

This paper summarises a Centre for Mental Health evidence review[1] gathered from an evaluation of three projects in London run by the mental health charity MAC-UK.

Excluded and vulnerable young people, including those in contact with the criminal justice system, often experience multiple risk factors for poor mental health, exacerbated by services that are experienced as 'hard-to-reach', leading to wide health inequalities. The MAC-UK INTEGRATE approach harnesses the power of young people themselves to be part of the solution. INTEGRATE seeks to wrap holistic and responsive support, including mental health and emotional wellbeing provision, around excluded young people.

The INTEGRATE model was developed at the very first MAC-UK project, Music and Change, in Camden. This project launched in 2008 and closed towards the end of 2015. From the very outset Music and Change incorporated co-production with young people and this is a key feature of all projects. Positive Punch opened in 2011, also in Camden but focusing on a different peer group in and around a different estate. Positive Punch was funded through Camden Community Safety Board and ran for three years, closing in late 2014. The third INTEGRATE project, RO|ОЯ , launched in Southwark in 2012 with funding from the Guy's and St Thomas' Charity, and completed in 2015. While the Music and Change project worked in partnership with both statutory sector and voluntary sector partners in the borough, both Positive Punch and RO|ОЯ were established, co-commissioned and staffed by both NHS and local authority staff as well as MAC-UK.

Centre for Mental Health provided evaluations for all three completed INTEGRATE projects. Although each project was different (reflecting lessons learned from previous projects and particular local needs) the evaluation methodology across all three was very similar and utilised both quantitative and qualitative methods.

2. What needs to change?

Young people find much about traditional health care services challenging and those involved in gangs or antisocial behaviour are often regarded by health professionals as a difficult group. However, these young people are often the poorest and most excluded in our society, dealing with poverty, racism, deprived communities, domestic violence, abuse, neglect, leaving care and homelessness[2].

Child and Adolescent Mental Health Services (CAMHS) are not well designed for this group and have lacked adequate resources to meet their needs[3]. Barriers to this group accessing traditional mental health services are geographical (such as clinics located in unsafe areas), structural (such as services that do not have capacity and training to 'reach out'), and psychological (such as the mistrust of professionals by young people)[4]. Young people often struggle to engage with and navigate the many professional relationships required of them in the current service provision[5].

A new approach to interventions for excluded young people is urgently required to better meet their needs. MAC-UK therefore developed an alternative approach, co-produced with young people, to deliver services for them[6]. This became the INTEGRATE model.

3. Key features and principles of the INTEGRATE approach

Phase 1: Reaching young people, engaging and peer referral

Within the INTEGRATE approach, engagement and relationship-building with excluded young people is put front and centre; to build trust is the only agenda and if young people ask for support later that is then responded to. No professional referrals are taken, although partners, such as the local authority, help identify which young people would benefit from an INTEGRATE designed service.

Phase 2: Co-producing activities and relationship-building

As relationships build, it becomes possible to actively ask for help from young people to design a project that they want with the resources the INTEGRATE team brings. The INTEGRATE team explain that the project is about doing 'with' young people, not 'for' them. Young people choose, design and run a range of activities from music or sport to drama based on their passions and interests. Their help is actively requested in all aspects of the activities and young people can take up explicit leadership roles such as 'Head of Music' or 'Gym Project Lead', promoting a sense of ownership and responsibility.

Young people can be employed on an ad hoc and part time basis to carry out some of the project work. Employed or voluntary, INTEGRATE project activities provide opportunities for young people to develop professional skills, gain relevant work experience and earn a live employer's reference. It also means almost daily contact between staff and young people, who are all part of the same team. Young people are encouraged to support each other.

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Phase 3: Streetherapy and psychologically-informed environments

INTEGRATE projects have mental health and wellbeing support built in by supporting a psychologically-informed environment and a 'Streetherapy' approach. INTEGRATE teams are led by mental health professionals and made up of workers with lived experience and other professional staff, such as youth workers, all of whom are trained in mental health. The teams apply evidence-based psychological theory to their everyday practice with young people; this includes attachment theory, lifespan developmental theory and community psychology theory, as well as systemic practice, including narrative therapy. The teams regularly draw on the Adolescent Mentalization-based Integrative Treatment (AMBIT) framework for their clinical practice[7].

Phase 4: Building bridges

Young people can quite quickly start to ask for help with a range of needs, while continuing to also co-produce the project. This can include housing support, benefits applications, applying for passports and bank accounts. Again, at the young person's pace, staff may offer or be asked to support with CV writing, job applications or support and advocacy during their experiences of the youth justice system. As part of meeting these needs, the team will draw on the project's wider partners and relationships, building bridges between these resources and the young people. All of this helps to prepare young people to 'bridge out' of the project, becoming more stable, independent and able to access and use other services. Co-producing the project can often provide them with experience enough to gain entry level employment.

Building bridges in the other direction is also key. The INTEGRATE team supports community services and agencies to adapt to meet the needs of young people more effectively, for example encouraging them to come to the project to hold appointments or initially meeting the young people with project staff to broker trust. This could be physical health services, such as sexual health or dentistry, through to housing advice and job centre staff. This is part of the 'systems change' component of INTEGRATE projects and ideas for it are often generated directly by young people.

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Phase 5: Creating systems and social change

Often young people find they can trust their relationships with the INTEGRATE team enough to express their frustrations with their social worlds. This is encouraged and facilitated by the team, understanding that community and social context factors contribute vastly to young people's mental health. Through dialogue with young people, INTEGRATE teams can find ways to work in partnership with young people to create social change. This may involve young people co-producing training, campaigns and lobbying activities.

4. The impact of the INTEGRATE approach

Below we summarise the impact of the INTEGRATE approach as identified through the three evaluations undertaken by the Centre for Mental Health.

a. Enhancing engagement and co-production:

All three projects were incredibly successful in engaging with groups of young people who were marginalised, and who were engaged in offending or at risk of offending. Over the period Centre for Mental Health conducted the evaluations, the projects worked with approximately 360 young people in total. These young people were typically facing multiple and complex challenges in their lives, such as housing, education, employment, offending and poor mental health.

On all three sites, key local individuals supported the initial contact with young people. In each case these were local people with credibility among the young people who endorsed the project.

Co-production was at the very heart of everything that the INTEGRATE projects took part in, and each of the projects started with activities that were wanted by the young people and co-produced with them. These included music projects, sports projects, cookery projects and others. Through co-production, the projects positioned young people as experts in their own lives and sought to build a service that would be accessible and relevant to them. Co-production was key in building firm relationships between the INTEGRATE staff and young people.

Young people described how INTEGRATE staff "checked in" on them, maintaining engagement with young people not only directly at the projects and their activities but also through regular phone calls, texts and emails. This meant for some young people, who had not attended the project for a period, that they always felt there was an open door for them when they had need of support in the future.

b. Improving mental wellbeing:

The young people engaged in the project had high levels of need relating to mental health and wellbeing. Self-rated data on mental wellbeing at Music and

Change and RO|OЯ established that around one third of the young people in the samples reported a level of wellbeing that would warrant referral to a mental health service.

A consistent finding across all sites was that mental health awareness increased in young people and that stigma around it reduced during their involvement with the projects. Young people and staff across all three projects reported that young people's mental wellbeing improved through contact with them. Clinician-rated measures of mental wellbeing confirmed young people's reports, showing significant improvements in needs associated with mental wellbeing across all three projects, over the course of young people's engagement. However, across all three sites there remained a reluctance to use mainstream mental health services.

c. Working with young people entering or re-entering education, employment and training:

Most young people who engaged with the three projects wanted support in entering or re-entering education, employment and training (EET). The INTEGRATE projects were very successful in bridging young people into these. For example, at Music and Change between 2013 and 2014, the proportion of young people accessing EET increased, from 43% to 74%. At RO|OЯ , access to employment increased from 23% to 54% over the first two years.

At the outset a young person might be shown opportunities and given all the support necessary in taking their first steps towards these, from support in writing a CV to accompanying a young person to interview. The aim was that the young person would be able to do this more independently over time. However, because of the nature of employment contracts (often temporary and/or zero hour contracts), especially for young people seeking unskilled jobs, there was both a flow in and out of employment.

d. Diversion from further offending:

Most of the young people Centre for Mental Health spoke to stated that they had been in trouble with the police and that their involvement in their INTEGRATE project was having a significant role in keeping them "away from trouble".

Young people described how the support regarding offending at INTEGRATE enabled them to think about the choices in their life, opening up different options. INTEGRATE workers provided a very flexible service and would attend court attendances to support the young person and provide evidence and statements on the positive changes young people were trying to make.

Some young people engaged with the project did receive prison sentences during their period at the project (sometimes for offences committed prior to their engagement by INTEGRATE) and the projects continued to support them while in prison. The young people Centre for Mental Health spoke with reported just how stressful contact with the criminal justice system could be and were very appreciative of the support provided by INTEGRATE.

5. Conclusions

INTEGRATE's approach would enable other services to engage and support children and young people facing adversity more effectively. Specifically, positioning young people as experts in their life and co-producing a project with them results in a service which is accessible, relevant and in line with young people's needs. Taking a strengths-based approach (one which builds on young people's strengths and interests) empowers young people to make sustainable changes in their lives. And services underpinned by therapeutic principles of unconditional positive regard, acceptance and non-judgement support young people to build trust and repair relationships with professionals. Services should adopt a holistic approach which supports young people where they are at and with whatever need or problem they bring, underpinned by evidence based psychological approaches.

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23. Trauma-informed commissioning for substance misuse amongst young people

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1. Young people and substance use

Public misconceptions about both the prevalence of young people's use of substances, and their motivation for using them, are compounded by sensationalist accounts of drug use in the popular media. This media coverage frequently draws attention away from the fact that substance use among young people has been broadly in decline since 2001[1]. Despite the high profile of New Psychoactive Substances (NPS)[2] in recent years, alcohol and cannabis remain the most commonly used substances among adolescents.

Every young person has their own story about what led them to try a particular substance. For many, they do so having already researched the potential risks involved, aiming to manage their usage so it remains as safe and enjoyable as possible. The vast majority of young people's substance use is either experimental or recreational, and most people are capable of managing their intake of legal and/or illicit substances so that any unwanted consequences are minimised.

However, there are still many young people for whom substance use can become problematic. In 2015-16, 17,077 young people accessed specialist treatment services – a drop of 1,272 or 7% compared to 2014-15[3]. There are a wide number of determinants that might lead one individual into more dependent use of substances, where others may be able to desist. Recognised features that can play a key role in protecting people from risk include: having positive relationships with friends and family, engaging well in school or college and living in a stable home environment. Conversely, there are factors that may leave young people vulnerable to harm related to substance use, including: living in deprived areas, being excluded from mainstream education, and not feeling able to turn to others for support.

Substance use can be further complicated by young people's experiences during adolescence. This can be a period of great uncertainty, a time when

young people are attempting to navigate the confusing journey from childhood through to adulthood. As roles and responsibilities change, so does the chemical and hormonal make up of the human body. Teenagers experience higher levels of impulsivity, which is linked to the ongoing development of the adolescent brain.[4] Such limitations around consequential thinking explain why some young people expose themselves to, or engage in, greater risk-taking.

Substance misuse is just one form of risk-taking behaviour, but it can also be an indicator of other (potentially hidden) difficulties with identity formation or childhood adversity. For some young people, the use of drugs or alcohol is a form of 'self medication', which enables them to relieve stress, or block emotionally distressing thoughts. This usage can be heightened among groups of children who face additional complexity in their lives, including: looked-after children, those seeking asylum, those witnessing or involved in violence and those making sense of their gender identity or expression and sexuality.

2. Young people's experiences of adult substance misuse

Adverse Childhood Experiences (ACEs) are events that have a traumatic and lasting effect on the mental health and emotional wellbeing of young people. Childhood adversity can include experiences of neglect, abuse or violence within the family, being forced to take on adult responsibilities (as in the case of young carers), or living in households where people are misusing substances.

Substance misuse can significantly impact people's capacity to parent. This may include:

- increased volatility within the family or home environment.

- unsettling changes in the mood or behaviours of an adult resulting from intoxication.

- withdrawal from parental responsibilities, which might include not providing food or clothing, or asking children to take on adult responsibilities during periods of withdrawal or relapse.

- withdrawal, mistrust or aggression towards the child's wider social network, including their school, wider family or local community.

- misattunement and an inability to meet the emotional needs of the child.

- disorganised, ambivalent or avoidant attachment patterns formed between children and those with parental responsibility.

- isolation within the community, wider family, or from peers because of the stigma associated with using substances.

In addressing substance misuse within families, we need to take a trauma-informed approach, as there is a cyclical relationship between childhood experiences of, and exposure to, adult substance misuse, and subsequent misuse of substances in adolescence and adulthood. As the World Health Organisation suggests, those affected by ACEs are at increased risk of exposing their own children to ACEs (including substance misuse), and, as such, this intergenerational cycle constitutes a "cycle of violence"[5].

3. Childhood adversity and substance misuse

Experience of one or more childhood adversities has been linked to poorer physical and mental health outcomes in adolescence and adulthood[6]. The study of ACEs in England found that those adults who had experienced four or more adversities in their childhood, were two times more likely to binge drink, and 11 times more likely to have gone on to use crack cocaine or heroin[7].

The research from England also shows that the traumatic impact of living in a household with an adult who misuses substances can have a long-term, negative impact on these children's life satisfaction and emotional wellbeing[8]. This reflects international research describing the strong relationship between childhood adversity, and the development of enduring mental health conditions in adulthood, which include anxiety, depression and symptoms of traumatic-stress[9].

It has been shown that the higher the number of ACEs, the higher the likelihood that the child will go on to misuse substances, in part to manage the overwhelming emotional and somatic sensations associated with trauma[10]. The chances of developing a dependence on substances double if a child has also experienced sexual abuse[11] or other forms of violence[12].

Smoking, heavy drinking and cannabis use in adulthood all increase with the number of childhood adversities that a young person has experienced. This is echoed in recent research from England that found that two thirds (of a target sample of people misusing substances) had experienced four or more ACEs[13].

Many of the young people and adults who go on to misuse substances, or who become dependent on them, will have faced multiple adversities in their childhoods. It is therefore important to acknowledge that these behaviours can be attempts by young people to soothe, numb, cope with, or make sense of the trauma that they have experienced. Rather than expressions of criminality, they represent forms of risk-taking behaviour that are considered as normative responses to the social, emotional and somatic impacts of childhood adversity and trauma.

Young people may use substances (following experiences of adversity and trauma) in order to:

- 'escape from' or avoid invasive thoughts, images or memories.

- increase attention at school, or in their social life, to address the impact that chronic hyperarousal, and hypervigilance, has on their nervous systems, levels of anxiety and sleep patterns.

- strengthen trauma bonds and patterns of relationships that draw them closer to adults or peers who will expose them to further adverse events (for example participating in sexual or violent acts), or make them reliant on them for the supply of alcohol, legal or illegal substances.

- self-harm through (for example) overdosing, and self-punishing their bodies by ingesting or injecting performance enhancing substances.

Research demonstrates that the development of traumatic-stress often precedes the use or dependence on chemical substances, which are used to cope with the associated symptoms[14]. Trauma can cause a heightened sense of threat, where the child or young person is constantly in a state of alert in order to freeze, fight or flight in the face of further adversity.

If children regularly use substances from an early age it can have a substantial impact on their neurobiological and cognitive development, as well as affecting

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their ability to acquire skills that enable them to self-soothe or self-regulate in the face of further emotional distress[15]. Some young people 'self-medicate' to numb the overwhelming emotional distress that comes from constantly scanning for threats in their environment. It can offer an altered, and more tolerable, state of perception where young people can recall memories that would otherwise be intolerable for them.

Ultimately this 'self-medication', numbing or suppression only acts as a temporary solution, and in the mid- to longer-term has a negative impact on the physical and mental health of these young people. Recreational use of (for example) illicit drugs can lead to the traumatic release of memories, resulting in more extreme forms of disassociation during the 'come down' or withdrawal. It also risks growing a dependence on substances, or pushing them towards other forms of health- or self-harming behaviour. However, for some, 'self-medication' and 'micro-dosing' enables them to connect with repressed emotions, and strengthen positive or protective relationships with their peers.

4. Substance misuse and young people's mental health

Evidence suggests that there are some mental health conditions that may be more likely to be exacerbated by substance use than others, including experiences of psychosis, schizophrenia, bipolar and depression[16].

The impact of drug or alcohol use on young people's mental health varies depending on the age, genetics, and psychology of the young person, as well as the context in which it is being taken. The younger a person is, the greater the intensity of the drug in question, and the more frequently it is used, the higher the likelihood of negative or unwanted effects being generated. For example, a 12 year old smoking a strain of cannabis high in delta-9-THC (often colloquially known as 'skunk') on a daily basis is likely to be more vulnerable to experiencing mental ill health, than a 17 year old taking a milder strain on an infrequent basis.

Much of the media reporting around drug use and mental ill health becomes confused because of sensationalist headlines that lack the context of the detailed (and often conflicting) research that underpins them. For example, media coverage around psychosis masks the reality that most young people who try substances are unlikely to experience serious or long-lasting mental health problems. Where negative consequences do occur, it is perhaps

more likely that these may be linked to more general social functioning, their experiences in childhood and their relationships with others.

It is important to note that most young people who misuse substances do not experience psychosis. However, substance misuse increases the probability of an experience of psychosis. The risks are different for different substances. Research suggests that adolescents who misuse cannabis double their risk of experiencing psychosis by the time they reach adulthood[17].

Drug-induced psychosis is a historical term referring to psychotic symptoms occurring after the use of substances. Psychotic symptoms can include delusions (i.e. persistent false beliefs), hallucinations (i.e. hearing or seeing things that are not actually there), unusual behaviour, and disorganised thinking. Substances associated with drug-induced psychosis include: amphetamines, cocaine, cannabis, LSD and certain types of NPS, such as synthetic cannabinoids. The term 'drug-induced psychosis' is deceptive, and does not necessarily imply that the substance has caused the psychosis.

Drug-induced psychosis might be short-lived, lasting only while the user is intoxicated or withdraws. On other occasions the psychosis might last for many weeks. During that time the young person needs to be supported within a safe environment and if this is the first episode of psychosis, it is likely that they will be referred to the local Early Intervention Psychosis (EIP) service[18]. Once the crisis is over, many young people will make collaborative plans with the clinicians at the EIP team, an addiction specialist (if appropriate) and possibly a crisis mental health team. This support is put in place to help the young person to make sense of their experience of psychosis, to manage any resulting mental health or addiction-related needs, and to plan for any further escalation in need or experience of crisis.

More broadly, substance use clearly can trigger changes in young people's behaviour, attitude or mood. As well as having a negative impact on their physical health, it impairs their cognitive development and comprehension[19]. Furthermore, substance misuse can leave some young people feeling distant or disconnected from the peers and adults who may previously have been their support networks. Persistent and problematic substance use can trigger low levels of motivation, negatively impacting on daily routines and diminishing engagement in positive recreational activities. This can impact adversely on a young person's ability or desire to engage in education, training or employment which affect their chances of progressing into further education or with career choices.

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Problematic substance use can affect a young person's likelihood of becoming involved in the youth justice system[20]. Due to a significant number of substances remaining illegal, young people who buy, transport, or consume them are at risk of being criminalised by authorities. Once consumed, the effect of substances may impact the decision making skills of the young person, and due to a lack of inhibition they may be more likely to partake in behaviour they would normally avoid (for example aggressive, sexualised or exhibitionist behaviours). These behaviours can also lead to interaction with the police, criminal justice or disciplinary systems in schools and colleges. Finally, for those for whom substance use has become engrained within their lifestyle, criminal activities may be a way of access or funding their use.

5. Responding to childhood adversity and substance misuse

Recently, Public Health England published a support pack for commissioners to strengthen substance misuse services and interventions for young people[21]. We recommend that commissioners work through the comprehensive list of questions to assess the sufficiency of their local offer. In addition to these prompts, we have included priorities for commissioners to consider when creating trauma-informed practice around young people's mental health and substance misuse.

a. embed psycho-education in the universal education offer

While it is a minority of adolescents who develop a problematic relationship with substances, it is important that all young people receive universal-level drug and alcohol education. This age-appropriate education should include considerations of risk, relationships and how to build resilience in relation to decision making, experimentation and use of drugs and alcohol. To ensure it is trauma-informed, those delivering the training, or supporting teaching staff to do so, should have a good knowledge of the relationships between childhood adversity, trauma responses, mental ill health and use of substances.

Commissioners, mental health providers and specialist drug and alcohol services should take a collaborative role in supporting local schools to develop and deliver programmes meeting the requirement to embed relationships

education in all primary schools, relationships and sex education in secondary schools, and extend Personal, Social, Health and Economic Education (PSHE) to all schools[22]. For example, the Amy Winehouse Foundation Resilience Programme[23] uses the lived experience of people in recovery to explore with young people the thoughts, feelings, behaviours and underlying issues that can make people more susceptible to substance misuse. This is reinforced through skills-based sessions that seek to develop resilience, so that young people can make better informed decisions.

b. introduce routine enquiry within urgent and emergency care, and specialist drug and alcohol services

Routine enquiry about childhood adversity should be introduced into both A&E , urgent care, and specialist drug and alcohol services.

Routine enquiry involves training frontline professionals to sensitively gather information about whether someone's thoughts and behaviours are a symptom of a childhood adversity or trauma they have experienced. This might include adding a key line of enquiry into A&E assessment conversations when a young person has a serious first presentation of self-harm through intoxication, or if a trend of recurrent harm through intoxication is identified. This opportunity is frequently missed if an A&E or urgent care doctor does not deem the young patient to have a level of mental ill health that would meet their threshold for contacting the hospital's dedicated mental health team.

Likewise, if a young person is already in contact with a specialist drug and alcohol service, initial assessment should include enquiry on childhood adversity to identify whether the health-harming behaviours seen in substance misuse are related to the 'self-medicating', coping or management of trauma-related symptoms. For example, young people who access specialist treatment support with Addaction will undertake a comprehensive assessment. Questions within this focus on the motivations for the young person's use, whether this is a form of escapism, and if so what the situation they are 'escaping from'. This question is combined with others which cover the young person's family life, physical and mental wellbeing, as well as risk-taking behaviour.

Routine enquiry should involve a warm transfer to trauma-informed models of rehabilitation, psycho-education and harm-mitigation. This would include referral to safeguarding leads if any child or adult safeguarding flags are

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triggered during the enquiry. Pathways to support from routine enquiry should be designed collaboratively by local commissioners, social services (depending on the circumstances of the young person and parents), young people and service providers.

c. invest in early intervention models

The charity Mentor UK has usefully summarised the factors that protect against, and increase the risk of, substance misuse (see table 1)[24]. Research shows that the age of a young person's use of substances is a strong predictor of the severity of their use later on in their life. Early intervention should be initially targeted towards those children who have a known risk factor, and are listed as belonging to a vulnerable group.

Table 1: Protective and Risk Factors

Protective factors	Risk Factors		
• Positive temperament • Intellectual ability • Positive and supportive family environment • Social support system • Caring relationship with at least one adult • In education, employment or training	Belonging to a vulnerable group: • Looked-after children • School non-attenders • Having mental health problems • Drug misuse by parents • Abuse within the family • Homelessness • Young offenders • Young sex workers	Social and cultural factors: • High levels of neighbourhood poverty and decay • High levels of neighbourhood crime • Easy drug availability • Widespread social acceptance of alcohol and drug use • Lack of knowledge and perspective of drug-related risks	Interpersonal and individual risk factors: • Physiology and psychology factors • Family dysfunction • Behavioural difficulties • Academic problems • Association with peers who use alcohol and drugs • Early onset of tobacco smoking • Early onset of alcohol and drug use

Successful early intervention can result in young people being less likely to require specialist support later in adulthood, and can reduce overall reliance on public services.

Addaction's Mind and Body programme (Cornwall, Kent and Lancashire)

The Addaction Mind and Body programme aims to support young people (aged 13 to 17) who are involved in, or may be vulnerable to, self-harming behaviours. The programme looks to support those who do not meet CAMHS thresholds but who could benefit from specialised input that universal services are often unable to provide.

A short online screening survey is used to help identify young people who might be at risk and to assess whether the programme would be right for them. Referrals may also come from local health partners and schools, while young people can self-refer too.

The programme was developed from RisKit[25], an early intervention initiative which has a proven evidence base in risk-reduction outcomes. In 2016-17 Mind and Body was delivered in Kent, Cornwall and Lancashire with over 600 young people completing the programme.

Mind and Body comprises of eight group sessions, accompanied by three one-to-one sessions with a practitioner for needs-based support. The diagram on the following page outlines the core themes within each of the group discussion sessions.

An independent evaluation by the University of Bath found that the screening processes identified young people who were 'under the radar', and who were not known to be at risk of harm.

As a result of the programme activities:

- eight in ten young people experienced a decrease in self-harming thoughts, or did not think about self-harm at all while they engaged in the programme.

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- nine in ten young people experienced a decrease in self-harm actions or did not self harm at all while they engaged in the programme.

- three in four young people reported an increase in their mental wellbeing.

More information can be found at: **http://tiny.cc/Mind_Body**

d. build targeted parental and whole family support models

It is vital that parents, and care givers, who are misusing substances are given targeted support to both promote their recovery from addiction, and to address the additional adversity they are exposing their children to.

For example, Breaking the Cycle (BtC) is Addaction's family-focussed service, offering interventions to families where children are affected by

adult substance misuse. The service works directly within family homes to establish routines and pro-social family behaviours, as well as providing specialist alcohol and drug services to mitigate the impact of substance misuse on children. In addition to this BtC provides parenting support, advice and advocacy, consultation with children, and signposting or referral to targeted statutory, primary care and voluntary community based services.

The service builds on early attachment theory, and aims to provide an opportunity for families to foster resilience and positive adaptation, despite adversity they have faced individually and collectively as family members. Families who are motivated to participate in family-focussed recovery plans tend to benefit from Breaking the Cycle, with an ambition to sustaining their recovery and providing a different life for their children, to give them a different trajectory to the pathway associated with substance misuse.

e. establish inter-agency collaboration

Young people affected by substance misuse are often involved with other agencies because of the criminalisation, stigma and associated behaviours (e.g. increase in impulsivity) associated with it. As such, local agencies need to adopt a holistic and collaborative approach to ensure that all of the young person's needs are being addressed[26]. This is an important starting point for all service interventions as it allows for a trauma-informed model of care, where the young person's needs are contextualised within the network of adversity they have experienced. Furthermore, such inter-agency working can help to identify moments in the care pathways, or gaps between service provision, where these young people are at risk of being re-traumatised.

The Kent Youth Drug Intervention Scheme

Addaction works jointly with local police to deliver The Kent Youth Drug Intervention Scheme (KYDIS). This is a restorative justice process for young people who are found in possession of a Class B or C drug, where they are offered a diversionary activity to avoid criminalisation. The young person has the option to attend a session with an Addaction worker in which the topics of substance awareness and education, consequential thinking and the legality of their actions are covered. If

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engagement and attendance is sufficient then no further action is taken by the police in regards to the initial incident.

Similarly, Addaction are also currently piloting an innovative way of working in partnership with a local provider. Addaction have seconded a member of staff to work as a Dual Diagnosis Navigator within a local agency who are delivering a programme to young people to support their transition into adulthood. The service works with young people facing multiple complexities in their life, including: criminal involvement, worklessness, mental health problems and substance misuse. The role of the Dual Diagnosis Navigator is to work alongside young people presenting with multiple needs, and acting as the specialist within the team to share knowledge and expertise with their immediate team members.

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24. Trauma-integrated psychotherapy for psychosis (TRIPP)

Dr Sarah Bendall,
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1. Childhood trauma and psychosis

The pervasiveness of childhood traumas and their devastating long-term impact on those children's mental health across their lives have only come to light in recent years. Startlingly high rates of childhood trauma have been found in young people accessing early psychosis services with over 65% reporting sexual, physical, emotional abuse or neglect[1]. Not only does childhood trauma lead to increased risk of developing psychosis, it also leads to a more distressed and disabled clinical picture in those with early psychosis[2]. This clinical picture includes more severe hallucinations and delusions, depression, suicidality, and post-traumatic stress disorder (PTSD) as well as poorer social functioning and engagement with treatment[3].

Specific interventions for the effects of trauma in those with chronic psychosis, adjunctive to standard treatment, are beginning to be evaluated with very promising results[4]. The most recent and largest of these found that 8-week, exposure-based interventions significantly reduced PTSD symptoms in those with chronic schizophrenia compared with waitlist control[5]. However, alongside specific interventions directly targeting PTSD such as these, there is a widely identified need for trauma-informed care, a broad, service-wide understanding of, and intervention for, trauma-exposed mental heath consumers that goes beyond the treatment of PTSD[6]. Despite excellent face validity, trauma-informed care has yet to be well evaluated in clinical services. There is a need in psychosis treatment services for both trauma-specific and trauma-informed approaches[7]. There is also need for trauma treatments specifically for those with early psychosis[8].

2. Trauma-integrated psychotherapy for psychosis (TRIPP)

Over the past five years, our team has developed and piloted TRIPP, a trauma-integrated treatment approach that: a) has been developed using principles of trauma-informed care; b) operationalises guidelines for addressing trauma in early psychosis services, and c) provides a flexible intervention strategy based on evidence-based elements for PTSD. The intervention is integrated into routine case management and can vary in duration from 3–12 months.

This paper will focus on a description and rationale for the intervention. The therapy comprises five modules set within a background of continual engagement and a strengths-based perspective (see Figure 1).

Figure 1: overview of the TRIPP model
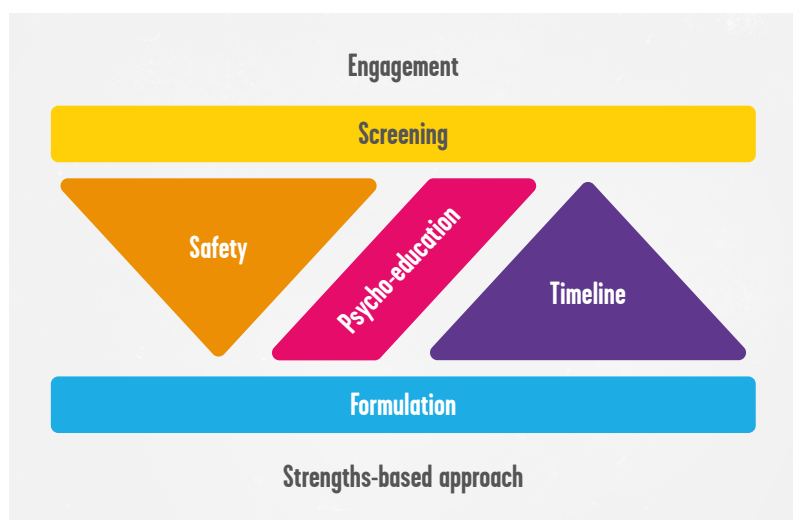
a. Engagement

Engagement is a key component of early psychosis service delivery[9]. It creates a collaborative therapeutic alliance that allows young people to trust clinicians. It is important to note that, in contrast to many people accessing mental health services, young people who attend early psychosis services are often not treatment seeking, and many may be ambivalent about the need for care.

Many young people with early psychosis may have had no or little prior contact with mental health services, have very little conceptualisation of talking therapies and may have very little experience of prolonged face-to-face talk with adults. This means that it may take them some time to trust in the clinical team to be helpful. Trust is central to therapy for trauma symptoms as trauma can involve betrayal by trusted individuals and thus clinicians can be seen as potentially untrustworthy. Engagement is important throughout TRIPP therapy but it is particularly central during the safety module where the young person can build confidence in how the clinician will approach trauma memories.

b. Screening

There is broad consensus[10] and national guidelines stipulate[11] that all people accessing early psychosis services should be screened and assessed for trauma exposure and symptomatic effects. However, there is evidence that only a minority of patients are screened for trauma in psychosis treatment settings[12]. This is due to concerns about the potentially distressing and destabilising effect of screening and assessment for trauma and clinicians' lack of skills to address any trauma that is reported[13]. In the TRIPP model screening and assessment are separated with the screening module developed as a way of gathering necessary information but having the young person approach the trauma memory as briefly and superficially as possible. A full assessment of trauma and its effects (*see timeline below*) is completed only after emotion regulation skills had been learnt (*see safety module below*).

Screening is completed for every young person via three written screening tools to very briefly assess for trauma exposure, PTSD and dissociation symptoms. This screening is introduced to the young person with some brief psycho-education regarding the high rates of trauma in early psychosis services and its importance as regards symptoms and functioning. The young person's permission is asked to complete the screening and young people are expressly told they do not need to do anything further than complete the written screeners. If they do however want to discuss the content of the screeners further then they have that opportunity. If trauma is detected then young people move onto the safety and psycho-education modules.

c. Safety

The safety module of TRIPP involves the assessment and treatment of safety

concerns such as suicidality, self-harm and substance abuse alongside skills development for noticing and communicating in-the-moment distress levels (using subjective units of distress (SUDS)) and learning and practice of distress coping strategies for use in and out of therapy. Emotion regulation and coping skills have been identified as evidence-based strategies for managing the distress that can accompany trauma assessment and treatment[14] and are particularly important for young people[15], those with more severe childhood interpersonal trauma[16], and with co-morbidities such as depression or anxiety[17]. We have added a specific strategy to enable the clinician to monitor the young person's feelings of distress, in response to widespread concerns that talking about trauma may be particularity distressing for young people with early psychosis and may exacerbate psychotic symptoms[18].

While all aspects of the safety module cannot be covered here, the "distress thermometer" (SUDS ratings), which is a core element of the module, will be described. Young people are shown a visual depiction of a thermometer with ratings of 0-100 and asked to rate their current in-the-moment "distress" on the thermometer. The thermometer is placed prominently and referred to often throughout TRIPP therapy. The young person is asked at least twice but often more during each session to rate their distress.

Early in the safety module, the case manger and young person experiment with relaxation, grounding, mindfulness and visualisation techniques (see Lanktree and Briere[19] for a description of such techniques) that are designed to reduce thermometer ratings. As the timeline module is started, thermometer ratings are taken more frequently when distressing past material is described or discussed and the young person's repertoire of identified distress tolerance techniques are used to reduce distress. The thermometer strategy enables young people to identify, communicate and take control of their feelings of distress in session, which can be generalised to other parts of their life. It also allows the clinician to know the young person's subjective experience of distress as, in our experience, this cannot be determined by how the young person looks or acts in a therapy session.

One of the overarching aims of the safety module is to increase young people's confidence and motivation in being able to feel in control when approaching trauma memories and other emotionally difficult situations. The duration of the safety phase can vary widely depending on the needs and motivation of the young person. Integrating TRIPP into routine case management (up to two years of care) means that slower, lower intensity safety module work can be integrated with other case management tasks.

d. Psychoeducation

One of the central tenets of early psychosis treatment is the early focus on comprehensive psychoeducation regarding psychosis for both the young person and their family. Early psychosis services have developed and deliver high quality, youth-friendly, optimistic, tailored, collaborative psychoeducation for their clients in both written and face-to-face forms[20]. A recent review of the common elements of a variety of evidence-based psychotherapies of PTSD found that psychoeducation about the nature and process of post-trauma reactions and the discussion of strategies for managing distress is a core part of all evidence-based treatments for PTSD. The aims of psychoeducation for both psychosis and post-trauma reactions align in that relapse prevention and engagement of the person in the treatment process are highly important in treatment for both.

In the TRIPP model psychoeducation is carried out concurrently with the safety and timeline modules. Psychoeducation is delivered from a broadly cognitive-behavioural perspective and core elements include: post-trauma intrusions, post-traumatic avoidance, hyper-arousal and dissociation. These elements are introduced if/when the symptoms are discussed in the timeline module. One of the main aims of psychoeducation is to normalise post-traumatic reactions. Psychoeducation may be distressing for a young person as it asks them to focus on their trauma experiences (even if they are not talking about them in detail). Thus it is linked with the safety module so the young person remains in control of distress levels even when receiving psychoeducation. Metaphors are used when possible to explain concepts (e.g. the filing cabinet analogy for intrusive trauma memories and post-traumatic avoidance).

e. Timeline

The timeline involves the young person describing major events or experiences over the course of their life, and reactions to those events. The description of these is noted on a written timeline, which is worked on collaboratively between clinician and young person in session. Included in the timeline are traumatic experiences, and other important events throughout life. When traumatic experiences are placed on the timeline little detail is gained about the actual traumatic experience. However, the effect of the experience on the client and on the family system immediately and over time are explored and noted on the timeline. Other traumas and the development and change in symptoms are then noted.

As the timeline comes closer to the present, more close-in descriptions of effects/symptoms are explored. As one of the functions of case management in early psychosis is to monitor current symptoms, this function is incorporated into the current end of the timeline and thus symptoms (e.g. post-trauma intrusions, avoidance, dissociation and hallucinations and delusions) are tracked and the temporal relationship between them is explored.

The timeline is primarily designed to elicit enough information about trauma and its effects in order to provide psychoeducation about symptoms (see above) and make a collaborative formulation (see below). However, in practice we have found that young people can demonstrate high distress thermometer ratings (see above) during this process. We conceptualise this as part of a PTSD avoidance process whereby young people feel intense fear of approaching trauma memories.

The timeline module was designed to provide information for a trauma-integrated formulation and a platform for psychoeducation. It is possible, however, that it acts as exposure to the traumatic memory and emotions associated with that memory but within a safe context, a common factor in PTSD treatment[21], as has been suggested with other comprehensive PTSD assessments in those with PTSD and psychosis[22].

We suggest the possibility that the much less intense engagement with the trauma memory in the current intervention may be sufficient to reduce PTSD for some young people. This population may be more amenable to a less intense dose of exposure treatment than others because they may have fewer years of PTSD symptomology than adults. They may also have less severe (and also sub-threshold) PTSD symptoms. This possibility accords with the clinical staging model of mental disorder that purports that those at earlier stages of the development of mental disorders may be more responsive to treatment and should be delivered more benign treatments[23]. This supposition is speculative and requires empirical testing. Our forthcoming publications on our pilot of TRIPP will begin to answer such questions.

f. Formulation

A comprehensive formulation is considered to be central to cognitive behavioural therapy (CBT) with particular utility in situations where empirically-supported treatment protocols are insufficient[24]. Formulation involves making a collaborative hypothesis about the psychological

underpinnings of a person's difficulties, highlighting factors that may have caused, precipitated and maintained these difficulties[25]. There is high utility in using formulation in both a trauma-informed and a trauma-specific intervention in early psychosis, as both models stress the importance of both clinician and client understanding the role of the trauma and peri-traumatic effects on presenting symptoms[26].

Within TRIPP, formulation occurs over 1-2 sessions at the conclusion of the timeline and operates from the following principles and assumptions:

i. Until TRIPP treatment, young people may have made no connection between their trauma experiences and the experiences/symptoms that have brought them to mental health services, and indeed may not have conceptualised their traumatic exposures as adverse, out of the ordinary, or potentially psychologically harmful.

ii. Young people with trauma and early psychosis often present with a variety of symptoms, which may or may not be directly trauma-related: PTSD intrusions and avoidance, dissociation, hallucinations and delusions, other psychiatric symptoms.

iii. There are many comprehensive evidence-based psychological models to formulate post-traumatic intrusions and avoidance and, to a lesser degree, dissociation[27].

iv. Psychological models of trauma and psychotic symptoms are currently early in development and empirical testing. Thus, we are not yet able to use a specific model in clinical practice.

v. The basic principles of CBT can guide formulating of psychotic symptoms in relation to trauma[28] together with emerging models of trauma and psychotic symptoms if appropriate[29].

vi. Formulating regarding hallucinations and delusions and trauma symptoms is exploratory, idiosyncratic, and based directly on each young person's own experience. Formulating can conclude, based on the young person's experience, that hallucinations and/or delusions are not trauma-related.

vii. The formulation includes personal strengths and important social supports.

viii. While the formal formulation is conducted at the end of the timeline the building blocks of the formulation will already have been explored with the young person during the timeline and psychoeducation modules.

ix. There is a collaboratively-written document of the formulation which is given to the client. This ensures that there is a record both for the young person and in the clinical file for possible future contact with mental health services.

Examples of formulations made in relation to psychotic symptoms in TRIPP

A young person had a delusion that her body and mind were being taken over by a powerful malevolent force. She regularly experienced intense depersonalisation (in this case the young person felt detached from both her body and mind) and amnesia at times. These dissociative symptoms were formulated as having developed as a way of mentally coping with ongoing trauma as a child (based on timeline evidence) but had generalised to become a way of coping when faced with a wide range of difficult situations. Depersonalisation had not been understandable to the young person and had been interpreted as having her body taken over by an external force hence becoming a delusion.

A young person had auditory verbal hallucinations of an unknown voice saying "you're an idiot". During the timeline the young person described being bullied at school and the development of PTSD intrusions of the high-school bullies teasing him including saying "you're an idiot". The young person tried to push these unwanted PTSD intrusions away and avoided many situations where he was reminded of the bullying. The hallucinations were formulated as potentially part of the same post-traumatic process as the PTSD symptoms.

A young person had more frequent and intense hallucinations when a past perpetrator of abuse was present. During the timeline the young person described the fear caused by the perpetrator in childhood.

> The hallucinations are formulated to occur more often due to the current distress and fear the young person still felt in the presence of the past perpetrator. That current fear was validated as understandable even though the abuse was not still occurring.

g. Strengths-based approach

We also take a strengths-based approach when conducting TRIPP. Strengths are defined by McQuaide and Ehrenreich[30] as "the young person's ability and capacity to cope with difficulties, to maintain functioning in the face of stress, to bounce back in the face of significant trauma, to use external challenges as a stimulus for growth and use social supports as a source of resilience". Thus, in the timeline module, we ask the young person to highlight social supports and the ways that they have coped with the traumas they have experienced. These are noted on the timeline and incorporated into the formulation.

3. Conclusions

We have designed and developed TRIPP as we believe that it is essential to develop and research not only specific treatments for PTSD but also broader approaches that support safe and effective screening, assessment and psycho-education in early psychosis from a trauma-informed perspective. Our in-depth qualitative assessments of young people's experience of TRIPP therapy tell us that, while it can be challenging for young people to undertake, TRIPP therapy is very worthwhile[31]. Randomised trialling is needed to establish the effectiveness of the intervention.

We envisage TRIPP or its adaptation as potentially useful in work with young people with a range of mental health problems. It may be particularly potent in situations where young people have not conceptualised their experiences as traumas or their symptoms as trauma-related, and/or where young people are reluctant to engage in, or decline exposure-based treatments. It is possible that an adaptation of the model could be used as preparation for evidence-based treatments for PTSD in these situations. It may also be useful in treatment settings where clinicians are not therapists or trauma-specialists.

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25. Supporting children who experience loss and bereavement

Dr Rebecca Adlington, **Dr Russell Hurn**, **Dawn Hewitt** and **Jan Cooper**

1. Introduction

CHUMS child and adolescent mental health and emotional wellbeing service is a community investment company offering front-line psychological support to children in Bedfordshire with mild to moderate mental health problems. In the last year, it is estimated that CHUMS offered support to 1,700 children and young people, and their families, while also providing input into schools and the wider community. In this way, CHUMS has become a multifaceted organisation which aims to meet the emotional wellbeing needs of the local community. However, at the heart of CHUMS is a drive to support families affected by adversity, trauma and loss. It was this agenda that fuelled CHUMS to break away from the NHS in 2011, and it is through our continued drive to deliver targeted services for children and young people and families affected by loss that CHUMS is now recognised as a benchmark service both regionally and nationally.

In this paper we consider the reasons why there is inherent value in supporting families through periods of loss, with reference to the evidence base and consideration of how this informed CHUMS' decision to establish an independent service. We then give an overview of the support CHUMS provides to those who have been bereaved, and how we continue to transform our services and develop understanding of how to help children and young people and their families in response to the evidence base and service user feedback. Finally, we will provide a summary of the key features which may be adopted by the NHS and children and young people services more generally, if we are to meet the needs of children and young people who experience loss and bereavement.

2. Recognising the needs of bereaved children and young people

CHUMS began in 1996 as a small voluntary service. In 2000, funding was received from the NHS allowing CHUMS to establish itself as a countywide child bereavement service. Nevertheless, CHUMS remained a small service comprising two employed staff members and several volunteers, and receiving only a small number of referrals annually. In the ensuing years, the growth of the service was staggering, and by 2011 there were 11 members of staff, and over 70 volunteers, supporting approximately 350 children and young people per year. During this period, CHUMS developed a unique, high-quality, evidence-based service, which prioritised and held the needs of children and young people and their families at its heart. However, in the context of mounting strain on staff and resources, it was felt that for CHUMS to continue to deliver effective bereavement support, it was necessary to establish the service as a social enterprise. This would enable CHUMS to access alternative sources of funding, provide a more cost-effective service, and reinvest in the community, allowing the service to expand and respond to needs as they arose.

Among those factors informing the decision to become independent from the NHS, was an understanding of the challenges faced by children and young people who had been bereaved, and the prevalence of this. In the bid to establish CHUMS as a social enterprise, it was stated that 22,000 children and young people in Bedfordshire alone would likely experience a bereavement[1]. This was based on National Statistics reporting that approximately 4% of children and young people under 18 years have been bereaved of a parent/sibling, 13% have been bereaved of a grandparent, and 6% have been bereaved of a friend[2]. Research has shown that of these deaths, approximately 25% occurred suddenly, with this figure rising to 42% if the number of people who died unexpectedly from chronic/long-term conditions were included[3].

2 in 50
children and young people under 18 years have been bereaved of a parent or sibling

3in50

children and young people under 18 years have been bereaved of a friend

7in50

children and young people under 18 years have been bereaved of a grandparent

Nevertheless, a survey of all local authorities and the former Primary Care Trusts in England, conducted by the Child Bereavement Network (CBN) to ascertain the provisions in place to support children and young people, received low response rates and discrepancies in responses. This suggested that bereaved children and young people's needs may not be recognised as the particular responsibility of any department or aspect of children and young people services[4]. This lack of specialist support was something that CHUMS were acutely aware of and keen to address.

> *While death is commonly perceived as an event that people encounter in adulthood, the reality is that it affects a large number of children and young people.*

The needs of children and young people who have been bereaved may be extensive. Fauth, Thompson, and Penny[5] found that 5-16 year olds who experienced a bereavement were 1.5 times more likely to be diagnosed with a mental health disorder. More specifically, they reported an increase in problems with anxiety and alcohol use related to the death of a parent or sibling, whereas the death of a friend increased the risk of conduct problems. While the directionality of the link between mental health problems and bereavement cannot be inferred from the data used by Fauth and colleagues, their findings are consistent with other studies demonstrating that following a bereavement, children and young people may display a range of emotional and behavioural symptoms including anxiety, low mood[6], low self-esteem and low self-efficacy[7], with 20% going on to experience a psychological disorder[8].

Further to the risks to emotional wellbeing, studies have demonstrated that experiencing a bereavement in childhood may have other deleterious effects. Worden[9] found that in the first year after a death children and young people were more likely to experience a serious physical health problem or somatic symptoms in the clinical range, with further studies demonstrating an increase in risk-taking behaviours[10] and the use of tobacco, alcohol and illicit substances[11]. Furthermore, there is some evidence to suggest that experiencing a bereavement in childhood, specifically that of a parent, may impact on attainment in school[12], and increase the risk of unemployment in adulthood[13]. Parental death has also been associated with increased criminality[14].

Reflecting on the above, the evidence clearly highlights the significant impact of bereavement on the emotional wellbeing of children and young people and the consequential risks to their future and society. The need for specialised support for these children and young people and their families is paramount.

3. Becoming an independent organisation

Under the Department of Health's Right-to-request programme, which encourages NHS staff to establish independent social enterprises, CHUMS made its successful bid to become independent from the NHS in 2011. Since that time, the service has continued to expand, developing in response to need and tailoring services according to service-user feedback and audit data, as well as guidance from organisations such as the CBN. Consequently, CHUMS now aims to provide interventions consistent with the tiered approach recommended by CBN[15] while also considering on a case-by-case basis the type of support needed. The interventions we provide are detailed in table 1 on the next page.

4. What informs our interventions?

While we recognise that most children and young people who are bereaved may not need professional support[16], we know that where support is required, it needs to be developmentally appropriate, sensitive to the degree of distress associated with the loss[17], and be delivered in a timely manner[18]. Concerning the latter, studies have shown that often support is offered too late, leading

Table 1: Summary of CHUMS interventions

Intervention type	Description
General Bereavement Support	- Brief individual interventions of 4-6 sessions - Specialised interventions for cases of traumatic loss - Group workshops (child and parent) - Telephone support - On-going groups - Teenage workshops - Residential weekends - Remembrance Services - Training and support to other professionals who may be involved in supporting families who have been bereaved (e.g. school staff, social care) - Training for volunteers
Specialist Services	- Neonatal service: includes an on-going group, brief interventions, and telephone contact - Pre-bereavement service: brief interventions and facilitated transition to the bereavement pathway - Crises Response Service: supporting families following a death by suicide or one that occurred in unexplained circumstance. Service aims to provide practical help in the weeks leading up to inquest, as well as an on-going support group.

to a reduction in the effectiveness of the intervention[19]. Consequently, we aim to ensure that every family referred gets the best possible care within a time frame that meets their needs. However, we have learned that what is meant by a 'timely manner' may differ between families, with some requiring immediate support following a death, while others may not be ready to access support until months, or even years, later. We therefore ensure that families are contacted within a week of CHUMS reviewing their referral, and if appropriate, that we offer an assessment soon after. From there, we acknowledge that the type of support also needs to be in keeping with the family's needs, whether it be individual or group intervention, brief telephone contact, on-going groups, or access to our remembrance services. Thus, we aim to offer support to all bereaved families with the understanding that not all will need it, but that some may come back to it when the time is right. Moreover, as CHUMS offer a wide range of emotional wellbeing services, we

are ideally placed to support children and young people with other difficulties that might prevent them from processing a death. As poor mental health prior to a death is associated with increased difficulty following the bereavement[20] we recognise that some of those who access our service may have additional needs that require targeted interventions in the first instance. As many of our staff work across multiple parts of the service, we are in a position to facilitate continuity of care, helping the young person and their family to feel contained and supported throughout their time with CHUMS. In addition, the bereavement referrals are now considered as part of a Single Point of Entry pathway developed with CAMHS. This has raised the awareness of the needs of bereaved children and young people and provided a greater multiagency approach to cases.

An awareness of the factors that mediate the impact of childhood bereavement on wellbeing informs how we support children and young people and their families. There is much that can be done both at the individual and family level to reduce the likelihood that a CYP might experience long-term difficulties following a bereavement[21]. Concerning the individual level first, studies have demonstrated that the way in which a child and young person makes sense of a death and relates to the loss can have a profound impact on subsequent wellbeing[22]. Consequently, a fundamental role of all our interventions is to provide children and young people with the opportunity to make sense of their loss. Our interventions therefore support children and young people to develop a narrative around the death. Furthermore, in our bereavement workshops children and young people are provided with the opportunity to put questions to a doctor and undertaker, who can in age appropriate ways, help the young person to understand what happens when someone dies.

In addition, we understand that emotional wellbeing following a bereavement is impacted by factors such as poor self-esteem[23] an external locus of control[24] and fewer coping strategies or a belief that coping strategies do not work[25]. Therefore, both our interventions aim to promote self-esteem and develop coping strategies such as decision making, problem solving and other life skills that might reduce distress and increase function.

At the family level, the extent to which a child feels secure[26] and perceives their circumstances as stable[27] can influence wellbeing following a bereavement. Several studies indicate the need for whole family support[28], with Haine and colleagues[29] recommending that bereavement interventions should facilitate positive parent-child communication and relationships, increase parental

warmth and effective discipline, reduce parental distress and increase the opportunity for positive family interactions while reducing the child's exposure to negative events.

With this in mind, we do not support the child in isolation, but aim to involve parents, siblings and extended family in the work that we do; helping other family members to process the loss themselves as well as exploring how they might support the child. Our workshops and remembrance services provide a facilitated space where families may begin to talk more openly about death and foster positive shared experiences. We also encourage families to access other services including adult mental health services where we feel this would benefit the long-term wellbeing of the family. Consequently, CHUMS continually strives to keep up-to-date with locally available services and to make links with other agencies.

Case Study: benefits of inter-agency working

A 13-year-old boy suffered the unexpected and traumatic loss of his sister and step-family. The impact of this devastating event on him and his mother proved to decimate their social network and prevented him from joining his new school at the point of transition. In addition to the personal and family support CHUMS has offered we are also working closely with the medical needs team to ensure he maintains his education and can be integrated back into his school and social network in a graded and structured way. Helping his mum to identify how she could facilitate this with her own gradual return to work has also been a crucial part of the work.

5. Working with the local community

As a social enterprise, a core value of CHUMS is investment in the local community.

CHUMS works with the local community through:

- Providing training for professionals who may work with children and

young people who have experienced death (e.g. school staff, social care, school nurses etc.)

- Consultation and guidance

- Development of volunteers from the local community

- Apprenticeship programmes to promote the continued development of children and young people

- Service user involvement

- Networking and educational events to promote CHUMS and make links with other organisations

The involvement of volunteers is a particular strength of CHUMS, enabling the delivery of a cost-effective service. We currently have over 100 volunteers, many of whom have used our service and so have first-hand experience of the challenges our families face. As members of the local community they provide local knowledge and raise the profile of CHUMS in their area, helping us to reach individuals that might not ordinarily access services. Their diverse backgrounds bring added richness and skills that we are able to employ not only clinically through their support in our workshops and short-term interventions, but in other areas of the service such as fundraising and administration.

Feedback from volunteers, as well as service-users in general, is welcomed. We ask all service-users to complete a feedback form at the end of their intervention, carry out a service user survey annually, and use the Session Rating Scale[30] to get a better understanding of the salient aspects of our interventions. We also have a service-user participation group who contribute to all aspects of the organisation from the development of resources and selection of staff members, down to the look of our clinic rooms and waiting areas. The feedback and involvement of our service-users ensures that all developments hold the best interests of the child at their core.

As we are not the only organisation that are likely to come into contact with children and young people who have experienced death, much of our work in the community aims to provide other professionals with the knowledge and skills to be able to support this client group. For example, we regularly deliver

training around loss and bereavement to staff working in Central Bedfordshire and Bedford Borough schools as part of a comprehensive package designed to promote emotional wellbeing in schools. Moreover, we provide regular consultation sessions for school staff and school nurses to discuss cases and share learning. Studies of school based interventions have produced mixed results[31], however there is support for the notion that it is helpful for staff to be able to acknowledge a death and provide words of encouragement or support[32]. In accordance with these findings, by training school staff to work with bereavement, it is hoped that they may be in a position to support students known to them, allowing the continuity of relationships that are helpful to the children, young people and families.

6. Future development and learning for services

Part of CHUMS' success stems from the fact that we continually seek to improve our services, allowing us to grow, and to learn from our mistakes. Accordingly, we have piloted services in response to perceived need, which proved unsuccessful. The first, an evening helpline, was set up to try to accommodate working families who might be unable to talk during our normal 9-5 hours. However, few families made use of this service and it was discontinued after only a brief period. We also developed a buddy system, whereby volunteers were assigned to families to regularly check-in with them and offer support. Again, very few families engaged in this service. Both these experiences served to remind us that families will only engage in interventions that are meaningful and relevant to them, and often where this is the case, will make contact with us when the time is right.

Looking to the future, we wish to continue to ensure that we provide an effective service. Service-user feedback and outcome data form an important part of this process. However, this in itself is an area for further development. While we excel in obtaining qualitative feedback from our service-users, we have encountered difficulties retrieving quantitative data. In line with the principles of Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) we routinely attempt to monitor outcomes using a range of nationally recognised measures, as well as through the use of measures specific to the challenges faced by bereaved families. However, the response rate for data collection is lower than the national average[33]. In our experience, the timing of data collection is a crucial factor and something which we continue to experiment with to generate higher response rates. It is

intended that over the coming year, we will see an increase in this figure with goal progress charts being brought into every session (where appropriate), and end of therapy measures being completed during the last session of an intervention, rather than being sent to clients to complete. It is hoped that through these steps, we may be able to get a better understanding of the efficacy of our services, informing best practice which we may then share with other services dedicated to supporting CYP who have experienced death.

Finally, we set out the learning points from CHUMS' experience of working with children and young people who have been bereaved, which could be embedded into NHS and children's services.

- Bereavement services must be flexible to the needs of the young person and their family, and be able to provide support in a time frame that is meaningful to them.

- There is a need to provide adequate information addressing any anxieties or questions in an age appropriate way which is respectful of the family's values and beliefs, and informs the development of a coherent narrative about the death including consideration of how to continue to remember their loved one.

- Bereavement services should provide support to the system around the child to ensure everyone can work together to meet the child's needs, with specific emphasis on facilitating a positive parent-child relationship in which families are encouraged to have fun together.

- Bereavement services should make good links with other local agencies to ensure that families get a holistic service where effort is made to provide continuity of care.

- Training volunteers to support the delivery of interventions may ensure the long-term cost-effectiveness of services, while also bringing added richness, a diverse skillset, and promoting the organisation within the local community.

- Services should ask for feedback, both qualitative and quantitative, which may be regularly reviewed and used to revise the interventions available.

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26. Re-thinking family interventions from an ACE perspective

Clare Wightman and Rob McCabe

1. Introduction

Young people in Birmingham are being expelled from schools for exhibiting educational and behavioural issues and are being wrongly placed into special schools and settings for those with Special Educational Needs and Disability (SEND). Many of these children and young people have mental health problems, rather than special educational needs, which arise from the trauma they have experienced at home and in care. In our experience, schools recognise they cannot provide the support these pupils need, because of their focus on educational outcomes, which are driven by a national focus on academic outcomes, also embedded in Ofsted ratings.

A multi-agency pathfinder in Birmingham is aiming to address this problem. Six schools specialising in Social, Emotional and Mental Health (SEMH) and six mainstream schools are offering a new kind of intensive and relational support, wrapped around by a multi-agency team, dedicated to the most troubled pupils, and their families. Results are showing that family members feel more able to disclose the real problems that need resolution. Staff share an understanding of the multiple and complex needs of their clients. As a result, help is reaching families earlier and more quickly, meaning that positive and longer-term relationships create more capacity in families to enable sustained change.

This paper draws on learning from this pathfinder programme in Birmingham to suggest ways of ensuring that family interventions take an approach informed by understandings of Adverse Childhood Experiences (ACEs), and better recognition of the relationships between problematic behaviours, criminality and experiences of individual and inter-generational trauma.

2. The problem

> **Case study**
>
> 'T' (10 years old at the time) heard a thud, when he went downstairs he found his mother who had died instantly. He stayed with his mother's body for about half an hour in which time the children (siblings) became extremely distressed, at one point T 'closed' his mother's eyes because she was staring and this was upsetting his siblings. Doctors had later told T's Grandmother that the impact of his mother's death had in effect caused T to 'shut down' emotionally. Grandmother stated that T has never 'recovered', nor has he cried about his mother's death or allowed anyone to broach the subject in any meaningful way.

The sheer weight of emotions that many students in Birmingham's special schools bear is difficult to comprehend. Research conducted in 2012 and 2014 has shown how violent, traumatic and disturbing experiences like those of T dominate their thoughts and memories, and give rise to the behaviour that has seen them placed into SEMH schooling.

The first of these two reports on the lives of pupils at a school in Birmingham looked at the interaction of pupils with the criminal justice system, the level of risk at schools and the huge financial costs of not providing the right support to these young people. The second report in 2014 left costings aside to detail their real lives. Social service records of pupils and their families were examined, producing an upsetting report showing intergenerational violence, abuse, trauma and the impact on their lives. High levels of exposure to domestic abuse, alcohol or substance misuse, criminality, self-harm, and sexually harmful behaviour were revealed. Retrospective police checks on former pupils painted a picture of escalating offending behaviour, which in some cases led to imprisonment.

For example, currently, there are approximately 800 children in five SEMH schools, 80% of whom (according to Troubled Family Team data) are known to social services. Last year there were 89 convictions from a cohort of less than 500 secondary school age pupils. In May 2016, a fight between two of them resulted in one pupil being stabbed four times. The victim of that attack

meanwhile is serving a custodial sentence for stabbing a female victim in a separate incident committed earlier in the year. In November 2016 a pupil was attacked in school by youths armed with machetes.

Students were typically born into families and communities with entrenched cultures of violence and intimidation, and this had been either witnessed or experienced from an early age. In addition to this, families were contending with severe poverty and disadvantage.

The majority of these pupils' families were well-known to social services, local health services and the criminal justice system in Birmingham. Despite this, there seemingly had been limited success in bringing information, insight and intelligence together to form an understanding of the whole picture of these children's and families' lives until the independent reports.

The pathfinder found that schools recognised they cannot provide the support such pupils need because of their focus on educational outcomes, driven by national policy and Ofsted ratings. They suggested they risked further harming the students by simply "hot housing" together a population of traumatised and reportedly 'unstable' young people. This was exacerbated by schools attempting to contend with restrictions on their funding, resulting in the number of social workers, nurses and classroom assistants being reduced.

To leave the present system unchanged would mean many families continuing to live with significant disadvantage, children exposed to significant levels of adversity and trauma, which would have a wider impact on the levels of violence and crime across Birmingham.

3. Systemic concerns

Analysis from our pathfinder programme, reveals that four core issues seem to be complicating and concealing the problem:

a. lack of understanding of multiple and complex needs (and trauma)

within the education and criminal justice systems. In particular there was no consideration of the wider social context of the poverty, abuse and adversity that underlay young people's behaviour and enactment of criminality. Instead

children, whose behaviour was seen as 'out of control' and at risk of 'becoming criminal', were treated in isolation from their wider family and community experiences. For example, the drivers of a traumatised young person's behaviour resulting from 25 care placement moves were not known or not acknowledged by workers in the care system, only emerging as mitigating factors when a court report was being prepared after the onset of criminal behaviours.

b. lack of meaningful engagement with families

The service and client divide was very pronounced in both the education and criminal justice systems, with little real engagement with families – who primarily were generally not seen as being a capable, or a strong source of solutions.

c. services working in isolation and fragmenting young people's needs

Worryingly, statutory and non-statutory services that might have helped families were disconnected from one another, limiting the depth of response that could be offered to young people. As a result, families reported frequent returns to agencies for short periods of support, that were uninformed by previous interactions, intelligence known about the family's circumstances and knowledge of what events and interventions had gone before. Analysis found that there was no effective way to share, and flag, evidence of young people's and familial involvement, so that professionals could see if levels of adversity or symptomology were escalating.

d. time-limited support from services did not match the complexity of need

Families separate interventions were offered on a relatively short-term basis, compared with the complexity and depth of the adversity, intergenerational trauma and rising concerns involved. Six months was the longest consistent period of intensive family support available, which was felt to be inadequate to ensure recovery and to acquire new resources to support family resilience.

4. The Birmingham pathfinder approach

The Birmingham SEMH Pathfinder Project is a collaborative response to this systemic failure. Six special SEMH schools and six mainstream schools are participating in a new way of working. A new kind of intensive and relational support is provided via a re-worked Pastoral And Learning Support (PALS) role, and wrapped around by a multi-agency team dedicated to the most troubled pupils and their families. That team, located together with PALS, includes dedicated workers from the Department for Work and Pensions, Child and Adolescent Mental Health Services (CAMHS), the Aquarius substance misuse agency, school nurses, a proposed domestic violence and abuse specialist from Birmingham and Solihull's Women's Aid and a proposed specialist in positive masculinity from Call to Men UK.

At the very heart of the approach is the strength and quality of the relationship between all Pathfinder staff (both PALS and Multi Agency staff) and the family. It is a relationship characterised by a desire to understand the adverse experiences, and wider circumstances of a family, and to enable them to use their strengths to overcome barriers affecting their lives. By demonstrating a more Adverse Childhood Experience (ACE) informed collaborative, or 'co-resolve', approach to building stronger families the pathfinder is attempting to re-imagine the 'statutory service-client' relationship.

A Parent's Forum has been established and aims to shift family awareness from 'what's wrong with my child?' to 'what's happened to my family?' and, as confidence grows, to develop a more systemic understanding of the problems they face. Parents produce a manifesto and establish their voice in both the development of the pathfinder and the West Midlands Combined Authority (WMCA) work on those with multiple and complex needs. At this early stage of the programme, it's all about establishing protected time for parents and care-givers, and to give them ample positive regard. Having fun and meeting others with shared and common experience, is an important emotional investment that we see as paying dividends in the future for both the family's development and the longer-term engagement with the programme.

Currently, PALS from pathfinder schools are released for one day per week to work with two families each for as long as needed. They already have a wealth of experience in engaging in a relationship with those who are seen to be 'resistant' and/or 'difficult to reach'.

PALS acts as a conduit between involved agencies and the family, attending

a range of meetings and facilitating interventions and programmes for both pupils and families. The team undergo a raft of training to further develop their skills including an understanding of Psychologically Informed Environments (PIE) and Mental Skills Training. PALS use an ACE-informed assessment tool called My Concern, (likely to soon be replaced by an ACE routine enquiry tool) as they begin their work. The programme will soon adopt assessment software that will help them properly map family support networks and skills. In addition to this, they undergo specialist training so they themselves will be able to offer interventions of mentoring in specialisms such as Sexually Harmful Behaviour, alternative educational approaches, as well as emotional resilience and parenting strategies.

The PALS team members can work with young people in this way throughout their school career, and the pathfinder as a whole can potentially work with families after statutory school involvement. The intention is that maintaining regular contact with young people and families when they leave school will divert young people away from engaging in criminal behaviour as they get trusted help, referrals and supported signposting to housing advice, mental health services, education, training and employment advice.

The multi-agency team wrapped around these PALS have the flexibility to work with all family members, and are released from a single issue or single client focus. Service involvement with a family is being streamlined so that a family has one regular, named worker, rather than many, such as one school nurse or one substance misuse worker per family. As part of its day to day involvement in the team, CAMHS are exploring how it can improve the relationship and flow between its services and families from the pathfinder schools.

This co-location and joint caseload allow all team members to develop a shared understanding of individual and family needs that are multiple and complex. It allows for joint case reviews to be undertaken and most, with the exception of School Nurses, who are NHS staff, are able to use the My Concern system as a way of consolidating information, insight and learning.

5. Emerging impact from the pathfinder

The Birmingham pathfinder model is still forming and learning, and more attention will be paid to underpinning what has been described so far with adversity and trauma-informed practice. That said, the early impact shows that:

- Working together throughout the school life of the student offers families, and professionals, an opportunity for longer-term and more positive relationships. Already we have started to see how this creates more family capacity offering the prospect of sustained change.

- Parents, many of whom tell us of the high turnover of social workers in their lives, are disclosing adverse experiences and difficulties for the first time. They say this is also the first time they have ever felt listened to. The real problems that need resolution can emerge.

- Practical help is reaching families earlier and more quickly than it would otherwise. PALS has been effective in identifying problems early that could have otherwise thrown families into a state of crisis or chaos, and warranted additional statutory involvement. One of the very first pathfinder client assessment visits found that a family had £2,500 of housing arrears, and were at risk of eviction. Pathfinder staff involved the DWP, and now a court process is underway to clear the debt.

- Sustainable impacts are more likely because of a focus on clients rather than on tasks of each individual agency. The staff pathfinder role is open-ended and 'humanistic', with more flexible professional role boundaries.

- Staff are now closer to a shared understanding of the multiple and complex needs of their clients, and the impact of adversity and trauma on their lives.

- PALS, some of whom have worked at schools across two or three generations of the same families, have become more motivated and act as an impassioned and energised resource for families. The pathfinder has given team members much greater levels of investment in their development, clear direction and new responsibilities. It has fully recognised, developed and utilised their expertise and skills in engagement and relationship building.

- As a result of the above, families are reporting that they too feel energised and more confident with the support they are receiving.

6. Building towards system change

The Pathfinder, with statutory partners and the support of Lankelly Chase Foundation, is now planning to bring people from across Birmingham together so that they can decide together what needs to happen at the end of each of its phases, and to build a shared vision for and commitment to system change. Our shared aim is that local systems will have a more strategic awareness for those whose profile indicates that they will have life-long involvement with statutory agencies. This should help produce early and effective ways of responding to their difficulties, circumstances and experiences. Recent West Midlands Combined Authority involvement also allows learning from the Pathfinder to inform the 'Multiple Complex Needs' strand of its 'Public Sector Reform' work, and vice versa.

Conclusion

An agenda for change

27. Addressing adversity — an agenda for change

Sarah Brennan OBE

This collection sets out an ambitious, and implementable, vision for what adversity and trauma-informed care should look like for children and young people in England. *Addressing Adversity* extends the proposals I put forwards as co-Chair of the Vulnerable Groups and Inequalities Task and Finish Group, along with my colleagues who served on the Independent Taskforce that created *Future in Mind*[1].

In the preceding papers, contributors provide a compelling case for addressing the common mental health needs that arise from traumatic and adverse childhood experiences. The evidence cited clearly demonstrates the urgent need to intervene early in order to mitigate and address the impacts of adversity and trauma on children's health, wellbeing and outcomes in adulthood.

We must ensure that the local transformation of children and young people's mental health becomes the impetus for more sustainable models of adversity and trauma-informed support. As the papers in this collection suggest, this can only be achieved by increasing the awareness, knowledge and competence of all workforces who work with children and young people. This is a message we have heard time and time again from the frontline professionals who have attended our YoungMinds workforce training in adversity and trauma-informed practice kindly funded by Health Education England in 2017.

In addition to this, models of provision must aim to increase the understanding and skills of children and young people themselves, as well as those who care for them – be they parents, carers or the State. Building individual, collective and workforce reliance, through adversity and trauma-informed care, enables us to intervene early in emerging problems that otherwise would become lifelong and enduring mental health problems.

It is clear that there will always necessarily be a place for adversity-specific pathways and models of care. That said, all commissioners and providers need

to respond to these children and young people's needs by ensuring they take a holistic view in embedding adversity and trauma-informed pathways and provision in their local area. In this way, Directors of Public Health, local clinical and authority commissioners can make a significant contribution to forwarding this agenda by implementing three urgent actions that would address childhood adversity and trauma in their local area.

As we have noted previously these actions include:

1. making childhood adversity and trauma a **local commissioning priority**.

2. creating a **common identification and enquiry framework** for identifying mental health need.

3. investing in **adversity and trauma-informed models of care**.

3 urgent actions to address childhood adversity and trauma

1. **Making childhood adversity and trauma a local commissioning priority**

2. **Creating a common identification and enquiry framework for identifying mental health need**

3. **Investing in adversity and trauma-informed models of care**

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Annexes

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RESEARCH ARTICLE   **Open Access**

National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England

Mark A Bellis[1,2*], Karen Hughes[1], Nicola Leckenby[3], Clare Perkins[4] and Helen Lowey[5]

Abstract

Background: Epidemiological and biomedical evidence link adverse childhood experiences (ACEs) with health-harming behaviors and the development of non-communicable disease in adults. Investment in interventions to improve early life experiences requires empirical evidence on levels of childhood adversity and the proportion of HHBs potentially avoided should such adversity be addressed.

Methods: A nationally representative survey of English residents aged 18 to 69 (n = 3,885) was undertaken during the period April to July 2013. Individuals were categorized according to the number of ACEs experienced. Modeling identified the proportions of HHBs (early sexual initiation, unintended teenage pregnancy, smoking, binge drinking, drug use, violence victimization, violence perpetration, incarceration, poor diet, low levels of physical exercise) independently associated with ACEs at national population levels.

Results: Almost half (47%) of individuals experienced at least one of the nine ACEs. Prevalence of childhood sexual, physical, and verbal abuse was 6.3%, 14.8%, and 18.2% respectively (population-adjusted). After correcting for sociodemographics, ACE counts predicted all HHBs, e.g. (0 *versus* 4+ ACEs, adjusted odds ratios (95% confidence intervals)): smoking 3.29 (2.54 to 4.27); violence perpetration 7.71 (4.90 to 12.14); unintended teenage pregnancy 5.86 (3.93 to 8.74). Modeling suggested that 11.9% of binge drinking, 13.6% of poor diet, 22.7% of smoking, 52.0% of violence perpetration, 58.7% of heroin/crack cocaine use, and 37.6% of unintended teenage pregnancy prevalence nationally could be attributed to ACEs.

Conclusions: Stable and protective childhoods are critical factors in the development of resilience to health-harming behaviors in England. Interventions to reduce ACEs are available and sustainable, with nurturing childhoods supporting the adoption of health-benefiting behaviors and ultimately the provision of positive childhood environments for future generations.

Keywords: Child abuse, Childhood, Alcohol, Smoking, Violence

Background

Non-communicable diseases (NCDs) have risen to become the greatest contributors to burden of disease globally, accounting for two thirds of all deaths (34.5 million [1]) and 54% of disability adjusted life years (DALYs; 1.3 billion [2]) in 2010. In high-income countries this proportion is typically much higher, reaching 87% in western Europe [3]. Two

of the most common causes of NCDs, alcohol use and tobacco smoking (including second-hand smoke), are now the leading risk factors for burden of disease and injury in 15 to 49-year-olds, and globally attributed to around 800,000 and 565,000 deaths respectively in this age group in 2010 [4]. Obesity and drug use contributed an additional 325,000 and 107,000 deaths, respectively [4]. Thus, at global [5], regional (for example, Europe [6]), and national levels, tackling NCDs and the health-harming behaviors (HHBs) that cause them are health and economic priorities.

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Although HHBs such as drug misuse, smoking, violence, and poor nutrition are apparent in all sectors of society, they are typically more prevalent in the poorest communities [7-9]. However, even in such communities, most individuals in high-income countries do not abuse alcohol, take illicit drugs or smoke, and their diet and exercise regimens remain sufficiently balanced to at least avoid obesity (for example, in England [10]). Equally, although often at a lower prevalence, HHBs are far from absent in more affluent communities. Consequently, although socioeconomic gradients are strong predictors of HHBs, additional factors are required to explain the resilience and susceptibility of individuals to developing HHBs throughout the life course.

Over the past two decades, studies have begun to explore how early life experiences impact on behavior and health during adolescence and adulthood. Adverse childhood experience (ACE) studies show that adult health profiles relate to the abuse individuals experienced during childhood as well as to other childhood stressors such as parental substance misuse, incarceration, and domestic violence [11,12]. The initial ACE study in the USA emerged from work identifying strong relationships between ACEs and adult obesity [13]. Since then, ACEs have been related to increased propensity for substance use (alcohol, tobacco, and drugs), anti-social behavior, and ultimately development of cardiovascular disease, cancer, chronic lung disease, and diabetes [11,12]. Critically, studies have established that the quantity of stressors (that is, the ACE count) is an important predictor of poor behavioral and consequently poor health outcomes over the life course. Moreover, exposure to multiple stressors in childhood is also associated with subsequent unintended pregnancies [14], and being a victim or perpetrator of violence, including intimate partner violence [15]. Together, these sexual and violent behaviors create a mechanism for intergenerational passage of ACEs and their health consequences [16].

Through a range of evidence-based interventions, ACEs are a modifiable factor in children's lives [17]. However, there is currently little understanding of the potential impact of reducing ACEs independent of socioeconomic factors (for example, deprivation) that are also associated with poor health choices and anti-social behavior. Consequently, here we used a national ACE survey to measure levels of ACEs across England, calculated the prevalence of exposure to multiple ACE counts, and examined the relationships between ACE exposure and HHBs. After accounting for deprivation and other demographic effects, we modeled the impact of reduced ACE prevalence on resilience to HHBs. We considered how supportive childhoods allow individuals to resist the commercial, cultural, and environmental pressures that promote substance use, obesity, and anti-social behavior throughout the life course.

Methods

A national household survey of adults resident in England was undertaken between April and July 2013. Ethical approval was obtained from Liverpool John Moores University and the study adhered to the Declaration of Helsinki.

The study used an established survey tool [16] that includes questions on participant demographics, ACEs, and HHBs. ACE questions used the Centers for Disease Control and Prevention short ACE tool, which forms part of the US Behavioral Risk Factor Surveillance System [18]. The tool includes 11 questions on different childhood exposures to abuse and family dysfunction. These form nine distinct categories of ACE covering: physical, verbal, and sexual abuse; parental separation; exposure to domestic violence; and growing up in a household with mental illness, alcohol abuse, drug abuse, or incarceration (Table 1). The HHB outcomes examined in this study were: early sexual initiation (<16 years); unintended teenage pregnancy (<18 years); daily smoking; binge drinking; cannabis use (lifetime); heroin or crack cocaine use (lifetime); violence perpetration (past year); violence victimization (past year); incarceration; poor diet; and low levels of physical exercise (see Table 2). Although other HHBs, such as suicide attempt [11], have also been strongly linked to ACEs, our pilot survey [16] identified increased questionnaire length as detrimental to compliance, and therefore not every HHB could be included.

Questionnaires were completed by participants in their places of residence, under the instruction of a professional survey company directed by the research team. All sampled households were sent a letter providing study information and the opportunity to opt prior to the surveyor visiting. At the door, surveyors again explained the study and its voluntary and anonymous nature, and provided a second opportunity for individuals to opt out. Participants were offered the choice of completing the questionnaire through a face-to-face interview using a hand-held computer (with sensitive questions self-completed; n = 3,852), or to self-complete using paper questionnaires (n = 158). The questionnaire took an average of 13 minutes to complete.

Sample selection

A target sample size of 4,000 was based on ACE prevalence identified in a pilot study [16]. Sampling used a random probability approach stratified first by region (n = 10, with inner and outer London treated as two regions) and then small area deprivation in order to provide a sample representative of the English population. Samples for each region were proportionate to their population. Within each region, lower super output areas (LSOAs; geographical areas with a population mean of 1,500 [19]) were categorized into deprivation deciles based on their ranking in the 2010 Index of Multiple Deprivation (IMD; a composite

Table 1 Adverse Childhood Experiences (ACEs)

All ACE questions were preceded by the statement "While you were growing up, before the age of 18…" Responses listed are those categorized here as an ACE.

ACE	Question	Response
Parental separation	Were your parents ever separated or divorced?	Yes
Domestic violence	How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?	Once or more than once
Physical abuse	How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? This does not include gentle smacking for punishment	Once or more than once
Verbal abuse	How often did a parent or adult in your home ever swear at you, insult you, or put you down?	More than once
Sexual abuse	How often did anyone at least 5 years older than you (including adults) ever touch you sexually?	Once or more than once to any of the three questions
	How often did anyone at least 5 years older than you (including adults) try to make you touch them sexually?	
	How often did anyone at least 5 years older than you (including adults) force you to have any type of sexual intercourse (oral, anal, or vaginal)?	
Mental illness	Did you live with anyone who was depressed, mentally ill, or suicidal?	Yes
Alcohol abuse	Did you live with anyone who was a problem drinker or alcoholic?	Yes
Drug abuse	Did you live with anyone who used illegal street drugs or who abused prescription medications?	Yes
Incarceration	Did you live with anyone who served time or was sentenced to serve time in a prison or young offenders' institution?	Yes

measure including 38 indicators relating to economic, social, and housing issues [20]). Two LSOAs were randomly selected from each deprivation decile in each region for sampling (n = 200 LSOAs). Within each sampled LSOA, between 40 and 120 addresses were randomly selected from the Postcode Address File[*], with 16,000 households initially sampled to allow for non-response, ineligibility, and non-compliance.

Of all sampled households, 771 (4.8%) opted out following receipt of the study letter. Household visits were made on all days of the week and between the hours of 09.30 and 20.30 hours. At least three attempted visits at differing days/times were made before an address was removed, with sampling completed once the target sample size was achieved.

Inclusion criteria for the study were: residence in a selected LSOA; age 18 to 69 years; and cognitive ability to participate in a face-to-face interview. A total of 9,852 households were visited, of which 7,773 were occupied. Of the occupied households, 2,719 (35.0%) opted out, 1,044

Table 2 Outcome variables

Outcome	Question (text in brackets is the response indicating behavior)
Unintended teenage pregnancy	Did you ever accidentally get pregnant or accidentally get someone else pregnant before you were aged 18 years? (*Yes*)
Early sexual initiation	How old were you the first time you had sexual intercourse? (*<16 years*)
Smoking	In terms of smoking tobacco, which of the following best describes you? (*I smoke daily*)
Binge drinking	How often do you have 6 or more standard drinks on one occasion (*Weekly or daily or almost daily*)[a]
Cannabis use	How often, if ever, have you taken the following drugs…cannabis? (*any level of use*)
Heroin/crack cocaine use	How often, if ever, have you taken the following drugs… heroin/crack cocaine? (*Any level of use*)
Violence perpetration	How many times have you physically hit someone in the past 12 months? (*Any frequency*)
Violence victimization	How many times have you been physically hit in the past 12 months? (*Any frequency*)
Incarceration	How many nights have you ever spent in prison, in jail or in a police station? (*Any number of nights*)
Poor diet	On a normal day, how many portions of fruit and vegetables (excluding potatoes) would you usually eat (one portion is roughly one handful or a full piece of fruit such as an apple)? (*<2 portions*)
Low physical activity	Usually, how many days each week do you take part in at least 30 minutes of physical activity that makes you breathe quicker, like walking quickly, cycling, sports or exercise? (*<3 days*)

[a]Questions on alcohol consumption were drawn from the AUDIT C tool, and participants were provided with information on what constitutes a standard drink (UK = 10 mg of alcohol).

(13.4%) were ineligible, and 4,010 completed a study questionnaire. Thus, compliance was 59.6% across eligible occupied households visited, and 53.5% including those opting out at the letter stage.

Statistical analysis

All analyses were undertaken using PASW Statistics v18. Only individuals with complete data relating to all ACEs, age, sex, ethnicity, and IMD quintile were included in the analysis, yielding a final sample size of 3,885. Although ethnicity was initially collected through self-identified UK Census categories, these were combined into White, Asian and Other because of the small numbers within individual ethnic groups (Table 3). Where individuals did not answer all relevant questions, adjusted sample sizes are presented in the tables.

Owing to highly significant correlations between all ACE types (see Additional file 1: Table S1), and consistent with ACE study methodology elsewhere [11,12], ACE counts were calculated for all individuals as a proxy for severity of childhood adversity and classified into four

Table 3 Sample demographics and comparison with the English national population[a]

	Sample		Population		χ^2	P
	n	%	n	%		
Age, years						
18 to 29	815	21.0	8623299	24.2		
30 to 39	772	19.9	7051522	19.8		
40 to 49	795	20.5	7773559	21.8		
50 to 59	699	18.0	6426080	18.1		
60 to 69	804	20.7	5719911	16.1	72.016	<0.001
Sex						
Male	1749	45.0	17685329	49.7		
Female	2136	55.0	17909042	50.3	33.837	<0.001
Ethnicity						
White[b]	3354	86.3	30499391	85.7		
Asian[c]	308	7.9	2912044	8.2		
Other[d]	223	5.7	2182936	6.1	1.471	0.479
Deprivation quintile						
1[e]	782	20.1	7149675	20.1		
2	758	19.5	7305972	20.5		
3	766	19.7	7199331	20.2		
4	773	19.9	7054694	19.8		
5	806	20.7	6884699	19.3	6.423	0.170

[a]Population data obtained from Office for National Statistics, Lower Super Output Area population estimates mid-2012 [21].
[b]Including White British, White Irish, White Gypsy or Irish Traveller, White Other.
[c]Including Indian, Pakistani, Bangladeshi, Chinese, Other Asian.
[d]Including Mixed/Multiple ethnic group, Black/African/Caribbean/Black British, Other ethnic group.
[e]From 1 (least deprived) to 5 (most deprived).

retrospective cohorts (0 ACEs, n = 2,084; 1 ACE, n = 881; 2–3 ACEs, n = 597; 4 + ACES, n = 323). Bivariate analyses used χ^2 tests with conditional binary logistic regression (LR) to examine independent relationships between ACE counts and HHBs of interest. Best-fit LR model parameters were used to calculate the numbers and proportions of each HHBs relating specifically to ACE count. Thus, for each HHB, model parameters for age, sex, ethnicity, and deprivation were applied to national and sample populations with ACE count parameters set to the observed values, and then with ACE count parameters set to zero ACEs.

Results

The sample was not significantly different from the overall English population for either deprivation or ethnicity. However, the ACE sample had an over-representation of females and included a higher proportion of individuals in the age category 60 to 69 years, with a corresponding underrepresentation of those aged 18 to 29 years (Table 3). Individual ACEs ranged in prevalence from 3.9% with a drug-using household member during their childhood to 22.6% experiencing parental separation or divorce. After correction to national population demographics, these prevalences increased to 4.1% and 24.3% respectively. Overall, 46.4% of the sample had experienced at least one ACE (population-adjusted 47.9%; Table 4). Higher ACE counts were associated with deprivation, and were lower in Asian ethnicity populations, males, and the oldest age group. In childhood, living with a drug user, parental separation, having a household member incarcerated, and living with an alcohol abuser all increased in prevalence with deprivation and reduced with increasing age (Table 4). Experience of physical abuse, verbal abuse, or domestic violence within the childhood household was also highest in the most deprived quintiles. For all ACEs, Asian ethnicity had the lowest prevalence while 'Other' ethnicity had the highest prevalence for each ACE except living with a household member with mental illness or alcohol abuse. Differences by ethnicity did not reach significance for any ACE type. Variations in prevalence of ACE types by gender were significant for childhood sexual and verbal abuse and having a household member with mental illness or alcohol abuse, with the prevalence being higher in females.

In bivariate analysis, the prevalence of all HHBs except low levels of physical exercise increased with ACE count (Table 5). Thus, prevalence of having had or caused unintended teenage pregnancy and all violence and criminal justice outcomes (violence perpetration, violence victimization, incarceration) was more than five times higher in those with 4+ ACEs (versus those with none). All HHBs except binge drinking were also associated with deprivation; for example, prevalence of early sexual initiation increased from 12.0% in the least deprived

Table 4 Bivariate relationships between participant demographics, individual ACEs and ACE count

| | Individual ACEs | | | | | | | | | ACE count | | | |
| | Parental separation | Childhood abuse | | | Household member | | | | | 0 | 1 | 2 to 3 | 4+ |
		Verbal	Physical	Sexual	Mental illness	Domestic violence	Alcohol abuse	Incarceration	Drug abuse				
Prevalence, %	22.6	17.3	14.3	6.2	12.1	12.1	9.1	4.1	3.9	53.6	22.7	15.4	8.3
Age, years													
18 to 29	34.6	17.4	11.4	4.8	13.1	10.2	10.1	6.7	6.1	47.2	25.0	19.1	8.6
30 to3 9	25.1	18.9	14.6	6.0	12.7	14.0	11.3	5.8	6.3	52.8	21.8	14.2	11.1
40 to 49	25.9	19.5	15.6	7.2	13.0	14.2	10.4	3.9	3.9	51.1	23.6	14.6	10.7
50 to 59	16.6	17.3	16.7	7.4	11.6	12.6	8.3	2.7	2.1	58.2	19.3	14.2	8.3
60 to 69	10.1	13.4	13.7	5.6	10.1	9.7	5.3	1.2	1.0	59.5	23.1	14.4	3.0
χ^2	161.302	12.498	10.329	6.548	4.889	13.253	21.283	41.206	46.586	71.239			
P	<0.001	0.014	0.035	0.162	0.299	0.010	<0.001	<0.001	<0.001	<0.001			
Sex													
Male	21.4	15.8	14.9	4.5	10.0	11.5	7.9	3.7	3.8	54.3	23.8	15.0	6.9
Female	23.6	18.5	13.9	7.5	13.8	12.6	10.0	4.4	4.0	53.1	21.8	15.6	9.5
χ^2	2.802	5.116	0.888	14.729	13.093	1.097	4.994	1.355	0.097	9.628			
P	0.094	0.024	0.346	<0.001	<0.001	0.295	0.025	0.244	0.755	0.022			
Deprivation quintile[a]													
1	16.8	12.7	10.4	5.1	10.6	8.3	5.2	1.4	1.8	59.1	24.9	11.6	4.3
2	21.8	17.2	13.6	5.3	11.5	12.8	9.1	3.3	3.4	52.5	25.1	14.8	7.7
3	22.5	15.5	14.2	5.2	12.9	11.2	8.4	3.0	3.1	54.2	23.1	15.9	6.8
4	24.3	18.4	14.9	7.6	11.3	12.3	10.1	5.8	5.4	53.8	18.9	17.3	10.0
(most deprived) 5	27.7	22.6	18.5	7.4	14.1	15.8	12.5	6.7	5.8	48.8	21.5	17.1	12.7
χ^2	28.715	29.779	21.916	8.875	6.075	21.608	27.001	37.976	23.569	66.372			
P	<0.001	<0.001	<0.001	0.064	0.194	<0.001	<0.001	<0.001	<0.001	<0.001			
Ethnicity													
White	23.9	17.7	13.9	6.4	12.6	11.9	9.5	3.9	3.9	52.1	23.9	15.7	8.3
Asian	5.5	10.4	12.7	3.2	7.1	11.7	5.8	2.9	2.9	70.1	14.6	10.1	5.2
Other	26.5	20.2	22.9	7.2	11.2	15.2	8.1	8.1	5.8	54.7	14.8	18.4	12.1
χ^2	56.670	12.028	14.390	5.136	8.109	2.221	4.738	10.425	2.959	49.138			
P	<0.001	0.002	0.001	0.077	0.017	0.329	0.094	0.005	0.228	<0.001			
Adjusted ACE prevalence[b]	24.3	18.2	14.8	6.3	12.0	13.1	9.7	4.3	4.1	52.1	22.8	16.1	9.0

Abbreviations: ACE adverse childhood experience.
[a]From 1 (least deprived) to 5 (most deprived).
[b]Adjusted to English national population by age, sex, ethnicity and deprivation quintile of residence. Sources for population data: Office for National Statistics Lower Super Output Area population estimates mid-2012, [21] and 2011 Census [22].

quintile to 22.3% in the most deprived, and prevalence of smoking increased from 12.9% to 38.1%, respectively (see Additional file 1: Table S2). After using LR models to account for the confounding effects of deprivation and other demographics, odds of all HHBs except low physical exercise were significantly higher in those with 4+ or 2 to 3 ACEs (versus none). Having one ACE (versus none) was associated with a significant increase in unintended teenage pregnancy, early sexual initiation, binge drinking, cannabis use, violence perpetration, violence victimization, and incarceration (Table 6). The impact of deprivation remained significant for unintended teenage pregnancy, early sexual initiation, smoking, binge drinking, incarceration, poor diet, and low exercise levels after accounting for relationships with ACE counts.

For each HHB, the best-fit LR models were used to calculate expected HHB prevalence in the sample and national population if no ACEs were experienced. Although causality could not be established in this study, modeling estimated that nationally 13.6% of poor diet and up to 58.7% of heroin or crack cocaine use is related to ACEs. ACEs also accounted for approximately half of all

Table 5 Bivariate association between health-harming behaviors and ACE count

Outcome	All		ACE count, %				X^2_{trend}	P
	%	n	0	1	2 to 3	4+		
Sexual behavior								
Unintended teenage pregnancy (<18 years)	5.5	3836	2.9	5.6	8.3	17.0	106.097	<0.001
Early sexual initiation (<16 years)	16.8	3374	10.0	19.4	23.0	37.8	164.629	<0.001
Substance use								
Smoking (current)	22.7	3885	17.7	21.8	28.3	46.4	127.022	<0.001
Binge drinking (current)	11.3	3885	9.3	13.2	12.6	16.7	18.579	<0.001
Cannabis use (lifetime)	19.5	3878	12.2	21.5	27.0	47.7	241.570	<0.001
Heroin or crack cocaine use (lifetime)	2.2	3882	0.9	1.5	4.0	9.0	84.106	<0.001
Violence and criminal justice								
Violence victimization (past year)	5.3	3883	2.4	4.2	10.7	16.1	137.578	<0.001
Violence perpetration (past year)	4.4	3884	2.0	3.6	8.7	13.9	119.609	<0.001
Incarceration (lifetime)	7.1	3879	3.1	8.1	10.2	24.5	182.58	<0.001
Diet, weight and exercise								
Poor diet (current)	15.6	3879	13.3	15.9	18.3	25.1	31.679	<0.001
Low physical exercise (current)	43.0	3881	44.1	41.4	41.2	42.7	1.434	0.231

Abbreviations: ACE adverse childhood experience.

individuals experiencing violence in the past year, either as a perpetrator or a victim. At a national population level, this would account for over a million individuals being assaulted and just under 900,000 assaulting someone else at least once in the past 12 months (Table 7). Similarly, modeling suggested that nationally 37.6% of individuals who have experienced an unintended pregnancy before the age of 18 years (equivalent to 826,352 individuals) could be accounted for by ACEs.

Discussion

Results suggest that nearly half of all individuals in England are exposed to at least one adverse experience during childhood, and 9% experience four or more ACEs (Table 4). ACEs and HHBs were both associated with deprivation. Thus, four or more ACEs were reported by 4.3% of individuals in the most affluent quintile, rising to 12.7% of those in the most deprived. Equally, all HHBs, with the expected exception of binge drinking [23] increased with deprivation. However, we identified a strong relationship between ACEs and HHBs, independent of deprivation (Table 6). Modeling suggested that ACEs contributed to as many as one in six individuals smoking and one in seven with poor diet and binge drinking (Table 7). Links between such behaviors and childhood circumstances are likely to operate through the impact of ACEs on the developing brain. Thus, early life trauma can lead to structural and functional changes in the brain and its stress regulatory systems, which affect factors such as emotional regulation and fear response, and this may predispose individuals to HHBs [24]. Consequently, the impact of

ACEs on engagement in anti-social behavior and problematic drug use appears particularly marked. Over half of cases of violence perpetration, violence victimization, incarceration, and heroin/crack cocaine use could be explained by ACEs. These HHBs represent major health, social, and economic burdens across communities, and when expressed in family environments mean subsequent generations are exposed to ACEs. Moreover, we found that ACEs accounted for around a third of individuals reporting early sexual initiation and unintended teenage pregnancy. Such pregnancies can mean that individuals are born into settings typically less prepared for the needs of children, with fewer resources for child-rearing, poorer parenting skills, and consequently greater opportunity for child abuse [25], again ensuring intergenerational transmission of ACEs and related harms.

Although the ACE methodology has been refined and extensively tested [26], it remains prone to issues associated with any cross-sectional study. Results rely on accurate recall and willingness to report ACEs even after assurances of anonymity. In older individuals especially, recollection of childhood issues may be limited, although studies elsewhere suggest that false-positive reports are rare [27]. Moreover, although prospective studies may allow more immediate recording of ACEs, they are ethically problematic if identification of ACEs in children does not lead to intervention [28]. Further, our measures of ACEs are in part subjective, with individuals having to self-identify childhood abuse and other stressors relating to household members (for example, mental health problems). However, despite definitional differences, independent comparable measures of ACEs for England are relatively consistent

Table 6 AORs for health risk behaviors in ACE count groups

Outcome	n	ACE Count (reference category 0 ACEs)							Demographic factors			
		P	1	*P*	2 to 3	*P*	4+	*P*	Ethnicity	Age	Sex	IMD
			AOR (95% CI)		AOR (95% CI)		AOR (95% CI)					
Sexual behavior												
Unintended teenage pregnancy (<18 years)[a]	3836	<0.001	1.95 (1.32 to 2.89)	<0.01	2.72 (1.83 to 4.04)	<0.001	5.86 (3.93 to 8.74)	<0.001	<0.05	ns	<0.001	<0.001
Early sexual initiation (<16 years)	3374	<0.001	1.93 (1.52 to 2.47)	<0.001	2.39 (1.83 to 3.10)	<0.001	4.77 (3.56 to 6.39)	<0.001	<0.001	<0.001	<0.001	<0.001
Substance use												
Smoking (current)	3885	<0.001	1.20 (0.98 to 1.47)	ns	1.64 (1.32 to 2.04)	<0.001	3.29 (2.54 to 4.27)	<0.001	<0.001	<0.001	<0.001	<0.001
Binge drinking (current)	3885	<0.001	1.36 (1.05 to 1.75)	<0.05	1.34 (1.00 to 1.80)	<0.05	2.08 (1.47 to 2.94)	<0.001	<0.001	<0.01	<0.001	<0.05
Cannabis use (lifetime)	3878	<0.001	1.80 (1.45 to 2.23)	<0.001	2.53 (2.01 to 3.20)	<0.001	6.20 (4.74 to 8.12)	<0.001	<0.001	<0.001	<0.001	ns
Heroin or crack cocaine use (lifetime)	3882	<0.001	1.58 (0.77 to 3.26)	ns	4.79 (2.55 to 8.97)	<0.001	10.88 (5.86 to 20.18)	<0.001	ns	<0.001	<0.001	ns
Violence and criminal justice												
Violence victimization (past year)	3883	<0.001	1.60 (1.04 to 2.48)	<0.05	4.42 (3.00 to 6.51)	<0.001	7.48 (4.92 to 11.38)	<0.001	ns	<0.001	<0.001	ns
Violence perpetration (past year)	3884	<0.001	1.71 (1.06 to 2.75)	<0.05	4.30 (2.80 to 6.59)	<0.001	7.71 (4.90 to 12.14)	<0.001	ns	<0.001	<0.001	ns
Incarceration (lifetime)	3879	<0.001	2.63 (1.84 to 3.77)	<0.001	3.65 (2.50 to 5.33)	<0.001	11.34 (7.67 to 16.75)	<0.001	<0.05	<0.05	<0.001	<0.001
Diet, weight and exercise												
Poor diet (current)	3879	<0.001	1.23 (0.99 to 1.54)	ns	1.38 (1.08 to 1.77)	<0.05	2.00 (1.49 to 2.67)	<0.001	ns	<0.01	<0.001	<0.001
Low physical exercise (current)	3881	ns							<0.05	<0.001	<0.01	<0.01

Abbreviations: ACE adverse childhood experience; AOR adjusted odds ratios; IMD Index of Multiple Deprivation; NS not significant.
[a]Accidentally got pregnant (females) or got someone else pregnant (males).

Table 7 Modeled impact of preventing ACEs at sample and national population levels on health-harming behaviors[a]

Outcome	Sample						Adjusted to national population					
	Current prevalence		Estimate with 0 ACEs		% change	Number saved	Current prevalence		Estimate with 0 ACEs		% change	Number saved
	%	n	%	n			%	n	%	n		
Sexual behavior												
Unintended teenage pregnancy (<18 years)	5.4	211	3.0	117	−44.5	94	6.2	2199164	3.9	1372812	−37.6	826352
Early sexual initiation (<16 years)	14.6	566	9.4	363	−35.9	203	16.4	5821047	10.9	3870314	−33.5	1950733
Substance use												
Smoking (current)	22.7	880	18.7	727	−17.4	153	22.7	8075185	18.9	6742668	−16.5	1332517
Binge drinking (current)	11.3	439	9.6	371	−15.5	68	11.9	4226450	10.1	3581091	−15.3	645359
Cannabis use (lifetime)	19.5	757	12.9	500	−33.9	257	20.8	7392259	13.9	4945099	−33.1	2447160
Heroin or crack cocaine use (lifetime)	2.2	84	0.9	35	−58.3	49	2.4	861075	1.0	355251	−58.7	505823
Violence and criminal justice												
Violence victimization (past year)	5.3	204	2.6	100	−51.0	104	5.8	2061912	2.9	1018287	−50.6	1043626
Violence perpetration (past year)	4.4	170	2.1	81	−52.4	89	4.8	1708728	2.3	820709	−52.0	888019
Incarceration (lifetime)	7.1	276	3.3	126	−54.3	150	7.5	2683464	3.5	1259175	−53.1	1424289
Diet, weight, and exercise												
Poor diet (current)	15.6	606	13.5	525	−13.4	81	16.1	5712524	13.9	4933592	−13.6	778932
Low physical exercise (current)	42.9	1667	NC[b]	NC[b]								

Abbreviations: ACE adverse childhood experience; NC not calculated.
[a]See Methods section for details of modeling.
[b]Not calculated as model identified no independent impact of ACEs.

with this study. Thus, point estimates from national surveys have suggested that 5.9% of children in England live with an adult who is a dependent drinker, 2.8% with an adult who is drug-dependent, and 7.8% with an adult with a mental health problem [29]. Our estimates for exposure to these ACEs at any stage in childhood were marginally higher, at 9.7% for alcohol abuse, 4.1% for drug abuse, and 12.0% for mental illness. Our sample size (n = 3,885) and compliance (59.6% at the door and 53.5% including households withdrawing at the letter stage) were also comparable with other major national surveys (for example, British Social Attitudes Survey 2012, n = 3,248, compliance 53% [30]; Adult Psychiatric Morbidity Survey 2007, n = 7,353, compliance 57% [31]). Finally, although many individuals stated time constraints as their reason for non-participation, we could not measure whether ACEs or HHBs were of a different prevalence or displayed different relationships in non-participants.

In England and elsewhere, attempts to reduce financial and other inequities relating to NCDs have met with limited success [32]. Equally, calls to limit the promotion and sale of alcohol, unhealthy foods, and to a lesser extent, tobacco, are routinely blocked by industry [33]. However, resistance to commercial, cultural, and other environmental pressures to adopt HHBs appears to be related to childhood stressors, with nurturing, ACE-free childhoods increasing personal resilience [34]. There is a range of evidence-based interventions already available to improve parenting and support child development (for example, home visiting programs, parenting programs, social development programs). Many of these interventions have been developed and tested in North America, where they have reduced ACEs, increased child pro-social behavior, prevented HHBs, and been identified as cost-effective [17,35-37]. The evidence base is also developing for their use in the UK and elsewhere in Europe [17]. Thus, the relationship between child adversity, HHBs, and poor health and social outcomes identified here provides a compelling case for investing at scale in parental well-being, parenting skills, and coordinated health, education, and criminal justice services to prevent and identify child maltreatment. Moreover, measuring the benefits of such investments on such a multi-disciplinary basis strengthens the economic case for investment, with total savings potentially exceeding program costs within a year [38]. Critically, investing in parenting should be seen as a sustainable intervention that has the potential to break cycles of adversity, with positive parenting practices likely to be passed down through generations once established.

Conclusions

Emerging international literature is beginning to describe consistent impacts of ACEs on behavior and both physical and mental health outcomes across a variety of nations [16,17,39]. However, empirical evidence on prevention is more limited, largely to the USA [17]. A better

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understanding of the potential impact of integrated, large-scale interventions is required in countries where universal health systems already support all parents and prospective parents. Thus, brief motivational parenting interventions communicating the benefits of warm and consistent parenting are largely untested, despite the success of such approaches in other areas [40]. Neurobiological studies have already identified changes to the hippocampus and prefrontal cortex associated with ACEs, while epigenetic studies are exposing gene-environment interactions with negative health consequences once exposed to stressors [24]. Consequently, a joint research agenda between epidemiological and other sciences is required to identify the points in a child's development at which interventions to prevent ACEs are most important and when their impacts are largely immutable. Moreover, from a policy perspective, child health is typically considered to begin from conception. However, positive parenting outcomes are also impacted by spacing between siblings [41]. Further examination is required of how contraceptive and maternity services can better assist especially vulnerable parents with family planning. Moreover, although policies providing financial and other support for deprived parents are critical, their impact on decisions to conceive, reductions in child spacing, and consequently ACEs requires urgent attention [42]. Finally, measures to reduce other drivers of domestic violence and child maltreatment such as alcohol and drug use are also likely reduce childhood adversity. Although ACEs are linked with deprivation, they are by no means limited to poor communities, and consequently ACE prevention activities should be both universal and proportionate to need. Our results demonstrate that the absence of ACEs is linked with resilience to commercial and cultural pressures to binge drink, smoke, abuse drugs, adopt poor diets, engage in early and unprotected sex, and become involved in violent and criminal behavior. The importance of addressing ACEs is often hidden, along with the voices of the children affected. However, exposing the levels of ACEs experienced even in a developed country like England and investing more in their prevention makes both ethical and economic sense.

Additional file

Additional file 1: Table S1. Changes in odds of reporting any specific adverse childhood experience (ACE) with experiencing any other ACE. **Table S2.** Bivariate association between health-harming behaviours and deprivation quintile of residence.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

MAB designed the study, analyzed the data, and wrote the manuscript. KH contributed to study design, coordination, data analysis, and manuscript

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Relationships between adverse childhood experiences and adult mental well-being: results from an English national household survey

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Abstract

Background: Individuals' childhood experiences can strongly influence their future health and well-being. Adverse childhood experiences (ACEs) such as abuse and dysfunctional home environments show strong cumulative relationships with physical and mental illness yet less is known about their effects on mental well-being in the general population.

Methods: A nationally representative household survey of English adults ($n = 3,885$) measuring current mental well-being (Short Edinburgh-Warwick Mental Well-being Scale SWEMWBS) and life satisfaction and retrospective exposure to nine ACEs.

Results: Almost half of participants (46.4 %) had suffered at least one ACE and 8.3 % had suffered four or more. Adjusted odds ratios (AORs) for low life satisfaction and low mental well-being increased with the number of ACEs. AORs for low ratings of all individual SWEMWBS components also increased with ACE count, particularly never or rarely feeling close to others. Of individual ACEs, growing up in a household affected by mental illness and suffering sexual abuse had the most relationships with markers of mental well-being.

Conclusions: Childhood adversity has a strong cumulative relationship with adult mental well-being. Comprehensive mental health strategies should incorporate interventions to prevent ACEs and moderate their impacts from the very earliest stages of life.

Keywords: Adverse childhood experiences, Child maltreatment, Mental well-being, Life satisfaction, Prevention

Background

Individuals' childhood experiences are of paramount importance in determining their future outcomes. Research exposing the harmful effects that childhood adversity has on adult physical and mental health has advanced significantly over the past few decades. For instance, the Adverse Childhood Experiences (ACE) framework has provided a mechanism for retrospectively measuring childhood adversities and identifying their impact on health in later life [1]. ACEs include child maltreatment (e.g. physical, sexual and verbal abuse) and broader

experiences of household dysfunction, such as witnessing violence in the home, parental separation and growing up in a household affected by substance misuse, mental illness or criminal behaviour. Studies show a dose-responsive relationship between ACEs and poor outcomes, with the more ACEs a person suffers the greater their risks of developing health harming behaviours (e.g. substance misuse, risky sexual behaviour), suffering poor adult health (e.g. obesity, cancer, heart disease) and ultimately premature mortality [1–6].

Much research on the long-term impacts of ACEs has focused on their relationships with mental illness. Thus, studies have found increasing numbers of ACEs to be associated with increasing risks of conditions including depression, anxiety, panic reactions, hallucinations,

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psychosis and suicide attempt, along with overall psycho-pathology, psychotropic medication use and treatment for mental disorders [2, 3, 7–11]. However the literature on the impact of ACEs on broader measures of mental health and well-being is less extensive. While definitions vary [12], mental well-being is widely recognised as being more than just the absence of mental illness; incorporating aspects of mental functioning, feelings and behaviours and having been simply described as feeling good and functioning well [13]. Positive mental well-being has been associated with better physical and mental health and reduced mortality in both healthy and ill populations [14, 15]. Correspondingly, the promotion of mental well-being has become a public and mental health priority both globally and in countries such as the UK [16, 17].

Understanding how different factors impede mental well-being in adults is imperative to investing effectively and efficiently in its promotion. With little longitudinal data available, considerable focus has been placed on the associations between current conditions (e.g. social relationships, residential deprivation, physical exercise, health status) and mental well-being rather than longer-term drivers. However, a US study using the ACE framework found a cumulative relationship between childhood adversity and markers of mental well-being in the general population, including mentally healthy days and life satisfaction [18]. In England, we conducted a pilot ACE study in a local administrative area which found increased odds of low life satisfaction and low mental well-being in adults with increased ACEs [19]. Following this pilot, we undertook a national ACE study of adults across England that included validated measurements of mental well-being and life satisfaction. Here we explore relationships between levels of exposure to adversity during childhood and current mental well-being in adults. Finally, we discuss the convergence between the roots of poor physical health and poor mental well-being in early years and consequently, how poor mental well-being in one generation may adversely impact well-being in the next.

Methods

A target sample size of 4,000 adult residents of England was established based on the prevalence of ACEs identified in the pilot study [19]. Study inclusion criteria were: aged 18–69 years; resident in a selected LSOA; and cognitively able to participate in a face-to-face interview. Households were selected through random probability sampling stratified by English region ($n = 10$, with inner and outer London treated as two regions) and then by small area deprivation using lower super output areas (LSOAs; geographic areas with a population mean of 1,500) [20]. Within each region, LSOAs were categorised into deciles of deprivation based on their ranking in the 2010 Index of Multiple Deprivation (IMD; a composite measure including 38 indicators relating to economic, social and housing issues) [21]. Two LSOAs were then randomly selected from each decile in each region and for each LSOA between 40 and 120 addresses were randomly selected for inclusion from the Postcode Address File*. Sample sizes in each region were proportionate to their population to provide a sample representative of the English population, with a total of 16,000 households initially sampled to account for ineligibility, non-response and non-compliance.

Sampled households were sent a letter prior to researchers visiting providing information on the study and the opportunity to opt out; 771 (4.8 %) households opted out at this stage. Operating under the direction of the research team, a professional survey company visited households on differing days/times (seven days a week, 9:30 am to 8.30 pm) between April and July 2013. The protocol employed by the survey company was to remove households after four attempted visits with no contact. Where contact was made and more than one household member met the inclusion criteria, the eligible resident with the next birthday was selected for interview. Interviewers explained the purpose of the study, outlined its voluntary and anonymous nature and provided a second opportunity for individuals to opt out, with informed consent obtained verbally at the point of interview. Household visits ceased once the target sample size was achieved. Thus, 9,852 of the sampled households were visited of which 7,773 resulted in contact with a resident. Of these households, 2,719 (35.0 %) opted out, 1,044 (13.4 %) were ineligible and 4,010 completed a study questionnaire. Compliance was 59.6 % across eligible occupied households visited and 53.5 % when including those opting out at the letter stage.

The study used an established questionnaire covering demographics, lifestyle behaviours, health status, mental well-being, life satisfaction and exposure to ACEs before the age of 18 [19]. Participants were able to complete the questionnaire through a face-to-face interview using a hand held computer (with sensitive questions self-completed; $n = 3,852$), or to self-complete using paper questionnaires ($n = 158$). Mental well-being was measured using the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) [22], which asks individuals how often over the past two weeks they have been: *feeling optimistic about the future; feeling useful; feeling relaxed; dealing with problems well; thinking clearly; feeling close to other people; able to make up their own mind about things.* Responses are scored from 1 (none of the time) to 5 (all of the time) and an overall mental well-being score is calculated, ranging from 7 (lowest possible mental well-being) to 35 (highest possible mental well-being). Life satisfaction was measured on a scale of 1–10 using the standard question: *All things considered how satisfied are you with your*

life, with 1 being not at all satisfied and 10 very satisfied [23]. ACEs were measured using the Centers for Disease Control and Prevention short ACE tool [24] which comprises eleven questions covering nine ACE types: physical abuse; verbal abuse; sexual abuse (three questions); parental separation; exposure to domestic violence; and growing up in a household with mental illness, alcohol abuse, drug abuse or incarceration (for further information see [4]). Ethnicity was recorded using standard UK Census categories [25] and categorised as White, Asian and Other due to small numbers within individual ethnic groups. Respondents were allocated an IMD 2010 quintile of deprivation based on their LSOA of residence. Ethical approval for the study was obtained from Liverpool John Moores University's Research Ethics Committee and the study adhered to the Declaration of Helsinki.

Analyses were undertaken using SPSS v20. Only individuals with complete data relating to all ACEs, age, sex, ethnicity, and IMD quintile were included in the analysis, resulting in a final sample size of 3,885. Bivariate analyses used chi-squared with backwards conditional logistic regression to examine independent relationships between ACEs and adult mental well-being and life satisfaction. Consistent with other work including previous ACE studies [1–3] and the World Mental Health Surveys [26–28], the number of ACEs participants reported exposure to was summed into an ACE count (range 0 to 9) and here categorised into four groups for analysis: 0 ACEs (n = 2,072), 1 ACE (n = 879), 2–3 ACEs (n = 594) and 4 + ACEs (n = 322). We also explored relationships between outcome variables and individual ACEs, with analysis focusing on those with highly significant relationships. The seven individual components of SWEMWBS were each dichotomised to indicate poor ratings (never or rarely in the last two weeks). Overall SWEMWBS scores and life satisfaction (LS) ratings were dichotomised to indicate low scores as >1 standard deviation (SD) below the mean (SWEMWBS, mean 27.5, SD 4.4, low <23; LS, mean 7.7, SD 1.7, low <6).

Results

The demographic breakdown of the sample is shown in Table 1. Compared with the English population the sample overrepresented females (55.0 % v 50.3 % in England) and individuals aged 60–69 years (20.7 % v 16.1 %) and underrepresented those aged 18–29 (21.0 % v 24.2 %). There were no differences by deprivation quintile or ethnicity. Just under half of participants reported having suffered at least one ACE (46.4 %) with 15.4 % reporting 2–3 ACEs and 8.3 % 4+ ACEs. The proportion of participants with low measures (never or rarely in the last two weeks) for the individual components of SWEMWBS ranged from 2.5 % (able to make up own mind) to 14.5 % (feeling relaxed). Thirteen percent were categorised as

having low SWEMWBS scores (<23) and 11.6 % as having low life satisfaction (score <6; Table 1).

Low SWEMWBS scores and LS were both associated with age, being most prevalent in the 50–59 year age group (Table 1). Significant relationships with age were also seen for all individual SWEMWBS components except feeling useful and dealing with problems. There were no relationships between gender and LS or overall SWEMWBS score, although among the individual SWEMWBS components more females had low scores for feeling relaxed and more males for feeling close to others. There were no significant relationships between ethnicity and either low SWEMWBS score or low LS. However both outcomes increased with deprivation, as did low levels of all individual SWEMWBS components except feeling relaxed.

There were strong associations between ACE count and all markers of low mental well-being. Thus the prevalence of low SWEMWBS score tripled from 9.5 % in those with 0 ACEs to 30.7 % in those with 4+ ACEs, while the prevalence of low LS more than tripled from 7.9 to 26.6 % respectively. These significant relationships remained after controlling for confounders in logistic regression analysis with adjusted odds ratios (AORs) for low SWEMWBS score and low LS increasing with ACE count and reaching 3.9 for both outcomes in those with 4+ ACEs (compared with 0 ACEs; Table 2). Importantly, while associations between both outcomes and age also remained in LR, running separate models for each age group showed the relationships between high ACE count and low mental well-being to be consistent across age groups. Thus, compared with individuals with no ACEs, AORs for low SWEBWBS scores in those with 4+ ACEs ranged from 3.08 in both 18–29 year olds (95 % CIs, 1.56–6.07) and 30–39 year olds (95 % CIs 1.66–5.72) to 5.34 (95 % CIs 2.10–13.57) in 60–69 year olds (all p < 0.001) and for low LS from 2.54 (95 % CIs 1.09–5.90, p = 0.030) in 18–29 year olds to 11.20 (95 % CIs 4.43–28.29, p < 0.001) in 60–69 year olds.

Figure 1 presents AORs for low scores for each component of SWEMWBS by increasing ACE count (all ages). All relationships were significant and cumulative with AORs for those with 4+ ACEs (compared with 0 ACEs) ranging from 2.23 (95 % CIs 1.22–4.10) for never or rarely being able to make up one's own mind to 4.09 (2.70–6.20) for never or rarely feeling close to others.

Table 3 shows the relationships between measures of mental well-being and the nine individual ACEs examined. Physical, sexual and emotional abuse, witnessing domestic violence, and living in a household affected by mental illness or drug abuse were significantly associated with low levels of all mental well-being measures and household alcohol misuse and incarceration with low levels of all except the ability to make one's own mind

Table 1 Sample characteristics and prevalence of low mental well-being and life satisfaction

| | All | % in the last two weeks that have never or rarely been[a] | | | | | | | % with low[b] | |
		Feeling optimistic	Feeling useful	Feeling relaxed	Dealing well with problems	Thinking clearly	Feeling close to others	Able to make up own mind	SWEMWBS score	LS
n	3,885	3,876	3,882	3,882	3,879	3,883	3,879	3,883	3,868	3,884
All		12.9	8.4	14.5	6.2	3.5	5.3	2.5	13.0	11.6
Age group										
18–29	21.0	9.7	8.7	13.7	6.5	2.5	4.4	3.1	11.2	8.3
30–39	19.9	8.4	7.6	16.7	6.0	3.1	4.3	2.1	11.3	8.3
40–49	20.5	14.2	8.2	17.7	7.0	4.8	6.5	2.8	15.9	15.4
50–59	18.0	19.5	10.0	16.2	6.4	4.7	7.3	4.0	17.1	16.6
60–69	20.7	13.2	7.7	8.7	5.1	2.5	4.0	0.9	10.0	9.8
P		<0.001	0.461	<0.001	0.579	0.015	0.008	0.002	<0.001	<0.001
Gender										
Male	45.0	13.7	9.3	11.6	6.0	3.2	6.1	2.8	12.7	10.8
Female	55.0	12.2	7.7	16.9	6.4	3.7	4.6	2.3	13.3	12.2
P		0.163	0.067	<0.001	0.549	0.397	0.041	0.318	0.604	0.156
Ethnicity										
White	86.3	12.7	8.5	14.6	6.0	3.5	5.2	2.5	12.9	11.4
Asian	7.9	12.4	7.5	14.6	6.8	3.9	5.5	3.2	11.8	10.7
Other	5.7	16.1	9.0	13.5	9.0	3.1	5.4	1.3	16.6	14.4
P		0.321	0.794	0.896	0.178	0.887	0.973	0.384	0.226	0.363
IMD Quintile										
(least deprived)1	20.1	7.4	5.5	13.3	4.1	1.9	3.5	1.7	8.2	7.4
2	19.5	12.1	6.5	15.0	5.7	3.0	3.3	1.6	10.6	8.8
3	19.7	12.6	8.0	13.0	6.6	3.8	4.7	2.5	12.4	8.2
4	19.9	13.6	8.5	14.9	7.0	3.9	6.0	3.4	14.6	14.2
(most deprived) 5	20.7	18.5	13.4	16.4	7.7	4.7	8.7	3.5	19.1	18.8
P		<0.001	<0.001	0.291	0.033	0.034	<0.001	0.036	<0.001	<0.001
ACE count										
0	53.6	10.7	6.5	10.9	4.8	2.5	3.3	2.0	9.5	7.9
1	22.7	12.9	6.9	14.1	5.7	3.5	4.9	2.4	12.1	11.7
2–3	15.4	15.3	11.7	20.1	8.2	4.2	8.6	3.5	17.2	16.1
4+	8.3	22.3	18.9	28.8	13.3	8.0	13.0	4.6	30.7	26.6
P		<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	0.012	<0.001	<0.001

[a]Variables represent the individual component questions in the SWEMWBS scale. [b]SWEMWBS (Short Warwick-Edinburgh Mental Well-being Scale) score <23; LS (life satisfaction) rating <6

up about things. However parental separation or divorce was only associated with two of the seven SWEMWBS components (feeling useful, feeling relaxed) and an overall low SWEMWBS score. For each marker of mental well-being, a logistic regression model was run that included individual ACE types significantly related to the marker (in bivariate analysis, see Table 3) and demographic variables. Here, household mental illness was found to have independent relationships with the most mental well-being marker, being associated with all except

the SWEMWBS component of feeling relaxed (Table 4). Childhood sexual abuse was associated with all except the SWEMWBS components of feeling useful and feeling close to others. Emotional and physical abuse each had independent relationships with five of the nine measures and household alcohol problems with four. Feeling close to others (the SWEMWBS component with the strongest relationship with ACE count; Fig. 1), was independently associated with household mental illness, emotional abuse and physical abuse.

Table 2 Adjusted odds ratios for low mental well-being and life satisfaction

| | | Low[a] | | | | | |
| | | SWEMWBS score | | | Life satisfaction | | |
		AOR	95 % CIs	P	AOR	95 % CIs	P
Age	18–29 (Ref)			***			***
	30–39	1.049	0.763–1.444	ns	1.057	0.734–1.521	ns
	40–49	1.609	1.196–2.165	**	2.227	1.612–3.076	***
	50–59	1.893	1.398–2.562	***	2.683	1.992–3.774	***
	60–69	1.100	0.795–1.523	ns	1.572	1.108–2.229	*
Deprivation quintile	1 (least deprived; Ref)			***			***
	2	1.244	0.877–1.765	ns	1.135	0.783–1.647	ns
	3	1.517	1.081–2.130	*	1.073	0.736–1.564	ns
	4	1.770	1.270–2.465	**	1.992	1.414–2.808	***
	5 (most deprived)	2.382	1.734–3.273	***	2.714	1.952–3.774	***
ACE count	0 (Ref)			***			***
	1	1.350	1.048–1.739	*	1.636	1.256–2.132	***
	2–3	1.946	1.497–2.529	***	2.235	1.696–2.947	***
	4+	3.856	2.896–5.134	***	3.893	2.867–5.286	***

[a]SWEMWBS (Short Warwick-Edinburgh Mental Well-being Scale) score <23; Life satisfaction rating <6. *AOR* adjusted odds ratio; *95 % CIs* 95 % confidence intervals; *Ref* reference category; *P < 0.05, **P < 0.01, ***P < 0.001, *ns* not significant. Analyses used backward conditional logistic regression. Gender and ethnicity were also entered into the model but were not significantly related to low SWEMWBS score or low life satisfaction (data not shown)
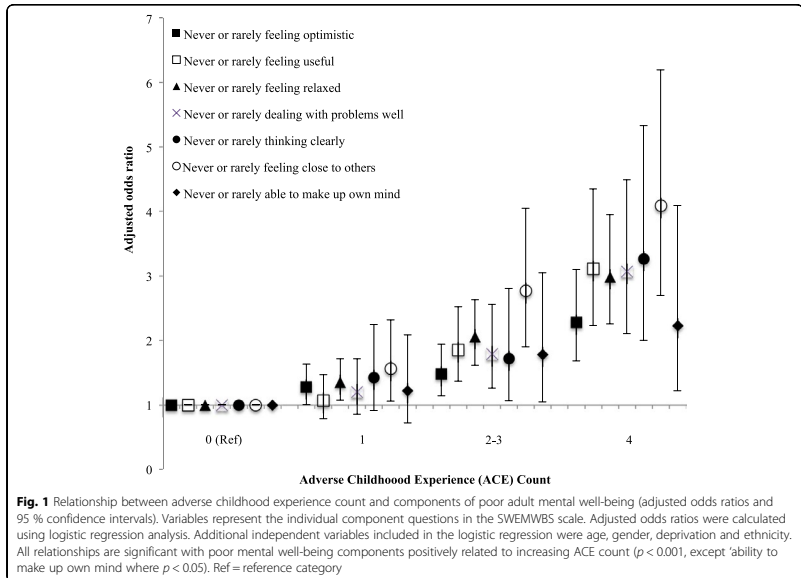
Discussion

Promoting mental well-being has become a major public health priority as recognition of the links between well-being and broader health and social outcomes has grown. This has contributed to the emergence of broader policy approaches to mental health, both globally and nationally, that incorporate population-level prevention and promotion activity alongside traditional therapeutic responses to mental illness [16, 17]. In England, motivation for increased investment in mental well-being promotion has centred around the notion that interventions to improve mental well-being at a population level could produce greater benefits than those to prevent mental illness in at-risk populations [29, 30]. However, the evidence base on which such approaches are based is being questioned as broader measurements and studies of mental well-being emerge [12]. Thus, existing studies have largely associated mental well-being in adults with factors linked to their current circumstances, such as employment, residential deprivation, social participation, physical exercise, relationship satisfaction and health status [31]. Correspondingly, interventions have often focused on promoting individual behavioural change through, for example, increasing social connectedness and physical activity [32, 33]. A life course perspective that incorporates the longer-term impact of childhood adversity has largely been absent from discussions on mental well-being.

Using a randomly selected national household sample of English adults, our study found a strong cumulative relationship between childhood adversities and two widely used measures of mental well-being. The more ACEs participants reported having suffered during their childhood the more likely they were to report low SWEMWBS scores and low life satisfaction (Table 1). These relationships remained after controlling for demographics, with odds of poor outcomes for both measures being elevated in those with even a single ACE and almost four times higher in those with four or more ACEs (compared with those with no ACEs; Table 2). We also found ACE count to be independently related to each of the seven individual components of SWEMWBS; individuals with higher ACE counts were more likely to report never or rarely (in the last two weeks) feeling optimistic, useful, relaxed or close to others, dealing with problems well, thinking clearly and being able to make up one's own mind (Fig. 1).

A variety of mechanisms link ACEs to poor adult mental well-being. Critically, maltreatment and other stressors in childhood can affect brain development and have harmful, lasting effects on emotional functioning [2, 34]. Children who are maltreated can develop attachment difficulties, including poor emotional regulation, lack of trust and fear of getting close to other people. They can also form negative self-images, lack self-worth and suffer feelings of incompetence, all of which can be retained into adulthood [2, 34, 35]. The relationships between ACEs and factors including poor educational attainment and the development of health-damaging behaviours mean that individuals who suffer ACEs can

Fig. 1 Relationship between adverse childhood experience count and components of poor adult mental well-being (adjusted odds ratios and 95 % confidence intervals). Variables represent the individual component questions in the SWEMWBS scale. Adjusted odds ratios were calculated using logistic regression analysis. Additional independent variables included in the logistic regression were age, gender, deprivation and ethnicity. All relationships are significant with poor mental well-being components positively related to increasing ACE count ($p < 0.001$, except 'ability to make up own mind where $p < 0.05$). Ref = reference category

also face a range of risk factors for poor mental well-being in adulthood, such as poor health, low employment and social deprivation [2, 4, 36]. These effects can contribute to cycles of adversity and poor mental well-being whereby individuals that grew up in adverse conditions are less able to provide optimum childhood environments for their own offspring [37]. Here, and consistent with previous work [38], the SWEMWBS component with the strongest relationship with ACE count was never or rarely feeling close to others. Children whose parents show poor relationships with them are at greater risks of ACEs [39], thus individuals who cannot feel close to others as a result of their own ACE history may subsequently be more likely to expose their own children to ACEs. These relationships may also have implications for the implementation and effectiveness of interventions to improve mental well-being through social connectedness.

While analysis based on ACE count highlights the cumulative impact of childhood adversity on mental well-being, it is also useful to explore which ACEs may have particular effects. All ACE types showed significant bivariate relationships with low SWEMWEBS scores, and

all except parental separation/divorce with low life satisfaction and most individual SWEMWBS components. In multivariate analyses, however, the ACEs with the most independent relationships with markers of low mental well-being were growing up in a household with someone affected by mental illness and suffering childhood sexual abuse.

The links between growing up in a household affected by mental illness in childhood and low mental well-being in adulthood may in part reflect genetic risk factors that make the offspring of individuals with mental disorders susceptible to poor mental health themselves [40]; although genetic explanations for the transmission of mental disorders are disputed [41]. Thus, parental mental illness can have broader impacts on children's social and emotional development when parenting practices are affected by factors such as low emotional warmth, reduced responsiveness, impaired attention and unpredictable behavioural patterns [42]. An extensive body of research provides evidence that exposure to childhood adversity such as parental stress, disrupted care patterns and abuse increases risks of mental illness [43], while studies are increasingly identifying how

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Table 3 Bivariate relationships between mental well-being measures and individual adverse childhood experience types

ACE	All	In the last two weeks, % never or rarely[a]:							% with low[b]:	
		Feeling optimistic	Feeling useful	Feeling relaxed	Dealing well with problems	Thinking clearly	Feeling close to others	Able to make up own mind	SWEMWBS score	LS
Physical abuse										
No	85.7	11.6	7.2	13.0	5.6	3.0	4.2	2.3	11.1	9.6
Yes	14.3	20.5	15.6	23.9	10.1	6.5	11.9	3.9	24.2	23.2
P		<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	0.020	<0.001	<0.001
Emotional abuse										
No	82.7	11.9	7.1	12.6	5.5	3.0	3.9	2.2	10.7	9.3
Yes	17.3	17.6	14.7	24.0	9.8	5.8	11.9	4.0	24.0	22.2
P		<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	0.007	<0.001	<0.001
Sexual abuse										
No	93.8	12.2	7.9	13.6	5.7	3.0	4.8	2.3	11.7	10.4
Yes	6.2	23.4	16.7	28.9	14.2	10.9	13.0	6.7	33.2	28.9
P		<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Parental separation										
No	77.4	12.9	7.8	13.2	6.1	3.5	5.2	2.5	12.4	11.1
Yes	22.6	12.8	10.5	19.2	6.7	3.3	5.4	2.7	15.1	13.2
P		0.906	0.013	<0.001	0.486	0.744	0.880	0.657	0.040	0.084
Domestic violence										
No	87.9	12.2	8.0	13.3	5.6	3.2	4.7	2.3	11.8	10.7
Yes	12.1	18.1	11.7	23.2	10.4	5.7	9.2	4.0	21.6	17.9
P		<0.001	0.006	<0.001	<0.001	0.004	<0.001	0.025	<0.001	<0.001
Mental illness										
No	87.9	12.0	7.6	13.3	5.4	3.0	4.3	2.2	11.2	10.2
Yes	12.1	19.1	14.7	23.4	12.4	7.2	12.0	4.9	25.9	21.5
P		<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Alcohol misuse										
No	90.9	12.3	7.7	13.4	5.5	3.2	4.8	2.4	11.9	10.3
Yes	9.1	19.0	16.1	25.8	13.0	6.5	9.9	4.0	24.4	23.8
P		<0.001	<0.001	<0.001	<0.001	0.001	<0.001	0.070	<0.001	<0.001
Drug misuse										
No	96.1	12.5	8.2	14.2	5.8	3.2	5.0	2.4	12.6	11.2
Yes	3.9	20.9	15.0	22.9	16.3	11.1	11.2	5.2	23.7	19.6
P		0.002	0.003	0.003	<0.001	<0.001	0.001	0.030	<0.001	0.001
Incarceration										
No	95.9	12.5	8.1	13.9	5.9	3.3	5.0	2.5	12.5	11.1
Yes	4.1	21.5	17.1	28.5	13.9	7.0	12.0	2.5	24.7	22.2
P		0.001	<0.001	<0.001	<0.001	0.015	<0.001	0.995	<0.001	<0.001

[a]Variables represent the individual component questions in the SWEMWBS scale. [b]SWEMWBS (Short Warwick-Edinburgh Mental Well-being Scale) score <23; LS (life satisfaction) rating <6

exposure to such adversity can trigger epigenetic modifications to gene expressions, altering brain structure, stress reactivity and consequently vulnerability to both mental and physical ill health [44]. Childhood sexual abuse can have particularly damaging effects on individuals'

emotional development, having been linked to feelings of shame and self-blame, powerlessness, inappropriate sexual beliefs and difficulties forming and maintaining intimate relationships [45, 46]. Correspondingly research has identified strong relationships between childhood sexual abuse

Table 4 Adjusted odds ratios for low ratings on SWEMWBS components, low overall SWEMWBS scores and low LS in those reporting individual adverse childhood experience types

ACE		In the last two weeks, never or rarely[a]							Low[b]	
		Feeling optimistic	Feeling useful	Feeling relaxed	Dealing well with problems	Thinking clearly	Feeling close to others	Able to make up own mind	SWEMWBS score	LS
Physical abuse	AOR	1.50	1.53	1.39			1.55			1.49
	95 % CIs	1.16–1.94	1.11–2.13	1.06–1.83			1.05–2.28			1.11–2.00
	P	**	*	*	ns	ns	*	ns	ns	**
Emotional abuse	AOR		1.46	1.47			2.12		1.73	1.54
	95 % CIs		1.06–2.00	1.13–1.89			1.46–3.08		1.36–2.20	1.16–2.05
	P	ns	*	**	ns	ns	***	ns	***	**
Sexual abuse	AOR	1.55		1.52	1.82	2.68		2.5	2.30	1.79
	95 % CIs	1.10–2.20		1.08–2.12	1.19–2.79	1.64–4.38		1.40–4.49	1.67–3.18	1.27–2.54
	P	*	ns	*	**	***	ns	**	***	**
Parental separation	AOR	na			na	na	na	na		na
	95 % CIs									
	P	-	ns	ns					ns	
Domestic violence	AOR									
	95 % CIs									
	P	ns	ns	ns	ns	ns	ns	ns	ns	ns
Mental illness	AOR	1.43	1.44		1.78	1.79	2.04	1.85	1.97	1.47
	95 % CIs	1.09–1.88	1.04–2.00		1.25–2.53	1.15–2.78	1.42–2.94	1.12–3.07	1.52–2.55	1.09–1.97
	P	*	*	ns	**	*	***	*	***	*
Alcohol problem	AOR		1.46	1.41	1.56			na		1.52
	95 % CIs		1.02–2.07	1.06–1.89	1.04–2.34					1.11–2.08
	P	ns	*	*	*	ns	ns		ns	*
Drug misuse	AOR				1.76	2.45				
	95 % CIs				1.06–2.93	1.34–4.46				
	P	ns	ns	ns	*	**	ns	ns	ns	ns
Incarceration	AOR			1.53				na		
	95 % CIs			1.03–2.26						
	P	ns	ns	*	ns	ns	ns		ns	ns

[a]Variables represent the individual component questions in the SWEMWBS scale. [b]SWEMWBS (Short Warwick-Edinburgh Mental Well-being Scale) score <23; LS (life satisfaction) rating <6. Analysis used backward conditional logistic regression. Separate models were run for each SWEMWBS component, low SWEMWBS score and low LS. Models included ACE types significantly related to each outcome in bivariate analysis along with age, gender, IMD quintile of deprivation and ethnicity. *na* not applicable; variable not included in the model due to lack of relationship in bivariate analyses. For each ACE, the reference group is those that did not report the ACE. *$P < 0.05$, **$P < 0.01$, ***$P < 0.001$, *ns* not significant

and adult mental illness [11]. For example, in England sexual abuse in childhood has been attributed to 11 % of all common mental disorders, along with 7 % of alcohol dependence disorders, 10 % of drug dependence disorders, 15 % of eating disorders and 17 % of post-traumatic stress disorders [47].

The WHO Mental Health Action Plan 2013–2020 incorporates the promotion of mental well-being as part of its overarching goal: highlighting the need for a life course approach that intervenes early to prevent mental health difficulties; recognising the importance of reducing violence; and emphasising the importance of services being responsive to the needs of survivors of violence [17]. Interventions that seek to reduce ACEs, develop parenting skills and promote resilience in children should thus be considered essential elements in comprehensive mental health strategies. Starting at the very earliest stages of life, these can include measures to train midwives, health visitors and other early years professionals to enquire about parental mental well-being and identify and treat post-natal depression and other mental health concerns [48]. The ante- and post-natal periods also offer the opportunity to identify and address a broader range of ACEs including parental substance use and domestic violence as well as to increase parenting skills and knowledge. Effective interventions include home

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visiting and parenting programmes that promote parent-child bonding and develop parenting skills, along with social and emotional development programmes that strengthen life skills and thus resilience in children [49, 50]. Measures should also be taken to ensure service providers across a broad range of disciplines are cognisant of the lasting damage that ACEs place on mental well-being and wider health and social outcomes, and are trained to recognise and respond appropriately to clients with adverse backgrounds [51]. In particular, professionals in mental health services should be trained to routinely enquire about childhood experiences during client assessments. Studies suggest such enquiry is often lacking, with mental health treatment typically based on a medical model that focuses on biological factors and ignores the profound influence of socio-environmental experiences on brain development and functioning [52, 53].

While the ACE methodology has been widely employed [54] it remains vulnerable to issues associated with any cross-sectional and retrospective survey with, for example, results relying on accurate recall and willingness to report ACEs. While adults with low mental well-being may have more negative perceptions of their childhoods, studies suggest false-positive reports of ACEs are rare [55]. Measures of current mental well-being and life satisfaction were also self-reported and therefore vulnerable to subjectivity, while the exclusion of individuals cognitively unable to participate in a face-to-face survey may have created bias in our sample. The dichotomisation of well-being scales may also have resulted in loss of information, although we used a consistent method to identify low mental well-being of greater than one SD from the sample mean. We used a recognised tool to measure nine important ACEs yet other common adversities such as neglect, bullying and parental death were not recorded. We explored the independent associations between outcome variables and both ACE counts and individual ACEs. However, we had insufficient sample size to look at how interactions between the individual ACE types, different combinations of ACEs and demographics may have resulted in different relationships with mental wellbeing. Such limitations aside our analyses did include multiple statistical analyses potentially increasing risks of type I errors. Consequently, while we have presented all figures for transparency, discussion has focused on highly significant results [56]. Finally, our study did not measure resilience resources [57], and developing understanding of factors that promote resiliency in those affected by ACEs would be an important future research priority.

Conclusions

While the high prevalence of mental disorders in the most vulnerable children (e.g. those in child protection systems) and the continued risks of mental illness in adults who suffered ACEs are widely recognised, data linking childhood adversity to the development and persistence of low mental well-being in the broader population is scarce. Our study suggests that almost half of the general English population have experienced at least one ACE and over one in twelve have suffered four or more ACEs. Such childhood adversity places individuals at significantly increased risk of low mental well-being and may have implications for the implementation and success of interventions that seek to promote mental well-being in the general population. The strong links between ACEs and adult mental well-being emphasise the need for a life course approach to mental health with the drivers of poor mental and physical health outcomes rooted together in childhood issues. Many of the ACEs that impact on children's long term health and well-being are linked to familial behaviours and mental health (e.g. mental illness, substance abuse, violent and aggressive behaviour) suggesting that the mental health impacts of ACEs are what pushes much of their cyclical nature. A life course approach suggests that preventing ACEs would contribute to better physical and mental health from childhood through to old age and thus improve mental well-being in future generations.

Availability of data and materials

Data sets and other materials used in this article can be accessed by request to Professor Karen Hughes.

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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.

Section 1: Understanding adversity, trauma and resilience includes evidence and analysis of the impact that adverse childhood experiences and trauma have on children and young people's mental health and wider outcomes across the lifecourse.

Section 2: Addressing childhood adversity and trauma includes insights from the NHS in England, organisations and clinicians working with children and young people who have experienced forms of adversity and trauma.

Section 3: Emerging good practice includes insight, case studies and working examples of adversity and trauma-informed service models being developed across England.

The collection ends with an agenda for change, calling on all Directors of Public Health, commissioners and providers to make adversity and trauma-informed care a priority in their locality.

You can download the Addressing Adversity ebook at youngminds.org.uk/BeyondAdversity

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