Routine Enquiry About Adversity in Childhood

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Why am I here?

• 24 years ago I started working with people with serious MH problems, associated social problems and poor health.

• I noticed that despite having different diagnoses, labels and coming from diverse backgrounds; they had two things in common:
  • They didn't seem to be getting better
  • They all had experienced significant adversity and trauma

• I have spent the last two decades working with individuals, families, organisations and governments; with the mission of making it ok for people to tell us what happened to them

• I do this by training professionals how to ask appropriately
  • And by helping create trauma informed services
Public Sector Context

• Eye-watering cuts to Public Health budgets

• LAs, CCGs and Providers ‘re-designing’ to meet financial targets!

• Sustainability of current model of NHS and Social Care provision doubtful - more structural and cultural upheaval to come

• Contribution of Universal Services to prevention, early help and building community resilience is significantly reduced in many areas

• CAMHS and Adult MH services can’t meet demand
What are ACEs?

• Physical abuse
• Sexual Abuse
• Emotional Abuse
• Living with someone who abused drugs
• Living with someone who abused alcohol
• Exposure to domestic violence
• Living with someone who was incarcerated
• Living with someone with serious mental illness
• Parental loss through divorce, death or abandonment
Key Research Findings

• Adverse Childhood Experiences are unfortunately common yet rarely asked about in routine practice (Felitti et al., 1998; Read et al, 2007.)

• In the English National ACE study, nearly half (47%) of individuals experienced at least one ACE with 9% of the population having 4+ ACES (Bellis et al, 2014.)

• There is a casual and proportionate (dose-response) relationship between ACE and poor physical health, mental health and social outcomes (Skehan et al, 2008; Kessler et al, 2010; Varese et al, 2013; Felitti & Anda, 2014.)
Adverse Childhood Experiences ACEs - The Life Course

Bellis 2016 Developed from Felitti et al. 1998
ACE Research (Felitti et al 1998)

4 or more adverse childhood exposures significantly increase the odds of a person

By nearly 5x Increased risk
Having sexually transmitted infections

By 2.5x Increased risk
Using illicit drugs

Over 7x Increased risk
Being addicted to alcohol

Over 12x Increased risk
Attempting suicide

9,508 Americans completed an ACE questionnaire as part of standardised medical evaluation
Latest Findings From Vincent Felitti and Centre for Disease Control

The ACE study is still an ongoing collaboration between the CDC and Kaiser’s Dept of Preventative Medicine in San Diego.

More recent findings:

- 6 ACEs increased the risk of becoming an IV drug user by 46 times.
- 6 ACEs increase the risk of suicide by 35 times.
ACEs increase individuals’ risk of developing health-harming behaviours

- 2 Times more likely to currently binge drink and have a poor diet
- 3 Times more likely to be a current smoker
- 5 Times more likely to have sex while under 16 years old
- 6 Times more likely to have had or caused an unplanned teenage pregnancy
- 7 Times more likely to have been involved in violence in the last year
- 11 Times more likely to have used heroin/crack or been incarcerated

Preventing ACEs in future generations could reduce levels of:

- **EARLY SEX** (before age 16) By 33%
- **UNINTENDED TEENAGE PREGNANCY** (before age 16) By 38%
- **BINGE DRINKING** (current) By 15%
- **HEROIN/CRACK USE** (lifetime) By 59%
- **VIOLENCE PERPETRATION** (past year) By 52%
- **HEROIN/CRACK USE** (lifetime) By 59%
- **VIOLENCE VICTIMISATION** (past year) By 51%
- **INCARCERATION** (lifetime) By 53%
- **POOR DIET** (current; <2 fruit & veg portions daily) By 14%
- **BINGE DRINKING** (current) By 16%
- **CANNABIS USE** (lifetime) By 33%
- **VIOLENCE VICTIMISATION** (past year) By 51%
- **INCARCERATION** (lifetime) By 53%
- **POOR DIET** (current; <2 fruit & veg portions daily) By 14%

The English national ACE study interviewed nearly 4,000 people (aged 18-69 years) from across England in 2013. Around six in ten people, who were asked to participate, agreed and we are grateful to all those who freely gave their time. The study is published in BMC MEDICINE:

WHO (Kessler et al. 2010) – 52,000 participants from 21 countries

The authors estimate that the absence of childhood adversity would lead to reduction in:

- 22.9% of mood disorders
- 31% of anxiety disorders
- 41.6% of behavioural disorders
- 27.5% of substance-related disorders
- 29.8% of mental health diagnosis overall
- 33% of Psychosis (Varese et al 2013)
The case for routine enquiry in health and social care

Waiting to be told doesn’t work...

Victims of childhood abuse have been found to wait from between nine to sixteen years before disclosing trauma with many never disclosing

(Frenken & Van Stolk, 1990; Anderson, Martin, Muller, Romano, & Herbertson, 1993; Read, McGregor, Coggan, & Thomas, 2006)

Read and Fraser (1998) found that 82% of psychiatric inpatients disclosed trauma when they were asked, compared to only 8% volunteering their disclosure without being asked.

Felitti & Anda (2014) report a 35% reduction in doctor’s office visits and 11% reduction in ER visits in a cohort of 140,000 patients asked about ACEs as part of standard medical assessment in the Kaiser Health Plan.
Of course… so what’s been done to address this?

- Services don’t ask routinely about ACEs
- Treating the symptoms is expensive and ineffective
- The system reacts to diagnoses
- Labels can attract stigma
- Can lead to learned helplessness –
  “I have an illness, what’s the point – there is nothing I can do, it’s not my fault”
- Health and Social Care system can not meet the growing demand and has run out of money
- We can’t afford to keep doing the same things and expecting a different outcome
Future in Mind Report 2015

Promoting, protecting and improving our children and young people’s mental health and wellbeing.

Experiencing or witnessing violence and abuse or severe neglect has a major impact on the growing child and on long term chronic problems into adulthood.

Ensuring assessments carried out in specialist services include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse.
Policy Context

Tackling Child SEXUAL Exploitation Report March 2015

Expand routine enquiry from 2015-2016 made by professionals in targeted services such as mental health, sexual health and substance misuse services.

Professionals include questions about child abuse, to help ensure early intervention, protect those at risk and to ensure victims receive the care they need.
REACH implementation across settings & agencies

- LCFT South East Team and Health Visitors
- Blackburn with Darwen Children’s Services Family Support Team
- Greater Manchester NHS Foundation Trust Substance Misuse Service
- Evolve (Substance Misuse Service)
- Child Action North West, Familywise Team
- Lifeline, Substance Misuse Practitioners
- Women’s Centre (Counselling, Support and Employment)
- W.I.S.H. (Domestic Abuse)
REACH Model

- **Readiness**
  - Checklist and organisational ‘buy in’

- **Change Management**
  - Systems and processes to support enquiry

- **Evaluation and Research**

- **Training Staff**
  - Hearts and minds & how to ask and respond appropriately

- **Follow-up support**
  - And supervision for staff and leadership team

Follow-up support
And supervision for staff and leadership team
Key Findings

• Most participants were not aware of the impact of adversity on later life outcomes before the training.

• REACh training equips practitioners with the knowledge, confidence and skills to conduct routine enquiry with the people they support.

• Routine Enquiry is feasible and acceptable to staff and service users.

• There have been no reported significant increases in service need following practice change. Most service users are well supported by the worker they disclosed to or were currently working with.

• The REACh approach was the catalyst for increased frequency of disclosures, better therapeutic alliance and more targeted interventions.

• Following routine enquiry people report considering the impact of ACEs in relation to their own children.

• Routine enquiry can quickly become business as usual.
A strategic perspective

- Understanding the scale of the problem – and associated service need
- Asking the right questions in every appropriate health assessment - routine enquiry about adversity in childhood.
- Improving access to evidence based interventions – secondary, tertiary and quarternary prevention.
- Moving upstream – primary prevention of childhood abuse and adversity.
Adversity will affect children in every class, in every school

- 1 in 10 children will experience 4 or more ACEs
- 1 in 20 children have been sexually abused
- 1 in 14 children have been physically abused
- 1 in 5 children have been exposed to Domestic Abuse
- 1 in 10 children will experience neglect
- 1 in 3 children have experienced cyber-bullying
Should schools enquire routinely about ACEs?

- **TEACH** in a trauma-sensitive environment
- **Targeted Enquiry about Adversity in Childhood**
- Asking about what is going on in a child’s life outside of school is valuable and can safeguard children
- But, like any sensitive conversation, it has to be done carefully, thoughtfully and in the context of a trusting, safe, ongoing & nurturing relationship
Trauma-sensitive?

‘The term “trauma-sensitive” school describes a school in which all students feel safe, welcomed, and supported and where addressing trauma’s impact on learning on a school-wide basis is at the center of its educational mission. The focus is on creating a whole-school culture that serves as a foundation for all students to learn and experience success at school.’

Trauma and Learning Policy Initiative (TLPI)
Why trauma-sensitive?

• Toxic-stress caused by unsafe home or abusive parent is damaging to health & wellbeing
• Short-term a child who is in ‘fight, flight or freeze’ mode, will struggle to self-regulate and cannot learn
• They are hyper-vigilant to threat, so over-react and live in a state of fear
• Punishing ‘bad’ behaviour doesn't work – it just compounds the trauma
What is the prize?

• Learning how to get along with adults and other children is crucial

• Self regulation, self soothing, reciprocation, self appreciation/ compassion & responsibility are the skills that need to be learned.

• Better safety, emotional wellbeing, and resilience does not always equal better test scores!

• But, these factors predict success in adult life better than test scores at school…
‘the most powerful childhood predictor of adult life-satisfaction is the child's emotional health, followed by the child's conduct. The least powerful predictor is the child's intellectual development. This may have implications for educational policy.’

OK, so what can Devon C&F partnership do to help?

- Submit evidence to the Science and Technology Parliamentary Committee
- A position statement or good practice guidance along with accessible training and CPD opportunities
- The knowledge and science required is freely available – Leaders curate & share quality content
- Implementation is the challenge – How can DCFP support cultural, organisational and individual practice change?
- Educate and raise awareness across communities – a cultural shift is required
- Don’t wait to be told...make sensitive enquiry about ACEs routine practice
- Aspire to a system that doesn't miss opportunities – Schools, CAMHS, GPs
- Support the movement for trauma-sensitive schools...
Thank you…

Please drop me a line!

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