

Introduction

Adverse Childhood Experiences (ACES) – Implications and Challenges

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In the context of rising interest in Adverse Childhood Experiences – more popularly referred to as ACEs – amongst policymakers and a range of practitioners in the childhood and families fields internationally, this themed section examines the concept and methodology of ACEs. Academic experts and contributors from the policy and practice fields examine the state of the art, implications of and challenges to the notion of ACEs from a number of different disciplinary and political perspectives: from epidemiology to psychology to sociology, and from supportive to critical, as we outline in this Introduction to the themed section.

The concept of ACEs is gaining increasing traction in the UK and more widely as a means for policymakers and professionals in a range of services, especially health, social work and policing, to develop and use ‘tickbox’ protocols that generate individual ACE ‘scores’, and to make algorithmic-based decisions: about how to target resources and at whom, and when and how to intervene. A state of the art discussion in this themed section from epidemiologists attached to the Academy of Medical Sciences, Andrew Steptoe and colleagues, considers the evidence for links between ACEs and long term health outcomes, identifying where these have been established for different traumatic ACE experiences and specific health outcomes, as well as where there are gaps in epidemiological knowledge. From their perspective, the state of knowledge points towards the need for policies that promote ‘trauma-informed’ care, development of a strong base of evidence for interventions that work, and a focus that places children at the centre.

ACEs form part of the contemporary dominant approach to family and public health policies that is preoccupied with the identification of dysfunctional families in order to target them for early intervention, informed and underpinned by the steady rise of ‘prevention science’ (White and Wastell, 2017). The piece from Kristen Asmussen and colleagues, from the UK Early Intervention Foundation, reviews the potential of early intervention to address ACEs, with the stated aim to prevent damage and disadvantage, or at least stop it in its tracks, so to ensure optimal human flourishing. They identify sets of universal activities such as perinatal screening and parenting support, and targeted ones such as psychotherapeutic interventions for parents and children, that can prevent or alleviate ACEs. And they call for more evidence about ACEs and their prevention in relation to child neglect in particular.

The keystones of prevention science are: risk, with its associated probabilistic reasoning, the notion that variance may indicate impending morbidity, a preoccupation with identifying underlying causes, ensuring efficacy and cost-effectiveness with rigorous methods and translation of the scientific findings for an audience of policy actors (Wastell and White, 2017). As Jan Macvarish and Ellie Lee note in their contribution to this themed section, this translation can involve working with public relations agencies to produce catchy phrases – such as ACEs itself – to enhance the purchase with policymakers and professionals.

The notion of ACEs has become internationally mobile from its creation in the USA two decades ago. The set of social indicators that is the ACE protocol was developed in the USA and attempts to link adverse early childhood experiences of abuse and household dysfunctions to disease and health risk behaviour outcomes (Felitti et al., 1998). The notion of a critical ‘dose’ of ACEs (a threshold of four) associated with adult health status was developed, with calls for screening of children at risk of ACEs and preventative intervention. Similar protocols have been developed in the UK (e.g. Bellis et al., 2015), along with calls for application of ‘checklist’ ACE screening by service providers and for early intervention (e.g. The Wave Trust: <https://www.wavetrust.org/what-are-adverse-childhood-experiences>). ACEs ideas have been profoundly influential in social policy internationally, with Eileen Joy and Liz Beddoe noting the creeping agenda of ACEs in Aotearoa New Zealand in their article for example, and ACEs being promoted through the World Health Organisation (WHO, 2009) including a WHO ACEs international protocol: https://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/questionnaire.pdf?ua=1.

In the UK, ACEs have found a foothold in relation to the Troubled Families Programme, with its focus on targeted, intense and time-limited intervention to ‘turn around’ families displaying dysfunction according to a set of social indicators, to address and prevent the ‘root causes’ of mental and physical disease and intergenerational social disadvantage in early childhood experience (Crossley, 2018). This rationale makes explicit links with biological changes in the body, and coalesces with economic forms of reasoning that privilege the early years as the way to ensure value for money in state expenditure. In Scotland in particular, as Emma Davidson and Eric Carlin note in their contribution, ACEs have been embraced enthusiastically by policymakers and many practitioners, with a grand aim of becoming an ‘ACE-aware’ nation, e.g. <http://www.gov.scot/Publications/2017/09/8468/9>.

The evidence on ACEs and implications for policy-making and practice has been the subject of a UK House of Commons Science and Technology Committee inquiry (<https://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/news-parliament-2017/evidence-based-early-years-inquiry-launched-17-19/>). Macvarish and Lee provide an analysis of the various perspectives on the advantages and limitations of an ACEs approach in the written and oral evidence to the inquiry, arguing that there are links into the wider ‘first three years movement’ which homes in on parents as both the cause and solution to childhood adversities and determining of future outcomes. While the majority of submissions took for granted the existence of and need to address ACEs through interventions in parenting, challenges to the assumptions, methodology and implications of ACEs as a guide for policy development and practice intervention nonetheless were evident.

These challenges are also raised and elaborated in the contributions to this themed section. They coalesce around weak and inconsistent measures and extrapolations,

concerns about moving from population to individual level application, and a focus on intra-familial relations at the expense of material deprivation with gendered, classed and raced inequalities. We overview each of these in turn.

The lack of a consistent definition of ACEs across studies and protocols is pointed out by those with a positive view of the relevance of the concept such as Steptoe and colleagues as well as by contributors from a more critical stance. But there are broader concerns about the methodology deployed, including statistical practices and consequent assertions. Dimitra Hartas tackles the USA and UK foundational studies referred to earlier. She challenges the basis for their causal claims, identifying the limitations of the retrospective approach and presence of multicollinearity, and the dangers of a shift from epidemiological research at population level to service provision at the individual level. Michelle Kelly-Irving and Claude Delpierre provide a considered discussion of this slippage in their state of the epidemiological art review. They support the positive value of epidemiological ACEs research at the population level for developing policies to address more structural and communal interventions, but are concerned about the 'diagnosing' of individuals in ACEs practice. They argue that methodologically this misunderstands the concept of risk, but also raises ethical issues about an individualistic and determining practice that risks stigmatising and causing harm.

In their methodological critique, Sue White and colleagues identify ACEs as a 'chaotic concept', with an unstable knowledge base, and overextrapolation from small effect sizes in some key studies. They also firmly identify that the way in which the ACEs focus on intra-familial relations is at the expense of considering poverty and hardship as causal in poor health and education outcomes. The links between ACEs and material deprivation are noted in epidemiological contributions too. The associated gendered, classed and raced prejudices in ACEs thinking are drawn out in other contributions. Macvarish and Lee identify the way that ACEs discourse is heavily gendered, with mothers positioned as deterministic mediators for their children with little consideration of their own adversities. Davidson and Carlin consider class-based inequalities and values in resilience-informed youth policy and practice in the 'ACE-aware' nation of Scotland, to unpack the way that injustice is reframed as individual deficiency and young people in deprived areas are assessed and held to account against middle class social values. They call for policies that change circumstances rather than individuals. Joy and Beddoe provide a telling discussion of the way that ACE checklist items are differentially impacted by race/ethnicity, using the example of criminal behaviour and sentencing, within the cultural context of Aotearoa New Zealand. As they remark, the ACEs protocol fails to consider societal processes, with entanglements of ACEs with poverty, racism and colonisation. They call for a more humanistic approach to family support policy and practice.

In conclusion, ACEs are invoked in policy and practice in contrasting ways. The focus can be on strengthening families, or ensuring services take clients' complete social history. Epidemiologists stress that their focus primarily is on understanding the mechanisms underlying chronic non-communicable diseases of late adulthood at the level of population probabilities, whilst, in social and education services for children, ACEs are invoked to indicate the possibility of risk and the need for intervention at the individual level. These tensions mean that ACE narratives are often highly moralised and create new arenas for state action.

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