



Fostering Understanding, Empowering Change: Practice Responses to Adverse Childhood Experiences (ACEs) and Intergenerational Patterns of Domestic Violence



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Foreword

Cuan Saor provides a range of services for women and children who experience domestic violence, this is the mission statement that we work from daily. Cuan Saor has developed its services over the past 25 years, growing from providing support and information to introducing a freephone helpline, opening a refuge in 2000, developing an outreach support and information service, court support, group work and an extensive childcare service. With the growth of the service Cuan Saor has continuously examined responses and interventions to ensure the organisation is meeting the needs of women and children. Key has been the changing landscape, such as understandings around how social media, substance use, and mental health impact and intersect with the dynamics of power and control in abusive relationships.

On this journey of change and professional development Cuan Saor were very fortunate to have close collaborative relationship with the UCD Community Drugs Programme, allowing for a generative and practice focused research alliance. This report is the result of the latest of a number of research projects Cuan Saor have engaged in. Key in proceeding with this work has been the support of Thelma Blehein (DSGBV), Tusla who provided match funding for this UCD collaborative project. The research journey began with ACE's training being delivered by Andrew Bennet Public Health Research, Training & Consultancy, and this report is the conclusion of this stage of the project. It has been an amazing journey of commitment by the staff of Cuan Saor and they have demonstrated their dedication to practice development yet again. Recognition is also due to the IMH Steering Group for their involvement and also to acknowledge the participation in the ACEs training of the Clonmel Community Mothers Programme, and Spina Bifida Hydrocephalus Ireland.

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Elizabeth Moloney
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Table of Contents

Acknowledgements	4
Foreward	5
1. Introduction and background	8
Context	8
Research aims	9
Report outline	9
2. Literature review	10
Background	10
Understanding ACEs: an overview of Adverse Childhood Experiences	10
A note on ACEs and Infant Mental Health (IMH)	14
Integrating ACEs into policy and practice	19
Conclusion	20
3. Methodology	21
Research design	21
Procedure	22
ACEs routine enquiry	22
<i>Cuan Saor practitioner and Infant Mental Health practitioner inquiry groups</i>	22
<i>Cuan Saor practitioner inquiry group</i>	23
<i>Infant Mental Health practitioner inquiry group</i>	23
Data analysis	23
<i>ACEs routine enquiry with service users</i>	23
<i>Practitioner inquiry groups</i>	24
4. ACEs Routine Enquiry Results	25
5. Findings and discussion: Cuan Saor Practitioners	29
Implementing ACEs routine enquiry	29
<i>Training</i>	29
<i>Implementation</i>	29
Lessons from ACEs routine enquiry practice	30
<i>Relevance of the ACEs tool</i>	30
<i>Timing ACEs routine enquiry within the helping process</i>	33

<i>Understanding and empowerment for service users</i>	35
<i>Inter-agency work</i>	38
6. Findings and Discussion: Infant Mental Health Group practitioners	40
<i>Relevance and implementation of ACEs routine enquiry</i>	40
<i>Mothering, children and inter-generational patterns</i>	42
<i>Inter-agency work</i>	43
7. Considerations and implications	45
Service Users	45
ACE scores of women accessing a domestic violence service	45
Practitioners	46
Organisations	46
Inter-agency considerations	47
Funders	47
Limitations and further research	48
References	49
Appendix A	55
Appendix B	56

Table of figures

Figure 2.1 Model of ACEs impacts across the life course	11
Figure 4.1 Prevalence of ACEs: Cuan Saor in a comparative context	25
Table 4.1 How many adults exposed to each type of ACE in their childhood?	26
Figure 4.2 Most common type of ACE experienced by Cuan Saor service users	27

1. Introduction and background

The long-term impacts of Adverse Childhood Experiences (ACES), including domestic violence, poverty and substance use, have been widely evidenced in recent decades (Bellis et al., 2013). Further to this, attention has been paid to effective screening for ACES within a range of health settings. In recent years, both researchers and practitioners have considered and explored interventions for those who have experienced adverse childhood experiences, with a view to lessening the impact of these experiences, and improving health and other personal outcomes (Ashton et al., 2016; Hughes et al., 2016). Within the Irish context, there have been a number of cross-sectional studies considering ACES within specific populations, and some attention to post-screening intervention. There has also been initial consideration of how ACES screening can inform practice responses in relation to trauma within homeless and substance use settings. However, there has been little focus on the role of ACES for women experiencing domestic violence, despite growing recognition of inter-generational patterns of domestic violence, childhood sexual abuse and substance use (Morton, 2016). This study sought to pilot ACES routine enquiry within a domestic violence agency, with a view to developing practitioner and organisational responses.

Context

While much of their work is crisis-based, Cuan Saor – a well-established organisation serving women and children experiencing domestic violence in South Tipperary, Ireland – is also committed to helping women and their children find a sustainable path to a safe and secure future. Among their range of services, they offer: refuge, support and advocacy, helpline, support for children, court accompaniment, and outreach. Recent years have seen an increased recognition of trauma histories, intergenerational issues of compromised parenting, substance use and domestic violence, and Infant Mental Health (IMH) across the domestic violence service landscape in Ireland. These trends have also been reflected in the rise of complex cases presenting at Cuan Saor's service site in Clonmel, Co. Tipperary. Given the attention that is being paid to the long-term traumatic impacts of ACES, exploring a trauma-informed care approach to women's childhood experiences offers a potential new way for Cuan Saor to support and improve the life chances of the women and children they serve.

In 2018, Cuan Saor embarked on a TUSLA-funded project to consider both the prevalence of ACES for women accessing a domestic violence service and the integration of trauma-informed responses to women's childhood experiences into all areas of their practice. In moving towards actively screening for and responding to ACES within their services, consideration has also been given to supporting mothers to address possible ACES impacts for their children, thus providing the possibility of intervention within intergenerational patterns. This research addresses the current gap in ACES work on the role of ACES for women experiencing domestic violence, and in doing so, expands the Irish evidence base on the role of ACES in service delivery and public supports.

Research aims

The aims of this study were to:

- Identify the level of ACEs for women accessing a domestic violence service.
- Consider and explore trauma informed responses to women's childhood experiences and the inter-generational transmission of trauma, based on the process of the ACEs routine enquiry process.
- Consider the role of ACEs routine enquiry and intervention in relation to Infant Mental Health (IMH), a key area of work for childcare workers within domestic violence settings.

Report outline

The following section provides an overview of the research literature in relation to ACEs, with a focus on the evidence in relation to the health impact of ACEs, ACEs and trauma informed practices and the implementation of ACEs routine enquiry. Section 3 outlines the research methodology and Sections 4-6 present and discuss the research findings. The concluding section, Section 7, considers implications for service users, service providers, practitioners and funders.

2. Literature review

Background

Increasing recognition of links between ACEs and domestic violence, poverty, and substance use, among other things (Bellis et al., 2013), has resulted in increasing acknowledgement of ACEs within public service response and delivery strategies, often beginning with the point of first contact. This work is taking place across countries, with a particular emphasis in health-related sectors (Ashton et al., 2016; Hughes et al., 2016; Gilliver 2018; Bellis et al., 2015). Within the Irish context, a number of cross-sectional studies considering ACEs within specific populations, with attention to post-screening interventions, have taken place (Lambert & Gill-Emerson, 2017). The remit for potential application of ACEs enquiry is now expanding across service areas, with examples of how ACEs screening can inform practice responses in relation to trauma within homeless and substance use settings developing as well. However, despite the growing recognition of intergenerational patterns of domestic violence, childhood sexual abuse, and substance use (Morton and Hohman 2016), there has been little focus on the role of ACEs for women experiencing domestic violence.

Understanding ACEs: an overview of Adverse Childhood Experiences

An expanding evidence base tracks the impact of childhood experiences on the trajectory of an individual's entire life course. The specific look at "long-term harms that can result from chronic stress on individuals during childhood" (Bellis et al., 2015:3) underpins the growing body of research and evidence-based practice on Adverse Childhood Experiences, or ACEs. The term originated in a US study of the same name conducted by the American health care provider, Kaiser Permanente, and the Division of Violence Prevention in the US Centers for Disease Control and Prevention (CDC) in the mid-1990s. Results, published by Felitti et al., (1998), revealed a strong interrelationship between 'adverse childhood experiences' (here: abuse and/or forms of household dysfunction, specified below) and severe chronic disease and premature death in adulthood¹. This launched a new field of study into the combined effects of children's relationships and children's home environment on their future emotional, health, education, financial (and more) outcomes, as well as any intergenerational implications, with respect to the potential impact of transmitting the effects of, or replicating, this trauma on their own children.

The original study identified seven ACEs categories of focus, establishing a model for enquiry that has continued since. Expanded in subsequent studies to nine (Bellis et al., 2015), the current categories include:

¹ Rutter (1980), writing earlier, also identified similar long-term effects from negative childhood experiences.

- *Child Maltreatment*: sexual abuse, physical abuse, verbal abuse
- *Children's Environment*: domestic violence, parental separation², mental illness, alcohol abuse, drug abuse, incarceration.

A 'score' of four issues or more is seen to significantly increase the likelihood of a child engaging in risky future behaviour, experiencing poor health outcomes (e.g. smoking, alcohol/drug misuse, poor diet and obesity, teen pregnancy, chronic disease, violence or incarceration), and having 'difficulty in changing course' as they move through adulthood (Felliti et al., 1998; Bellis et al., 2015; Bond 2018; Edwards et al., 2019).

The range, and increasing severity, of potential effects of ACEs is often modelled in the pyramid image seen below.

Figure 2.1
Model of ACEs impacts across the life course

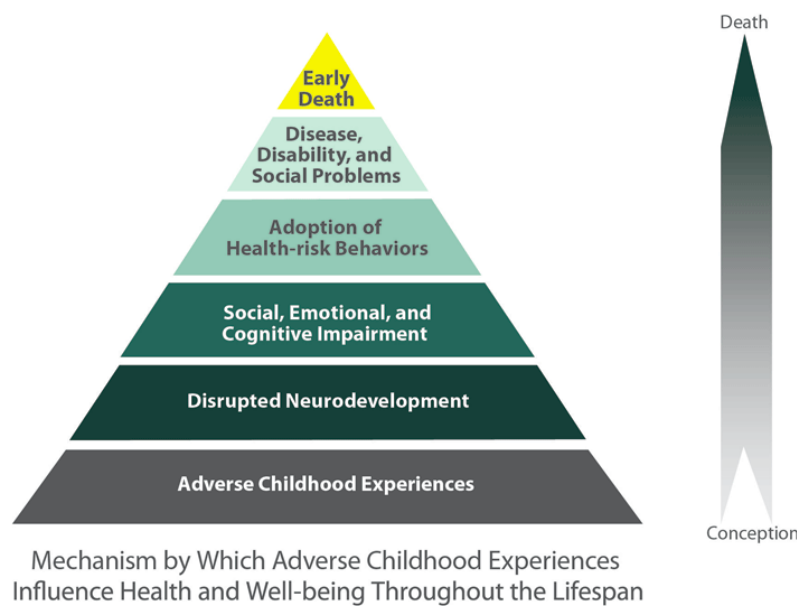


Image reproduced from CDC (2016).

ACEs are revealed to be prevalent across the populations of the high-income countries where most studies have been conducted to date. The inaugural US study in the late 1990s found that 40 per cent of those in the study experienced at least two categories of ACEs and 12.5 per cent

² As Bellis et al (2015:9) write: "[t]he specific act of divorce or parental separation can be either harmful or beneficial to the child but in ACE studies divorce or parental separation is often used as a marker of substantive, often long-term conflict between parents".

had experienced four or more (CDC 2018); a 23-US state follow up published in 2018 reported similar results. UK regional studies present similar levels. A 2015 Wales NHS national ACEs study revealed that just under 50 per cent of the population had experienced one or more ACEs, with 13.6 per cent having experienced four or more (Bellis et al., 2015). As yet, no such data exists within the Irish context.

The impacts of ACEs also stretch well beyond the individual who immediately experiences them. In addition to increasing the likelihood of significant personal struggle, ACEs are linked to intergenerational effects – as those who encounter ACEs are more likely to engage in behaviour that creates potential ACEs for their own children (Bellis et al., 2015; Renner and Slack 2006). Drug and alcohol misuse, violence, and incarceration affect communities as a whole. Services – from health (physical and mental health sectors) to schools to crisis agencies (e.g. domestic violence or homelessness service providers) – can be stretched up to and beyond capacity with the presentation of increasingly complex cases. Prevention and early intervention have become a focus of national and local strategy for services funding and coordination across countries, including Ireland (Burstow et al., 2018; TUSLA, 2015). A recent meta-analysis of Europe and North America conducted by Bellis et al. (2019) found millions of adults have been exposed to ACEs. Looking in particular at health effects, annual costs incurred by health systems linked to the legacy of ACEs (the bulk of which incurred to serve individuals with a history of two or more ACEs) were over 530 billion EUR across Europe and 683 billion EUR annually in North America. Bellis et al. (2019) found that reducing the prevalence of ACEs by just 10 per cent in the population – through the use of programmes to moderate the effects of ACEs, or prevent them altogether for children – could produce an annual savings of 96 billion EUR in the area of healthcare alone.

ACEs cautions and critique

The recent findings by Bellis et al. (2019) with regard to the economic benefits of preventing ACEs or tackling the potential effects of ACEs early on suggest a role for ACEs-related work in policy and services. ACEs frameworks, however, have not been operationalised without critique. Kelly-Irving and Delpierre (2019) provide an overview of literature and practice examples on the potential for ACEs theory and screening tools (mis)use. They write with particular reference to the field of public health, but their observations and cautions are relevant across disciplines.

A primary challenge lies in ACEs measurement. Hartas (2019) calls for more conceptual clarity and a more precise delineation between association and causality in the presentation of identified links between the set of adverse experiences described above and later life outcomes. ACEs are often identified through questionnaires or surveys that are most able to capture exposure, but not level or duration. With respect to the overall ACEs ‘score’ produced, there is no distinction made between the different types of experiences in terms of weighted value (or the fact that individuals will be impacted differently by different experiences). ACEs screenings with adults rely on retrospective self-reporting, which may reflect inadvertent

inaccuracy (Reuben et al., 2016). Appleton et al. (2017) note that the definition of the events that qualify as ACEs is not uniform across studies; in particular, there is a notable discrepancy in the inclusion of material hardship and related socio-economic factors (Steptoe et al., 2019). This complicates comparisons over time, as well as across populations.

A second challenge – and one relevant for incorporating ACEs into trauma-informed care and community practice – is distinguishing between individual-level and group- or population-level application. Kelly-Irving and Delpierre (2019) note that while the promotion of ACEs awareness in health, educational, and service settings is often both useful and commendable, placing a focus on an individual's ACEs score poses ethical questions and is a departure from the spirit of Felitti et al. (1998) original ACEs study, which – Kelly-Irving and Delpierre (2019:452) argue – did not promote “the use of their measure for identifying people, but rather referred to the need for structural change, improved health visitation schemes, and better awareness about the impacts of stressful life conditions”. In the absence of an emphasis on interpreting ACEs in a broader population-level context in the push for better integrated systems of care, prevention, and early intervention, individuals looking at their own ACEs scores may face fear over their future outcomes, stigma from others about their personal circumstances, and a burden of a now ‘individualised’ problem.

Incorporating ACEs into trauma-informed care

These issues are of particular importance to account for with respect to the incorporation of ACEs in trauma-informed care. Trauma-informed care, Reuben et al., (2019) note in a review of the evidence base on early years interventions, is a model with origins in the United States. It sought to account for the fact that a high proportion of mental health service users have experienced trauma in the development of staff policy and practices in ways that would not re-traumatise them. As a form of trauma, ACEs exposure has the potential to alter both the development of children's brains, as well as their immune and hormone systems (Bellis et al., 2015). Kelly-Irving and Delpierre (2019) discuss these potential effects in the context of the epidemiology and public health literature. The central issue is that experiencing ACEs – and the potential resulting physiological changes – within critical phases of child development interrupts the ability of children to securely explore their world and form relationships. This interrupts the process of attachment theory, which is most often discussed in the context of infant mental health (Gilliver 2018; Bowlby 1988). Instead of forming secure bonds, ACEs result in a state of chronic stress for children.

A note on ACEs and Infant Mental Health (IMH)

Infant mental health (IMH) is a concept used to describe the social and emotional development of a child from age zero to three (HSE 2017). Attachment theory represents a key part of this development, as the strength of the nurturing relationship in a child's early years has a direct impact on brain development. A poor or stressful relationship with their caregivers will induce stress in the child, potentially affect both their cognitive and physical abilities (Curtin et al 2013).

ACEs can have direct and indirect effects on IMH. Children from infancy may be exposed to ACEs in the home, either through maltreatment or through factors in their home environment. Research indicates that substance-misusing parents, for example, may be less able to provide high-quality parenting – a particular risk for attachment when children are very young (Horgan 2011). Infants can also be affected, perinatally, by maternal ACEs (e.g. the adverse childhood experiences of their mother). McDonnell and Valentino (2016) found an intergenerational effect of maternal childhood trauma on infants, in the form of lower birth weight and reducing infant functioning, and a link between higher ACEs scores and maternal depression (pre- and post-partum), with implications for infant attachment. They also found an association between ACEs and pregnancy at an early age, as well as other risky behaviours and links to other forms of social disadvantage.

Research indicates a comprehensive public investment approach can help mitigate the worst of these effects, by targeting the roots of toxic childhood stress and ACEs, supporting parents and caregivers, and strengthening communities. Bellis (2015) and Hardcastle and Bellis (2019) identify home visiting programmes, parenting programmes, and high-quality preschool as examples of prevention and early interventions to support IMH. Ellis and Dietz (2017) discuss the development of the Building Community Resilience model in the US that integrates child health, public health, and community-based human services agencies to prevent and reduce ACEs impacts among children in their early years.

Chronic stress is toxic for young children – it “can result in individuals whose systems are ‘locked’ into a higher state of alertness; permanently prepared for further trauma” (Bond 2018). The effects are difficult to change and difficult to anticipate how with respect to how they may manifest themselves in the future. Gilliver (2018) cites an example from an NHS Education for Scotland (2017) report describing a GP trying to address a patient's repeated missed attendance at a routine cervical smear test; the GP eventually discovered that the patient's difficulty with the procedure was connected to her experience of childhood sexual abuse. This information was not immediately disclosed; it was revealed only after the GP “used trauma-informed principles of choice, collaboration, control and safety to build trust...to help

her manage the procedure as well as possible” (Gilliver 2018:48).

Models exist for treating traumatic stress in children. Trauma-focused cognitive behavioural therapy (TF-CBT) (designed by Cohen, Mannarino, and Deblinger (2012)), for example, is an example of short-term therapy for children to enable them to “identify appropriate techniques for coping, process past traumatic memories, and establish behaviours that enhance safety” (Wenocur et al., 2016:254). The long-term impact of ACEs, however, may mean that the effects of childhood stressors and trauma may not play out – or be recognised for redress and treatment – until an individual is well into adulthood. With ACEs specifically in mind, researchers are now developing therapy strategies and service responses to deliver new trauma-informed models of care (Gilliver 2018). One such model, by Menschner and Maul (2016), was developed in the US for specific use in human services programmes. It provides a framework for re-orienting organisational approaches and clinical practice in a way that prepares organisations to anticipate potential trauma in adult service users and prepare clinical staff to address such trauma, if it exists.

Gilliver (2018:48) describes how this work has been taken up in a similar fashion in the UK. Scotland has emerged as an example of good practice on linking trauma-informed care with healthcare service delivery. Outlined in their NHS Education for Scotland (2017) framework is the details of the approach, including the trauma-informed practice training mandatory for all staff – regardless of area of work or particular role. In 2015, NHS Wales launched a series of reports based on a large-scale ACEs study on how to understand and address the impact of ACEs across all areas of public health and social care services (Bellis et al., 2015; Ashton et al., 2016a; Ashton et al., 2016b; Hughes et al., 2018; Hardcastle & Bellis 2019).

While ACEs research and remediation has its origins in the health sector, the principles of trauma-informed care have since been rolled out across social care sectors. Examples can now be found in criminal justice, schools, children and family services, and homelessness services, among others (Gilliver 2018). Wenocur et al. (2016) describe the results of implementing TF-CBT interventions for children in emergency family housing. Their review of a US programme, delivered at a small shelter in Philadelphia, Jane Addams Place, contributes to the emerging, but still developing, literature on the use of mental health interventions for children in homeless services. Its early success suggests a role for ACEs work with adults in the same situation, for – as the authors note –

[h]omelessness is typically a symptom of a greater problem; it occurs when an issue in another sphere of one’s life spirals out of control. This may include untreated mental illness, persistent abuse, or stagnant financial circumstances due to lack of education. Offering comprehensive behavioral health services in the shelter presents an opportunity to address the issues that precipitated homelessness

(Wenocur et al., 2016:257).

Similar connections are starting to be made in the areas of domestic violence (Stainbrook and Hornick, 2006; Clarey et al., 2010; Nathanson et al., 2012; Pill et al 2017) and substance use (Fenton et al., 2013; Gutierrez and Van Puymbroeck, 2006; Fuller-Thomson et al., 2016;

Scheidell et al., 2017), where the impact of childhood maltreatment plays out in adulthood in both of these areas. To date, however, there has not been as much of a focus on the potential for incorporating an ACEs-informed approach into services in these areas, for both women and their children who present to them.

ACEs connections to domestic violence and substance use

Domestic violence is an issue that was historically linked to social learning theory – a concept that posits the behaviour of adults is learned from childhood (Bandura, 1973). This also informs the “cycle of violence hypothesis [that] assumes children learn violence and then the violence becomes transmitted across generations” (McRae et al., 2017:332). Guedes and Mikton (2013) observe that because “child maltreatment and IPV [intimate partner violence] occur within the same household”, the exposure to violence (either as witness or victim) as a child significantly increases the risk of exposure or perpetration of violence in the home later on. Attachment and IMH impacts have been linked to inter-generational patterns of domestic violence (Lieberman, 2007), though wider cultural and societal issues are also important. Fasang and Raab (2014) for instance, argue that inter-generational patterns of domestic violence occur due to an intersection of family patterns and larger macro-structural issues, such as societal expectations and response to violence and abuse. Cuan Saor, like many domestic violence services, is seeing an increase in complex cases, with a particular increase in substance use issues among women presenting for refuge and other support services. As it turns out, ACEs have strong links to both³.

Brown et al (2015) explore the co-occurrence of substance use and domestic violence, finding that substance use is often a mediating factor between the violence and earlier ACEs trauma. It acts as such in two ways. Experiencing childhood abuse increases the likelihood of experiencing intimate partner violence as an adult (Ørke et al., 2018) and substance use is often used to cope with the repeated trauma. Recent research shows that this works in the opposite direction as well; childhood abuse results in substance use, which in turn increases the risk for domestic violence (for both potential victims and potential aggressors). Violence and substance use become intertwined, but it can be ACEs that drive them both.

It is important to note that there is a gender difference in how this plays out, with a resulting impact on the services operating at the intersection of these two areas. Women are significantly more likely to experience domestic violence as both children and as adults than are men (Bellis et al., 2015). Women are also more likely to use substances as a means of coping with this. Gutierrez and Van Puyumbroeck (2006:502) report that 90 per cent in substance misuse treatment have a history of traumatic violence; there is also evidence of a “lifespan victimization among women who misuse substances”, as the combination of ACEs and substance use puts these women at further risk for future domestic violence and sexual abuse.

³ Fuller-Thomson (2016) found three particular types of ACEs, the ones associated with direct and indirect violence, have an independent relationship to lifetime drug and alcohol dependency.

This ‘lifespan’ aspect is key. An important element of ACEs research emphasises the fact that different types of adverse experiences often co-occur for children (e.g. physical abuse *and* mental illness in the household *and* parental separation) and the cumulative effect of these interrelationships is critical to understanding ACEs’ long-term effects (Dong et al., 2004). Just as ACEs themselves co-occur, so too, do their effects. In this way, ACEs offer a useful – indeed, arguably necessary – framework for interventions and services, especially those that deal with complex cases (such as women with children who present with domestic violence experiences and substance use in tandem), because the cases may contain “a complex set of highly interrelated experiences” (Dong et al., 2004:773) that need to be dealt with as such, and with a trauma-informed approach to care.

ACEs routine enquiry

Underpinning the idea of trauma-informed care is “the simple and direct approach of listening and validating [an individual’s] experience” that shifts from asking, “‘What is wrong with you?’” to ‘What has happened to you?’” (Gilliver, 2018:49; Menschner and Maul, 2016:2). The latter question, asked specifically with regards to childhood experiences no matter the age of the individual at the time of screening, aims to ensure that practitioners can offer the most appropriate interventions (McGee et al., 2015). Such interventions would not only mitigate any potential negative outcomes resulting from the ACEs, but also break any potential intergenerational cycles of ACEs with the affected individuals and their children moving forward. Importantly, the direct enquiry is also meant to “convey the message that ACEs are both common and acknowledged” (Gilliver, 2018:49).

In terms of performing this enquiry, a range of screening tools have emerged in recent years that use the child maltreatment (sexual, physical, or verbal abuse) and children’s environment (domestic violence, parental separation, mental illness, alcohol abuse, drug abuse, incarceration) categories as the basis for a set of questions posed to the service user. Screenings tend to be conducted face-to-face, though some organisations employ self-completed questionnaires. McGee et al., (2015) published a scoping study of the implementation of the REACH tool – Routine Enquiry about Childhood Adversity⁴ – in the UK, detailing the various ways in which organisations on the ground adapt the framework for their use, often in line with the particular remit of their services⁵. Closed questioning (e.g. ‘did you experience X, yes or no?’) was the pre-dominant approach, though some employ open-ended questioning to elicit more detail. With respect to violence, Gutierrez and Van Puyumbroeck (2006) note that multiple inquiries may be necessary to overcome the potential reluctance of a victim of abuse to identify as such. They found the approach taken to questioning to be key:

⁴ For more information on REACH implementation, see also Quigg et al, 2018.

⁵ McGee et al (2015:7) note, for example, “[d]ifferences in the questioning relating to domestic abuse of the mother/stepmother (e.g. mother being treated violently (n=2); witnessing mother/step mother being subjected to physical abuse (n=1); and witnessing violence in the home (n=1)”.

asking if an individual has ever “experienced sexual or physical abuse” as many clinical intake interviews do is likely to result in frequent false negative responses. Inquiring about specific events is more likely to elicit an accurate endorsement of experiences with violence. For example, “Did your father or mother ever hit you so hard it left a bruise? Did your father or mother ever intentionally burn you with a cigarette or with scalding liquid?” are the types of questions that are more likely to get accurate responses

(Gutierrez and Van Puyumbroeck:504).

In practice, organisations also differ in terms of which service users they screen. Some target only those individuals who present to a specific piece of their service (e.g. in the domestic violence cases, those seeking refuge), while others adopt a universal approach, screening all service users for ACEs, regardless of specialist or intensive need. The timing of the screening is also variable: some organisations implement it at “first point of contact with service users”, while others consider it “imperative to firstly establish a rapport with clients” (McGee et al., 2015:8). For domestic violence organisations specifically, who often deal with crisis situations, “other pressing issues, such as negotiating a plan with service users takes precedence and REACH is therefore conducted with clients at the discretion of the practitioner” (McGee et al., 2015:8). This reflects the approach taken by Cuan Saor in this study, and may be relevant for the use of ACEs enquiry across the domestic violence services sector more broadly, but is an important point of distinction to make in terms of trauma-based care.

Quigg et al., (2018) review a set of pilot ACEs routine enquiry programmes across the UK across a range of sectors (including a domestic violence service), all of which were ultimately not taken up for full integration into their service delivery practice. The reasons for this ranged from unclear results for and/or impact on service users to organisational expertise, capacity, and commitment. The documentation of these pilot programmes offer useful insight into future programming efforts and ACEs integration efforts. McGee et al., (2015) also offer a set of recommendations for the future, which serve as useful reference points for services as ACEs routine enquiry expands. They emphasise the importance of making ACEs screenings routine across human services, but also point out the need for data sharing systems and other forms of co-ordination across agencies and sectors so that the same individual is not asked repeatedly about the same traumas if they present to different services to address different needs. They also addressed a potential concern, from a service delivery capacity perspective, that ACEs enquiry could lead to increased demands for trauma-related supports in areas (e.g. counselling and related services) where availability tends to be scarce, finding that while some did ask for more support, many did not.

Integrating ACEs into policy and practice

ACEs screenings can be conducted in a variety of ways, but they are all designed to produce a cumulative ACEs ‘score’⁶ to guide subsequent attention and intervention. As mentioned earlier, exposure to at least one or two forms of ACEs is quite prevalent across countries; exposure to four or more is associated with increased likelihood of future risky behaviour, poor outcomes, and intergenerational ACEs transmission. At the same time, Finkelhor (2018:175) is careful to point out that “high ACEs scores...are not the same as trauma symptoms” and therefore cannot be taken as an indicative measure (on their own) for individual treatment. Employing the more systems-based approach Finkelhor (2018) recommends, Bond (2018) identifies three strands of policy and practice: prevention, early intervention, and mitigation.

Moving from last to first, mitigation centers around being able to identify the particular types of trauma(s) in those who have experienced it and being able to target ‘appropriate’ interventions and supports accordingly. These services would aim “to develop different thinking processes so that children and adults are less likely to ‘flip’ into the fight/flight type response that is associated with threat and stress” (Bond, 2018:25). Early intervention also seeks to mitigate any potential ill effects of ACEs, but does so with the specific intention of building resilience and other protective factors, often drawing on strengths-based approaches. Schools (including early years work), peer-relationships and supports, and counselling all play a role (Moses and Villodas 2017; Bellis et al 2018; Hughes et al 2018). Prevention efforts seek to specifically tackle the intergenerational aspect of ACEs, promoting infant mental health and attachment (through the use of home visiting programmes, for example) and ensuring an overall safe and secure environment for the child of an ACEs-affected parent (Bond, 2018; Pournaghash-Tehrani and Feizabadi 2009).

Gutierrez and Puyumbroek (2006:504) stress, though, the importance of sensitivity to the gendered experience of some forms of co-occurring ACEs experiences and effects. They note, in particular, the intersection of violence and substance use, as the “psychological pattern likely to result from multiple experiences of victimization – depression, guilt, blame, low self-esteem and feelings of hopelessness and powerlessness – should be a major focus of treatment for women, particularly women who have a long history of violent trauma”. This suggests an intervention approach that centers confidence and capacity-building at all levels, rather than approaches that use confrontation (as can often be seen in US substance use treatments⁷), as well as ‘cross-training’ for service providers across the areas of domestic violence and substance use, given the specific interlinks between the two. This focus would also support Kelly-Irving and Delpierre’s (2019:453) caution against an individualistic framing of ACEs – as evidence on ACEs should not “be used to incriminate parents, but rather reveal the conditions, particularly social conditions, in which parents and children live and how they cope”.

⁶ Other tools used in the field take a similar approach. Simon and Brooks (2017) review the US Family Assessment Form (FAF) that assesses a ‘family functioning score’ across eight domains for the purposes of child protection and services intervention.

⁷ See Gutierrez and Puyumbroek (2006:504) for a reference list of research and practice examples.

Incorporating ACEs work into domestic violence service provision, as this study specifically explores, has the potential to improve the overall life chances of women and their children who access them, while also specifically future-proofing not only the adult women from abusive relationships, but also their children.

Conclusion

As can be seen from the literature, ACEs and their role within health and social care is a complex topic and there has been significant consideration of the long-term health impacts of ACEs, as well as the implications of society, communities and individuals for such experiences. Policy and practice responses to ACEs have been broad, and there has been some criticism of both the conceptual and practical application of ACEs within public health and social care settings. Despite these challenges, examples are emerging of the implementation of ACEs routine enquiry as a mechanism for initiating trauma informed responses, and it is within this context that this study progressed, with a view to contributing to the ongoing consideration of the enactment of trauma-informed responses within social and care settings.

3. Methodology

Research design

This study was based in Cuan Saor Women's Refuge in Clonmel, Co Tipperary. This study site was identified because of their existing work over a number of years of developing innovative responses to women and their children (Morton, 2015; Cuan Saor, 2016) and their work on interventions for women experiencing the dual issues of domestic violence and substance use (Morton, Hohman & Middleton, 2015). The organisation has also evidenced their focus on practitioner skill development and resiliency (Morton, 2016). Ethical approval for the project was obtained from the Principal Investigator's (Dr Sarah Morton) university, University College Dublin.

As noted, the aims of the research were to:

- Identify the level of Adverse Childhood Experiences for women accessing a domestic violence service.
- Based on the outcomes of the ACEs screening process, consider and explore trauma informed responses to women's childhood experiences and the inter-generational transmission of trauma.
- Consider the role of ACEs screening and intervention in relation to infant mental health, a key area of work for childcare workers within domestic violence settings.

To meet these aims, an action research approach was taken. Action research offers the potential to understand professional judgement, lived experiences and multiple ways of knowing when seeking to develop effective practice (Gaventa & Cornwall, 2008; Reason & Bradbury, 2008), and is particularly applicable to health and social care settings where there is a desire to move beyond measuring outcomes and explore processes of change and practice development (Donnelly and Morton, 2019). The study incorporated both routine enquiry for women accessing the domestic violence service, with cooperative inquiry groups with relevant practitioners. Co-operative inquiry groups involve cycles of action and reflection, with a focus on the building of skills, knowledge and action as a method of generating and understanding practice knowledge (Donnelly & Morton, 2019)

The research had three phases which were completed over a nine-month period as follows:

1. Implementation of ACEs routine enquiry women accessing Cuan Saor Women's Refuge over a four-month period.
2. A series of co-operative inquiry groups facilitated with staff to support the implementation of the ACEs routine enquiry and development of responses to women who have participated.

3. The facilitation of an inter-agency co-operative inquiry group in regard to potential to integrate ACEs into wider inter-agency work, especially where there is a focus on infant mental health.

Procedure

ACEs routine enquiry

This quantitative element of the study involved the implementation of ten-question ACEs questionnaire for women accessing Cuan Saor Women's Refuge over a four-month period. Questions were adapted from established ACE questions from the Centers for Disease Control and Prevention short ACE tool (CDCP) and have been used in similar ACEs routine enquiry implementation (Hardcastle & Bellis, 2019).

Inclusion criteria were set in regard to women accessing any of Cuan Saor's support and refuge services. To be invited to complete the ACEs routine enquiry women had to:

- Be fully aware of the range of supports offered by Cuan Saor.
- Not be in crisis.
- Have attended the service on at least three occasions.
- Not be significantly affected by immediate drug or alcohol use.

Posters outlining the study and what ACEs routine enquiry consisted of were placed in all public spaces in the Cuan Saor building. All women who met the above criteria were invited to participate over a four-month period. Women also self-selected, asking to participate when they saw the poster. The ACEs routine enquiry was explained by the practitioner. All participants signed forms of consent and were informed that they could change their mind at any time. Participants were informed their ACEs routine enquiry form would be anonymised. Over the four-month period, sixty completed the ACEs routine enquiry (n=60 women). All of the women invited to complete the ACEs routine enquiry agreed, though one requested to complete it on a different occasion.

Cuan Saor practitioner and Infant Mental Health practitioner inquiry groups

For the practitioner-focused phase, the study used a qualitative design in an effort to provide grounded, rich descriptions and explanations of processes in identifiable local contexts (Miles and Huberman, 1994). Two sets of practitioner inquiry groups were run: one with Cuan Saor staff and one with practitioners who are members of the South Tipperary Infant Mental Health group. In both cases, the research participants were involved in the structure and design of the inquiry groups; were invited to reflect on their practice in regard to ACEs routine enquiry; and were invited to consider and undertake actions in regard to implementation between inquiry group meetings. All practitioners across both of the inquiry group types had extensive experience, accreditation and professional recognition in regard to responding to issues of domestic and sexual violence, substance use and childhood legacies of trauma. As a preamble

to the routine enquiry and inquiry process, a one-day training was provided to all Cuan Saor practitioners and members of the Infant Mental Health Group, by Andrew Bennett, Independent Consultant, on the implementation of ACEs routine enquiry. This training covered the evidence base in regard to ACEs, skills in enacting ACEs routine enquiry and case examples of public health implementation of ACEs routine enquiry within the UK.

Cuan Saor practitioner inquiry group

All Cuan Saor practice staff were invited to participate ($n=14$), ten decided to proceed. Three inquiry groups were run at four to six-week intervals during the ACEs routine enquiry process, with each inquiry group running for approximately 90 minutes. Each inquiry group was audio recorded, with the consent of participants. Themes for each inquiry group were agreed with ongoing input from the participants, and the practitioners were encouraged to describe their practice and skills, as well as explore the experience of enacting ACEs routine enquiry.

Infant Mental Health practitioner inquiry group

All of the members of the South Tipperary Infant Mental Health Group who attended the ACEs training were invited to participate in the inquiry group process. Seven decided to participate, with the practitioners coming from a range of agencies including social work, family support, community agencies and substance misuse services. Two inquiry groups were run, with a four-week interval, with each group running for approximately 90 minutes. Each inquiry group was audio recorded with the consent of participants. Given the practitioners came from a range of agencies, with a range of developments in regard to ACEs and routine enquiry, the discussion and themes for this inquiry group focused on the feasibility and possibility of integrating ACEs into their existing work and organisations.

Data analysis

Given the mixed methods approach the research design, quantitative data analysis was conducted for the routine enquiry questionnaire data and qualitative data analysis was conducted for the practitioner inquiry groups.

ACEs routine enquiry with service users

The quantitative analysis is based on data from surveys⁸ completed by sixty women accessing Cuan Saor services over a three-month period. The questionnaires were administered by Cuan Saor staff, but no personal information was included on survey papers and the data was anonymous to the research team. The survey itself featured ten questions to which the women answered yes or no. Four of the questions focused on direct maltreatment experienced as a child (e.g. abuse experienced themselves) and six of the questions focused on their home environment as a child (e.g. abuse experienced by other members of the household or

⁸ See Appendix for the survey questions asked as part of the Cuan Saor ACEs screening.

substance misuse by household members, among other things). The set of included questions were adapted from established ACE questions from the Centers for Disease Control and Prevention short ACE tool (CDC 2019) used extensively in previous research to measure childhood exposure to forms of abuse and household dysfunction⁹. It is important to note that through collaborative discussion with the Cuan Saor practitioners, it was agreed the questionnaire would be explained to women and given to them to complete, with the practitioner staying present to answer any queries or talk through any of the questions. Where there were literacy or language issues, the practitioner helped the woman to complete the questionnaire by reading the questions or particular questions if needed.

In the analysis, each anonymous respondent was accorded a sum of the number of ACEs experienced. In keeping with the existing empirical literature using ACEs survey data (Bellis et al., 2015; Hardcastle and Bellis, 2019), these ACEs totals were also grouped into four ACEs 'count' categories: 0 ACEs; 1 ACE; 2-3 ACEs; or 4+ ACEs experienced. The ACEs survey question results were divided into bivariate data ('child maltreatment' versus 'childhood home environment') and descriptive analysis on the prevalence of each specific type of adverse experience within those categories was conducted. Results from the Cuan Saor sample were also compared to the results of ACEs studies in Wales (Bellis et al 2015) and the United States (Merrick et al., 2018; Felitti et al., 1998) in order to understand the ways in which the prevalence (and types) of ACEs experienced by women accessing domestic violence services differed from the ACEs experience of broader populations in primary care settings. The order of prevalence of individual ACEs types within the Cuan Saor population was also specifically noted, along with the correlation of the most common ACEs type to other ACEs experienced, in order to identify trends within this cohort of women and to inform practitioners moving forward.

Practitioner inquiry groups

The practitioner inquiry groups generated a good deal of qualitative data which was analysed thematically (Hardwick and Worsley, 2011) to explore key issues emerging from the data. To reduce the data and make it more manageable (Miles and Huberman, 1994), two levels of coding, open and axial, (Strauss and Corbin, 1998) were conducted. The first step allowed for categories to be identified and assigned to elements of the recorded material and the second step allowed for relationships between the categories to be established (Strauss and Corbin, 1998). Themes were constructed providing the foundation for later analysis of the participants' experiences with respect to the efficacy and challenges of delivering low threshold substance use services, with particular consideration of practitioner approaches.

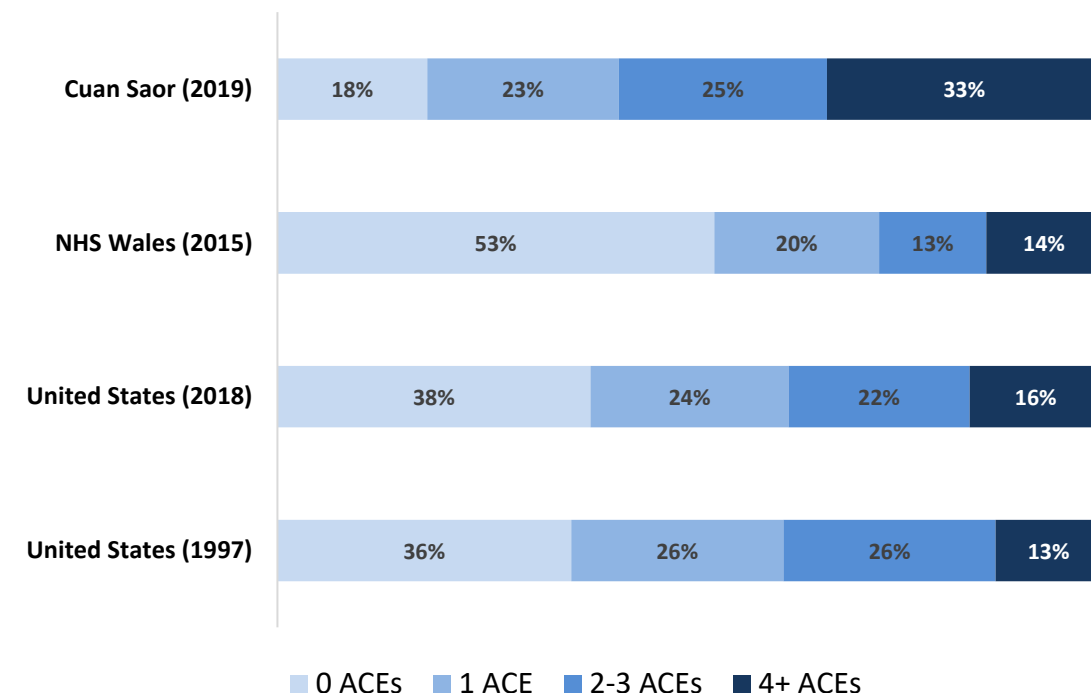
⁹ See Hardcastle and Bellis 2019 for more detail.

4. ACEs Routine Enquiry Results

The survey results reveal ACEs to have a significant presence among Cuan Saor service users. The mean ACEs score for the women surveyed was 2.7. While 18 per cent of Cuan Saor service users reported having experienced no ACEs in their childhood, over one-half (58 per cent) of Cuan Saor service users experienced at least two ACEs in their childhood.

To place these results in a broader context, Figure 4.1 compares the prevalence of ACEs among Cuan Saor service users to the general population samples of primary care service users in Wales and the United States. The prevalence of ACEs among the domestic violence service users surveyed is revealed to be notably higher – the proportion of Cuan Saor service users experiencing two or more ACEs as children is twice that of the Welsh general population, where 27 per cent experienced two or more ACEs, and one and a half times that of the US general population¹⁰ in both 2018 and 1997 (where it was 38 per cent and 39 per cent, respectively).

Figure 4.1
Prevalence of ACEs: Cuan Saor in a comparative context



As noted, caution is required when comparing ACEs results across populations and across time, given the lack of uniformity in terms and the definitions of ACEs events (Appleton et al., 2017; Steptoe et al., 2019). The rationale for the international comparison here is to identify broader trends in similarities or differences between the ACEs routine enquiry responses of

¹⁰ National US figures, though, belie more pronounced ACEs patterns among population subgroups, with the prevalence of ACEs following a striking social gradient (Merrick et al 2018).

general populations presenting at primary health care settings and women presenting at domestic violence services. Indications of differences in ACEs prevalence – either by volume or type – are useful for informing future work on ACEs routine enquiry implementation in service delivery settings.

As was also noted in Section 2, an ACEs score of four or more is associated with a range of negative health and other personal effects, as well as intergenerational effects, for individuals later in life. One-third (33 per cent) of Cuan Saor service users experienced four or more ACEs events in childhood, more than double the proportion of the general population in Wales or the United States who report experiencing this many adverse experiences in their childhood. Table 4.1 charts the most common types of ACEs experienced, comparing those reported by Cuan Saor service users to the Welsh and US general populations.

Table 4.1
How many adults exposed to each type of ACE in their childhood?

Child Maltreatment

	<i>Verbal abuse</i>	<i>Physical abuse</i>	<i>Sexual abuse</i>
Cuan Saor Service Users (2019)	50%	32%	27%
NHS Wales (2015)	23%	17%	10%
United States (2018)	34%	18%	12%
United States (1997)	11%	28%	21%

Childhood Home Environment

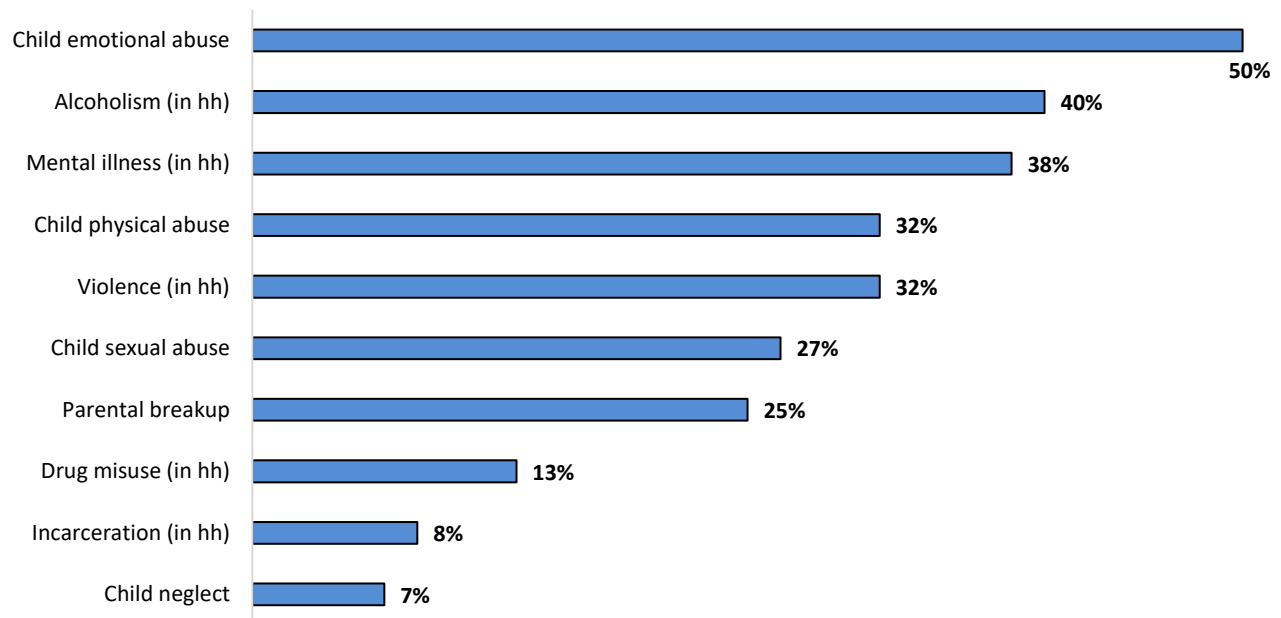
	<i>Alcohol misuse</i>	<i>Drug misuse</i>	<i>Mental illness</i>	<i>Domestic violence</i>	<i>Parental breakup</i>	<i>Incarceration</i>	<i>Physical Neglect</i>
Cuan Saor Service Users (2019)	40%	13%	38%	32%	25%	8%	7%
NHS Wales (2015)	14%	5%	14%	16%	20%	5%	n/a
United States (2018)	28%		8%	17%	18%	28%	n/a
United States (1997)	27%		5%	19%	13%	23%	10%

Source: 2015 NHS Wales data from Bellis et al.(2015); 2018 US data from 23-US state study, Merrick et al (2018); 1997 US data from Felitti et al. (1998).

All three locations – Cuan Saor, Wales, and the US – see similarities in the most common types of ACEs exposure. Child maltreatment in the form of verbal abuse emerges as one of – if not *the* – most prevalent, followed closely by physical abuse (of both the child and of other members in the household) and substance misuse (alcohol and/or drugs). Cuan Saor service users, however, experience these and all other types of ACEs at noticeably higher rates than do the general populations of Wales or the United States. The one exception is with respect to incarceration, which emerges as a prevalent ACE in the United States only¹¹.

Figure 4.2 focuses specifically on Cuan Saor service users. Half of the service users surveyed experienced verbal/emotional abuse as a child. Over half (53 per cent) lived in a household where substances were misused (40 per cent with alcohol abuse and 13 per cent with drug misuse). Mental illness¹² in the household was the third most common type of ACE experienced by Cuan Saor service users. Violence in the household, in the form of physical abuse of the child or physical abuse of other family members, affected one-third of respondents. Sexual abuse and parental breakup follow closely thereafter, affecting at least one-quarter of service users surveyed.

Figure 4.2
Most common type of ACE experienced by Cuan Saor service users (%) (n=60)
(2019)



¹¹ The US has one of the highest incarceration rates in the world (860 out of every 100,000 US residents aged 18 and over in 2016; down from a high of 1,000 out of every 100,000 US residents aged 18 and over in 2006-2008) (Gramlich 2018).

¹² This includes living with a parent or family member who was depressed, suicidal, or mentally ill in another way.

In overview, Cuan Saor service users are affected by both direct maltreatment experienced as a child and adverse home environments. The most prevalent ACEs experienced are also not happening in isolation – each were revealed to be highly correlated with one another. Of all the respondents who reported experiencing emotional/verbal abuse as a child (n=30), 60 per cent also reported alcoholism in their household, 53 per cent reported having experienced physical abuse, 50 per cent reported domestic violence in the household, 46 per cent reported mental illness in the household, and 40 per cent reported experiencing sexual abuse.

ACEs routine enquiry is best able to capture exposure and patterns of association; it offers much less in terms of identifying the intensity or duration of adverse experiences and does not offer a causal link between ACEs in childhood and later life outcomes. What these findings do offer, though, are early indications of both ACEs prevalence as well the types of ACEs that most define the experience of the women presenting to the Cuan Saor service; Section 5 details how Cuan Saor domestic violence service practitioners responded on how this might enhance their understanding, responses, and service provision

5. Findings and discussion: Cuan Saor Practitioners

Implementing ACEs routine enquiry

Training

The practitioners agreed that the one-day training on ACEs and ACEs routine enquiry was essential to implementing the questionnaire with service users. Key aspects they felt were useful within the training were:

- The history, evidence base and debates in regard to ACEs and ACEs routine enquiry.
- Examples of where routine enquiry had been implemented and the successes and challenges.
- Skills work in actually working with the ACEs questionnaire as a tool.

It was felt the inclusion of these aspects helped them to commence and integrate the ACEs routine enquiry into their practice.

Implementation

Beyond effective training, the practitioners felt a number of factors supported the implementation of the ACEs routine enquiry. These included:

- Ongoing conversations and updates about the ACEs routine enquiry implementation at handovers and staff meetings.
- Inclusion of all practitioners across the range of services in both the training and routine enquiry implementation.
- Provision of opportunities for relief and night/weekend staff to implement ACEs routine enquiry given the low possibilities within their own shift patterns.

All of the procedures were agreed within the organisation prior to implementation. This included: having the ACEs questionnaire printed and available within all client support areas; having a specific signed consent form that explained ACEs and what it was and how any data would be handled; explaining to women that her ACE score would not be recorded in her file but it would be noted that she had completed the ACE questionnaire.

The practitioners expressed numerous concerns prior to, and in the early stages of the ACEs routine enquiry implementation mostly in regard to the relevance and wording of the ACEs questionnaire and the potential impact on clients of raising traumatic childhood issues with clients. Specifically, the practitioners were concerned about meeting women's needs if significant issues emerged. This echoes a theme arising often in the literature from other studies of ACEs routine enquiry implementation around the ethics of discussing ACEs in the absence of confirmed access to additional support services (Quigg et al., 2018; Finkelhor, 2017).

Ultimately, however, the consensus was that the ACEs routine enquiry had the potential to enhance their practice:

I was thinking of it as a toolbox, really. You're working with a woman, all these little things come out in your mind that you can more understand and a bit more compassionate. And I suppose a bit more patience...every woman that walks in the door, really would...unless they haven't recognised it...will tick some of the ACEs on that page.

It was also agreed that it was helpful to have key staff committed to and encouraging ongoing participation and engagement with the project across the organisation and that this ensured engagement with the project:

You know, and there are lovely smaller group discussions happen from time to time about our client group, about the service users, about who's doing the ACEs, about who might not have done the ACEs or how many ACEs enquiries they have completed with women. That's all lovely energy in the organisation as well.

Organisational commitment (at both staff and leadership level) to the ACEs routine enquiry tool has been noted in other evaluation studies (Quigg et al., 2018) as a deciding factor in whether or not ACEs screening is a suitable or feasible tool to incorporate into service provider work.

Lessons from ACEs routine enquiry practice

Five key themes emerged from the Cuan Saor practitioners' experiences of implementing the ACEs routine enquiry: (1) how relevant or otherwise they found the tool in the context of their work with women; (2) how they responded to disclosures of trauma; (3) the timing of the routine enquiry within the helping process; (4) understanding and empowerment they witnessed for women they were working with; and (5) tensions and challenges for inter-agency work. Each of these themes are explored below.

Relevance of the ACEs tool

As outlined in the previous section, the practitioners had initial concerns about the ACEs routine enquiry tool, including the ACEs questions themselves, how they would integrate the ACEs routine enquiry into their existing work with women, and how women would respond to the routine enquiry. Overall the practitioners did not report any issues with the questions on the ACEs questionnaire, despite their reservations at the start of the process. It had been agreed within the inquiry process that on completing the questionnaire with the service user, the practitioners would ask if there was anything that was not on the questionnaire that they felt had impacted on them. The practitioners found this to be generative in their work with women, that in asking if there was "any other aspect of your childhood that caused you concern...opened up a conversation that may never have happened".

The practitioners had also initially queried whether, given their experience and expertise, an ACEs questionnaire was needed to explore or discuss these issues with women. They agree that the ACEs questionnaire provided a framework for a discussion with a woman, with one practitioner stating:

Some of the women don't realise that their experience is good or bad, or that it has had such a profound impact on them. The client mightn't realise that these things are linked.

Another worker felt it helped to keep her tuned into the woman she was supporting, stating it slowed down her practice in a positive way:

You're going at the woman's pace. You're not 10 steps ahead, it just brings you back. Kind of holds you with her.

The practitioners did query the relevance of the ACEs questionnaire and carrying out ACEs routine enquiry with older women, particularly if the women were mothers of adult children. They agreed that the ACEs questionnaire can sometimes be viewed as a tool to support early intervention in regard to a woman's children, rather than a support for the woman herself. There was general agreement that:

And maybe we were trying to focus a little bit on what the outcome would be, a positive angle for the women. And we were thinking that it would be that you can understand better the effects of where you're at on your children and possibly do some preventative work now at an early stage. But I think we might be losing the bit in relation to the healing that might be in it for the women herself, and to focus on that.

Responding to disclosures of trauma

Practitioners acknowledged that the ACEs questionnaire provided a framework for exploring childhood trauma with women. In the words of one practitioner, it helped refine what she described as their 'traditional intuitive practice':

As workers in the field, we all had a suspicion, we know that childhood impacts women, but there's a big difference between having a suspicion and having a researched framework to put that in...this gives actual knowledge of something that's research-based. And that deepens certainly my own practice. It's not anymore something I think, or intuitively feel when I support a woman...[that] she had a tough childhood, which we would so regularly do with our clients before...ACEs has put that framework on the traditional practice.

Some of the ACEs questions raised issues of societal and cultural norms in regard to parenting and how these may have changed over time. Specifically a number of women highlighted to the practitioners that previously it was 'normal' to get a 'clout' or 'clip around the ear' by a

parent or within the school system from a teacher. For the practitioners those brought up two issues, how women understood the impact of such experiences and the reluctance of some women to tick yes to relevant questions because this was 'normal' behaviour in the home when they were growing up.

In regard to the impact, one practitioner outlined it this way:

Some can accept, you know, that they grew up in that generation. Kids got a clip around the ear and they're fine. And then in another group of people it wasn't so fine and there's a thin line between when it happened, how it happened, how often it happened, do you know? So there's so many variations of the questions and maybe that feeds into why some people don't have ACEs, because they don't view it as it was, you know? They might have issues in their life but they're not linking the two.

One practitioner noted that one client felt she was doing an injustice to her parents if she ticked yes:

That came up with one of the women that I was doing in the interview as well. The very same thing and she actually felt guilty ticking the box because she felt she was doing an injustice to her parents.

For another woman, she did not feel she should tick 'yes' because there had only been one incident:

And I had a similar thing as well, and she was like, "Excuse me. It was only once. It was only once." But she said once but when it transpired at the end of it, her description of the incident was fairly graphic and she kind of got upset about it. So it did have a massive impact on her.

The practitioners had numerous other examples of cases where one ACE might have had a significant impact on a woman's adult life, which was contrary to their initial presumptions around high ACEs equating with high negative impacts on women:

With one woman, I had a preconceived idea that she wouldn't tick any of the boxes, and she ticked one box and that had a really adverse effect on her. And so for me, it's to not go in with anything in my head, just to give her that space.

Like in other settings (Quigg et al., 2018) early in the process the practitioners voiced concerns about how disclosures during or after the ACEs questionnaire would be handled and responded to, and if the agency had the appropriate resources to respond effectively to women's disclosure of traumatic experience. For the practitioners, a major disclosure often invoked anxiety about further traumatising the woman by exploring this experience, or that she needed specialist support that may not be available. This was highlighted by one practitioner:

I have one woman that I see on a regular basis and when she did the ACEs questionnaire, she then spoke about her sexual abuse for the first time ever to somebody apart from her husband. She'd never told anybody. And since then, I have been trying to get her into counselling because I'm thinking that maybe she should go onto counselling, but she doesn't want to because she's got this trust in me. But she gets something from having me be the first person that she spoke to but then sometimes I worry that I'm not a psychotherapist to support her ongoing... and I don't want to put that woman in any kind of risk or danger.

The practitioners agreed it was important to revisit the ACEs routine enquiry with women and provide the opportunity to discuss the issues further if she wished. As one practitioner outlined:

I think we owe it to them and ourselves to go back at least once, even just to say, "God. You know, do you remember what we did with that ACEs questionnaire?" And loads of things came out of it. Is there anything you'd like to discuss or, you know, what you think about this? And just give that opportunity to go, if they don't wanna go there, fine, but I have had some really good conversation from saying that.

Timing ACEs routine enquiry within the helping process

There was considerable discussion about ensuring the time was 'right' to invite women to complete the ACEs questionnaire. There was no agreement about whether a woman needed to have an established relationship with the practitioner or not, as there was a variety of experiences within the implementation phase. Some practitioners preferred to have a relationship with the woman, whereas for those on the relief panel or working in different roles, this often was not possible. Only one practitioner reported a practice example where she felt in hindsight that the lack of relationship with the woman meant that the routine enquiry did not add anything positive to the support process. Other practitioners highlighted that they sometimes did not get the opportunity to follow up with a woman after completing the ACEs routine enquiry, which made them wonder how useful it had been. One said:

I suppose for me, being on the relief panel, we don't necessarily get to follow on with women that we would have done implemented the ACEs questionnaire with. The only woman, that I have had the chance to do follow-up work with, she's very caught up in the court and legal system and her living conditions. I've met with her a couple of times since and most recently last week and there didn't seem to be an opening to go there about ACEs or to see if we could pick it up again.

There was ongoing debate between the practitioners about getting the timing right in terms of how well they knew the client, but one practitioner explained.

I had no relationship with the other two women that I met that day. And the first one, it flowed really well and she made some connections around being the peace keeper in the

house and...even though she was years separated from her husband she was still trying to keep the peace with him and she made that connection and kind of had a light bulb moment. And then the third lady, it was a bit like, "Yeah. I know all this. I've done personal development. I'll do it but ..." and I don't think it really added anything for her.

This debate was ultimately underpinned by concerns that completing the ACEs routine enquiry would not be of benefit to every woman who completed it, although this often focused on whether they had a strong enough relationship with her or whether she had too many other things going on in her life at that time:

But from a crisis point of view, I think, "Well, it's not for me to decide whether that lady is ready to do this or not. I'm just going to present it to her." That's what I was thinking-my thoughts afterwards. Because I'm actually not giving her an opportunity in a way.

The ACEs routine enquiry implementation literature does note that in considering ACEs screening within domestic violence service settings, it is important to recognise that many service users would be in or recently near crisis point. While Cuan Saor specifically offered the ACEs routine enquiry only to those women not in crisis, Quigg et al. (2018) and Leitch (2017) observed in past reviews of ACEs implementation the importance of considering service users' resiliency levels and capacity to ensure the discussion of past trauma does not undermine any receipt of services meant to address their current situation (e.g. domestic violence).

The practitioners had a lengthy discussion during one inquiry group in regard to women who had no ACEs, questioning whether this was the case or whether there were other factors that may have impacted on health and relationships. They cited a number of cases where a single traumatic incident such as a random assault outside of the home or bullying by a teacher in school actually had a significant impact on the women they worked with in regard to such traumas. There was a general conclusion that the ACEs routine enquiry did not lend insight into the gendered cultural and societal expectations women may experience as children, though discussing the ACEs routine enquiry provided an opportunity to discuss this with women afterwards:

The routine enquiry allows you to go her through experiences of ACEs and then say, "Do you know what? We're finding that for some women that don't tick those boxes, it turned up that this was the reason. It was society. It was your expectations. It was what might be expected of you in terms of relations - and it's just given us something to work off of now.

Understanding and empowerment for service users

A major theme for the practitioners was the degree and mechanisms by which the women articulated greater understanding and empowerment from completing the ACEs routine enquiry and from the subsequent conversations. The practitioners agreed that the ACEs routine enquiry process often helped ameliorate the self-blame women felt about both their lives and negative impacts on their own children. One practitioner stated:

I think it dilutes self-blame, so yeah I had my childhood but as a result of that I'm doing all of this. But if somebody else says, well, you know, what did happen? You kind of go, okay so what I was feeling is actually valid. So it dilutes the blame and it allows the woman to talk a bit more.

One practitioner maintained that the understanding generated by ACEs routine enquiry became the antithesis of self-blame for one woman – she:

took it on as empowering, as understanding, a self-understanding....It's the release of self-blame there that she feels: 'There was a reason why I took this bad boyfriend I took that bad husband, I started drinking, I started using substances'.

Another practitioner stated that the positive impact of ameliorating self-blame was beneficial over the following weeks and months for women she had worked with during the ACEs routine enquiry process:

What I found the biggest benefit was over time empowering for her. Rather than putting the total blame on herself for how her life has turned out and the things that have happened to her, it gives her a better overview of where she might have started from initially and why she made the choices she made.

It was felt that this ultimately led to a greater understanding of life patterns for the women, as one practitioner outlined, saying a woman has:

A deeper understanding of where she came from. And also I think there is a deeper level of communication with the women....it's easier for her to speak about her childhood because there's a link for her now. That is what I think it does. It makes that link between childhood and where she is now.

In one case, the practitioners agreed that not only was the process empowering for the woman, allowing her to advocate for her own children, but also allowed her to start to move on from her own experiences:

It put structure on her past, but it also gave her the strength to move forward. I think she argued it with social workers that, I am the way I am because of what happened to me and my childhood and now that's going to happen to my children if things don't change. That was her argument, and I think she used ACEs did she, to try and get her children back? So, it was amazing to hear and watch that process taking place. Now she's a long way down the road in her process but it was great for her, and she actually said, which was massive, that, I have to let go of the experiences that happened to me as a child because, how can I be a better mother if I don't let go of them?

In one case there was an immediate link for the woman in terms of inter-generational patterns and substance use and she requested an appointment with the substance misuse service:

I would be very aware that her ACEs would be high. She had a seven score. I knew that it would be that at least, but her father was a drinker, and she made that link, which was so quite amazing, between her father being a drinker, she herself would be quite drink dependent I would say a lot of the time. And we made an appointment with the substance misuse service for the afternoon. Now I genuinely feel that link would not have happened because she didn't want her kids to see her like she saw her father, without you doing the ACEs first....

In one case, completing the ACEs routine enquiry provided the woman with an opportunity to consider how her own mother had sought to protect her from her own ACEs, and then the degree to which her own children may have experienced ACEs and it was important for the practitioner not to reinforce any guilt or shame:

You've gotta be very careful in how you support somebody, that it doesn't make them leave thinking, "Well, my mum was so great and I've been so bad." You know, that's not going help the woman and not going to help the child but it might help this particular woman to leave the relationship because she's withering and she's becoming much more stronger in her belief that he's never going change.

For some of the practitioners, completing the ACEs routine enquiry had a profound effect on the woman they were working with:

She was like, "Oh, God. I'm ticking them all, nearly." And then she was saying "Yes, I did have such a dysfunctional family and the pain I was in, and that all I ever wanted was to feel loved or to have someone to love me," and how she ended up in domestic violence relationships trying to feel loved as well. And we spoke about the addiction being a reaction to all the pain she had. And it was really like, "I can see how my life went down

that route because of what I've experienced as a child." And these tools have really helped her to say, "Okay, I've had a dysfunctional family; it's been unbelievable. But by God, it's not going to happen to my children. That was then and this is now. I'm working so hard now". I just found it, the conversation after, extremely empowering for both of us.

Another practitioner added:

And for me, it's how we always work from where the women are at, but it helps us to look where they came from. And that that sentence, not asking what's wrong with them but what happened to them. That's really powerful.

For some of the practitioners, insight into the issues their clients were facing intersected with the client herself gaining insight into the impact of her experiences:

Sometimes your work is so busy you don't get the opportunity to go back into the past or ... because there's other issues that you're dealing, but for one woman that I'm thinking about that her mum, she came from an abusive relationship. Her dad was abusive to her and she got animated and things. She said, "Why did my mother stay there? She wasted 10 years of her life. Now look at me. I'm doing the exact same".

The practitioners discussed what they found worked in relation to support women's resilience as part of the ACEs routine enquiry. They felt acknowledging her past experiences and highlighting her emotional and practical strengths was really important, but also supporting her to see a different life path for herself, as one practitioner outlined:

One lady who ticked all the boxes, now she became really, really upset, but she already had identified that all those adverse child experiences had affected her life. She was really interested in resilience, and she got it that it didn't define her, which was really interesting - just looking at all of those questions, ticking all those boxes, she said it really reinforced that her childhood really affected her and how she has lived her life, how she has parented. But she can see that she can make changes. But it was like a clear picture for her.

The practitioners highlighted a number of cases where women had older children and that it was key that in such instances that completing the ACEs routine enquiry did not reinforce guilt or shame she may have where older children were now in care settings or were already dealing with the impact of their own ACEs. The workers agreed that guilt is an emotion that should be named and talked about, as it is so often a feature for women who have experienced domestic violence, especially guilt in relation to the impact of domestic violence on children:

But I think guilt with domestic violence goes hand in hand. So again, even when you're supported, the guilt is going to be there regardless of staying for the children. Guilt is so key to domestic violence.

As identified by Bond (2018) a mitigation response to disclosed trauma seeks to ameliorate the impacts by recognising trauma triggers and supporting individuals to react and act differently to perceived threats and stress. Responses that are capacity and confidence building are key, especially where there are experiences of domestic violence and substance use (Gutierrez & Puyumbroeck, 2006). Illuminating wider social conditions is also important (Kelly-Irving & Delpierre, 2019), rather than reinforcing the individual ACE experience. The practitioners within this study reported responses that correlated broadly with this approach, focusing on fostering understanding of childhood experiences and exploring the links to life patterns and trauma responses. The practitioners also focused on advocacy, both encouraging self-advocacy with the women, and advocating on their behalf with other agencies. There was limited discussion of the wider social conditions beyond gender, perhaps highlighting the risk that ACEs routine enquiry may eclipse wider issues such as poverty, community violence or social disadvantage that may impact on women's lives.

Inter-agency work

The final key theme emerging from the practitioner inquiry groups was in relation to inter-agency work and ACEs routine enquiry. The practitioners felt those in other related agencies would take women's experiences more seriously because of the evidence base evident in relation to ACEs:

Once there's that name, or that label to it, people tend to stand up and listen a bit more. And I think that's the bit as well with other agencies, the fact that it's evidence-based and that they can research it and there's actual weight to it makes it more meaningful.

There was agreement that the evidence base in relation to ACEs routine enquiry might mean women were listened to more in other agencies related to their care and support, but there was also a concern that the ACEs routine enquiry could be implemented in agencies without important aspects of support, empowerment and follow up:

Yeah, okay you train 50 more professionals out there, and you do have the social work department, which is integral to the work that we do here with the women and the children. How do you put feeling into it? How do you put the compassion into it? Because if they don't go in there with feeling and compassion, then the client won't have a result.

There were also concerns that a woman would be 'reduced' to her ACEs score or would be requested to complete the routine enquiry within several agencies. It was felt the logistics needed to be worked out at inter-agency level so that the implementation would be effective. The practitioners also highlighted the importance of good training prior to implementation, and time and resources being allocated to practitioner skill development to ensure a positive experience for those being invited to complete ACEs routine enquiry:

Yeah and I think that there is a risk that ACEs will broaden itself out for the fact of saying, well we have five agencies that are doing ACEs. Where if it gets broadened out too much, it might be better to keep ACEs with four agencies who would give the woman the support and the acknowledgment of the non-judgmental part that they will need if they complete an ACEs questionnaire. There is that thing where the people in the supermarket are doing ACEs. That's not good, in my opinion there's risk.

In particular the practitioners were concerned about the level of supports women might need after a disclosure and how an agency might enact a client-centred response:

If you provide or implement a framework which allows her to acknowledge some of her vulnerabilities, then you have a lovely piece of work and a responsibility to support her... we do this on the Pattern Change [Programme¹³], about how those vulnerabilities are perceived, and understood, and talked about to others. Because they're hers and she a right to boundary those.

The practitioners also voiced the concern that women may feel there were implications for acknowledging some childhood experiences, depending on the remit of the agency:

And I wonder how effective and truthful the response would be if the social workers carrying it out, because it's just a different support session and people are going to be terrified of, if I tick this, what will this result in?

However, it was also felt that the ACEs routine enquiry could be useful in providing an agreed language to describe the impact of a woman's past experiences, and also provide a further basis for advocating on behalf of women with other agencies:

And I think that's where it will impact on the lives of the women that we support as well in that advocacy bit that we do all the time, and from child protection conferences to professional meetings to referrals. I think it'll make a huge difference.

Both the concerns and potential for the integration of ACEs tools within inter-agency work reflect themes also prevalent in Quigg et al. (2018), along with Dube (2018) and Public Health England (2017). The issue of 'who's doing the asking?' matters. Of particular importance in this respect is "ensuring professionals are aware of the power they hold is promoting disclosures of abuse, and subsequent access to supports" (Quigg et al., 2018:41).

¹³ The Pattern Change Programme is a twelve-week group-work programme for women who have experienced domestic violence (Morton & Hohman, 2016).

6. Findings and Discussion: Infant Mental Health Group practitioners

The infant mental health practitioners were not engaged in a systematic implementation of ACEs routine enquiry, so the themes emerging from the inquiry groups reflected this difference. The agencies represented included community organisations, social work and substance misuse agencies. Of the six agencies represented, there was a range of responses to ACEs from contemplation of ACEs routine enquiry being introduced to being implemented in a briefer format as part of client assessments. Three key themes emerged from the inquiry groups: (1) the relevance and implementation of ACEs routine enquiry; (2) mothering, children and inter-generational patterns, and (3) inter-agency work.

Relevance and implementation of ACEs routine enquiry

For the practitioners, the role and remit of their agency was a key determinative factor in whether they should consider integrating ACEs routine enquiry into their work. There were different thoughts and opinions about this, depending on the agency. As one practitioner highlighted, the purpose of the agency should influence the decision to consider implementing ACEs routine enquiry:

There has to be a consideration for the agency, about what's the purpose of this, so why would we do this as opposed to any other agency that those moms might be in contact with. Well, she has a relationship with us and we think we could positively influence her parenting of her own kids or dealing with some issues in her life by doing that routine inquiry.

The practitioners felt that the ACEs questionnaire had real value, but that important questions needed to be considered before it was enacted as routine enquiry:

Because I do think it's a very valuable questionnaire. I absolutely do. But I just think we have to look at it in terms of the system and the organisation that you work in, and in terms of support for the worker as well.

Nevertheless, the practitioners felt there was an opportunity to integrate ACEs with theoretical and practical attachment-based approaches:

I suppose from an infant mental health point of view, I think for everyone's informed on his mental health now that's great. But I think just a lot of practitioners out there who aren't informed a lot around attachment theory and the importance of attachment for all relationships. So, I don't know, coming from infant mental health, say some staff, even in our team who wouldn't have an understanding or a great recognition of it, but I mean just a huge piece of work that could be done around ACEs and attachment as well as there's an intervention to help parents better understand.

Similar to the Cuan Saor practitioners and existing literature (Quigg et al., 2018; Finkelhor 2017) noted earlier, a recurring theme is the concern raised about organisations implementing ACEs routine enquiry without certainty that resources would be there to respond to client issues that were raised. While referral pathways for counselling and other therapeutic interventions currently exist, it was felt these were limited, often with significant waiting lists or limits on the duration of the intervention. The infant mental health practitioners also debated whether the ACEs tool had value over other interventions or ways of considering trauma:

So there is something very pivotal about as practitioners, I think I would want to know, well, we have some understanding of why this would be more useful than just doing what we do -because I talk to women about these issues anyway.

For some of the practitioners, they were the only one in their agency considering the role or value of ACEs, which raised questions about how to or whether to proceed with integrating ACEs into their work. For those practitioners that had implemented a full or brief form of ACEs routine enquiry, they had to find a way to integrate it with their existing practice and this took time as they found the wording and structured approach formal:

When I first started asking the questions, I was really nervous and I was, you know what I mean? So it's only with use again and again. And I was very kind of like a bit nervous even about how I'd word to explain it to people. Now I'm familiar with the wording and I feel I may explain it a bit better because I'm probably a bit more confident myself around the explanation of it.

As with the domestic violence service practitioners, it was agreed that many issues on the ACEs questionnaire were normalised in many families, and that completing the routine enquiry could provide a framework for understanding these family experiences.

Because it is the norm in a lot of families - like people grow up in domestic violence, in trauma-based homes. To them that was normal. You can explore with them the home they grew up in, they are better equipped to understand it. Then they are more informed leaving. That those things weren't okay.

Another practitioner added:

There's a deep complexity about this work. And the reluctance nearly as well, because if you do open up, where does it lead and can you support the family? And I had said that as well, isn't it better to know than not to know? Because at least if you have some idea of what's going on and you can offer support, you can think about it, you can empathise a bit more. You can encourage the parents to offer supports or whatever.

However, it was highlighted that some parents may have concerns about the implications of disclosing their own childhood experiences, in terms of current child protection and welfare concerns, particularly where an agencies remit is to work with the children:

But there is this other thread where you have a remit around child protection. So therefore, but there's even an unspoken fear, if you disclose this, the ACE is evidence to say that your children are therefore going to be at higher risk. So that's the double bind.

The infant mental health group, similar to the Cuan Saor domestic violence practitioners, also questioned the relevance of completing ACEs routine enquiry with older service users. Several of the practitioners spoke about 'not going there' with older clients, usually those over the age of 60. Mostly this decision was based on the fact that if the person had children, they would now be adults, but also because of assumptions in regard to general understandings about trauma:

I think there's our own assumptions, right or wrong. That somewhat of an older generation kind of 60 plus may not have the same kinds of, normative experiences around talking about trauma, and some of the issues that are in the ACEs. Whereas the next generation, it is more normalised. I'm not saying it's okay, but there's more of a discussion. So we make assumptions around older people. It's much more difficult for them to talk about it.

Mothering, children and inter-generational patterns

Given the practitioners were drawn from an infant mental health networking group, there was, unsurprisingly, significant discussion around supporting mothers with new babies, particularly where the mother has substance use issues. There were concerns that women could be dealing with a lot already, without the inclusion of ACEs routine enquiry. It was highlighted that women have already provided some of the information on the ACEs questionnaire as part of their referral to some agencies, and if the referral is in regard to infant mental health and parenting issues the nature of the ACEs questionnaire might not be helpful:

Issues usually come up during the course of the conversations with parents, out of their story, and I wonder that if you push the stories, the questions too much, they would back off.

However, the point was also made that the evidence base underpinning the ACEs questionnaire is helpful in advocating for children, where their mothers have completed a routine enquiry:

It's very useful when you're fighting for services or you're seeking a case conference are your view to say, well, yes we have the research now to back it up or this is the word to describe what this young child is going through. Or why this adult can't care for this child. So I find it very helpful to explain to people what it is because for a long time, people weren't giving it the attention it deserves.

As with the domestic violence service practitioners, there were concerns about igniting parents' guilt if inter-generational patterns were being considered:

There's no parent sits in any room that doesn't feel guilty about something they have done wrong. Let alone if you have a parent and they have guilt around whatever issue they're there for. That they want to do the best they can for their children. I think that's maybe part of the openness around the ACEs. That if they can do anything to try and help change in parenting with, you know what I mean? With their own children. I have found the ACEs helped with supporting mothers around that.

For some of the practitioners, the opportunity to engage with inter-generational patterns was an important aspect of considering the use of ACEs routine enquiry. Some of the practitioners were now working with the children and grandchildren of original clients:

So now like you can actually say no, this doesn't have to be, your life can change. You don't have to go down that path. You can change your life, you can go on a different branch, different direction. And by using that, those questions, I think is very powerful. It's just like a light bulb moment. I think that's fantastic.

Inter-agency work

Given the range of agencies involved in the inquiry group, there was significant discussion about inter-agency working and about the general trends and developments of interventions. On a practical level, the issues in regard to data protection and ethics was highlighted, particularly when multiple agencies were working with a family.

Is there a way, now obviously this is the practical piece around confidentiality, data protection, especially when you know that a family is accessing multiple services. Is there a way to save that person from having to tell every other service? Also that the other services can benefit from some of the information that might improve their response.

Another practitioner added:

And they're sharing the person's history, why don't we talk about that you shouldn't be defined by your ACE score. I wouldn't want us talking about clients 'oh she's a four plus' [ACE score].

The practitioners had a wider, more philosophical discussion about the future of services delivery and how ACEs might fit into that. It was pointed out that it can be much harder for statutory agencies to innovate and introduce new practices. One practitioner drew the analogy of the statutory agencies being like a large tanker, given organisational infrastructures and numbers of staff, and that – with respect to making changes in approaches to working with and offering support services for families, children and trauma – it can take “9 miles for one of those tankers to turn or go back”. Working with this analogy, the group discussed how smaller NGOs and community agencies can essentially act as smaller, more nimble boats providing more tailored family support. As one practitioner described:

I think if we were to go with this analogy, which is very powerful actually...There's people on the big ship [i.e. statutory agencies] who are looking to see what's happening and waiting for the turn to happen...[but] it's also empowering because... there's more mobile craft [i.e. smaller community agencies] that are starting to innovate and pick people up.

This potential for innovation at ground-level in service settings has been noted elsewhere and work continues to develop – most notably in recent years in the United States and United Kingdom – on the best ways to implement screenings in a way that is sensitive and supportive of services users and results in improved and effective service coordination and delivery (Quigg et al., 2018; Ford et al., 2017; Larkin et al., 2012; McGee et al., 2015; Ellis and Dietz 2017).

7. Considerations and implications

This research sought to identify the level of ACEs for women accessing a domestic violence service and explore both the enactment and responses by practitioners to ACEs routine enquiry. In addition, the study also sought to consider the possibilities in regard to the use of ACEs routine enquiry with a range of practitioners who had an infant mental health remit. As such, this study was situated in a very specific setting. It took an action research approach to exploring the practice responses aspect of the project, collaboratively working with practitioners to build an understanding of the relevance, usefulness and responses to ACEs routine enquiry. The findings of this study offer considerations and implications for a number of groups: service users, practitioners, organisations (both individually and in an inter-agency context), funders, and future researchers. Key points drawn from this project should be considered in the context of the range of evidence and literature emerging in regard to the use and implementation of ACEs routine enquiry within health settings.

Service Users

In their interactions with women, the practitioners identified a number of practice issues and responses that may be useful in informing other practitioners and agencies who are considering ACEs routine enquiry. There were many examples of positive impacts from women completing the ACEs routine enquiry, and practitioners reported the potential of ACEs to provide a simple and explainable framework for considering the impact of childhood experiences. One key aspect was the potential for practitioners to work with women to address guilt and self-blame, particularly where she had children who had subsequently experienced ACEs. The practitioners reported that the ACEs routine enquiry resulted in women experiencing an understanding of their past and igniting both desire and action to seek the supports to address the impact of ACEs for themselves and their children. There were questions raised by the practitioners about the relevance of the ACEs routine enquiry for older women, especially if their children were now adults. At the nub of this issue is the delineation between ACEs routine enquiry as a tool for early intervention for a service user's child or children, versus, or as well as, an intervention for her. As highlighted by Kelly-Irving and Delpierre (2019) the ACEs questions were primarily designed as a research tool, not a personal intervention tool, meaning organisations and practitioners must assess its usefulness as the basis of an intervention and then attend to developing a practice response subsequent to this.

ACE scores of women accessing a domestic violence service

The survey results reveal ACEs to have a significant presence among Cuan Saor service users. 18 per cent of Cuan Saor service users reported having experienced no ACEs in their childhood, but over one-half (58 per cent) of Cuan Saor service users experienced two or more ACEs in their childhood and one-third (33 per cent) experienced four or more. The prevalence of ACEs among the domestic violence service users surveyed is revealed to be notably higher than that of the general population samples accessing primary health care settings in previous studies. Cuan

Saor service users are affected by both direct maltreatment experienced as a child and adverse home environments. Child maltreatment in the form of verbal abuse emerges as the most prevalent ACEs, followed closely by physical abuse (of both the child and of other members in the household) and substance misuse (alcohol and/or drugs). The ACEs 'scores' revealed in these screenings do not offer a causal link between ACEs in childhood and later life outcomes. Rather, they are early indications of both ACEs prevalence as well as the types of ACEs that most define the experience of the women presenting to the Cuan Saor service.

Practitioners

Trauma-informed responses (TIR) are being widely discussed, considered and implemented in different social and community service settings, with ACEs being just one of these. Across all of the range of agencies and practitioner remits, there were initial and similar concerns about the relevance of the ACEs routine enquiry for the variety of reasons outlined within this report. Similar to other settings, the majority of these concerns were not borne out in practice, but the practitioners were adamant this was because of the way in which the ACEs routine enquiry was embedded into existing client-centred approaches. The ACEs routine enquiry was utilised then as a tool within relationships already based on empowerment and collaboration. The process of women completing ACEs routine enquiry fostered greater understanding of what the client had experienced for the practitioners, and provided a basis for conversations and discussions about intergenerational patterns and positive change that may not have otherwise happened.

The practitioners highlighted the importance of time and resources being allocated to suitable training and support for ACEs implementation and follow up to ensure integration into existing practice. In addition, the impact on practitioners of support work needs to be attended to, as the practitioners gave numerous examples of disclosures and subsequent conversations that had the potential to be both emotionally transformative for the client, but also emotionally impactful on the practitioner. This highlights an important question for those engaged in support work about both the boundaries and limitations of such work, and the impact on the practitioner of working with such issues (Morton & Hohman, 2016).

Organisations

Just as practitioners need to consider how any trauma informed response (TIR) may be integrated into practice, organisations need to carefully consider their remit in regard to TIR, the tool or approach to be used, what training and support is required for practitioners, the follow up and referral services for clients and how the introduction of a TIR is evaluated. Within this study, the 'simplicity' of the ACEs questionnaire was originally a concern for those implementing it, but in practice and within the organisation, this became a strength. While this research focused on practitioners' experiences of implementing the tool, there was strong positive feedback in regard to the usefulness of the ACEs questionnaire for providing a framework for opening conversations with clients about trauma and trauma histories. The ACEs questionnaire was therefore not viewed as all-encompassing solution to address childhood

legacies of trauma, but instead as a mechanism for opening a topic or aspect of a client's life patterns. While this project takes care not to position ACEs screenings as causal identifications of later life outcomes, the evidence link in relation to patterns of association between ACEs and potential health implications of ACEs appeared useful in motivating services users to consider how they might be supported to change inter-generational patterns. It is imperative therefore that organisations consider the aim of introducing ACEs routine enquiry in a way that is line with good practice that continues to develop in the literature (McGee et al., 2015; Quigg et al., 2018; Bellis et al., 2015).

Inter-agency considerations

Building on the previous points, three aspects emerged that may need consideration if ACEs routine enquiry is being introduced within an inter-agency context. The first was whether NGOs and community organisations are better placed to pilot or innovate practice changes given both the structures and funding constraints within large statutory organisations, such as Tusla. The practitioners highlighted the capacity of community agencies to both access small relevant funding streams for such work, and to be more flexible in relation to practice changes due to their size and more flexible remit. The second aspect was in relation to data protection and data sharing implications of implementing ACEs routine enquiry. Concerns were raised that a client 'would become their ACE score', only have entitlement to further supports if their score was 4+ or have to retell their ACE history repeatedly to different agencies, particularly where child-related services and supports were involved. This raises the question of how agencies can work together to co-ordinate responses and interventions, while also protecting the privacy of service users. The final aspect was in relation to the remit of agencies within a given network, with general agreement that those with statutory responsibility may not be best placed to implement ACEs routine enquiry although examples were given of good examples of social work ACE aware responses and interventions. Good examples were also provided of the domestic violence and other services working in partnership with Tusla to address the impact of ACEs in a mother's life. Inter-agency planning may require differentiation between being ACEs-aware and implementing ACEs routine enquiry.

Funders

Key challenges exist for funders in relation to more generally supporting and resourcing the development of TIR within health and social care, and in specifically resourcing ACEs based intervention. As with any practice based innovation, change requires consideration of the evidence, development and implementation of an intervention, practitioner training and organizational support, all of which needs to be resourced. While this project was completed with a limited budget, there was reliance on existing robust supervision and support structures within the host organisation, and strong inter-agency relationships between the IMH practitioners. This network and infrastructure may not always be in place, which adds to funding considerations. In addition, follow on evaluation on impact and outcomes for practice change requires a continuing funding stream.

Limitations and further research

This action research study was situated in a specific setting and sought to implement ACEs routine enquiry, while inquiring with practitioners on aspects and responses to this innovation. As noted earlier, the routine enquiry questionnaire has the potential to provide a level of insight into the prevalence and types of ACEs among domestic violence service users for the purposing of implementing more responsive services. It is best suited to capturing exposure, but is not intended to make a causal link between ACEs experienced in childhood and subsequent life outcomes. The results in regard to practice responses are limited to the views of the practitioners, and do not include the views of the women who completed the ACEs routine enquiry. It would be envisaged that if ACEs routine enquiry continues to be implemented, the views and outcomes for women of this practice development should be monitored and evaluated.

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Appendix A

ACEs questionnaire

The questionnaire involves 10 questions about your childhood.

If you never experienced the things listed below, answer 'no'. If you experienced them once or twice or more frequently, please answer 'yes'.

While you were growing up, during your first 18 years		Yes	No
1	Did you live with a parent or other adult in the household who was depressed, mentally ill or suicidal?		
2	Did you live with a parent or other adult in the household who was a problem drinker or alcoholic?		
3	Did you live with a parent or other adult in the household who used illegal drugs or who misused prescription medications?		
4	Did you live with a parent or other adult in the household who served time in a prison or young offenders institution?		
5	Were your parents ever separated or divorced?		
6	Did your parents or other adult in your home ever slap, hit, kick, punch or beat each other?		
7	Did a parent or other adult in the household swear at you, insult you, put you down, or humiliate you or act in a way that made you feel worthless or scared?		
8	Did a parent or other adult in the household push, grab, slap, or throw something at you or ever hit you so hard that you had marks or were injured?		
9	Did an adult or other person touch you or make you touch their body in a sexual way or attempt or actually have oral, anal, or vaginal intercourse with you?		
10	Did your parent(s) make you go without enough food or drink, clean clothes, or a clean and warm place to live for long periods of time?		

Appendix B

Inquiry Group Discussion Themes

- How have you experienced the process of learning about ACEs and incorporating routine enquiry into your work with women?
- What have been the challenges and the aspects that have worked well?
- Is there anything you would highlight in terms of your practice that you feel has been effective in incorporating ACEs routine enquiry?
- What has been productive and what has been challenging in terms of engaging with women about ACEs and the possible implications for their children (if they have them)?
- What would you share with others as useful to try in your practice? What may you now incorporate?
- How has incorporating ACEs routine enquiry changed or developed your practice? How do you perceive this has impacted on the women you work with?
- Has ACEs routine enquiry, and subsequent work with women, been useful in engaging with possible inter-generational patterns? How have you seen this evidenced?
- What do you think is the role of ACEs routine enquiry within domestic violence and/or substance use services?
- Are there any factors, supports or relationships that are key?

Notes

