Routine Enquiry into Adverse Childhood Experiences (ACEs)

Monday 22 February 2016
Birmingham
#WMidsACEs
#Childhealth
Welcome and introduction

Dr Lola Abudu, Deputy Director, West Midlands, Public Health England
Adverse Childhood Experiences and the life course: An international perspective

Professor Mark A. Bellis, UK Focal Point to the World Health Organisation on Violence and Injury Prevention; Director of Policy, Research and International Development, Public Health Wales
Adverse Childhood Experiences: The local perspective

Dr Helen Lowey, Consultant in Public Health, Blackburn and Darwen Borough Council
An ACE Framework
Individual & Community Resilience

Dr Helen Lowey
Consultant in Public Health
Blackburn with Darwen Borough Council
Adverse Childhood Experience

Definition
A complex set of related childhood experiences that include directly affect a child or, the environment in which they live, i.e. household dysfunction

The ACE Study
Large study that describes long-term relationships between childhood maltreatment & later-life health and wellbeing.
Over 17,000 people interviewed.

ACEs have created a Chronic Public Health Disaster

Dr Robert Anda
ACE Study: BwD

- Cross sectional survey:
  - 1,500 residents
  - 18-70 years; Live in BwD
- Questionnaire developed for delivery by trained researchers
- Face-to-face interviews / self-completion
- Final tool: 42 questions; 10mins to complete
- Available: English; Urdu; Gujarati; Hindu; Polish
- Problematic alcohol & drug users often under-represented – specialist sample
- Full Ethical Approval Granted
ACE Study: BwD

• Specialist sample
  • Sample self selected
  • Staff informed eligible clients of study during routine contact time, invited to attend sessions
  • Clients could drop in on day/ring up in advance
• Key advocates – absolutely crucial
• Challenges
  • STAFF - can’t ask direct questions, esp if in treatment
  • No where else in the country had asked such questions
  • Short localised leaflet if people wanted further advice
ACE Study: BwD

- [The questionnaire covered] highly relevant questions
- Enjoyed completing the questionnaire
- I found the survey very interesting. It made me think about some bad things and some good things. I know my parents had a hard life but I understand why you need to ask the questions
- I only hope this study helps children or vulnerable adults to not go through what I did whilst growing up
- Thank you very much for understanding
Blackburn with Darwen (2012)
Adverse Childhood Experience (ACE) & Adult Health Outcomes

Increased risk (adjusted odds ratio) having health behaviours and conditions in adulthood for individuals experiencing four or more ACEs in childhood.

- Pregnant or got someone accidentally pregnant Under 18 x 4.5
- Stayed overnight hospital in last 12 months x 1.5
- Liver or digestive disease x 2.3
- Morbidly Obese x 1.82
- Heroin or Crack user x 9.7
- Regular Heavy drinker x 3.7
- Had a sexually transmitted infection x 30.6
- Current Smoker x 3.9
- Been hit in last 12 month x 5.2
- Hit someone last 12 months x 7.9
- Been in prison or cells x 8.8
ACE Intelligence

- Surprisingly Common; Co-occur; Associated with health outcomes; Intergenerational
  - USA: 9%; UK: 9%; BwD: 12% (nearly 18,000)
- Those in Substance Misuse Services:
  - 64% had 4+ ACE
- Those with Mental Health Condition:
  - >60% had 4+ ACE
- Those in Social Care Employment:
  - 16% had 4+ ACE
- Those who are homeless:
  - Over 50% had 4+ ACE
- Those who are in Transforming Lives:
  - Estimate at least Two-Thirds
What have we done so far?

It does not matter how slowly you go as long as you do not stop. - Confucius
ADPH 2015: Integrated delivery of Public Health outcomes through delivery model Transformation

What good looks like:
Improving the Public’s Health is integral to the work of public services in this place

Transactional  Transformational

Safe  Informed  Embedded  Empowered

Criterion: The core services and functions and well delivered and effective

- Services in place
- Contracts sound
- Clinical Governance & quality processes in place
- Access comprehensive
- Monitoring in place
- Best Value
- Safe services
- Regular review of services against need and evidence

Criterion: The system understands why the population’s health is important

- System understands: a sick population is costly
- Articulate prevention: primary, secondary and tertiary
- System benefits of a PH approach is understood – pathways, outcomes, cost savings
- Barriers to growth are understood
- Narrative of importance of PH is understood

Criterion: PH skills and tools are in use and being embedded across the system

- Everyone in the organisation knows why PH is important to their job
- There is a prevention strategy across services with clear aims
- Workforce health programmes in place
- There is a commissioning cycle with PH concepts and tools as a core part

Criterion: The wider workforce are actively contributing to a PH agenda

- There is health equity in all policies
- People in the system think about inequality and equity in the work they do
- The principles of: need; equity; evidence; evaluation; impact & change are embedded within the skill set of all officers

Evidence of leadership for public health being built from officers to members, at all levels
Explicit comparison with and learning from other systems
BwD: Public Health Council
Transformational
5th Wave Public Health

Figure 2: A culture for health as the fifth wave of public health improvement
Blackburn with Darwen Joint Health & Wellbeing Strategy Refresh 2015 – 2018:

**Our ambitions:**
- Increase life expectancy year on year for both males and females, and narrow the gap with the rest of England
- Narrow the inequalities in life expectancy within Blackburn with Darwen
- Pursue policies that will maximise the number of years spent in good health
- Improve children and young people’s emotional health and wellbeing
- Manage demand and improve outcomes by creating a 2% year-on-year shift in investment from treatment and care into prevention
- Ensure that Blackburn with Darwen has ‘healthy places’ to live, work and play

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Principles</th>
<th>Cross cutting themes</th>
<th>Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing poverty, deprivation and disadvantage</td>
<td>• Work together and integrate where it makes sense</td>
<td>Start Well (0-25yrs):</td>
<td></td>
</tr>
<tr>
<td>Increasing inequalities in unemployment and worklessness</td>
<td>• Build on strengths (assets)</td>
<td>1. Ensure an effective multi-agency Early Help offer provides the right help at the right time</td>
<td></td>
</tr>
<tr>
<td>Harmful impact of alcohol</td>
<td>• Address inequalities (fairness)</td>
<td>2. Support families through a consistent approach to parenting skills and support</td>
<td></td>
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<tr>
<td>Poor quality and diversity of housing</td>
<td>• Tackle wider determinants</td>
<td>3. Improve children and young people’s emotional health and wellbeing</td>
<td></td>
</tr>
<tr>
<td>High levels of fuel poverty</td>
<td>• Health in all policies and places (including social value)</td>
<td>4. Embed routine enquiries about childhood adversity into everyday practice</td>
<td></td>
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<tr>
<td>Poor health outcomes in children</td>
<td>• Good governance</td>
<td>Live Well (people of working age):</td>
<td></td>
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<tr>
<td>High premature mortality and disability from long term conditions</td>
<td></td>
<td>1. Develop and support opportunities for employers to improve workplace health and wellbeing</td>
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<tr>
<td>Increasing numbers of older people needing support to remain socially included and independent</td>
<td></td>
<td>2. Develop BwD as a healthy place - where people have access to healthy homes, healthy neighbourhoods and health promoting services</td>
<td></td>
</tr>
<tr>
<td>Significant sections of the population socially isolated</td>
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<td>3. Encourage people to take control of their own health and wellbeing</td>
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**Priorities**

- Start Well (0-25yrs):
  1. Ensure an effective multi-agency Early Help offer provides the right help at the right time
  2. Support families through a consistent approach to parenting skills and support
  3. Improve children and young people’s emotional health and wellbeing
  4. Embed routine enquiries about childhood adversity into everyday practice

- Live Well (people of working age):
  1. Develop and support opportunities for employers to improve workplace health and wellbeing
  2. Develop BwD as a healthy place - where people have access to healthy homes, healthy neighbourhoods and health promoting services
  3. Encourage people to take control of their own health and wellbeing

- Age Well (50+):
  1. Develop BwD as a dementia friendly community
  2. Increase support to reduce social isolation and loneliness
  3. Tackle the wider determinants of health of older people including finance, employment, housing and fuel poverty
  4. Develop the local integrated service offer to promote independence

**OPPORTUNITIES/DRIVERS /ENABLERS**
- Locality Working, Transforming Lives, Welfare Reform, ISNA, Early Help, Social Value Act, Better Care Fund, Adverse Childhood Experiences (ACE); Digitalisation
Embedding ACE into delivery

- Contracts: Sexual Health; Substance Misuse; MEAM
- Be ACE Aware
  - Across culture of workforce
  - Universal and opportunities for earlier intervention
  - PH Challenges: unconscious attempted solutions to problems that date back to childhood that are hidden by SHAME, SECRECY, SOCIAL TABOO
- Knowledge of ACE levels with patients
  - Complement wider support packages
  - Identify and Address root causes of symptoms
Making Every Contact Matter MEAM

• People living in Houses of Multiple Occupancy
  – Poor quality accommodation, housing management & support (519 bed spaces across 41 places)
  – Residents vulnerable to exploitation
  – Increasing pressure: Health, A&E; Police; Council services
  – Difficulty engaging in services

Objectives:

• Work with most chaotic adults living in HMOs
• Consult with service providers/service users to re-design support & interventions; improve longer term population health approaches
• Align to the strategic principles and developments of ‘Transforming Lives; Strengthening Communities’
Causes of Homelessness
Links to MEAM & Transforming Lives

**Interior Individual**
- ACE impact on developing self
- Overwhelming emotions
- Derailed psychological development
- Cognitive deficits
- Poor self-esteem

**Exterior Individual**
- Substance abuse
- Disruptive behaviors
- Inability to hold a job
- Poor Health/illness/injury

**Interior Collective**
- Lack of supports
- Inter-subjective stories of failure
- Victim blaming in larger culture

**Exterior Collective**
- Family relational system/ACEs
- Lack of jobs
- Lack of affordable housing
- Inadequate access - treatment
- Poverty, social violence

Studies show that ACEs are strong predictors of homelessness (Burt, 2001)
Dr. Felitti’s redefinition of addiction informed by the ACE Study:

- Addiction is the unconscious, compulsive use of psychoactive materials or agents in an attempt to deal with a problem.
  - “It’s hard to get enough of something that almost works.”
- Addiction is evidence of another problem.

Opportunity to change our approach

- Many Chronic Diseases & lifestyle behaviours in adults
  - Determined decades earlier, in childhood
- Risk factors underlying adult disease & lifestyle behaviours
  - Effective coping devices
- Conventionally viewed as problem
  - Actually solution to an unrecognised prior adversity
Opportunity to change our approach

- Bring in resilience, hope & belief
- Trauma-Sensitive Schools – ‘what happened?’
- Raise awareness of ACEs – own organisations
- Be ACE Aware – change our thinking; our approach and our solutions
- Bring local intelligence; brain development – innovative solutions
- Foster resilience; Embed principles across the community

www.communityresiliencecookbook.org
Opportunity to change our approach

New findings: we are ready for new approaches to address early childhood trauma & stress

To do that in a big way, we need more than science—we need a movement

Dr Nadine Burke Harris
ACE Framework - Next Steps

• Continue to Win Hearts & Minds

• ACE Framework as a determinant
  – Of a child’s ability to be successful in school
  – Of an adult’s ability to be successful in employment
  – To avoid behavioural and chronic physical health conditions & build healthy relationships
  – To prevent a violent life (victim/perpetrator)

• ACE Outcomes
  – To prevent ACE
  – To mitigate effects from ACE
  – To consider ACE when assessing effectiveness of services for vulnerable people
Thank you

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In order to change your future, you have to realize that your past has created your present.
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Routine Enquiry about Adversity in Childhood (REACH)

Dr Warren Larkin, Clinical Director, Children and Families Network, Lancashire Care NHS Foundation Trust
Public Health England

Routine Enquiry about Adversity in Childhood

(REACH)

Birmingham
February 22nd 2016

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Background and Context

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

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

• There is a causal and proportionate (dose-response) relationship between ACE and poor physical health, mental health and social outcomes (Skehan et al 2008; Kessler et al, 2010; Varese et al 2013; Felitti & Anda, 2014)

• People exposed to 4+ ACEs die 20 years earlier compared with those with 0 ACEs (Felitti et al 2014)

• WHO & consider ACE a global PH imperative and data is being collected currently in 14 countries
ACE research (Felitti et al 1998)
9,508 Americans completed ACE questionnaire as part of standardised medical evaluation

- Four or more adverse childhood exposures significantly increase the odds of a person:
  - developing cancer (by nearly two times);
  - being a current smoker (just over two times);
  - having sexually transmitted infections (by two and a half times);
  - using illicit drugs (by nearly 5 times increased risk);
  - being addicted to alcohol (over seven times increased risk);
  - attempting suicide (over 12 times increased risk).

- The ACE study is still an ongoing collaboration between the CDC and Kaiser’s Dept of Preventative Medicine in San Diego
- More recent findings:
  - 6 ACES increased the risk of becoming a IV drug user by 46 times
  - 6 ACES increase the risk of Suicide by 35 times
WHO (Kessler et al 2010) – 52,000 participants from 21 countries

• The authors estimate that the absence of childhood adversity would lead to a reduction in:
  • 22.9% of mood disorders
  • 31% of anxiety disorders
  • 41.6% of behavioural disorders
  • 27.5% of substance-related disorders
  • 29.8% of mental health diagnoses overall
  • 33% of Psychosis (Varese et al 2013)
ACEs increase individuals’ risks of developing health-harming behaviours

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

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

Preventing ACEs in future generations could reduce levels of:

- Early sex (before age 16) by 33%
- Unintended teen pregnancy by 38%
- Smoking (current) by 16%
- Binge drinking (current) by 15%
- Cannabis use (lifetime) by 33%
- Heroin/crack use (lifetime) by 59%
- Violence victimisation (past year) by 51%
- Violence perpetration (past year) by 52%
- Incarceration (lifetime) by 53%
- Poor diet (current; <2 fruit & veg portions daily) by 14%

The English national ACE study interviewed nearly 4000 people (aged 18-69 years) from across England in 2013. Around six in ten people asked to participate agreed and we are grateful to all those who freely gave their time. The study is published in BMC Medicine:


May 2014

Centre for Public Health, Liverpool John Moores University
WHO Collaborating Centre for Violence Prevention

www.cph.org.uk
Tel: +44(0)151 231 4510
The case for routine enquiry in health and social care

• Waiting to be told doesn’t work...

• Victims of childhood abuse have been found to wait from between nine to sixteen years before disclosing trauma with many never disclosing (Frenken & Van Stolk, 1990; Anderson, Martin, Mullen, Romans & Herbison, 1993; Read, McGregor, Coggan & Thomas, 2006)

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

• Felitti & Anda (2014) report a 35% reduction in doctor’s office visits & 11% reduction in ER visits in a cohort of 140,000 patients asked about ACEs as part of standard medical assessment in the Kaiser Health Plan
National Context

Future in Mind Report 2015 – Promoting, protecting and improving our children and young people’s mental health and wellbeing

National Institute for Health and Care Excellence (2014). NICE public health guidance 50

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

• Ensuring assessments carried out in specialist services include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse. For young people aged 16 and above, as part of the Government’s response to the concerns arising about child sexual exploitation, routine enquiry in line with NICE guidelines (whereby every young person is asked during the mental health assessment about violence and abuse) will be introduced from 2015-16

Tackling Child Sexual Exploitation Report March 2015

• Expand routine enquiry from 2015-16 made by professionals in targeted services such as mental health, sexual health and substance misuse services so that professionals include questions about child abuse, to help ensure early intervention, protect those at risk and to ensure victims receive the care they need.
National Context

Report of the U.K. Childrens Commissioners

Protecting Children from Harm – a critical assessment of child sexual abuse in the family network in England and priorities for action November 2015

Some of the major barriers to initial disclosure:

• Self Blame
• Guilt and fear of the consequences
• Fear of the perpetrator
• Being judged
• A lack of opportunities to tell someone
• A fear of professionals
Local Context

- Three years experience and successful delivery in Blackburn with Darwen
- Commissioning Intentions now reflect this in a number of CCGs in Lancashire
- Key priority for Childrens Partnership Board in Blackburn
- REACh is a key principle of Lancashire wide Children and Young People Transformation Plan
- Support from North West Coast AHSN
- LCFT Making Every Contact Count (MECC) programme e-learning module developed and will reach 40% of trust staff over next 12 months
REACH Model

- **Readiness** checklist and organisational ‘buy in’
- **Change Management** – systems and processes to support enquiry
- **Training Staff** – hearts and minds & how to ask and respond appropriately
- **Follow-up support** and supervision for staff and leadership team
- **Evaluation & Research**
REACH

REACH - the practice of routinely enquiring about adverse childhood experiences.
Our evaluation evidence would support the view that whilst REACH is not a risk assessment tool or an intervention in its own right it can:

• Enhance and add valuable information to any assessment which has not previously been disclosed despite numerous assessments and periods of intervention enabling a much more informed decision/intervention
• Speed up the intervention process as disclosure appears to enable the individual to relate their history to their current situation and making sense of it enables them to move forward – the change of focus from ‘what’s wrong with me’ to ‘what happened to me’
• Enable parents to realise that their children may already have ACE’s and understand the potential impact on them facilitating the discussion about prevention and current circumstances or lifestyle in a positive way
REACH YEAR 1

- LCFT South East Team, Health Visitors and School Nurses
- Blackburn with Darwen Children’s Services Family Support Team
- Child Action North West, Familywise Team
- Lifeline, Substance Misuse Practitioners
Key Findings Year 1

• Most participants were not aware of the impact of adversity on later life outcomes before the training
• Following training participants are not reporting difficulties with enquiring
• There has been no reported increase in service need following the enquiries made
• Participants report that if disclosures are made the individual will very often have been in services for a period of time and report that (a) they have never been asked about their experiences before and (b) have not self disclosed
• Participants and managers feel that they are able to create with the individual a more appropriate intervention plan if they have enquired about previous experiences dealing with the root cause of presenting issues rather than the ‘symptom’.
• Participants and managers report that they feel assessments are enhanced by knowledge about adverse experiences
• Routine enquiry can easily be accommodated in current working practices
REACH YEAR 2

- Greater Manchester West (NHS Foundation Trust Substance Misuse Service)
- Evolve (Substance Misuse Service)
- Womens Centre (Counselling, Support and Employment)
- W.I.S.H. (Domestic Abuse)
- New Ground (Young Peoples Service)
Key Findings Year 2

• REACH training equips practitioners with the knowledge and skills to conduct routine enquiry with the individuals they support.

• All practitioners who attended the training reported it was useful, enjoyable and increased their knowledge about ACEs and increased confidence in their ability to conduct routine enquiry.

• The REACH approach has been the catalyst for increased frequency of disclosures, earlier/ more targeted interventions and positive impact for individuals.

• Following routine enquiry people report considering the impact of ACEs in relation to their own children.
REACH YEAR 3

- North West Coast Academic Health Science Network – developing and implementing routine enquiry in new settings
- Blackpool Better Start - early help and prevention
- Blackburn with Darwen Transforming Lives
- Lancashire Safeguarding Childrens Board – missing from home pathway
- Blackburn with Darwen Virtual School – creating a trauma informed school environment
- West Lancashire G.P.’s – Implementing routine enquiry in general practice
- MECC Adverse Childhood Experience module for online training
Department of Health

2016 will see LCFT implement a pathfinder programme on behalf of the DOH

Proposed settings include:

• Child and Adolescent Mental Health Services
• Sexual Assault Referral Centres
• Substance Misuse Services (Young People)

The work will include developing good practice standards and an accompanying manual, creating tools for enquiring with young people and a feasibility exercise on national data collection for CSA and CSE
Conclusions

• Case for REACH is compelling in adults – acceptable, feasible and enhances potential for positive outcome

• HVs and FSWs experience of REACH shows the opportunity for early help and prevention with young and vulnerable parents

• Potential to stop the intergenerational impact of ACEs and better target root cause—fix problems once

• Evaluate the clinical, social & economic impact in a range of settings – GPs, Sexual Health, CAMHS, Schools

• More work needed to establish best practice in routine enquiry with children and service users with LD
Next Steps

• Inclusion in MHSDS
• Deliver DH pathfinders and associated publications
• National roll out by HEE and DH
• Expansion into other areas of practice
• Research feasibility and good practice in enquiring with children
• Implementing routine enquiry within a multi agency partnership – challenges and solutions
• Longitudinal evaluation and data collection – service utilisation
• Identify evidence based strategies which could help to prevent ACE’s and mitigate their impact
Key data on adolescence

Dr Ann Hagell, Research Lead, Association of Young People’s Health, Editor-in-Chief of the Journal of Adolescence. People’s Health
Key Messages about young people’s life experiences and health outcomes from *Key Data on Adolescence 2015*

Ann Hagell

*Association for Young People’s Health*
Demographics – 11.7m young people 10-24yrs

Chart 2.2
Proportion of population by age group in the UK, 2013

Demographics – living at home?

Chart 2.8
Young people and adults aged 15-34 years living with parents in the UK, by age and gender, UK 2014

Source: Labour Force Survey (LFS), Office for National Statistics » Download data

NB: University students are coded as not living with their parents, and young people in prison are not part of the survey
Social determinants
- low income and poverty

1.9 MILLION
YP people aged 10-19 live in the most deprived areas of England

In a poll of 1,800 young people aged 18-24, more than half said their debt had increased over the last five years.

Source: Salter (2014)

Chart 3.8

Source: Health and Social Care Information Centre • Download data

NB Where Decile 1 is most deprived and Decile 10 least deprived
Social determinants - housing and living circumstances

Chart 3.11

87,420 children living in temporary accommodation in England, 2013

Source: DCLG 2014

39,600 young people over 10 were being looked after by the local authority in 2014

Source: DfE 2014
Long term health conditions?

Approximately 800,000 teenagers in the UK suffer from asthma.

Source: Couriel (2003)

23% of 11-15 year olds report that they have a long term illness or disability.

Source: Brooks et al 2015

Peak age for diagnosis of type 1 diabetes is between 10 and 14 years.

Source: Diabetes UK 2014

One in 220 young people under 19 has epilepsy.

Source: Joint Epilepsy Council 2011
Other pressures young people face?

• Bullying and social media issues
• Peer problems
• Academic pressures
• Pressures on body confidence
• .....
Key Data on Adolescence 2015
...surprising trends?

• New psychoactive substances
• E-cigarettes
• Rise in use of smartphones

ESTIMATES OF SECONDARY SCHOOL CHILDREN WHO HAVE TRIED E-CIGARETTES RANGE FROM ONE IN 12 TO ONE IN FIVE

THE AVERAGE 16-24 YEAR OLD SPENDS 9 HOURS AND 8 MINUTES EVERY DAY ON MEDIA AND COMMUNICATIONS ACTIVITIES

Source: Ofcom, 2014
Key Data on Adolescence 2015
...worrying trends?

- Possible rise in self harm?

**41,921**

Source: Hospital Episode Statistics
Key Data on Adolescence 2015
...areas where best progress made?

• Teenage pregnancy

Source: ONS, Conception Statistics, England and Wales, 2013
Key Data on Adolescence 2015
...areas where best progress made?

- Smoking and drinking
Chart 4.18
Prevalence of drinking alcohol in the last week, by age, 2003-2014

Source: HSCIC (2015b), Smoking, Drinking and Drug Use Among Young People in England in 2014 » Download data
“…the transition to adulthood is a window of opportunity for changing the life course”

*Masten et al, 2004*
More info

• www.ayph.org.uk

• info@youngpeopleshealth.org.uk

• @AYPHcharity

• 0207 922 7715
Q&A session

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Introduction to the world café session after lunch

Dr Lola Abudu, Deputy Director, West Midlands, Public Health England
World café session

Station one: Adversity in childhood and mental health

Station two: Where does an ACE informed approach sit within your local strategies and what would be required for your organisation to implement this approach across different levels within your organisation

Station three: How to ensure that enquiry becomes routine and is embedded within an organisation

Station four: Taking a public health approach to promoting young people’s resilience
Station four: Taking a public health approach to promoting young people's resilience

Dr Ann Hagell, Research Lead, Association of Young People’s Health, Editor-in-Chief, Journal of Adolescence. People’s Health
Feedback

Dr Lola Abudu, Deputy Director, West Midlands, Public Health England
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