Evaluation of a system wide approach to implementing routine enquiry about adversity in childhood (REACh™) across Nottinghamshire

(Final report)

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Executive Summary

Background to ACEs and ACE enquiry

A growing body of global research has identified the heavy burden that adverse childhood experiences (ACEs) place on individuals' health and social prospects across the life course. ACEs include a range of stressful and potentially traumatic experiences that children can be exposed to. These can include experiences of child maltreatment or living in a dysfunctional household and/or community. Research consistently shows that ACEs are associated with increased risk of poor health and wellbeing (1,2). Importantly, the more ACEs children suffer, the greater their risk of poor outcomes later in life (2,6,7). This includes increased risk of adopting health harming behaviours (such as smoking, harmful alcohol consumption, drug use, risking sexual activity and violence) (1,3,29,30), poorer mental and physical health, chronic disease, and early mortality (39). Individuals who have suffered ACEs can be vulnerable to exposing their children to ACEs resulting in cycles of adversity, social disadvantage and poor health which may affect families across generations (8-10).

Policymakers and practitioners are increasingly focused on preventing and responding to ACEs (11-13) and various stakeholders across the UK have begun to explore how existing community systems and approaches can be enhanced to mitigate or prevent the impact of ACEs (11). Enquiring about adults' experiences of ACEs is one such approach which has been piloted in a number of UK settings (14-18). ACE enquiry typically uses the 'ACE questionnaire' and aims to promote a trauma-informed approach and to enquire about ACEs sensitively and routinely with (predominantly) adult clients. This builds on the premise that adults rarely spontaneously disclose their ACEs to practitioners (68), with ACE enquiry offering the opportunity to identify individuals at high risk of poor health and wellbeing outcomes and tailor support accordingly (70-72). However, there remains a lack of evidence on the process of implementing ACE enquiry into existing health and wider community services, and its effectiveness in improving health, wellbeing, and service use outcomes for clients (79).

In light of this evidence, Nottinghamshire County Council and partners have increased efforts to prevent and respond to the impacts of ACEs and implement trauma-informed practices, and in 2019 commenced a **test and learn project to develop and implement the Routine Enquiry about Adversity in Childhood (REACh™) programme across services in the county**.

The Nottinghamshire REACh™ programme model

The Nottinghamshire REACh™ programme is supported by a countywide approach to developing and implementing trauma-informed approaches. Twelve services in Nottinghamshire have voluntarily explored their engagement in the test and learn project, and nine have piloted and/or implemented ACE enquiry at some point from 2019-2022.

The programme aims to enable services and practitioners to implement ACE enquiry as part of routine assessment processes, with all or selected service users. **ACE enquiry involves the use of an ACE questionnaire to facilitate service users' disclosure of ACEs in the context of a person-centred conversation**. The REACh™ model includes **five key stages:**

- **REACh™ readiness audit:** of services' organisational readiness including best fit for the care pathway, safeguarding, staff training and supervision needs, recording of ACE enquiry and programme monitoring and evaluation.
- **Planning and implementation:** services ensure the implementation activities identified are implemented or in process and regularly reviewed.
- **REACh™ training:** staff anticipated to implement ACE enquiry and attend a full day training session covering the underpinning research and the practice of ACE enquiry (including the ACE questionnaire).
- **REACh™ follow-up and support:** provided by the REACh™ programme team in both group and one-to-one formats according to practitioner needs to promote sustained change.
- **Evaluation and research:** services encouraged to develop processes and systems to monitor ACE enquiry and resulting client outcomes.

Evaluation methods

The evaluation aimed to

- Understand and document the development, implementation and embedding of the REACh™ programme across and within services in Nottinghamshire, including facilitating and mediating factors.
- Explore practitioners and clients' views on the programme.
- Consider the impact of the programme on clients, practitioners, and services.

A mixed-methods approach was used to gather evidence to address the evaluation objectives. A summary of methods is provided below and full details are included in Appendix 7.1.

Interviews (n=37) with programme commissioners (n=3), and the REACh™ Implementation Team (n=5), and service leads and practitioners (n=29) from 10 services.

Pre (n=398) and post (n=436) training surveys assessing practitioner knowledge on ACEs, and confidence to discuss ACEs with clients (and respond); and follow-up surveys (n=72) exploring views and experiences of programme implementation.

Review of programme documentation (e.g., strategy group minutes; REACh™ programme documentation / materials / anonymised monitoring data) and observations of programme implementation (e.g., strategy group; training sessions).

Collation of client feedback/experiences across four services: Interviews with clients (n=3, from one service); review of service user feedback videos (including two clients from another service); case studies prepared by practitioners (n=3, from another service); and qualitative feedback collected by practitioners (38 client comments from another service).

Development and implementation of the REACh™ programme

The Nottinghamshire REACh™ programme began in April 2019 as a two-year test and learn project to develop and implement the programme across services. The project was paused during the Covid-19 pandemic due to national restrictions and recommenced in 2020/21 with activities extended to Summer 2022. Up to the end of March 2022, nine services had implemented ACE enquiry (to some extent). Throughout the project period, all implementing services had progressed through the REACh™ programme model, having identified strategic and implementation leads, completed a readiness audit and staff training, and established and implemented service level procedures for the piloting and/or full implementation of ACE enquiry.

Programme fidelity and adaptions

"…that process is sometimes straightforward and other times it's complex for so many reasons, operational reasons, personnel reasons, organisational change, reasons, natural disasters like pandemics, or unexpected reasons, so there's so many factors that make any kind of practice change in the real world a challenge." (Implementation Partner)

The core aim of the Nottinghamshire REACh™ programme was to implement a whole system, place-based approach to ACE enquiry. Delivery partners recognised that implementation of the five-stage model may need to be tailored according to different service models, service user needs and service outcomes. The complexity of programme implementation was compounded by the new challenges and considerations brought by the Covid-19 pandemic which occurred during the implementation stage. Key facilitators, barriers and adaptions of the model are summarised below:

Facilitators

- **A considered and reflective approach to programme implementation:** was taken by the REACh™ programme team, including contextualising training *"so it's still the same training but we've tried to obviously tailor a little bit to their needs"* (Implementation Partner) and adapting follow-up into *"a much more interactive support"* offer (Implementation partner). This approach was highly regarded in terms of supporting services to fully consider if and how REACh™ may be implemented in their service.
- **Ongoing commitment, support and supervision:** was seen as key to ensuring successful programme implementation. The REACh™ programme team were seen as a *"massive support"* who were responsive to staff needs as they developed knowledge and confidence. Buy-in from strategic and operational level service leaders (e.g. through guidance documents and flowcharts for staff) was seen to increase ownership of the programme and facilitate implementation. Lastly, practitioners (including Champions) providing peer support and reflective practice were seen as vital to helping staff *"to get over our own worries, issues"* (Practitioner, Service 2).
- **A trusted relationship and flexible approach with clients:** having a good relationship with clients and a caring, non-judgemental approach was viewed as influencing successful client engagement with ACE enquiry *"I asked for help, and it takes a lot… Because you feel like a failure. So, I do think that they need to build a really good relationship with you"* (Service User).

Barriers

- **Service and staff readiness:** some services or practitioners expressed initial reservations about ACE enquiry which included being unclear how ACE enquiry would fit into their service delivery model, lack of confidence to implement ACE enquiry, and desiring greater supervision and senior

management support. Upon further exploration and engagement (e.g., through training, support, and implementation of ACE enquiry) many of these concerns have been allayed.

Adaptions

- **Countywide and service level opportunities to reflect on whole system implementation:** a community of practice via whole system implementation meetings was developed to reflect and share learning across services, with Champions identified to support ACE enquiry implementation in their services. These communities of practice were seen as building momentum, keeping ACE enquiry on the agenda, and identifying any challenges. As one practitioner (Service 2) described *"what you don't want is to be that lonely person that's trying to implement this on your own…from senior managers down to the [service name] workers…having key people that understand and are passionate about it to drive those other people forward."*
- **A new 'ACEs Deck':** was developed as a tool to support the implementation of compassionate conversations about ACEs, other traumatic life experiences, their impacts, resilience factors and other protective assets. This was particularly where the ACE questionnaire was felt by practitioners not to be the best match to the service context, ways of working or client preference/needs including the needs of young people.

Implementation of ACE enquiry

"…as well as being a burden off my shoulders that I've carried around for all these years…opened up a doorway that I've been looking for a long, long time…why couldn't anyone have told me about this (ACE enquiry) before." (Service user)

Up to the end of March 2022, nine services had implemented ACE enquiry (to some extent) and the majority aimed to continue programme implementation. Practitioner's acceptability of the programme was viewed to have developed over their time engaging with REACh™, with staff growing to feel more confident and supported to implement ACE enquiry and assisting clients with any follow-up support they needed. Clients' acceptance was also seen as reassuring and encouraged practitioners to continue to undertake ACE enquiry.

Findings from the follow-up practitioner survey (n=72) show that amongst those implementing ACE enquiry (n=69), the majority agreed that:

- Their service is a suitable place to enquire about ACEs (72.5%).
- That it is useful to the client for the practitioner/service to enquire and know about a client's experience of ACEs (75.4%).
- ACE enquiry was **acceptable to their clients (63.8%)**, and this was echoed in client feedback. However, in some services and for some clients, the use of the ACE's Deck, rather than the ACE questionnaire was deemed a more appropriate and strengths-based tool to facilitate a conversation about childhood adversity and offer and provide support.

Amongst survey respondents who had implemented ACE enquiry:

- 42.0% agreed that there was sufficient time during appointments to conduct ACE enquiry and 42.0% reported that there was sufficient time to respond to disclosures of ACEs.

- When ACEs were disclosed, 81.3% of practitioners estimated that ACE enquiry took more than 10 minutes, compared to 83.6% estimating it took less than 10 minutes when no ACEs were disclosed.
- 36% of practitioners reported that the process often or always changes their clinical care/intervention or referral pathways. One in four agreed that there were sufficient resources available within (40.6%) or beyond their service (42.0%) for follow-up support for clients disclosing ACEs.

Outcome of REACh™ and ACE Enquiry

"If we become upset, angry about what's happened to us, and how it's affecting us, then that's fine, from our point of view we're saying that we really trust you if we're opening up in that way to you, so please do ask the questions and listen, and if someone has spoken to you about those things, we don't want to be told there's another service that can deal better with that as we're opening up to you and feel comfortable with you, so please just be with us in that moment, just listen." (Service user)

Across the nine services who had piloted or commenced ACE enquiry, some promising narratives were emerging around the positive experiences and outcomes for their clients, which are described in Case Studies 1-3 from three different services (a family service, a children's centre and a substance use service [additional case studies are provided in the Annex]).

ACE and trauma-informed services and practitioners

Between May 2019 and February 2020, over 500 practitioners received REACh™ training and training participation was associated with significant increases in knowledge on ACEs and ACE enquiry, confidence to ask service users about ACEs and confidence to respond to disclosures and refer for support. Findings from the follow-up survey show high levels of confidence to implement ACE enquiry and respond to disclosures with 79.7% feeling confident to respond appropriately to clients disclosing ACEs, 72.5% feeling confident to routinely ask clients about ACEs and 66.7% feeling confident to refer clients to services in response to these disclosures.

Client Outcomes

The majority (>70%) of practitioners agreed that when implementing ACE enquiry, the process often or always improved their understanding of their clients' issues and thus their relationship with their client and the help and support they provided also improved.

"Thank you for your non-judgemental approach. Even though I did not wish to continue with support for my own personal reasons, the help I received was so valuable. Thank you so much." (Service User)

A third (36.2%) of practitioners surveyed reported they had observed changes in their clients since implementing ACE enquiry. Across the nine services who have implemented ACE enquiry, qualitative data suggests several positive outcomes for clients:

- Feeling heard, empowered, and supported.

"Asking these questions could change the course of your future. It makes you relate to your current situation and be more open to make changes for the sake of your own children." (Service User)

- Having improved knowledge on ACEs and trauma, and their potential impacts and ways to mitigate these impacts.
- Being more receptive of support and receiving better and more tailored support.
- Having improved health and wellbeing and decreased feelings of isolation.
- Parents exploring, understanding, and wanting to make changes to their behaviour to protect their children from intergenerational ACEs.

> *"Because of the work that they've done, one service user drove back to the village where she was brought up…because she got these visions in or out of what it looked like. A lot of it was true, but a lot of it wasn't. But just the experience of driving there, retracing her steps, looking at the places where she had these big memories and coming back free. She said she drove there full of fear and she drove home free. But she would never have done that without the routine enquiry." (Practitioner)*

Conclusion

Findings from the evaluation suggest that it is both feasible and generally acceptable to implement the REACh™ programme across a range of service types, and across a whole county. Furthermore, a number of positive outcomes for clients are starting to emerge. A range of factors have facilitated or impeded the implementation of the programme, and these should be considered for future programme implementation. Furthermore, programme processes and outcomes should be continually monitored via the strategy and implementation groups, and other programme monitoring and evaluation processes. Whilst there is a real need for further study of ACE enquiry and the longer-term impacts of this approach, emerging evidence of the REACh™ model suggests that when implemented following careful planning by trained and supported staff, ACE enquiry appears to be acceptable, feasible and can contribute to individual service users' recovery journeys.

Recommendations

Implementation

- This evaluation highlights how the staff within services are the drivers of REACh™ implementation. Many service leads and practitioners noted that service-level Champions and the Community of Practice were integral to the successful implementation of REACh™; the importance of this should be highlighted to all new (and existing) services during their planning and implementation phase, to ensure they have appropriate buy-in from staff across all levels.
- Practitioners and service leads discussed the importance of continuous training, support, and opportunities for staff supervision to ensure the programme is successfully implemented. The nature of this training and the ability for services to provide this should be explored further; it will be vital to distinguish between the follow-up support that is built into REACh™ (provided by Warren Larkin Associates Ltd [WLA]) and any follow-up support that is offered/implemented by services (in-house).
- A service-wide peer support programme, along with additional training/supervision, may be useful to provide support to staff experiencing concerns about implementing ACE enquiry. Again, any support programmes and additional training/supervision that is developed and provided should be monitored and factored into the REACh™ model, in terms of what additional support services should expect to deliver on a longer-term basis and to ensure that a suite of evidence-based recommendations are provided to services, so as not to dilute the REACh™ model.

Follow-up support for services

- Future implementation of REACh™ (within and beyond NCC) should monitor the required follow-up time to ensure that the typical six months of external support (provided by WLA) is sufficient and to ensure that the possibility of any additional, longer-term support, is factored in from both a funding and service capacity perspective.

Adaptability

- This evaluation suggests that the implementation of REACh™ may be adapted to a younger age-group; the ACE's Deck (and accompanying suggestions for using the cards) were felt by practitioners to be a valuable alternative to the original ACE questionnaire. Further, some services had introduced group sessions and a peer support group to further aide discussions about ACEs, thus highlighting the adaptability of use of the cards and ACE tool. Further research is required to fully explore and evidence the implementation and outcomes of the ACE's Deck and to understand if, where and how group sessions/peer support groups could be used to complement and enhance REACh™. This evidence can subsequently be added into future training materials.
- Services used their initiative to determine the most appropriate time to implement ACE enquiry with clients, as it was not always appropriate to enquire about ACEs upon initial assessment. The flexible nature of the programme enabled practitioners to develop a relationship with clients and gain their trust before enquiring about ACEs; this was felt to be very important and a key strength of REACh™.

Appropriateness

- This evaluation has identified key points in the client journey and/or key client groups where REACh™ may not be appropriate. For example, ACE enquiry may not be appropriate for use where children/families are presenting with multiple complex needs that require immediate support. Furthermore, REACh™ requires the practitioner to build trusting relationships with clients and to conduct ACE enquiry in a safe and trusting environment. REACh™ should not be advocated for use where this cannot be achieved.
- The 'formal' nature of the ACE questionnaire may not lend itself to being implemented in all settings, such as those where young people attend to let off steam and have fun with friends (such as Youth Clubs). Here, although formal ACEs enquiry may not be appropriate, training staff to understand and recognise the importance of a trauma-informed approach is vital, to further build awareness of ACEs and the impacts of trauma, and ensure young people are appropriately safeguarded and supported. For example, one service used the ACE's Deck in groups to educate clients and stimulate discussion.

Monitoring and Evidencing Impact

- Given the limited but emerging evidence around the public health impact of ACE enquiry, it is vital to ensure that the use and outcomes of REACh™ are appropriately monitored. Whilst this was the case in some services, not all had a process in place to enable this. Recording accurate details about when ACE enquiry is used and with additional context, if possible (such as whether it is used at assessment or at a particular point through the client journey and why), would help further evidence the implementation and use of the ACE enquiry. Recording outcomes of use for the client and/or practitioner (such as 'parent engaging with additional support' or 'onward referral to other services', for example) would provide further evidence to justify use and assess outcomes.

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1. Introduction

A growing body of global research has identified the heavy burden that adverse childhood experiences (ACEs) place on individuals' health and social prospects across the lifecourse. ACEs include all forms of child maltreatment, as well as other factors that affect the environment in which a child grows up that increase children's risks of exposure to trauma, including living with a household member who uses substances, has a mental health problem or has been incarcerated. Critically, experience of ACEs has been associated with greater risk of a range of health harming behaviours, chronic disease and ultimately early death. For example, studies consistently link ACEs to smoking, alcohol and drug use, risky sexual activity and violence *(1,2)*, and to conditions such as mental illness, sexually transmitted infections, obesity, heart disease, and cancers *(3–5)*. Importantly, the more ACEs children suffer, the greater their risk of poor outcomes in later life *(2,6,7)*. These relationships also mean that individuals that have suffered ACEs can be vulnerable to exposing their own children to ACEs, leading to cycles of adversity, social disadvantage and poor health that may affect families across generations *(8–10)*.

As understanding and awareness of the influence of childhood adversity throughout the lifecourse has grown, policy makers and practitioners have increased their focus on preventing and responding to ACEs *(11–13)*. Across many areas in the United Kingdom (UK), various stakeholders have, and continue to explore if and how existing community systems and/or prevention approaches may be enhanced to prevent or mitigate the impacts of ACEs and associated trauma *(11)*. Enquiring about ACEs with adults is one such approach that has been piloted in recent years across a number of UK settings *(14–18)*. ACE enquiry aims to promote a trauma-informed approach and move professionals away from responding to ad hoc disclosures of childhood adversity, to sensitively and routinely enquiring about ACEs with, in the most part, adult clients. As part of a countywide approach to preventing and responding to ACEs and developing trauma-informed approaches, in 2019 Nottinghamshire County Council embarked on a test and learn project, to implement a whole system approach to routine ACE enquiry across the county, commissioning Warren Larkin Associates Ltd to implement the Routine Enquiry about Adversity in Childhood (REACh™) programme. The REACh™ programme includes:

- Supporting services to develop processes for implementing REACh™ within their service, ensuring that they are organisationally ready to implement ACE enquiry prior to implementation.
- Training practitioners within the service to increase knowledge and awareness of ACEs and associated impacts and develop practitioner skills and confidence to implement ACE enquiry sensitively with clients.
- Supporting services to embed practice change and ACE enquiry into assessment and support procedures, promoting ACE awareness in individual practitioners and across services, and to monitor and evaluate outcomes.

Since 2019/2020, the REACh™ Implementation Team (i.e. Warren Larkin Associates Ltd) and Nottinghamshire County Council have been working with a range of universal and targeted services across the county to support and enable them to implement REACh™.

1.1 Evaluation objectives

In 2019, the Public Health Institute, Liverpool John Moores University was commissioned to carry out a two-year service evaluation of the system wide approach to implementing REACh™ across Nottinghamshire.

The service evaluation aimed to explore the feasibility, acceptability and impact of the implementation of the REACh™ programme across services in Nottinghamshire County Council.

An Interim Evaluation Report, covering April 2019 to February 2020 was published in summer 2020 (Quigg et al, 2020[1]), with a final report anticipated for March 2021. However, due to COVID-19 and in line with UK Government guidance around social distancing, in March 2020 elements of the programme were cancelled and in April 2020 full programme implementation was paused. Whilst programme implementation recommenced in 2020/21, COVID-19 restrictions continued to impact upon programme delivery and thus the test and learn project and service evaluation was extended until summer 2022. This report presents the final evaluation findings and should be considered in light of key findings from the Interim Evaluation Report and the impacts of COVID-19 on continued programme delivery (discussed further within the report). The final evaluation report aims to:

- Understand and document the development, implementation and embedding of the REACh™ programme across and within services in Nottinghamshire, including facilitating and mediating factors.
- Explore practitioners and clients' views on the programme.
- Consider the impact of the programme on clients, practitioners, and services.

1.2 Evaluation methods

A mixed-methods approach was used to gather evidence to address the evaluation objectives. A summary of methods is provided below and full details are included in Appendix 7.1.

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Review of programme documentation (e.g., strategy group minutes; REACh™ programme documentation / materials / anonymised monitoring data) and observations of programme implementation (e.g., strategy group; training sessions).

Collation of client feedback/experiences across four services: Interviews with clients (n=3, from one service); review of service user feedback videos (including 2 clients from another service); case studies prepared by practitioners (n=3, from another service); and qualitative feedback collected by practitioners (38 client comments from another service).

[1] https://www.ljmu.ac.uk/~/media/phi-reports/pdf/07-2020-nottinghamshire-reach-evaluation--interim-report-june-2020.pdf

2. Literature review

2.1 Adverse childhood experiences (ACEs)

Adverse childhood experiences (ACEs) incorporate a range of stressful and potentially traumatic experiences that children can be exposed to whilst growing up *(3)*. ACEs include all forms of child maltreatment, as well as other factors that affect the environment in which a child grows up, including living in a dysfunctional household and/or community where there is poverty or violence (experiences that may negatively impact on safety or nurturing, essential factors for healthy child development) *(2,19)*. Whilst there is no universal definition of what ACEs incorporate, following the first ACE study in the USA (Box 1) a range of ACE studies have been conducted across countries that focus on 10 types of childhood trauma *(2,3,20)*. The ten common ACEs explored in research include being a victim of child abuse (physical, sexual, or psychological abuse, or emotional or physical neglect); witnessing domestic violence; parental separation; and having a member of the household who has been in prison, misuses drugs or alcohol, or has a mental health problem.

In 2013, a nationally representative household survey across England estimated that 48% of adults (aged 18-69 years) had experienced at least one ACE and 9% had experienced four or more *(3)* (Table 1). Comparable levels of ACEs across adult populations have been identified in recent studies conducted at regional (e.g. Luton, Hertfordshire and Bedfordshire *(20)*) and national (e.g. Wales *(21)*) levels across the UK. Further, data from the Crime Survey for England and Wales estimates that one fifth of adults (an estimated 8.5 million people, aged 18-74 years) experienced at least one form of child abuse (i.e. emotional, physical or sexual abuse, or witnessing domestic violence or abuse), before the age of 16 years *(22)*. ACEs are often hidden and thus it is difficult to accurately estimate the current prevalence of ACEs amongst children *(23)*, however, sources of administrative data can illustrate the breadth and potential extent of some types of adversity that children experience in the UK. For example:

- In 2019 the Children's Commissioner estimated that across England *(24)*:
  - 2.3 million children were living with risk because of a vulnerable family background.
  - 723,000 children were receiving statutory support or intervention.
- Information from the Office for National Statistics shows that, at the end of 2019 *(23,25,26)*:
  - 2,230 children in England were the subject of a child protection plan.

Box 1: The original ACE study, USA

The original ACE study was conducted between 1995-97 by Dr Felitti from Kaiser Permanente in the USA *(2)*. Dr Felitti ran an obesity clinic, with most patients losing weight. However, a high number of patients were also dropping out of the programme prematurely, including patients that had successfully lost weight. Upon investigation, Felitti identified that many patients were suffering from unresolved childhood trauma, and that to them their eating behaviours were a solution, helping them to cope with their distress. Subsequently, Dr Felitti and colleagues from the US Centers for Disease Control and Prevention (CDC) developed and implemented the Adverse Childhood Experiences (ACE) study, asking over 17,000 Kaiser Permanente adult patients about their experience of ACEs, and exploring the relationship with their current health and wellbeing. The study identified a high level of ACEs amongst the study sample, and critically a dose-response relationship between ACEs and current health and wellbeing.

- 49,570 children in England were looked after by their local authority because of experience or risk of abuse or neglect.

Table 1: Prevalence of ACEs amongst adults in England (2013)

	Adverse childhood experience	Prevalence
Child maltreatment	Verbal abuse	17.3%
	Physical abuse	14.3%
	Sexual abuse	6.2%
Childhood / childhood household included	Parental separation	22.6%
	Alcohol use	9.1%
	Domestic violence	12.1%
	Mental illness	12.1%
	Drug use	3.9%
	Incarceration	4.1%
For every 100 adults in England, 48 suffered at least one ACE, 9 suffered four or more		

Crucially, ACEs typically occur in clusters, with children who experience one ACE at increased risk of experiencing other ACEs. Findings from a recent study which combined data from 10 European studies (including over 1.5 million adults from 12 countries) suggest that 19% had experienced more than one ACE. Estimates from a recent meta-analysis suggest that potentially 142 million individuals in Europe have experienced multiple ACEs *(27)*. The clustering of ACEs has important implications for prevention and support, particularly given the dose-response relationship between increased numbers of ACEs and greater risk of experiencing poor health and social outcomes.

2.2 ACEs and impacts across the lifecourse

A growing body of global research has identified the heavy burden that ACEs may place on individuals' health and social prospects across the lifecourse. ACEs can have immediate consequences for a child's health through physical and mental injury, and in severe cases can result in death *(28)*. Beyond the direct immediate impact of abuse and adversity, ACEs increase the risk of adopting health-harming behaviours and studies consistently link ACEs to smoking, harmful alcohol consumption, drug use, risky sexual activity and violence across the lifecourse *(1,3,29,30)*. Importantly, the more ACEs children suffer, the greater their risk of poor outcomes in later life (see Box 2).

The adoption of health-harming behaviours is one mechanism through which later life chronic ill-health is linked to ACEs. However, biomedical studies suggest that toxic stress and trauma can also directly affect the development of children's nervous, endocrine, and immune systems *(31–33)*. Such disrupted development leads to increased allostatic load (physiological damage), impaired cognitive, behavioural and emotional functioning in both the short and long-term, and is a precursor to chronic, stress-related physical and mental illness later in life *(31–33)*. Impaired cognitive and behavioural functioning can impact on children's opportunities and abilities to access and engage with education, and this can have consequences for long-term socioeconomic outcomes. Studies suggest experiencing ACEs is associated with poor educational attainment, and school absence and dropout *(34–37)*. Findings from a US study show that adults with three or more ACEs were one and a half times more

Box 2: ACEs and associated harms in adulthood in England (2013) *(3)*

In a nationally representative household study of ACEs across England, compared to adults with no ACEs, adults with four or more ACEs were:

- 2 times more likely to be a current binge drinker, or have a poor diet
- 3 times more likely to be a current tobacco smoker
- 5 times more likely to have engaged in sex before the age of 16 years
- 6 times more likely to have ever used cannabis or had an unplanned teenage pregnancy
- 7 times more likely to have been a victim or perpetrator of violence in the past year
- 11 times more likely to have ever used crack cocaine or heroin, or to have been incarcerated

likely not to graduate from high school and two and a half times more likely to be unemployed *(37)*. Findings from a UK study demonstrate similar results; compared to adults with no ACEs, those with four or more were over one and a half times more likely to have no qualifications, and almost three times more likely to be currently unemployed *(38)*. ACEs are also strongly related to mental and physical health, chronic disease, and early mortality. Results from the World Health Organization (WHO) mental health surveys (published in 2010) suggest that 30% of adult mental illness across 21 countries is attributable to ACEs *(39)*. Studies from the US and the UK demonstrate a graded relationship between the number of ACEs experienced and the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease *(2,40)*. The substantial increased health risks associated with experiencing ACEs have implications for health service provision, and across England and Wales studies suggest that health service use is indeed higher amongst adults who have experienced ACEs *(7,38)*. These findings suggest that preventing and addressing early childhood adversity could potentially reduce demand on strained healthcare, and other services.

The strong graded relationships between ACEs and health outcomes, health-harming behaviours and socioeconomic outcomes also have implications for the intergenerational transmission of ACEs. Many of the outcomes associated with ACEs, for example poor mental health, substance use and experiencing violence, represent adversities for the next generation. The disrupted allostasis, neural functioning and increased inflammation in parents with exposure to ACEs may in turn also affect their children through physiologic or epigenetic pathways *(41)*. Further, ACEs are linked to dysfunctional parent-child interactions and poor parenting attitudes and behaviours *(42,43)*. Research on the prevalence and mechanisms of intergenerational transmission of ACEs is limited *(44,45)*, however some research has found that higher numbers of parental ACEs are associated with increased risk of poor child health outcomes *(46)*. Thus, individuals that have suffered ACEs can be vulnerable to exposing their own children to ACEs and associated poor outcomes, leading to cycles of adversity, social disadvantage and poor health that affect families across generations.

2.3 Preventing and responding to ACEs

In the original ACE study, the authors concluded that primary, secondary and tertiary prevention is necessary to prevent ACEs and mitigate their negative impacts on health and wellbeing *(2)*. At community and familial levels there are a range of evidence-based interventions shown to prevent ACEs such as child maltreatment (e.g. home visitation; parenting programmes) *(47,48)*. While the eradication of child abuse and other types of adversity remains the primary aspiration, developing resilience to cope with adversity can mitigate the impact of ACEs and prevent the associated harmful effects *(1)*. A range of factors can impart resilience, including individual traits such as self-regulation and executive function, access to trusted adult support, and community and system level factors,

including supportive infrastructure, community values, supportive social networks and connections and availability of resources *(48–50)*. Those who have experienced ACEs but have access to early life support and resilience building assets have been shown to be less likely to experience long-term consequences, compared to individuals who experience ACEs but who have no such support or resilience *(51–53)*.

The clustering of ACEs and their association with a broad range of outcomes, mean multidisciplinary prevention is necessary across different sectors including health, social, criminal justice, and educational services. Evidence suggests that different sectors can play a key role in preventing ACEs and reducing their associated effects *(54,55)*. For example, in health sectors, targeted interventions for families such as home visitation, have demonstrated some effectiveness in reducing child abuse, domestic violence, and maternal depression, and improving parent-child interaction and child outcomes *(56–59)*. In the educational sector, school-based interventions aimed at supporting children's social and emotional development and preventing health-harming behaviours, can mitigate the impacts of adversity which children experience at home and prevent further incidents of victimisation (e.g. bullying) *(60)*. Multi-sector efforts are increasingly underway to develop trauma-informed services, which recognise the relationship between current health and social problems and previous experience of trauma *(61,62)*. The underlying principle is that health, social, criminal justice and educational services which are trauma-informed are likely to provide better outcomes for those presenting with chronic adversity in their life histories *(63–65)*. Further, a system-wide trauma-informed approach provides a common language and understanding about trauma-informed practice across different sectors and has the potential to improve joined up working. Consequently, much can be done to both prevent ACEs and reduce their consequent harms at individual, community, and societal levels. However, the hidden nature of ACEs can prevent children and adults from accessing and receiving support and prevent service providers from identifying those who would benefit from such support.

2.4 Routine or targeted ACE enquiry

An emerging strategy for responding to ACEs is routine or targeted enquiry about ACEs, predominately with adults in health and other settings *(66,67)*. It is typically completed using items from the 'ACE questionnaire' to ask service users about their history of ACEs. Models of ACE enquiry aim to train practitioners to proactively and sensitively ask clients about their history of ACEs. This is based on the premise that disclosures about ACEs are rarely made spontaneously by clients and even in cases of spontaneous disclosure responses by professionals are typically ad hoc. One study of psychiatric patients found that 82% disclosed trauma when they were asked, compared to just 8% who spontaneously disclosed *(68)*. Crucially, awareness of ACEs and their impact is not sufficient for practitioners to routinely enquire about ACEs, with one study of doctors in the US finding that, despite 80% agreeing they had a responsibility to ask about ACEs, only half felt confident to do so and the majority reported that they did not regularly enquire with their patients *(69)*.

It has been argued that awareness of ACEs through routine or targeted enquiry offers the opportunity to identify individuals at high risk of poor health, wellbeing and behavioural outcomes, and tailor support and treatment options accordingly *(70–72)*. It has also been suggested that the enquiry process itself may be therapeutic for adult clients because it allows the client to disclose their experiences, reflect on the role of these experiences in current health and behavioural problems, and elicit sympathetic acknowledgement and understanding of these experiences from their practitioner *(66,73)*. Routine enquiry about ACEs with adults was first implemented by the author of the original ACE study *(2)*, who reported a 35% reduction in GP attendance and 11% reduction in Emergency Department attendance for individuals who had engaged in routine enquiry *(72)*. Since then, limited

but emerging evidence from studies of routine enquiry implementation suggest that, in general, service users find enquiry about ACEs to be acceptable, important and that their experience of service support was improved as a result of their practitioner knowing about their childhood *(15,75–78)*.

Further evaluation is however needed around the process of implementing routine or targeted ACE enquiry, and implications for services, including the ease of embedding enquiry into standard practice *(79)*. To date ACE enquiry has generally been implemented and evaluated in health settings, thus the expansion of such enquiry to other settings necessitates further evaluation *(79)*. Crucially, evidence on outcomes for service users' health, wellbeing, or service use because of enquiry is scarce. A recent scoping review of the evidence base for ACE enquiry into childhood adversity found no published research which supported the reports from Felitti et al. *(2)* and other colleagues, that routine enquiry about ACEs provides positive therapeutic benefits *(79)*. Findings from a recent qualitative study of practitioners trained to routinely enquire about ACEs indicate that practitioners perceive routine enquiry to have a positive impact on their clinical practice through an increase in therapeutic conversations, collaborative working, and more empathic ACE-informed understanding of their clients' difficulties, which in turn is perceived as facilitating more lasting change for clients. However, further research on how practitioners respond to disclosure of ACEs and implications for treatment and referrals for further support is needed to support these findings *(79)*. The lack of an existing evidence base on outcomes of enquiry has fuelled concern about the widespread implementation of ACE enquiry without further evaluation. Recent debates and concerns have focused on the *(19,81–86)*:

- Types of adversities enquired about (i.e., beyond the 10 commonly explored ACEs).
- Validity of the ACE questionnaire as a screening measure (i.e., accuracy and diagnostic sensitivity), and conversely if it should be viewed as a screening tool or rather a tool to facilitate service users' disclosure of ACEs in the context of a person-centred conversation.
- The use of the ACE questionnaire to 'score' a person's ACEs.
- The use of the ACE questionnaire within a strengths-based approach (considering protective factors).
- Availability and accessibility of evidenced based treatments for those identified with ACEs.
- Potential for negative effects of ACE enquiry (e.g. re-traumatisation) and overtreatment.

The current lack of evidence around routine enquiry about ACEs means its appropriateness and effectiveness in supporting people who have experienced ACEs is still relatively unknown *(84)*. In recent years however, a number of pilot projects have been implemented and evaluated across the UK *(15–17)*. Findings from these evaluations suggest that routine ACE enquiry can be implemented across different settings, is acceptable to practitioners and clients, and has potential benefits, including developing the client-practitioner relationship. Studies also suggest that many service users had not previously disclosed their ACEs to another practitioner. The implementation of ACE enquiry is currently being piloted and/or implemented across a number of UK areas (e.g., Wales, Scotland, and Lancashire) and other countries (e.g., USA and Macedonia), and many settings are monitoring and evaluating implementation and impacts.

3. The Nottinghamshire REACh™ programme

The REACh™ programme aims to enable services and practitioners to implement ACE enquiry as part of routine assessment or support processes, with all or selected service users. **ACE enquiry generally involves the use of an ACE questionnaire to facilitate service users' disclosure of ACEs in the context of a person-centred conversation**. The REACh™ programme model has five core stages: organisational readiness, planning and implementation, staff training, follow-up support, and evaluation and research. In Nottinghamshire, implementation of the REACh™ programme is embedded in a whole system place-based approach to preventing and responding to ACEs. Full details of the Nottinghamshire REACh™ programme model is provided in the Interim Evaluation Report (Quigg et al, 2020[1]), and a summary of all stages is provided below.

Figure 1: The REACh™ programme model

REACh™ readiness audit

With support from the REACh™ Implementation Team, the service/organisation explore and audit their organisation's readiness to implement the programme. Through this process, service managers and 'anticipated' programme implementation teams explore:

- Whether there is organisational commitment to implement REACh™, and the service and staff are ready and willing to do so.
- Where routine or targeted ACE enquiry may fit best within the service and client care pathway, including identifying which staff need to receive training, and the type of training (e.g., ACE aware or full REACh™ training).
- Safeguarding arrangements for clients and onward referral for specialist care.
- Staff supervision and self-care, and support for staff who may be affected by ACEs.
- How and where they will record implementation of ACE enquiry, including whether the client agreed or declined to participate, and the outcomes of their participation (e.g., disclosures / support / referral). This is to ensure clients do not have to unnecessarily repeat their story, that relevant staff/teams are aware of the client's engagement and outcomes of enquiry, and for audit purpose.
- Programme monitoring and evaluation.

Planning and implementation

Following the readiness audit, services work to ensure that activities to support implementation (as identified by the audit) are implemented or significantly in process before moving onto the staff training phase. It is anticipated that services will review organisational readiness and practice change management repeatedly throughout the duration of implementation.

REACh™ training

Relevant staff members, who are anticipated to implement ACE enquiry, are invited to participate in a REACh™ training session. Pre-course materials are distributed to ensure staff are aware of the purpose and nature of the training (ensuring staff can access further information or support as required) and to aid learning and engagement in the training session. The training takes place over a full day and covers:

- **The underpinning research** - the evidence around ACEs and the science of childhood trauma; the science of resilience, recovery and coping with trauma, stress and adversity; the case for change; and evidence on ACE enquiry.
- **The practice of enquiry -** this includes discussion about where enquiry fits best for a team or service care pathway; role play practice; going through the ACE questionnaire and how this might be embedded in practice; and watching ACE enquiry specific training videos.

The ACE questionnaire used in the REACh™ programme is a 14-item questionnaire (Appendix 7.2), covering child maltreatment and household experiences, an opportunity to raise any other childhood adversities/traumas, and a final question asking about the presence of a trusted adult during their childhood (a factor associated with building resiliency and mitigating the impacts of ACEs).

REACh™ follow-up and support

Follow-up support is provided by the REACh™ programme team to offer guidance to services/staff and promote sustained practice change. Support has typically been provided via group reflective practice sessions, case discussions, attendance at service/staff team meetings, and one-to-ones with service leads and practitioners. Follow-up support is provided and tailored based on the needs of the service/practitioners.

Evaluation and research

Services are encouraged to develop processes and recording systems to monitor the implementation of ACE enquiry and measure outputs and outcomes resulting from clients' engagement with the enquiry process.

Whole system implementation

The Nottinghamshire REACh™ programme is supported by a countywide approach to developing and implementing trauma-informed approaches:

- The Director of Public Health's annual reports have focused on investing in future generations and ensuring a healthy start; and raised the prevention of ACEs and the development of a public health approach to violence prevention as key priorities for Nottinghamshire.
- The Adult Social Care and Public Health Committee approved funding for the development and implementation of ACE enquiry across services in Nottinghamshire, and in 2019 Warren Larkin Associates Ltd were procured by Nottinghamshire County Council to commence implementation of the REACh™ programme in 2019.

- Wider partners (e.g., Nottinghamshire Violence Reduction Unit) are developing trauma-informed approaches across services in the county. Warren Larkin Associates Ltd have provided a number of inputs to Nottinghamshire Violence Reduction Unit, including the delivery of a bespoke trauma-informed programme of training and education to the regional Prevent Team (counter terrorism Police).

4. Nottinghamshire REACh™ programme: implementation

The Nottinghamshire REACh™ programme commenced in April 2019, with resources provided to enable a two-year test and learn project to develop and implement the programme across services. However, due to COVID-19 and in line with UK Government guidance around social distancing, in March 2020, elements of the programme were cancelled and in April 2020, full programme implementation was paused. Whilst programme implementation recommenced in 2020/21, COVID-19 restrictions continued to impact upon programme delivery and thus the test and learn project and service evaluation was extended until summer 2022.

As of March 2022, nine services had commenced or completed **training** of staff and six services were **implementing ACE enquiry** following a person-centred approach. All services were receiving **follow-up support** to develop processes to implement and/or embed ACE enquiry. A summary of programme implementation per year is provided below, and an overall summary of programme implementation across the full project period is provided in Figure 1 and Table 2. Findings are drawn from all evaluation methods.

47.8% of practitioner survey respondents reported routinely enquiring with all clients. 11.6%/38.9% reported implementing with selected client groups/individuals.
Of these, **71%** reported that they complete the ACE questionnaire through discussion with the client. Other processes reported included client self-completion with the practitioner present (39.1%) or not present (8.7%).

4.1 Implementation during 2019/20

Several core activities were implemented to facilitate a whole system approach to programme implementation, including strategy and implementation group meetings, process workshops with individual services and the development of a memorandum of understanding between programme commissioners and services.

During 2019/20, nine services from across Nottinghamshire had agreed to explore their potential engagement in the REACh™ programme:

- **Healthcare Services:** Health visitors.
- **Support Services:** Substance use, intimate partner violence, children's centres, family services, GP social prescribing.
- **Criminal Justice Services:** Police, community rehabilitation service (CRS), youth justice.

All services completed (or had started to complete) the **REACh™ readiness audit,** most had trained staff, and five had commenced the implementation of ACE enquiry with clients following a person-centred approach. Full details of programme implementation during 2019/20 are detailed in the Interim Evaluation Report (Quigg et al 2020[1]).

4.2 Implementation during 2020/21 and 2021/22

Due to COVID-19, there was a substantial pause in programme implementation during 2020/21, particularly from April to October 2020. During the first seven months of 2020/21, project meetings were paused, and services paused programme implementation. Communication was maintained between project commissioners, the REACh™ Implementation Team and steering group

members/service leads to determine the appropriateness and capacity of services to continue to engage with the project. Whilst there were discussions with one service regarding piloting implementation of ACE enquiry with clients via online meetings, this did not progress.

In November 2020, the project steering group reconvened to review programme implementation and the support that services may require to recommence their involvement (e.g., refresher training for staff). Subsequently, programme implementation recommenced across most services[2], yet at a gentler pace to allow services to reflect on how to effectively, and safely, continue with programme implementation, with consideration of the impacts of COVID-19 on service demand and delivery, staff, and clients. Additional training sessions were implemented during this period:

- Additional online training programmes were offered to services, including refresher training for staff who had attended the initial training sessions in 2019/20, and full training for new staff members, or services who were yet to participate in training.
- Additional bespoke training on the use of The ACE's Deck (an additional product developed in response to learning from the test and learn project) to facilitate ACE enquiry (see Section 4.3). During 2021/22, around 15 staff attended an ACE's Deck training session, including service leads who then repeated the training in-house for their staff. The online training session was also recorded and shared with service leads who requested it.

Three additional services joined the project – Hetty's, a support service for families affected by someone's alcohol or drug use; the Education Team within Nottinghamshire County Council; and youth service (however, the Education Team paused engagement during the readiness stage in 2021/22).

Figure 1: Nottinghamshire REACh™ programme implementation

Nottinghamshire REACh™ programme strategy group

REACh™ Implementation Team / NCC Project Manager
County / service level support; project management

Implementation group
Community of practice; support; information sharing

Regional strategic support: Director of Public Health annual reports; Public Health Nottinghamshire Substance Misuse Framework; Nottinghamshire Violence Reduction Unit

Healthcare
Healthy child programme (0-19) - Health visitors

Specialist support
Substance use (*2), domestic violence, youth services

Criminal justice
Police, youth justice service

Family support
Children's centres, family service

REACh Readiness Audit
Planning & Implementation
REACh Training Skills & Confidence to ask and respond appropriately
Follow-up support Consultation & Coaching
Evaluation and Research

[2] Two services ceased their engagement in the project / programme – the GP social prescribing team and the community rehabilitation service.

Table 3: Details of implementation of the REACh™ programme across Nottinghamshire

Service	Readiness		Training	ACE enquiry implementation		
	Strategic lead	Readiness audit	n trained (during 1st round of training)	Lead (s) identified	ACE enquiry	Target group and enquiry point
Substance use support (CGL)	✓	✓	~80	✓	✓ Commenced 19/20	Whole service, new clients age 18+, voluntary, during single/multi-agency/group sessions as appropriate (determined by practitioner [DbP])
Substance use support (Hetty's)	✓	✓	~10	✓	✓ Commenced 21/22	Whole service, all clients, voluntary, during one-to-one support programme at ~ session 5 of 12 (DbP)
Domestic abuse support	✓	✓	~50	✓	✓ Commenced 19/20 (implementation paused)	Refuge only, women age 18+ out of crisis, voluntary, during session as appropriate (DbP)
Police school liaison officers	✓	✓	~19	✓	✓ Piloted implementation in 19/20 only	School early intervention officers only, young people (YP) aged 14+, voluntary, during support session with YP as appropriate (DbP)
Youth offending team	✓	✓	~45	✓	✓ Commenced 2019/20	Whole service, YP age 14+ years, voluntary, during session as appropriate (DbP)
Health visitors	✓	✓	~130	✓	✓Commenced 21/22	Mothers aged 18+, voluntary, at antenatal, 6-8 week visit or 'listening visits', during session as appropriate (DbP)
Early help and family services	✓	✓	~50	✓	✓Commenced 19/20	Whole service, clients age 18+, voluntary, during session as appropriate (DbP)
Children's centres	✓	✓	~130	✓	✓Commenced 19/20	Whole service, parents age 14+, voluntary, during session as appropriate (DbP)
Youth services	✓	✓	N unknown	✓	✓ Piloted implementation in 21/22 only	Whole service, young people (YP) aged 14+, voluntary, during support session with YP as appropriate (DbP)

4.3 Fidelity and adaptations

A core aim of the Nottinghamshire REACh™ programme is to implement a whole system, place-based approach to ACE enquiry across Nottinghamshire. It was hoped that the test and learn project would explore the acceptability of ACE enquiry within services, whether service users are accepting of the questions they are being asked, whether they see a benefit, and how this might impact upon their outcomes. From the outset, delivery partners recognised that the five stages of REACh™ are *"bringing a set of principles and ideas" (Implementation Partner)* that can be adapted at a service level to meet the needs of the service and clients. Thus, it was acknowledged that delivery may look slightly different because teams have different service models and service user needs, along with differing service outputs and outcomes, although it was anticipated that the five stages of the model would be followed. Whilst overall the five stages of the model have been followed across all participating services, Nottinghamshire REACh™ programme has been adapted to support whole system implementation and to meet the emerging needs of services and practitioners. Key adaptations are summarised below.

Staff training

Whilst training was delivered in the same way across sessions, it was highlighted that some of the training was contextualised for the services being trained and/or adapted during the session to focus on questions or concerns raised by trainees. Furthermore, in year 2 and 3, additional training has been provided for new staff, refresher training for staff trained in year 1 (pre-COVID-19), and specific training on the use of the ACE's Deck (see below) for selected services. One service reported that senior staff who had attended the ACE's Deck training went on to deliver similar training to their staff teams.

"I suppose, one thing is that we've tried to lean the training delivery a little bit towards their sector or context, so it's still the same training, but we've tried to obviously tailor a little bit to their requirements so that you - so we're speaking very much to their world." (Implementation Partner)

"…the leadership team went on some training around the ACE cards and what we're doing is delivering that to our teams that we manage, so that we can adapt it so that they understand it and it's their learning style. And that's currently where we're at." (Practitioner, Service 1)

Implementation group, REAChTM champions and reflective group meetings

An implementation group was established, chaired by the project commissioner, and included representatives from all services, providing an opportunity to reflect on programme implementation and share learning (and resources) across services. Across many services, service-level REACh™ champions were also identified and supported to have a key role in developing and implementing ACE enquiry across their service. This included implementation of reflective group meetings within services, including implementation leads, REACh™ champions and other staff as appropriate. To learn about staff experiences and support them further, the REACh™ Implementation Team and project commissioner attended team meetings at the request of the service.

"I think it's organically happened as a result of how it's been implemented within each service, and because each service has rolled it out or implemented it slightly different in line with how that service is delivered. I think those champions have organically grown or, you know, there's been a conscious effort to develop champions." (Implementation Partner)

"… in the reflective practice sessions, in the implementation and support we're obviously immersing ourselves in their world a little bit, so we're developing our understanding of what their day-to-day work is about, and I think as we go on this journey, we're just get better at being attuned to their needs and their challenges and the context in which they're working." (Implementation Partner)

Follow-up support

Follow-up support provided by the REACh™ Implementation Team was initially anticipated to involve monthly sessions with service leads for six months following staff training. As the test and learn project progressed, and with the complexities of the pandemic, follow-up support has been enhanced to meet the varying needs of services and practitioners. Thus, facilitated by additional funding from NCC (and additional in-kind resources from WLA), the REACh™ Implementation Team offered services support until the service was confident that they did not need support or guidance anymore. Furthermore, support was tailored to the service's needs, with, for example, REACh™ Implementation Team members attending reflective group sessions within services.

"It sort of evolved into a much more interactive support, which I think's been critical." (Implementation Partner)

Adapting the ACE questionnaire for children and the development of the ACE's Deck

Several services participated in the project work with children and were exploring the appropriateness and practicalities of implementing ACE enquiry with children aged 14+ years (who may also still be experiencing ACEs). Prior to the Nottinghamshire REACh™ project, implementation with children had not been tested (although it had been considered and explored elsewhere). Through discussion with service leads and practitioners and the REACh™ Implementation Team, particularly during the readiness and implementation phase, it became apparent that the ACE questionnaire in its original format may not be an appropriate tool to use with this age-group, and that questions posed required adaptation. Thus, the ACE questionnaire was adapted to ensure the questions posed and the terminology used were relevant to their client's age group.

"…we adapted the [ACE] questionnaire to be more young people friendly. So obviously ACEs being based on childhood experiences, these young people may still be in those experiences. So we did amend the questionnaire to feel, well we worded a little bit more friendly towards people, so we changed some of the terminology so it made more sense to them…And then obviously, we also got the opportunity to look at the ACE deck of cards as a different approach to an enquiry, which is something that as a service, we felt was a lot more appropriate to people." (Practitioner, Service 1)

Further, some services felt that additional tools may need to be developed that were more child friendly and strengths-based. Consequently, WLA developed the ACE's Deck (see Box 3) and worked with three services to begin a test and learn pilot of the use of the cards with children and other clients as appropriate. During piloting, staff used the cards as part of a wider conversation with children who they had been working with for some time (and thus had a trusting client-practitioner relationship), in one-to-one or group sessions; or as part of a small focus group discussion with children (aged 16-18 years) about their views on the cards. Use of the cards was discussed

with the children prior to implementation, with children volunteering to participate. Staff piloting the cards were asked by WLA to provide feedback to inform their development and future use. Generally, views on the cards were positive, with practitioners reporting that they were age appropriate, and the children appeared comfortable with using the cards and discussing ACEs, acknowledging however that for some their experience of ACEs was seen as a normal life experience.

"I think the ACE Deck will be a useful tool to engage young people with when trying to look at any possible ACEs with them. They are an age-appropriate tool for the young people that they are working with and the look and feel of them isn't too daunting or too advanced to put young people off from engaging or disclosing." (Practitioner, WLA feedback form)

"Again, young people said that they would be a useful tool to use with young people and thought that they would be good for prompting discussions and disclosures. They did struggle with the wording on a few of the cards…and suggested that these could do with breaking down into simpler language, especially for the younger age ranges." (Practitioner WLA feedback form)

Staff and children offered some suggestions for developing the cards including providing examples of positive actions to prompt ideas and discussion; reconsidering some terminology to ensure it is understandable for children[3]; and ensuring images reflect that domestic violence can be perpetrated by males and females.

Following piloting, the ACE's Deck was adapted, and services involved in the pilot were introduced to them and offered training on the use of the cards - with around 15 staff from two services attending the training session. Trainees' views on the cards were generally positive with practitioners noting they are a better option for some clients compared to the ACE questionnaire; they are more interactive and can help people think about their experiences and provide a reflective aid for future discussions.

"..they [the young people] liked the way you could visually see a process." (Practitioner, Service 1)

"Much more engaging [I] really like the cards" "[it] offers interactive prompts too" "I really like the cards idea... a lot less daunting than the questions" "Visual aids are really valuable." (Practitioners, WLA training comments)

Exploration of ACEs in group sessions

In addition to implementing ACE enquiry on a one-to-one basis with clients, some services had used their learning from REACh™ and the ACE questionnaire and ACE's Deck to develop and facilitate group discussions with their clients about ACEs. This included sessions to raise awareness about ACEs and introduce the concept of, and an invitation to take part in, ACE enquiry (either within the session or at a latter point). For example, in one service, two peer group sessions were developed – an educational session introducing ACEs: and a peer support session focused on supporting clients whose family members had ACEs. In the peer support group, the sharing and discussing of similar experiences with peers was anticipated to have a therapeutic impact (like other peer support groups). The ACE's Deck was viewed as a useful tool here because it was an easy visual aid for the group to see the different ACEs, but also to discuss the resilience factors.

[3] E.g., Past times, incarceration, criminal justice, marginalised, exploited, incarcerated, high school (due to some areas using the term Secondary School).

Box 3: ACE's Deck

The ACE's Deck (and accompanying suggestions for using the cards) aim to provide practitioners with a creative tool to facilitate a conversation with teenagers and adults about the impact of life events on health and wellbeing and to encourage conversations about coping and resilience building. There are different types of cards covering:

- ACEs (25 cards)
- Impacts of adversity (24 cards)
- Resilience and coping: in childhood (22 cards) and throughout life (10 cards)
- Hopes, dreams, and plans (27 cards)
- Anything else (i.e., other things not covered by the cards that the client wishes to cover)

Practitioners are advised to use the cards in order (i.e., from ACEs to impacts, resilience, hopes, dreams, and plans), with the different categories/suits of cards used over several sessions or over a longer single session. Practitioners are advised to use their professional judgement and use the cards at the pace of the client, offering a compassionate response and providing opportunity to summarise and reflect on what they have discovered through their engagement and discussion with the practitioner using the cards.

4.4 Facilitating factors

Cautious, considered, and reflective approach to implementation

The REACh™ model aims to support services to take a cautious, considered, and reflective approach to implementing the programme. This approach was generally viewed as being a key facilitator for programme implementation at both whole system and service level. From tailoring training to meet services and practitioners' needs, the development of new tools (e.g., ACE's Deck; service level practitioner and client facing documents), piloting approaches in services (e.g., Champions piloting implementation before wider staff implementation), and ensuring implementation was person-centred (see below); this well-considered, reflective, and responsive approach appears to have been critical to facilitating programme implementation across services.

"[Implementation Team] have been really flexible and key to supporting services when things weren't particularly going well and trying to find solutions being solution focused with adopting the implementation per service." (Implementation Partner)

"One of the practitioners spoke about the benefits of case management meetings to look at introducing routine enquiry to families and that this may be beneficial for those who have concerns around implementation." (Practitioner, Service 2)

Ongoing commitment, support, and supervision

Ongoing commitment, support, and supervision from service leads, practitioners (including Champions), and the whole system implementation team was viewed as extremely valuable in supporting programme development and implementation. Support to services and staff from the REACh™ Implementation Team in setting up and developing ACE enquiry, enabling delivery to be service- and client-centred, was considered a massive support across many services. For some services, the evolving and fluid nature of support provided by the REACh™ Implementation Team was seen to be important, especially in the early days whilst the practitioners were developing their knowledge and confidence in the area. One of the practitioners spoke about receiving their training

pre-COVID and that the refresher training they had attended had been very important as a reminder and encouraged recall.

"[REACh™ Implementation Team], he's been a massive support and also [REACh™ Implementation Team], have been really, really good…. I think the training has been very, very important. And also the fact that if I can email [REACh™ Implementation Team], and he'll always respond…you know, to any queries, especially in the early days, and they would come along to meetings, when we needed them to because sometimes it's about making sure that it's that knowledge, isn't it and my knowledge, in the beginning was less than it is now. Having them able to explain much better than I could, as to the reasons why we're doing it was really important." (Practitioner, Service 2)

Buy-in from services at both a strategic and operational level was viewed as critical in helping to drive programme implementation across services. Services with clear strategies for implementation appeared to have been able to implement ACE enquiry with ease. Many services developed additional resources to support programme implementation such as guidance documents for staff, prompt sheets, flow charts of programme implementation, directories of support, and strap lines with what to record in case notes. Many services complete a spreadsheet detailing when they have offered an enquiry and the outcome, which many practitioners reported helped to develop ownership of the programme. Some services also worked with the REACh™ Implementation Team to enhance the REACh™ resources, including developing and testing the ACE's Deck with young people.

"I think what it's shown has been services that have really thought about REACh™ in a more strategic way, have taken it on board and run with it." (Implementation Partner)

"I've been trying to get it so that it's something that you offer to everyone who's having a [service name] assessment now. We're there now. We've got that, it's gone out. The guidance went out yesterday. And but also, I think that quite a lot of xxx workers have started to do that already. Because I'd covertly kept saying that there's been a lot of, we've had, like flowcharts that we've completed, we've had directories of support. And we've had strap lines to support workers in what they're putting case recording. A lot of work has been undertaken to support xxxx workers to actually ask the ACEs questionnaire." (Practitioner, Service 2)

"At the time we also employed a clinical psychologist, and in terms of trauma, we're trying to develop our approach to trauma, be more trauma informed as a service. So it's fit quite nicely with that as an approach, it was about getting better outcomes for the people." (Practitioner, Service 3)

Staff within services were seen as the driving force behind programme development and implementation, with REACh™ leads and Champions within services being vital to success. Peer support provided through supervision, by Champions and through reflective practice sessions were noted as vital in ensuring that practitioners had the skills, confidence, and support to implement ACE enquiry. In one service, service leads were concerned that the manager-practitioner relationship may discourage staff from speaking honestly about their experiences. Thus, a major facilitating factor was the availability of external clinical support for staff to discuss their experiences implementing ACE enquiry.

"We bought together our own little update package. So, one of the leads myself and another worker… we started asking people how they felt about it. And, you know, we had some information up on the screen. We did it over teams, but then people were asking questions, and so we were able to answer them…. as we progressed, what the lead started to do was go right okay, for next case

discussion, I'd like you to identify a family that you're going to do an ACEs with. So, I think that allowed us to feel more comfortable. You know, so to get over our own worries, issues, and then we identified in case discussion, we will set a target of by a next case discussion, which is six to eight weeks, you know, we will have attempted to have had a go at that, we would have introduced it, we'd have, then put a session in, where it's purely just ACEs…So it allows us time… We could feedback straight away after that session if we wanted to. But then it was the next supervision. How did it go? How did you feel about it? What was going off? So that really, it put deadlines in place, but it didn't make people feel rushed." (Practitioner, Service 2)

"We have had clinical supervision specifically around ACEs, so there's been that sort of safety net where we can go to an outside provider and say so I had this client, it was heavy, and discuss it. So, we've had lots of different opportunities to discuss it in different ways and having that private clinical supervision has definitely helped." (Practitioner, Service 5)

Some interviewees noted how practitioners' personalities and awareness of the impact of ACEs and trauma on their clients, including from their own lived experience, may facilitate their interest in implementing ACE enquiry.

"Yeah, and also it's down to the personalities as well. I think you've got - If you've got a tenacious personality, which you have in [service] and that tenaciousness is totally shown in terms of implementation." (Implementation Partner)

"…their own adversity trying to see, seeing that, and then going well, I want to make this better for everybody else. Which is, you know, interestingly, why a lot of people go into health services, a lot of people go into public health. You know, there's a driving force behind that. There's a rationale. There's a reason why you do what you do, isn't there." (Implementation Partner)

In several services, collecting and having access to more data around ACE enquiry was seen to be a facilitator as it enabled practitioners to see the number of enquiries that had been completed and those declined, in which areas ACE enquiry was being carried out, and any onward referrals and signposting. In one service, it was felt that if this had been available at the beginning of implementation, the pace would have increased a lot quicker.

Trusted relationships and client-informed choice

The ability to successfully engage with a client around their ACEs was seen to be influenced by the relationship that was present between the practitioner and client. Having a 'good relationship' and developing and establishing trust with clients was seen to be vital when implementing ACE enquiry, as was having a 'caring' and 'non-judgemental' approach. This was so that clients knew why they were being asked the ACE enquiry questions, they felt comfortable to talk openly about their experiences, but also so that they felt they had a choice and could say 'no'.

> *"I asked for help, and it takes a lot… Because you feel like a failure. So, I do think that they need to build a really good relationship with you." (Service User)*

"I think what was the biggest thing that they worried that they were doing is highlighting adversities that maybe young people aren't ready to deal with. And I think that's one of the things that we have, we did find was that some young people will be ready to look at their previous ACEs and some aren't…it is based on the relationships that they've got with those young people in those centres. I

can’t say how that looks. It’s all about that their youth work approach and that trusting relationship that they've got and how they build on that.” (Practitioner, Service 1)

A practitioner from one service felt the manageable caseloads (they have a cap on how many they see at any one time) could be the reason it is working well at their service and not in others (who have substantial caseloads), in addition to them having quite a long programme (12 sessions) of one-to-one support as standard, enabling a trusting client-practitioner relationship to be developed, and sufficient time to implement ACE enquiry at an appropriate point in the client’s journey (discussed below).

Flexible approach to ACE enquiry implementation

Ensuring there was flexibility around if, and when ACE enquiry was implemented during a client’s journey, and how it was implemented, was noted as crucial.

“I think that you're more likely to get buy in from, from those services if you're flexible in how it's implemented.” (Implementation Partner)

This linked to the importance of ensuring a trusting client-practitioner relationship was developed prior to implementation. A safe introduction to the topic was also considered important, and across services, this meant that clients could explore their participation over one or multiple sessions (where feasible within the service). For some services, staff would introduce ACEs and/or ACE enquiry to clients through one-to-one or group discussion, or provision of an information leaflet at one session, with the option for clients to then have further discussion, and potentially fully engage in ACE enquiry at a later point. Equally, clients could decline their participation during one session but still take part later should they choose to. Where engagement with a client was in a more open environment, such as the home or a public setting, some services noted how critical it was to consider the appropriateness and method of implementing ACE enquiry, considering for example if anybody else was present (e.g., children, partner, peers).

“…youth club setting, it's a chance to have our session with up to 30 young people now when am I expected to deliberately enquire with those 30 people. And we don't assess each of those 30 young people, they come in, and we do focused youth work stuff, but what we said is that we wouldn't be able to commit [to ACE enquiry], we were concerned about the commitment in terms of time, actually, what we established was that, you know, you can start an enquiry and it doesn't need to be all in one go. You know, we could introduce ACEs, for example, and just even helping a young person understand what adversity in childhood is, and what trauma is like and saying, we've got this in process, or we've got this tool that we can use to look at that we're interested in that’s session one and then session two actually then be looking at it.” (Practitioner, Service 1)

“I think some parents, although they are willing and wanting to engage with this support for the sake of their children or themselves, depending on their situation, I think it can be quite hard to hear, so sometimes I just kind of read people and you gauge ‘how do I think they're gonna respond to me reading out the question, do I think they might be better reading it themselves and sort of having that quiet moment?’ So sometimes I will give it to them, especially if there's younger children around.” (Practitioner, Service 4)

“We are doing it later on, we’re not doing it straight away so we’ve been able to build up that relationship with our clients... Gives us time to build up rapport and trust with them so they feel relatively comfortable to talk about those things.” (Practitioner, Service 5)

Furthermore, for some services, ACE enquiry was identified as being more appropriate for specific clients only, and/or for clients at a point in their journey when they are engaging in specific interventions, or specific needs are identified. This again highlights the importance placed on implementing person-centred and trauma-informed approaches where *"it's not a one size that fits all"* (Practitioner, Service 3). This may mean that the ACE questionnaire is not used if not appropriate for the client and other tools are more fitting for the client's journey (e.g., in the Youth Justice Service) or rather than introducing ACEs and ACE enquiry at an initial assessment, it is introduced later in the client's journey as appropriate to their needs and journey through the service, and when a trusting client-practitioner relationship has been developed.

"What's happened, what's working well is the interventions team are doing REACh™ rather than the assessment team, and I can't really work out why because you would have thought the assessment team would be, but actually in a way, maybe it is OK that the intervention team… are doing it because they're going to have the ongoing relationship with these individuals." (Implementation Partner)

"Within the assessment we have some sessions with the parents, and I would ask them about their childhood and what their experience of being parented was and how they think that's impacting on their parenting today…if there were any kind of indicators at that point, then I would perhaps offer the tool, but if it's already been identified in the referral, I would offer that straight away." (Practitioner, Service 4)

Practitioners felt it was important to deliver ACE enquiry in a conversational manner and to respond and address what the service user was disclosing so that they did not feel like it was a 'tick box' exercise. The ability to use the ACE questionnaire, both formally or as part of a conversation, or to use the ACE's Deck was viewed as beneficial to enabling services and practitioners to tailor the implementation of ACE enquiry in a client-centred way. The ACE's Deck was noted as supporting the implementation of ACE enquiry; the cards were viewed as being more accessible to young people (who may still be experiencing ACEs) and enabled practitioners and clients to open up conversations about ACEs and trauma focusing on a strengths-based approach.

"And what's almost been a game changer is the implementation - that is the, the introduction of the piloting of the cards, the ACE Deck of Cards. And those services that were struggling around the [ACE] questionnaire] have almost gone 'Oh yeah, we can see the how the cards will help us." (Implementation Partner)

"…how the cards are structured in terms of hopes and dreams and things for the future. The [ACE] questionnaire doesn't really do that, but what the cards do is that, so it actually gives a different perspective to those young people, that actually there is a possible different outcome for them." (Implementation Partner)

"I guess it felt like a mapping exercise, once you identified an ACE, and then you will move on to the next set of cards, you could really paint a big picture of what the whole problem was, kind of looking at what the solution might be." (Practitioner, Service 1)

Despite the clear support for a flexible approach to implementation, some practitioners across multiple services highlighted the importance of ensuring that ACE enquiry was still implemented as part of routine practice and should be offered to all relevant clients at the appropriate time. For

example, in one service the inclusion criteria relating to who may be asked about ACE enquiry had changed over the duration of the test and learn project, from one that only asked those families whom a practitioner felt might need it, to being a universal offer to all families who meet set criteria. Here, one practitioner highlighted that it was important to offer it to all relevant families, because they felt that it was possible to make assumptions and judgements of where it might be most appropriate to carry out ACE enquiry, that are not necessarily right.

"What I've found and is I think we can make judgments with our families are they don't need this. I am not going to ask them. I do not think that is right at the time for them right now. Because the first well, not the first time I did it, but a second family I did it with I made that assumption. You know, I thought I knew what she was going to say…And actually she came up with five ACEs…but this was right at the end of my programme of work with her. And actually, it just all made sense to how the referral came in…how it was phrased, I just sat down and went, Oh, okay, this makes complete sense." (Practitioner, Service 4)

Community of practice - sharing experiences and learning within and across services

Implementation across several services and the participation of service leads in steering group and implementation group meetings has enabled practitioners to share their views and experiences of the programme on a regular basis, forming a community of practice. This was particularly useful for services joining the test and learn project at a later point, or when services were at different stages of implementation. Where services had developed new resources for staff, the meetings provided a platform to discuss the rational for developing such resources, staff views on them, and if and how they were supporting programme implementation. Subsequently, resources developed by one service have been shared with others to use within their service, or as a template to develop their own service-level resources.

The Champions were seen to play a pivotal role in the implementation of REACh™ across all services who had them. Regular Champion meetings helped to build momentum and keep ACE enquiry 'on the agenda.' They were also a supportive forum for staff to discuss their experiences (and those of their colleagues) and highlight any challenges they may be experiencing.

"It's a good place to discuss things and share any ideas." (Practitioner, Service 2)

"…professionals who aren't quite confident, they've got someone to talk to and air their views and get given the right support to implement." (Implementation Partner)

"So, somebody who has already has been part of REACh™ who don't want to be Champions as such because they don't like the term…But they'll obviously be there to support their colleagues with rolling it out and delivering it and at least be the support to that small team of [service name] workers who will then be offering it in that setting." (Practitioner, Service 1)

"Because what you don't want is to be a lonely person that's trying to implement this on your own… it's finding ways and that's why I think it's having, you know, from senior managers down to the [service name] workers, of having key people that understand and are passionate about it to drive those other people forward in the fact that then becoming the majority rather than a minority. Working with those people they're quite receptive to it." (Practitioner, Service 2)

"Because I think they act as peer support, and they act as advocates for the programme, and that that advocate and that person that's always, so they make it on the agenda all the time. So, there's almost no getting away from it, so you almost have to do it because you know that, there's going to be a Champion on your back." (Implementation Partner)

"One of the positives about REACh is that it got us all talking about the difficult conversations and how we approach it. For instance, we've got a practice development session planned across all teams on the back of the cards training, asking case managers how do we have those difficult conversations with young people? Do we have them? How do we have them? So its opened up the conversation and made us more aware." (Practitioner, Service 3)

4.5 Barriers and mediating factors

The REACh^{TM} model and Implementation Team acknowledge that practice change is a "*process and that process is sometimes straightforward and other times it's complex for so many reasons, operational reasons, personnel reasons, organisational change, reasons, natural disasters like pandemics, or unexpected reasons, so there's so many factors that make any kind of practice change in the real world a challenge" (Implementation Partner).* The cautious and reflective nature of the test and learn pilot has enabled both the REACh^{TM} Implementation Team and participating services to both recognise, and where feasible, adapt to emerging barriers. Key barriers that have mediated programme progression are summarised below.

Pause and delays in programme implementation due to COVID-19

Whilst the COVID-19 pandemic led to a substantial pause in programme implementation, it also presented new challenges and considerations for programme delivery. Thus, along with the impacts of the pandemic on client and practitioner mental and physical health and wellbeing (including possible increases in trauma and engagement in risk-taking behaviours as a coping mechanism), the impacts of lockdowns and other measures to reduce the transmission of COVID-19 meant that many services had to adapt their delivery models. For most services, engagement with clients moved to online activities, with face-to-face activities only recommencing when restrictions permitted. Discussions were held around the appropriateness and practicality of conducting ACE enquiry virtually, with one service exploring the possibility of piloting this approach to inform future delivery across the whole system. However, partners were "*concerned that there was little or no evidence around implementing REACh™ in a virtual world," (Implementation Partner)* and thus the pilot did not progress, and the full project only recommenced once *"COVID looked like it was becoming much more manageable, and services were transitioning back to face-to-face contact" (Implementation Partner).*

"I think services were so stretched that we almost had to start from scratch again with all services as a result of COVID. So we had to put additional money in to support those services that were trained for mop up training, to try and get them back into a position of thinking about REACh." (Implementation Partner)

"OK, so obviously with the pandemic we had to pause the REACH programme, because services were then running very differently, and it was almost like a crisis management of services of what they were delivering." (Implementation Partner)

On-going changes to service delivery and working practices due to COVID-19 meant that many services were either not meeting clients face-to-face, and/or were not in regular contact with clients throughout 2020/21 and to a lesser extent 2021/22. It was felt that this directly impacted upon being

able to develop relationships of trust with the clients who were regarded as important when introducing and implementing aspects of REACh™. Further, for some services the focus on contacts with clients was to ensure immediate client needs were met, especially for safeguarding reasons. When face-to-face engagement with clients increased, implementation of ACE enquiry generally recommenced (or began) in implementing services.

"I'd probably done a couple before COVID struck…and we were doing most of our support during COVID over the telephone, and that type of conversation sometimes they're face-to-face. So since we've come back and doing more face-to-face visits, I'd say that I've asked every family and none of my families have said no so far." (Practitioner, Service 2)

Service and staff readiness, and staff support

Across all services, substantial engagement and buy-in from service leads, and staff, was needed to ensure both the service and staff were ready to engage in ACE enquiry. Whilst for some it was clear from the outset how ACE enquiry would fit within the service delivery model and with their client group, for others this was less clear, and queries were made by staff at different periods throughout their engagement with the test and learn project regarding this. This was particularly so for services supporting children (aged 14+ years), who were focused upon supporting the child's current and immediate needs, which may include safeguarding and dealing with current experience of childhood adversity. One service was further complicated in that it is an 'open-access' service, with no set assessments or intervention pathway for clients. Here, a number of the practitioners who were interviewed felt that it was not necessarily appropriate to carry out ACE enquiry routinely due to numbers of children attending and the range of activities they can engage in. They spoke about ideally being able to carve out time before the main sessions to be able to speak to clients. As such, here a flexible approach to implementation was taken, ensuring that clients were only introduced to ACEs and ACE enquiry if, and when, appropriate (e.g., a trusting relationship has been built between the client and practitioner).

"And I think that's probably more so how, because I said, it's open access, it's tier one, so they're not, under any orders or have to see workers, they come in, in the big groups, potentially up to 50 young people in this building with a couple of youth workers." (Practitioner, Service 1)

"We do it beforehand [the youth work sessions] so it was small group or one-to-one work outside of the main youth work session. Just so it's probably a bit more private. I can personalise it a little bit more. And it's not so I mean, especially on my junior night, because at the minute there's about 35, which is quiet for us….we do activities, but they're more activities where people can dip in and out of and do whatever they like. So it's hard to really sit down with a specific group and do something structured….where it needs a bit more time." (Practitioner, Service 1)

Whilst staff confidence to engage in ACE enquiry was noted as a common barrier, for most services this was often overcome once staff had been trained, were supported by service leads, Champions, and other staff as appropriate, and had started to implement ACE enquiry.

"I'd say our first few sessions were mainly around feedback on the training and how we would see it sit in a [service name] setting. The main thing that we had to work on was supporting our [service name] workers, to not see this as something extra for them to be a part of. I think looking at ACEs specifically and trauma informed approaches, it felt there was a little bit of concern that it felt like we

were opening a can of worms, but essentially, it just took a bit of time to get practitioners to feel confident in delivering an enquiry." (Practitioner, Service 1)

"If they've [the case manager] got a relationship with the family it should be easy to ask the questions. It is the workers own experiences that makes them more anxious about asking the questions. They need to prepare, consider the impact and make sure a resilience package is built in at the end. Their anxiety is usually not borne out." (Practitioner, Service 4)

"…for all the reasons we talked about the training, you know the barriers to professionals not doing this, is that they worry that they're going to make somebody upset. They worry that they might not be able to cope with what that person tells them. I think even today, practitioners worry about handling safeguarding issues. It makes people hugely anxious; they worry about am I going to get it right? Am I going to mess it up? Is it going to be too much for me? Is it - am I out of my depth? Am I going to get any support with this, I've already got a high caseload, so I think there's all of those understandable anxieties. Also, people worry about not having an adequate response, maybe they feel that they, they somehow need to fix it, or they need to be a therapist." (Implementation Partner)

However, across a few services, concerns were raised around a lack of support and supervision for staff, and how this can cause a barrier to implementation. This was particularly so if staff concerns were not heard and resolved, and/or staff were not supported to reflect on their personal views and experiences of ACEs, their engagement and experience of ACE enquiry, and access peer support or supervision. For example, in one service it was commented that practitioners may not want to 'unpick' issues that may need a lot of support because they did not necessarily have the skills to do this. It was also highlighted that as practitioners they do not have any clinical supervision, in terms of risk management for themselves. They wanted to safeguard their own mental health and wellbeing as it was acknowledged that some of the conversations around ACEs may be triggering and therefore clinical supervision maybe necessary. It was felt that more formal training and service-wide peer support may help to address these potential barriers. In another service, practitioners own experience of ACEs was also seen to be a potential barrier to implementing ACE enquiry and it was identified that it would be important to explore this further with individual staff in their personal supervisions. Across a number of services, the value of independent supervision, outside of current management structures, was noted as important to enabling staff to access and utilise supervision effectively.

"It's your confidence as well, isn't it? Because, if something's going to trigger you. And I think that's what you've got to be mindful of when you look at those questions is there going to be things on there that could affect you as a person. So, I think you need to get that support in place for you to be able to then deliver it to clients." (Practitioner, Service 2)

"And where it's not worked, it's quite evident that where there's not been Champions that those services haven't embedded it." (Implementation Partner)

"Support our staff if they have also been affected by ACEs themselves." (Practitioner Survey)

"I don't feel managers are trauma-informed with regards to supporting staff who have been subject of trauma. Poor understanding around how trauma impacts staff's lives at work leads to poor practice amongst managers. Staff are supported well in listening to parents and past experiences but as a service I feel we aren't doing enough to understand staff." (Practitioner Survey)

For some services, there was an apparent disconnect between senior managers and front-line practitioners regarding the appropriateness and feasibility of REACh™ being implemented in their service.

"…A lot of resistance, so they felt like there was a disconnect between what the managers and leaders were saying - yes, it, this will be great for us, this is absolutely in line with what we do and our values and our practice - but actually when you got to talk to practitioners - and despite the readiness exercise you got to talk to practitioners, they were saying our caseloads are too big, it doesn't really fit with how we work. This is so alien to our culture, we're not sure how this will, how we will do this, we lack confidence, we don't get much supervision." (Implementation Partner)

"It just wasn't realistic and you could feel it in the trend in, you know their hearts were saying yes, this is the right thing to do, but their minds were saying I barely get through the week as it is, how am I gonna incorporate this, even though it's good idea." (Implementation Partner)

"...but actually when you get to meet the teams, when you start to work with them, you then start to get a feel that you know that this might not be the best timing for them, it might not be a point where they can accommodate this due to capacity, due to staff turnover, due to caseload size due to pressures externally." (Implementation Partner)

For some, this disconnect was overcome through provision of further engagement with front-line staff to explore if and how ACE enquiry could be implemented within their service, with more confident staff piloting implementation prior to full roll-out. In addition, services provided resources to staff to support their engagement and implementation. One service implemented meetings with staff prior to their participation in the REACh™ training to discuss the programme, enable staff to share their views and concerns, and overcome any initial hesitations, allowing them to go into the training more informed. The inclusion of managers within the training was also seen as beneficial in supporting management/staff discussions on the programme, facilitating programme implementation.

For a few services, despite supporting programme implementation in their service, organisational change slowed down or halted programme implementation, with one service disengaging from the project due to substantial changes taking place within their organisation (following training of many staff).

"…I think there are couple of services that were very keen and very passionate about doing this, but actually... I don't think the timing was right for them. So, for example [service], you know they were really keen to do this, but right at the beginning we said, well, you're going to be going through some significant changes organisationally…so we had a question about whether that would potentially be a distraction or you know it's far enough in the distance, not to be a problem. It turns out that was a massive problem, that everybody was distracted, everybody was concerned, everybody was going through multiple and complex feelings and emotions about change." (Implementation Partner)

Changes in service structure / management

For two services, changes in strategic management or organisational structure created either a pause in programme implementation or the need for the service to drop out of the test and learn project.

"So, we attended the training. And then we brought it back into the [service] …to be fair, we didn't use it for a while, because it was in the process of changing systems and those kinds of things. But

now it's been implemented routinely, really, with families. So it's been offered to every family that we're all working with." (Practitioner, Service 2)

Age of client - children

The test and learn project has highlighted a number of considerations for implementing ACE enquiry with children. The ACE tool is not designed for children and was adapted for implementation with this age group, with further developments through the production of the ACE's Deck as a more client-friendly and strengths-based resource. For a few services, some staff reported that due to the nature of the service the immediate priority was to focus on addressing the child's presenting (often complex) needs rather than introducing ACEs and ACE enquiry. Critically, ensuring there was sufficient time to build a good client-practitioner relationship, that their immediate needs were met and that they were in a safe space to discuss ACEs (which may be recent, current, and on-going) was deemed critical to preventing re-traumatisation. Where these aspects were not in place or could not be implemented due to the limited period for engaging with clients, there was general agreement that ACE enquiry should not be implemented.

"…we've only got them for a maximum of three months, and we probably see them once a fortnight, so you're not really building a good enough relationship I don't think to start asking those sorts of questions." (Practitioner, Service 3)

"…interestingly, what I think is those services where I think that they've struggled to find it, it fit in. It's those services that are working with young people." (Implementation Partner)

"You've got to be really careful, you have to cherry pick who you pick because these kids have gone through so much trauma we don't want to re-traumatise them." (Practitioner, Service 3)

Implementation in the youth clubs was problematic as they were considered a place that young people can escape and have some fun. The ACE questionnaire was considered to be very formal, and it was highlighted that it may prove 'tricky' and 'awkward' to sit down formally with a young person to complete it. One practitioner felt that it was very important for the young people to feel comfortable in the environment and that Youth Workers are seen as neutral, trusting, and approachable and that asking these questions could impact negatively upon this. This practitioner's main focus was on having "regular contact so that they're [the young people] safeguarded and I know that they're happy and safe."

"The top and bottom of it for me is that a lot of young people come just to kind of escape…they have a game a pool, they have a cup of tea and a chat and a laugh and talk about the football, whatever it is that they want to kind of have a bit of fun around. So, for me to sit down and say right I'd like to start this conversation, it would be a little bit potentially off putting and actually prevent them from actually talking more in the future or feeling comfortable to kind of naturally find those things out about themselves." (Practitioner, Service 1)

The age of the young people was seen to be a challenge for practitioners for a number of reasons, for example, where a young person may be living with their ACEs but is not ready to address them, or they acknowledge their ACEs but do not see how they may be impacting upon their current behaviour(s).

“We’re not bothered about the safeguarding element because we get disclosures all the time, you know when you start getting a good relationship with a young person, but we don’t want to force their hand by asking these questions and then we leave them in a really dark place.” (Practitioner, Service 3)

“..cause they may not see what they're in is a challenge because that's just what going on, do you know what I mean? But when you’re an adult, you can reflect back.” (Implementation Partner)

Lack of evidence on impact of ACE enquiry

In one service, some interviewee’s reported that practitioners had divided opinions when it came to ACE enquiry. Whilst some found the ACE questionnaire to be a valuable tool and used it routinely in their sessions, others were more hesitant due to the scarcity of research on ACE enquiry. Building the evidence base on ACE enquiry however was also a reason why the service was keen to take part in the test and learn project.

“... I suppose that’s the thing about REACh is that we can’t say definitively that if you do this then it’s going to reduce offending or it's going to reduce them accessing services, we can't definitively say it's better for young people, because the research isn’t there, which is why we're doing this.” (Practitioner, Service 3)

5. Nottinghamshire REACh™ programme: acceptability, outcomes, and impacts

This section explores programme acceptability, outcomes, and impacts, with findings drawn from all evaluation methods.

5.1 Acceptability

Participating services are all self-selecting and participating because they have chosen to test and/or adopt the practice of routine or targeted ACE enquiry as part of a commitment to become more trauma-informed. Whilst a few staff were apprehensive of implementing REACh™, for most services these concerns appear to have been allayed and a person-centred approach to implementing ACE enquiry was deemed to be acceptable. Practitioner's acceptability was viewed to develop over time throughout practitioners' engagement with REACh™, with practitioners going on a journey of understanding the value of asking the questions, and being supported by senior managers and peers, and now feeling more confident implementing ACE enquiry and supporting clients with any follow-up support that may be needed.

"I think it's acceptable, definitely acceptable in the services that have totally run with it… I don't think it's acceptable for the ones that have partially or have stalled implementing it." (Implementation Partner)

"I think when the training was delivered, I think all of us were a little bit wary about initiating the enquiry, just because of the kind of questions that they were asking. And I think we were worrying that you'd ask those questions, and then what do you do with them, then? Where do you go? Or if it's the last thing on a Friday, you go visit a [client], and you do the [ACE] questionnaire for the weekend, and I think that was initially a worry right at the beginning, when we did the training." (Practitioner, Service 2)

"After I'd done the training…I wouldn't say it's rare, but it's not frequent that something new piques my interest to get involved with, but this is more trauma-informed, it's very much strengths-based, which I would love us to move better and more quickly into that area." (Practitioner, Service 4)

"They've [staff] not had any issues with it as far as I'm aware. They've not given me any negative feedback. So that's positive." (Practitioner, Service 2)

"I think it's great because you know some things [ACEs], it's a bit taboo. And oh it's big and scary and no one wants to talk about those things. It's like opening the box in the basement but having done it loads of times now, that's exactly what needs to happen. You know there needs to be air around it. It needs to be brought up from the basement and have a bit of air around it, and that's what's healing. It doesn't necessarily have to be like a really stressful, heavy conversation. So I think it's a very positive thing to do and I'm very pro." (Practitioner, Service 5)

Findings from the follow-up practitioner survey[4] show that most respondents agreed that (Figure 2):

- Their service is a suitable place to enquire about childhood adversity (70.8%).

[4] n=72, across six services.

- It is useful to the client for the practitioner/service to enquire and know about a client's experience of adversity in childhood (72.2%).
- They were clear on the process to be followed when routinely enquiring about adversity in childhood (75.0%).

"I feel it is so valuable to ask the question." (Practitioner Survey Respondent)

Six in ten (61.1%) survey respondents agreed that enquiring about adversity in childhood was acceptable to their clients. In interviews, practitioner's views on the acceptability of ACE enquiry amongst clients varied across services. For services working with adults, ACE enquiry was generally reported as acceptable to most clients (whether or not they had experienced ACEs). Clients' acceptance of ACE enquiry was seen to be 'reassuring' and supportive for practitioners, encouraging them to continue to undertake ACE enquiry with their clients.

"Because most people, in fact all of the people that I've spoken to, have all given just great feedback and I have enjoyed doing this and I'm relieved I've done it. That you for asking the questions. That generally is the feedback we're getting [from clients]." (Practitioner, Service 5)

"I think we've had one declined. Out of all the ones we've done. And that was very recently, we've got a new worker, and she offered it up and mum went…'Oh, no, no, I'm not answering that. I'm asked too many questions about that. I've got a worker and no, I don't need to do that'… But mum declined, because she's getting support elsewhere. So, it's like, brilliant. You know, she might bring it up later. But it's about the opportunity to ask those questions." (Practitioner, Service 2)

Interviews conducted with three service users from one service and secondary data from three other services supported practitioner reports of clients' acceptance. Clients highlighted how it is difficult to know what is going on in a client's life if you don't ask them, and the positive potential impacts ACE enquiry could have for them and others. For clients where ACEs were seen to have already been identified, with many having support in place, it was still seen to be beneficial for clients to know that the practitioner recognised what they had experienced and could look to engage with them in different ways.

"Asking these questions could change the course of your future. It makes you relate to your current situation and more open to make changes for the sake of your own children."

(Practitioner report of service user feedback)

"I had a family that I've been working with a while. So, I introduced it later on, because I'd already had them open for a long time. And the mum was saying, I can really see that this is beneficial for families when you're asking these questions, even though she didn't need any support, and she was fine. She said, I can really see why these questions would benefit some families. And she said that she found it useful to be asked those questions for if there was anything that she needed support with." (Practitioner, Service 2)

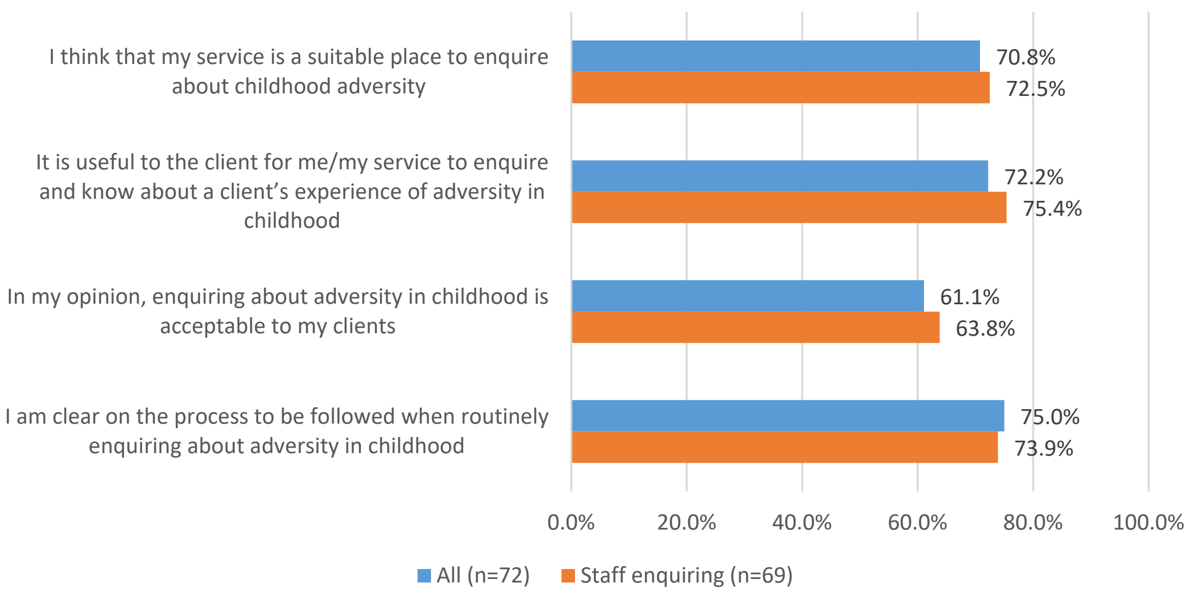
"[Parents are] quite open to talking about their childhood and things that happened to them...it's just a great tool to start those conversations around what has happened and where we're at now. [Asking] 'do you recognise if there's any similarities in the experiences you're having with your children'… it's just a fantastic tool for opening up those discussions." (Practitioner, Service 4)

"…sometimes it's just nice for them to recognise that we know that's happened to them. Actually, it might be the first time they have spoken about it in ages. So, I feel that it has a benefit in that way. Because it allows us to get to know our families that bit better." (Practitioner, Service 2)

"I think that's very important, because you don't know anyone's situation and what they might be in at that time when these questions are asked. You don't know if they're going through any kind of problems." (Service User)

"I don't know how it will help, but I do think it is a good idea, because you know not everybody's, open and things unless they're approached." (Service User)

Figure 2: Proportion of practitioner survey participants agreeing with selected statements on the value and acceptability of ACE enquiry



ACE enquiry appears less acceptable for practitioners in services working with children. This related to practical concerns such as the ACE questionnaire not being designed for children, but also wider issues relating to the nature of service provision provided by the service for the child (see Section 4.5, Barriers). Practitioners reported mixed experiences of implementing ACE enquiry with children. Thus, whilst some practitioners reported positive experiences and client acceptance, others reported that many declined and were not comfortable answering the ACE questions or discussing ACEs.

"They both seemed to enjoy sharing with me and each other their ACEs, especially if it was the same. They laughed and didn't think it was an issue both their parents went to prison or that they had been a member of a gang or sent personal pictures online. It seemed like all the ACEs were normal to them and their family life." (Practitioner, WLA feedback form)

"Many young people are not comfortable answering the questions or do not want to open up about it. Particularly early into any intervention." (Survey Respondent)

"And that's currently where we're at. We've not had any [service name] workers that have done a full ACE enquiry, young people have declined it who have been asked. But what they have done is generally just been talking about ACEs and what they are and sort of raising awareness with young people." (Practitioner, Service 1)

"I would not complete a tick box questionnaire around trauma. This is insensitive in my opinion and as a company I do not have the resources to manage traumas. This survey is a cause for triggers. Our service users use substances to manage triggers. Unless disclosed personally I would not consider asking, unless I have concerns over a person's safety or risk of harm." (Survey Respondent)

For some services and practitioners, the ACEs Deck appeared more acceptable than the ACE questionnaire, and the introduction of this as a tool increased practitioners' acceptability of ACE enquiry, particularly for use with children.

"…based on the stuff that we usually do and how we usually operate, to sit down formally with a clipboard and go through questions and interview format really, so I was always a bit dubious whether or not that'd be successful. And actually, when I went to sort of plucked up the courage to have an attempt, I circumnavigate that by doing the card game approach, we felt that was much more engaging for the young people." (Practitioner, Service 1)

"That's more than just getting to the end and saying well your life is [***] isn't it, see you next week. That's more about actually I can see how has it impacted on you and actually how are we going to get through this? How do we build that resilience? Some of our case managers had the training on the cards really like them, and are willing to give them a go I think that'll get a lot more bite because it's a lot more interactive as well." (Practitioner, Service 3)

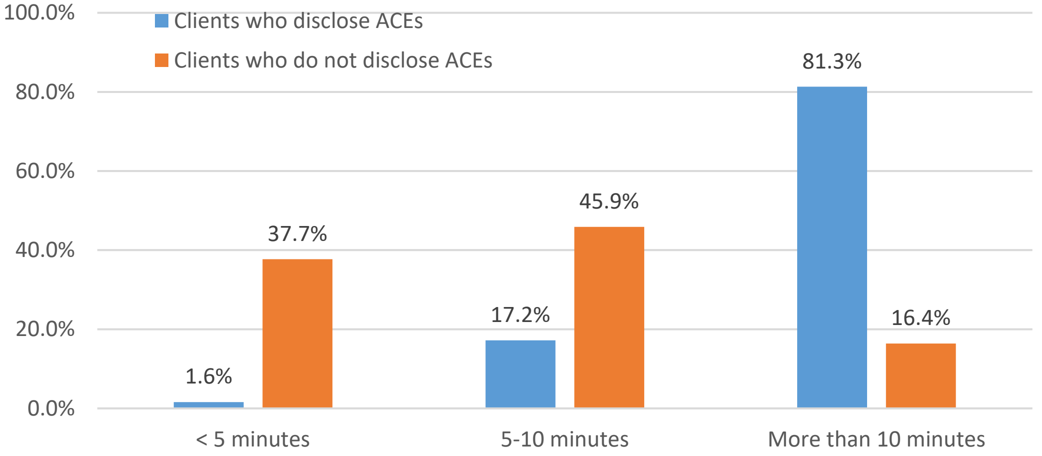
"Our workers really received the cards quite well, because it can be adaptable, in the sense it doesn't have to be personalised. So, if people are in that position to sort it out straightaway, workers could do some scenarios and the young people could start to identify with the information they were given. So, it just starts the thinking process." (Practitioner, Service 1)

"She didn't like the questionnaire…But she really liked the cards, and she liked the fact that it gave her, it showed some of the things that she was doing already to deal with things. But it also gave her other ideas of other things that she can do to try and help. She liked that, she liked that it was giving her ways to tackle some of the issues that she was dealing with. So it was good. And then obviously, then we can also use that to help us to implement things with her. So yeah, I found it really good…I think the questionnaire was quite formal, whereas the cards probably work better for us as a [service name] service just because we are that slightly more informal. I do think the questionnaire has its place, probably just not with us. But other young people it might, I think it depends on how their brain works as well, some young people like things done in a different way don't they." *(Service 1, Practitioner report of implementing ACE enquiry)*

Amongst survey respondents who stated that they had implemented ACE enquiry (n=69), 42.0% of practitioner survey respondents agreed that there is sufficient time during appointments to conduct ACE enquiry. Practitioners estimated that the time to implement ACE enquiry varied by whether or not the client disclosed ACEs. When no disclosures were made, most (45.9%) practitioners estimated that ACE enquiry took between 5-10 minutes. When disclosures were made, most (81.3%) practitioners estimated that ACE enquiry took more than 10 minutes. Further, just over four in ten reported that there was sufficient time to respond to disclosures of adversity in childhood (42.0%) and sufficient resources within their service (40.6%) or beyond the service (42.0%), for follow-up support for clients disclosing adversity in childhood (Figure 3).

"If someone's disclosing, hold them in that moment, keep them there, just listen and show interest, and don't try and [demonstrate you] haven't really got time to deal with this, you got to deal with it then, you've got to make time for that person." (Service user)

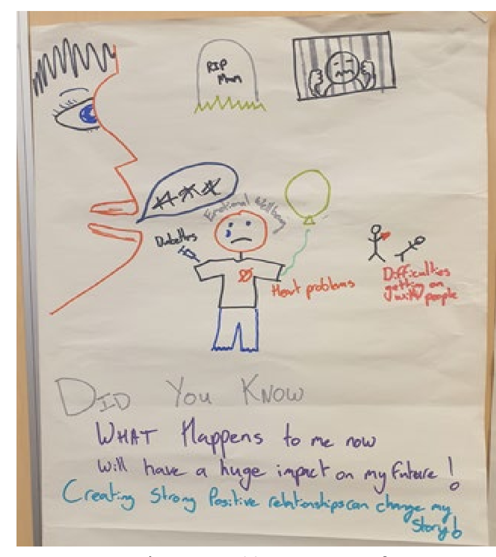
Figure 3: Estimated additional time to implement ACE enquiry (practitioner survey, n=69)



5.2 Outcomes and impacts for services

5.2.1 Developing trauma and ACE-informed services

During May 2019 to February 2020, over 500 practitioners received the REACh™ training, including access to pre-training materials and attendance at a one-day training session. Evaluation of the training (reported in the Interim Evaluation Report; Quigg et al, 2020[1]) found that the training was associated with significant increases in trainees': knowledge on ACEs and ACE enquiry; confidence to ask service users about ACEs; and confidence to respond to disclosures and refer for support. Most participants agreed that the training was easy to understand, the trainers were knowledgeable and interacted well with them, and that they would recommend the training to others. Additional practitioners were also trained following the pause in programme implementation (total unknown); 15 practitioners attended the ACE's Deck training. The training was reported by trainees as being beneficial in allaying staff concerns and improving their acceptance of the programme and developing more trauma-informed practitioners.



Trainee's pictorial brainstorm of ACEs

"I thought the training was excellent and it made a lot of sense for our service. There were quite a few in our service that were very rigid in their thinking - no this young person has done this they need to punish them. Well actually that's a young person, so in that respect its helped because it's kind of changed people's perspectives which is really good." (Practitioner, Service 3)

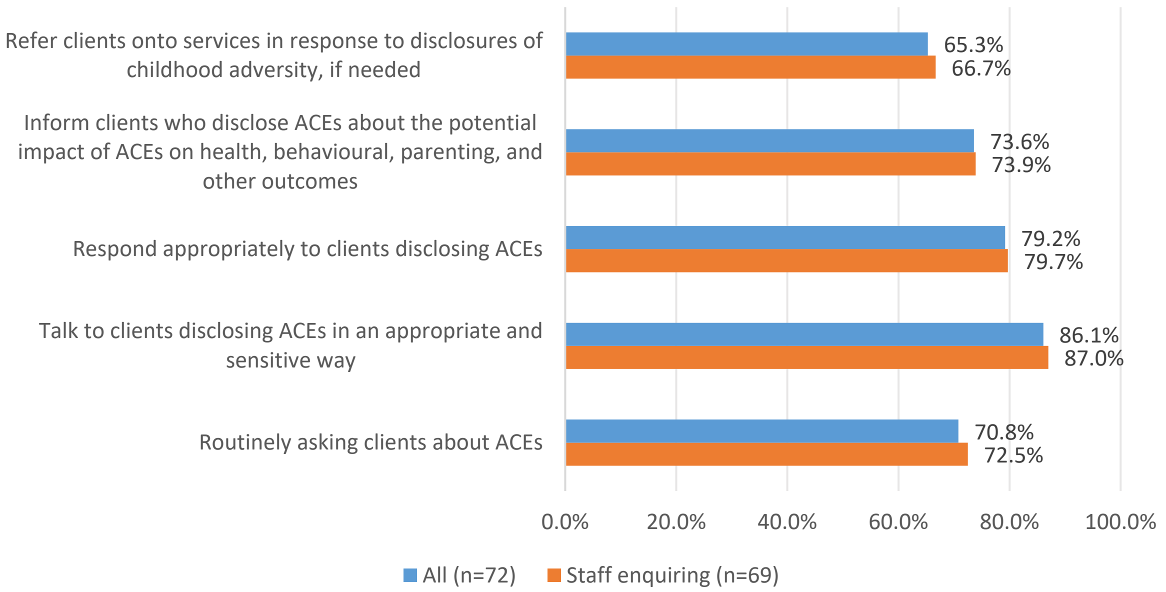
"So the training that I went on I thought was amazing. It was really comprehensive… I thought it was well delivered… I thought the training was really imperative and I think without the training I would be worried about a practitioner delivering it. Because I don't think that they would deliver it in the way, that they would pick up their own slant to it and then it wouldn't be delivered how it's been researched and evidenced." (Practitioner, Service 5)

Findings from the follow-up practitioner survey[5] show that most respondents were confident in implementing ACE enquiry and responding to disclosures (Figure 4).

"ACEs are a priority for [service]. Some practitioners are more comfortable than others asking about ACEs." (Survey Respondent)

[5] n=72, across six services.

Figure 4: Proportion of practitioner survey participants reporting being confident in implementing ACE enquiry



Furthermore, half of practitioners described how REACh™ had led to changes in themselves (Figure 5), enabling them to better understand how ACEs affect clients' behaviour, how to be more empathetic, and enabling them to provide better support.

"More confident in approach, insight into the whole family dynamics, empathetic with clients always." (Survey Respondent)

"Much more conscious of how I approach the subject and being aware of how painful this practice could be for the parent." (Survey Respondent)

"I have always been aware of a trauma informed approach to my work however the ACEs questionnaire is a further tool which supports these discussions with families." (Survey Respondent)

"I feel that consideration of the impact of ACEs gives me more of an understanding about parent's behaviour." (Survey Respondent)

"More aware of the impact of ACEs and therefore better able to support." (Survey Respondent)

"I feel it builds the foundations for a more meaningful piece of work and helps me to understand the parent better which improves the outcomes for the family and builds my confidence working with families." (Survey Respondent)

"Have more insight and understanding of a person's experiences which makes me more mindful of best ways to support and engage with clients." (Survey Respondent)

Interviewees from one service noted how practitioners who had experienced ACEs also had an opportunity to discuss their experiences with colleagues. This was perceived as helping practitioners to then support their service users better. In another service, one of the practitioners felt they had learned a lot from the questions and that they were able to regulate themselves should something be triggering. Taking time for reflection was also seen to be important.

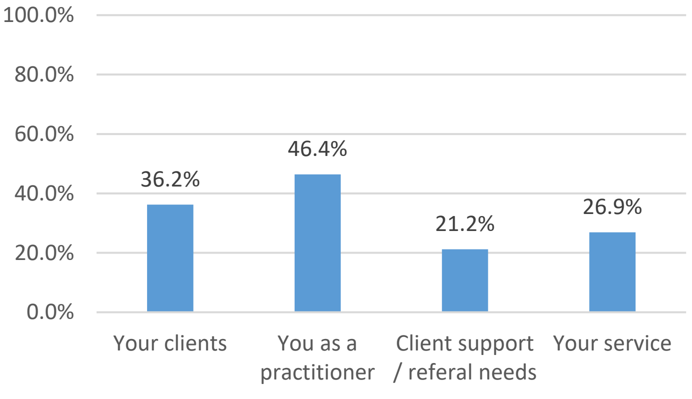
"I think the whole learning and training processes helped practitioners grow because they've had to confront their own ACEs and potentially your own history and do reflective work on it and this increases knowledge and experience around these topics." (Practitioner, Service 5)

"I think I personally learned a lot from that… on a personal level that I thought this is me. And actually… I didn't get that support, but actually, I can offer really good support…and I've been able to regulate myself, but then I have done a couple where I thought, well, that's triggered me a little bit. And I've gone back and then said, I just need a little bit as for guidance on this…And I've not been, it's not triggered me where I think I need to be signposted. Because they've talked me through and said, you know, this is how it's such and you're regulating this way, and you find a way to deal with it." (Practitioner, Service 2)

Overall, most practitioners participating in the follow-up survey reported that when implementing ACE enquiry (n=69), the process often or always (Figure A1, appendix 8.3):

- Improves their understanding of their clients' issues (85.5%).
- Improves the help and support they provided to clients because they understood their childhood better (78.3%).
- Improves their relationship with their client because they understood their childhood better (72.5%).
- Leads to them discussing the identified items of childhood adversity during the appointment (65.2%).

Figure 5: Proportion of practitioner survey participants reporting observing changes in clients, themselves, and their service since commencing ACE enquiry (n=69)



Around a third reported that the process often or always (Figure A1, appendix 8.3):

- Changes their clinical care/intervention at the time of the appointment (when there is a disclosure) (36.2%).
- Changes their plan for the client's follow-up care with them /at their service (when there is a disclosure) (31.9%).
- Changes the referrals they make for their client to other services/support (when there is a disclosure (33.3%).

"All of mine that I've done have been absolutely fine. They've answered all of the questions. And a lot of them if they've answered yes to any of the questions, they've already got support in place, majority of the time I've found so they've already been receiving that support. So I've not had to signpost to any of the services for them at the minute." (Practitioner, Service 2)

"Better working relationships together. They show trust towards myself." (Survey Respondent)

The majority of practitioner survey respondents described how REACh™ had led to changes in their service (Figure 5), with a greater awareness of ACEs and trauma-informed approaches and inclusion across service meetings / agendas, implementation and confidence to implement ACE enquiry,

enabling them to better understand how ACEs affect client's behaviour, be more empathetic and enabled them to provide better support.

"It has become part of the assessment process, confidence is increasing, attitudes are varied but changing towards the using of the questionnaire. [Clients] are offered the choice so do not always choose to complete but the majority will do." (Survey Respondent)

5.3 Outcomes and impacts for service users

Nine services had piloted or commenced ACE enquiry with some service users, and partners highlighted that some organisations were beginning to show 'wonderful narratives' around the 'impactful experiences' they were having with their clients. Box 4-6 provide examples of case studies from different services.

"A couple of the teams are really seeing transformational results in people. We've had some really positive case studies shared with us. Even if we only make a difference to a handful of people then I think that's something worth celebrating." (Implementation Partner)

A third (36.2%) of practitioner survey respondents reported that they had observed changes in clients since implementing ACE enquiry. Examples of client outcomes and impacts were also reported in practitioner and client interviews, and programme documentation. This included:

- **Clients feeling heard, empowered, and supported**, having had the opportunity to reflect on their childhood and consider how this may relate to their current life experiences. Practitioners reported that ACE enquiry provided clients with the opportunity to open up and be 'truthful', to talk about things that many have not done before and provide them with the opportunity to discuss their experiences in a non-judgmental forum. Further, it showed them that they are not alone and that there was support available if they needed it.

"…as well as being a burden of my shoulders that I've carried around for all these years, when (facilitator) briefly told me about this REACh project, it sort of opened up a doorway that I've been looking for a long-long time, and I thought you know what, why can't anyone have told me about this before." (Service user)

"They feel listened to and more empowered as someone is taking an interest to what has happened to them." (Survey Respondent)

"They feel listened to and happy to discuss this." (Survey Respondent)

"They have become more open and honest and mental health is talked more openly about than it was." (Survey Respondent)

"But he [client] said, 'You know what, in order for me to do my best for my son, I need to tell you this, and you need to know, I need to be truthful." (Practitioner, Service 2)

"I think I did one dad it was like two and a half hours. And he was crying. And he just said to me, I've never, ever had anybody sit and listen to me and allow me space, and I've actually said things that I've not told my partner… He says I can actually see where things were missing. He says but there was

nobody. There was no teachers, no friends, nobody that could just say, you know, is everything okay? Or you know what's happening?" (Practitioner, Service 2)

"I wanted her to hear what I say saying, not in a professional term, but in a personal term, because I felt it the right time to tell this person that was sat in that room with me." (Service user)

"It's nice to have somebody actually come round and get to know your family and actually be able to talk to you in confidence and obviously pick up on things obviously, they believe that might have been the situation without imposing too much." (Service user)

In two services, ACEs and/or ACEs enquiry had been introduced in a number of client peer group sessions. In one service, practitioners felt these groups provided an important space for individuals with similar experiences to meet and discuss those experiences and how to deal with them, reducing feelings of isolation and blame by seeing that such experiences are not unique to them. Here, the ACE's Deck was considered particularly useful to group work as it provided a great visual aid to orientate the discussion and remind individuals what the ACEs were. It was felt it worked better than the questionnaire in a group setting where the focus is not on enquiring about each individual's ACEs, but rather on discussing in general, shared experiences and how this may have impacted them. Further, because it also includes sources of resilience it stimulated discussion on some of the factors that can help individuals overcome ACEs.

"[Service users said] I'm glad I could talk to my peers about it, and I'm really pleased that we can discuss it together." (Practitioner, Service 5)

- **Improved knowledge on ACEs and trauma, and their potential impacts, and ways to mitigate the impacts of trauma.** This included helping clients to identify and begin to understand what they may be experiencing and look to find a possible solution-focussed response to that, through for example, learning new coping strategies and techniques. For some clients it was seen to help them to understand and put 'pieces of the jigsaw together'. Furthermore, in one service, kinship carers were reported to have improved understanding of the difficulties of family members who engage in health risk behaviours (e.g. substance use) and intergenerational trauma, and subsequently have increased motivation to engage in kinship care support. Reports of clients informing family members about ACEs were also noted.

"I think this definitely gives people a nice insight of being able to deal with things that are very deep within the skin." (Service User)

"My client went back to her parents to inform them about the ACEs and how it had affected them." (Survey Respondent)

"…it helped in a way that she [young person] could see that actually, what she was feeling, and experiencing there was others out there that were experiencing and feeling those same things and it was because of a reason, a reason that wasn't in her control, either. So, it was something that things that were happening that she had got no control over. So they realised it wasn't her fault that she felt the way she did, which was a relief for her because she was a bit like, she was really low and down. And so I think it just helped with the fact that it was normal, not normal, well, normal for people that were experiencing the things that she was experiencing to feel that way. Then we also could give her some support and tools to help combat those feelings as well. So, I think she's been much better. And she's been much better at school as well. So, something's obviously, between us we're obviously doing something right." (Practitioner, Service 1)

“She was quite happy to do the questionnaire and she did. She did say about it [ACEs] but then she just started crying, so we couldn't answer the rest of the questions I said we'll revisit it if you like….But she's since gone to counselling and she's doing really well. And then when we spoke about it in the visit, she didn't realise there was help out there. She was just stuck with it and she didn't realise that something could be done. So yeah, she's doing really well. And she had post-natal depression with other two. And this third baby, she hasn't. She's doing amazing.” Practitioner 9

- **Clients being more receptive of support and receiving better and more tailored support,** having considered their experience of ACEs and how this may relate to current behaviours, and prior engagement in support and interventions. An example was provided where ACE enquiry had highlighted a number of issues that were being experienced by a family; here, a parent needed much more intensive support than the service could provide, and the service were able to refer them for mental health and domestic abuse support. A fifth (21.2%) of practitioner survey respondents reported that they had seen a change in client support/ referral needs since implementing ACE enquiry.

“It’s a massive opportunity to rescue someone from the past, and even from the present of what they’re going through, up here (head/brain), the damage that’s in there, feel it as an opportunity, you’re saving that person’s life really.” (Service user)

“Their answers to REACh indicated this parent had not moved on at all and we could not move them forward to manage this child until all these issues had been addressed. [REACh] gave us great info to take back to [service name] to stop sending them to us for more parenting, because they will never be able to parent effectively until their own trauma has been addressed…It was really good, it was evidence, ‘because I don’t know where we’d have got that from, I don’t know how we would have evidenced it without.” (Practitioner, Service 4)

“A further understanding for them as to why they may respond to situations the way they do and to help them identify any support that may be of benefit to them. Or not as the case may be.” (Survey Respondent)

“Others are aware of impact but don't know where to go so I signpost.” (Survey Respondent)

“They can start to realise that childhood may/can/does impact us, confidence can start to change which allows them to be more receptive to understanding/support (if needed) as they have been heard.” (Survey Respondent)

“I also think it was an opportunity for me to share a little bit about myself as well to the young person…in this case it improved the level of trust, or the nature of the [the service], to go to relax and socialise it’s somewhere where you can seek support and advice. That was one that was a good takeaway. That was a good benefit.” (Practitioner, Service 1)

“It [ACE enquiry] gives a more holistic view of what may be going on for them.” (Survey Respondent)

"It's crazy isn't it, just opening up just something like that, something massive, and then something good can come to it." (Service user)

"Accepting what's happened to me as a child that has affected me as an adult, and I always thought that I was over it but all I'd done was bury it really, so moving forward I can see myself working through that and coming out the other side with not needing to drink to push all those feelings down." (Service user)

"Opened up another doorway, I wouldn't say it's put closure on my experience, bad experience, it's partial closure but it's also helped me now to open up another doorway, and to move on and deal with it in a positive way. Whereas it's always been something that I've been embarrassed about, and felt that I was guilty to a point, but over the years I have learnt that I wasn't guilty, I was the innocent party, I was abused." (Service user)

- **Parents exploring, understanding, and wanting to make changes to their behaviour to protect their children from intergenerational ACEs**, having reflected on their childhood experiences, and how this may relate to their parenting behaviour (or that of their family members). This included being more receptive to support to help them change their behaviours.

"Asking these questions could change the course of your future. It makes you relate to your current situation and be more open to make changes for the sake of your own children." (Service User)

"For some parents it is a light bulb moment where they realise why they parent the way they do." (Survey Respondent)

"[It's] almost like a light bulb moment for the parents really...getting them to recognise that actually 'what I've been through, my children, and our experience, I know how I feel now. I could have probably had some support at that point' and they're sort of more open and willing to having their children accessing some support." (Practitioner, Service 4)

"A further understanding for them [the parents] as to why they may respond to situations the way they do and to help them identify any support that may be of benefit to them. Or not as the case may be." (Survey Respondent)

"Parents are more likely to ask for support if it's something they haven't shared before. Often it will improve the outcomes for the child." (Survey Respondent)

"So for one client she didn't disclose anything for herself but it immediately, because we see it in parents often they're struggling with a lot of guilt or blame themselves for their child's drug or alcohol use, she immediately went to what ACEs have I given my son. So, she interpreted it that way but it led to a conversation about how it wasn't her fault because she can't control it, cure it. So, I think it's great for opening up conversations and just looking at everything from different angles. So, it helps that kind of reflective work with the client. And just seeing how family patterns can repeat, or how unhealed trauma does sort of continue down the line and how you just get that realisation that maybe I did go through something. Maybe that did affect me." (Practitioner, Service 5)

- **ACE enquiry helping service users to recover, address negative thoughts and cognitions, increase wellbeing, and decrease feelings of isolation.** The process of engaging in ACE enquiry was noted as having the potential to be a therapeutic experience for some clients. Both

practitioners and service users noted how it could help those who are suffering from ACEs and trauma, through building client understanding, ensuring they feel heard and are supported with a compassionate response, building their resilience and coping strategies.

"Service user enjoyed being listened too and has returned to informal sessions presenting less unhappy." (Practitioner, WLA feedback form)

"…he felt he needed medication to compress it, but actually he didn't, because he had been able to train his mind to say you know there's other ways to deal with things, and he stopped his drug and alcohol [use]. And so that was, you know, we do these things to mask it, we think it's helping it, but actually by addressing them, and I think his, his motive was in his action, was it was going to write things down more." (Practitioner, Service 2)

"Using aspects of REACh was considered to be impactful in that it helped the young person to identify their problems and coping mechanisms and tools to better manage how they are feeling." (Practitioner, Service 1)

"Because of the work that they'd done, one service user drove back to the village where she was brought up... because she got these visions in or out of what it looked like. A lot of it was true, but a lot of it wasn't. But just the experience of driving there, retracing their steps, looking at the places where she had these big memories and coming back free. She said she drove there full of fear and she drove home free. But she would never have done that without the routine enquiry." (Practitioner, Service 5)

"I can think of an example one lady disclosed something and she'd never told anybody that she'd been abused by her…[family member]. And of course, when something like that is disclosed, we have to protect any children that [family member] may still have access to so that the details were asked of her and [family member] had moved to another area…the health visitor told her that the police in that area would be informed and social care in that area…we wouldn't speak to [family member] or anything like that, and she was very, very anxious and upset, , she didn't really want anything to happen from her disclosure. She just wanted to get it out there. But did explain very clearly that we have to think of the children that [family member] might still have access to, and [family member] did have access to other children. And so the health visitor went back for another visit to that lady to try to let her talk through her anxieties and, come to terms with it really, and that was fine. That's all she needed. We just, the health visitor just reassured her and explained processes and that sort of thing." (Practitioner, Service 9)

- **Service users coproducing programme materials** (e.g., video of their views on ACE enquiry to inform and support implementation)**, reviewing programme materials** (e.g., ACEs Deck) **and providing practitioners with their views on ACE enquiry, and the ACE questionnaire** to inform and/or support future implementation. For example, in one service, clients who had engaged in ACE enquiry attended staff training sessions, to dispel staff concerns around how they thought clients may view ACE enquiry, and/or react following ACE enquiry.

Overall, 17.4% of practitioners participating in the follow-up survey reported that when implementing ACE enquiry, the process often or always causes their client more trauma and distress. Some practitioners and clients noted that the process of being asked about ACEs and disclosing ACEs can make clients upset, angry and/or anxious. One of the clients who was interviewed spoke about the importance of understanding why the ACE questions were being asked. Another also noted that these are natural responses and that it is okay for clients to react in such a way, and whilst this may be uncomfortable for practitioners (and clients) that it is still important to ask, listen, and support in a compassionate manner.

"…they did set my anxiety off thinking oh, are they asking the questions because they think that maybe my childhood has caused my child to be the way she is and is it affecting her do you know what I mean, I don't think it was about that, but I don't know." (Service user)

"There can be positives as the client understands you are to support them throughout all their experiences in life and have a more holistic approach to problem solve. However, it can also be a negative outcome as some people choose not to disclose and can evoke memories that they have suppressed, and they will withdraw from support." (Survey Respondent)

"If we become upset, angry about what's happened to us, and how it's affecting us, then that's fine, from our point of view we're saying that we really trust you if we're opening up in that way to you, so please do ask the questions and listen, and if someone has spoken to you about those things, we don't want to be told there's another service that can deal better with that as we're opening up to you and feel comfortable with you, so please just be with us in that moment, just listen." (Service user)

Despite these emerging findings, many practitioners noted however that at this stage of programme implementation it was difficult to identify and measure outcomes and impacts for clients. This was further complicated for services who may only engage with service users for a small amount of time, reducing opportunities for follow-up and capturing medium to long-term impacts. Further, for some services, providing tailored and appropriate support for clients following ACE enquiry may require an escalation in service provision, which may appear to be a negative outcome both for the client and service performance indicators (e.g., through increases in number of safeguarding referrals, or clients moved to more intensive support). However, ensuring clients receive the correct support for their needs was noted as the key priority, and through identifying such support needs through ACE enquiry, this was envisaged to have more sustainable long-term impacts for clients.

Box 4: Case study (The Family Service)

Prior to ACE enquiry: The parent/family had been involved with the Family Service previously (prior to REACh being implemented in the service). During previous engagement with the parent, discussions highlighted that the parent had experienced trauma during childhood

How and why ACE enquiry was implemented

Following agreement with the parent for the Family Service to work with their family, a Child and Family Assessment was completed. As part of this, the parent shared that they had experienced trauma during childhood and adulthood. Subsequently, the practitioner introduced the ACE questionnaire, explaining the research on ACEs and the impacts of trauma across the life course, and how discussing this may help the parent (e.g. feel listened to / support needs identified). It was noted that:

- The practitioner recognises that these experiences may be upsetting, and they can provide support.
- There may be questions asked that are not relevant to their own past or they do not want to answer or discuss further, and this is respected and okay; and, if they want to stop the questionnaire at any time they can do so.
- If there are any help/advice/referrals they want or need from these discussions, the practitioner can support this.
- They could complete the questionnaire alone or with the practitioner.
- Participation in ACE enquiry is voluntary.

The parent agreed to take part and completion of the questionnaire was undertaken together as requested by the parent over two sessions, as during the first session the parent felt that discussion about some experiences was too emotional for them.

Outcome: Following support from the practitioner, the client felt able to independently access mental health support services via their GP and were referred to the Adult Mental Health Team for long term counselling support.

Outcome: The parent accepted support (the parent had previously declined support as they thought by sharing their past / thoughts / experiences this would result in their child being removed from them). Through several discussion sessions, the parent was able to recognise the timing for them was right to access the support they needed, to start to look at their own emotional health and wellbeing.

Outcome: Additional discussions followed these sessions, helping the parent to recognise their experiences were not their fault and they were not to blame.

Box 5: Case study (Children's Centres)

Prior to ACE enquiry: Jemima* has been engaged with her current Family Support Worker (FSW) for 1.5 years, during which time she has seen her FSW face-to-face at home and at the Children's Centre as well as spoken to her over the telephone when it was not possible to see her face-to-face during covid restrictions.

Client experience of ACE enquiry

Jemima said that discussion around completing the ACEs questionnaire had come up in conversation with her FSW when she had spoken about her childhood experiences. She was asked if she would like to complete the ACEs questionnaire and was given some information about it by her FSW and given time to think about it, which she felt was important. She completed the questionnaire the next time she saw her FSW, which was a space of around one week.

"I didn't do it there and then…I had another appointment with her and she said did I want to go ahead with it and I said that yeah I was more than happy to so we did it the following time, so it was over two appointments."

Jemima said that she understood why she was being asked the questions, due to her previous childhood experiences, and that she felt comfortable talking about these to the FSW. She said that she had a good relationship with her FSW and felt that was important. She did, however, say that she is a very open person and thinks that she would have been happy to have spoken to any professional about her experiences even if she hadn't had that developed relationship with them. She had previously shared her experiences with her counsellor.

*A pseudonym has been given for the purpose of anonymity

Outcome: Jemima felt that appropriate support was there for her, and she didn't feel that the support she'd received had changed as a result of the information she had told her FSW. She did, however, feel that it had made her realise that the things that have happened to her in the past may be the reasons 'why I am the way I am', for example with her mental health, and that these experiences could affect how people parent.

"No, I don't think it's had a different impact. It's made me realise maybe that's why I am the way I am because I think I've always looked for answers in why I am the way I am with mental health. It hasn't really, she just advised I went to counselling but life's a bit up in the air at the minute and I just never got round to it. It is what it is and it's never going to change me as a person, so I suppose it's just to help deal with it really."

Client view on ACE enquiry: She felt that the questions were clear, and that the Children's Centre was a suitable setting to be asked the questions. She said that it is an important process that can help people but wondered (as she wasn't aware) whether there were support networks available to other people who may need more support than she did, especially for those who may not have spoken about their ACEs before.

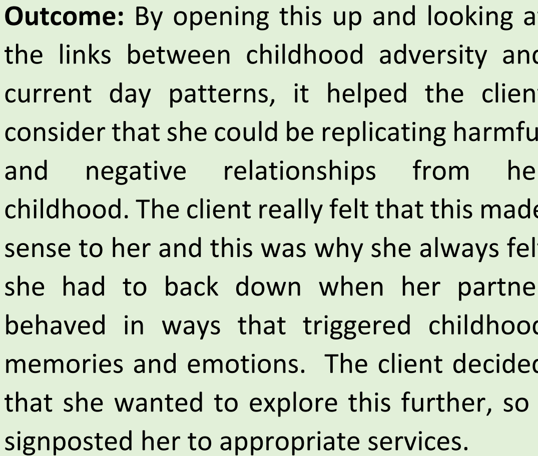
Box 6: Case study (Hetty's)

Prior to ACE enquiry: The Client felt unable to stand up to her partner who abuses illicit drugs, and that even at points where she feels strong, if he was to insult her, make her feel unworthy, it would make her succumb to his abusive behaviours too, thus leading to her failing to maintain boundaries which help her look after herself.

Practitioner's overview of how and why ACE enquiry was implemented

We completed the ACEs enquiry on session 7 of the pathway. I feel this gave me enough time to build a relationship with the client in which she could be open about her experiences as a child, and adversity which she'd experienced. Whilst we wouldn't ask a client to expand on any of these experiences, we allow clients to talk openly and freely about them, and in return we listen, and signpost should the client request this either there and then or further down the line. The client started to talk about feeling put down a lot by her parent, and made to feel stupid a lot, especially around schoolwork. The client told me she felt that she could never get it right and therefore succumbed to this behaviour and started to believe that she really wasn't good enough.

Outcome: By completing the ACE enquiry, it has enabled the client to positively move forward to maintain her boundaries. She has been working with services alongside myself, which complement the work we carry out as a service. Her partner has also moved into more established recovery and past behaviors are repeated a lot less often, which has led to positive outcomes all around.



Outcome: By opening this up and looking at the links between childhood adversity and current day patterns, it helped the client consider that she could be replicating harmful and negative relationships from her childhood. The client really felt that this made sense to her and this was why she always felt she had to back down when her partner behaved in ways that triggered childhood memories and emotions. The client decided that she wanted to explore this further, so I signposted her to appropriate services.

5.4 Sustainability and future considerations

"There are more than just these [the organisations / services included in the test and learn project], but this is amazing as a starting block…to have a whole community approach you need to think about all the services that families, young people and vulnerable adults come into contact with and make them all ACE aware and trauma informed." (Implementation Partner)

The Nottinghamshire test and learn project is the first to implement the REACh™ programme across a whole system (including multiple services of a varying nature). Thus, from the outset it was envisaged that it would take time to develop and implement the programme across services, and that a cautious, considered, and reflective approach to programme implementation would be required (elements that are embedded in the REACh™ programme model). Despite the implications of COVID-19, partners reflected how programme implementation had taken longer than expected. Whilst there were various reasons for this (see Section 4.5), the importance of taking time to progress through the five stages of the REACh™ model, at a time and pace that was appropriate to supporting a client and service-centred intervention was noted as vital.

"I think what we've learned is that it, you know, as always, it takes longer than you anticipate." (Implementation Partner)

"…because it might be that some bits where you thought it might fit actually doesn't fit. So you need to change it." (Implementation Partner)

Whilst most services had commenced ACE enquiry, some had paused implementation (primarily due to COVID-19), and some had only recently began implementation. Further, for some services, ACE enquiry was not being implemented routinely, but rather at the practitioner's discretion. Whilst all services were supportive of embedding trauma-informed practices and ACE enquiry generally, embedding of ACE enquiry has varied across services – whilst some services anticipated that ACE enquiry would be sustained within their service, others felt that if was too soon in their implementation process to tell.

"Experience will say there are staff that use any tools more than others, it's about the level of encouragement we get about any tools we use. Some are required, so it's an additional piece of paperwork. It won't ever be done by everyone, there will be some reluctance… I wouldn't want to pull it, where it's effective, it's really effective. Where it's utilised properly it can provide us with a lot of information." (Practitioner, Service 4)

"We've got our local partnership board; it's not been raised as a priority for them. It's not coming up when I go to workforce development council for the council. It's not coming up on the development council. So, if it's not being pushed sort of wider then I think for us as a service, it's at risk of petering off as new stuff comes in because if it's not being pushed financially wider, we as a [service name] service going to say, them five new staff, they need REACh training. Especially if we know that it's having limited use across the service, we would put the money into something else." (Practitioner, Service 4)

"We've completely embedded it within our pathways with our clients and I want it to continue. The groups will also continue." (Practitioner, Service 5)

Interviewees raised a number of key considerations for supporting programme implementation, embedding and sustainability going forward:

Community of practice: It was stated that through the sharing of service level experiences and service user feedback, and professionals talking to each other at the implementation group, ACE enquiry would become more embedded. It was acknowledged that it was still 'early days' and this would grow as organisations had been offering ACE enquiry for longer. The implementation and steering groups were seen as a great platform to share ideas and resources across organisations, thus supporting / strengthening the whole system approach. It was highlighted that conversations were already beginning in Nottinghamshire, particularly where services had clients in common, and this was seen as a positive development.

"Some of them are talking about getting themselves together outside of our sessions [i.e. Implementation Group] to look at how they work and interact and become more integrated." (Implementation Partner)

Training, support, and supervision: Continuous training, support and opportunities for staff supervision were consistently reported as vital for supporting programme implementation, and ensuring the programme is embedded and sustained. It was considered important that an element of peer support was available to practitioners who were implementing REACh™, with sustainability felt to be dependent upon the practitioners and their level of confidence. Practitioners advocated for the role of Champions as being a key part of the REACh™ model.

"So we've got two of our workers now that have sort of become ACEs Champions. So, if there is a query or any training that they, maybe new staff or old staff needed for example the ACE cards. Or if there's any new research that they found or anything like that, that they wanted to deliver or if there's been a positive story, that we'll share in our weekly meetings. Just that overall this has really helped and they're doing really well on that, doing amazing and it's been a weight off my shoulders." (Practitioner, Service 5)

"I think going forward, having Champions and peer support, peer mentors as part of that programme will also aid facilitation and, sustainability." (Implementation Partner)

"I think that if moving forward to me, I think knowing what I know now in relation to how resistant some individuals can be, I think it would be about having that supervision, that clinical supervision with individuals to open their mind before the training even starts because it's almost as though they've done the training and there's still resistance you've got to try and unpick why they're resistant, why they're closed down." (Practitioner, Service 5)

The need for continued training for new staff and/or refresher training for existing staff was noted as being required, and additional bespoke training depending on services and practitioner's needs (e.g., how to support young people; trauma-informed practice; mental health). It was also highlighted that it would be beneficial to include within the REACh™ training, how to manage the emotions that may be triggered by recounting personal experiences of ACEs. Wider training for service staff (who may not be engaged in ACE enquiry) on ACEs and trauma-informed practices was seen to also add value and support sustainability. Funding for training of new staff in future was highlighted as a possible barrier to implementation and sustainability. The perception was that internal training may eventually dilute fidelity to the original training and concept of REACh™.

"You forget stuff, you get in one mindset and you kind of run along with that so I think refresher training is really good to just kind of remind us because we have to go on safeguard refresher training it is a similar thing. It just helps make you realise and helps remind you." (Practitioner, Service 3)

"…because if they feel affected by it personally, they're going to be reluctant to want to have these conversations with clients. But if that's roughly half the people [having experienced ACEs] then we need to then be paying close attention and offering the appropriate support and care to those people." (Implementation Partner)

"The worrying part for me would be that over time people leave and people come in and it's whether there's that funding there to get that comprehensive training. Because obviously that is quite expensive. Organisations, especially ourselves as a charity would end up doing in house training and support over years and years and years, then that training is going to get changed, so numerous years down the line it's going to be completely different isn't it?" (Practitioner, Service 5)

Continuous review and reflection (readiness and implementation monitoring): For many services, planning how best to fit ACE enquiry into their service and with their clients was a process that went beyond the readiness and planning phase. Practitioner engagement at the training and, prior and subsequent discussions within staff teams (often supported by the REACh™ Implementation Team) was a key part of developing an approach that fits service, practitioner, and client needs. Experience of implementing ACE enquiry and sharing learning within (and across) services was also an important aspect of determining and adapting processes for implementation. A number of practitioners highlighted the importance of spending more time on the readiness phase of the model (and including front-line practitioners in this phase), and continually reviewing and reflecting upon the implementation of ACE enquiry, and where relevant, adapting processes as required. For a couple of services, it was still felt that further investigation over time was needed to explore whether it was appropriate to deliver the ACE enquiry to clients within their services, and how best to do so. For others, continuous review and reflection was seen as vital to ensuring that the programme was maintained and implemented appropriately and effectively and was not dropped due to other emerging agendas or service demands.

"Pre assessment…everybody thought it would fit in a certain place. It's only through implementation that's evolved and that's changed." (Implementation Partner)

"What has been brought up in our meetings is that when something new comes something old gets put to one side. So, I always am the Champion. I'm going to be making sure that you know, it's not the REACh that we put to one side…I think [practitioner] done a crib sheet with what things we should be looking at. So it's there…it's just keeping it on the agenda." (Practitioner, Service 2)

"It's not just a single training session, and then that's it. And you leave them to it, because we know that doesn't really result in sustained practice change." (Implementation Partner)

Establishing a strong trusted relationship with a client was believed to be essential to allow the practitioner to enquire about ACEs. For many services this meant that a flexible approach to implementation was needed, with practitioners only implementing ACE enquiry at an appropriate point in the client's journey.

"We need to build a relationship with that young person because they have been let down many times by adults they won't talk to us about it. They will tell us to F off, which is a usual phrase. So we were told it was at our discretion and we could do it when we felt our young people were ready to do it." (Practitioner, Service 3)

Follow up support: In the practitioner survey, less than half of respondents implementing ACE enquiry agreed that there are sufficient resources available:

- Within their service for follow-up support for clients disclosing adversity in childhood (40.6%).
- Beyond their service for follow-up support for clients disclosing adversity in childhood (42.0%).

Practitioners in one service raised the importance of using and acting upon ACE enquiry. It was acknowledged that practitioners may need to go back and discuss ACEs with client several times to make progress.

"One key thing we're very reluctant is to leave it there and have them do it, unless you've got a plan to go back and do a session. It needs to be acted upon, not just taken away and left there. You couldn't equate that to progress." (Practitioner, Service 4)

Whole system support and community ownership: Whole system implementation of REACh™ across Nottinghamshire was a key facilitating factor for service level implementation. Practitioners across many services noted how maintaining this whole system approach and Nottinghamshire wide community of practice is important for future programme sustainability. This would include ensuring the full programme has support across organisations and that there is funding available for future staff training. Further, that service and/or wider partnerships embed trauma-informed approaches and the implementation of REACh™ into their policies, strategies, and commissioning processes. Many practitioners also raised the importance of identifying service user views on ACE enquiry and ensuring their perspectives inform if and how ACE enquiry is implemented.

"So it's almost like we need some money. We need some money to embed it, but we also need it to be part of what we commission going forwards." (Implementation Partner)

6. Key lessons and recommendations

Since 2019/20, twelve services from across Nottinghamshire have voluntarily explored their engagement in the REACh™ test and learn project, and nine services have piloted and/or implemented ACE enquiry at some point throughout 2019/20 to 2021/22. Implementing services cover: healthcare; criminal justice; and specialist support and family services. Throughout the project period, all implementing services had progressed through the REACh™ programme model, having identified strategic and implementation leads, completed a readiness audit and staff training, and established and implemented service level procedures for the piloting and/or full implementation of ACE enquiry.

The evaluation shows that countywide and service level strategies and activities have supported whole system and service level programme implementation. Readiness, training, and support processes have been hugely beneficial, and strategic and implementation groups have supported the development and implementation of the programme. Critically, the support needs of services have varied, and for some services, on-going support (provided by WLA) has been key to ensuring successful programme implementation. Similar to pilot studies implemented elsewhere, whilst some services or practitioners may have had initial reservations about ACE enquiry, upon further exploration and engagement (including through training, support and implementation of ACE enquiry) many of these concerns have been allayed *(14,15,79).* During the test and learn project, nine services had piloted/implemented ACE enquiry with their clients following a person-centred approach, and most of these services aimed to continue programme implementation. A number of other services who had paused implementation, or where implementation had slowed down (mainly due to the impacts of COVID-19 and staff changes), were aiming to re-establish ACE enquiry within their service. The remaining services who had either explored potential implementation, or piloted implementation as part of the test and learn project, had subsequently decided that ACE enquiry did not fit well within their service and/or with their clients, however, they were implementing or were supportive of implementing trauma-informed practices.

All services had developed plans for the implementation of ACE enquiry, considering which service users it may be appropriate for, and when it could be implemented in their care and support pathway. Critically, practitioners across all services were encouraged to use their professional judgement to determine when ACE enquiry should be implemented with a client (considering the safeguarding and support needs of practitioners and clients). Thus, ACE enquiry is not 'routine' per se, but was embedded in care pathways as appropriate to the client/service. This was seen as important to ensuring that the ACE questionnaire and subsequent discussions were only implemented when it is appropriate for the service user (e.g. they are out of crisis; have a good rapport with the practitioner), and it is an appropriate point in the care pathway when they can still receive adequate support should they need it. A concern from the practitioner survey was that less than half of respondents implementing ACE enquiry agreed that there were sufficient resources available within or beyond their service for follow-up support for clients disclosing adversity in childhood. Ensuring support is available for clients if they need it has been identified elsewhere as a key consideration to ensure the ethical and sustainable implementation of ACE enquiry *(84)*.

This evaluation supports emerging evidence that ACE enquiry, implemented in a person-centred and compassionate way (and as part of a conversation) can be acceptable to practitioners and their clients *(14,15,79).* Findings from the practitioner survey show that amongst those implementing ACE enquiry, the majority agreed: that their service is a suitable place to enquire about ACEs (72.5%) and that it is

useful to the client for the practitioner/service to enquire and know about a client's experience of adversity in childhood (75.4%). Two-thirds (63.8%) also agreed that ACE enquiry was acceptable to their clients, and this was echoed in client feedback. However, for some services and for some clients, the use of the ACE's Deck, rather than the ACE questionnaire was deemed as a more appropriate and strengths-based tool to facilitate a conversation about childhood adversity and offer and provide support.

Ensuring there is adequate time within client appointments to implement ACE enquiry and to provide a compassionate response is a key consideration, and other studies have found varying impacts of ACE enquiry on the time practitioners need to engage with and/or support clients *(14,15,79)*. This study suggests that the time to implement and respond to ACE enquiry should be a key consideration. Amongst survey respondents who stated that they had implemented ACE enquiry, only 42.0% agreed that there was sufficient time during appointments to conduct ACE enquiry. Further, less than half reported that there was sufficient time to respond to disclosures of adversity in childhood (42.0%). When ACEs were disclosed, 81.3% of practitioners estimated that ACE enquiry took more than 10 minutes, compared to 83.6% estimating it took less than 10 minutes when no ACEs were disclosed.

A number of positive outcomes are evident from the test and learn project. Over 500 practitioners were trained, and like other studies, training participation was associated with significant increases in knowledge about ACEs and routine or targeted ACE enquiry, and confidence to discuss adversities with clients and support them appropriately *(14,15,79)*. Findings from the follow-up survey also show high levels of confidence to implement ACE enquiry and respond to disclosures. However, across services, it was highlighted that some staff were reticent to discuss ACEs with their clients, due either to their own experiences, their lack of confidence to discuss the topic, or concerns about their ability to manage disclosures. Across the nine services who have piloted and/or implemented ACE enquiry, several positive outcomes have emerged for clients. Evidence from qualitative data suggests outcomes such as clients:

- Feeling heard, empowered, and supported.
- Having improved knowledge on ACEs and trauma, and their potential impacts, and ways to mitigate the impacts of trauma.
- Being more receptive of support and receiving better and more tailored support.
- Parents exploring, understanding, and wanting to make changes to their behaviour to protect their children from intergenerational ACEs.
- Having improved health and wellbeing, and decreased feelings of isolation.
- Coproducing programme materials, reviewing programme materials and providing practitioners with their views on ACE enquiry.

Furthermore, findings from the follow-up survey show that the majority (>70%) of practitioners agreed that when implementing ACE enquiry, the process often or always: improves their understanding of their clients' issues and thus their relationship with their client and the help and support they provided. Fewer (<37%) practitioners reported that the process often or always changes their clinical care/intervention or referral pathways.

Whilst implementation has seen positive outcomes for many clients (and no change/outcomes for others), just under one in five practitioners participating in the follow-up survey reported that when implementing ACE enquiry, the process often or always causes their client more trauma and distress. This may be somewhat expected given the nature and purpose of the programme. As noted by one

client, these are natural responses and it is okay for clients to react in such a way, and whilst this may be uncomfortable for practitioners (and clients) it is important to ask, listen, and support in a compassionate manner.

Conclusion

Findings from the evaluation suggest that it is both feasible and generally acceptable to implement the REACh™ programme across a range of service types, and across a whole county. Furthermore, a number of positive outcomes for clients are starting to emerge. A range of factors have facilitated or impeded the implementation of the programme, and these should be considered for future programme implementation. Furthermore, programme processes and outcomes should be continually monitored via the strategy and implementation groups, and other programme monitoring and evaluation processes. Whilst there is a real need for further study of routine and targeted enquiry and the longer-term impacts of this approach, emerging evidence of the REACh™ model suggests that when implemented following careful planning by trained and supported staff, ACE enquiry appears to be acceptable, feasible and can contribute to individual service users' recovery journeys.

Recommendations

Implementation

- This evaluation highlights how the staff within services are the drivers of REACh™ implementation. Many service leads and practitioners noted that service-level Champions and the Community of Practice were integral to the successful implementation of REACh™; the importance of this should be highlighted to all new (and existing) services during their planning and implementation phase, to ensure they have appropriate buy-in from staff across all levels.
- Practitioners and service leads discussed the importance of continuous training, support, and opportunities for staff supervision to ensure the programme is successfully implemented. The nature of this training and the ability for services to provide this should be explored further; it will be vital to distinguish between the follow-up support that is built into REACh™ (provided by WLA) and any follow-up support that is offered/implemented by services (in-house).
- A service-wide peer support programme, along with additional training/supervision, may be useful to provide support to staff experiencing concerns about implementing ACE enquiry. Again, any support programmes and additional training/supervision that is developed and provided should be monitored and factored into the REACh™ model, in terms of what additional support services should expect to deliver on a longer-term basis and to ensure that a suite of evidence-based recommendations are provided to services, so as not to dilute the REACh™ model.

Follow-up support for services

- Future implementation of REACh™ (within and beyond NCC) should monitor the required follow-up time to ensure that the typical six months of external support (provided by Warren Larkin Associates Ltd [WLA]) is sufficient and to ensure that the possibility of any additional, longer-term support, is factored in from both a funding and service capacity perspective.

Adaptability

- This evaluation suggests that the implementation of REACh™ may be adapted to a younger age-group; the ACE's Deck (and accompanying suggestions for using the cards) were felt by practitioners to be a valuable alternative to the original ACE questionnaire. Further, some services

had introduced group sessions and a peer support group to further aide discussions about ACEs, thus highlighting the adaptability of use of the cards and ACE tool. Further research is required to fully explore and evidence the implementation and outcomes of the ACE's Deck and to understand if, where and how group sessions/peer support groups could be used to complement and enhance REACh™. This evidence can subsequently be added into future training materials.

- Services used their initiative to determine the most appropriate time to implement ACE enquiry with clients, as it was not always appropriate to enquire about ACEs upon initial assessment. The flexible nature of the programme enabled practitioners to develop a relationship with clients and gain their trust before enquiring about ACEs; this was felt to be very important and a key strength of REACh™.

Appropriateness

- This evaluation has identified key points in the client journey and/or key client groups where REACh™ may not be appropriate. For example, ACE enquiry may not be appropriate for use where children/families are presenting with multiple complex needs that require immediate support. Furthermore, REACh™ requires the practitioner to build trusting relationships with clients and to conduct ACE enquiry in a safe and trusting environment. REACh™ should not be advocated for use where this cannot be achieved.
- The 'formal' nature of the ACE questionnaire may not lend itself to being implemented in all settings, such as those where young people attend to let off steam and have fun with friends (such as Youth Clubs). Here, although formal ACEs enquiry may not be appropriate, training staff to understand and recognise the importance of a trauma-informed approach is vital, to further build awareness of ACEs and the impacts of trauma, and ensure young people are appropriately safeguarded and supported. For example, one service used the ACE's Deck in groups to educate clients and stimulate discussion.

Monitoring and Evidencing Impact

- Given the limited but emerging evidence around the public health impact of ACE enquiry, it is vital to ensure that the use and outcomes of REACh™ are appropriately monitored. Whilst this was the case in some services, not all had a process in place to enable this. Recording accurate details about when ACE enquiry is used and with additional context if possible (such as whether it is used at assessment or at a particular point through the client journey and why), would help further evidence the implementation and use of the ACE enquiry. Recording outcomes of use for the client and/or practitioner (such as 'parent engaging with additional support' or 'onward referral to other services', for example) would provide further evidence to justify use and assess outcomes.

Nottinghamshire REACh™ programme logic model

Assumptions

SERVICE USERS

- High ACEs prevalence across England; prevalence higher amongst clients in specialist support services
- ACEs associated with health harming behaviours, poor health and well-being, chronic disease and premature mortality, and increased health service utilisation
- Unmet need arising from exposure to ACEs and trauma
- Service users do not routinely disclose ACEs

STAFF: Staff may have difficulty recognising and supporting service users experiencing consequences of ACEs

SERVICES: Whole service-system approach is more effective than those aimed at individuals / increase impact of individual interventions

Inputs

Organisational readiness: Service receives support to ensure it is ready to implement ACE enquiry prior to implementation, considering factors that lead to sustained practice change (e.g. service commitment; staff training and supervision; safeguarding; external support; and referral pathways)

Pre-learning: Staff who will be attending the training receive a number of learning aids to review before the training commences

Staff training: Staff receive training on ACEs, ACE enquiry and therapeutic response

Planning and implementation: Procedures and processes implemented to enable safe and effective ACE enquiry and therapeutic response. ACE enquiry implemented.

Follow-up support: Service/staff receive on-going professional supervision and support from WLA; Services may be required to provide additional training and peer support groups to staff on a continuous basis.

Outputs

Number of staff trained in ACEs, ACE enquiry and therapeutic response

Number of staff implementing ACE enquiry

Number of service users engaged in ACE enquiry, including:
- % completing ACE tool
- % requesting/ accepting follow-up support

Service user views on ACE enquiry including acceptability and impact

Level of service utilisation and performance

Services need to have processes in place to accurately collect this information

Short-term outcomes

STAFF

- Increased knowledge and confidence in undertaking ACE enquiry & therapeutic response
- Increased ability to recognise consequences of experiencing ACEs and support clients
- Better therapeutic alliance with service user

SERVICE USERS

- Increased knowledge of how ACEs relate to current circumstances
- Experiences validated
- Freed from the psychological burden of concealment
- Move from thinking 'what is wrong with me' to 'what has happened to me'
- Increased trust and therapeutic alliance with staff
- Better understanding of what can help to improve their health and well-being, and where and how to access support
- Enhanced sense of control over their lives
- Better able to identify past and ongoing adversity in their own and others' lives

SERVICES

- Increase in appointment time, support provision, and referrals to external support providers in the short-term (expected to decrease in the longer-term)
- Services are better able to recognise and respond to patients/clients experiencing or at risk of harm; interventions delivered are more timely/appropriate/resilience building
- Improved working/communication between services

Longer-term outcomes

SERVICE USERS

- Better able to engage with services and to make use of treatment and advice
- Engage in healthier behaviours/ less health harming behaviours
- Can identify and are better able to undertake resilience-building activities
- Improvement in health, well-being, and quality of life
- Self-esteem and self-confidence improved
- Able to recognise and modify their own ACE-generating behaviour
- Improved self-reported recovery
- Increased self-care

STAFF

- Increased self-efficacy in practice and job

Impacts

Service users receive relevant support sooner

Care/support is person-centred, taking a life course approach

Service users' care experience is improved

Service users' health and well-being and intermediate outcomes (e.g. resilience) improved

System-wide changes: shifting culture and working practices

Services contribute better to improving population health and addressing health inequalities

Less demand for health and support services – cost savings to services

Reduced ACEs in future generations

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8. Appendices

8.1 Core evaluation methods

Stakeholder interviews: Semi-structured interviews were conducted with key members of the REACh™ programme team, programme commissioners, and service level project leads at various time points throughout year one and three of the test and learn project. Interviews explored: background to the test and learn project; REACh™ programme theory; experiences of, and progress in implementing REACh™ across the county/services, including supporting and mediating factors; the acceptability, uptake and impact of REACh™ amongst and on, service users, practitioners and services; areas for development; and intervention sustainability across services/the county.

Interviews (n=37) with programme commissioners (n=3), and the REACh™ Implementation Team (n=5), and service leads and practitioners (n=29) from 10 services.

Practitioner surveys and interviews

A series of surveys were administered to the practitioners who participated in the REACh™ training sessions and were thus anticipated to implement ACE enquiry.

Pre- and post-training surveys: A pre-training questionnaire provided a baseline assessment of trainees' knowledge on ACEs, and confidence to discuss ACEs with clients (and respond); and how trauma-informed trainees are (using the validated 35-item Attitudes Related to Trauma-Informed Care [ARTIC] Scale). Pre-training survey questions around knowledge and confidence were repeated in a post-training survey to assess the impact of the training, with additional questions exploring trainee views of the training session. For initial training sessions, the Warren Larkin Associates (WLA) training surveys were implemented,[6] and following ethical approval LJMU training surveys were implemented,[7] collecting similar information but tailored to meet the long-term needs of the evaluation.

Pre (n=398) and post (n=436) training surveys assessing practitioner knowledge on ACEs, and confidence to discuss ACEs with clients (and respond); and follow-up surveys (n=72) exploring views and experiences of the programme implementation.

In year three, practitioners from services who had commenced ACE enquiry were invited to take part in a REACh™ implementation survey. The questionnaire aimed to identify practitioner views of the implementation of REACh™ within their service including the acceptability and impact amongst and on, clients, practitioners, and the service. Interviews were also conducted with a sample of practitioners to further explore: experiences of, and progress in implementing REACh™ across the service, including supporting and mediating factors; the acceptability, uptake and impact of REACh™ amongst and on, service users, practitioners and the service; areas for development; and intervention sustainability across services/the county.

[6] WLA: Pre, n=185; post, n=263.
[7] LJMU: Pre, n=213; post, n=173.

Client survey and interviews

In year three, interviews were conducted with three clients from one service exploring their views on, and experiences of ACE enquiry. In addition, secondary data collected by services on clients' views of REACh™/ACE enquiry was collected as evidence to support the evaluation. This included service user feedback videos (including 2 clients from another service); case studies prepared by practitioners (n=3, from another service); and qualitative feedback collected by practitioners (38 client comments from another service).

Collation of client feedback/experiences across four services: Interviews with clients (n=3, from one service); review of service user feedback videos (including 2 clients from another service); case studies prepared by practitioners (n=3, from another service); and qualitative feedback collected by practitioners (38 client comments from another service).

Monitoring of programme development, implementation, and outcomes

To add context to the evaluation, programme documentation or other information produced by the REACh™ programme team, commissioners or services that relates to programme development, implementation and embedding across the services/county was collated and reviewed, and where relevant incorporated into evaluation outputs. In addition, evaluation team members overtly observed programme events, such as training sessions across different service types, where the content and delivery of the training was documented.

Review of programme documentation (e.g., strategy group minutes; REACh™ programme documentation/materials) and observations of programme implementation (e.g., strategy group meetings; pre-implementation meetings; training sessions).

8.2 REACh™ ACE questionnaire

Please read the following information. If you wish, you can ask a member of staff to help you.

- We know that certain experiences during the first 18 years of life can have harmful effects on our health and wellbeing as adults.
- This information can help us to work together to find the right help and advice for you.
- If you agree, we would like you to answer some questions about these types of experiences.
- You can fill out the questionnaire on your own or you can do it together with the person you are seeing today.
- You do not have to complete the questionnaire and you can stop at any time.
- You do not have to answer every question.
- If you want to, once you have finished this questionnaire, you can talk about your experiences with the person you are seeing and think about what these experiences mean for you.
- If you have trouble understanding any of the questions or would like to ask anything, please speak to the person you are seeing today.

Confidentiality – What Does This Mean?

- We want you to feel comfortable talking about private information, and to feel safe and confident that what we talk about stays between us.
- Your answers to these questions will remain part of your private care record and will not be shared with anyone without your permission.
- However, during your appointment, if you tell us anything that makes us think that you or anyone else may be at risk of serious harm, we may need to share that information.
- If your worker does need to share any information, they will try to make sure that you are aware of what information will be shared, and who it will be shared with.
- This helps you and others to be safe.

Adverse Childhood Experiences (ACE) Questionnaire

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 you go without enough food or drink, clean clothes, or a clean and warm place to live for long periods of time?		
10	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?		
11	Have you been asked to show or send images of a sexual nature, or been asked to behave in a sexual way in person or via social media (i.e. Facebook, Twitter, Instagram, Snapchat or other)?		
12	Have you ever done or were you ever forced, threatened or asked to do anything sexual (in person, online or via social media) in exchange for money, drugs , alcohol, gifts, affection, protection/safety, accommodation, employment, status (popularity), or anything else?		
13	Are there any other experiences from your life that you feel we should know about?		
14	While you were growing up, before the age of 18, was there an adult in your life who you could trust and talk to about any personal problems?		

8.3 Additional tables

Figure A1: Proportion of practitioner survey participants (implementing ACE enquiry) reporting that selected outcome often/always occur when implementing ACE enquiry (n=69)

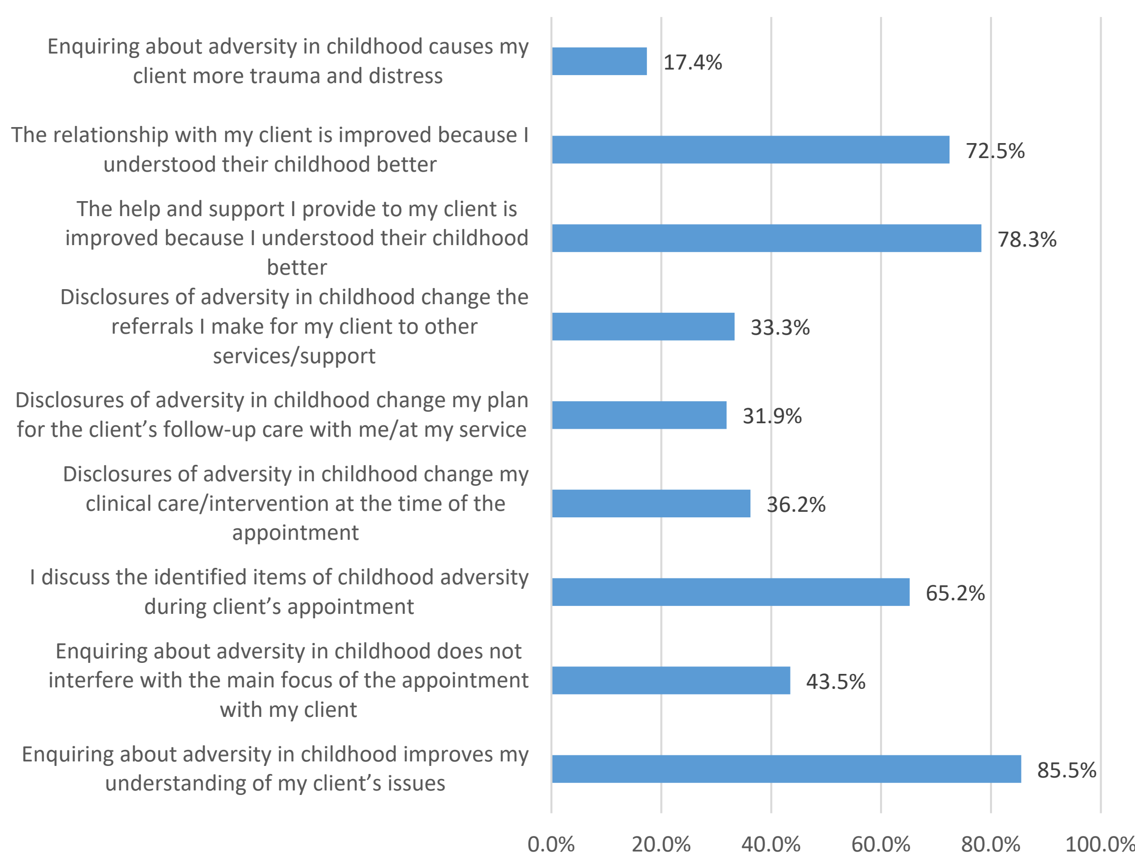
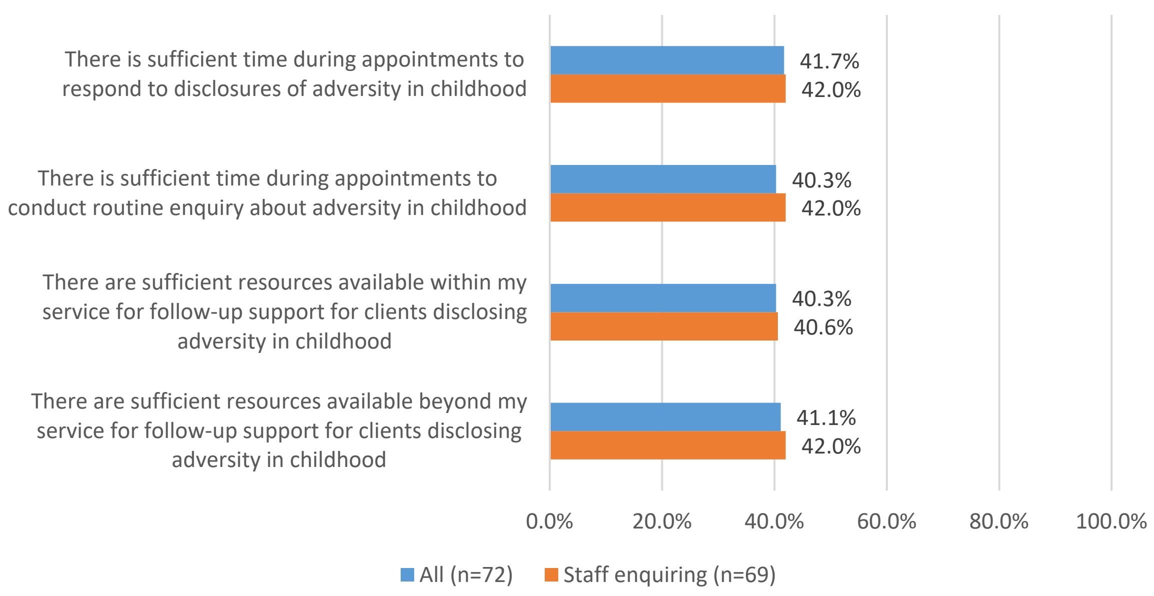


Figure A2: Proportion of practitioner survey participants agreeing that there is sufficient time and resources to implement ACE enquiry and respond to disclosures



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