Adverse Childhood Experiences

Be the Change

EITP ACEs & Trauma Informed Practice Project

Headline Findings from the Training Needs Analysis for Learning & Development Organisations

June 2019


SBNI
Safeguarding Board
for Northern Ireland


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Introduction

The Safeguarding Board for Northern Ireland (SBNI) has been funded through the Early Intervention Transformation Programme (EITP) to deliver ACE Awareness and Trauma Informed Practice Workforce Development Training across health, social care, education, justice and the community/voluntary sector in Northern Ireland. The National Children's Bureau (NCB) is supporting this work with the SBNI. NCB has been commissioned to support the SBNI to determine the current levels of knowledge and expertise about ACE/trauma informed practice among practitioners working across health, social care, education, justice and the community and voluntary sector. This baseline of information will be used to inform training design and delivery.

An initial action in this project was the facilitation of stakeholder events for a range of different sectors. A total of 29 people from learning and development organisations within the health and social care sectors, colleges and universities attended a stakeholder event in Antrim, on 12 June 2019. A list of the organisations represented at this event is contained in Appendix 1.

The purpose of this report is to present headline findings from the training needs analysis (TNA) that relate to the learning and development organisations within the health and social care sectors. Other headline reports covering the voluntary and community sector, health and social care, early years, Family Support Hubs, education, housing and GPs are also being written.

Section 1: Profile of Participants

A total of 27 educators from organisations mentioned above completed TNA surveys at the event. The surveys explored a number of different aspects of ACES and TIP including levels of awareness, training needs and applicability to current role. This headline report provides the data relating to each question and concludes with a summary of the discussion held at the workshop.

All percentages are given for those who answered each question. 42% indicated that they worked in the social care sector, 38% in the education sector and 19% in the health sector.

The following tables summarise the roles undertaken by respondents, number of years in those roles and areas in which their work is based (please note: figures may not total 100% due to rounding):

Role	**%**
Service Manager	19
Other	74

Figure 1: Respondents by role

Roles specified in the 'other' category included trainers, lecturers, course directors and educationalists for health and social care staff (professionally and vocationally qualified).

Years in current role	%
Less than 1 year	22
1-3 years	15
4-6 years	11
7-10 years	4
11+ years	48

Figure 2: Respondents by years in current role

Area	%
All of NI	27
BHSCT	23
SEHSCT	27
SHSCT	14
WHSCT	5
NHSCT	5

Figure 3: Respondents by area in which work is based

Section 2: Awareness and Understanding of ACEs

All 27 respondents indicated that they had heard of the term ACEs prior to the event.

Levels of knowledge of ACEs and their impact

The following table summarises levels of knowledge by aspect in relation to ACEs:

Extent of knowledge and understanding of the following:	**No, I don't know anything %**	**Yes, I know a little %**	**Yes, I know a lot %**
a. The prevalence of ACEs	0	50	50
b. The types of ACEs that a child may experience	0	35	65
c. Potential short-term and long-term effects of ACEs on children	0	40	60
d. How ACEs may affect brain development	0	46	54
e. How ACEs can affect a child's physical development	0	50	50
f. How ACEs may affect social and emotional skills development	0	42	58
g. Cultural differences in how children and families understand and potentially respond to ACEs	0	65	35
h. ACE triggers/reminders and their impact on a child's behaviour	0	54	46

Note: figures may not total 100% due to rounding

Figure 4: Levels of knowledge by aspect in relation to ACEs

As Figure 4 shows, levels of knowledge are high across almost all aspects of ACEs, with all respondents indicating that they know something about each one. The types of ACEs that exist and potential short and long term effects were particularly well known. Some aspects such as the cultural differences in how ACEs are understood and responded to scored slightly lower (in the 'know a lot' option) than the other aspects as did ACEs triggers and their impact on behaviour.

Understanding of parent/adult ACE history

The following table summarises levels of knowledge by aspect in relation to parent/adult ACE history, its impact on parenting and responses to services:

Awareness of parent/caregiver ACEs and their impact	**Yes %**	**No %**
I am		
a. Aware that many birth parents can have an ACE history	100	0
b. Knowledgeable about intergenerational cycles of abuse	100	0
c. Familiar with cultural issues that may impact disclosure of parents' ACEs and seeking treatment	89	11
d. Knowledgeable about the potential impact of past ACEs on a parent's ability to care for his/her children, potentially manifesting itself in mental health or substance abuse problems	100	0
e. Aware of how service providers' activities can trigger a parent's own ACEs history and affect a parent's response to staff and engagement with services	96	4

Figure 5: Awareness of parent/caregiver ACEs and their impact

As Figure 5 shows, all participants are aware that parents can have their own ACE history, are knowledgeable about intergenerational cycles of abuse and the potential impact of past ACEs on ability to parent. Almost all are aware of how service providers' activities might trigger parents' ACEs history and therefore affect responses to service providers. There was less awareness of how cultural issues may impact disclosure of ACEs by parents and the subsequent treatment that might be sought.

Participants were asked if they considered ACEs to be important to their current role. The majority (96%) of respondents regarded ACEs to be important to their current role, 4% (one person) was unsure. Reasons for regarding ACEs as important included the relevance to their current roles in training mental health practitioners, nurses, health visitors, social workers, for safeguarding reasons and also to understand the needs of service users both adults and children. The respondent who indicated that they were unsure did so because they work mainly in adult services. However, they did also state that they manage other practitioners in the HSCT area who may encounter service users who have experienced ACEs, or indeed the team members may have experienced ACEs.

Section 3: Awareness and Understanding of Trauma Informed Practice

All 27 respondents indicated that they had heard of the term Trauma Informed Practice prior to the event.

Levels of knowledge of Trauma Informed Practice and its impact

The following table summarises levels of knowledge by aspect in relation to trauma informed practice (TIP) and its impact:

Extent of knowledge and understanding of the following:	**No, I don't know anything %**	**Yes, I know a little %**	**Yes, I know a lot %**
a. What constitutes a trauma informed organisation	8	77	15
b. What is trauma informed practice	0	62	38
c. Impact of trauma on individual's physiological, neurological development and their social and emotional development	0	46	54
d. How to recognise trauma	0	62	38
e. How to respond in a trauma informed way	0	69	31
f. How to avoid re-traumatising service users	0	77	23
g. How to develop a trauma informed culture	4	81	15

Note: figures may not total 100% due to rounding

Figure 6: Knowledge and understanding of TIP and its impact

As Figure 6 shows, the only aspects of TIP where there was no knowledge was what constitutes a trauma informed organisation and how to develop a trauma informed culture. The aspect in which there was the most knowledge was the impact of trauma on development, though how to recognise trauma, what trauma informed practice is and how to respond in a trauma informed way also scored relatively highly in terms of knowledge.

Participants were asked if they considered knowledge of TIP to be important to their current role. All respondents indicated that knowledge of TIP was important to their current role. Reasons for this included its relevance to the training that is currently being provided, enhancing their own knowledge and therefore the provision that is offered to students regarding training and being aware of the potential impacts of TIP for students and colleagues.

Section 4: Training and Workforce Development: Embedding ACEs and TIP

Training Received

Just over half (54%) indicated that they had received training in their current organisation in relation to ACEs and/or TIP, 46% had not received training in their current organisation and less than a quarter (24%) had received training in ACEs and/or TIP while in a previous workplace.

Some of this training was specifically on ACE awareness and one person mentioned training specifically in trauma informed practice. More often, respondents mentioned training in which ACEs and trauma were elements of other training such as the Solihull Approach, safeguarding training, counselling, sexual abuse and family therapy. Often such training was received for a very short time, e.g. one day or even less.

Although respondents were not asked about the sources of such training, some volunteered this information. Sources included organisations such as the CEC (Clinical Education Centre), SBNI, SHSCT and named individuals such as David Pichers and Christine Anderson.

Future Training Needs

The following table summarises interest in receiving training on different aspects of ACEs:

Aspects of ACEs in which training would be welcomed (%)	
Cultural differences in how children and families understand and respond to ACEs	78
Cultural issues that may impact disclosure of parent ACEs and seeking treatment	70
How service providers' activities can trigger a parent's own ACEs history and affect a parent's response to staff and engagement with services	70
ACEs triggers/reminders and their impact on a child's behaviour	59
Intergenerational cycles of abuse	48
The potential impact of past ACEs on a parent's ability to care for his/her children, potentially manifesting itself in mental health or substance abuse problems	48
Parents' ACEs history	48
How ACEs may affect social and emotional skills development	44
Potential short-term and long-term effects of ACEs on children	44
How ACEs can affect a child's physical development	44
How ACEs may affect brain development	41
The prevalence of childhood ACEs	41
The types of ACEs that a child may experience	33
Other – please state	11

Figure 7: Aspects of ACEs in which training would be welcomed

The 'Other' aspect identified included; treatment intervention, assessment, management of evidence based therapies and supporting social workers in coming to terms with their own ACEs (which may be undisclosed) and preventing these from being barriers to learning.

The following table summarises interest in receiving training on different aspects of TIP:

Aspects of trauma informed practice in which training would be welcomed (%)	
How systems can become more trauma sensitive	89
How to create a trauma informed organisation	85
How to develop a trauma informed culture in my workplace	81
The impact of trauma on individual's physiological, neurological development and their social and emotional development	78
How to become a more trauma informed practitioner	71
How to avoid re-traumatising service users	70
How to respond in a trauma informed way	67
How to recognise trauma	59
Other – please state	4

Figure 8: Aspects of TIP in which training would be welcomed

The 'other' aspects of TIP in which training would be welcomed included psychological therapies and treatment implementation.

Summary of the discussion with delegates

Delegates worked in small groups to consider the following 3 questions:

- Where does the ACE agenda fit in your aspect of workforce development?
- How can trauma informed practice happen within your role/organisation?
- What additional supports do you need to make this happen?

The event closed with an invitation to delegates to 'be the change' in making commitments to how their agency/team might take forward action on TIP. These commitments along with the wider discussion feedback are captured below.

Where does the ACE agenda fit in your aspect of workforce development?

There was a general feeling that ACE awareness was relevant to both the initial training and continuous professional development of health and social care professionals from a wide range of disciplines in order to better understand service users' needs and choices, how they might respond to services offered and to support/train practitioners in how to convey empathy.

It was acknowledged that some professional training, especially social work and psychology, already includes ACE awareness and the underpinning concepts, though it may not use this exact language. Delegates therefore welcomed the focus and momentum that the TIP Project brings to their work, by 'shining a light' on this area of work, but were keen to point out that ACEs and relational trauma were not 'new' to many of the professions they educate and train.

Links to existing training programmes and practice approaches, specifically including Signs of Safety and Solihull Approach, were identified. Positively, this could support take up of the ACE agenda as a natural 'fit' but the potential for saturation might also impact negatively on efforts to embed new training.

Reach into the areas of mental health, addiction and adult services more generally was raised as an area for development and delegates urged that the SBNI TIP Project ensure that training, messaging etc. was clear on this lifespan approach. Further, ACEs do not happen in isolation. Poverty and other issues – including post-conflict and transgenerational trauma - also impact negatively on children and families in Northern Ireland. There is a danger that the focus on ACEs masks such issues and places the responsibility for addressing their negative impacts at the level of the individual service user and/or health and social care professional, rather than the responsibility lying with the state to address the root cause of health inequalities.

The need to look beyond workforce training into staff supervision and wellbeing was also raised. The fit for those professions' practice in, and with access to, reflective supervision is obvious but so is the need to address gaps in these areas across the health and social care system.

How can trauma informed practice happen within your role/organisation?

There was some consensus among delegates that there is potential to use existing education and training programmes as the primary means of embedding TIP. Additionally, specific initiatives and approaches such as Signs of Safety, Think Family, the Solihull Approach, safeguarding and child protection provide current platforms for highlighting ACE awareness as a connected and complementary way of working.

Delegates were interested in discrete material or modules that would give visibility and appropriate priority to ACE awareness and TIP but felt that integration should be the longer term approach. Delegates also wanted the flexibility to pick and choose what elements of any ACEs training materials they needed or wanted to use as an enhancement of their own materials.

There was considerable interest in receiving Train the Trainer training and in accessing any e-learning that might be developed as part of the SBNI initiative but, as with other stakeholder events, delegates felt face-to-face training and education offers were most likely to have an impact on practice change.

On a number of issues, delegates urged that practice wisdom and learning from previous initiatives be applied, for example:

- Be aware of workforce gaps and workload issues in setting practice change expectations
- Review skill sets (especially containment and reciprocity) and attitudes, not just knowledge and awareness required for embedding TIP
- Be cognisant of issues for staff including vicarious trauma, compassion fatigue and becoming aware of their own ACEs and impact of same on their wellbeing

- Acknowledge that workforce development can only be progressed in tandem with system development. In relation to trauma in particular, raising staff awareness without having referral pathways or appropriate services to meet client needs could be considered unethical or unsafe. The issue of potentially re-traumatising service users by the manner in which systems operate was also raised by delegates
- Avoid exclusive language such as acronyms and language which could be unintentionally reductionist or negative.

Connected to the point on the importance of language was a discussion on the now common use of the acronym ACEs and whether this could be argued to already be excluding by presuming knowledge, by being reductionist and conveying a simplicity of adversities, rather than their often complex, inter-connected nature.

Further, a concern was voiced that professionals should not misinterpret their role or responsibilities around ACES to view themselves as 'saving children from their parents', rather their professional response should be one of self-reflection and the positive role they could play in preventing, mitigating or supporting people to heal from adversity and trauma. Using whole family approaches could be empowering and facilitative of self-efficacy and growth.

While Implementation Managers were clear that ACE questionnaires/screening tools were not being recommended as part of the EITP TIP Project, there was some discussion on when they might be appropriately used. Concerns around traumatisation and having 'nowhere for those assessments to go' dominated the discussion.

Finally, delegates acknowledged that conversations on how trauma informed practice can happen need to be held within organisations, in teams and at different levels of management. Decisions would then be informed by a review of what practice, policy and training exists and how much of that needs reform. An important question posed by delegates was: 'What happens after awareness has been raised?'

The quantity and quality of reflective supervision available to the workforce was agreed as a key element of trauma informed practice. Not all professions receive clinical supervision so this needs to be unpicked at a number of levels to see 'who needs what'.

What additional supports do you need to make this happen?

Delegates raised a number of high-level issues which may be beyond the remit of the TIP Project but which need to be acknowledged in moving forward with project activity. These 'additional support requirements' included:

- Commitment from the Department of Health beyond workforce training to address and resource the other key components of trauma informed practice including staff safety and wellbeing and evidence based treatment

- Longevity of change management on the ACE agenda to minimise concerns that this could be replaced by the 'next big thing' after March 2020 (when the TIP Project comes to an end)
- Enhanced capacity within the system by addressing workforce gaps in a number of professions, enabling TIP through job description and workload change where necessary
- Effective clinical supervision and support for staff to acknowledge, process and undertake self-care for their own experiences of early adversity as well as for vicarious trauma
- Financial input for whole system change

In respect of the Implementation Managers' offer on TIP, project training materials being made available to colleges and learning and development teams in Trusts etc., delegates were agreed that they would need sight of the curriculum to determine what their specific interests in using some/all of that might be. There were requests however for:

- Poverty analysis of ACEs (2-3 slides and supporting detail)
- Packages for social workers
- 'Use of Self' reflective materials to support staff in engaging safely with their own adverse childhood experiences and in understanding vicarious trauma
- NI prevalence research/data

What commitments can you make to 'be the change'?

Averil Bassett, CEC: work with Stranmillis University College & FE colleges; review CEC education offer

Deirdre O'Neill, School of Nursing & Midwifery, QUB: Going to do train-the-trainer

Lelia Fitzsimons, BHSCT: Will work with Implementation Managers to review and improve regional supervision model and offer

Toni McNaughton, UU: Will look at integrating materials from L1 & L2 into nursing curriculum

Safeguarding Level 2 will include ACE slides and have more focus

Test if Trusts have enough knowledge and/or materials to support TIP

Section 5: Conclusion

There is a higher level of knowledge of ACEs and their impact than there is for TIP among the stakeholders from learning and development organisations within the health and social care sectors. Correspondingly, higher levels of interest for training in the various aspects of TIP are indicated in comparison to ACEs, though some aspects of ACEs (e.g. cultural issues and parental experiences of ACEs also score highly here). While there is an appetite to support this initiative through programmes of initial

professional training and CPD, a myriad of other issues was also raised by delegates who are keen to ensure long-term sustainability of an approach that will be used, rather than something which is currently the focus of attention. Training can do so much but without investment in other areas beyond workforce development (e.g. service development, systems change) the potential for ACEs/TIP to impact on people's lives will be limited.

Appendix 1

Organisations represented at the Health and Social Care Sector Learning & Development Stakeholder Event

Belfast Metropolitan College

BHSCT

Clinical Education Centre

Queen's University Belfast

SEHSCT

SHSCT

Ulster University

WHSCT