Using the ACE survey to inform service development in a social care organisation: A case study

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Signed declaration

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Abstract

In recent years implementation of the Adverse Childhood Experience (ACE) survey within social care organisations has steadily increased. Despite the sustained implementation, there is limited research on how and if ACE survey implementation informs social care service provision. This study employs a case study design to address this gap by examining the routine administration of the ACE survey by professionals working in family and early childhood education centres within the Daughters of Charity Child and Family Services (DoCCFS). The central research questions of the study examined workers' perspectives on what the transition to routine administration was like, and what impact, if any, administering the survey had on workers' relationships with service users and the pathways of care provided to them. The study also examined if and how the survey data was used to inform service provision within the social care organisation and if there were any differences in implementation and interpretation of the survey between the family and early childhood education workers. This study implemented a mixed-method research methodology. Qualitative data was collected from workers in semi-structured interviews and focus groups. In order to develop DoCCFS service user ACE profiles, aggregated quantitative data relating to ACE scores collected as part of a collaborative DoCCFS research project with the Trinity Research in Childhood Centre (TRiCC) was also examined.

Compared to other research populations, the study determined ACEs were common for children and their parents and caregivers within the DoCCFS. It also established that although the overall experience of routine ACE survey administration was perceived as positive by workers, the implementation process resulted in several practical and emotional challenges for staff. The study further determined that translating ACE data into informing social care service delivery remains a work in progress. As there is a gap in the literature relating to ACE survey administration within social care settings, this study makes a significant contribution via the development of the PEAR implementation model. This model is based on the study's findings and is designed to help social care organisations considering the introduction of routine administration of the ACE survey.

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List of abbreviations

ACE	Adverse Childhood Experience
ARs	Academic researchers
CAMHS	Child and Adolescent Mental Health Services
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CPM	Child Protection Manager
CSA	Childhood Sexual Abuse
CSO	Central Statistics Office
DoC	Daughters of Charity
DoCCFS	Daughters of Charity Child and Family Service
ECDS	Early Childhood Development Service
ECDSC	Early Childhood Development Service Centre
ECDSM	Early Childhood Development Service Manager
ECDSWs	Early Childhood Development Service Workers
FC	Family Centre
FCM	Family Centre Manager
OMS	Outcome Measure Survey
PACE	Protective Adverse Childhood Experiences
PCEs	Positive Childhood Experiences
SLES	Significant Life Events Scale
SMT	Senior Management Team
STS	Secondary Traumatic Stress
SU	Service User
TCD	Trinity College Dublin
TCDAR	Trinity College Dublin Academic Researchers
TRiCC	Trinity Research in Childhood Centre
UCD	University College Dublin
UK	United Kingdom
USA	United States of America

WHO	World Health Organisation

Chapter 1
Introduction

1.1 Introduction

This chapter provides context for the study. It commences by outlining the purpose of the research presented within this thesis and providing an overview of the research questions and objectives. As the current study's primary research questions centre on professional interpretations of the routine administration of the Adverse Childhood Experience (ACE) survey within a social care organisation, the chapter provides some background to the broader collaborative research project which incorporated the survey. An outline of the chapters within the current study follows this.

1.2 Purpose of the current study

The current study examines the introduction of routine administration of the ACE survey by professionals working in Child and Family Centres across the Daughters of Charity Child and Family Service (DoCCFS). The DoCCFS is a not-for-profit public service organisation in the greater Dublin region. The service works in partnership with Tusla Child and Family Agency to provide a variety of therapeutic supports to children and families. The service also has an Early Childhood Development Service (ECDS) (DoCCFS, 2023). In June 2018, the DoCCFS decided to incorporate the ACE survey as part of a broader collaborative research project with Academic Researchers (ARs) from the Trinity Research in Childhood Centre (TRiCC) at Trinity College Dublin (TCD). This research project involved administering a broader research survey to measure outcomes for children attending the DoCCFS. Staff within the DoCCFS ECDS Centres (ECDSCs) and Family Centres (FCs) began to administer the Outcome Measures Survey (OMS) in 2015. The rationale for introducing the survey was not only to enable the service to examine the relationship between exposure to early life stress and later adverse outcomes among service users (SUs) but also for the organisation to better respond to the needs of its SUs (Spratt, Swords, and Vilda, 2018). The survey version implemented by the DoCCFS was adapted from the original ACE survey designed by Felitti and colleagues (Felitti et al. 1998). It contained eleven questions relating to experiences of childhood maltreatment, neglect, and social challenges within a household, such as mental health difficulties, substance misuse problems,

parental separation or divorce, exposure to maternal or paternal domestic violence and imprisonment of a family member encountered by individuals in their first 18 years of life. The ACE survey will be discussed in greater detail in chapter 2.

The rationale for the current study centres on meeting an identified gap in the literature concerning professional interpretations of routine ACE survey administration in social care organisations. The results of a scoping literature review by Ford et al. (2019), which examined the evidence base for routine ACE enquiry, established that most studies had been undertaken in health care rather than social care settings. The literature review determined that no research measured the impact of routine survey administration on SU engagement. The authors also noted that most studies involved self-completion of questionnaires by SUs, and few examined professionals verbally administering the survey. Lastly, the literature review established that examining any longer-term impact on SUs or their relationship with the practitioner was not evident in existing research. Given the global interest in and growing practice of health and social care organisations asking SUs about childhood adversities, Ford et al. (2019) affirm that these research gaps should be addressed. As the DoCCFS facilitated SUs (parents or caregivers) in self-completing the survey by verbally administering it, this provided an ideal setting for the study. The significance of the current study is that the routine administration of the ACE survey in the DoCCFS provided an opportunity to address the outstanding research questions that have been identified.

The collaborative DoCCFS/TRiCC research project has a quantitative research focus. The research project involves the completion of the DoCCFS/TCD OMS (a composite of standardised instruments measuring child and parent wellbeing) with each family/SU and the subsequent analysis and interpretation of aggregated data (Spratt, Swords, and Vilda, 2018). The present study employs this quantitative data in tandem with qualitative data to examine the survey's introduction within a social care organisational setting. The present study will involve analysis of OMS data as well as data collected from semi-structured interviews and focus groups with the DoCCFS Senior Management Team (SMT) and Child Protection Manager (CPM) and staff within the ECDSCs and FCs.

1.3 Research questions

The central aim of the current study is to examine the introduction of routine administration of the ACE survey in a social care organisation from manager and worker perspectives. The central research questions of this study are:

1. Did ACE training prepare Family Centre Managers (FCMs), ECDS Managers (ECDSMs), Family Workers (FWs) and ECDS Workers (ECDSWs) for routine administration of the ACE survey?
2. What was the experience of transitioning to the routine administration of the ACE survey like for FCMs, ECDSMs, FWs and ECDSWs?
3. To what extent and in what ways did routine administration of the ACE survey impact both FWs' / ECDSWs' relationships with SUs?
4. What impact, if any, did routine administration of the ACE survey have on the pathways of care experienced by SUs?
5. To what extent was ACE data (alongside other data from the TCD study) used to inform service delivery?
6. What impact did the existing differences between the services provided by the DoCCFS ECDSCs and FCs have on how the ACE survey was implemented and interpreted by workers?

1.4 Research Objectives

The study focuses on several research objectives to answer the research questions. These included the following:

- Ascertain to what extent the ACE training provided by the TCD Academic Researchers (TCDARs) prepared the SMT, CPM, FCMs, ECDMs, FWs and ECDSWs for implementation of the ACE survey
- Establish what were the gateways and barriers to administration of the ACE survey from managerial, ECDSWs and FWs' perspectives
- Gauge what impact (if any) administration of the ACE survey had on FWs and ECDSWs

- Examine how the differences, if any, between the services provided by the ECDSCs and FCs impacted the implementation and interpretation of the ACE survey by DoCCFS workers
- Establish profiles from aggregated ACE data at location and organisational levels
- Compare profiles with those from similar studies (where available)
- Examine the processes by which ACE data (alongside other data from the TCD study) were used to inform service development decisions by managers
- Examine the processes by which ACE data (alongside other data from the TCD study) were used to inform the development of assessment and intervention practices
- Use the findings to develop a model for the implementation of ACE-informed practices in social care organisations

1.5 Overview of the DoCCFS

The DoCCFS incorporates four different services: FCs, ECDSCs, Dublin Safer Families (DSF) and Assessment Centres (ACs) (DoCCFS, 2023). The current study focuses on the experiences of administering the ACE survey for staff within the FCs and ECDSCs. According to the DoCCFS website (DoCCFS, 2023), there are seven FCs located throughout the Dublin region and one in County Wicklow. FCs offer varied therapeutic supports and interventions to children and their families or caregivers. These services are free of charge and include scheduled appointments in the FCs, home visits, drop-ins, and outreach work. The work of staff within the FCs is focused on helping children and their families build resilience and develop coping skills, identify and develop social supports in their locality, and facilitate positive attachment and relationships. To achieve these aims, FWs undertake evidence-based programmes, family and group work, advocacy tasks, parenting work, and individual support with the children and their families who attend the DoCCFS (DoCCFS, 2023).

The ECDS is a dedicated preschool service which focuses on providing early childhood care and education to children aged two to six years and support to their parents or caregivers. Several bodies regulate the ECDSCs, and staff undergo regular training and continuous professional development (DoCCFS, 2023). The DoCCFS has six ECDSCs in total. Five are in Dublin, and one is in County Meath. Staff within the ECDSCs focus on helping children to develop age-appropriate self-sufficiency skills. ECDS Workers (ECDSWs) engage children in education and developmental activities

that help them become more confident, inquisitive and social (DoCCFS, 2023). To ensure effective childhood education and development, the ECDSWs implement the HighScope curriculum (Weikart, 2004), a renowned early childhood education approach in their work with children (DoCCFS, 2023). The ECDSWs also complete observation records to monitor the child's language, communication, maths, music, science, and movement development. When necessary, the ECDSWs work with children, their parents, and caregivers to address their development issues. They also make referrals to external agencies such as speech and language, psychology, social work, and occupational therapy (DoCCFS, 2023).

1.6 The DoCCFS and TRiCC OMS collaborative research project

In their report about the DoCCFS/TRiCC collaborative OMS research project, Spratt, Swords, and Vilda (2018) provide some background on how the research partnership between the social care organisation and TCDARs was initiated. The DoCCFS completed a smaller research project with the School of Psychology at University College Dublin (UCD). This research project examined the use of a family assessment questionnaire within eight of the DoCCFS FCs and four ECDSCs (Carr and Hamilton, 2013; Hamilton et al., 2015). One of the recommendations of this study was that the DoCCFS should introduce a standardised instrument to measure child outcomes. The DoCCFS tendered for ARs to move forward with this recommendation, and the ARs from TRiCC in TCD were successful. As part of their tender, the TCDARs agreed to develop a survey, provide training for staff regarding its implementation, monitor the survey's administration, and provide interim feedback. The TCDARs, in collaboration with the DoCCFS SMT, developed the standardised OMS, which contained a composite of validated standardised measures (Spratt, Swords and Vila (2018). A research measure is a question or collection of questions that facilitate a researcher to quantify the topic or problem under investigation (American Psychological Association, 2022). Validated research measures refer to research questions tested to ensure that they capture accurate and valid data (University of California, San Francisco, 2022).

According to Spratt, Swords, and Vilda (2018), two versions of the OMS were developed for the DoCCFS. One was created for implementation within the ECDSCs, and the other was for the FCs. The validated research instruments included in the OMSs were chosen to measure child and parental adjustment, the parent-to-child relationship, stressful life events and childhood adversities (Please refer to Table 1.1

for an overview of the standardised research measures included in the OMS). The OMS had two parts, the first was scheduled to occur when the child commenced engagement with the ECDSCs or FCs, and the second was to occur when the intervention was near completion or in the latter part of the school year in the ECDSCs. The rationale for this was to measure if there were any changes between Time 1 and Time 2 scores. As previously mentioned, the ACE survey was not incorporated into the OMS until June 0f 2018. The staff within the DoCCFS FCs and ECDSCs had been implementing the OMS for approximately three years before the organisation introduced the ACE survey.

Table 1.1
Standardised research measures included in the OMS
(Adapted from Spratt, Swords, and Vilda, 2018)

Measures:	Scale:	Administered to:	Service:
Child adjustment	Strength & Difficulties Questionnaire (Goodman, 1997)	Children aged 9 years and over. Parents and guardians	FCs & ECDSCs
	Santa Barbara School Readiness Scale (Pyle, 2009)	ECDSWs	ECDSCs
	Kidcope (Spirito et al. 1988)	Children aged 9 years and older	FCs
Parent adjustment	Mental Health Inventory-5 (Berwick et al., 1991)	Parents	FCs & ECDSCs
Parent-child relationship	Parenting Style Inventory-II (Darling & Toyokowa, 1997)	Parents or caregivers	FCs & ECDSCs
	Pianta Child-Parent Inventory-II (Pianta, 1992)	Children aged 9 years and over	FCs
Stressful life events	SLES (Williamson et al. 2003)	Parents or caregivers	FCs & ECDSCs
Childhood adversities	ACE-IQ survey WHO (2023)	Parents or caregivers	FCs & ECDSCs

The OMS also included demographic and socioeconomic questions to help provide context for the data collected (Spratt, Swords and Hanlon, 2022). The OMS questions related to SU's gender, age, nationality, and marital status. The sociodemographic measures also asked the SU to indicate their highest level of education attained, literacy difficulties, sources of income and the degree of difficulty they encountered in meeting household costs. The OMS also asked parents or caregivers to indicate their relationship to the child attending the service.

Given that the current study focuses on examining the introduction of the ACE survey in a social care organisation from manager and worker perspectives, it is important to contextualise the level of previous experience that workers had in administering surveys. As previously mentioned, the survey was not incorporated into the OMS until June 0f 2018. The staff within the DoCCFS FCs and ECDSCs had been implementing the OMS for approximately three years before the organisation introduced the survey. The final part of this chapter provides an outline of the study's chapters.

1.7 Outline of the current study

The current study is comprised of thirteen chapters. The first chapter contextualised the study by providing an overview of its purpose, research questions, objectives, and background. Chapter 2 provides an overview and examination of the literature to understand ACES. Chapter 3 builds on this knowledge by reviewing the literature on the evolution of routine ACE enquiry within social care organisations. Chapter 4 examines the literature relating to the impact of routine ACE enquiry within social care organisations. The methodology for the current study is outlined in Chapter 5, followed by the theoretical framework, which underpins it, in chapter 6. The qualitative findings of this study are presented in chapters 7 and 8.

Chapter 7 presents the findings relating to the experience of transitioning to routine administration of the survey for workers within the DoCCFS. The qualitative findings outlined in Chapter 8 relate to how DoCCFS staff adapted to routine survey administration and what advice they would give other social care organisations considering introducing it into their services. Chapter 9 provides an overview of the quantitative findings of the current study. It details the relevant sociodemographic results and outlines the ACE profiles derived from quantitative data analysis. The discussion of the study findings commences with the consideration of the quantitative data findings in chapter 10. The qualitative data findings are discussed across two chapters. Chapter 11 provides an analysis and consideration of the findings relating to the first two research questions of the current study. Chapter 12 outlines the discussion on the final four research questions. The conclusion of the study is outlined in chapter 13. This chapter summarises the study's main findings, its overall contribution to the research, and its limitations. It identifies areas for further research and finishes by

outlining a model for implementing the ACE survey within other social care organisations.

1.8 Conclusion

This chapter introduced the purpose of the current study. It identified a gap in the literature relating to routine ACE survey administration within social care organisations. The current study aims to fill this gap by examining the introduction of the survey in a social care organisation from manager and worker perspectives. This chapter established that the DoCCFS was an ideal setting to conduct research surrounding routine survey administration because its implementation of the research instrument was done via self-completion by SUs and oral administration. Given the organisation's acquired experiences in administering research instruments, the DoCCFS also provides a unique opportunity to examine how administering the survey is influenced by it being incorporated as part of a larger composite of research measures. The next chapter will review the literature relating to the origins of the ACE survey and provide an understanding of the ACE evidence base.

Chapter 2
An understanding of the ACE evidence base

2.1 Introduction

This chapter will provide an understanding of the origins of the ACE evidence base. Pallipedia (2023) defines an evidence base as a 'body of information drawn from routine statistical analyses, published studies and 'grey' literature about what is already known about factors affecting health'. The ACE evidence base contains information relating to all these information types. The chapter will commence by outlining the foundation of the ACE evidence base by examining the literature concerning the background of the original ACE study. After doing so, the chapter will consider literature relating to the genesis of the ACE survey questions. Following this, the first study's results will be considered alongside literature about the implementation and associated results of survey questions in subsequent studies. This chapter will also examine the literature on how ACEs can lead to negative outcomes across the lifespan. It will discuss the biological and behavioural pathways that can lead to unfavourable consequences in life for children who encounter adversities. After considering this, the chapter will discuss literature that emphasises the need to recognise that the negative outcomes associated with ACEs are probabilistic and not predetermined. The chapter will conclude by examining the literature on criticisms of the ACE evidence base.

2.2 The first ACE study

Unusual clinical observations by Dr Vincent Felitti were the catalyst for the first ACE study (Waite and Ryan, 2020). In the mid-1980s, Dr Felitti was a physician and then chief of the Department of Preventative Medicine at Kaiser Permanente, a non-profit medical centre in San Diego, California. His role as a physician involved treating patients with health-related obesity issues. Although the Department of Preventative Medicine ran weight management programmes for individuals who were at least thirty pounds overweight, most patients needed to lose anywhere between one hundred to six hundred pounds (Stevens, 2012). In 1985, he became perplexed by the unexpected decisions of many patients to drop out of the programme (Waite and Ryan, 2020). Dr Felitti could not understand why patients who were losing weight, some as much as

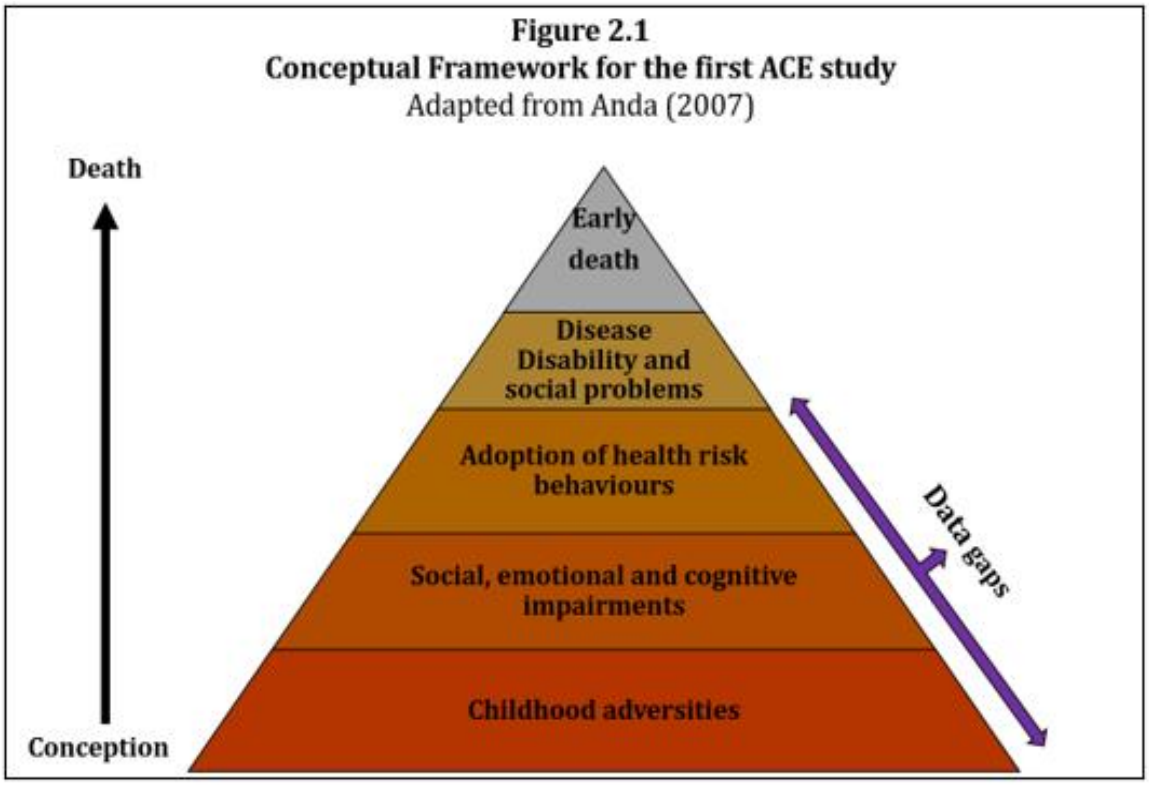
100 pounds would stop engaging when they were doing so well (Stevens, 2012). Over several years half of the participants, who were steadily losing weight on his weight management programme, ceased participating. In conjunction with the dropout rate, Dr Felitti also could not understand why some patients would be fully committed, successfully lose weight, and suddenly regain it without apparent cause (Felitti, 2019).

Discovering the significance of Adverse Childhood Experiences (ACEs) in developing later-life obesity issues was accidental (Stevens, 2012). A specific female patient triggered Dr Felitti's awareness of the possible impact of childhood adversities on subsequent adult obesity (Waite and Ryan, 2020). This female patient was forty years of age at the time and had entered the weight management programme weighing over 400 pounds. During her one-year participation in the programme, her weight loss was significant at 132 pounds. According to Dr Felitti (2019), he was mystified when this patient suddenly regained almost 40 pounds in three weeks. Dr Felitti met with the patient, and during the interview, she informed him that she was eating unconsciously at night-time. The patient described being in a sleep-like state during these binge-eating episodes. When Dr Felitti queried if the patient was aware of any triggers for this behaviour, she alluded to the fact that she was distressed by an older married man at work making unwanted sexual advances towards her. In response to this information, Dr Felitti queried why this man's unwarranted behaviour had triggered such an extreme behavioural response by her. The patient disclosed that it brought up upsetting and overwhelming feelings relating to the sexual abuse of her by her grandfather at ten years of age. This experience, alongside his other clinical observations, led to Dr Felitti conducting a research study to ascertain if there was a correlation between patients' life events and their propensity to become obese (Waite and Ryan, 2020). The study involved physicians within the weight management programme conducting interviews with two hundred and eighty-six participants. Study participants included adults entering the weight management programme and a control group of adults of healthy weight (Felitti, 2002).

Results from the interviews indicated that 55% (N=157) of the obese cohort participants had experienced sexual abuse during their childhoods (Felitti, 2019). In addition to experiences of childhood sexual abuse (CSA), participants from the obese cohort also had higher rates of experiencing parental alcohol misuse and loss of a parent during childhood than the healthy weight study participants (Dube, 2020). One of the study's most significant findings was the correlation between experiencing

adversities during childhood and using food as a coping mechanism. The study determined that participants used food to assist them in managing the emotional toll their childhood adversities had on them. In particular, overeating and subsequent obesity enabled some participants to protect against and dissuade further sexual abuse (Felitti, 2002). Despite his recognition of the significance of these findings, Felitti (2002) recalls that when he tried to disseminate them to other obesity physicians, they were dismissed as being subjective and an anomaly. In 1990, Felitti attended a dinner hosted by the Centre for Disease Control and Prevention (CDC) in Atlanta, Georgia. At this dinner, he met a CDC Senior Researcher in preventative medicine and epidemiology named Dr David Williamson. When Dr Felitti advised him of his study findings, Dr Williamson acknowledged their significance. He invited Dr Felitti to speak to his CDC colleagues at a subsequent event. At this speaking event, Dr Williamson introduced Dr Felitti to Dr Robert Anda, a medical epidemiologist at the CDC and collectively, they planned a larger-scale study at Kaiser Permanente.

Figure 2.1
Conceptual Framework for the first ACE study
Adapted from Anda (2007)



Dr Felitti, Dr Anda and the CDC developed a conceptual framework for the study (Please refer to Figure 2.1). The rationale for the first ACE study was to 'assess retrospectively and prospectively, the long-term impact of abuse and dysfunction during childhood on the following outcomes in adults: disease risk factors and

incidence, quality of life, health care utilisation, and mortality' (Felitti et al., 1998:246). This primary concept for the first study was the hypothesis that events that resulted in trauma or significant stress for individuals during their childhood could lead to cognitive, social, and emotional impairments in coping with the experiences. Once developed, these impairments increase the likelihood of individuals with adversities during childhood adopting maladaptive coping strategies such as health-risk behaviours. Adopting health-risk behaviours was viewed as a pathway to developing diseases, becoming disabled or encountering social problems in adulthood. The researchers perceived these health and social ailments as potentially significant precursors to early adult death (Anda, 2007). According to Anda (2007), the work on the conceptual framework identified three scientific data gaps concerning the development of disease, disability and social problems and their relationship with early death. These data gaps included establishing the prevalence of childhood adversities for a large adult population and ascertaining if there was a correlation between adversities experienced during childhood and an increased risk of developing social, cognitive, or emotional impairments. The last data gap related to determining if there was a relationship between these impairments and the subsequent adoption of health-risk behaviours. The study set out to address these data gaps. Once the conceptual framework was finished, an application for research funding was submitted to the CDC. This application was successful (Anda, 2007).

The first phase of the Adverse Childhood Experience (ACE) study was a collaborative research project started in 1996 by the CDC and Kaiser Permanente in San Diego, California (Felitti et al., 1998). It took place between January to March 1996. The study examined the impact of experiencing adversity before age nineteen on later life health outcomes for patients who attended the Department of Preventative Medicine at Kaiser Permanente. The second phase of the study took place between June to October 1997. There were over 17,337 adult participants in the first ACE study. The total number of participants for the first phase was 13,494, and 3,506 for the second phase (CDC, 2022). This cohort of people was born between 1900 and 1978 (Dube, 2020). The original ACE study examined the relationship between retrospectively assessed adversities during childhood and the adoption of health-risk behaviours such as alcohol addiction; use of illegal drugs; intravenous drug use; having a history of an excess of fifty sexual partners, and being diagnosed with a Sexually Transmitted Disease (STI). The study also prospectively examined participants' experiences of

developing diseases and medical conditions throughout their lifespan. In particular, it focused on whether participants had been diagnosed with cancer; ischemic heart disease; chronic emphysema or bronchitis; diabetes or whether they ever had a stroke (Felitti et al., 1998). As part of the ACE study research, participants had to undergo a standardised medical evaluation. After completing this evaluation, the participants received a questionnaire containing ACE questions for self-completion in the mail (Felitti et al., 1998).

The Kaiser Permanente–CDC ACE study was one of the most extensive epidemiological studies conducted to determine how instances of child abuse, neglect and household challenges can lead to poor adult health outcomes (CDC, 2022). The study coined the acronym Adverse Childhood Experiences (ACEs) to describe the most severe and recurrent forms of stress that children encounter (WHO, 2018). The ACEs examined in the original study included questions relating to child maltreatment, neglect, and household dysfunction. The questions about child maltreatment included experiencing physical, emotional, and sexual abuse. Questions relating to neglect included parents or caregivers omitting physical and emotional care to children during childhood. The remaining questions asked participants about adverse experiences in their childhood homes. These experiences included witnessing domestic violence between parents/caregivers, parental separation or divorce, growing up in a home where a family member was in prison or substance misuse was an issue and having someone in the household with a mental illness (Felitti et al., 1998). Although the first wave of the ACE study occurred between 1995 to 1997, participants and their associated health outcomes were followed for 20 years. Data collection for the study officially ceased in 2017 (Prewitt, 2020).

2.2.1 The origins of the first ACE survey questions

The original ACE questions were divided into three categories (Please refer to Table 2.1 for an overview of the original questions). These categories included experiences of child maltreatment, child neglect and household dysfunction (Felitti et al., 1998). The questions in the first study were adapted from several validated research measures. A research measure is a question or collection of questions that facilitate a researcher to quantify the topic or problem under investigation (American Psychological Association, 2022). Validated research measures refer to research questions tested to ensure that they capture accurate and valid data (University of

California, San Francisco, 2022). According to Dube (2020), there were twenty-eight survey questions in total in the original study. These twenty-eight questions were adapted and identified from the Childhood Trauma Questionnaire (Bernstein et al., 1994), the Wyatt Sex History Questionnaire (Wyatt, 1984), and the Conflict Tactics Scale (Straus, Gelles and Asplund, 1990). The Childhood Trauma Questionnaire contained seventy research measures relating to childhood and adolescent experiences of child abuse and neglect (Bernstein et al., 1997). The Wyatt Sex History Questionnaire research measures included 478 research measures. These research measures related to participants' retrospective and current reports of both consensual and non-consensual sexual experiences (Wyatt et al., 1992). Lastly, the Conflict Tactics Scale contained eighty research measures which aimed to quantify the level of human aggression, violence and reasoning implemented during conflict situations within families (Straus, 1988).

2.2.2 Results of the seminal ACE study

Participants in the first ACE study were predominantly female (54%), with males making up the remaining 46% (Felitti et al., 2019). Participants' racial background was White (48%) followed by Hispanic (11.2%), Asian/Pacific Islander (7.2%), Black (4,5%), and the remaining participants identified their race as other (2.3%). The age range of participants varied from 5.3% (19-29 years), 9.8% (30-39 years), 18.6% (40-49 years), 19.9% (50-59) years, and 46% were aged 60 years or over (CDC, 2022). The mean age of participants was 56 years (Anda, 2007). Research participants educational backgrounds included 7.2% who did not finish high school, 17.6% who completed high school, 35.9% who completed some college education and 39.3% who were college graduates or had completed postgraduate studies (Felitti et al., 2019).

Table 2.1 Original ACE research measures (Adapted from Dube, 2020)	
During your first 18 years of life:	
Did you live with anyone who was a problem drinker or alcoholic?	Household dysfunction
Did you live with anyone who used street drugs?	Household dysfunction
Was anyone in your household depressed or mentally ill?	Household dysfunction
Did anyone in your household attempt to commit suicide?	Household dysfunction
Were your parents ever separated or divorced?	Household dysfunction
Did anyone in your household ever go to prison?	Household dysfunction
Sometimes physical blows occur between parents. While growing up in your first 18 years of life, how often did your father (or stepfather) or mother's boyfriend do any of these things to your mother?	
Push, grab, slap or throw something at her?	Household dysfunction
Kick, bite, hit her with a fist, or hit her with something hard?	Household dysfunction
Repeatedly hit her over at least a few minutes?	Household dysfunction
Threaten her with a knife or a gun, or use a knife or a gun to hurt her?	Household dysfunction
While you were growing up, during your first 18 years of life:	
You didn't have enough to eat.	Neglect
You knew there was someone to take care of you and protect you.	Neglect
Your parents were too drunk or too high to take care of the family	Neglect
You had to wear dirty clothes.	Neglect
There was someone to take you to the doctor if you need it.	Neglect
There was someone in your family who helped you feel important or special.	Neglect
You felt loved.	Neglect
People in your family looked out for each other.	Neglect
People in your family felt close to each other.	Neglect
Your family was a source of strength and support.	Neglect
Sometimes parents or other adults hurt children. While growing up, during your first 18 years of life, how often did a parent, step-parent, or adult living in your home:	
Swear at you, insult you, or put you down?	Child maltreatment
Act in a way that made you afraid that you might be physically hurt?	Child maltreatment
Actually push, grad, shove, slap you or throw something at you?	Child maltreatment

Hit you so hard that you had marks or were injured?	Child maltreatment
Some people growing up in their first 18 years of life, had sexual experiences with an adult or someone at least 5 years older than them. These experiences may have involved a relative or stranger. During the first 18 years of life, did an adult or older relative, family friend or stranger ever:	
Touch or fondle your body in a sexual way?	Child maltreatment
Have you touch their body in a sexual way?	Child maltreatment
Attempt to have oral, anal, or vaginal intercourse with you?	Child maltreatment
Actually have oral, anal, or vaginal intercourse with you?	Child maltreatment

Overall results from the ACE study determined that ACEs were common and could be considered determinants for poor adult health outcomes and early death (Felitti et al., 2019; Anda, 2007). Of the 17,337, just one-third of participants, 32.7%, reported no history of ACEs. Responses from remaining participants indicated that 25.6% had encountered one ACE, 15.5% had two ACEs, 9.9% reported three ACEs, 5.9% had four ACEs, and the remaining 10.5% reported five or more ACEs during their childhoods (Anda, 2007). Table 2.2 provides a breakdown of the reported ACEs by category. The most pervasive ACE was physical abuse (28%), and the least common ACE reported was the imprisonment of a family member (6%).

Of fundamental importance were the results, which showed that where a participant reported one ACE, they were 87% more likely to report additional childhood adversities (Waite and Ryan, 2020). Results further suggested that participants with an ACE score of four or more had a significantly increased risk of being diagnosed with skeletal fractures, ischemic heart disease, cancer, sexually transmitted infections, jaundice, and hepatitis. They were also more inclined to be obese and engage in illicit drug misuse, including intravenous drug use. In addition, those with an ACE score of four or more were more at risk of reporting mental ill health, such as experiences of depression and suicidal ideation. The results also established a correlation between four or more ACEs and chronic medical conditions such as bronchitis, diabetes, and emphysema (Felitti et al., 2019).

Table 2.2 **Breakdown of ACEs reported in the first study** (Adapted from Waite and Ryan, 2020)	
Drug or alcohol misuse within the home (27%)	Household dysfunction
Domestic violence towards mother (13%)	Household Dysfunction
Household members imprisoned (6%)	Household dysfunction
Household members with mental ill health or suicidal ideation (17%)	Household dysfunction
Parental separation or divorce (23%)	Household dysfunction
Physical neglect (10%)	Neglect
Emotional neglect (15%)	Neglect
Emotional abuse (11%)	Child maltreatment
Physical abuse (28%)	Child maltreatment
Contact sexual abuse (22% overall, 28%=F, 16%=M)	Child maltreatment

2.2.3 Health-risk behaviours

The original ACE study found that experiencing adversities in childhood could have significant long-standing negative implications for individuals across the trajectory of their lifespan (Felitti et al., 1998). More specifically, the study established a graded dose relationship between exposure to ACEs and adopting health risk behaviours in adulthood (Felitti et al., 1998). A graded dose relationship refers to the relationship between the level of exposure to adversity and negative health outcomes (CDC, 2022). The first ACE study determined that the more ACEs a participant experienced, the more likely they were to adopt health-risk behaviours, resulting in negative health outcomes across the lifespan (Felitti et al., 1998). Table 2.3 provides an overview of reported ACEs and increased health-risk behaviours. Hilgen-Byran (2019) describes health risk behaviours such as alcohol and drug addiction, promiscuous behaviour, or unhealthy eating as a means of coping with the impact of ACEs. Furthermore, the author stresses that health-risk behaviours constitute markers for a bigger problem.

Similarly to Dr Felitti's original study examining how life events correlated with adult obesity, the first ACE study reaffirmed the finding that individuals who encounter several adversities during childhood adopt coping mechanisms to help to alleviate their emotional distress (CDC, 2022). These maladaptive coping strategies can act as a pathway to individuals experiencing poor health outcomes in later life (Lazenbatt, 2010). The original ACE study found that patients with multiple adversities

were likelier to engage in health-risk behaviours. These behaviours were related to drug and alcohol misuse and a history of suicide attempts. In addition, results indicated an increased likelihood of participants with four or more ACEs having over fifty sexual partners and a history of sexually transmitted infections (Felitti et al., 1998).

Table 2.3
Overview of the number of ACEs and associated health-harming behaviours
(Adapted from Felitti et al., 1998)

The number of ACEs reported	0	1	2	3	4
Health-harming behaviour					
Considered self an alcoholic	1.0	2.0%	4.0%	4.9%	7.4%
Used illicit drugs	1.0	1.7%	1.9%	3.6%	4.7%
Injected drugs	1.0	1.3%	3.8%	7.1%	10.3%
Had 50 or more sexual intercourse partners	1.0	1.7%	2.3%	3.1%	3.2%
Had been diagnosed with a sexually transmitted infection	1.0	1.4%	1.5%	1.9%	2.5%

Literature suggests that health-risk behaviours represent a behavioural pathway to negative outcomes in adulthood (Anda, 2007). Interestingly though the literature is not confined to physical health risk behaviours alone, it extends to consider the relationship between behavioural psychology and the development of maladaptive coping strategies (Weiss, Peasant, and Sullivan, 2019; Rosenthal et al., 2005). Experiences of persistent stress, repetitive emotional upset, or regular instances of witnessing violence or experiencing maltreatment and neglect can result in children adapting their behaviour to survive (Sheffler, Stanley and Sachs-Erricsson, 2020). An example of this type of behaviour is avoidance. Literature suggests that children frequently exposed to the threat of violence learn to avoid situations and people (Weiss, Peasant, and Sullivan, 2019; Rosenthal et al., 2005). Although this avoidance strategy helps in moments when they feel threatened, increased chronicity in exposure can result in children maintaining avoidant behaviour regardless of whether there is an actual threat of harm (Rawlins, Brooks, and Khan, 2020). Abusing substances can assist with avoiding the emotions associated with ACEs. As the child reaches adolescence and adulthood, this avoidant behaviour can incorporate drug or alcohol misuse (Asberg and Renk, 2012). Avoidant behavioural strategies can impair an individual's ability to function in adulthood, as continued avoidance throughout

childhood results in them not engaging in activities to build resilience or develop problem-solving skills. Additionally, behavioural adaptations can damage health and lead to problematic social behaviours and negative social relationships in adulthood (Sheffler, Stanley and Sachs-Erricsson, 2020).

2.3 Subsequent ACE studies

Massetti et al. (2020) highlight that ACEs have garnered significant attention from researchers globally. Since disseminating the first ACE study results in 1998, subsequent studies have validated the correlation between adversities during childhood and the potential for negative outcomes across the lifespan (Waite and Ryan, 2020). Globally, the results of subsequent ACE population studies have indicated that the potential negative impact of adversities during childhood is cross-cultural (Massetti et al., 2020; Pace et al., 2022). Despite the significant number of studies, national population-based studies have been primarily limited to the USA and other high-income nations (Hughes et al., 2017). In their review of ACE data relating to prevalence by context, culture, and country in 2020, Massetti et al. (2020) established that although there is data from global studies, many regions worldwide are not represented within this data. Table 2.4 provides an overview of the countries that have conducted national population studies. In the current study context, it is important to note that Ireland has yet to conduct an ACE national population study.

Results from both national and smaller-scale studies affirm the link between ACEs and the adoption of health risk behaviours (Raleva, Jordanova-Peschevska and Sethi., 2013; McDonald et al., 2019) and the correlation between multiple ACEs and negative later life outcomes (Duke and Borrowsky, 2018; Bellis et al., 2017; Hillis et al., 2004; Hornor, 2015). For example, in their study, which examined the impact of ACEs on adult education, employment and financial standing, Metzler et al. (2017) established that the more ACEs encountered by an adult, the more likely they were to end up living in poverty. This outcome for adults increased the possibility that their children would have the same experience, sometimes referred to as intergenerational transmission.

Table 2.4 **Countries that have undertaken ACE prevalence population studies** (Adapted from Masset et al., 2011)			
Country	**Number of studies**	**Country**	**Number of studies**
Canada	2	Sri Lanka	1
USA	13	China	1
Mexico	1	Republic of Korea	1
Brazil	1	Philippines	1
Finland	2	Vietnam	1
Denmark	1	New Zealand	1
Sweden	1	Kenya	1
Spain	1	Malawi	1
Eastern Europe	1	Nigeria	1
UK	5	Saudi Arabia	1
Tunisia	1		

The impact of multiple ACEs also emerged as a finding for Anderson et al. (2018) in their paper, which investigated the *'Intergenerational transmission of child abuse: Predictors of child abuse potential among racially diverse women residing in domestic violence shelters'* in the USA, they report that women who ended up in domestic violence shelters had experienced multiple ACEs. The most common experiences within their study cohort were witnessing domestic violence, experiencing physical violence and sexual abuse as a child. A notable finding in this study was that most of the research participants reported that each of their reported ACEs were not once-off occurrences but clarified that they had experienced them repeatedly throughout their childhoods. A study by Blodgett and Lanigan (2018) to explore the association between ACEs and school success in elementary school children in the USA found that as the children's ACE scores increased, the students were more likely to feature absenteeism, behavioural problems, and poor educational performance.

Results outlining the potential cumulative impact of multiple ACEs have also increased the need for professionals who come in contact with children and families to be mindful of their significance. Spratt (2012) argues that accepting that children who come in contact with child and family social workers have a high probability of having experienced high numbers of ACEs could lead to more targeted interventions to diminish the impact of such challenges. He postulates that before the seminal ACE study, child maltreatment studies had not generally differentiated between individual and multiple experiences of adversity. Since experiencing numerous hardships in childhood has been confirmed as a significant risk factor for encountering poorer

outcomes across the lifespan, researchers have highlighted this finding as necessary for health and social care professionals. Spratt (2012) draws attention to the fact that the ACE evidence base provides a first-time opportunity for services to take a fresh approach to children and families who experience multiple ACEs. He affirms that addressing multiple ACEs in child and family services would call for social workers to be trained in the ACE evidence base and introduced to developing assessment tools and subsequent interventions (Spratt, 2012).

2.4 Pathways to poorer outcomes

The Early Intervention Foundation in the UK published 'Adverse Childhood Experiences, What we know, What we don't know and What should happen next?' (Asmussen et al., 2020). This paper determined that as interest in ACEs increased and the survey was replicated in different settings and populations, researchers estimated that only 50% of negative outcomes arising from ACEs could be attributed to individuals adopting health-risk behaviours. This approximation resulted in researchers considering different biological, behavioural, and social pathways that increase the likelihood of poorer outcomes across the lifespan (Asmussen et al., 2020).

Biological pathways

Since disseminating the first ACE study findings, clinical research into biological pathways for poorer outcomes has established that childhood adversities can result in neurophysiological changes (Sheffler, Stanley and Sachs-Ericcson, 2020). Neurophysiology is a branch of neuroscience that examines the abnormal and normal functioning of the body's nervous system (Carpenter and Reddi, 2012). Research indicates that ACEs can result in neurobiological adaptations to assist the body in coping with prolonged and overwhelming stress (Sheffler, Stanley and Sachs-Erricson, 2020). Asmussen et al. (2020) identify three neurophysiological pathways for understanding the biological pathways to poorer outcomes. These pathways include latent vulnerability, epigenetic modulation, and toxic stress.

Latent Vulnerability

Latent vulnerability is a concept for understanding how early experiences of childhood mistreatment elevate children's vulnerability to mental health problems in

adolescence and later life. Latent vulnerability refers to the neurocognitive and biological systems that alter in response to childhood adversity experiences. These alterations provide short-term benefits to the child but inevitably lead to poorer mental health outcomes (McCrory, Puetz and Viding, 2017). A study by McCrory, Peutz and Viding (2017) in the UK demonstrates the impact of latent vulnerability as a neurophysiological pathway to adverse outcomes arising from ACEs. This study investigated the effect of child maltreatment on the autobiographical memory of 67 children aged 10-14. Findings from the study established that participants who had experienced child maltreatment (n=34) had altered brain functioning. More specifically, these participants reported reduced activation of positive memory recall and increased activation of negative memories. The study's authors concluded that these adaptations, although helpful during the child maltreatment period, inevitably resulted in these participants being more susceptible to experiencing depression and post-traumatic stress disorder at a later stage. McCrory, Peutz and Viding (2017) affirm that children's brains learn to adapt to ACEs to cope with chaos, violence or unpredictability in their homes and communities. Latent vulnerability refers to changes such as becoming vigilant in the presence of violence so that they can survive. In the short term, the brain responding in this alert way is helpful, but over time, these brain adaptations cannot differentiate between the threats in the home and other environments. The brain's vigilant adaptations start to cause problems in the long term because the child is constantly in a state of arousal regardless of the setting.

Epigenetic modulation

The CDC (2022b) defines epigenetics as the study of how one's environment and behaviours can result in changes in how genetics operate. Genes have a central role in health, but an individual's behaviours and environment also influence how they work. Epigenetic modulation refers to a set of processes which can result in specific genes activating or deactivating (Asmussen et al., 2020). Genetic modulation can occur in children due to prolonged exposure to child maltreatment specifically (Asmussen et al., 2020). According to Lang et al. (2020), epigenetic modulation silences or activates genes during acute distress. Children who encounter abuse develop epigenetic markers. These markers do not change the DNA but control how it looks and behaves. Epigenetic modulation is a complicated concept related to neuroscientific research. This research examines how changes to DNA code, phenotypes, and genotypes occur

in response to repeated exposure to child abuse. Most of these terms are unfamiliar to those without neuroscientific training and are hard to understand in layperson's terms (Wastell and White (2017). Difficulties with comprehension surrounding epigenetic modulation will be examined later in this chapter under the heading of 'Simplistic Use of Complex Neurological Data'.

A clear and somewhat more explicit demonstration of ACE research relating to epigenetic modulation is that of a study by Klopack et al. (2022). This study examined participants' DNA samples to assess whether accelerated ageing mediated the link between ACEs and depression in older adults. The study's findings determined that exposure to early life adversity was associated with changes in participants' DNA. These epigenetic changes led to accelerated ageing. The gene for accelerated ageing did not mutate, but it was expressed more rapidly in adults with histories of child maltreatment ACEs. Similarly, a study by Kaufman, Ortiz, and Hudziak (2019) to determine if there was a correlation between ACEs and epigenetic changes to DNA which lead to childhood obesity, established that there was evidence to suggest that experiences of child maltreatment resulted in changes to DNA. These DNA changes were pervasive in child participants who were obese.

Toxic Stress

Since the dissemination of the original ACE study, academics and clinicians alike have coined new concepts to promote understanding of the impact of ACEs across the lifespan. The most significant of these is that of toxic stress. Williams-Shanks and Robinson (2013) acknowledge that the concept of toxic stress has been extensively developed by Jack Shonkoff, a paediatrician, along with colleagues from the Centre for the Developing Child at Harvard University. In their paper titled *'The Lifelong Effects of Early Childhood Adversity and Toxic Stress',* Shonkoff et al. (2012) suggest that a tolerable stress level can act as a buffer for children during development. They argue that stress is not bad; however, intolerable stress (termed chronic) can result from exposure to ACEs or unexpected traumatic life events, such as natural disasters or repeated exposure to domestic violence within the home. Toxic stress refers to the distress experienced when children are exposed to high-stress levels over a sustained period. For example, a child exposed to regular domestic violence within their home may experience repeated periods of overwhelming stress. According to Franke (2014), toxic stress is a biological reaction that increases cortisol levels to tolerate prolonged

periods of stress. Although cortisol is the fight or flight hormone intended to assist the body during stressful times, prolonged exposure to stress and persistent cortisol increases inevitably damages the body. As the child ages, the ability of the body to fully recover decreases.

Selvaraj et al. (2019) define toxic stress as chronic, repetitive, and prolonged stress compounded by insufficient ameliorating factors. In their book *'The Spirit Level, Why Equality is Better for Everyone'*, Richard Wilkson and Kate Pickett pay particular attention to the impact of inequality on the social determinants of health. Wilkinson and Pickett (2010) argue that recognising that the mind has the potential to impact the body emerged in ancient times and that neurological research is merely broadening what people knew already instead of introducing new understandings. Middlebrooks and Audage (2008) use the example of child maltreatment to demonstrate the correlation between toxic stress and ACEs. They argue that children who experience repeated physical abuse, sexual abuse and neglect are often without the support or protection of an adult and that, in such cases, these children experience chronic and prolonged periods of toxic stress. Middlebrooks and Audage (2008) affirm that exposure to toxic stress will likely disrupt children's brain development and compromise their nervous and immune system functioning. Shonkoff et al. (2012) maintain that exposure to toxic stress during childhood can impair neurological development. They further affirm that altered brain development in response to toxic stress can help to explain the link between adversities in childhood and subsequent language, educational, behavioural, and cognitive development issues. Shonkoff et al. (2012) suggest ACEs can lead to impaired neurological development in childhood long before adopting maladaptive coping mechanisms are developed.

ACEs and the toxic stress pathway concept have become known to many health and social care professionals through the distribution of a 2016 movie,' *Resilience: The Biology of Stress and the Science of Hope.'* The film, which James Redford directed, includes contributions from leading academics and clinicians. The movie introduces the viewer to ACEs and toxic stress research. It illustrates their impact via interviews with individuals with early adversity experiences and effects across their lifespan (KPJR Films, 2020). The popularity of this movie is evident in the results of a recent Google search for current film screenings in January 2022. This search indicated 3,084 results for screenings in locations including Scotland, Ireland, Australia, and multiple sites in the USA. The literature suggests that health and social care settings use this

movie to educate staff and SUs about ACEs and toxic stress (Farmer, 2017; Alliance Scotland, 2022; Irish Association of Social Workers, 2020; All Events In Tennessee, 2020).

Behavioural Pathways

Health-risk behaviours are not the only behavioural pathway to negative outcomes. Asmussen et al. (2020) affirm that research shows that ACEs related to child maltreatment and household dysfunction are often an intergenerational phenomenon. Children who grow up in chaotic and unsafe environments frequently end up recreating the same situation for their children as parents. Asmussen et al. (2020) argue that the biological pathway to negative outcomes does not account for these repetitive patterns. In realisation of this, they outline social learning as another behavioural pathway to negative outcomes associated with ACEs. Social learning is a theoretical framework developed by Albert Bandura in 1971. This theory proposes that human behaviour is influenced by cognitive processes based on individuals' experiences in their social environment and relationships (Payne, 2021). In their paper outlining a framework for developing a society that ensures health and wellness, Biglan, Ryzin, and Hawkins (2017) argue that social interactions and conditions reinforce the negative outcomes associated with ACEs. They identify the experience of family coercion during childhood as one of these conditions.

According to Biglan, Ryzin and Hawkins (2017), family coercion refers to familial interactions involving aggressive and aversive behaviours. They affirm that children who grow up in a home where aggressive or hostile measures are implemented in response to a conflict are more likely to perpetrate the same behaviour outside the home. Coercive family interactions can increase children's likelihood of violent behaviour in adolescence and childhood. This increased likelihood can result in contact with the criminal justice system. Basto-Pereira et al. (2022) examined the global impact of ACEs on criminal behaviour. They established that offenders had higher rates of child maltreatment, physical neglect, and household substance abuse than non-offending populations. This finding was consistent across all participating countries, including Portugal, Spain, Thailand, France, Australia, Mozambique, South Africa, Brazil, Iraq, and Palestine.

The intergenerational transmission of ACEs

Hays-Grudo and Sheffield (2020) examined the intergenerational transmission of ACEs and Protective Adverse Childhood Experiences (PACEs) in their book *'Adverse childhood experiences and protective childhood experiences: A development Perspective'*. The authors explain that the biological and behavioural pathways, such as latent vulnerability, epigenetic modulation, and toxic stress, which lead to negative outcomes, can lead to the replication of ACEs. Overall, the literature suggests that these pathways lead to individuals with ACEs experiencing negative outcomes and facilitate the intergenerational transmission of childhood adversities (Narayan, Liberman and Masten, 2021; Hays-Grudo and Sheffield, 2020). They propose that when infants are raised in a safe and positive environment, their brain develops the ability to regulate emotions, grow physically and emotionally, experience empathy and develop resilience in response to stressful or adverse situations. Infants born in unsafe and negative environments do not have the same quality of brain development. The authors postulate that these children are ill-prepared emotionally and cognitively for adulthood. These impairments can potentially impact how they behave and navigate the world. They also increase the potential for children to mature into adults perpetuating similar insecure attachment styles they encountered in being parented with their children (Hays Grudo and Sheffield, 2020). Similarly, a paper examining the intergenerational transmission and prevention of ACEs by Narayan, Lieberman and Masten (2021) affirms that biological adaptations that occurred during a parent's childhood in response to ACEs can make them more susceptible to encountering parenting difficulties when raising their children. However, the authors stress that early intervention measures to increase the likelihood of PACEs, such as parenting supports, education about emotional regulation and helping parents process the trauma associated with their ACEs, can reduce the likelihood of intergenerational ACE transmission.

2.5 Understanding the 'probabilistic' nature of ACEs

Encountering ACEs during childhood does not predetermine negative outcomes across the lifespan; instead, they increase the probability of such consequences (Bellis et al., 2017). Literature suggests that many people who encounter ACEs do not report difficulties across their lifespans (Bethell et al., 2017). Given this, researchers have

focused on ascertaining what alleviates the impact of ACEs. Literature suggests resilience is a significant buffer for encountering negative outcomes across the lifespan for those with ACEs (Powell, Rahm-Knigge and Conner, 2021; Beutel et al., 2017). Resilience refers to the ability to recover from difficult experiences and situations (Payne, 2021).

A report prepared using data from an ACE population study in Wales by Hughes et al. (2018) determined that opportunities to build resilience during childhood and throughout the lifespan were the most significant mitigating factor in reducing negative mental health outcomes. This report identified both child and adult opportunities to build and maintain resiliency. Interestingly, the most reported childhood resilience opportunities were exposure to support from one good adult and team sports participation. Regular access to a positive adult was found to equip the child with opportunities to build resilience by availing of this adult's support during adversity. In addition, participating in team sports placed the child in situations where they had the support of peers and associated adults. Similarly to the results concerning children, Hughes et al. (2018) also identified participation in sports as an adult resilience-building opportunity. In addition, the report outlined participating in community groups and social clubs and engaging in one's community and social traditions as opportunities for adults to build resilience. According to Hughes et al. (2018), these contexts enabled adults to develop and maintain social relationships that they could draw upon when they required support. Lastly, the report determined that financial security was a vital resiliency factor for adults who encountered ACEs. Hughes et al. (2018) postulate that the absence of socioeconomic concerns and stress lessened the negative impact of ACEs.

2.6 ACE – International Questionnaire (ACE-IQ)

Hilgen-Bryan (2019) argues that since the dissemination of the results of the original ACE study, there has been a growing global emphasis placed on professionals working within clinical settings to ask their SUs about ACEs. Multiple studies using the original survey format, as well as some using the initial questions with minor additions/alterations, have been completed in predominantly healthcare settings (Duke and Borrowsky., 2018; Albaek et al., 2018; Sun et al., 2017; Munoz et al., 2014; Counts et al., 2017; Bethell et al., 2017). These studies examining ACEs have affirmed not only the findings of the original research but also revealed adverse physical health,

mental health, behavioural and environmental outcomes for SUs with higher ACE scores across the trajectory of the lifespan (Radcliff et al., 2019; Corney et al., 2022; Brown et al., 2022; Bosch, Weaver, and Arnold., 2021).

Examples of studies that have affirmed the original ACE study findings and highlighted other negative outcomes are Brown et al. (2022) and Corney et al. (2022). Both examined the relationship between ACEs and negative health outcomes in adulthood, with Corney et al. (2022) noting a clear link between ACEs and Alzheimer's disease. Similarly, Bosch, Weaver, and Arnold (2021) considered the impact of ACEs on females' oral Health in the USA. This study determined that those with an ACE score of four or more reported higher smoking levels, resulting in poor dental hygiene and tooth loss. The common research aims of these studies include focusing on the prevalence of ACEs; the negative outcomes associated with ACEs; how SUs feel about being asked about ACEs, and how professionals respond to asking SUs about potentially traumatic experiences during childhood (Ford et al., 2019).

In response to the growing interest in examining ACEs, in 2018, the World Health Organisation (WHO) developed the Adverse Childhood Experience International Questionnaire (ACE-IQ) as a tool to assist countries in measuring the relationship between ACEs and health risk behaviours in adulthood (WHO, 2023). According to the WHO (2023), the ACE-IQ should always be integrated into a broader survey to include demographic information. The rationale for this instruction is explained as the benefit of identifying ACEs and the association between such adversities with patterns associated with age, gender, ethnicity, and other socio-demographic characteristics (WHO, 2023). The ACE-IQ was initially designed to be a retrospective tool administered to adults aged eighteen years and older. However, since its inception, there has been a growing number of occasions when it has been used both retrospectively with adult parents/caregivers and as a survey with children to identify their current and retrospective childhood adversities (Bethell et al., 2017; Bruner, 2017; Fordstadt et al., 2015; Selvaraj et al., 2019; Duke and Borrowsky, 2018).

2.7 Criticisms of the ACE evidence base

The ACE evidence base has not been without its critics. While there is little evidence in the literature to suggest any disagreement with the fact that childhood adversities have the potential to lead to poorer later life outcomes, there are nonetheless criticisms (Sirvastav et al., 2017; Edwards et al., 2017; Steptoe et al., 2019; Hartas, 2019; Hilgen

Bryan, 2019; Forstadt et al., 2015). A general critique in the literature relates to the need for a clear rationale for asking about ACEs before implementing the survey. In an article examining screening for ACEs, Finklehor (2018) acknowledges that few professionals would refute the grounds for asking SUs about ACEs. However, equally, he stresses that asking about adversities in childhood should be aligned with providing appropriate services. Finkelhor (2018) argues that translating ACE scores into the provision of proper interventions remains a work in progress. Duke and Borrowsky (2018) suggest that when considering screening for ACEs, organisations must do so in a way that is appropriate but also helpful and constructive for SUs. Finkelhor (2018) describes how funding for appropriate training for practitioners to inquire about ACEs routinely is not feasible for all services.

In a recent paper exploring the ACE research measures' strengths, limitations and misapplications, Anda and colleagues have acknowledged deficits in subsequent applications of the original ACE questions (Anda, Porter and Down, 2020). As the ACE research measures were designed to ascertain the correlation between adversities during childhood and subsequent adverse outcomes across the lifespan, Anda, Porter and Down (2020) affirm that the research measures should not be used as a clinical or diagnostic screening tool. Despite this criticism, the literature suggests that the ACE research measures are being used as a screening tool in clinical care settings (Pardee et al., 2017; Glowa, Olson, and Johnson, 2016). Hughes et al. (2017) suggest that screening for ACEs does not require the identification of health problems but should be used to ascertain the risk factors associated with probable poorer outcomes.

Simplistic use of complex neurological data

Edwards, Gilles and White (2019) express concern about how policymakers and professionals promote and use the ACE evidence base. They further stress that complicated neuroscientific terminology is inappropriately used to support claims about the impact of ACEs on later life outcomes (Edwards, Gilles and White, 2019). Despite these neuroscientific assertions being problematic for most people to understand, they are readily accepted as accurate and used to label children who encounter adversities as more vulnerable to physiological deficits and poorer outcomes (Wastell and White, 2017). A paper by Sue White, a Professor of Social Work at the University of Sheffield, postulates that ACEs are a chaotic concept that emphasises the presence of risk whilst ignoring the sometimes noticeable impact of

living and social environments during childhood on poorer adult outcomes (White et al., 2019). Wastell and White (2017) further argue that policymakers are so overwhelmed with arguments derived from epigenetics that they are making decisions which impact families without considering all factors.

The fact that the ACE measure is too simplistic is also highlighted as a significant deficit. White et al. (2019) argue that allowing only *yes* or *no* answers to questions such as 'were your parents ever separated' does not allow for an understanding of whether or not the child's experiences of parental separation were amicable or adversarial. White et al. (2019) stress the importance of understanding such nuances to ensure the provision of appropriate interventions. Their paper postulates that the ACE evidence base puts unfair responsibility on parents and families to stop the intergenerational transmission of ACEs. According to White et al. (2019), because ACEs are understood to be individual experiences, the focus of intervention is on parents and guardians. They argue that this promotes a judgemental stance by professionals as it does not recognise the impact of poverty, social exclusion, or lack of community-based resources on the adversities experienced by children.

The absence of resilience

One of the original ACE questions' consistent criticisms is that they do not include resilience. In their paper exploring *'Childhood adversities and distress – The role of resilience in a representative sample',* Beutel et al. (2017) argue that while studies to ascertain the prevalence of ACEs have been helpful, few studies have examined the impact of resilience on negative later life outcomes. Correspondingly, Steptoe et al. (2019) emphasise that focusing on ACEs does not help facilitate an understanding of how resiliency factors can help to mitigate whether a child will experience poor outcomes across the lifespan. The ACE evidence base has been criticised for failing to sufficiently acknowledge that every child who experiences adversities during childhood does not inevitably encounter poorer outcomes. Understanding what resiliency factors enable such children to overcome adversity is particularly important to ensure equal opportunities for children (Jackson Nakazawa, 2016).

A good example of the importance of considering resilience in tandem with ACEs is that outlined in a study by Powell, Rahm-Knigge, and Conner (2021). This study implemented the survey question with the Resilience Protective Factors Checklist with 1,256 undergraduate students in the USA. Findings from the study indicated that

exposure to tolerable stress levels during childhood resulted in participants having opportunities to adapt and bounce back. The authors affirm that opportunities to build resilience are central to mitigating the potential negative impact of ACEs and should always be considered when inquiring about an individual's experiences of adversity during childhood (Powell, Rahm-Knigge, and Conner, 2021).

Ignoring the contribution of poverty to causation and outcomes

Kelly, Irving and Delpierre (2019) argue that the original and most of the subsequent ACE studies have not recognised the contribution of socioeconomic circumstances to negative outcomes. They affirm that deprivation and poverty should be considered co-predictors alongside ACEs when developing public health policy to respond to and intervene in disease pathways. Hartas (2019) expands on this critique by highlighting that poverty and deprivation have been linked to the intergenerational transmission of ACEs. He draws attention to the fact that the ACE evidence base has established that people with four or more ACEs tend to live in lower socioeconomic areas, encounter difficulties maintaining employment and have lower educational attainment rates. Hartas (2019) argues that asking SUs about ACEs without understanding their socioeconomic circumstances is ineffective. Steptoe et al. (2019) support this viewpoint, arguing that an understanding of an individual's social and financial situation is essential when it comes to responding to and understanding ACEs, as evidence is emerging which suggests that there are links between poverty and the adoption of maladaptive behaviours that harm health.

Drawing conclusions about ACEs without considering contextual factors

Consistent with the above criticisms, a study completed by McDonald et al. (2019) draws attention to issues arising from using the original ACE research measures to collect data without other necessary information. The study examined how ACEs relate to maternal postpartum well-being, coping and parenting in Canada. It found that the information collected about ACEs did not provide enough of a picture to articulate SU needs. McDonald et al. (2019) affirm that ACE data should be collected along with information about individuals' social circumstances and behaviour. Building on this, Hetzman (2013) suggests that as there is no single life pathway along which SUs who have experienced ACEs progress to later life negative emotional, behavioural, health

and social outcomes; consequently, interventions and responses should not consider ACEs alone.

Kelly-Irving and Delpierre (2019) argue that ACEs must be considered in tandem with the SUs' unmet social needs and existing social support networks. Similarly, Lacey and Minnis (2020) emphasise that omitting research data relating to context results in false assumptions by professionals. They explain that these assumptions relate to the misperception that all ACE scores are equal regardless of context or chronicity and that those with the same ACE score will similarly engage and benefit from interventions. Lacey and Minnis (2020) stress that these presumptions result in developing interventions which ignore the importance of individual personalities and circumstances. Building on this, a paper by McLeannan, MacMillan and Afifi (2020), which critically examined both original and subsequent surveys, affirmed that a significant deficit in surveys is the lack of psychometric assessment. Psychometric assessment involves the evaluation of an individual's personality characteristics, mental ability and opinions (Cambridge Dictionary, 2022). As participants can only indicate that they have or have not encountered specific ACEs, McLeannan, MacMillan, and Afifi (2020) argue that data analysis is too simplistic. As there is a lack of asking people for contextual information, survey data does not account for the influence of individual personality factors on participant responses.

Retrospective recall

The fact that ACE measures are generally used to gather retrospective information from adults about their childhood adversities has also been criticised. A study by Hardt and Rutter (2004) which examined the accuracy of adult retrospective reports of ACEs, found that the information disclosed by some participants was false or minimised. Relying on memories from childhood can result in research participants remembering past experiences inaccurately or omitting important information. In research, this error is called recall bias (Spencer, Brassey and Mahtani, 2017). Holden, Gower and Chmielewski (2019) emphasise that accurate retrospective recall can be particularly difficult for adults regarding traumatic adversities. They also note the influence of gender on providing precise information, stressing that feelings of shame can often lead males to under-report experiences of CSA. Hardt, Vellaisamy and Schoon (2010) affirm that the validity of ACE study findings has been questioned due to the heavy reliance on participants recalling adversities from the past.

Finkelhor, Shattuck and Turner (2013) are also critical of the retrospective bias of the original ACE research measures. They argue that the measures should be adapted to enable the collection of data about adversities that children are having or have experienced. They affirm that doing so would lead to better service planning and development. Opposing this suggestion, the WHO (2023) asserts caution in asking parents/caregivers about their children's ACEs as they suggest that, in some cases, they may be responsible for neglect or the perpetrator of abuse. Surprisingly, research is lacking regarding data accuracy relating to participants who intentionally respond incorrectly to survey questions. This absence of critique is surprising given that the literature suggests that shame can be a significant barrier to individuals indicating that they have experienced child maltreatment (Becker Blease and Freyd, 2007; Halvorsen, Solberg, Halvorsen and Stige, 2021; Easton, 2013). A study by Halvorsen, Solberg and Stige (2020), which explored disclosure barriers relating to CSA by adults, found that fear of being stigmatised by others or being perceived differently were significant obstacles. In addition, participants (N=12) aged 18-57 indicated that disclosure of CSA was perceived as threatening because doing so put them at risk of not being perceived as normal or like everyone else. Additionally, participants noted that this fear also exacerbated their reluctance to disclose as they may be accused of lying and thus not getting the support they hoped to achieve.

A study by Schomerus et al. (2021) which examined stigma as a barrier to the disclosure of childhood trauma in Germany, conducted telephone surveys with 1320 participants aged 18 years or over. As part of the telephone survey, participants were presented with a short scenario describing an interaction with a new neighbour. Each participant was randomly assigned a scenario that related to four maltreatment events, physical abuse as a child (N=329), CSA (N=330), involvement in a severe accident as a child ((N=330) and physical abuse as an adult (N=331). Participants were advised to imagine a situation where the new neighbour indicated during a conversation that they had experienced [traumatic event] and were still negatively impacted by it. Participants were then asked how likely they would be to discuss the person's experience with them in a subsequent conversation. The study determined that negative attitudes toward child maltreatment were evident. Results indicated that participants were more reluctant to engage in further conversations about CSA or trauma. Interestingly 65% of participants agreed with the statement that victims of CSA were permanently damaged. The study's authors argue that the results indicate

that there is stigma and reluctance for individuals to engage in conversations about child maltreatment (Schomerus et al., 2021).

Critique of the ACE research measures

Steptoe et al. (2019), in their paper, *'ACEs: Evidence, Gaps, Evaluation and Future Priorities'*, highlight gaps in ACEs research concerning the level of consistency and clarity surrounding measurement. They argue that this lack of standardised measurement evokes queries about how generalisable ACE study findings are. Interestingly, examining modified versions of the original ACE measures by Holden, Gower and Chmielewski (2019) uncovered twenty versions. The authors argue that this breath of variation in the ACE research measures makes it hard to quantify and validate subsequent ACE study findings comparatively. In their study examining the development of a global ACE concept, Steptoe et al. (2019) also highlight that the identified ACEs from the original study are not the only adversities children experience. They affirm that experiencing a single ACE, such as parental substance misuse, can be exacerbated if the child has the added stress of growing up in poverty.

Steptoe et al. (2019) caution that when using the ACE measure to help identify poor outcomes for children, we should remember that adversity is more complicated and diverse than the original ACE research measures capture (Steptoe et al., 2019). The need for additional ACE research measures is supported by the findings of a study by Merskey, Jancezewski and Topitez (2017). This study involved a sample of women (N=1,241) of lower socioeconomic status who availed of home-visiting support in the USA. This study employed the ten original survey questions alongside seven potential new ACE measures (Please refer to Table 2.5) to examine the prevalence of conventional and potential ACEs and their correlation with adverse health outcomes. Results from the study determined that the ten original ACEs were prevalent in the research population. Participants also endorsed the seven potential new survey measures. Except for experiencing a parent's or sibling's death during childhood, results indicated that all other ACEs were associated with each other. Participants reported conventional alongside new potential ACEs. Aside from parent or sibling bereavement, a relationship between new potential ACEs and two factors contributing to negative health outcomes, smoking and increased stress perception, was established. Mersky, Jancezewski and Topitez (2017) affirm that the study's results suggest that adversities during childhood are broader than those accounted for in the

original ACE measures and that additional ACE measures should be developed and validated for use in subsequent studies.

Table 2.5
Overview of conventional ACE and new ACE research measures
(Adapted from Mersky, Janczewski and Topitzes, 2017)

Conventional ACEs		New potential ACEs	
1.	Physical abuse	**1.**	Household financial difficulties
2.	Sexual abuse	**2.**	Household food insecurity
3.	Emotional abuse	**3.**	Homelessness
4.	Physical neglect	**4.**	Parental absence or abandonment
5.	Emotional neglect	**5.**	Childhood peer victimisation
6.	Household alcohol or drug misuse	**6.**	Parent or sibling death
7.	Household mental illness	**7.**	Childhood victim of violent crime
8.	Exposure to parental domestic violence		
9.	Household imprisonment		
10.	Parental separation or divorce		

2.8 A benchmark for the Irish socioeconomic context

Given that the current study findings will consider socioeconomic factors relating to an Irish SU research population attending a social care organisation, the last part of this chapter will provide an overview of the literature relating to the general socioeconomic profile of Irish citizens. The rationale for discussing this literature is to provide a comparative context for the findings. The literature considered in this section was obtained from statutory reports from the Central Statistics Office (CS0). The CSO collects, analyses and publishes statistical data about Irish society, the economy and its population (CSO, 2023). As the CSO has yet to publish the 2022 census of the Irish population, the most recent census was completed in 2016. Table 2.6 provides an overview of the gender breakdown according to males per 1,000 females in urban and rural areas. The data outlined indicates fewer males than females per 1,000 from 0-19 years. The gender balance shifts from predominantly females to males for all age categories after 19 years except the 35-39 and 45-49 age ranges (CSO, 2016a).

The 2016 census also examined how many Irish people were born in Ireland or another country by county. This data proves interesting to the current study as it provided insights into the immigration population for the counties where the DoCCFS FCs and ECDSCs are located. These counties include Dublin, Meath, and Wicklow. The

census findings indicate that 66.8% of people living in Dublin were born in Ireland, with 12.4% reporting that they had been born in another country. In Wicklow, 38.2% indicated they were born in Ireland, and 12.6% reported being born elsewhere. Interestingly, Meath reported a higher population of people born in other countries, 34.9%, than those born in Ireland, 49.9% (CS0, 2016b).

Table 2.6
Males per 1,000 females in urban/rural areas by age group – Census 2016
[Adapted from - CSO, 2016a)

Age range	Males per 1,000 urban	Females per 1,000 rural
55-59	943	1,039
50-54	946	1,021
45-49	979	1,024
40-44	986	986
35-39	968	952
30-34	914	925
25-29	932	1,020
20-24	981	1,088
15-19	1,028	1,077
10-14	1,041	1,054
5-9	1,036	1,052
0-4	1,045	1,056

The census in 2016 also provided some insights into the educational attainment of the Irish population per age category (please refer to Table 2.7). The census data indicates that most in all age categories achieved a leaving certificate qualification or higher (CSO, 2016c). The 2016 census does not provide a data breakdown of educational attainment according to nationality. However, the CSO published Population and Migration Estimates in April 2022 (CS0, 2022a), which indicated that 58.2% of immigrants in Ireland had a third-level qualification. The level of employment in 2016 was 61.4%, and 12.9% reported that they were unemployed. The census data, unfortunately, did not extend to identifying the income sources for unemployed individuals. It did, however, note that 158,348 people reported being unable to work due to permanent illness or disability (CS0, 2016d).

In 2022 the CSO completed a Survey on Income and Living Conditions (SILC). This survey considered the level of difficulty that the Irish population was encountering in meeting household costs. The survey findings indicated that four out of ten households (42.0%) said they experienced some degree of difficulty, and 5.6%

reported that they had 'great difficulty'. Households with the greatest reported difficulty comprised one adult with one or more children aged 18 years or less (CS0, 2022b). Interestingly, the survey also indicated that although 30% of the population resided in rented or rent-free accommodation, they comprised 70% of those experiencing consistent poverty (CS0, 2022c).

Table 2.7
Educational attainment according to population age category
[Adapted from CSO, 2016c]

Age	No formal education	Junior Certificate	Leaving Certificate	3rd Level Cert/Dip	Primary Degree	Post-graduate
55-59	12%	23%	31%	11%	14%	8%
50-54	8%	22%	31%	13%	17%	10%
45-49	6%	18%	31%	14%	19%	12%
40-44	5%	13%	29%	15%	24%	15%
35-39	4%	9%	28%	15%	27%	17%
30-34	4%	8%	27%	15%	29%	17%
25-29	3%	8%	30%	13%	32%	15%
20-24	4%	8%	47%	11%	25%	4%

2.9 Conclusion

This chapter provided an understanding of the origins of the ACE evidence base and survey. It critically evaluated literature about how ACEs has become a world-renowned acronym synonymous with acknowledging the need to recognise the impact, prevent the occurrence and intervene to stop the potential negative impact of childhood adversities across the life course. Additionally, the chapter outlined criticisms of the evidence base, drawing attention to the fact that although interest in ACEs has increased since the first study, there are several concerns relating to the survey and the data collected via its implementation. Lastly the chapter focused on literature relating to providing the reader with a benchmark for understanding the Irish socioeconomic context. Given that the current study findings will consider socioeconomic factors relating to an Irish SU research population attending a social care organisation this literature provided details to facilitate comparison and understanding. The next chapter will examine and discuss literature on the evolution of routine ACE enquiry in social care organisations.

Chapter 3

The evolution of routine ACE enquiry in social care organisations

3.1 Introduction

This chapter examines the literature on the evolution of routine ACE enquiry within social care organisations. It commences with a discussion of literature concerning the influential role that social epidemiology played in the foundation of the ACE evidence base. The chapter will then consider the literature on ACE prevalence studies in representative population samples in the USA, Ireland, Wales, and Scotland. The rationale for examining this literature is to provide context and understanding of subsequent ACE studies and comparative results for the current study's quantitative findings. This chapter will also discuss the literature concerning the increased professional and policy interest in the ACE evidence base. The chapter will focus on literature from the UK and Ireland to consider how the ACE evidence base informs governmental decisions within these countries. The chapter will also examine the literature on implementing the ACE survey in social care settings. It will consider literature relating to resilience and trauma-informed social care service responses, together with the ACE-ameliorating interventions which have emerged from the evidence base. The final section of the chapter examines the literature concerning professional training in ACEs and survey implementation.

3.2 Epidemiological influence

The first ACE study was epidemiological in nature (CDC, 2022). Adopting this research approach in the original study was unsurprising given that the CDC, which funded the seminal ACE study, is a science-based organisation underpinned by epidemiological principles and data. Dr Anda was also a medical epidemiologist employed by the CDC (Felitti et al., 2019). Coggon, Rose and Barker (2009:1) define epidemiology as 'the study of how often diseases occur in different groups of people and why. Epidemiological information is used to plan and evaluate strategies to prevent illness and as a guide to managing patients in whom the disease has already developed'. Gulis and Fujino (2015) acknowledge the importance of epidemiology as it helps define diseases, recognise risk factors, and analyse the contribution of human behaviour to illness. In addition, they stress that epidemiology is fundamental to ensuring public

health as it leads to recognising patterns of disease development and ways to prevent it.

An example of the power of epidemiology in influencing change is its role in establishing the link between smoking and later-life health outcomes. Samet (2016) explains that epidemiological studies initiated by the John Hopkins Bloomberg School of Public Health in the 1960s were pivotal in establishing links between tobacco use and cancer. He argues that the findings of these studies were a catalyst for change. For the first time, there was scientific proof that smoking played a role in early death, legitimising the need for public health intervention. According to Samet (2016), smoking started to decline when public health policies began to invest in cancer research and education surrounding tobacco use and how tobacco was advertised. Before researchers undertook epidemiological studies, understanding illness was focused on the here and now. Shifting this focus to examining how individuals became unwell resulted in examining childhood experiences' contribution to ill health patterns across the lifespan.

Social epidemiology

There is a strand of epidemiology known as social epidemiology. This approach sets out to understand why and how social problems lead to negative health outcomes and identify what preventative measures and interventions can be implemented (Berkman, Kawachi and Glymour 2014). The use of social epidemiology to understand and respond to negative life outcomes has not been linear (Miettinen and Karp, 2012). Several factors influenced its use in the reconceptualisation of childhood adversities. Kerbo and Coleman (2007) explain that social problems are often referred to as instances when community members deviate from social norms and that in doing so, they cause harm to themselves or others. He argues that many social problems have historically been linked to crime and social deviance. Social problems such as drug and alcohol misuse, violence and sexual aggression have long challenged communities. With the establishment of statutory obligations to protect and maintain social order, a gradual shift to needing to understand why some members of society became deviant emerged. Recognising the pathway to criminality became crucial to responding to the impact of such behaviour on society.

Social epidemiology being implemented as a science to understand childhood adversity is evident in the literature on birth cohort studies (Xie, Mestral and Batty,

2020; MacCleod et al., 2008; Langenberg et al., 2006; Dickerson et al., 2016). A birth cohort study is research conducted with participants at several points throughout their lifespans. Birth cohort studies' central purpose is to understand better the aetiology of health and social outcomes (Canova and Cantarutti, 2020). One of the most well-known international birth cohort studies is the 1970 British Cohort Study (Brown, 2014). Since 1970, this study has collected data from a participant population of 17,000 people born in England, Wales, and Scotland. At the following ages: 5, 10, 16, 26, 30, 34, 38 and 42, researchers met with participants to collect data about their physical, social, and educational development, health, and social circumstances. The data collected has been used to inform service provision and interventions in Britain and internationally (Brown, 2014).

The first ACE study was one of the most significant social epidemiological investigations concerning childhood adversities and adverse later life outcomes (CDC, 2021). Anda (2007) proposes that the study results were disseminated widely because of the unique research focus. He explained that prior to the ACE study, research into the long-term impact of adverse experiences during childhood had primarily centred on one or two experiences, such as child abuse or child maltreatment and parental substance misuse. Anda (2007) further notes that research predating the ACE study generally focused on a restricted range of outcomes. He further affirms that the ACE Study has garnered attention from researchers because it is, to date, one of the most extensive studies designed to assess the correlation between a broader list of childhood adversities and later poor health and social outcomes.

Despite this affirmation, there was a gap in the literature relating to studies that examined using the survey originally intended as an epidemiological research tool in social care settings. No studies were identified relating to how the epidemiological origins of the ACE survey as a clinical research tool transitioned into social care settings. The literature also did not clarify whether social care professionals' training about survey implementation included information about the significance of social epidemiology in developing the ACE survey research measures.

3.3 ACE prevalence studies

Subsequent studies exploring ACE prevalence and associated negative life-course outcomes legitimised the original research by coming to similar conclusions (Bellis et al., 2016). However, studies relating to ACE prevalence amongst parents, caregivers and their children availing of early school year education or family support from a

social care organisation in Ireland or elsewhere were not identifiable in the research literature. The next section of this chapter will examine ACE prevalence studies in Ireland, each of the four countries comprising the United Kingdom (UK) and the United States of America (USA).

Ireland

In Ireland, only one identifiable study implemented ACE survey questions with a nationally representative population-based sample (McCutchen et al., 2022). McCutchen et al. (2022) examined if there were significant differences between the prevalence of ACEs and their relationship to mental health in Irish and USA populations. Table 3.1 provides the socioeconomic profile of the participants.

Table 3.1
Participant socioeconomic profile
(Adapted from McCutchen et al., 2022)

	Irish (N=1020)	**USA (N=1839)**
Gender		
Male	49% (N=500)	48% (N=883)
Female	51% (N=520)	52% (N=956)
Age in years		
18-24	12.3% (N=125)	10% (N=184)
25-34	20.2% (N=206)	20.7% (N=383)
35-44	23.5% (N=240)	19% (N=350)
45-54	19.1% (N=195)	18.5% (339)
55-64	14.1% (N=144)	21.6% (N=398)
65+	10.8% (N=10.8)	10.2 (N=187)
The median age of the participants	43.10	44.55
Level of educational attainment		
Did not complete secondary school	7.1% (N=72)	9.1% (N=168)
Completed secondary school	39.2% (N=400)	48.4% (N=891)
Completed an undergraduate degree	36.9% (N=376)	30.3% (N=558)
Completed a postgraduate degree	16.9% (N=172)	12.1% (N=223)

The USA participant cohort within the study derived from a market research company's pre-existing online research panel. These participants (N=1893) were non-institutionalised adults over the age of 18 years. Participants from Ireland were also over 18 and did not reside in institutions such as hospitals, nursing homes or prisons. Irish participants (N=1020) were obtained using a survey research company. The mental health disorders examined in the study included major depressive disorder

(MDD), post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD). Results of the study determined that more Irish participants reported one ACE or more and had higher numbers of ACEs than participants from the USA (please refer to Table 3.2 for an outline of the ACE scores). In addition, Irish participants were more likely to meet the diagnostic criteria for several mental health disorders. These disorders included MDD, CPTSD and GAD (McCutchen et al., 2022). These results prove interesting for the current study as they suggest that the Irish population has a higher prevalence of ACEs than the other nationally representative sample.

Table 3.2
ACE prevalence by country
(Adapted from McCutchen et al., 2022)

Type of ACE	Irish participants	USA participants
Any ACE	65%	61%
Emotional abuse	36%	21%
Physical abuse	27%	16%
Sexual abuse	16%	16%
Emotional neglect	30%	18%
Physical neglect	10%	17%
Parental separation or divorce	20%	5%
Exposure to parental domestic violence	13%	34%
Household alcohol misuse	25%	12%
Household mental illness	23%	16%
Household member imprisoned	7%	8%

Wales

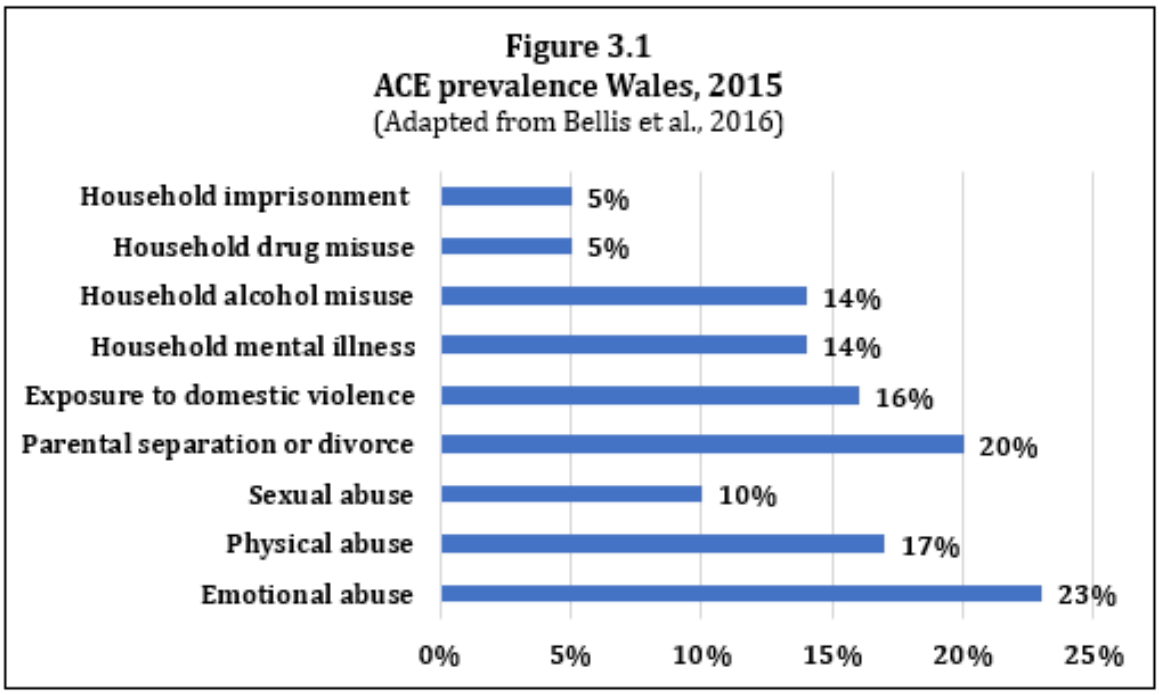
ACE prevalence data from the Welsh ACE study conducted by Bellis et al. (2016) to establish the prevalence of ACEs and the relationship between adversities during childhood and the adoption of subsequent health-risk behaviours in the Welsh adult population also provides interesting results. This study was undertaken with 2,028 adult participants, 1,009 males (49.75%) and N=1,019 females (50.25%) aged 18-69 years, during a three-month timeframe in 2015. As part of the study, face-to-face interviews using a validated research survey were conducted by individuals from a market research company and researchers from Public Health Wales and John Moores University (Bellis, 2016). Administering the survey to participants involved these individuals being assigned a random starting address within a housing area in Wales and knocking on individual doors. Once prospective participants answered their doors,

the interviewers provided them with a letter from Public Health Wales outlining the purpose of the study and how their information would be used. If prospective participants met the inclusion criteria of being residents in the home, aged 18-69 years, and had the cognitive capacity to participate, they were invited to participate in the interview (Bellis et al., 2016). Please refer to Table 3.3 for an overview of participant socio-demographic information).

Table 3.3
Participant socio-demographic information
(Adapted from Bellis, 2016)

Gender		
Male	49.8% (N=1009)	49.6% (N=1,012,433)
Female	50.2% (N=1019)	50.4% (N=1,028,135)
Age		
18-29	30.4% (N=617)	23.9% (N=487,274)
30-39	14.2% (N=287)	17.1% (N=349,286)
40-49	17.8% (N=360)	20.8% (N=423,900)
50-59	17.5% (N=355)	19.7% (N=401,040)
60-69	20.2% (N=409)	18.6% (379,068)
Deprivation quintile		
1[a]	21.7% (N=441)	19.8% (N=404,334)
2	19.4% (N=394)	25.8% (N=527,384)
3	19.4% (N=393)	15.4% (N=314,271)
4	18.7% (N=380)	20% (N=407,730)
5	20.7% (N=420)	19% (N=386,849)
Ethnicity		
White[b]	96.6% (N=1933	95.6% (N=1,943,973)
Asian[c]	3.5% (N=69)	4.5% (N=89,539)

Although the researchers conducted part of the survey face-to-face with respondents in their homes, they did not verbally administer the survey questions. Instead, during interviews, participants who consented to complete the survey questions were provided with the option of self-completing a paper version or inputting responses on a computerised version on the laptop brought by the researchers (Bellis, 2016). The ACE component of the survey included two of the original survey categories, child maltreatment (emotional, physical, and sexual abuse) and household dysfunction (household alcohol and drug misuse, parental separation or divorce, exposure to domestic violence, household mental illness and imprisonment of a family member) (Bellis, 2016). The study, however, rephrased the questions to ask about physical abuse and neglect and emotional abuse and neglect collectively.



Two age cohorts were overrepresented within the study. These included those aged 18 to 29 and 60-69. Results also indicate an overrepresentation of participants from higher socioeconomic areas within Wales. The study divided participants' ACEs into four categories. These categories included those with no ACEs (N=1103), those with one ACE (N=385), those with two or three ACEs (N=264) and lastly, those with four or more ACEs (N=276). Population analysis of the data was striking as it concluded that ACEs were prevalent for just under half the adult population in Wales. Results indicated that for every one hundred Welsh adults, 47% would report experiencing some form of childhood adversity. This percentage represented 20% reporting one ACE, 13% reporting two or three ACEs, and 14% encountering four or more adversities during childhood (Bellis et al., 2016). A breakdown of the estimated prevalence by ACE type is illustrated in Figure 3.1.

Similarly to the original ACE study, Bellis et al. (2016) established that health-risk behaviours were particularly prevalent for participants who reported four or more ACEs (as illustrated in Figure 3.2). The authors of the Welsh ACE study concluded that results affirmed the need to take a proactive approach to prevent, intervene in and respond to ACEs at a national level. They further stressed that the Welsh government should increase awareness of ACEs and their potential negative impact on children's economic, health and social outcomes. Of particular interest to the current study was the recommendation that ACE education should be prioritised for professionals whose

work could prevent ACEs or ameliorate their impact on the Welsh population. The authors referenced professionals working with families and those engaged in early childhood education services (Bellis, 2016).

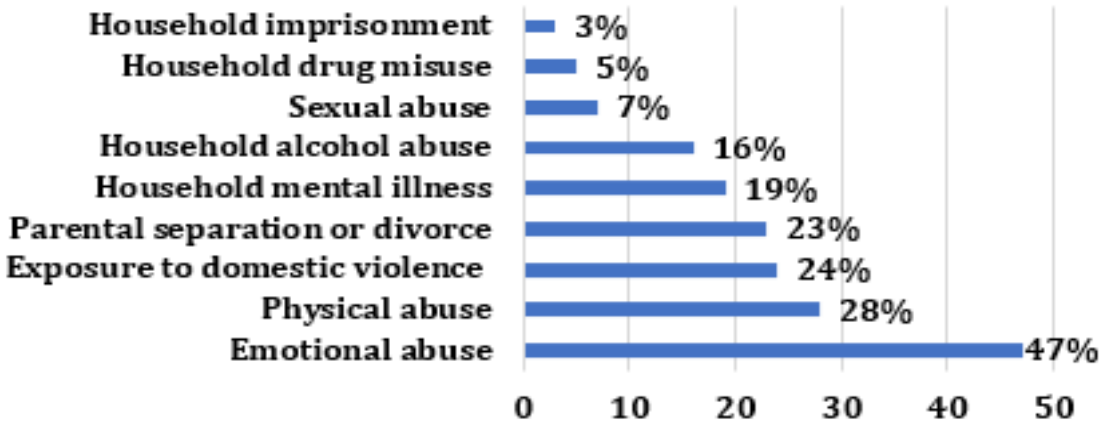
Figure 3.2
When compared with people with no ACEs, those with 4+ ACEs were:
Adapted from Bellis et al. (2015:5)

4 times more likely to be a high-risk drinker
6 times more likely to have had or caused unintended pregnancy
6 times more likely to smoke e-cigarettes or tobacco
6 times more likely to have sex under the age of 16 years
11 times more likely to have smoked cannabis
14 times more likely to have been a victim of violence during the preceding 12 months
15 times more likely to have committed violence during the previous 12 months
16 times more likely to have used crack cocaine or heroin
20 times more likely to have been incarcerated at any point in their lifetime

Scotland

In 2019, Scotland also included ACE research measures as part of its national Scottish Health Survey (SHeS) (McLean and Wilson, 2019). The SHeS is a yearly survey which provides information about the health of individuals living in non-institutionalised settings within Scotland. The rationale for the survey is to effectively monitor and respond to health concerns in Scotland (Scottish Government, 2022). Participants in the SHeS are selected via random sampling. In 2019, 6,451 addresses were selected using a multi-stage stratified design (McLean and Wilson, 2020). Multi-stage stratified design is a sampling method that divides large populations into smaller groups (Sedgwick, 2015). All individuals over 18, residing in randomly selected addresses, were eligible to answer the ACE section of the survey. The number who participated in the survey was 4,903 adults.

Figure 3.3
Prevalance of ACEs SHeS 2019
Adapted from McLean and Wilson (2020)



Unlike the Welsh survey administration approach, participants in SHeS were not provided with a computerised version of the ACE research measures. Instead, they were given a paper copy to self-complete (McLean and Wilson, 2020). The ACE research measures used in the SHeS included questions relating to physical abuse, emotional abuse, sexual abuse, household imprisonment, household substance misuse (drug and alcohol), household mental illness, parental separation and divorce and exposure to domestic violence. The SHeS survey determined that 71% of adults in Scotland had experienced one ACE or more. The exact breakdown of the number of ACEs reported was as follows: no ACEs (29%), one ACE (26%), two to three ACEs (31%) and four or more ACEs (15%). These results concluded that one in seven Scottish adults had experienced four or more ACEs. The breakdown of ACEs experienced by percentage is outlined in Figure 3.3. Results indicate that emotional abuse was the most common ACE reported by Scottish adults (47%), and the most uncommon ACE was the imprisonment of a household member (3%).

Participant's level of educational attainment in the Scottish survey ranged from 15% who had no educational qualification, 5% who obtained some level of education, 18% who had achieved a standard grade in secondary school, 16% had obtained a higher grade or equivalent, 17% progressed to obtain a Higher National Certificate or Diploma and 28% had a university degree or higher. The study found a correlation between educational attainment and the number of ACEs. It determined that adults with four or more ACEs were less likely to have attained a university

qualification. Similarly to the Welsh ACE study, the SHeS also examined the correlation between ACEs and the socioeconomic profile of the residential areas where participants lived (Please refer to Table 3.4). Results were similar for participants with no ACEs, ranging from 27% in the most deprived area to 30% in the least. Those with one ACE ranged from the minimum percentage of 22% in the fourth and fifth most deprived areas to 27% in the least deprived. As the ACE number increased, the variances in percentages became higher. Adults in the most deprived socioeconomic areas had a higher percentage of four or more ACEs (20%) when compared with adults in the least deprived area (11%) (McLean and Wilson, 2019).

Table 3.4
ACE count, 2019, by area deprivation and sex
(Adapted from McLean and Wilson, 2020)

Base: Aged 18 and over		*2019*				
		Scottish Index of Multiple Deprivation				
		5th (Least deprived)	4th	3rd	2nd	1st (Most deprived)
Number of ACEs		%	%	%	%	%
All adults	0	30	30	28	29	27
	1	27	29	27	22	22
	2-3	32	26	32	32	31
	4 or more	11	15	13	17	20

ACE prevalence in child participant cohort in the USA

Literature concerning ACE prevalence studies for children in Ireland or the UK could not be identified. There was, however, an ACE population study concerning the prevalence of ACEs in children living in the USA. Crouch et al. (2019) examined the prevalence of ACEs for children in the USA and whether there was a correlation between ACEs and the child's socio-demographic characteristics. The study involved a cross-sectional analysis of data from an online and mail survey completed in 2016. This survey was called the National Survey of Children's Health (NSCH) and was conducted by the Data Resource Center for Child and Adolescent Health (DRC). The study used survey data provided by the parents of 45,287 children. Eligibility inclusion for the study specified that parents or caregivers had to reside in a home with at least one child

at the time they completed the survey (Crouch et al., 2019). The ACE research measures used in this study differed from the original. They did not include measures concerning child maltreatment or neglect (Please refer to Table 3.5 for an overview of study results and participant socio-demographic information).

Table 3.5
ACE prevalence and participant socio-demographic information
(Adapted from Crouch et al., 2019)

Gender	
Male	50.8%
Female	49.2%
Age	
5 years or younger	32.5%
6-12 years	39.3%
Race/Ethnicity	
Non-Hispanic White	53.8%
Non-Hispanic Black	12.2%
Hispanic	23.2%
Hispanic (Other)	10.7%
ACE prevalence	
Parental separation or divorce	21.9%
Death of a parent or guardian	2.9%
Household imprisonment	7.0%
Exposure to domestic violence	5%
Household mental illness	7.1%
Household drug or alcohol misuse	8.1%
Exposure to neighbourhood violence	3.3%
Treat unfairly due to race/ethnicity	3.3%
Economic hardship	22.5%

Instead, the study focused primarily on household problems (parental separation or divorce, parental death, exposure to domestic violence, household mental illness, household substance misuse and household imprisonment) and community dysfunction (witnessing neighbourhood violence, racial/ethnic mistreatment, and economic hardship). Results indicated parents' most commonly reported ACEs concerning their children were parental separation or divorce (21.9%) and economic hardship (22.5%). Living in a household with alcohol or drug misuse was experienced by 8.1% of children, and just over seven per cent (7.1%) of children had lived in a home where an adult was mentally ill. Five per cent of children had been exposed to domestic violence, whilst exposure to neighbourhood violence and being maltreated due to race or ethnicity was reported for only 3.3% (Crouch et al., 2019).

Kerker et al. (2015) conducted a study using cross-sectional analysis of a nationally represented sample of children engaged with child welfare services in the USA. Using pre-existing data from the 2008-2009 wave of the National Survey of Child and Adolescent Well-being II survey, the study examined the prevalence of ACEs for parents and caregiver reports of 912 children aged 17-71 months who were not in out-of-home care. In addition to ACE prevalence, the study also set out to establish if there was a relationship between chronic medical conditions, mental health, social development, and ACEs for children engaged with the child welfare system. The study compared social worker and caregiver child welfare and protection concerns against a ten-item ACE survey. The questions in the survey related to the three ACE categories of child abuse, neglect and household dysfunction. Results determined that most children (98.1%) had at least one ACE. Of that percentage, 7.7% had one ACE, 39.9% had 2-3 ACEs, and 50.4% of parents and caregivers reported that their child had four or more ACEs. The mean number of ACEs reported for children attending child welfare services was 3.4. Emotional abuse (78%) and physical abuse (70.8%) were the most common ACEs reported for children. Sexual abuse was the least reported ACE (7.6%). Emotional neglect accounted for 10.6% of reported ACEs, and over half of the children encountered physical neglect (53.5%). The household dysfunction ACEs reported for children included exposure to domestic violence (49.8%), parental separation or divorce (26.7%), household substance misuse (22.2%), imprisonment of household member (10.5%) and household mental illness (10.5%) (Kerker et al., 2015). The next section will review the literature concerning the increased policy and professional interest in ACEs since the dissemination of the first study results.

3.4 Increased professional and policy interest in the ACE evidence base

Since the findings of the original ACE study were published, ACEs have been widely promoted as a critically important public health discovery (Stevens, 2012). Given the attribution of such importance, it is not surprising that ACEs have become a buzz term in global health and social care settings. Professional and policymaker interest in ACEs in the USA has grown steadily since the original ACE study, with a marked acceleration in the increase in interest in recent years. Based on the success of the first ACE study, the CDC added an ACE survey to the Behavioural Risk Factor Surveillance System (BRFSS) in 2009 (Ports et al., 2020). The BRFSS is a system coordinated by the CDC to collect health-related data about residents across fifty states in the USA. The BRFSS

involves continuous data collection with an adult population of eighteen years or more living in households (Prewitt, 2020). The system collects this data via implementing telephone surveys relating to health-risk behaviours, chronic health conditions, and engagement with health and preventative services. The BRFSS was introduced in 1984 and initially collected data from fifteen states within the USA. Since its inception, the BRFSS has expanded to collecting data in all 50 states, the District of Columbia, and three US territories. As part of the system, 400,000 telephone surveys are conducted yearly (CDC, 2014).

Several research measures on the BRFSS are optional for each state to implement. The ACE survey, when first introduced, was one of these optional measures (Ports et al., 2020). As discussed in chapter 2, subsequent implementation of the ACE research measures led to adaptations (Steptoe et al., 2019). The BRFSS made significant adaptations (Marks, Mokdad and Town, 2020; Ports et al., 2020). It reduced the original twenty-eight-item ACE research questions to an eleven-item survey and omitted questions relating to experiences of neglect during childhood. (Please refer to Table 3.6 for an illustration of the BRFSS ACE survey). Interestingly, the literature does not account for the rationale behind the BRFSS excluding the original ACE neglect category. From 2009 to 2022, the inclusion of the survey as part of BRFSS within individual American states has grown exponentially (Port et al., 2020).

Table 3.6 **BRFSS ACE survey questions** (Adapted from Ports et al., 2020)		
1.	Did you live with anyone who was depressed, mentally ill or suicidal?	Household dysfunction
2.	Did you live with anyone who was a problem drinker or alcoholic?	Household dysfunction
3.	Did you live with anyone who used illegal street drugs or who abused prescription medications?	Household dysfunction
4	Did you live with anyone who served time or was sentenced to serve time in prison, jail, or other correctional facility?	Household dysfunction
5.	Were your parents separated or divorced?	Household dysfunction
6.	How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?	Household dysfunction
7.	Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	Physical abuse
8.	How often did a parent or adult in your home ever swear at you, insult you, or put you down?	Emotional abuse
9.	How often did anyone at least 5 years older than you or an adult ever touch you sexually?	Sexual abuse
10.	How often did anyone at least five years older than you or an adult, try to make you touch them sexually?	Sexual abuse
11.	How often did anyone at least 5 years older than you or an adult, force you to have sex?	Sexual abuse

Currently, forty-nine of the fifty states in the USA are using ACE research measures as part of their BRFSS. Figure 3.4 shows the states collecting ACEs data in 2009. Figure 3.5 shows the states from 2009-2020. Notably, in Figure 3.4, the states marked in white (those not collecting ACEs data) in 2009 have reduced from forty-four to just one by 2022. Both of these illustrations have been extracted directly from the ACEs Connection website. This website was established in the USA as a forum for exchanging ACE knowledge and expertise. The ACEs Connections (2022) website notes that visits to the page' *increased from a few hundred a month in 2012 to between two million and five million a month by the end of 2019'*. This significant increase in numbers demonstrates the growing interest in ACEs. The next part of this chapter will examine the governmental responses to the ACE evidence base within the UK and Ireland.

Figure 3.4
ACEs Data collected across the USA in 2009
(ACEs Connection, 2022)

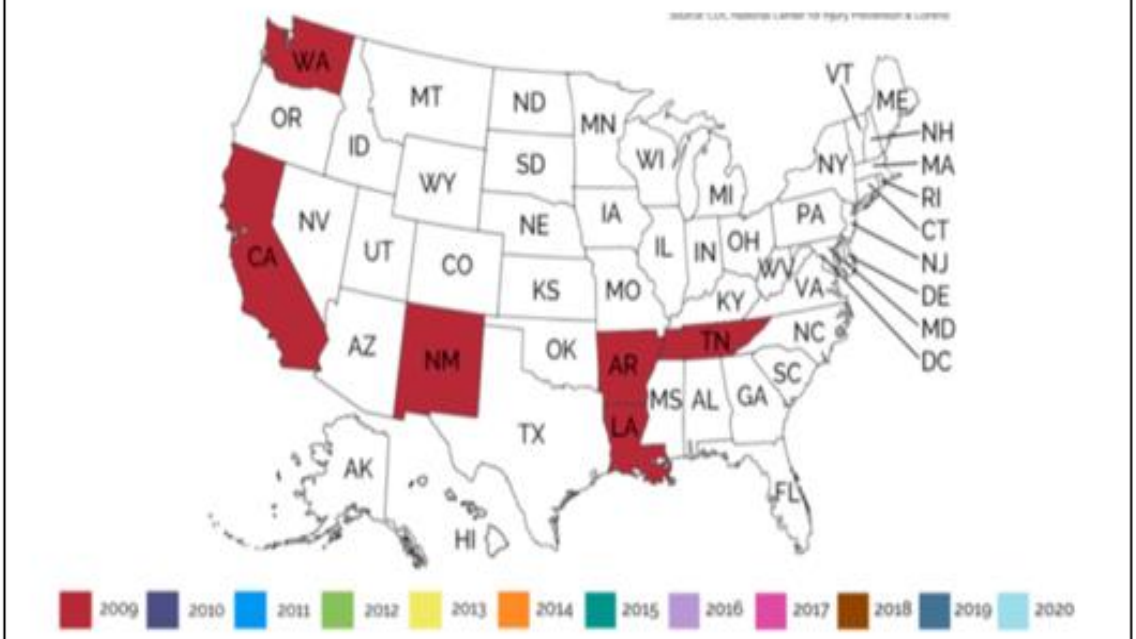
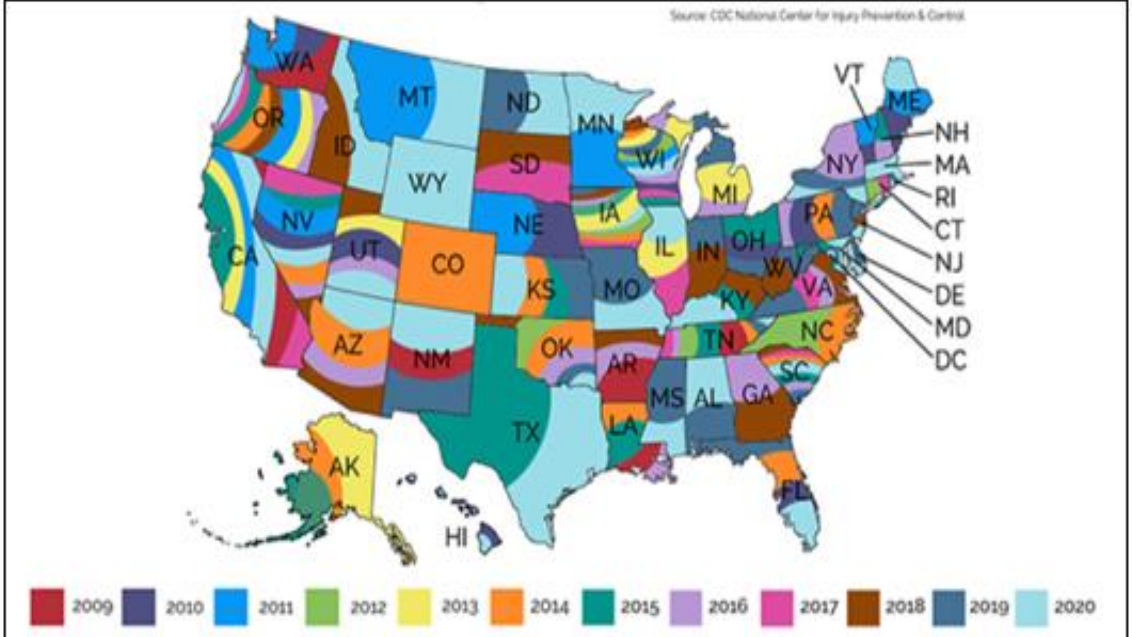


Figure 3.5
ACEs Data collected across the USA from 2009-2022
(ACEs Connection, 2022)



The influence of the ACE evidence base in England

Although ACEs have not yet influenced legislation in England, there is evidence that the matter has been given some political consideration. The House of Commons Science and Technology Committee enquired into evidence-based early intervention and ACEs. The enquiry specifically focused on the strength of the evidence linking ACEs with long-term negative outcomes; the evidence base for related interventions; whether the evidence was being used effectively in policy-making in England, and an exploration of the oversight and support for research in this area (Molloy and McBride, 2017). The findings of this inquiry were published in November 2018. Overall, it identified ACE literature as central to supporting the need for early intervention (House of Commons Science and Technology Committee, 2018).

English academics and professionals from several related sectors have also contributed significantly to the ACEs evidence base with research studies (Asmussen et al., 2020; Lewer et al., 2020; Bellis et al., 2014; Larkin and Cairns, 2020). Examples of this are studies by Lewer et al. (2020), who used data from police, social service, schools, and population statistics to map ACEs in England, and Bellis et al. (2014), who surveyed a national adult representative sample of the English population to investigate the relationship between ACEs, resilience, and health-risk behaviours. Publications of this type, however, are not the only evidence of the importance of responding to ACEs in England. ACE-based projects and interventions have also garnered interest and approval from funding bodies. The Health Foundation (2023) is an independent charity committed to ensuring improved health and awards funding to Public Health Organisations and community-based organisations within the UK. One of the applications submitted by the foundation which secured funding was for a project titled, '*Creating ACE-informed places: promoting a whole-system approach to tackling Adverse Childhood Experiences in local communities*'. The project aims to promote a whole-system approach to tackling ACEs in local communities to prevent and intercept the impact of ACEs with particular emphasis on prevention and early intervention.

There are also indications that the ACEs evidence base is being integrated into service provision in England. An example is the Department of Health and Social Care asking the Lancashire Care Foundation Trust in Liverpool to develop an implementation pack to support services to enquire about ACEs. This request resulted in the Routine Enquiry About Adverse Childhood Experiences implementation pack (REACH). This pack was subsequently adopted across heath and social care services

in Lancashire.

The influence of the ACE evidence base in Wales

Developments across Wales provide an excellent example of increased professional and policy interest in the ACE evidence base. Wales has been at the forefront of ACE research (Bellis et al., 2016; Ashton, Bellis and Hughes, 2016). This research has not only focused on establishing the prevalence and impact of ACEs via undertaking population studies, but researchers in Wales are also leading the way in exploring and identifying the ameliorating factors that help to reduce the effects of ACEs across the life span (Hughes et al., 2018). The Welsh government used this research to justify the establishment of ACE-Aware Hubs. The ACE-Aware Wales website defines the purpose of these hubs is to facilitate 'Sharing information and knowledge about ACEs; sharing evidence about what organisations can do differently to help prevent and mitigate ACEs; developing knowledge and skills among professionals; learning from one another, and sharing information that leads to action and driving change by challenging ways of working, throughout Wales' (ACE-Aware Wales, 2023). The ACE-Aware Hubs not only build awareness about what ACEs are and their potential negative outcomes but also emphasise ways in which the negative impacts can be countered.

Wales has also been at the forefront of social media campaigns to increase understanding of ACEs. An example is the widespread dissemination of a video titled *'Adverse Childhood Experiences Wales'* in 2007 by Public Health Wales and Blackburn with Darwen Local Authority. This video aimed to raise public awareness of ACEs, their potential to damage health across life, and different agencies' roles in preventing ACEs (Public Health Network Cymru, 2018). This video has had over 151,000 views on YouTube.

The influence of the ACE evidence base in Scotland

As with Wales, Scotland has also developed a video for circulation on social media. This video, titled *'Adverse Childhood Experiences – We need to make Scotland a better place to grow up*', has had 166,000 views (Public Health Scotland, 2019). The Scottish government has used the ACE evidence base to inform its Programme for Government (NHS Scotland, 2018). Comparably to Wales, Scotland also established an ACE hub. This

hub collaborates with the government and health and social care organisations to promote understanding of ACEs. The hub also sets out to contribute to developing an evidence base for ACEs to further inform policy and practice approaches to preventing and mitigating adverse outcomes (Scottish Government, 2018). ACEs have become a recognised consideration for the Scottish government in health and social care policy development. The Scottish Public Health Network' *Polishing the Diamond' Addressing Adverse Childhood Experiences in Scotland Report'* by Couper and Mackie (2016) explored ACEs with implications for various policy issues, including prevention, the importance of building resilience, the economic impact of ACEs and the further scope for addressing ACEs in Scotland.

The influence of the ACE evidence base in Northern Ireland

In Northern Ireland, the ACE evidence base was central to a successful application to the European Union for a cross-border ACEs project submitted in response to a funding call from INTERREG (Department of Health Northern Ireland, 2023). The evidence base was employed by policymakers and health and social care professionals to support their proposal to fund a cross-border project between Ireland and Northern Ireland. INTERREG is one of the critical instruments of the European Union, encouraging cooperation across borders through funding projects. It aims to collaboratively address common obstacles and develop shared approaches in health, environment, research, education, transport, sustainable energy and more (INTERREG, 2020). The project was awarded 5-million-euro funding for the cross-border *MACE (Multiple Adverse Childhood Experiences) Breaking the Cycle – Children's Services Project.* This project is a cross-border collaboration between the Southern and Western Health and Social Care Trusts, the Health and Social Care Board and Public Health Agency in Northern Ireland and the Health Service Executive and Tusla Child and Family Agency in the Republic of Ireland (CAWT, 2018). The MACE project has established five cross-border community networks. It aims to use those networks to dramatically improve the lives of children and families by identifying their encountered ACEs, providing early intervention for ACEs, and ensuring nurturing support in their communities and homes. The project delivers universal, targeted and specialist approaches to ACEs (Department of Health Northern Ireland, 2023).

Northern Ireland has utilised the ACEs evidence base somewhat differently than other UK jurisdictions. The primary difference is that Northern Ireland has used the evidence base to highlight the importance of developing trauma-informed policies. In 2017, the Northern Irish Department of Health announced the provision of 1.5 million pounds to facilitate the cross-departmental Early Intervention Transformation Programme (EITP). The purpose of this programme is similar to that of Wales and Scotland. It sets out to educate professionals about ACEs; however, it differs in that it aims to equip them with the skills and understanding of how to recognise and respond to trauma (as a result of exposure to ACEs) where appropriate (SBNI, 2020). This SBNI developed trauma-informed training, which it now facilitates with professionals across health, social care, housing, justice and the community and voluntary sectors (SBNI, 2020). As with the Scottish and Welsh responses, the SBNI has also identified social media platforms to disseminate ACEs information. They produced and released a video animation about ACEs. This video details the impact of ACEs on a fictitious Northern Irish teenager named Joe (ESC Films, 2020).

The influence of the ACE evidence base in Ireland

Unfortunately, the literature suggests that the ACE evidence base has yet to influence government decision-making in Ireland directly. After an extensive search, the only evidence of partial ACE consideration on behalf of the Irish government was the Irish statutory child protection and welfare agency, Tusla's involvement in the INTERREG MACE project (INTERREG, 2020).

3.5 The integration of the ACE evidence base in social care organisations

As mentioned in chapter 1, the scoping literature review by Ford et al. (2019), to examine the evidence base for routine ACE enquiry, established that most literature related to research conducted in clinical and not social care settings. The data for this study was gathered via a literature search of three research databases (CINAHI, MEDLINE, and PsycINFO). This scoping literature review set out to identify journal articles about ACE enquiry and the acceptability of enquiry about ACEs in any setting. The authors of the scoping literature review set a timeframe parameter for articles published between 1997 and the end of April 2018. The initial literature search identified 380 articles, of which 15 met the criteria and were examined by the authors. The scoping literature review established that the focus of the ACE evidence base was

concentrated on routinely asking about ACEs; the prevalence of ACEs in specific populations; the types of health-risk behaviours adopted by these populations; the impact of routinely enquiring about ACEs on professionals and SUs, and identifying the types of negative health outcomes that these populations experience. Ford et al. (2019) further found limited research on what services were doing to respond to ACEs after enquiry. This finding suggests that examples of using the ACE evidence base to prevent, intervene in, and respond to ACEs remain largely unknown.

Despite this gap, the literature suggests that the concepts of resilience and trauma have been adopted to bridge the gap between ACE research and how this may inform service delivery (Spratt and Kennedy, 2019). Spratt and Kennedy (2019) describe the development of resilience and trauma-aware services and affirm that the increased interest in ACEs has resulted in social care services adopting trauma and resilience-informed responses. While they acknowledge the importance of these responses in informing interventions to ameliorate the negative outcomes associated with adversities during childhood, the authors caution against services ignoring other essential considerations. They outline these considerations as the need for services to conduct research to determine what interventions and service provision conditions are effective to minimise ACEs and reduce the impact for SUs who encounter negative outcomes (Spratt and Kennedy, 2019).

3.5.1 Implementation of the ACE survey in social care settings

As mentioned, the original ACE study was undertaken in a clinical setting (Felitti et al., 1998), with many of the subsequent studies having been completed by clinicians (Albaek et al., 2018; Sun et al., 2017; Duke and Borrowsky., 2018; Hillis et al., 2004; Szilagyi et al., 2016). Therefore, it is unsurprising that the literature primarily reports on how the ACEs evidence base is used in these settings. It is, however, essential to acknowledge that the majority of this literature focuses on the routine enquiry about ACEs, identifying the health-risk behaviours associated with ACEs, exploring the negative health and later life outcomes and the education and perception of professionals in response to undertaking routine enquiry (Szilagyi et al., 2016; Ford et al., 2019; McDonald et al., 2019; Read and Mayne, 2017). However, the literature suggests that some social care organisations are also introducing routine ACE enquiries (Bethell et al., 2017; Counts et al., 2017; Larkin and Records., 2006).

A report by Quigg, Wallis and Butler (2018) provides an example of routine ACE survey implementation within social care. This report detailed an evaluation of a pilot study on implementing Routine Enquiry about Childhood Adversity (REACh) in three services in Lancashire in the UK. These services included a Child and Adolescent Mental Health Service (CAMHS), a sexual violence support service and a drug and alcohol service. The routine Enquiry about Adversity in Childhood (REACh) implementation training programme was developed by Lancashire Care NHS Foundation Trust (LCFT). The rationale for developing the REACh programme was to deliver ACE implementation training, increasing service providers' knowledge of ACEs' potential negative impact on adult health and social outcomes across the lifespan. It was also created to increase routine enquiry about ACEs in SU assessments (Quigg, Wallis and Butler, 2018). Results from this study will be discussed under several headings within this chapter.

Although literature concerning the implementation of routine ACE enquiry in Ireland is lacking in both health and social care contexts, there is some evidence of social care organisations implementing routine ACE enquiry for research purposes. Examples include Lambert et al. (2017) and Morton and Curran's (2019) studies. The study by Lambert et al. (2017) examined ACEs and the relationship between childhood trauma and adversities and negative events for adult SUs availing of support from a homeless service in Cork. The study aimed to establish the prevalence of ACEs, assess the service provider's ability to provide Trauma Informed Care (TIC) and establish if the findings had implications for clinical and non-clinical interventions for homeless services. As part of the study, participants (N=50) were asked to complete ten ACE measures. These measures included the three conventional ACE categories as follows, child maltreatment (emotional, physical, and sexual), child neglect (emotional and physical) and household dysfunction (parental separation or divorce, exposure to domestic violence towards mother, household mental illness, household substance and alcohol misuse). The results of implementing the survey determined that ACEs were significant in the research population. The mean ACE score for participants was 5.15, and 77.6% (N=39) reported an ACE score of four or more.

Morton and Curran's (2019) study examined a pilot routine ACE enquiry project within a domestic violence service. The study's main objective was to develop organisational and professional responses to ACEs. Participants in the study included staff members (N=14) and SUs (N=60). It involved staff members asking participants

the survey questions. The survey questions administered were similar to those used in the Lambert et al. (2017) study. The only difference was that participants were asked about exposure to domestic violence within the household instead of maternal domestic violence. The study results determined that ACEs were significant for participants availing of support from the domestic violence service. Overall, 82% (N=49) reported one or more ACEs. Over half of the participants (58%/N=35) reported two or more ACEs, and one-third (33%/N=20) experienced four or more. The prevalence of ACEs was higher than that of the general population samples accessing general health-related services (Morton and Curran, 2019). Given that this study also examined professionals' experience of routine ACE enquiry, this study will be revisited later in this chapter.

3.5.2 The need for ACE awareness in social care organisations

Emphasis on the need for specific professions within the social care sector to be introduced to the ACEs evidence base and integrate this into their practice is also evident in the literature. A literature review undertaken by Spratt (2011) to examine families with multiple problems, and the challenges associated with identifying and experiencing adversities across the lifespan, emphasises some necessary changes for social work practice. The author argues that the main issue for social workers in integrating knowledge of ACEs into practice is that it will challenge their perception of the causes and consequences of child maltreatment, which tends to focus on immediate risks with a priority to mitigate these. According to Spratt (2011), integrating the ACE evidence base would necessitate a significant shift in perception. Social workers would need to see child maltreatment in the context of multiple risk factors and probable negative outcomes over the longer term. Spratt postulates that children who experience one adversity are more likely to encounter others. As a result of cumulative ACEs, these children are more at risk of being disadvantaged. Therefore, Spratt (2011) affirms that their needs are more complex and should not be viewed under singular domains such as child maltreatment (Spratt, 2010). Spratt suggests that understanding the impact of adversity during childhood would provide social workers with a valuable opportunity to address multiple risk factors impacting children and families rather than focusing primarily on resolving or modifying specific behaviours associated with child maltreatment (Spratt, 2010).

Although the literature is lacking for ACE prevalence studies specific to social care organisations, there is some indication that individuals who encounter higher numbers of childhood adversities may have a greater need for the services they offer. A systematic literature review and meta-analysis by Liu et al. (2021), which examined ACEs and their impact on outcomes for adults experiencing homelessness in the USA, Canada and the UK, determined that childhood adversities were substantially more pronounced for homeless adults when compared with general populations. The review identified 2129 studies through systematic search, of which 29 studies (16,942 individuals) met the criteria for inclusion in the meta-analysis. The studies pertained to adults experiencing homelessness in the USA, Canada, and the UK. Participants were predominantly male and aged between 18 to 58 years. Of the participants included in the studies, 89·8% reported at least one ACE, and 53·9% reported four or more. The literature review established that homeless adults with four or more ACE scores were more likely to be impacted socially by mental health, incarceration, substance misuse, physical abuse, verbal abuse and intimidation issues. An article by O'Malley, Devaney and Millar (2022) draws attention to how the adversity experiences of incarcerated mothers' in Ireland impacted mothers' parenting experiences. The authors of this study implemented a mixed-method participatory research approach with mothers in prison. The study determined that the adversities and trauma experienced by the mothers during childhood and adulthood were identified as contributing to addictive and criminal behaviours. The mothers in the study recounted their experiences of being parented during childhood and how their trauma and adversities led them to adopt maladaptive coping strategies. Participants described how parenting with addiction issues was challenging and how some of their children had ended up in the care of child protection and welfare services. This study suggests that in some circumstances, those with ACEs may be more inclined to come to the attention of child protection and welfare services due to the social impact of their maladaptive coping strategies on their parenting or as a consequence of their being imprisoned and being unable to care for their children physically.

An interesting observation from the literature is the recognised importance of professionals working with young children in supporting families. The literature also extends to the need for professionals in social care to become ACE-aware because of the important role they can play in helping to prevent and intervene when childhood adversities occur. A study by Eismann et al. (2020), which examined the feasibility of

the Strengthening Families intervention in helping childcare providers support families with ACEs, stressed that the regular contact professionals working with children have with families provide them with vital opportunities to intervene in times of stress. The researchers in this study introduced a project of professional development workshops and universal and targeted parenting interventions in ten licensed childcare programmes in the USA. The project aimed to determine how feasible it was for childcare providers to identify ACEs and ameliorate their potential negative impact by supporting families to strengthen and increase their protective factors. As part of the project, the parenting interventions included ACE screening, parent cafes, parenting workshops and motivational interviewing. As part of the study, 159 parents or caregivers completed the ACE survey questions. The study's findings determined that 60% of participants had experienced ACEs and that there was a correlation between parents' and caregivers' ACEs and the likelihood of their children reporting similar adversities. The authors of this study emphasise that consistent interaction with children and their parents as part of their role provides childcare professionals with opportunities to shape a child's cognitive, emotional, and social development. The authors further argue that regular contact results in these professionals quickly recognising families experiencing stress and its negative impact on children (Eismann et al., 2020). The literature suggests that early childhood educators can potentially intervene in ACEs.

3.5.3 Resilience and trauma-informed social care service provision responses

The literature relating to routine ACE enquiry has drawn attention to the fact that while some individuals encounter ACEs, it has also clearly established that not everyone with childhood adversities experiences negative life outcomes (Shaykhi et al., 2018). Cichetti (2010) stresses that recognising this fact is imperative for health and social care services. While acknowledging that ACEs can lead to poorer outcomes across the lifespan is evident in the literature, there has been a marked shift in recent years to consider why some people who experience ACEs do not experience such negative impacts. Crandall et al. (2019) coined the term *counter-aces* to refer to possible reasons people do not experience negative outcomes.

Crandall et al.'s (2019) study entitled, 'ACEs and counter-ACEs: How positive and negative childhood experiences influence adult health' defines counter-ACEs as positive childhood experiences that curb ACEs' risks and provide protective factors.

They list counter-ACEs as interpersonal connection; school engagement; familial warmth; extra-familial support; high parental education; high socioeconomic status; living in a two-parent family; having secure accommodation; high emotional support, and access to opportunities to develop resilience. (Crandall et al., 2019). The authors describe these resilience opportunities as exposure to positive relationships, interpersonal connections, and persistent school engagement. Furthermore, the authors affirm that counter-ACEs allow children to build resilience and that, in turn, this resiliency enables them to navigate adversity and achieve better outcomes. Given that resiliency has been identified as an ameliorating factor regarding the negative outcomes associated with ACEs, it is not surprising that some social care organisations are incorporating the concept of resiliency into service provision.

Leahy et al. (2014) evaluated a resiliency-based intervention in Australia. They evaluated the Resilient Families Intensive Family Support Service. They described this as an intervention offered to families in Sydney, Australia, where there were concerns about minors' safety and well-being (Leahy et al., 2014). They further explain that the Intensive Family Support Service aims to build resilience within these families by focusing on achieving the following outcomes: Increasing safety; ensuring secure and stable relationships; increasing self-efficacy; improving empathy; increasing coping skills and the ability to self-regulate emotions (Leahy et al., 2014). Leahy et al. (2014) determined that the intervention was helpful for families with complex needs. They, however, highlight that evaluating the intervention was difficult as its implementation was in its infancy. The implementation would need to be embraced on individual and organisational levels to ascertain the true impact of this resiliency-based work with families.

There is also a growing development in the literature, which stresses the importance of promoting trauma-informed approaches in response to ACEs (Krug et al., 2002). Knowing how to respond to SUs who have experienced trauma is essential in effectively addressing the impact of ACEs across the lifespan (Sweeney et al., 2016). However, some authors advise caution in this approach, reminding practitioners that trauma can be a personal perception and that sometimes practitioners' prejudices and interpretations about what they perceive trauma can cloud their judgement and responses (Reuben et al., 2016). Earls (2018) suggests that practitioners should resist labelling SUs as traumatised and instead focus on building resilience and coping skills to assist SUs in overcoming and addressing the negative outcomes associated with

their ACEs. Lamphere (2021) challenges the deficit discourse associated with the trauma-informed concept. The author emphasises that implementing the survey can be harmful in practice because the commonality of trauma-informed responses has resulted in professionals viewing individuals with ACEs as being 'traumatised'. Given that trauma can be viewed as a significant barrier to effectively managing and overcoming, Lamphere (2021) argues that professionals label individuals with ACEs as having deficits. In their paper considering trauma as a systemic problem in educational settings, Khasnabis and Goldin (2020) support this argument further with their perception that trauma-informed responses often retraumatise people with ACEs because they feel labelled or stigmatised by professionals.

Across the UK and Ireland, several services identify themselves as 'trauma-informed' rather than ACE-aware (Barnardos Ireland, 2019; Novas, 2023; Saol Project, 2023; NHS Herefordshire and Worcestershire Health and Care Trust, 2023). Despite Felitti et al.'s., (1998) affirmation that the original ACE study found that adversities during childhood were *potentially* traumatic experiences, some social care organisations interpret such adversities as *actual* traumatic experiences, generating the adoption of trauma-informed approaches. Sweeney et al. (2016) argue that adopting a trauma-informed approach does not mean that all professionals within a service need to know how to diagnose or treat SU trauma. Instead, they clarify that trauma-informed practices mean that their professionals recognise that SUs may have experienced trauma and that they know that coming in contact with services may be a triggering event for them. In addition, Sweeney et al. (2016) argue that becoming trauma-informed involves professionals within organisations shifting their viewpoint from asking 'what is wrong with this SU' to 'what has happened to them'. Intriguingly, the adoption of trauma-informed approaches by services has been criticised for entirely focusing on negative aspects of childhood and not providing a lens for professionals to recognise resilience or positive experiences (Leitch, 2017).

Table 3.7 ACE-ameliorating interventions in social care (Adapted from Asmussen et al., 2020)		
	Intervention	**Age range**
1.	Strengthening Families*	10-14
2.	Empowering Parents/Empowering Communities (EPEC)	2-11
3.	Level 4 Triple P Group & Standard	2-5
4.	Family Check-up for Children	2-5
5.	Helping the Non-Compliant Child	3-8
6.	Hitkashrut	3-5
7.	The Incredible Years Preschool Basic*	3-6
8.	The Incredible Years School Age Basic*	6-12
9.	Family Transitions Triple P	2-18
10.	New Beginnings	3-18
11.	Trauma-focused Cognitive Behavioural Therapy	2-18
12.	Multidimensional Family Therapy	10-18
13.	Child First	6-36 months
14.	Functional Family Therapy	10-18
15.	Multisystemic Therapy	12-17
16.	Multisystemic Therapy for Child Abuse and Neglect	6-17

3.5.4 ACE-ameliorating interventions

Since the dissemination of the original ACE study findings, ACE-ameliorating interventions have been reported in the literature. As discussed in chapter 2, Asmussen et al. (2020) published a report relating what was known about ACEs, gaps in the literature and how the ACE evidence base should develop. In this report, the authors draw attention to the fact that thirty-three ameliorating interventions have emerged from the ACE evidence base. They describe the search criteria for their identification as '*interventions with 'robust evidence of preventing at least one of 10 original ACE categories, reducing the health-risk behaviours associated with ACEs, and specifically reducing ACE-related trauma'* (Asmussen et al., 2020:14). The authors indicate that the identified interventions are from health, social care, and educational settings. They affirm that integrating these ACE interventions into public health strategies could help reduce ACEs' occurrence and counteract the associated negative impacts (Asmussen et al., 2020). Table 3.7 provides an overview of the social care interventions identified.

Interestingly sixteen of the thirty-three identified interventions are conducted in social care rather than clinical or educational settings. Of particular relevance to the current study is that the DoCCFS staff have training in three (those marked with an *) of the sixteen social care ACE-ameliorating interventions (DoCCFS, 2023).

3.6 Professional training in ACEs and ACE survey implementation

Unsurprisingly, asking people about childhood adversities can evoke significant anxiety and resistance among health and social care practitioners (Sziligyi et al., 2016; Anderson et al., 2015, Dube, 2018). Reflecting on the seminal ACE study, Felitti et al. (1998) emphasise the importance of practitioners building rapport with the SU before asking them about adversities experienced during childhood. Since the widespread publication of the original ACE study, other studies have repeatedly drawn attention to the paramount importance of the practitioner–SU relationship in the successful administration of the survey (Fordstadt et al., 2015; Selvaraj et al., 2019). However, ensuring positive engagement and building rapport with SUs does not always develop naturally for practitioners. Knowing when the right time is to ask about ACEs and how to respond appropriately must be facilitated via training for practitioners (Selvaraj et al., 2019; Counts et al., 2017).

The previously mentioned study by Quigg, Wallis and Butler. (2018), concerning the implementation of REACh, also examined the impact of training in the administration of routine enquiry. According to the researchers, the study found multiple positive outcomes of ACE training for practitioners. Primarily, the study established that training appeared to ameliorate practitioner resistance and concerns regarding asking about ACEs and responding to potential disclosures. In addition, it determined that practitioners felt that having access to trainers on-site made the implementation process less stress-provoking. Interestingly, some aspects of the training were also critiqued by practitioners. Quigg, Wallis and Butler (2018) highlight that some practitioners felt the training placed too much time and emphasis on detailing the original ACE study. Practitioners suggested that training should be pragmatic rather than theoretical. Practitioners called for training to focus on how they should administer the ACE questions and how they should respond to SUs. Practitioners wanted to know how to ask about ACEs in the best possible way so that their working relationship with the SU would not be damaged.

Professionals have identified a lack of ACE training as a barrier to asking about and discussing ACEs with those they care for (Bora et al., 2022). Findings from a cross-sectional study by Bora et al. (2022) exploring the variances in primary care providers (PCP) ACE training, knowledge, screening practices and observed intervention barriers in the USA are stark in this regard. Participants in the study included medical physicians and paediatricians in a not-for-profit health care service. This study determined that out of 72 participants, the majority (n=52) ranged from having no familiarity (n=27) or vague familiarity (n=25) with ACEs. Most participants (90.3%) reported having no formal ACE training. Given these results, it is unsurprising that a significant percentage of participants (52.8%) reported not screening patients for adversities during childhood. The study concluded that only 2.8% of participants used a validated ACE research tool to screen. In contrast to the lack of ACE knowledge and training reported by participants, the study findings suggest that when asked, 98.5% of participants believed they would benefit from training about ACEs. Participants further outlined that their preferred training approach would be attending a lecture about ACEs and participating in an ACE workshop. They also attributed importance to receiving ACE educational literature and providing online ACE training modules.

The literature suggests that several factors influence training effectiveness. One of the most important has been identified as the trainer's personality. A study by Margiono and Hanafi (2020), which considered the relationship between trainers' personality characteristics and their impact on participants' perceptions of training effectiveness, determined that personality attributes were significant. The findings of this study suggested that trainers' personality characteristics were essential to ensure participant engagement in the learning processes. This study was undertaken with 257 participants in training programmes in the largest business school in India. The study's findings determined that trainers with pleasant personalities developed positive learning relationships with participants, making them more open and motivated to learn. Similarly, a study by Ghosh et al. (2012), which considered how trainers' attributes resulted in more effective training, found that trainers perceived as being comfortable and knowledgeable about the training topic were better received. In addition, trainers who were warm, approachable, and open to answering questions were viewed as having a more positive rapport with professionals engaging in their training.

Another factor influencing training effectiveness is how participants process and retain the information they are exposed to during training. A study by Surr et al. (2020) which examined the barriers and facilitators to effective training for health and social care professionals, outlined that many factors influence participants' perceptions and recollections of training. The study determined effective training should employ interactive face-to-face learning to increase professional knowledge and skills. Additionally, the study affirmed that training must incorporate opportunities to apply the learning in practice. Introducing routine survey administration should invite practitioners with lived experience implementing the survey to come and speak with professionals.

A literature review by Surr and Gates (2017), which examined perceptions of effective dementia training for health and social care professionals, emphasises the importance of ensuring that the training content is specific to the worker's role and context. As part of the literature review, 152 papers were identified. These papers related to the perceptions of training nurses and staff held in care homes in the USA and the UK. The study's findings established that participants perceived the need for training to encompass information and skills that applied to their specific roles and setting. Participants in this study outlined the importance of implementing role-plays relevant to real-life practice scenarios for professionals.

Research relating to general training about ACEs for professionals, as opposed to survey implementation, is evident in the literature. Randall et al. (2020) evaluated the use of social simulation to teach occupational and physical therapy students about ACEs and trauma-informed care in the USA. Participants (N=26) completed the Professional ACEs Informed Training for Health (PATH) training model. This model is a training approach that implements scenarios to train students to recognise and respond to patients' ACEs. In addition to being ACE-informed, PATH also implements a trauma-informed training approach. The PATH model aims to equip students to talk with patients about their ACEs. It includes training in introducing the topic of ACEs, assisting the patient in seeing the relationship between childhood adversities and health-risk behaviours and conditions, and enabling professionals to engage patients in collaborative treatment planning and decision-making. The findings of this study demonstrate that participants' self-efficacy and knowledge about ACEs and trauma-informed care increased post-training. The results suggested that after completing the training, participants also acknowledged the significance of professionals discussing

adversity and trauma with patients effectively and in a supportive manner. After completing the training, participants recognised the importance of discussing ACEs with patients. Participants perceived that effective discussion of ACEs required additional training to engage in uncomfortable and difficult conversations, recognise trauma symptoms and primarily feel equipped to respond to patients for whom the questions may trigger emotive reactions.

The ACE survey was not originally intended as a diagnostic or assessment tool. It was designed to be a research instrument to assist services in understanding their SU populations and responding to their needs appropriately (WHO, 2018). Bethell et al. (2017) stress that the ACE research measures can be easily implemented across various settings, and, as a consequence, many service providers and organisations have implemented them. Predominantly, studies examining routine ACE enquiries have occurred with adult SUs within adult mental health, prenatal, housing and addiction services (Hillis et al., 2004; Dube et al., 2002; Larkin and Records, 2006; Read and Mayne, 2017) or; with parents of children in paediatric, primary care or family care hospital settings (Szilagyi et al., 2016; Brody et al., 2017; Kolta et al., 2018). The administration of the survey in most of these settings involved handing an envelope to adult SUs containing the survey and asking them to self-complete it (Selvaraj et al., 2019; Rose et al., 2016; Goldstein et al., 2019).

However, increased interest in ACEs has led to an expansion beyond just the implementation of the survey. Countries such as Wales and Scotland and regions like San Francisco within the USA are implementing similar ACE-informed approaches. These approaches involve all frontline health and social care workers, such as police, ambulance drivers, home visitors, general practitioners, public health nurses, paediatricians, etc., being trained in ACEs (Craig, 2017; Burke-Harris, 2018; Public Health Wales, 2019). The health and social care practitioners within these countries/regions do not routinely inquire about ACEs. The grounded objective of the ACE training is to ensure that all frontline practitioners know about ACEs and that they are aware of their roles and responsibilities in signposting SUs and assisting them with accessing both appropriate and helpful interventions (Craig, 2017; Burke-Harris, 2018; Public Health Wales, 2019).

3.6.1 The use of ACE-themed videos

ACE-themed videos, such as those discussed in chapter 2, have been implemented by health and social care providers in professional ACE training (Cork Education Support Centre, 2022; Trauma Matters Omaha, 2022; Children's Home Society of South Dakota, 2022). Given that they are being used to educate professionals about ACEs, it is surprising that the literature evaluating these videos is limited. Only one study could be identified that examined professionals' perceptions of a short-animated ACE film (Ford et al., 2021). The film involved in the evaluation was the ACE Wales video, available to the general public, entitled *'Adverse Childhood Experiences Wales'* (Public Health Wales, 2020). Ford et al. (2021) completed a short survey with 239 professionals to explore the relationships between their ACEs and their perceptions and attitudes about the film. Findings established that despite the film triggering feelings of sadness and upset for some participants (15.1%), most perceived it as positive in enabling them to discuss ACEs. Interestingly participants with an ACE score of four more were overrepresented in this finding. The number of participants reporting negative emotions increased with the ACE count (11.4% for those with no ACEs to 47.4% for those with an ACE score of four or more).

There is also evidence within the literature of videos designed for training professionals. Cribbs et al. (2020) assessed the video-based PATH training programme's use to address adversities during childhood with primary care medical students and occupational and physical therapy students' practice. As part of this training, students participated in a programme which involved an ACE and Trauma Informed Care (TIC) -based lecture and discussion about the importance of implementing ACEs as a consideration for patient care. The training also included a video simulation of professional ACE interactions and students practising implementation via roleplays, group feedback and evaluation of these roleplays, education about Secondary Traumatic Stress (STS) and discussion. STS refers to the emotional distress individuals experience when they hear personal accounts of trauma such as histories of abuse, childhood adversities, experiences of violence and natural disasters (The National Child Traumatic Stress Network, 2022). Although the study findings indicate that overall, students' abilities to discuss and explain ACEs with patients improved, it did not specifically explore how much of this improvement was related to the video simulation. The findings are limited as they are specific to

participants' experiences of the PATH training video and not to the use of other ACE videos in training professionals.

3.7 Conclusion

This chapter examined the literature on the evolution of routine ACE enquiry within social care organisations. In doing so, it critically considered literature on how implementing a social epidemiological research tool like the ACE survey transitioned to non-clinical settings. The chapter also reviewed the literature concerning how increased interest in the ACE survey manifested in governmental responses in the USA, Ireland and the UK. It also provided an understanding of training approaches adopted to enable social care professionals to implement the ACE survey. The next chapter will review the literature on the impact of routine ACE enquiry within social care organisations

Chapter 4

The impact of routine ACE enquiry in social care organisations

4.1 Introduction

This chapter examines literature relating to the impact of routine ACE enquiry within social care organisations. It begins by exploring factors influencing professional and SUs' experiences of routine ACE enquiry. Literature on how professional discomfort can impact survey administration and concerns about SU retraumatisation will be discussed. The chapter also examines the literature on SU and professional perspectives concerning routine ACE enquiry and the barriers reported by professionals in asking SUs about their childhood adversities. Literature relating to the impact of a professional's ACEs on their role and ability to implement routine ACE enquiry will also be outlined. The last section of the chapter discusses literature relating to organisational factors which can influence the implementation of routine ACE enquiry within a social care organisation. In particular, the literature presented in this chapter pertains to the organisational change process associated with introducing routine ACE enquiry. Literature concerning the role of organisational culture, professional emotions associated with organisational change and research considerations for social care organisations will also be examined.

4.2 Professional discomfort with ACE survey questions

Professionals have identified their discomfort in asking SUs about adversities experienced during childhood as a barrier to administering the survey. Several studies relating to ACE survey implementation outline findings of staff discomfort with asking survey questions (Mersky, Plummer-Lee, and Gilbert, 2019; Clark and Jones, 2022). Clark and Jones's (2022) study involving nursing practitioners and nursing students in the USA aimed to identify barriers to screening for ACEs in nursing practice. Findings established that some participants were reluctant to implement the survey because they did not feel equipped to address the topic of adversities experienced during childhood with parents. Participants attributed their reluctance to the fact that they had no qualifications or training which would enable them to verbally administer the ACE research measures and manage potential distress exhibited by patients in response to being asked about their childhood adversities (Clark and Jones (2022). In

their paper, *'Walking Children Through a Minefield: How Professionals Experience Exploring Adverse Childhood Experiences'*, Albaek et al. (2019) provide a detailed examination of the reservations held by professionals working in child and adolescent health and well-being services. Albaek et al. (2018) determined that professional reservations included the feeling of being ill-equipped to respond to ACE disclosures and the fear that asking about ACEs would cause further hurt to the child. In addition, the professionals described how they experienced significant emotional discomfort when asking about ACEs and that this discomfort led to them adopting avoidance behaviours regarding the routine ACE enquiry.

Similarly, the study noted previously by Quigg, Wallis and Butler (2018) to examine the implementation of REACh in the UK determined that professionals were not always enthusiastic about routine ACE enquiries. Results from the study indicated that professionals from Child and Adolescent Mental Health Services (CAMHS), in particular, noted that they were resistant to asking about ACEs because they were unsure how the knowledge could effectively support the SUs. Professionals in the sexual violence service advised reluctance to ask about ACEs until they had established a relationship with the SU. Professionals affirmed that they needed to ensure SUs had the resilience to cope with being asked the questions. They disclosed additional resistance due to the fear that asking about ACEs would lead to the retraumatisation of SUs.

As a result of the literature search for this study, a significant gap in the research was identified. Despite the identification of publications relating to professionals feeling ill-equipped to deal with disclosures of ACEs, there was no literature on how professionals with therapeutic training and who had the skill set to respond to SUs felt about administering the survey. Despite an extensive literature search, publications detailing the use of and attitudes to routine ACE enquiry by psychologists, counselling professionals, psychotherapists and trauma-informed therapists could not be identified. Presently, the ACEs evidence base does not include an understanding of how routine ACE enquiry is implemented and managed by these professionals. This gap in the research contributes to the rationale for the current study and will be elaborated on in the methodology chapter of this thesis.

There was evidence in the literature relating to discomfort reported by therapeutically trained professionals concerning mandatory reporting obligations arising from retrospective child maltreatment disclosures (Romme and Kirk, 2021).

Romme and Kirk (2021) conducted a study with humanistic integrative counselling supervisors in Ireland to examine the ethical dilemmas involved in retrospective child maltreatment reporting to statutory services. The study conducted qualitative interviews with five research participants who supervised therapists. The results established that retrospective disclosures were unsettling for the therapists they supervised. Participants described how the legal obligation associated with mandatory reported left therapists unable to offer their clients the time to process their disclosures. As mandatory reporting obligations stipulate that therapists must report retrospective disclosures as soon as is practicable, this resulted in therapists feeling pressured. Participants reported that it was challenging to balance the request for practicable reporting with the time they would like to give their clients to explore their disclosure of child maltreatment and its impact on their lives (Romme and Kirk, 2021).

The literature suggests, however, that once practitioners become experienced in asking SUs about adversities during their childhoods, skills in administering the survey and signposting SUs to appropriate support increase. The literature also affirms that health and social care practitioners perceive asking SUs about ACEs as beneficial to their practice and that it strengthens their rapport with SUs (Counts et al., 2017; Quigg, Wallis and Butler., 2018). Contrary to the hesitation to undertake ACE enquiries noted amongst health and social care professionals, studies have also established that training in routine enquiry about ACEs and the practice of undertaking same is essential to reducing practitioner stress and anxiety (Romero, Robertson and Warner, 2018; Burke-Harris, 2018).

4.2.1 Professional discomfort with specific ACE research measures

Despite evidence of discomfort with asking ACE questions being reported in the literature, it is surprising that few studies relate to professional discomfort with asking specific ACE questions. Recalling his experience during the first phase in 1995, Dr Felitti states that as soon as staff within the Department of Preventative Medicine at Kaiser Permanente were tasked with asking the ACE research measures that thirty of them transferred to other departments. Dr Felitti noted that their decision to move was motivated by their discomfort with asking patients the CSA question (Felitti et al., 2019). Findings relating to professional discomfort are often reported in terms of the survey and not for individual questions (Mersky, Plummer-Lee, and Gilbert, 2019; Clark and Jones, 2022). There is, however, some evidence from the literature to suggest

that questions relating to child sexual abuse may result in discomfort for professionals (Schomerus et al., 2021; Leder et al., 1999; Nixon and Quinlan, 2022).

A study by Nixon and Quinlan (2022) with psychologists in Australia exploring professional discomfort when inquiring about sexual abuse histories found that participants did not routinely ask about the client's sexual abuse histories. Most participants were uncomfortable asking clients (adults, adolescents, and children) about sexual abuse. They described the manifestation of this discomfort as shutting down clients who started to disclose, becoming anxious when sexual abuse came up, asking sexual abuse questions more quickly, and becoming more detached during sessions with their clients. In addition to this, participants reported that their discomfort led to avoidant behaviours. They noted that not feeling comfortable enough to inquire about sexual abuse resulted in them adopting behaviours such as avoiding discussing sexual abuse or superficial exploration of the details.

A study by Leder et al. (1999) with pediatric physicians adds weight to these findings. This study examined the factors that motivate pediatric physicians to query sexual abuse, enquiry barriers, and case management approach. It determined that the level of discomfort in enquiring about sexual abuse was directly related to the training physicians received. Participants in the study reported that a lack of training regarding sexual abuse enquiry had direct implications for patient discussions. Participants reported difficulties with sexual abuse terminology; they noted that they felt uncomfortable using the term' sexual abuse' and often needed to change the words to reduce their discomfort. Some words they identified as alternatives to' sexual abuse' were asking clients if they had been touched in their 'private parts', 'down there' and 'between their legs'. The study established that many participants encountered challenges in using the correct sexual abuse terminology when discussing sexual abuse with families but acknowledged that their use of other languages was also problematic. The absence of a uniform way to ask patients about sexual abuse resulted in patients misinterpreting the questions they were being asked and potentially providing incorrect responses (Leder et al., 1999).

4.2.2 The impact of professional ACE scores on the implementation process

Lack of training and feeling ill-equipped to discuss childhood adversities are not the only factors causing discomfort for professionals emerging from the literature. How professionals experience asking about ACEs that they have encountered themselves

are also considered. Findings from a study by Mersky, Plummer-Lee, and Gilbert (2019) exploring client and provider discomfort with the ACE survey in home visiting programmes in the USA offer a unique insight. This study asked home visitors to self-complete the ACE questionnaire. It also requested home visitors to ask clients the ACE questions. After both processes were complete, home visitors and clients were asked about their level of discomfort with the ACE questions. The study examined whether the clients' discomfort with the questionnaire differed by score, type of ACE, age, educational attainment, mental health, and race/ethnicity. It further considered if there was any relationship between client discomfort and the ACE score and the discomfort rating of the home visitor who asked them the ACE questions. Findings determined that although clients did experience some discomfort with the questions, most reported that they answered the questions without feeling extreme distress. Home visitors reported slightly higher rates of discomfort than clients. Although the study established that home visitors' ACE scores were not related to client discomfort with the survey, it did determine that clients reported more discomfort with the survey when the home visitor reported any level of discomfort. These findings suggest that if a professional feels uncomfortable with the survey questions, this discomfort may impact their administration. One of the most thought-provoking findings from this study was that individuals with a history of CSA reported elevated rates of discomfort with the questions across both participant groups. The authors note that this finding is consistent with research, which indicates that sexual abuse questions may evoke feelings of shame and distress in those who have experienced this type of abuse (Mersky, Plummer-Lee, and Gilbert, 2019). These findings are further supported by a study of maternity services in the UK by Mortimore, Richardson, and Unwin (2021) with mothers, their partners, and professionals. This study aimed to identify ACEs in families who used the services and ascertain professional responses to risk. Findings determined that although many midwives were comfortable asking the ACE questions, those with a history of ACEs found it challenging.

Research about how encountering ACEs during childhood may have impacted the professionals administering the survey is, however, limited. There are no studies concerning whether increased awareness about ACEs impacts the practice of professionals who encounter adversities during childhood. While researchers have examined adversities during childhood across multiple settings and contexts, most of this research relates to clinical settings and predominantly to individuals who avail of

health services (Hughes et al., 2017). Returning to the report by the Early Intervention Foundation (Asmussen et al., 2020) as discussed in chapter 2, despite affirming the intention of thoroughly interrogating the ACE evidence base to determine what was known, what was not known and what should happen next concerning ACE data, policy, and interventions, it is surprising that nowhere in the report do the authors refer to this gap in ACE literature. The authors do not emphasise the need to consider the possible impact of a professional's ACEs on effective service delivery. In addition, the report does not examine how survey implementation may impact professionals with a history of ACEs.

Interestingly governmental and social policy documents relating to survey implementation and ACE-informed approaches also fail to examine these issues. An example is the 'Review of Adverse Childhood Experiences (ACE) Policy: Report' by the Welsh Government (2021). This report outlines the findings of a review of the ACE Policy, which was implemented across statutory services in Wales in 2018. Although this report provides an overview of how professionals interpreted ACE-informed service provision and responses to SU ACEs, it does not specify the need to consider how a professional's childhood adversities could influence their work. It also did not account for the potential impact of educating these professionals about ACEs on their emotional well-being. This gap is evident in other governmental and social policy documents. Although reports provide extensive findings and conclusions about ACEs and the need for ACE-informed service provision, they do not consider the potential impact of personal childhood adversities on ACE implementation or ACE-informed approaches for health and social care professionals (Safeguarding Board for Northern Ireland, 2021; Scottish Adverse Childhood Experiences Hub, 2017; Centers for Disease Control and Prevention, 2021).

The fact that there is limited literature surrounding these topics is surprising, given the emergence of data relating to how adversities experienced during childhood by professionals have the potential to impact their work as well as their well-being (Evans and Evans, 2019; Grist and Caudle, 2021; Fernández-Arana et al., 2022; La Mott and Martin, 2017). The literature suggests that a professional's ACEs should be considered during pre-qualification training and education before they commence employment. The social work profession, in particular, has explored the impact of social work students' ACE scores on their learning and preparation for practice (Copeland, Howard, and Razuri, 2021; Lyter, 2021; Butler, Maguin and Carello, 2018).

A study by Lyter (2021) to assess the extent of ACEs and resilience amongst social work students in a university in the USA found that social work students reported higher levels of ACEs than students studying other subjects. The most common ACEs reported by participants were that of loss of a parent, depression or suicide of a family member and familial alcohol and drug addiction. Research participants also reported high levels of resilience. The author suggests that these reported levels of resilience may be related to the participant's ACEs. Lyter (2021) proposes that encountering adversities during childhood provides participants with opportunities to problem-solve and overcome obstacles, enabling them to build resilience. Furthermore, Lyter (2021) affirms that the study findings suggest the need to alter social work curriculums to include training about the potential impact of childhood adversity on professionals; an understanding of post-traumatic growth; self-care, and coping skills to cope with work-related stress.

As mentioned in chapter 3, STS refers to the emotional strain professionals encounter when SUs recount their experiences of trauma, such as histories of abuse, childhood adversities, experiences of violence and natural disasters (The National Child Traumatic Stress Network, 2022). Professionals in health and social care settings often hear personal accounts of this nature from individuals availing of their services. In recognition of this, it is unsurprising that a professional's ACEs have also been examined as predictors of STS (Gaboury and Kimber, 2022; Janczewski and Mersky, 2022; Butler, Maguin, and Carello, 2018). The literature suggests that professionals with four or more ACEs are more likely to experience STS than those with lower ACE scores (Jancsewski and Mersky, 2022). A narrative review of the literature by Gaboury and Kimber (2022) examining the relationship between hearing first-hand accounts of trauma and subsequent experiences of STS symptoms in mental health professionals in the USA established that the higher a professional's ACE score, the more likely they were to exhibit the STS symptoms of hyperarousal and increased intrusive thoughts. These participants were also more inclined to experience distorted thinking surrounding perceptions of themselves and others in the context of safety, trust, and intimacy. The authors suggest that services could address this increased likelihood of STS for professionals with higher ACEs via adequate training and effective clinical supervision. They further affirm that professionals should be provided with a safe space to help manage the impact of their ACEs on their experiences of working with individuals who disclose trauma to them.

A study by Lee et al. (2017) examining how child welfare professionals (n=104) ACEs impacted their approach to self-care, the experience of work stress and coping strategies adds weight to this recommendation. The ACE scores of participants in the study were higher than that of the general population. Incidentally, participants with higher ACE scores were also found to have elevated levels of work stress and maladaptive coping strategies, including drug and alcohol misuse. The main qualitative themes that emerged from participants concerning why they were experiencing work-related stress and adopting negative coping strategies included having increased workloads, coping with family stress and work-related stress, and experiencing a lack of appropriate supervision and support. The recommendations of this study affirm the need for employees' ACE scores to be assessed so that service providers can identify and introduce mechanisms to prevent work-related stress and respond effectively where this has already occurred (Lee et al., 2017).

The literature suggests that a professional's awareness of their ACEs can be beneficial. A study by Strait and Bolman (2017) examined the impact of graduate students' ACEs on how their perception and implementation of ACE and Trauma Informed Care (TIC) principles influenced the implementation of an ACE and TIC care curriculum. The study involved 967 medical students. These postgraduate students were attending osteopathy, podiatry, optometry, dental, physical therapy, veterinary and pharmacy programmes within universities in the USA. As part of the study, participants were asked to complete a pre and post-curriculum survey. The results determined that students who completed the survey were more likely to comprehend and integrate the principles into their professional practice than those who did not. The study's authors affirm that recognising and understanding one's ACEs, in conjunction with ACE and TIC education during professional training, can facilitate a better professional understanding of the impact of childhood adversities and trauma on SUs' lives. They affirm that the results of their study are significant because they demonstrate that acknowledging personal ACEs can enable professionals to build better connections with patients.

4.2.3 Impact of professional ACEs on role and context

Interestingly, concerning the present study, the question of the influence of personal ACE scores on the practice of early childhood professionals has been examined by researchers. In their study of early childhood professionals in the USA, Grist and Caudle

(2021) considered the relationship between professional-related burnout, personality traits, and ACEs. This survey sought to establish if there was a correlation between early childhood educators' ACEs and personality traits. The study determined that 23.6% of participants reported four or more ACEs. Regarding the correlation between personality traits and ACEs, the study determined that as participants' ACE scores increased, so did their likelihood of reporting the personality traits of neuroticism and openness to new experiences. Neuroticism is a personality trait related to emotional distress and dissatisfaction. Individuals with this trait are prone to experiencing negative emotions and reporting minor health problems more frequently. They are also more likely to experience the world as unsafe, distressing and threatening (Weed and Kwon, 2023). Openness to new experiences is the personality trait of being curious, artistic, imaginative, insightful, and open to new ideas (McCrae and John, 1992). Individuals scoring high in this personality trait tend to be more independent-minded and more tolerant of uncertainty in life (Schretlen et al., 2010).

The study postulates that it is not surprising that participants who experienced higher numbers of ACEs were more likely to exhibit these personality traits, as growing up in an unpredictable and perhaps unsafe environment could potentially lead to adults experiencing the world as dangerous and threatening. They further suggest that multiple childhood adversities could result in participants developing a more independent mindset and feeling more tolerant of less certainty in life. The study concludes that early childhood education services must recognise that early childhood educators may have elevated ACE scores compared to the general population. The authors stress that more professional development and support are required to help professionals who experience neuroticism. The authors affirm that those with the personality trait of neuroticism are at increased risk of experiencing work-related stress and subsequent professional burnout (Grist and Caudle, 2022).

Another study, which examined the prevalence of self-reported ACEs in a sample of 349 early care and education teachers in the USA, provides a unique insight into the importance of considering the impact of professional ACEs on professionals' interactions with students. As part of the study, Hubel et al. (2020) compared the self-reported ACE scores of fifty-eight teachers in tandem with observations of their classroom interactions with students. Observational assessments utilised The Climate of Healthy Interactions for Learning and Development tool (CHILD). This tool enabled the researchers to assess the social and emotional climate facilitated by the

participants in their classrooms. The findings indicated that teachers with higher ACE scores were observed to have classrooms with less engaging social and emotional climates. Social and emotional climate is a term used in education to refer to psychosocial interactions within the school environment that impact social and emotional learning. The social and emotional climate in the classroom can influence students' participation in learning. It can also influence their relationships with other students, staff, family, and broader community members. Poor social and emotional climates have been linked to lower academic achievement (Greenberg et al., 2017; Reyes et al., 2012). In addition, teachers who experienced physical abuse, emotional abuse and incarceration of a parent were the most prevalent in the group with poorer social and emotional climates in their classrooms.

In his book on emotional intelligence, Goleman (1996) argues that emotional intelligence can be more important than IQ. He further emphasises the crucial window of opportunity to build emotional resilience and develop emotional responses during childhood. He argues that experiences during childhood assist children in understanding the importance of expressing emotional needs and obtaining parental responses. Hubel et al. (2020) explain that losing a parent to incarceration and experiencing physical and emotional abuse can result in the child being ill-equipped, due to inexperience in having their own emotional needs met, to respond emotionally to children as an adult.

There are also studies considering the impact of professional ACEs in settings similar to those working in the DoCCFS Family Centres (Brown et al., 2022; Gaboury and Kimber, 2022; Steen, Straussner and Senreich, 2021). A study by Brown et al. (2022) examining the possible correlation of therapeutic professionals' positive and negative childhood experiences with experiences of compassion satisfaction, burnout, and STS in the USA, notes that therapists should build awareness of how their own childhood experiences may impact their professional practice. This cross-sectional study involved conducting a survey with 138 therapists in a mental health counselling service. Findings indicated that participants had elevated ACE scores compared to the general populations, with 43% (n=60) reporting four or more ACEs. Participants with higher ACE scores were likelier to score lower for compassion satisfaction. Compassion satisfaction refers to the level of pleasure that a professional experiences from helping others (Proqol, 2022).

A correlation was also established between participants with elevated ACE scores and experiences of professional burnout. Professional burnout is a reaction to unsuccessfully managed chronic workplace stress. Professionals who experience burnout experience exhaustion, cognitive distancing from their role and negative feelings about their work, such as cynicism and apathy (WHO, 2022). Alongside these negative professional implications arising from participants' ACEs, the study also established a mediating relationship between participants having increased Positive Childhood Experiences (PCEs) and subsequent burnout. The results suggest that participants with four or more ACEs who reported five or more PCEs were less likely to report professional burnout. The authors stress that over half of the participants in this study indicated that they had five or more PCEs (Brown et al., 2022). Table 4.1 provides an overview of participant PACEs.

Table 4.1
Overview of PCEs reported by study participants
(Adapted from Brown et al., 2022)

PCE	Percentage	Number
opportunities to talk about feelings	71%	98
Had family support	71.2%	99
Engaged in community and traditions	76.3%	106
Had a sense of belonging in school	73.6%	103
Felt supported by friends	77.7%	108
Had support from a positive adult outside of the home	80.7%	113
Felt safe and protected in the home	80%	112

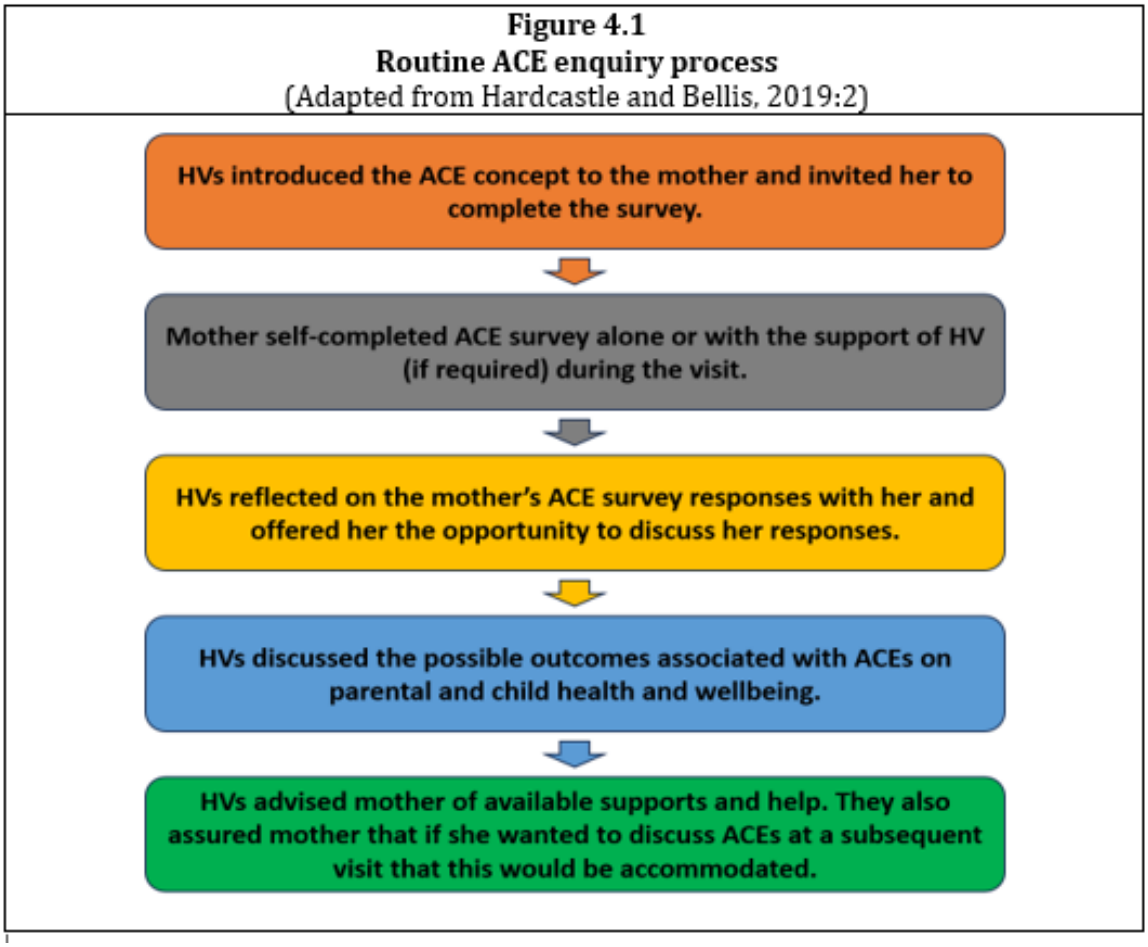
4.2.4 Concerns about SU retraumatisation

The fear that asking ACE survey questions will retraumatise SUs has been identified as an implementation barrier for professionals (McFarlane and Hawes, 2022; Maunder et al., 2020). A study by McFarlane and Hawes (2022) exploring health professional's (social workers, caseworkers, psychologists, nurses, psychiatrists, general practitioners, and paediatricians) perceptions and competencies surrounding the assessment of child and parent ACEs in Australia determined that participants expressed concerns that asking ACE questions would be too upsetting and distressing for parents. Similarly, a study examining Physician's ACE screening practices and knowledge in Canada by Maunder et al. (2020) found that one of the most prominent

barriers to asking ACE questions was the physician's perception that it would cause distress for patients (McCrae et al., 2014).

Hardcastle and Bellis's (2019) conducted a pilot study of routine ACE enquiry by health visitors (HV) during home visits in Wales. This study provides interesting findings regarding SUs' reactions and experiences of ACE enquiry. Participants in the study were home health visitors and the post-partum mothers they visited in their homes over a year commencing in 2017. The pilot study involved home visitors following a particular routine ACE enquiry process. This process is outlined in Figure (4.1).

Figure 4.1
Routine ACE enquiry process
(Adapted from Hardcastle and Bellis, 2019:2)



The findings of the pilot established that 91% of the mothers involved in the study agreed with the need for ACE enquiry. Most of the mothers noted that being asked the ACE questions had not resulted in retraumatisation as their experiences were perceived as positive. They attributed their positive perceptions to their receiving help and support arising from their ACE enquiry responses. The post-partum mothers' cohort participants reported their belief that being asked the ACE questions

resulted in their home health visitor better understanding the impact of their childhood adversities on their present needs.

4.3 SU's perspectives about being asked the ACE survey questions

Studies examining SUs' perspectives on being asked about ACEs consistently report that they are generally open and receptive to it (Edwards et al., 2007, Bethell et al., 2017; Counts et al., 2017). Practitioners asking them about their experiences of adversity during childhood has been interpreted by SUs as a demonstration on behalf of the practitioner that they care and that they want to hear their stories (Woods-Jaeger, Cho, and Goggin., 2018; Felitti et al., 1998; WHO, 2018; Burke-Harris, 2018; Kolta et al., 2018). Counts et al. (2017) completed a pilot study involving home visitors who implemented an ACE and trauma-informed approach in the USA. Results from this study indicated that SUs felt that being asked about ACEs enabled them to build rapport with practitioners and to feel safe and secure in engaging in the interventions offered. Counts et al. (2017) further determined that being asked about ACEs enabled SUs to understand their childhood adversities' impact on their lives and encouraged them to lessen the consequences for their children. However, not all SUs' experiences of being asked about ACEs are positive (Rodriguez et al., 1998; Sweeney et al., 2016). Some studies highlight instances where SUs have encountered practitioners who appeared to lack empathy and demonstrate poor practice skills in responding to their ACE disclosures (Becker-Blease and Freyd, 2007; Goodman, 2017; Counts et al., 2017). Importantly, and as mentioned previously, no research has examined the longer-term impact of being asked about ACEs on SUs (Ford et al., 2019). The potential for negative consequences for SUs in routine ACE-IQ administration remains unknown.

SUs' perceptions of survey questions were not the only perspective on the ACE evidence base identified in the literature. A study by Woods-Jaeger, Cho, and Goggin (2018) examined parents' perceptions of the intergenerational transmission of childhood adversities. The study completed qualitative interviews with eleven participants from low-income urban areas in the USA. Participants in the study were Black parents of children between 6 weeks and five years attending an early years health programme in a pediatric health clinic (Woods-Jaeger, Cho, and Goggin, 2018). The study objectives were to determine the prevalence of ACEs in the participant population and to ascertain participants' perceptions of how their ACEs may have influenced their parenting. In addition, the study also set out to determine the

ameliorating factors that reduced the negative impact of ACEs on the participants' lives and parenting. Some participants described how their parents' ACEs had become their ACEs. Results from the study suggested that increasing their understanding of ACEs resulted in parents recognising the intergenerational transmission of childhood adversity and trauma. Regarding this perception, participants affirmed that they had tried to reduce the repetitive cycle, and results indicate that participants expressed aspiration to improve their children's lives. Participants described the process involved in meeting these aspirations as learning from their parent's mistakes. In addition to intergenerational transmission, participants also recognised the role of the social environment in ACE replication. In light of this recognition, participants suggested that ACEs could be reduced for future generations by community awareness of the impact of childhood adversity on adult outcomes, providing opportunities for parents to avail of education and training and building supportive and nurturing communities.

Additionally, despite some literature on low-income parents' perspectives on willingness to participate in screening concerning their children's social circumstances, there was no literature concerning parents of middle or higher-income status. Schleifer (2020) examined the approach low-income parents of children under five in New York thought paediatricians should adopt when screening for social factors that can impact children's health. This study implemented eight focus groups with parents and asked participants how they thought paediatricians should ask them about their children's social circumstances. The study determined that fear of mandatory child maltreatment reporting to statutory services was a significant obstacle for parents during screening. Participants noted that during screening, they feared disclosing social factors such as their child's exposure to domestic violence, parental mental health issues or criminality. They attributed this fear directly to thoughts of being discriminated against or judged and knowing that paediatricians would have to report the information to child protection and welfare social work departments. Given that ACEs are not restricted to children in lower-socioeconomic families (Halfon et al., 2017), and the original ACE study was undertaken with a predominantly white, middle class and educated participant cohort (Felitti et al., 1998), this current gap in the ACE literature is surprising.

4.3.1 Professionals' experiences of routine ACE enquiry

A systematic literature review by Cibralic et al. (2022), examining the implementation of ACE screening in paediatric healthcare settings, determined that routine ACE enquiry was generally a positive experience for professionals. The literature uncovered by the review indicated that professional ACE awareness and acceptability of screening for childhood adversities had steadily increased during the last decade. The results affirmed that professionals who implemented ACE screening perceived multiple benefits. These benefits included strengthening the therapeutic alliance between them and their SUs, helping them see the correlations between ACEs and mental and physical health, assisting them in identifying and supporting vulnerable children, and improving SUs' knowledge and understanding of the importance of parental attachment.

As discussed in chapter 3, Morton and Curran's (2019) study provides interesting findings concerning social care professionals' experiences of routine ACE enquiry. The study, which examined a pilot routine ACE enquiry project within a domestic violence service in Ireland, found that, generally, participants perceived the implementation of routine ACE enquiry as a positive experience. When asked to describe the positive aspects, participants affirmed that implementing the ACE survey gave them a structured opportunity to engage SUs in a discussion about their adversities during childhood. Participants noted that this was helpful because it validated their professional intuition. They described this experience as being able to recognise prior to survey enquiry that a SU may have encountered childhood adversity from their demeanour and not having the confidence or cause to explore this intuitive perception with them (Morton and Curran, 2019).

According to Morton and Curran (2019), results indicated that participants stressed the importance of timing for survey administration. Participants clarified that building rapport and ensuring the SU was not acutely distressed or in crisis was essential. Some participants noted that routine ACE enquiry was beneficial because it resulted in them slowing their practice responses down and providing time and space for SUs to process their experiences. Although this required additional time on their behalf, perhaps surprisingly, participants did not identify this as a negative implication arising from routine ACE enquiry. Additionally, they noted that the disclosure of ACEs during survey implementation provided additional opportunities for SUs to discuss

their experiences in subsequent meetings. Participants stressed that they felt they owed it to SUs to facilitate this type of discussion if it was required.

Interestingly, results from the study suggest that participants were surprised that SUs could not always perceive their childhood experiences as adversities. Morton and Curran (2019) state that participants described how some participants would not recognise adversity due to the perception that they were related to social and cultural norms during childhood. Participants also advised that some SUs expressed reluctance about acknowledging their ACEs because they did not want to label their parents unjustly. Participants noted that the impact on some SUs when they realised they had encountered significant ACEs was profound. They described instances when SUs would exhibit shock that their childhood experiences were considered adversities.

Morton and Curran's (2019) study also determined that participants noted positive implications for SUs from completing the survey. These implications included SUs recognising the positive aspects of parenting they had experienced. Some SUs would reflect on how their parents had tried to protect them from child maltreatment or exposure to domestic violence. Participants also noted that when SUs recognised that they had encountered ACEs and understood that they may have impacted their journey through life, they were less likely to engage in self-blaming. Participants described SUs as recognising their resilience and stressing the importance of improving the outcomes for their children.

4.3.2 Professionals' perspectives about barriers to survey implementation

The literature suggests that health and social care practitioners are more resistant to routine administration than SUs (Sziligyi et al., 2016; Anderson et al., 2015; Dube, 2018). This resistance has repeatedly been linked to practitioner anxiety regarding asking SUs about childhood adversities (Walsh, 2002; Follette et al., 1994). Studies examining ACE enquiry from practitioner's perspectives have established that health and social care professionals feel ill-equipped and not adequately trained to ask SUs such questions (Becker-Blease and Freyd., 2007; Kerker et al., 2015). In addition, research has revealed that some practitioners do not feel it is part of their professional remit to ask SUs about ACEs and deem this to be ‘somebody else's job’ (Black and Black, 2007). Practitioners also highlight time constraints and lack of resources as barriers to administering ACE research measures effectively. Some report fears of the impact of asking ACE questions on their relationships with SUs. They further highlight their

ethical and legislative duty to report child protection concerns as a deterrent to them asking about ACEs (Albaek et al., 2018; Szilagyi et al., 2016).

The results of the scoping literature review by Ford et al. (2019), as discussed in chapter 3, provide an overview of the barriers surrounding survey implementation that have emerged in the literature. The barriers identified included professionals reporting difficulties in administering the survey due to time constraints and a lack of confidence in asking about childhood adversities. The issue of time constraints was noted, particularly concerning professionals not being able to counsel or provide the SU with emotional support should they become distressed by the survey. In addition, professionals reported obstacles such as being unsure of how to help the SU and fearing offending them. Furthermore, professionals noted a reluctance to ask about ACEs because they did not have the appropriate support to respond to the SU.

Interestingly, the scoping literature review also noted several gaps in the ACE literature in terms of if these reported barriers had any impact on service provision. Ford et al. (2019) affirm that there was a lack of studies on whether the provision of services or the practitioners' response differed after SUs reported ACEs. They further highlight that there was no clarity in the literature about how professionals responded to SUs. Studies comparing whether administering the survey resulted in notable changes in the practice or identification of ACEs by professionals or their practice were noted as absent in the literature. The scoping literature review also determined that there was an absence of studies exploring professionals' perceptions about whether routine ACE enquiry enabled them to understand better or explore the impact of SUs' ACEs in terms of their symptoms, needs or presenting difficulties. The current study is designed to address a number of these gaps in the literature.

4.3.3 Mandatory reporting as an obstacle in ACE survey implementation

Mandated reporting represents a significant issue for professionals. Asking SUs about their ACEs can result in the professional having to report retrospective child abuse concerns to statutory bodies. A wealth of literature has identified training as necessary for mandated reporters (Goodyear-Smith, 2012; Baker et al., 2021; Pietrantonio et al., 2013; Alvarez et al., 2004; Reiniger et al., 1995). Goodyear Smith (2012) argues that a lack of mandatory reporting training leads to under-reporting by professionals as they lack knowledge of what constitutes child protection concerns. A study by Goldman (2010) examining undergraduate primary school teachers' responses to child sexual

abuse and subsequent mandatory reporting established that research participants did not feel confident in their role as mandated reporters. Participants reported feeling ill-equipped to meet their obligations. They attributed this feeling to not understanding how to identify abuse and what they should do if they suspected that one of their students was experiencing child abuse or neglect. Building on these findings, Baker et al. (2021) call for all professionals to have continuous training throughout their careers to ensure they can fulfil their safeguarding obligations. Pietrantonio et al. (2013) argue that healthcare professionals are uniquely situated to identify child protection concerns and take effective action, but they lack standardised training. Alvarez et al. (2004) affirm that this lack of training is a significant barrier to professionals engaging in mandatory reporting effectively.

A systematic literature review by Alvarez et al. (2004), which explored professional deterrents to mandated child abuse reporting, outlines the main reasons professionals resist mandatory reporting. The authors interrogated the literature to identify obstacles to mandatory reporting for professionals, including ignorance surrounding the recognition of child maltreatment, misunderstanding laws relating to child abuse and neglect, and apprehensiveness of the impact of making the report on their interactions and engagement with SUs. The review's findings indicated that professionals resisted mandatory reporting because they lacked knowledge and training. Additionally, professionals were concerned about the risk of negative implications for SUs arising from reports. Furthermore, professionals' willingness to report coincided with their positive or negative perceptions of statutory child protection and welfare services.

The literature further indicates that mandatory reporting can present multi-faceted professional and personal challenges for professionals. A study by Pellegrini et al. (2022) which examined the mandatory reporting experiences of psychologists in Ireland, conducted three focus groups with eighteen participants. Study participants were professionally qualified psychologists working for the national health service, the Health Service Executive in Ireland, who had been required under mandatory reporting legislation to report their client's current and retrospective experiences of child maltreatment. This study established that participants perceived that retrospective reporting, in particular, had the potential to damage the therapeutic relationship. They noted that adult clients would become upset and that participants found it challenging to feel comfortable causing this distress. The findings of this study

determined that the requirement for mandatory reports had a profound impact on participants. Participants reported invoking maladaptive coping behaviours, such as avoidance and rumination, to regulate these emotions. They reported engaging in excessive contemplation and perceiving themselves as engaging in similar abusive behaviour to the client's experience of child maltreatment as they opened them to a situation where they felt powerless.

Furthermore, this study determined that participants believed retrospective reporting left adult SUs feeling powerless and betrayed. They affirmed that recognising this emotional impact caused them to feel guilty. Participants described feeling like they were replicating the power and control behaviours that the perpetrator of abuse had exhibited to the SU in childhood. This realisation was difficult for participants to contend with. Participants also recounted that mandatory reporting of adult disclosures of child maltreatment frequently resulted in adult SUs becoming angry and aggressive towards them or inevitably disengaging from the therapeutic relationship. The findings of this study also suggested that the apprehension experienced by professionals related to retrospective child abuse reporting is connected to the feeling that it may not always be in the best interest of the adult SU (Pellegrini et al., 2022).

The literature suggests that mandatory reporting obligations add to the time and workload for professionals. Professionals have reported spending considerable time and effort repairing relationships where SUs exhibited distress (Pellegrini et al., 2022, Bean, Softas-Nall, and Mahoney, 2011). A study by Tufford and Lee (2020) with social workers in Canada provides unique insights. This study examined what participants did to repair their relationships with SUs after reporting child maltreatment concerns to statutory child protection services. Findings from the study determined that the relationship repair strategies implemented by participants included offering additional appointments and contacting the SUs by telephone to offer support. This study noted that professionals understood that their working relationship with adult SUs post-mandatory reporting was contingent on their ability to repair the perceived breach of trust.

Research by Reiniger et al. (1995) in the USA to examine mandated training for professionals concerning improving their reporting of suspected child abuse found that the training increased confidence and effective participation amongst the professionals involved. Pietrantonio et al. (2013) propose that the likelihood of a professional making a report was directly related to the amount of training the

individual received. Goldman and Grimbeek (2015) suggest that professionals should receive training about mandated reporting in university before entering professional service. They argue that a university provides the perfect environment for pre-service individuals to learn about child protection and welfare. Likewise, research by Bryant and Baldwin (2010) found that their participant group of school counsellors believed that universities should train professionals about child protection and welfare before taking up employment. Despite these affirmations regarding the importance of pre-service training, some of the literature reviewed calls for professionals to partake in continuous professional development about child protection and welfare matters. Szilassy et al. (2013) argue that training proves helpful in promoting an understanding of the need for inter-professional collaboration, differing professional roles concerning child protection, each profession's legal responsibilities and an understanding of how to safeguard children once concerns have been identified. Correspondingly, Goldman et al. (2010) found that pre-service primary school teachers who had undertaken a one-day mandated reported training course stated that they had improved confidence and a sense of empowerment in dealing with child protection and welfare concerns. In addition, the research established that their participation in training resulted in them being more mindful of their professional, legal, and ethical obligations to report suspected child abuse.

4.3.4 Professional supervision as a consideration

Implementing routine ACE enquiry represents an innovation for social care organisations. Despite studies indicating that routine ACE enquiry has emotional and practical implications for professionals (Walsh, 2002; Anderson et al., 2015; Pietrantonio et al., 2013), studies examining the role managers or supervisors play in alleviating these issues were not evident in the literature. This gap in the literature is surprising, given that professional supervision has been identified as vital when introducing organisational changes or innovations (Austin and Hopkins, 2004). In their book, which examined supervision as a collaborative process in health and social care services, Austin and Hopkins (2004) explain that successful organisations create new knowledge and share it throughout the organisation and beyond. The authors describe organisations adopting this approach as learning organisations and note that they emphasise shared learning and continuous professional development. According to Hopkins and Austin (2013), learning organisations engage in processes which focus on

improving professional practice, innovation, and experimentation. This literature proves relevant to the current study as organisations that introduce routine ACE enquiry are motivated to do so to learn about the prevalence of ACEs and the associated negative outcomes within their SU population (Ford et al., 2019).

Austin and Hopkins (2004) describe how anxiety is common for professionals within organisations who adopt a learning approach. The authors affirm that organisations can mitigate professional apprehension and anxiety by providing appropriate support to professionals. They outline these supports as training, ensuring precise and consistent communication between organisational management and professionals, group support and supervision. According to Austin and Hopkins (2004), supervisors in learning organisations within the health and social care sector often take on a mentorship role for staff. In addition, the authors describe how supervisors often provide emotional support and guidance for staff when they are emotionally impacted by the work associated with new learning.

4.4 The need to consider a SU's race, ethnicity, and language

Adversities experienced during childhood are a global occurrence (Alhowaymel, Kalmakis, and Jacelon, 2021). The WHO has internationally recognised ACEs as predeterminants for adult negative health outcomes (WHO, 2022). Despite this recognition, the ACE evidence base has been criticised for over-representing ACE survey data from middle to higher socioeconomic white participants (Cronholm et al., 2015). ACE data relating to participants from developing and lower-income countries is limited (Alholwaymel and Kalmakis., 2020; Massetti et al., 2020). This gap is concerning as the limited data suggests that adversities during childhood for this population warrant examination. A report by Wood et al. (2020) exploring ACEs in child refugee and asylum-seeking populations in Wales determined that children who sought asylum and humanitarian protection may have experienced additional adversities specific to their circumstances. These adversities relate to migration journey experiences, including physical, emotional, or sexual abuse within their communities, by authorities, in refugee camps or by traffickers. Being subjected to violence towards others, exposure to bombings and destruction of their homes, acts of community violence, abduction or imprisonment, and deprivation of basic needs. Wood et al. (2020) emphasise that these additional adversities, alongside the standard

ACEs, led to poor mental and physical health and problematic behavioural and academic achievement outcomes for participants.

A systematic literature review examining ACE survey implementation with adult asylum-seeking and immigrant populations in the USA adds weight to the Welsh report findings. Solberg and Peters (2020) postulate that children from poor, low, and middle-income countries may face a range of adversities that children in high-income countries do not. These adversities include food scarcity, war, obstructed healthcare access and insecure educational opportunities. They argue that the lack of funding in low and middle-income countries exacerbates the negative outcomes associated with ACEs because, unlike in higher-income countries, the infrastructure to respond to negative health, education and social outcomes in public service provision is restricted. Solberg and Peters (2020) draw attention to the fact that refugees and immigrants from low to middle-income countries who experience negative outcomes can be adversely impacted by the fact that the majority do not have health insurance or the financial means to access services to address their resulting needs. To ensure that these needs are met, Solberg and Peters (2020) affirm that internationally, policy needs to consider the impact of exposure to adversities during childhood in low and middle-income countries and the resulting complications for this population.

In addition to the evidence of elevated risk for refugees, asylum seekers and immigrants from middle to low-income countries encountering ACEs, as noted in the literature, there is also a concern relating to language as a barrier in survey implementation for these populations. This concern relates to the fact that most ACE survey implementation and subsequent research publications have emerged from countries where the primary spoken language is English (Hughes et al., 2017; Massetti et al., 2020). Even though the WHO developed the ACE-IQ to be implemented in all countries (WHO, 2022), evidence of the survey being translated into different languages for non-English speaking research populations in predominantly English-speaking countries is limited. On the contrary, research publications from English-speaking countries frequently note that one of the inclusion criteria for survey participation is fluency in English (Rariden et al., 2021). Interestingly, a systematic literature review by Rariden et al. (2021), examining the perspectives of clinicians and patients regarding the feasibility and acceptability of ACE screening in the USA, could only identify four studies where survey implementation had considered language barriers. Two of the studies translated the ACE questions into Spanish, and the

remaining two offered participants translation assistance. Unfortunately, none of these studies reported the implications of these language translation interventions. They did not examine if translation or the use of translators was positive or negative for participants and the overall implementation process.

To ensure equity in service planning and provision, Hunt and Bhopal (2004) stress the need to consider non-English speakers in epidemiological research. They acknowledge that non-English speakers have long been excluded from epidemiological research due to the lack of reliable, valid, and appropriately translated research measures. When epidemiological research measures are not translated effectively, essential data relating to ethnic and racial minorities are not captured (Hunt and Bhopal, 2004). Similarly, Squires, Sadarangani and Jones (2019) argue that it is necessary to ensure that researchers consider and address the participant's language to ensure that their voices are heard during the research process. In their paper describing best practices for implementing cross-language research with participants, they suggest that not considering this issue precludes participants from sharing vital information that could be used to inform service provision and policies (Squires, Sadarangani and Jones, 2019).

4.5 Positive impact

Surprisingly, ACEs have not only been linked to negative professional practice implications. Steen, Straussner and Senreich (2021) established that a social care professional's ACEs could also positively impact their approach to work. Their study of 1,828 licensed social workers in the USA involved qualitative analysis of participants' responses to two open-ended questions on the impact of their ACEs on their choice of profession and their experiences post-qualification. Findings from the study suggest that participants' ACEs influenced their decisions to enter the social work profession and impacted their approach to work. Participants described this impact as increased motivation to explore their client's ACEs and their own. They also reported wanting to address family dynamics, accessing personal therapy, actively trying to understand and relate to the client's experiences, seeking supervision, wanting to help others, and demonstrating a commitment to advocating for change within systems. Instead of negatively impacting professional practice, participants' ACEs were identified as motivating social workers to help others.

After reviewing the literature on the personal impact of routine ACE enquiry on professionals and SUs, this chapter will examine organisation-specific factors that could influence the implementation of routine ACE enquiry within a social care organisation.

4.6 Organisation change

Implementing routine ACE enquiry requires organisations to engage in a change management process. A change management process is a methodical and systemic process that facilitates an organisation to develop and implement innovations (Wang, 2012). In his book examining the resources and tactics for managing organisational change, Richard Bevan, an organisational consultant, stresses seven factors organisations must ensure to implement change. He labels these factors as clarity, measurement, engagement, resources, alignment, leadership, and communication (Bevan, 2011).

According to Bevan (2011), successfully implementing change within an organisation requires clarity about why the change is required and a clear definition of what the change will involve and its direction. Organisations must also have systems to measure the change and track its progress. Bevan (2011) argues that before implementing change, organisations must have justification for the change, and to do this, they should measure the potential financial and emotional implications for those involved. The engagement factor is defined as ensuring consultation with the organisation's stakeholders. Bevan (2011) emphasises that organisations should involve individuals whom the change will most impact before introducing an innovation. He argues that these individuals' insights are essential and should be acknowledged. The resources factor is defined as ensuring the organisation has the resources to implement the change. Bevan (2011) states that these resources include financial means, sufficient staff, and effective training programmes. Another core factor outlined by Bevan (2011) is alignment. He notes that this factor requires the organisation to develop and implement essential systems and processes to support the change, such as communication, training, education, feedback, and monitoring. Bevan (2011) defines leadership as ensuring that those in management and leadership positions are aware of the change, involved in the change process, and committed to it. He stresses that leadership is essential for the organisation because it equips it to solve problems, provides support and guidance to staff, and proactively manages the change

process. The last factor outlined by Bevan (2011) is communication. He proposes that for organisations to manage change successfully, they must communicate clearly, consistently, and promptly with stakeholders. He stresses that doing so enables stakeholders to feel part of the process, access additional information, and acquire feedback concerning implementation issues.

The literature highlights how organisations can obtain up-to-date and informed feedback from SUs. One of the most prominent formats outlined is that of organisations establishing SU advisory boards (Rosenberg and Hillborg, 2016). In their article exploring the use of SU advisory boards in adult mental health and substance misuse services in Sweden, Rosenberg and Hillborg (2016) determined that the expertise and insights of individuals who had used or were using services proved beneficial to organisations looking to improve service development and inform planning processes. The study established that using advisory panels enabled organisations to identify where SUs and professionals had common perspectives about encountered challenges, including resource accessibility and allocation, addressing power relations and facilitating SU participation and inclusion. Identifying these commonalities led to more collaborative and effective problem-solving processes for the organisations involved.

Similarly, the literature suggests that establishing SU youth advisory panels can benefit services children and young people attend. An article by Price and Feely (2017) examining the impact on the resilience level of young people aged 16-25 who participated on an advisory panel for an Irish organisation established that being part of the advisory panel was positive for both the young people and the organisation. This study involved completing semi-structured interviews with ten young people who sat on an advisory panel for Jigsaw, a youth mental health service provider. The role of young people on the SU advisory panel involved attending and participating in organisation meetings, staff inductions, peer education sessions, sitting on interview panels to recruit new staff and providing feedback and ideas about the promotion of the service. Overall, the study determined that being asked for their feedback increased the young people's resiliency as it resulted in them learning new transferable skills, obtaining a feeling of life satisfaction and recognising and recognising that they made a difference in others' lives.

Unsurprisingly, the literature indicates that all of the factors described by Bevan (2011) have been considered in ACE survey implementation models. This

recognition is evident in the study by Quigg, Wallis and Butler (2018), which evaluated the REACh implementation model mentioned in chapter 3. The rationale for developing the REACh implementation model was to increase professional awareness of ACEs and improve collaboration across health and social care services (Quigg, Wallis and Butler., 2018). To meet these objectives, the implementation model had five stages. Quigg, Wallis and Butler (2018) provide an overview of each model stage: Scoping is the first stage of the implementation model. This stage requires collaboration between the REACh implementation team and the organisation to develop an understanding of ACEs and routine ACE enquiry. This stage also involves assessing the organisation's motivation for considering the REACh model, meaning clarity is sought concerning whether the organisation wants to increase ACE awareness or if it is motivated to implement routine ACE enquiry. This stage also involves assessing the organisation's motivation for considering the REACh model, meaning clarity is sought concerning whether the organisation wants to increase ACE awareness or if it also intends to implement routine ACE enquiry. Once the motivation is established, the REACh facilitation team implements a bespoke programme to meet the organisation's objectives. As this stage involves an examination of the organisations' rationale for implementing routine ACE enquiry, it appears to address the clarity factor required for organisational change, as outlined by Bevan (2011).

The next stage of the REACh model, organisation readiness, is defined by Quigg, Wallis and Butler. (2018) as completing a readiness checklist with the organisation to ascertain if the appropriate systems are in place to implement routine ACE enquiry safely. This stage also considers the level of organisational commitment to implementing routine ACE enquiry, staff training needs, how ACE data will be processed and the potential risk involved. Compared with Bevan's (2011) seven core factors, this stage of the REACh implementation model demonstrates consideration of the measurement and resource factors. The training phase of the REACh implementation model involves developing and implementing bespoke training for the organisation. This training aims to increase ACE awareness for staff and, where appropriate, for organisations who want to introduce routine ACE enquiry; it provides opportunities for staff to build the necessary confidence and skills in administering the ACE research measures. As the training stage incorporates the development of training systems and processes, it includes aspects of the alignment factor outlined by Bevan (2011).

The follow-up and support stage of the REACh model is defined as a six-month process whereby the REACh implementation team provide ongoing support and guidance to organisation management and staff. Doing so aims to embed routine ACE enquiry as part of the organisation and monitor staff engagement and overall implementation progress (Quigg, Wallis and Butler, 2018). This stage incorporates the engagement and leadership factors as outlined by Bevan (2011). These factors are demonstrated via the engagement of organisation stakeholders to ensure that they understand routine ACE enquiry, ascertain implementation progress, and provide support. The final stage of the model incorporates the communication factor outlined by Bevan (2011). Quigg, Wallis, and Butler (2018) define this phase as an organisational-led evaluation of the REACh implementation. The evaluation stage both seeks stakeholder information and provides them with information about the REACh implementation process. It demonstrates a process whereby the organisation communicates about the model's effectiveness. The literature suggests that managing change within an organisation is complex, and several factors influence the outcome (Rapport, Clay-Williams and Braithwaite, 2018).

4.6.1 The importance of organisational culture

Bevan (2011) suggests that organisational culture can be an asset or a liability during a change process within an organisation. Considering organisational culture is important for social care organisations when they want to implement change. Introducing routine enquiry about ACEs, becoming ACE aware and adopting trauma-informed or resilience-based approaches depends on how individuals and organisations respond. A paper which explores the tactics for successful organisational change in a youth and family service in the USA by Packard (2017) argues that to bring about the service change, the organisation needs to introduce 'change leaders', further arguing that such change leaders should be managers. He suggests that choosing managers enables a unique opportunity for change because it facilitates the change leader with the power to support staff and allocate resources to assist the change process. Packard's paper examines the process of change involved in introducing a trauma-informed approach within a child and family service. Evaluation of this determined that the integration of this approach was successful because the service involved staff members and consulted with them meaningfully throughout the change

process. The paper highlights that feeling involved led to greater staff buy-in (Packard: 2017).

Fuller et al. (2018) emphasise the need for organisations to consider implementation science when they consider change within social care services. They argue that for change to be successful, staff need to have a 'work purpose'. Work purpose is defined as the staff member knowing that the change in their work would fit their organisation's purpose. In addition, Fuller et al. (2018) highlight the need for appropriate and effective training for staff about the proposed changes. They affirm that workers like hands-on practical training to demonstrate precisely what the organisation expects of them. Damian et al. (2017) postulate that for change to be implemented successfully, organisations must consider and plan for factors that could impact staff and the ability of the organisation to deliver. They outline these factors as safety issues, morale, managerial support, teamwork culture, ability and willingness to collaborate, how staff and the service respond to stress, burnout, compassion, and satisfaction with their jobs (Damian et al., 2017). Without considering these issues when planning for change, the organisation will likely fail to introduce new processes and behaviours (Damian et al., 2017).

The literature also suggests that the proposal for change must be supported at governance levels to instigate change within an organisation. Anheier (2014) explains that governance is how an organisation is directed and controlled. Unlike statutory services, non-profit organisations are generally governed by a non-elected board. Governing boards ensure that the organisation is well-managed, adheres to its values and meets its purpose. Board members are not employees of the organisation and are not responsible for direct management. Anheier (2014) argues that governance is not about making policies or evaluating employee performance; instead, it involves ensuring that the service provided by the organisation is safe and uncontroversial. Without support and an agreement at the governance level, proposals for change will not be effectively or ethically integrated into service provision.

4.6.2 The need to ensure professional buy-in

ACE survey implementation calls for change within an organisation. In order to bring about this type of change, the literature suggests that professional 'buy-in' is imperative (Stein, Swerlick and Chokshi, 2020). 'Buy in' is the acceptance and willingness to support something actively (Merriam-Webster, 2022). Lack of staff buy-

in and organisational resistance to change can obstruct implementation processes (Lau et al., 2016). Buy-in is not required for ACE implementation alone but is essential for organisational change. A study by McCrae et al. (2014) exploring child welfare workers' reported willingness and readiness to engage in organisational change determined that staff buy-in was essential for implementation success. The study involved implementing a state-wide practice model across all levels of a child welfare organisation in the USA. The study assessed staff buy-in using research measures relating to their awareness and support of the organisational change. Results indicated that male participants reported significantly higher levels of 'buy-in' than their female counterparts. Participants with 16 years or more experience working in the organisation also reported higher buy-in levels. Participants employed at senior management level or above were also determined to have more willingness and investment in the change process than participants in lower positions. Consultation and communication were identified as key to ensuring staff buy-in, with participants in lower power positions reporting that their investment in implementation would have increased had they been consulted during the planning stages of the change process. Lastly, the study concluded that participants in lower power positions within the organisation noted that their buy-in was related to perceptions of how committed and knowledgeable their supervisor was about the state-wide practice change.

An interesting interpretation of resistance arising from organisational change is outlined in a paper by Agboola and Salawu (2011). This paper examined the management of deviant behaviour and change resistance within organisations. The findings suggest that initiating change within an organisation can alter behaviour and redefine work procedures and relationships. They also note that it can result in the need to acquire or alter new and existing practice skills. Change can force staff within the organisation into unchartered territories where they encounter unprecedented problems and obstacles. Agboola and Salawu (2011) argue that as change conflicts with normal expectations, it naturally evokes reactions from staff. The authors affirm that new employees whose behaviour and expectations are not as embedded and those in management positions unaffected by the change are usually more responsive and less resistant to change.

Agboola and Salawu (2011) affirm that the organisation should prioritise obtaining 'buy-in' from this group. Not doing so will result in resistance, representing a significant barrier to the success of the change process. Furthermore, the authors

note that resistance and objections to change are more pronounced in staff who have worked in the organisation for a more extended period and are directly impacted by the change. The authors explain that this group is most resistant because the change can be interpreted as threatening their status, skills and usual behaviour within the organisation.

4.6.3 The role of emotions in organisational change

In his paper exploring the management of people during organisational change, Smith (2005) affirms that successful change within an organisation depends on its staff's capacity and capabilities. Therefore change can either be supported or impeded by the attitudes adopted by staff members. The ability and willingness demonstrated by staff when they encounter change are crucial. Staff within organisations may support the change process or obstruct it. Individuals working in organisations with established and settled cultures are more likely to resist change. This perception, however, is not reflective of all staff, and it is essential to remember that individuals react differently to change. Some perceive it as unsettling and threatening to their work practices and values, while others find the prospect of change exhilarating and are motivated to engage in the process (Smith, 2005). Zietsma et al. (2019) propose that emotions play a significant role in organisational change. In particular, they emphasise the significance of organisational learning during the change process. Defining this as a change in organisational thinking, routines, and behaviours as a result of new experiences, Zietsma et al. (2019) suggest that change within an organisation can evoke emotional responses from staff. They emphasise that these emotional responses are exhibited in anticipation of the change, during the implementation, and in the post-implementation reflection period.

Zietsma et al. (2019) note a range of emotional responses experienced by staff during periods of change, some positive and some negative. The authors state that positive emotions are exhibited in organisations where staff experience validation and support during the change process. Validation and support enable staff to feel safe, calm, and relaxed while implementing change. Zietsma et al. (2019) note that by confirming staff perceptions and emotions as valid and acceptable, organisations can encounter staff who feel enthusiastic, excited, and supportive of the change. These emotions often result in increased staff engagement and innovation to ensure the success of the organisational change. Although organisations can experience positive

emotional responses from staff, Zietsma et al. (2019) stress that negative reactions are common. They explain that if organisations do not provide staff validation, support or understanding during the change process, this can result in staff feeling cautious, threatened, angry and fearful. The authors affirm that these emotions can lead to difficulties with communication, obstruction and resistance during the change process. Zietsma et al. (2019) suggests that whether positive or negative, the most prevalent emotional response experienced by staff during organisational change is likely to be contagious. They propose that these emotions are projected as a shared experience by staff because they become persistent conversation topics and observations within the organisation.

Horwarth and Morrison (1999) consider the importance of training in addressing staff's adverse emotional responses during the change process in their book 'Effective Staff Training in Social Care'. The authors affirm that training is vital in enabling staff to manage the emotional upheaval associated with changes in their work practices. They further emphasise that training can make staff feel more at ease with change if it equips them with the specific skills, knowledge and support required to undertake their role in the change process. Horwarth and Morrison (1999) propose that increasing staff capabilities and confidence can help contain emotions such as anxiety and fear. Training enables staff to participate and engage meaningfully with the change process by counteracting these emotions. They argue that this results in staff feeling less threatened and more capable of ensuring the organisations' expectations of them implementing the change.

4.6.4 Research considerations for social care organisations

Conducting research in social care organisations is a complicated process. In order to ensure that a research project will be successful, organisations must establish a clear rationale from the outset (Byrne, 2015). Thomas and Hodges (2010) argue that organisations must have clear aims and objectives for the research. A paper by Rojon and Saunders (2012) which examined the importance of creating a convincing rationale for research studies within organisations, determined that justifying the need for a study enabled participants to recognise its importance. They explain this clarification as emerging from participants' understanding of how the study's results added to existing literature and helped to improve professional practices related to the research topic.

The rationale for research is not the only consideration to ensure successful research projects in social care. McGrath (2016) emphasises several vital considerations for ensuring the dissemination of research studies in her guide, which detailed steps for researchers to ensure broad dissemination and impact for researchers. McGrath (2016) stresses that organisations must ensure that they share the results of their studies so that other professionals can benefit from the data, conclusions, and recommendations. Furthermore, she insists organisations must ensure ownership of the research data to disseminate study findings widely. If organisations do not have autonomy over their research data, this can preclude them from controlling how and with whom the results are shared. McGrath (2016) encourages organisations to negotiate with research funders to secure data ownership before commencing the research project.

Additionally, McGrath (2016) notes the need for organisations to ensure that they consider how and where they will disseminate the results of their research project. McGrath recommends academic research journals as the primary dissemination pathway. She indicates that academic journals are the most accessible way for researchers to share and obtain research. McGrath (2016) explains that publications accepted by academic journals hold the most credibility with researchers. Interestingly, the literature suggests that successfully submitting articles to academic research journals is complicated (Mohajerzad et al., 2021; Hottentrot, Rose and Lawson, 2021). Mohajerzad et al. (2021) highlight the importance of research collaborations in influencing successful publications in academic journals. The authors emphasise that collaborations between researchers and professionals working in organisations can increase the potential for disseminating research studies. This increase in potential is related to the perception that research collaborations involving professionals within an organisation and researchers increase the relevance and integration of the study recommendations into professional practice.

Byrne (2016) affirms that ARs are the most prevalent submitters to academic journals. Byrne postulates that successful submissions to academic journals have been linked to the number rather than the quality of the AR's previous submissions. Byrne (2016) emphasises the importance of ARs publishing journal articles frequently to ensure their research makes the most significant impact. A study by Hottentrot, Rose and Lawson (2021) determined that studies with researchers who had affiliations with academic institutions were increasing in academic journals. The study examined the

prevalence and nature of multiple institutional affiliations in successful journal publications. The results of the 22 million journal articles and 15 million authors included in the study established that 60% of the total successful submissions to academic journals were from authors affiliated with academic institutions. This literature suggests that collaborations with ARs may be essential for social care organisations to consider as part of their dissemination plan for their research studies.

4.7 Conclusion

This chapter examined the literature on the impact of routine ACE enquiry within a social care organisation. The exploration and examination of the literature determined that implementing routine administration of the ACE survey within a social care organisation is a complicated process. Literature suggests that routine ACE enquiry can result in professional discomfort and that professional ACE scores can exacerbate this discomfort. Professional apprehension and barriers with the routine ACE enquiry were also evident within the literature. In particular, concerns about mandatory reporting and the fear of SU retraumatisation were evident. The chapter's final part considered organisational factors impacting routine ACE enquiry within a social care organisation. Literature within this section indicated that existing ACE implementation models consider factors which support organisational change. In addition, the literature suggests that organisational culture and the need to consider professional emotional responses are vital to successful ACE survey implementation. The next chapter will provide a methodological understanding of how the current study was conducted.

Chapter 5
Study methodology

5.1 Introduction

This chapter starts by outlining the focus of the study and the rationale for conducting it. The research questions and objectives will also be outlined. The chapter will then describe and justify the chosen research method, design, and strategy. Additionally, the study population will be described alongside the rationale for the chosen sampling procedures. The ethical issues that the researcher considered will then be described. The final section of this chapter will detail the data collection and analysis procedures implemented during the study and discuss how the researcher ensured data reliability and validity.

5.2 Original study focus

When data collection for the study commenced in 2019, the original purpose was to examine the routine administration of the Adverse Childhood Experience (ACE) survey by professionals working in FCs across the DoCCFS from manager, worker, and SU perspectives. As outlined in chapter 1, the DoCCFS is a not-for-profit public service organisation operating in the greater Dublin region. The service works in partnership with Tusla Child and Family Agency to provide a variety of therapeutic supports to children and families (DoCCFS, 2023). In June 2018, the service incorporated the ACE survey as part of a broader collaborative outcome measures research project with the Trinity Research in Childhood Centre (TRiCC) at Trinity College Dublin. The rationale for introducing the survey was to enable the service to examine the relationship between exposure to early life stress and later negative outcomes among SUs and also for the organisation to better respond to the needs of its SUs (Spratt, Swords, and Vilda, 2018).

As outlined in chapter 1, the collaborative DoCCFS/TRiCC research project has a quantitative research focus which involves the completion of the DoCCFS/TCD FC and ECDS OMSs with each adult SU (parent or caregiver) and the subsequent analysis and interpretation of aggregated data (Spratt, Swords, and Vilda, 2018). The FC and ECDS surveys included the survey from June 2018 until April 2020. At this time, the DoCCFS, in collaboration with TRiCC, decided to stop administering the survey as part of the

standardised OMS. The rationale provided for doing so was threefold. First, the DoCCFS SMT and the ARs from TCD felt that the organisation had collected sufficient ACE survey data about the SU population. Secondly, social distancing measures aligned with COVID-19 result in significant obstacles to survey completion for both the FCs and the ECDSCs. FWs, in particular, queried the appropriateness of administering the survey over the telephone. Thirdly, the DoCCFS SMT and TCDARs felt that it was appropriate to cease routine administration in response to the persistent concerns expressed by FWs that administering the survey was damaging their therapeutic relationships with adult SUs. The original focus centred primarily on the DoCCFS Family Centres (FCs) only. The ECDS Centres (ECDSCs) were omitted. This omission was related to the limited time and resources the researcher and her supervisor perceived to undertake a study based on both.

The original focus of the study with the DoCCFS FCs involved several research sub-populations; these included the DoCCFS Senior SMT and CPM; FCMs; FWs, and parents/carers who had completed the survey when they were Family Centre SUs (FCSUs). As data collection progressed, the study was impacted by several factors, including implications arising from the Covid-19 pandemic and unforeseen participant consent issues. Although these matters are outlined in detail later in this chapter, they are being highlighted to provide context and understanding that the study focus and research populations were changed and altered during the research process. The current study does not include FCSUs as a SU population and has extended to consider ACE survey administration within the DoCCFS ECDSCs. As part of this extension, additional research populations considered as part of the study include ECDS Centre Managers (ECDSMs) and ECDS workers (ECDSWs).

5.2.1 Rationale for the study

Ford et al. (2019:131) published the results of a scoping literature review, which examined 'studies published from 1997 until the end of April 2018 examining enquiry into ACEs, or the feasibility/acceptability of such enquiry across any setting'. This review identified 15 studies that met the eligibility criteria. After examining the findings of each, the conclusions indicated that all the research had been undertaken in health care rather than social care settings. Most studies identified involved self-completion of questionnaires by SUs, and few examined practitioners verbally asking SUs about ACEs. Given the global interest in and growing practice of health and social

care organisations asking SUs about childhood adversities, Ford et al. (2019) affirm that these research gaps should be addressed. DoCCFS is a social care organisation that facilitates self-completing the survey and routinely administers it verbally with SUs (parents retrospectively regarding their adversities during childhood and their children's current and retrospective experiences). The significance of this study is that ACE survey administration within the DoCCFS provided an opportunity to undertake a study that addressed the outstanding research questions identified by Ford et al. (2019) concerning the introduction of the survey within a social care setting.

An additional motive for the current study related to literature which indicated that professionals from clinical settings who participated in ACE enquiry studies reported resistance to asking about ACEs because they felt ill-equipped and inadequately trained to cope with SU's potential upset (Kerker et al., 2015; Becker-Blease and Freyd. 2007). The literature review in chapter 2 identified a significant gap in studies investigating the perception of professionals from clinical or social care settings with dual therapeutic training about routine ACE enquiry. To address this gap, the current study purposefully asked professionals in a therapeutic social care organisation about their experiences of administering the survey.

5.2.2 Research questions

The central aim of the current study is to examine the introduction of routine administration of the ACE survey in a social care organisation from manager and worker perspectives. The research questions of this study are:

1 Did ACE training prepare FCMs, ECDSMs, FWs and ECDSWs for routine administration of the ACE survey?
2 What was the experience of transitioning to the routine administration of the ACE survey like for FCMs, ECDSMs, FWs and ECDSWs?
3 To what extent and in what ways did routine administration of the ACE survey impact both FWs' / ECDSWs' relationships with SUs?
4 What impact, if any, did routine administration of the ACE survey have on the pathways of care experienced by SUs?
5 To what extent was ACE data (alongside other data from the TCD study) used to inform service delivery?

6 What impact did the existing differences between the services provided by the DoCCFS ECDSCs and FCs have on how the ACE survey was implemented and interpreted by workers?

5.2.3 Research Objectives

The study focuses on several research objectives to answer the research questions. These include the following:

- Ascertain to what extent the ACE training provided by TRiCC prepared the SMT, CPM, FCMs, ECDMs, FWs and ECDSWs for implementation of the ACE survey
- Establish gateways and barriers to administration of the ACE survey from managerial, ECDSWs and FWs' perspectives
- Gauge what impact (if any) administration of the ACE survey had on FWs and ECDSWs
- Examine how the differences, if any, between the services provided by the ECDSCs and FCs impacted the implementation and interpretation of the ACE survey by DoCCFS workers
- Establish profiles from aggregated ACE data at location and organisational levels
- Compare profiles with those from similar studies (where available)
- Examine the processes by which ACE data (alongside other data from the TCD study) were used to inform service development decisions by managers
- Examine the processes by which ACE data (alongside other data from the TCD study) were used to inform the development of assessment and intervention practices
- Use the findings to develop a model for the implementation of ACE-informed practices in social care organisations

5.3 Research paradigm

Adopting an appropriate research paradigm is essential in doctoral research (Gabi and Gabi, 2001). Research paradigms refer to the lens through which researchers view and interpret the world. A researcher's paradigm dictates how they conduct their study and ask questions. Simply defined, it refers to the common beliefs and consensus researchers hold about how research should be undertaken (Bryman, 2001). Research

paradigms incorporate assumptions about what reality is, how knowledge comes to be and what is valuable to determine. Researchers must be cognisant of their perceptions and beliefs in this regard. The researcher's paradigm is important because it permeates all study components (Baldwin, 2014). In developing this type of understanding and acknowledging their impact on the research process, researchers are better equipped to understand the importance of developing appropriate research questions, what methodologies are conducive to help answer their questions and how results should be interpreted (Davies and Fisher, 2018). A research paradigm incorporates the researcher's interpretation of what constitutes truth or reality (ontology) and what they know about reality, and how they come to know it (epistemology) (Davies and Fisher, 2018). Braun and Clarke (2022) stress that both paradigms are important because they enable the researcher to take a position about what is real and what exists (ontology) and what is possible to know, and the steps that should be taken to generate knowledge (epistemology). A researcher's ontological and epistemological positions assist them in identifying an appropriate methodology for their study (Ganiyu, Ebohon and Ajayi, 2020). Fryer (2020) argues that doctoral students must be clear about their ontological and epistemological positions before commencing their study; otherwise, they risk conducting research relating to knowledge that does not exist or overlooking important aspects of reality that are imperative to acquiring new knowledge. Concerning the current study, the following paragraphs outline the ontological and epistemological paradigms adopted by the researcher.

Ontological position

An ontological position represents how the researcher views the nature of reality. As it is an individual lens for viewing the world, the researcher's ontological position is impacted by their values and experiences. Due to this, their ontological position often permeates their motivation to conduct their study and the types of questions they want to ask (McManus, Mulhall and Ragab, 2017). According to Fryer (2020), there are two basic ontological positions, realism and irrealism. An ontological realism position incorporates three assumptions: (i) there is a single world; (ii) that reality is independent of human minds and language, and (iii) there is only one accurate and complete version of the world. Realism suggests that although reality can be comparative, it is consistent. Ontological realism calls for the researcher to search for a single version of reality. In doing this, the researcher acknowledges that the world

exists and that it is completely independent of how they or others think about it, what they believe about it and how they perceive it (Gentile, 2016).

On the other hand, ontological irrealism maintains that there is no specific reality and that there are, instead, conflicting versions. Researchers who adopt ontological irrealism believe that the multiple versions of the world make it difficult to define reality and one version of the truth concretely. Ontological irrealists believe that reality is influenced by how one thinks about and perceives it and that there is no one reality out there. As reality is impacted by individual cognition and perception, irrealism acknowledges that there can be multiple realities and versions of the truth due to inconsistencies. Ontological irrealists seek to identify the inconsistencies and multiple versions of reality in their studies (McLeod-Harrison, 2002).

Concerning the current study, the researcher adopted an ontological realism position. The rationale for this position was influenced by their experience as a social work practitioner and the literature review they conducted during the doctoral research proposal process. From social work practice experience, the researcher understood that although people can view a situation differently, there is a single version of the world. Despite acknowledging how individuals interpret reality, and the language they use to do so adds depth to their perception of it, the researcher's experience suggested that reality is consistent and singular. Similarly, the literature review conducted as part of the research proposal process indicated that the research findings concerning the implementation of the ACE survey in clinical settings had been consistent and that individuals who had administered the survey were concordant in how they portrayed the reality of their experiences. The barriers and emotional responses outlined in the empirical research affirmed that there was congruency, in reality, relating to the experience of implementing the survey.

Epistemology

A researcher's ontology underpins their epistemology position. Their assumption of reality determines how they generate knowledge and present their results to the world to be easily comprehended (McManus, Mulhall and Ragab, 2017). Fryer (2020) identifies two epistemological positions, objectivist and subjectivist. He further outlines that a researcher adopting an objectivist position assumes that there are no major obstacles to generating knowledge. This position maintains that to produce knowledge about the world; the researcher merely has to conduct research and

observe the world. Researchers adopting an objectivist position generate knowledge independent of human contextual factors and bias (Levers, 2013). Subjectivist epistemology takes a more complicated stance and expects the researcher to understand that knowledge is consistently influenced by social class, gender, ethnicity and race. It involves the researcher adopting the belief that knowledge is influenced by how individuals interpret the world, impose meaning, and understand it. A subjectivist epistemology also recognises that language and symbols influence the type of knowledge produced (Moon and Blackman, 2017). A subjectivist epistemology calls for the researcher to understand that generating knowledge is value driven. In addition, the researcher must recognise that their observation always influences knowledge and that their observation will be affected by what and who they have observed (Levers, 2013). According to Levers (2013), researchers who adopt a subjective epistemology do so to ensure that the knowledge produced by their research develops an understanding of their research topic, increases awareness of the associated moral and ethical issues and enhances individual and collective emancipation.

Regarding the current study, the researcher adopted a subjectivist epistemology. The justification for this position stems from the researchers understanding that examining how the ACE survey influenced service provision within the DoCCFS could be influenced by contextual factors. Given that the study encompassed several participant groups, the researcher accepted that their understanding and interpretation of the ACE survey could be influenced by their gender, social class, educational background and personal experiences of childhood adversities. The researcher also accepted that their perceptions, understanding of the world and previous experiences could influence how they collected and they collected knowledge and interpreted it. Similarly to the process for establishing the ontological position for this study, the literature review as part of the PhD proposal was influential in identifying subjectivism as an appropriate epistemological position. The empirical research studies reviewed indicated that perceptions of administering the ACE survey were subject to human bias and contextual factors. The researcher, therefore, needed to adopt an epistemological approach that would account for these subjective influences on the knowledge collected and generated by the study.

Critical realism – The research paradigm for the current study

The chosen research paradigm for the current study is that of critical realism. According to Fryer (2020), critical realism is a research paradigm incorporating the realism ontological position and the subjectivist epistemological position. Critical realism combines ontological realism (there is one version of reality which is independent of human thinking and interpretation) with a subjective epistemology (different people will view things differently depending on their individual bias and contextual factors) (Stutchbury, 2021). According to Morin, Olsson and Atikcan (2021), critical realism as a research paradigm calls for the researcher to consider how 'observable' and 'concealed' aspects of reality, such as social structures and culture, can impact the generation and interpretation of research knowledge. The authors further affirm that critical realists emphasise the importance of uncovering casual mechanisms that can impact structures and power within the cultures and organisations where they conduct their research studies. A researcher adopting this position accepts that independent structures can influence the actions and interpretations of research participants in a particular setting whilst also recognising that participants can be affected by contextual factors and reasoning (Mukumbang, 2023). The critical realism ontological position enables the researcher to identify and abstract the events or phenomena being studied, uncover the relationships between structural and contextual factors and how they influence the study findings, and employ multiple data collection methodologies.

Regarding the latter point, critical realism has been identified as an appropriate ontological position for researchers who want to implement mixed-method research methodologies (Ryba et al., 2020). It has also been identified as suitable for researchers undertaking case study research. As critical realism recognises the significance of structural and contextual factors, it aligns well with the subjective nature of the case study research design (Mukumbang, 2021). The rationale for adopting a critical realism ontological position for the current study is based on the researcher recognising that the DoCCFS has an individual culture and structure. The researcher understood that these cultural and structural factors could influence how participants experienced the administration of the ACE survey within the organisation and that the findings would be subjective. As the study adopted a case study design and employed a mixed method methodology (both of which will be explained in more detail

within this chapter), the researcher identified critical realism as the most appropriate ontological position.

5.3.1 Research method

Research methodology can be defined as the systematic way in which a researcher sets out to answer the research problem. Research methodologies can be qualitative, quantitative or mixed-method (Goundar, 2012). Researchers use qualitative research methods to gather, analyse, interpret, and present narrative information (Teddlie and Tashakkori, 2009). Kara (2022) explains that researchers can be biased towards one method. Qualitative researchers attribute significant importance to identifying themes and patterns within participant data concerning their thoughts, attitudes and beliefs about experiences and social phenomena. This approach aims to help the researcher to determine casual relationships in how participants experience and perceive social situations and circumstances (Alston and Bowles, 1998). Quantitative researchers, on the other hand, identify significant importance in numbers. They want to collect, analyse, and interpret data that can be statistically quantified. Creswell (2015) acknowledges that singularly, both qualitative and quantitative methods result in disadvantages for the researcher. Disadvantages of the qualitative method include a lack of generalisability, study populations tend to be smaller, and it provides soft data only; the method is primarily subjective. The disadvantages of the quantitative method include: it does not capture participants' narratives, provides a limited understanding of participant contexts, is impersonal, and largely depends on the researcher's mathematical and statistical research skills. To effectively conduct quantitative research, the researcher must be adept at creating statistical instruments such as surveys and questionnaires. In addition, they must have the statistical skills to analyse the data and generate accurate findings (Alston and Bowles, 1998).

After considering the qualitative and quantitative research approaches, this study used a mixed-method approach. Creswell (2015) affirms that the mixed method research methodology involves research combining both quantitative and qualitative data to provide a better understanding of a research problem. Bergman (2008) argues that combining both methods by implementing a mixed method approach enables the researcher to significantly reduce the disadvantages attributed to each. Creswell and Plano-Clark (2018) stress that a mixed method approach should be implemented where the researcher perceives that the singular use of qualitative or quantitative

methods is insufficient in answering the research problem. Implementing both approaches allows the researcher to obtain the scientific exactness of quantitative data while incorporating a broader understanding of the research problem from the qualitative approach and associated data (Brewer and Hunter, 2007). Practically speaking, Creswell (2015:3) outlines the core characteristics of the mixed methods approach as follows:

- 'The collection and analysis of both qualitative and quantitative data;
- Implementing conscientious qualitative and quantitative research methods
- Combining qualitative and quantitative data and analysing this integration
- Where necessary, framing this approach within philosophy or theory'.

A literature review examining the future of the mixed method research paradigm by Migiro and Magangi (2011) identified several weaknesses with the methodological approach. These weaknesses included that to implement the approach effectively, the researcher must be adept in multiple methods and understand how to implement them successfully. The fact that some details of the approach have not yet been refined, e.g. how to interpret and report conflicting results, was also highlighted as a challenge for researchers. Lastly, mixed method research was identified as potentially overwhelming for researchers when combining quantitative and qualitative research methods that run simultaneously. Despite these weaknesses, the mixed methods approach was implemented in this study because it enabled the researcher to examine the introduction of the ACE survey in a social care organisation from manager and worker perspectives. Singularly, neither quantitative nor qualitative methods would have been sufficient to answer the research aims or objectives. Simplistically justified, the mixed methods approach provided the researcher with a framework for considering quantitative data (ACE survey data) in tandem with qualitative data (DoCCFS manager and worker perspectives) to answer the research questions.

5.3.2 Research design

A research design outlines how the researcher will collect, analyse, and report study data. It details the exact sampling, data collection and analysis approaches implemented in the study (Alston and Bowles, 1998). The research design

encompasses how the researcher prioritises various issues related to the research process. These issues range from understanding participants' behaviour and its meaning from a contextual standpoint; generalising findings to larger groups than the study population; expressing casual relationships between variables, and having a time-related recognition of social phenomena and their interconnectedness (Bryman, 2001). This study implemented a case study design. Yin (2003) defines a case study as an inquiry examining a situation from a real-life contextual perspective. Contextual refers to 'factors dependent on or related to the circumstances that form a setting or event.' (Oxford Reference, 2022). Brewer and Hunter (2007) assert that a case study design enables the researcher to describe a particular phenomenon, event, situation, or experience. According to Creswell (2009), case studies implement qualitative and quantitative techniques. In addition, case study designs result in a research process restricted by time and specific activity. The design involves the researcher implementing several data collection procedures over a defined period (Creswell, 2009).

Adopting a case study design has been criticised by researchers, with some perceiving it as a less desirable form of enquiry than others (Yin, 2003). One of the design's major criticisms is that findings from case study design inquiries offer non-generalisable evidence (Bergman, 2008). Bryman (2001) notes that research designs need to be replicable. Since the case study design is weighted heavily on the specific context and associated variables, replication cannot be guaranteed. Whether case study designs can be deemed 'rigorous' enough is also an identified criticism. The case study design has been identified as requiring a more robust research protocol. When researchers do not follow rigorous procedures or allow ambiguous data to influence findings and conclusions, study findings can be questioned and called into disrepute (Yin, 2018). Creswell and Plano-Clark (2018) emphasise this design's limitation as it depends on the researcher's ability and previous expertise in implementation. The researcher must understand how to conduct case study research effectively. The researcher's abilities consequently play a significant role in the overall success of this design.

After considering these criticisms and notwithstanding them, the researcher deemed the case study design appropriate for the current study. Given that the study aimed to examine the routine administration of the survey within a specific social care organisation, the researcher was cognisant that this represented a particular setting.

The literature review uncovered that no other studies had been undertaken in a social care setting that offered ECDS and family support inputs. Focusing the study on the DoCCFS meant that the population sample was specific to the situation and context. The justification for implementing a case study design relates to the outline of appropriate situations for its use by Scapins (1990), as outlined in Table 5.1. The current study meets all of the appropriate criteria as described.

Table 5.1
Appropriate situations to implement Case Study Design
(Adapted from Scapins, 1990)

1.	Where the purpose of the study is to detail current practice
2.	Where the study aims to investigate new and potentially beneficial approaches that have been implemented in a particular setting or by a particular group
3.	When the study investigates the challenges in implementing new approaches or activities in an organisation and also evaluates the potential benefits of implementation
4.	Where existing theory can be used in considering and understanding processes or phenomenon
5.	Where there is insufficient knowledge to develop a hypothesis and/or where, there is a lack of theorisation

The rationale for undertaking the current study, as described in chapter 1, details how the study set out to address the existing gap in literature relating to how professionals in social care organisations perceived the ACE survey. No extant research on using the survey in a social care organisation meant that the researcher could only develop a proxy hypothesis based on the results of the survey implementation studies conducted in clinical settings. In recognition, the researcher decided that applying a case study design would effectively answer the research problem. Implementing this research design provided a pathway for the findings to make a unique contribution concerning professionals' experiences of administering the survey in social care organisations.

5.3.3 Mixed method research strategy

Creswell (2009) affirms that once the researcher has identified their research method, they must then consider and decide upon the strategy of inquiry that they wish to apply from within the method. Inquiry strategies are defined as specific instructions and

procedures related to the research design. Mixed method research strategies include concurrent procedures where the researcher collects and combines data to analyse the research problem comprehensively. Transformative strategies are mixed methods where the researcher examines the combined data through a theoretical lens (Creswell, 2009). A sequential mixed-method research strategy involves the researcher collecting or considering the data in sequence to use the data collected and part of one method to develop questions for the data collected by the other (Cameron, 2009). At the study's outset, the researcher implemented a concurrent research strategy. The rationale for doing this was that the researcher perceived that both data sets could be collected and analysed simultaneously. The researcher believed that the quantitative data would provide an ACE profile for the DoCCFS, and the qualitative data would deliver findings relating to managers' and workers' experiences of administering the survey. In effect, the researcher anticipated that although the quantitative and qualitative data would collectively answer the primary research question, the researcher did not foresee the need to consider the quantitative survey data for anything beyond establishing the ACE profiles of DoCCFS SUs.

The researcher identified a need to reconsider the research strategy during the data analysis process. This need arose when the themes that emerged from the qualitative data analysis evoked questions to which the quantitative data could offer insights. An example of one of these themes related to the impact of mandatory reporting obligations on staff experiences of administering the survey within the DoCCFS. When the researcher perceived the pervasiveness of this issue in the interview material, they recognised that the quantitative data could be examined to determine how many survey responses required mandatory reporting consideration during the study timeframe. As the data analysis continued, similar themes emerged. This chapter will discuss these themes more extensively under the quantitative data collection heading. Due to this realisation, the researcher changed the research strategy from concurrent to sequential during the data analysis process of the study (Creswell, 2009).

Creswell (2015) specifies three primary mixed-method sequential research designs and outlines them: The contemporary design, the explanatory sequential design, and the exploratory sequential design. Contemporary design is defined as the separate collection of qualitative and quantitative data. This design combines the results of both data sets to answer the problem. The explanatory sequential design

involves collecting quantitative data and then implementing qualitative methods to explain the quantitative results (Creswell, 2015). This study implemented the exploratory sequential design. Creswell and Plano-Clark (2018) describe this mixed method research design as a process that involves the researcher commencing with the collection and analysis of qualitative data, which is succeeded by a phase where the researcher uses qualitative data findings to develop a tool or an approach that can be tested quantitatively. This design results in a tool or approaches informed and guided by the qualitative data collected from participants in the first phase of the research process. The exploratory sequential design enables the researcher to develop a survey, intervention or new variables based on the culture or the setting of participants. It is tailored specifically to the study population and the research problem.

In considering the use of this design, the researcher examined the noted strengths and weaknesses in the literature. This design's strengths were outlined as its rigour which results in an intricate and advanced approach (Creswell 2015). The separate phases of the design were emphasised as offering a sequential process that was easy to describe, implement, replicate and report (Creswell and Plano-Clark, 2018). Lastly, the design offered researchers the opportunity to develop a new instrument was highlighted as positive. Producing new instruments was acknowledged as potentially adding merit and weight to a study's overall impact (Creswell and Plano-Clark, 2018). Disadvantages of using the design were identified as the need for researchers to plan for an extended time to complete their study. The progression from using qualitative data to developing a new quantitative analysis plan was highlighted as time-consuming. In addition to the time pressure, the need for the researcher to be skilled in qualitative and quantitative research methods was identified as a potential barrier (Plano-Clark, 2018). After considering the advantages and disadvantages of implementing this design, the researcher determined it was the most appropriate mixed-method design for the study.

Recognising the need to adopt a sequential mixed method strategy, the researcher paused the quantitative data analysis. The rationale for pausing data analysis was to ensure that the quantitative data findings would not skew the researcher's interpretations of the qualitative data. The researcher then proceeded to analyse the qualitative data. During the first qualitative data analysis phase, the researcher identified variables from the emerging themes, which assisted in

developing questions to inform the quantitative analysis phase of secondary data from the DoCCFS/TRiCC FC and ECDSC OMSs. After developing these questions, the researcher re-instigated and completed quantitative data analysis. The last phase of the exploratory sequential mixed method design involved the researcher considering if there were consistencies or discrepancies between the qualitative and quantitative data findings.

5.4 Research population

A research population comprises a sample of participants who share similar characteristics within the research setting (Edmonds and Kennedy, 2017). Through their participation, the participant group provides the researcher with data to assist them in investigating and developing findings relating to the research problem (Pole and Lampard, 2002). Given that the researcher employed a case study design, the research population was explicitly drawn from social care professionals employed in the DoCCFS. The DoCCFS offers a range of therapeutic child and family services, including seven FCs, six ECDSCs, Dublin Safer Families (DFS), a targeted domestic violence service, and two Tusla-affiliated services that undertake initial assessments for Ireland's statutory Child and Family Service (DoCCFS, 2023). The research population for the study did not include social care professionals from the DoCCFS DSF or the two Tusla-affiliated assessment services. The rationale for not including the Tusla-affiliated assessment services was that they did not complete the survey as part of the broader collaborative OMS. These services, therefore, did not offer social care professionals or secondary aggregated data from SUs that could address the research questions. Concerning excluding the DFS service from the study, the reasoning behind this was related to the fact that this service was targeted and specific. Although social care professionals within the DSF service participated in routine ACE inquiries with SUs, the number of social care professionals within the service was small, and the nature and approach to the work undertaken by the professionals varied considerably from those in the FCs and ECDSCs. Due to these factors, potential data collected from the social care professionals working in this service was deemed too small and incomparable with the data gathered from the more extensive research populations in the DoCCFS ECDSCs and FCs.

Sampling procedures

The research sample refers to the number of participants drawn from the research population. Simplistically put, it encompasses a portion of the larger research population (Gabi and Gabi, 2018). There are two types of sampling techniques in research, probability and non-probability (Showkat and Parveen, 2017). These techniques have significant differences (Pole and Lampard, 2002). Probability sampling is primarily applied in quantitative studies. The technique involves recruiting and choosing a smaller group of participants representative of the larger study population (Edmonds and Kennedy, 2017). Due to these factors, probability sampling enables the researcher to make statistically informed conclusions about the broader population. Comparatively, non-probability sampling involves a non-random selection of participants based on convenience, accessibility, and other factors for the researcher. In non-probability sampling, the researcher identifies and recruits participants based on a list of criteria or because of availability. This technique is often used in exploratory and qualitative research. Non-probability sampling enables the researcher to construct a deeper understanding of a smaller, specific population (McCombes, 2022). As the central research question aimed to examine the introduction of routine administration of the ACE survey in a social care organisation from manager and worker perspectives, the population sample had to meet a list of criteria to participate. This chapter will outline these criteria under the eligibility to participate headings later in this chapter. Due to this, a non-probability sampling technique was deemed the most appropriate sampling procedure for the study.

A researcher can draw from several forms of non-probability sampling (Pole and Lampard, 2002). Babbie (2017) outlines the sampling forms: convenience, snowball, quota and purposive. Convenience sampling refers to study participants drawn from people that are easily accessible and convenient for the researcher (Ayhan, 2011). Snowball sampling is defined as the researcher using existing study participants to assist them in identifying additional participants (Teddlie and Tashakkori, 2009). Quota sampling incorporates representative data to account for equivalent proportions of the broader population (Kara, 2022). Purposive sampling involves the researcher using special knowledge to purposefully identify a research sample (Ruane, 2016). The central aim of this study was to examine the introduction of the survey in a social care organisation from manager and worker perspectives, and given that the researcher identified social care professionals from the SMT, ECDSCs and FCs as the

primary focus of the study, purposive sampling was deemed to the most suitable form of non-probability sampling. Purposive sampling is generally implemented when the researcher's objective is to gather and generate substantive detail and understanding from a specific case (Teddlie and Tashakkori, 2009). In this instance, the researcher required a sample that would specifically assist them in examining how social care professionals perceived survey administration in two specific service settings within the DoCCFS. The following paragraphs detail the qualitative and quantitative sampling procedures implemented within the study.

Qualitative research sample

As the researcher employed purposive sampling, the sample identified for this study was based on information gathered from meeting with representatives from the DoCCFS during two stages of the research process. These stages included the research proposal planning phase and a time during the study when the researcher was required to change the sample configuration due to unforeseen issues with SU consent and COVID-19 implications; please refer to table 5.2, which outlines these amendments.

During the research proposal planning stage, the researcher met representatives from the DoCCFS SMT, FCMs and academics from TRiCC. The researcher also had access to the information contained within several publications relating to ACE survey administration as part of the DoCCFS broader collaborative outcome measures research project with the Trinity Research in Childhood Centre. These publications included a DoCCFS evaluation report by Spratt, Swords, and Vilda (2018) titled *'Why Measures Matter'* and two annual DoCCFS reports (DoCCFS, 2017; DoCCFS, 2018). As the original purpose was to examine the routine administration of the survey by professionals working in FCs across the DoCCFS from manager, worker, and SU perspectives, the researcher determined that the sample should be drawn from the DoCCFS head office (where the SMT was located) and the seven DoCCFS centres (Where the FCMs; FWs and FCSUs could be accessed).

Table 5.2 Changes to the study population sample	
Original Qualitative Sample ***(October 2019)***	**Amended Qualitative Sample** ***(May 2021)***
➢ DoCCFS SMT/ CPM ➢ DoCCFS FCMs from seven participating FCs ➢ DoCCFS FWs from seven participating FCs ➢ Twenty DoCCFS FCSUs from seven participating FCs	➢ DoCCFS SMT/CPM ➢ DoCCFS FCMs from seven participating FCs ➢ DoCCFS FWs from seven participating FCs ➢ ECDSMs from six participating ECDSCs ➢ ECDSWs from six participating ECDSCs

Eligibility for the first qualitative sample was restricted to the following:

- Members of the DoCCFS SMT who expressed interest in participating;
- DoCCFS FCMs who expressed interest in participating;
- DoCCFS FWs who expressed interest worked in the seven identified DoCCFS FCs and were administering the DoCCFS/TCD survey and;
- A maximum of twenty adult DoCCFS FCSUs who were availing of or had availed of support from the seven identified DoCCFS FCs from September 2019 until ACE survey administration stopped in April 2020; DoCCFS FCSUs also had to have completed the DoCCFS/TCD survey with FWs and have the ability to read and communicate in English.

In line with a purposive sampling approach, during the initial study sampling stage, the entire DoCCFS SMT and CPM were invited via email to participate (n=4). Similarly, all FCMs and FWs who met the eligibility criteria outlined in the preceding paragraph across the seven DoCCFS FCs were also invited to partake (potential sample number ranged depending on FC size, catchment population and staff ratios). Before the unforeseen consent issue relating to DoCCFS FSCUs (which will be described under the Data Collection heading), the researcher also circulated an email to FCMs to commence recruitment for this original population sample. The consent issue became apparent upon sending this email, and the DoCCFS SMT instructed the researcher that recruitment of DoCCFS FCSUs could not and should not proceed.

As the researcher could no longer collect data from DoCCFS FCSUs, the research sample had to be revisited. This led to a second stage of configuring the study sample. Although the ECDSCs had not been included initially as part of the study due to resourcing and timing issues for the researcher, at this stage in the research process, the inclusion of the ECDS was reconsidered. The rationale for this reconsideration emerged from preliminary findings relating to DoCCFS FWs data. Preliminary findings from the DoCCFS FWs sample determined an apparent inability within the population sample to purposefully articulate how administering the survey influenced service provision within the DoCCFS FCs. When the researcher provided the DoCCFS SMT with this feedback, they expressed confidence that, unlike the FCs, the ECDSCs would be able to make the connection. They explained that the ECDSWs had not administered the survey but had, as part of the implementation process, received training from the academic ARs from TCD. According to the SMT, since completing the training ECDSWs had been more vocal about the role that ECDSCs played in responding to children's ACEs. They further advised that ECDSWs had described changes to their practice approaches arising from their ACE training. The SMT affirmed interest in the study, expanding to compare and contrast the perspectives of professionals in both services regarding survey administration. At this point, the researcher liaised with her PhD supervisor and, in consultation, determined that it was feasible from a resourcing perspective for the study to expand to include the ECDSCs. After making this decision, the researcher emailed all ECDSMs (n=6) and ECDSWs (sample number varied depending on staffing and required child-to-ECDSW ratio), inviting them to participate.

Quantitative research sample

Unlike the process for identifying the qualitative sample, the quantitative sample for the study was determined entirely during the research proposal planning stage. Following liaison with representatives from the DoCCFS SMT, FCMs and academics from TRiCC, and after reviewing the publications relating to the ACE survey findings as part of the DoCCFS broader collaborative outcome measures research project with TRiCC, the researcher isolated several factors that assisted in identifying an appropriate quantitative study sample. These factors included the realisation that the DoCCFS possessed secondary aggregated data that could enable the researcher to address the research question. Secondary data is existing data that can be used for secondary analysis to answer a research question (Watkins, 2023). The secondary data

relates to the quantitative data collected in the collaborative DoCCFS/TCD OMS. Aggregated data refers to a collection of survey data completed by individual research participants, which is compiled and summarised as a sum total (Babbie, 2017). The DoCCFS/TCD OMS aggregated data concerning DoCCFS SUs' demographic information and ACE survey responses collected during the current study's timeframe were analysed. This aggregated data format made it not identifiable to any specific DoCCFS SU.

In addition to these factors, the researcher was aware that DoCCFS FWs were instructed to ask all FCSUs to complete the DoCCFS/TCD OMS. This meant that the researcher could access a large group of FCSUs availing of DoCCFS FC services during a specific timeframe. The researcher also established that the data collected related to the ACE survey and provided information regarding DoCCFS FCSU demographics, survey completion and response rates. This data was identified as pertinent to answering the quantitative component of the research question. In consultation with the DoCCFS SMT, FCMs, academics from TRiCC and the PhD supervisor, the researcher identified the following final quantitative study sample: Aggregated survey data relating to DoCCFS adult FCSUs and ECDSSUs OMSs, completion rates, ACE response rates, and demographic information from September 2019 until April 2020 (when completion of the survey as part of the DoCCFS/TCD OMS stopped).

5.5 Ethical considerations

Ethical considerations relating to this study included ensuring confidentiality and obtaining informed consent. Creswell (2009) stresses the importance of protecting participants' anonymity, ensuring that participants are provided with adequate information about the research purpose and process and asking participants to sign a consent form. Research participants were provided with an information handout explaining the purpose of the study, the process involved and the possible risks of participation before providing consent. As mentioned, the quantitative data for this study was taken from the OMSs completed by SUs in the DoCCFS FCs and ECDSCs during the study timeframe. The consent for the researcher to use this data was obtained via the consent form that adult SUs were asked to sign before completing the survey. This consent form advised participants that their data would be made available to researchers in aggregate form and that no identifiable information would be shared.

This consent explicitly asked participants to agree to their data being used for research studies by researchers affiliated with the DoCCFS and TCD.

Since some research participants could be potentially identified in the qualitative data by demographic information, such as their profession or employment location, their information was pseudonymised within the data findings. Rubin et al. (2014) explain that anonymisation guarantees that no identifying information about participants is revealed. Fiedler (2014:6) describes pseudonymisation as replacing a person's name or other identifying details with alternatives to make recognition exceptionally difficult. All data collected as part of the study adhered to data protection guidelines. Audio recordings, transcriptions and consent forms were saved in a password-encrypted folder on the researcher's laptop. The researcher informed participants that their data would be stored and destroyed per TCD policy.

The limitations of confidentiality were outlined in the Participant Information Sheet for those partaking in the focus groups and the semi-structured interviews. Participants were made aware that should they disclose anything during the study that suggested a current or potential risk (physical, emotional or sexual abuse, concerns for child protection, rape, self-harm, suicidal intent or criminal activity) to themselves or anyone else, or if a serious crime has been committed, that the researcher may have to contact the appropriate statutory body, e.g. Tusla Child and Family Agency, An Garda Síochána and/or a Health Service Executive Safeguarding, Vulnerable Adult Team. After reading this information sheet, participants were asked if they had any questions for the researcher. After answering any questions, the researcher asked participants to sign a consent form indicating their willingness to participate in the study.

5.6 Data collection

The data collection process of any study involves the researcher gathering information, which enables them to address the research question. Data collection procedures vary but usually represent several interconnected steps. These steps include participant recruitment, obtaining consent and collecting the data using different methods (Creswell and Plano Clark, 2018). Given that the study implemented a mixed method approach, the next part of this chapter will describe the qualitative and quantitative data collection methods the researcher implemented.

5.6.1 Qualitative data collection methods

The researcher employed two qualitative data collection methods during the study, semi-structured interviews and focus groups. Morse (2016) describes semi-structured interviews as questions developed by the researcher from the perspective that they possess enough knowledge about the research topic to create initial questions but not enough to anticipate the answers. Semi-structured interviews encompass the use of an interview guide. Interview guides provide a list of open-ended questions which assist the researcher in facilitating discussion about the research topic. They are designed to ensure flexibility and space for research participants to contribute perspectives and insights that may not be expected or accounted for by the researcher (Flick, 2018). The researcher's rationale for using semi-structured interviews aligns with the justification outlined by Dejonckheere and Vaughn (2019). The researcher wanted to generate open-ended data about participants' thoughts, attitudes, beliefs, and feelings about implementing the ACE survey. Additionally, the researcher wanted to develop a deeper understanding of any sensitive or personal issues that may have arisen for participants during the survey implementation process. A list of open-ended questions (Please refer to Appendices 1-4) was developed by the researcher and approved by both the DoCCFS SMT and the TCD School of Social Work and Social Policy Research Ethics Committee. The researcher used this list as a reference point throughout the, on average, hour-long semi-structured interviews with study participants.

Focus groups are defined as group discussions facilitated by a researcher which examine and explore a set of issues. Focus groups are different to semi-structured interviews because they involve several research participants in a group setting, with the data generated being influenced heavily by the interaction of the group (Barbour and Kitzinger, 1998). Focus groups establish collective and a range of divergent opinions rather than individual perspectives (Morse, 2016). Since focus groups are considered cost- and resource-effective for researchers, enabling participants to generate data by expanding and building on what others shared before them (Leung and Savithiri, 2009), the researcher identified this as an appropriate data collection method for the study. The researcher developed a list of open ending questions and probes (please refer to Appendices 5-6). The researcher referred to the list of questions and probes, where appropriate, throughout the hour-long focus groups.

5.6.2 Data collection process

The study data collection process involved four qualitative phases. The quantitative data for this study was gathered as part of the DoCCFS/TCD OMS, and the researcher was not involved directly in the data collection process. The quantitative data was made available to the researcher from the outset of the qualitative data collection phase. Table 5.3 provides an overview of the number of study participants. The researcher accessed this data briefly in December 2019 to commence data analysis but paused once the decision was made to change from a concurrent to a sequential research strategy. The following paragraphs outline each phase of data collection as well as factors which impacted the overall data collection process:

Table 5.3
Study participant overview

Phase	Study population	Number
1 = Qualitative Nov 2019 – Feb 2020	DoCCFS SMT and DoCCFS FCMs *(semi-structured interviews)*	SMT (n=3) FCMs (n=5)
2 = Qualitative Nov 2020 – Jan 2021	DoCCFS FWs *(focus groups)*	FSWs (n=16) FCs (n=5/7)
3 = Qualitative July 2021 – Aug 2021	DoCCFS ECDSMs *(semi-structured interviews)* & DoCCFS ECDSWs (focus groups)	EDCSMs (n=4) ECDSWs (n=12) ECDSCs (n=3/6)
4 = Qualitative August 2022	DoCCFS Managing Director *(semi-structured interview)*	(n=1)
5 = Quantitative June – August 2022	Secondary aggregated data from Outcome Measures Surveys completed by DoCCFS FC and ECDSC service users	ECDSCs (N=105) FCs (N=118)

Phase 1: Semi-structured interviews with DoCCFS SMT/CPM and FCMs

Timeframe: *November 2019 – February 2020*

The identified study sample of DoCCFS SMT / CPM and FCMS was invited to participate in the research study via email. After confirming participation and obtaining consent from each participant, the researcher conducted semi-structured interviews with members of the DoCCFS SMT (n=3). These interviews were held either in the DoCCFS Head Office or at the location where the DoCCFS SMT member was. Each semi-structured interview was recorded using an audio recording device. The DoCCFS Chief

Executive Officer (CEO) was not interviewed in the initial phase of the research as the researcher decided that it would be more beneficial to interview this individual once the other qualitative data analysis had been completed. The rationale for this is related to the realisation that the researcher may need to clarify data findings before commencing data analysis. Given that the DoCCFS CEO had primary responsibility and oversight of the collaborative DoCCFS/TRiCC survey implementation, the researcher determined that they were the most appropriate person to provide such clarification. As previously indicated, seven DoCCFS FCMs were invited to participate in this study. Once data collection had been completed, the researcher transcribed all the semi-structured interviews and commenced preliminary analysis. This preliminary analysis subsequently led to the researcher reconsidering the research question. The next section of this chapter will discuss the rationale and outcome of this reconsideration for the data collection process in detail.

Reconsideration of the research question arising from data analysis

Timeframe: *April 2020*

After a preliminary analysis of Phase 1, qualitative findings suggested that the DoCCFS SMT and FCMs perceived that FWs who identified as psychotherapists expressed the most reservations about administering the ACE survey within the organisation; the researcher completed a literature search to ascertain if this finding was evident. This literature search determined a gap in the research relating to this topic. Although there was literature which examined the perceptions and experiences of health and social care professionals in asking about ACEs (Pearce, Murray and Larkin, 2019; Albaek et al., 2018), there was no mention of studies involving psychotherapists in the literature. While there was mention in the literature of health and social care professionals' feeling ill-equipped to respond to disclosures of abuse or SU upset (Pearce, Murray and Larkin, 2019; Becker-Blease and Freydd, 2007; Kerker et al., 2015), there were no studies that examined the concerns of social care professionals who had therapeutic training. There was also no research regarding dually qualified professionals (health and social care professionals who were psychotherapists). Given the number of staff employed by the DoCCFS with dual training, the researcher perceived that the study could be extended to address this gap in the literature.

During the literature review, another gap in research was identified. This gap related to whether social care professionals had elevated ACEs scores compared to the

general population and whether this could impact service provision and professional practice (Hubel et al., 2020; Keesler., 2018; Branson et al., 2019). For example, a study completed by Hubel et al. (2020) in the USA to examine the effect of self-reported ACE scores by 349 early care and education teachers on the social and emotional climate within their classrooms found a correlation between teachers who had experienced emotional and physical abuse and incarceration of a parent and subsequent lower quality social and emotional teaching climates. No research was reported on the practice implications of social care professionals' self-reported ACE scores. After uncovering these gaps and consulting with the PhD supervisor, the researcher sent a letter (as an attachment to an email to the DoCCFS SMT on April 9th, 2020, requesting approval to make changes to the original research question. The researcher outlined these proposed changes as the study title would remain the same, 'Using the ACE Survey to inform service provision in a social care organisation: A case study'. However, two additional research questions would be added to the proposal. These questions were as follows:

- **Did FWs' ACE scores have any impact on their perception of administering the ACE survey?**
- **To what extent (if any) did a FWs' professional identity and/or background contribute to their perception of routine administration of the ACE survey?**

The researcher received an email response from the DoCCFS SMT on April 9th. This email response advised that the SMT would not approve the proposed changes. The SMT provided several reasons for declining the request. Consent was outlined as the first; the SMT indicated that because DoCCFS FWs agreed to participate in the research based on the original proposal that the SMT had approved, their consent had been provided based on the questions that the researcher had furnished at that time. The SMT noted that if there had been any questions relating to individual ACE scores of staff being part of the data collection process, the SMT would not have approved the PhD study. In addition, the SMT affirmed that under no circumstance would the DoCCFS endorse administering the use of the ACE survey at an individual staff level. They explained that they would have concerns about this leading to individual profiling of a staff member. The SMT noted several ethical questions about the proposed changes

that would cause concern and identified the primary implications of mandatory reporting concerning disclosures of retrospective abuse by FWs. Lastly, the SMT noted that the primary purpose of implementing the survey as part of the DoCCFS/TRiCC collaborative research project was to assist the organisation in better understanding its SU population. They emphasised their concern that asking DoCCFS FSCUs did not align with this purpose. The SMT stressed that asking FWs about their ACEs would be a misuse of the survey by the organisation as it would lead to profiling staff.

Upon receipt of this response from the DoCCFS SMT, the researcher liaised with the PhD supervisor. After consultation, the researcher responded to the email and apologised for any offence her email may have caused. The researcher explained that her intention relating to the proposed changes had not been to profile DoCCFS FCWs, but she understood why the DoCCFS had expressed concerns about asking FSWs about their ACEs. The researcher advised that having read and considered the concerns expressed by the DoCCFS SMT about the proposed changes, they were happy to shelve the idea and return to the original study. The DoCCFS SMT responded to this email, advising that they were happy for the researcher to return to the original idea and for the study to continue.

COVID-19 implications

Timeframe: *May 2020*

COVID-19 social distancing restrictions resulted in the researcher reconsidering the data collection process. In line with this reconsideration, the researcher submitted an amended research ethics application to the TCD School of Social Work and Social Policy Research Ethics Committee. This application was approved and allowed the researcher to amend data collection processes. These changes included the researcher moving data collection methods such as focus groups with DoCCFS FWs and semi-structured interviews with DoCCFS FCSUs to an online platform. Obtaining consent from participants was also restructured to facilitate online completion by participants.

Phase 2: Online focus groups with DoCCFS FWs

Timeframe: *October 2020 – January 2021*

In line with the research proposal data collection guidelines, the researcher sent an email invitation for DoCCFS FWs to DoCCFS FCMs so they could forward it to FWs working within their designated FC. After confirming participation and obtaining

written consent from research participants, the researcher facilitated five online focus groups via Zoom with DoCCFS FWs (n=16). Each focus group was recorded using an audio recording device. Once data collection had been completed, the researcher transcribed all the semi-structured interviews and commenced preliminary analysis.

Unforeseen issue of DoCCFS FCSU consent

Timeframe*: March 2021 – April 2021*

In March 2021, the DoCCFS SMT contacted the researcher to advise her of an issue with DoCCFS FCSU consent. They noted that the consent form that DoCCFS FCSUs signed when agreeing to participate in the DoCCFS/TRiCC research project did not accommodate consent for third parties to contact them to partake in additional research. Due to this, the DoCCFS informed the researcher that it was impossible to provide information to assist in identifying appropriate SUs to participate in the study. Given this information, and as previously outlined within this chapter, the researcher had to revisit the central aims of the study. After some discussion with the PhD supervisor and the DoCCFS, it was agreed that the study would no longer include DoCCFS SUs but would extend to considering how the ACE survey was informing service development in the DoCCFS ECDSCs, as well as the FCs. The case study would extend to include ECDS managers and ECDS workers. This change in the study's aims resulted in the need to resubmit a research ethics application for approval. A revised research ethics application was submitted to the TCD Social Work and Social Policy Research Ethics Committee in April 2021 and was subsequently approved in the same month.

Phase 3: Semi-structured interviews and focus groups with ECDSMs and ECDSWs

Timeframe: *July – August 2021*

During this timeframe, COVID-19 restrictions had been relaxed to enable in-person semi-structured interviews with ECDS managers and ECDS workers. Similarly to the recruitment process implemented with the DoCCFS FCs, the researcher sent emails to the DoCCFS ECDSMs to invite them to participate in the study and to seek their assistance in forwarding an email invitation to participate to the ECDSWs employed within their ECDS centre. The researcher received expressions of interest from ECDSMs (n=4), but unlike the FC recruitment process, the ECDSMs did not follow the suggested recruitment process. Instead of forwarding the email from the researcher to

ECDSWs within their centres and receiving individual email expressions of interest from ECDSWs, the researcher received emails from ECDSMs advising how many ECDSWs were interested. The ECDSMs also took primary responsibility for liaising with the researcher to identify a particular date and time for the focus groups.

In total, the researcher conducted three focus groups with a total number of twelve ECDSWs from three of the six ECDSCs invited to participate in the study. Due to the recruitment process and unlike with DoCCFS FWs, where the researcher had emailed back and forth before and after the focus groups, the first and only engagement that the researcher had with ECDSWs was when she arrived to facilitate the focus group. Each semi-structured interview and focus group was recorded using an audio recording device. Once data collection had been completed, the researcher transcribed all the semi-structured interviews and commenced preliminary analysis.

Phase 4: Semi-structured interview with DoCCFS CEO

Timeframe: *August 2022*

By this timeframe, the researcher had completed data analysis on the qualitative data collection during phases 1-3. The data analysis suggested that the researcher needed to clarify and obtain additional information from the DoCCFS CEO. Given this need, the researcher liaised with the DoCCFS SMT and PhD supervisor to seek agreement to amend the original DoCCFS SMT semi-structure list of questions. This agreement was provided, and the amendments implemented in the form of additional questions are outlined below:

- Did the organisation adopt different ACE survey implementation approaches within the ECDSCs and FCs? If yes, what were the differences, and why were they required?
- Were any variations in the training provided to the family and ECDSCs? If yes, what were these variations, and why did they occur?
- Did anything unexpected happen during the implementation process of routine ACE survey administration? If yes, can you describe what happened?
- Did the implementation process of the ACE survey and response to it differ between ECDSCs and FCs? Can you explain your answer?
- The DoCCFS stopped using the ACE survey as part of the outcome measures during this study; what motivated the decision to stop routine administration?

- What feedback have you received from the ECDSMs about giving the ACE survey to parents to self-complete?

The researcher conducted a one-hour semi-structured interview with the DoCCFS CEO in early August 2022. This semi-structured interview was recorded using an audio recording device. Upon completion of this semi-structured interview, the researcher transcribed the audio recording. Once this was finished, qualitative data collection for this study was complete.

Phase 5: Quantitative data analysis

Timeframe*: June-August 2022*

The quantitative data analysis phase of the study commenced in June 2022. Due to the sequential research strategy, the quantitative data analysis could not proceed until the final analysis of all qualitative data was complete. The data analysis process and how the researcher used it to interrogate and analyse the quantitative data within this study will be discussed in detail under the Data Analysis heading of this chapter. The following section provides an overview of this study's quantitative data collection method.

5.7 Quantitative data collection method

As previously mentioned, the quantitative data within this study were primarily collected as part of the DoCCFS/TCD OMS. The researcher did not develop the OMS. Instead, the researcher was granted access to the aggregated data collected during the current study timeframe. The researcher did not complete the primary data collection process relating to DoCCFS FC and ECDSC ACE survey responses. The researcher, however, was permitted access to data about the completion rates and SU anonymised demographic information over the specified timeframe of the study from September 2019 to April 2020. Aside from demographic information and response rates, eleven ACE survey questions were used within the DoCCFS/TCD ECDSC and FCs. Table 5.4 outlines the data used within this study.

After obtaining permission to proceed from the TCD School of Social Work and Social Policy Research Ethics Committee, the researcher was provided access to the Statistical Package for Social Sciences (SPSS) file containing the quantitative data. In line with the research proposal, the researcher only considered aggregated data

collected using the DoCCFS/TCD ECDSC and FC surveys from September 2019 until April 2020. The total number of OMSs completed during the study timeframe amounted to 105 from the ECDSCs and 118 from the FCs. Of the 105 OMSs completed within the ECDSCs, 16 contained ACE surveys for children, 31 for the parent or caregiver who completed the form and 16 for the other parent or caregiver. The FC OMSs yielded higher response rates for child ACE survey completion (N=78) and the parent or caregiver who completed the OMS (N=59).

Table 5.4
Content of aggregated data used as part of the study

DoCCFS / TCD ECDSC survey	DoCCFS / TCD FC survey
ECDSC centre ID Completion rates Demographic information (please refer to Appendix – for a list of same)	FC centre ID Completion rates Demographic information (please refer to Appendix – for a list of same)
If all ACE survey questions were completed	If all ACE survey questions were completed
ACE survey questions (11 in total) relative to adult parent/guardian and child	ACE survey questions (11 in total) relative to adult parent /guardian and child

The ACE survey data about the other parent or caregiver in the FCs have the lowest completion rate of the data included in the current study (N=6). Although the researcher had started to analyse the quantitative data when implementing the concurrent research strategy, they had not determined these completion rates by the time they switched to the sequential research strategy. The researcher, therefore, did not review this data until the qualitative data for this study had been analysed. The rationale for this aligns with the exploratory sequential mixed-method research design. The researcher used the qualitative data findings to provide parameters for examining the quantitative data. The researcher intended to compare and contrast the DoCCFS / TCD ACE data findings with that of other social care organisations but also needed to use this data to help illuminate the qualitative data shared by the research participants. Although chapters 7 and 8 of this thesis will provide a descriptive overview of the thematic coding and findings from the qualitative data, Table 5.5 notes the emerging themes that influenced the study's examination of the quantitative data.

Table 5.5 Quantitative research questions arising from qualitative data analysis	
Themes:	**Retrospective abuse questions were the biggest hurdle to overcome** **Expect mandatory reporting to be an issue**
Question:	What was the frequency of parents and caregivers who indicated that they or their children had encountered child maltreatment, particularly childhood sexual abuse, within the ECDSCs and DoCCFSCs?
Theme:	**The language of the ACE survey questions was identified as a barrier**
Question:	What were the English literacy levels and nationality of adult parents and caregivers who completed the Outcome Measures Survey?
Theme:	**The language of the ACE survey questions was identified as a barrier**
Question:	How many ACE surveys were completed by adult parents and caregivers from Ireland compared to those from other nationalities?
Theme:	**Service users socioeconomic status influenced the implementation**
Question:	What was the level of educational attainment for parents who completed the ACE survey?
Theme:	**The ACE survey should be adapted to reflect the service user population**
Question:	Did the demographic information collected as part of the Outcome Measures Survey indicate that children attending the ECDSCs or DoCCFSCs may have encountered other childhood adversities, such as homelessness or poverty?
Theme:	**Service users socioeconomic status influenced the implementation**
Question:	What was the prevalence of parental separation and divorce as an ACE in ECDSCs?

5.7.1 Data reliability and validity – Qualitative data

Reliability in qualitative research relates to a standard of stability and consistency in participant data and a commitment by the researcher to collect and record it precisely. Validity and reliability are fundamental to good qualitative research (Kirk and Miller, 1986). To obtain validity, a qualitative study must accurately depict what exists and implement valid instruments or measures to assist in doing so. For a study to achieve reliability, the researcher must implement consistent and comparable data collection methods (Brink and Wood, 1998). To ensure qualitative data validity and reliability, the researcher adhered to the following criteria used to determine a research study's credibility as outlined by Noble and Smith (2015):

Truth value

The researcher remained cognisant of multiple perceptions of realities throughout the qualitative data collection process. In particular, the researcher acknowledged the impact of personal experience and viewpoints on influencing methodological bias. Additionally, the researcher was cognisant of introducing research bias during the collection and interpretation of data phases of the study. The researcher also ensured that participant data was accurately recorded, transcribed, and subsequently analysed throughout the data collection and analysis process.

Consistency

The researcher remained committed to ensuring their decisions were consistently clear and transparent throughout the data collection and analysis process. The researcher implemented uniform data collection procedures and similarly approached each semi-structured interview and focus group. Consistency in data transcription and data analysis was also assured.

Neutrality

As part of implementing a case study research design, the researcher spent time within the organisation. This exposure was helpful as it provided the researcher with context for interpreting and contextualising the study findings. Spending time within the organisation also enabled the researcher to develop relationships with individuals and hear their perspectives on the organisational culture. To ensure that these perspectives and relationships did not impact the study findings, the researcher persistently acknowledged the complexities of this engagement and actively sought guidance from their PhD supervisor. The researcher sought the PhD supervisor's opinion about instances when the researcher felt that her objectivity was impacted.

Applicability

Throughout the research process, the researcher considered whether the findings could be applied to other organisations, contexts, research populations or settings. Interestingly applicability was at the forefront of the researcher's mind throughout the qualitative data collection and analysis processes because it coincided with the study's objective of using the findings to develop a model for implementing ACE-informed

practices in social care organisations. To develop this model, the researcher had to remain aware of how transferable the DoCCFS social care perspectives of ACE survey administration were to other settings. This chapter will now discuss the fifth and final phase of the data collection.

5.7.2 Quantitative data reliability and validity

Ensuring validity and reliability in quantitative research is imperative, as both are required to ensure that the research delivers accurate results (Sürücuü and Maslakci, 2020). Validity in quantitative research refers to the extent to which data is measured accurately. Reliability relates to the accuracy of the research instrument employed to collect the data (Heale and Twycross, 2015). To facilitate validity and reliability in data analysis, the researcher must ensure the quality of the research measures used in the primary research data collection process (Watkins, 2023). As discussed in chapter 1, the DoCCFS/TCD survey was a composite of standardised research instruments (Spratt, Swords, and Vilda, 2018). Taherdoost (2016) stresses that standardised research instruments are rigorously tested to ensure validity and reliability before being implemented for research purposes. The rigorous testing ensures the instruments' research measures collect the intended data. The ACE survey questions in the DoCCFS/TCD ECDS and FC surveys were standardised research measures from the ACE International Questionnaire (ACE-IQ). The WHO (2022) describes the ACE-IQ as a survey that should be integrated into a broader research survey. These research measures have been extensively validated and deemed adequate for data collection (Rutter, 2021). As described in chapter 2 of this thesis, the validity and reliability of the quantitative data used within this study were ensured because the data came from a primary survey that included standardised research instruments.

5.8 Data Analysis

Data analysis describes a researcher's process of analysing study data (Creswell, 2009). Data analysis involves the researcher using a specified framework to establish links and patterns and derive conclusions from the study data (Gabi and Gabi, 2018). This chapter section will outline the data analysis process used in this study.

5.8.1 Qualitative data analysis

The qualitative data analysis process used within this study was thematic analysis. Thematic analysis is a process that involves the researcher identifying, analysing, and understanding patterns in qualitative data sets (Kara, 2022; Gabi and Gabi, 2018). Braun and Clarke (2022) explain that thematic analysis requires the researcher to complete coding. They further define coding as a process that involves the researcher exploring and identifying patterns of meaning in qualitative data. During the coding process, the researcher develops codes. A code is a word or a short phrase assigned to portions of qualitative data. These codes help the researcher to capture or identify themes that emerge in portions of language shared by research participants (Saldana, 2016). Thematic coding is a systemic process that requires the researcher to adopt a rigorous approach. The process involves reviewing each qualitative data set carefully and marking sections of text where the research identifies relevance to the research question (Braun and Clarke, 2022). The researcher adopted the following six phases of thematic analysis as outlined by Braun and Clarke (2006) when identifying, analysing, and understanding the qualitative data as part of this study:

Phase 1: ***Familiarity with the data***

After each data collection phase, the researcher transcribed all the semi-structured interviews and focus groups. After doing so, the researcher read and re-read each transcription. During this process, the researcher made notes in the margins of the transcriptions.

Phase 2: ***Generating initial codes***

The researcher then reviewed the notes in the transcriptions' margins and began developing initial codes. The researcher separated the coding and searched for a typical pattern in qualitative data according to the following participant groups: DoCCFS SMT, FCMs; ECDSMs; FWs and ECDSWs. In addition to these particular groups, the researcher also searched for similar codes amongst several participant group combinations. These included: DoCCFS SMT and ECDSMs; DoCCFS SMT and FCMs; ECDSMs and ECDSWs; and lastly, FCMs and FWs.

Phase 3: ***Identifying themes***

Once coding had been completed, the researcher collated them to develop themes. The researcher used the same groupings as outlined in Phase 2.

Phase 4: ***Reviewing themes***

In this phase, the researcher confirmed that the codes correlated with the themes and, in doing so, created a thematic map for data analysis.

Phase 5: ***Defining and naming themes***

The researcher continued to consider and refine the specifics of each theme. Doing so enabled the researcher to define and develop accurate labels for each theme.

Phase 6: ***Production of the final report***

During this data collection phase, the researcher identified and extracted real examples from the qualitative data to depict the themes. These extracted examples will be evident in the next chapter.

As previously indicated, the qualitative data analysis process was fundamental in enabling the researcher to develop research questions and the parameters for the quantitative data analysis. Once the qualitative data analysis was complete, the researcher used the themes and questions outlined in Table 5.5 to analyse and interrogate the quantitative secondary data. The next section of this chapter will outline the quantitative data analysis process implemented within the study.

5.8.2 Quantitative data analysis

The quantitative data analysis method used in this study was that of SPSS. SPSS is a software package that assists researchers in completing quantitative statistical data analysis (Field, 2011). The rationale for using this method was pre-decided for the researcher. The DoCCFS/TCD collaborative research project used SPSS, and the aggregated data made available to the researcher for data analysis was located in an SPSS file. As the researcher had access to pre-existing data files, they were not required to set up the SPSS database. As mentioned in this chapter, the study used quantitative

data to answer the following research objectives: to establish profiles from aggregated ACE data at location and organisational level and to compare these profiles with those from similar studies (where available). In order to undertake quantitative data analysis, the researcher had first to determine what constituted an ACE profile in existing studies. The literature review for this study established that ACE profiles primarily described the cumulative ACE scores and the prevalence of individual ACEs within research populations (McCutchen et al., 2022; Bellis et al., 2016; McLean and Wilson, 2019; Crouch et al., 2019; Kerker et al., 2015).

Once the researcher established these expectations, they identified the most appropriate feature of SPSS to assist them in developing the ACE profile of DoCCFS SUs. The feature was identified as descriptive statistics. According to Salcedo and McCormick (2020), this feature is used to develop summaries of individual variables. In addition, they note that this feature provides researchers with information about sample size, demographics, and completion rates. The researcher, therefore, employed this feature to ascertain summaries relating to the number of OMSs completed, SU gender, age, and nationality. This feature also provides statistics relating to variability (Pallant, 2016). The researcher implemented it to determine the maximum, minimum and mean number of ACEs reported by DoCCFS SUs and the standard deviation. According to Salcedo and McCormick (2020:216), standard deviation measures the variation or dispersion of values associated with variables. According to Pallant (2016), the descriptive statistics feature also enables researchers to access statistics relating to the frequency of variables. This feature allowed the researcher to establish frequencies relating to specific ACEs reported by DoCCFS SUs within the OMSs. One of the most widely used components of the descriptive statistics feature is cross-tabulation. Pallant (2016) describes this as a process that studies the relationships between two or more variables. An example of how the cross-tabulation feature was implemented in this study was to establish the relationship between the CSA ACE question and the responses from DoCCFS FCs and ECDSCs. This feature enabled the researcher to determine the frequency of positive responses to this ACE question in each centre. The descriptive statistics feature of SPSS was effective for quantitative data analysis as it enabled the researcher to develop an accurate ACE profile relating to DoCCFS SUs.

5.9 Conclusion

This chapter outlined the study's methodology. It described the research question and justified examining the introduction of routine administration of the ACE survey within the DoCCFS. The chapter then described the mixed method research methodology and justified its use. The chapter described the research population and explained that non-probability sampling was identified as most appropriate for the study. The ethical issues the researcher considered before and during the data collection process were also outlined. The data collection processes were then discussed. The chapter also acknowledged and accounted for the changes and alterations made to the research methodology during the study. The next chapter will describe the theoretical framework that underpins the study. It will describe and justify using this framework to contextualise and interpret the findings.

Chapter 6

Theoretical framework

6.1 Introduction

This chapter will outline the theoretical framework which underpins this study. The origins of this theoretical framework and its rationale will be discussed. Specific components of the theory will also be considered and described. The chapter will conclude with an explanation of how the qualitative data findings of this study will be presented.

6.2 Implementation science

The central aim of this study is to examine the introduction of routinely administering the ACE survey in a social care organisation from manager and worker perspectives. Given that implementing the survey involved executing an innovation within the DoCCFS, the theoretical underpinning of the study must provide the reader with a basis for understanding how the implementation process may have impacted staff experiences. When considering the success or failure of innovation within an organisation, it is crucial to identify an appropriate theory which considers the implementation process. Doing so helps develop an understanding of how successful and beneficial an innovation might be. It also provides a basis for understanding why individuals and systems sometimes facilitate or obstruct organisational innovations (Nilsen, 2020). In recognition of this, implementation theory has been identified as the most appropriate theory for the current study.

Implementation theory stems from implementation science. This particular science originated in the 1970s and was born from the need to examine the implementation of evidence-based practice in healthcare settings (Albers, Shlonsky and Mildon, 2020). Implementation science is the 'scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services. It includes the study of influences on healthcare professional and organisational behaviour (Eccles and Mittman, 2006:3). Although implementation science is primarily identified as a healthcare science, since the 1970s, it has garnered attention from the social care sector also (Albers, Shlonsky and Mildon, 2020).

Implementation science concerns how interventions can be changed or improved to increase their use by professionals in practice. It also seeks to improve the sustainability of interventions. Implementation science recognises that successfully introducing new interventions or innovations within settings is based on a complex interplay of several moveable and connected factors (Douglas and Burshnic, 2019). Implementation science recognises that introducing innovations within an organisation is not linear, and the success of introducing new practices is contingent on a complex process. In addition, science acknowledges that organisations represent complex systems where habits, customs, values, beliefs, and subcultures impact the working life of staff members. These play a role in determining whether staff interpret innovations as applicable and are willing to engage effectively in the implementation process (Braithwaite, 2018).

As the need for evidence-based practice and interventions has increased in recent years, so has the interest in implementation science. The growing interest in evidence-based implementation during the last decade has led to an exponential rise in the emergence of theories, models and frameworks which aim to assess innovations' success. Healthcare, education, and social care professionals are turning to implementation science to help them understand how to integrate evidence-based innovations and interventions into practice successfully (Nilsen, 2015). In his paper which explored the importance of social workers using implementation science, Cabassa (2016) affirms that implementation science provides a range of methods, frameworks, and theories to enable social workers to understand the interrelated factors and processes that impact the introduction of innovations in practice. The author further asserts that implementation science is helpful in social work research and practice. From a research perspective, the author postulates that implementation science provides researchers with a means to understand how people, settings and behaviours can impede and facilitate the implementation of evidence-based changes in social work practice. Social work consideration of implementation science can also equip practitioners with the knowledge and skills to identify effective interventions and ensure they are successfully implemented into practice (Cabassa, 2016).

When organisations seek to implement an innovation, individual staff members must enact their agency. Agency refers to the capability of the individual to implement the actions associated with the innovation. Whilst enacting their agency, the innovation also requires staff members to engage with other individuals, systems, and

unfamiliar circumstances. Implementation science considers introducing innovations within an organisation a continuous and interactive process. It considers all the variables, not just those involving individual staff members (May, 2013). Considering the variables involved during the implementation process is evident in implementation theories, models, and frameworks.

A theory is defined as a set of ideas that help to structure thoughts, observations, and explanations of the world. A model differs slightly from a theory as it does not provide explanations for phenomena, but rather it describes them and the processes involved. A framework provides a structural outline, system or plan relating to the different variables and categories. A framework describes the relationships between these constructs and variables concerning the phenomena. Frameworks do not explain why the phenomena occur but provide a structure for differentiating between variables and categories (Nilsen, 2015).

In his article, which considered implementation theories, models and frameworks, Nilsen (2015) identifies three overarching aims for their use in implementation science. The author outlined these aims as (1) describing or guiding the transition of evidence-based research into practice, (2) recognising and comprehending what influences the successful implementation of innovations, and (3) evaluating the innovation implementation process. The author identifies the five theoretical approaches used in implementation science as determinant frameworks, evaluation frameworks, process models, classic theories and implementation theories. The author advises that the process models are used in implementation science to describe and guide the transition of evidence-based research into practice (what the innovation involved for staff). Models are not predictive or analytical. Frameworks are used in implementation science often to acknowledge and recognise factors which may have or did influence the implementation process (i.e. adaptations that staff made concerning the innovation). The author differentiates between models and frameworks and theories explaining that neither models nor frameworks account for how staff respond to innovation. Instead, they provide a checklist of various components of the implementation process.

On the other hand, implementation theory sets out to identify, define and account for interrelated factors that impact an innovation's implementation outcomes. A theory in implementation science considers the casual, systemic, behavioural and emotional components of the implementation process (e.g. how the individual or

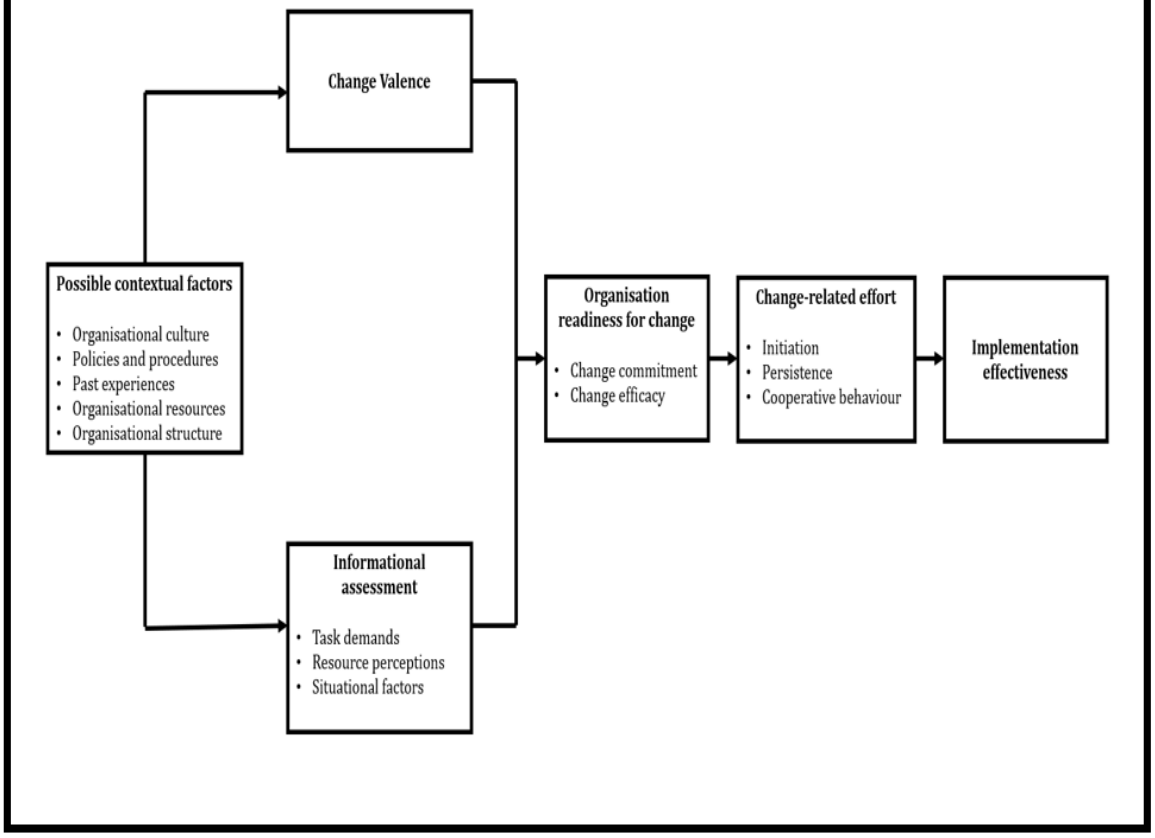
collective staff knowledge, attitudes and beliefs may have facilitated or impeded the implementation process) (Nilsen, 2015). Given that the central research question of the current study relates to how workers and managers interpreted the introduction of routinely administering the ACE survey within the DoCCFS, implementation theory was identified as an appropriate theoretical framework.

6.3 Organisational readiness for change theory

Many implementation theories are associated with implementation science (Nilsen, 2020). After carefully considering these theories, organisational readiness for change theory was identified as the most appropriate theory to assist in understanding and interpreting the current study's findings. This theory has been constructive for researchers trying to achieve heightened understanding and explanations concerning specific aspects of an implementation process (Nilsen, 2020). Professor Bryan Weiner developed organisational readiness for change theory from the Department of Global Health and Health Services at the University of Washington (Albers, Shlonsky and Mildon, 2020). The theory proposes that implementation is influenced by organisational members' attitudes, intentions, capabilities, beliefs, and available resources. It suggests these factors interrelate and determine whether the organisation is ready to implement innovations. The implementation could be negatively impacted if these factors do not support innovation (Weiner, 2020). In his paper introducing the theory, Weiner (2009) explains that organisational readiness is a psychological construct that determines whether organisational members are committed, capable and confident in fulfilling their collective implementation roles. He postulates that change largely depends on whether organisational members view innovation as beneficial.

Weiner (2009) stipulates that an organisation's structures and resources influence readiness for change. The author suggests these factors directly impact organisation members' perceptions during implementation. Figure 6.1 outlines the main factors the author identified that determine an organisation's readiness to implement changes. These factors include the following:

Figure 6.1
Determinants of Outcomes of Organisational Readiness for Change
(Adapted from Weiner, 2009:4)



Contextual factors refer to how broader environmental factors can impact an organisation's members' readiness for change. These contextual factors include the organisation's previous experiences in implementing change. If organisation members are familiar with change, they will be more receptive to implementing it. If change is not regular, the organisation members may be more apprehensive. The organisation must also be structured to support the implementation of the innovation. Organisations need to ensure that they have effective processes and systems in place. An organisation must also ensure that it provides adequate resources to support the implementation of change. This resourcing can relate to effective training, finances, and additional support that staff require to implement the innovation. In addition, the organisation's policies and procedures should support the change. Organisations with high readiness for change often report good working relationships and conditions. Organisation culture is emphasised as being one of the most significant contextual factors. The author postulates that if the innovation conflicts with organisational values

or previous working practices and expectations, the organisational culture can be a significant barrier to change implementation. Organisation culture must align with the innovation; otherwise, the organisation members may not identify that they are ready or willing to implement the change (Weiner, 2009).

According to Weiner (2009), change valence refers to how much value organisational members attribute to the innovation. The more they value the change, the more willingness and commitment they will expand during the implementation process. If organisational members do not view the innovation as beneficial, then change valence could impede the successful implementation of the innovation. Similarly, organisational members' readiness for change will coincide with their informational assessment of how prepared the organisation is to implement the innovation. Weiner (2009) proposes that an organisation's readiness for change depends on how capable members feel to meet the task demands associated with the innovation. Organisation members must fully understand what is expected of them, what resources they need and what format the innovation should follow. The theory suggests that organisation members' assessment of available resources must determine that they have the emotional, financial, practical and information resources required to undertake their implementation role. Additionally, organisation members' readiness for change depends on their assessment of situational factors. They must perceive that they have sufficient time to meet the expectations of their role and that their peers and the organisation also endorse the innovation's value. Should organisation members' assessments determine that the organisation is not supporting staff to implement their role, the theory postulates that they will be less willing to facilitate meaningful implementation.

Weiner (2009) explains that even if the contextual factors, change valence, and informational assessment within an organisation suggest readiness for change, the organisation still has to determine whether organisational members are committed to the innovation and whether they have achieved change efficacy. These factors are interrelated and are highlighted as having the potential to impede or facilitate the introduction of innovations within an organisation. The author explains that commitment to change within an organisation depends on the confidence that organisation members have in their capabilities to undertake their specific implementation role. Although organisation members may want to engage in the implementation process, their commitment and efficacy may be impaired if they do not

feel equipped or confident in their abilities. The author affirms that organisational readiness is likely less pronounced when organisational members lack the confidence to meet their implementation roles. Where there is a lack of commitment and efficacy, organisation members can become avoidant, fearful, hostile, and resistant. The theory suggests that these emotions can cause them to be more apprehensive during the implementation process and question or downplay their capabilities and professional judgements.

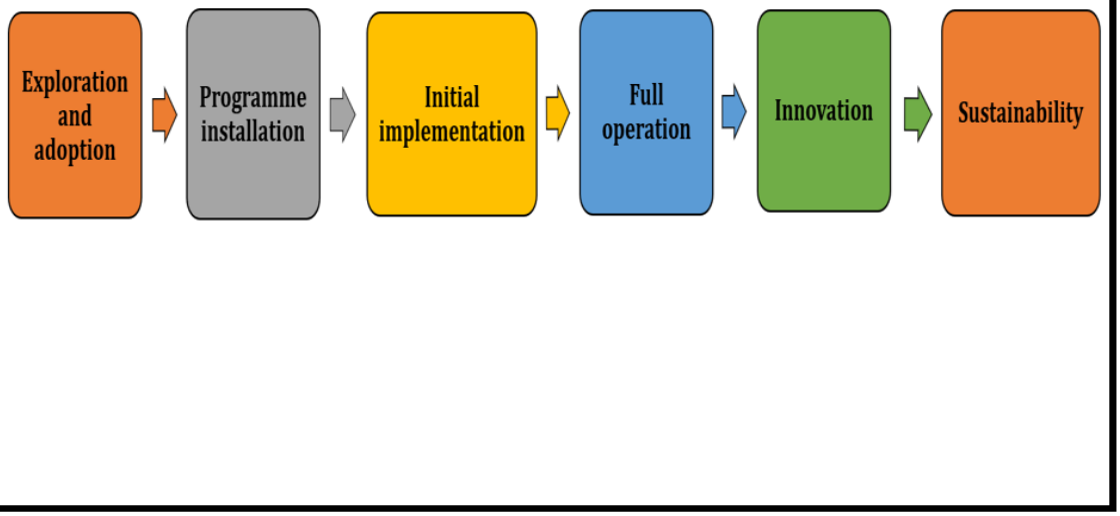
Weiner (2009) describes the change-related effort determinant of organisational readiness as how willing organisational members are to initiate the innovation, persist with implementation even when encountering challenges, and engage in cooperative problem-solving behaviour. The author defines this determinant as the organisation members' consistency and delivery of innovation. The author affirms that organisations with high readiness for change have staff members demonstrating these change-related behaviours. Weiner further explains that these change-related behaviours are contingent on several factors and usually represent the sufficient support staff members feel they receive concerning their implementation role. The final determinant of organisation readiness is termed by Weiner (2009) as implementation effectiveness. Implementation effectiveness does not refer to the innovation but more to how effective the implementation process was for the organisation members. In organisations with high readiness for change, organisation members involved in the implementation process will develop additional skills to benefit SUs and the organisation.

This theory provides a basis for interpreting and processing the findings. As the theory considers organisation readiness for change, it lends itself to explaining how managers and workers interpreted the introduction of the survey in the DoCCFS. As this study was a mixed-method study conducted in two different services within the DoCCFS, the qualitative data findings were quite expansive. As the services were so different, it was challenging to generalise the emerging themes. In light of this, a quandary arose regarding presenting the findings in an understandable and concise format. The implementation science offered a model for doing so. The next section of this chapter will outline this model.

6.4 Model for presenting the study findings

Process models are used in implementation science to describe and guide the transition of evidence-based innovations into practice (the stages of implementation for the organisation). As previously outlined in this chapter, a model describes implementation processes and does not explain how organisations engage in the stages or respond to them. Models are not predictive (Nilsen, 2015). After carefully considering implementation science models, the stages of the implementation process model by Fixsen et al. (2015) were identified as most appropriate to present the current study findings. Figure 6.2 outlines the implementation stages in this model.

Figure 6.2
Stages of the implementation process
(Fixsen et al. 2005:15)



Fixsen et al. (2005) developed this model to outline the discernible implementation stages for organisations. According to the authors, successful implementation is based on recognising the steps an organisation must take to introduce an evidence-based innovation. These individual stages will be used as headings within the qualitative findings chapters of this study. This model was deemed most appropriate because it aligns with the qualitative data findings of this study in both settings. The qualitative data indicated that the DoCCFS engaged in all of the

stages. Due to this, the model headings provide a clear format to collectively outline the findings of managers' and worker perspectives from both the DoCCFS ECDSCs and FCs. Each stage is defined below:

Implementation stage 1: Exploration and adoption

According to Fixsen et al. (2005), the first implementation stage within an organisation calls for information sourcing and exploring options. An organisation must assess an innovation's plausibility, transferability, and credibility before implementing it. The exploration and adoption stage relates to how the organisation identified the innovation and its rationale. The first section of chapter 7 will outline findings pertinent to the first implementation stage of routine ACE inquiry within the DoCCFS. These findings relate to the process involved in identifying the ACE survey for inclusion within the OMS and factors that the DoCCFS SMT and ARs from TCD considered before deciding to implement it.

Implementation stage 2: Programme installation

The model proposed by Fixsen et al. (2005) defines the second stage of the implementation process as programme installation. During this stage, the authors postulate that the organisation must implement several things before the innovation is rolled out. The organisation must have the appropriate structural support to ensure effective implementation. These supports include acquiring appropriate funding, introducing effective systems to support innovation, and ensuring that the organisation has sufficient staffing. The second section of chapter 7 will present findings under this heading. The findings outlined will be relevant to the DoCCFS experiences of the tasks that should have been addressed before routine ACE inquiry was implemented throughout the organisation.

Implementation stage 3: Initial implementation

According to Fixsen (2005), the initial implementation stage in the process refers to overall changes in the practice environment arising from the innovation. The authors identify some of these changes as the personal, educational, administrative, financial, and systemic factors that can impact a professional's work. During the initial implementation phase, the authors recognise that practitioners should encounter

alterations to their skill levels. They also note that the organisational response and culture should change somewhat in response to the innovation. The initial implementation stage can evoke fear, resistance and apprehension in those tasked with implementing the change. The authors affirm that this stage can be pretty challenging for the organisation as it usually involves altering existing work practices with staff who may feel overwhelmed and unsure about the benefits of doing so. The third section of chapter 7 will present findings regarding the initial implementation of routine ACE inquiry within the DoCCFS. In particular, the findings outlined in this section will be specific to the organisation's initial implementation experience concerning the required administrative, skill development and motivational changes necessary to facilitate the implementation of the ACE survey. In addition, this section will detail participants' perceptions of complex factors concerning the change process.

Implementation stage 4: Full operation

Fixsen et al. (2015) define the fourth phase of their implementation model as when the organisation fully implements the innovation, and the new learning becomes systemically integrated. During this model phase, the innovation is fully operational, and the organisation is sustaining it alongside staff workloads and the realities of day-to-day staffing and resourcing issues. Once the innovation has been fully implemented, the organisation should start to recognise the benefits associated with the innovation. The final section of chapter 7 will detail findings under this heading. These findings will relate to the organisation's experience when the survey was fully implemented as part of the OMS. In particular, this section will focus on the perceived effectiveness of introducing routine ACE survey inquiry into the DoCCFS.

Implementation stage 5 – Innovation

The innovation stage of the implementation process is defined by Fixsen et al. (2005) as the phase when staff become accustomed to and skilled in administering the innovation. During this phase, new staff members pose a challenge as they enter a workplace where the other staff members are habituated to the innovation. The authors explain that although workers' skills increase at this stage of the implementation process, this confidence can lead them to implement innovations. Some of these adaptations may not be helpful and represent a threat to the fidelity of

the innovation. Practical innovations implemented by staff can lead to positive implementation outcomes. They also offer suggestions for other services considering introducing the innovation. The first section of chapter 8 will outline qualitative findings under this heading. These findings will be pertinent to the adaptations and innovations that DoCCFS Staff made once routine ACE administration of the survey had been implemented throughout the organisation.

Implementation stage 6 – Sustainability

Fixsen et al. (2005) describe the final stage of the implementation model as assessing the sustainability of the innovation within the organisation. This phase involves the organisation critically reflecting on the implementation process's success and whether it is feasible to continue the innovation. If the organisation perceives it as feasible, then this phase requires it to identify what changes or additional supports it would require to continue. The final section of chapter 8 will outline findings under this heading. These findings will be relative to the contemplation process of examining the sustainability of routine survey administration within the DoCCFS.

6.5 Conclusion

This chapter outlined the theoretical framework which underpins this study. It identified implementation theory as the most appropriate theoretical framework for the study and described the rationale for this choice. The chapter also provided an overview of the origins of this theory. In addition, it identified and discussed the theory used to interpret the study findings. This theory was identified as organisational readiness for change theory. The final section of this chapter concluded by acknowledging the difficulties encountered in finding a clear and concise way to format and present the qualitative data findings of this study. An implementation process model was identified for use in this regard. This model was also described. The next chapter of this study will present the qualitative data findings relating to managers' and workers' experiences of the first four implementation stages of routine ACE inquiry within the DoCCFS.

Chapter 7

Qualitative findings:

The process of transitioning to routine ACE survey implementation

7.1 Introduction

This chapter outlines findings relating to managers' and workers' experiences of the first four implementation stages of routine ACE inquiry within the DoCCFS. These implementation stages relate to the exploration and adoption of routine ACE inquiry, installation of routine ACE inquiry throughout the organisation, initial implementation of routine ACE inquiry and lastly, full organisation-wide implementation of the ACE survey.

7.2 Implementation stage 1 - Exploration and adoption of Routine ACE inquiry

This section will outline findings pertinent to the first implementation stage of routine ACE inquiry within the DoCCFS. These findings relate to the process involved in identifying the survey for inclusion within the OMS and factors that the DoCCFS SMT and ARs from TCD considered before deciding to implement it.

7.2.1 Partnering with ARs was imperative for the organisation

The rationale for implementing the OMS in 2016 was linked to previous research that the DoCCFS had undertaken in 2010 in partnership with academic ARs from UCD. This research focused on establishing the impact that the work of the DoCCFS was making in SUs' lives. The SMT believed that evidencing this would strengthen funding applications. One of the additional research motivations at the time was to familiarise DoCCFS staff with standardised research measures. The DoCCFS wanted staff to develop a more scientific approach to evaluating the organisation's work (please refer to the interview extract in Table 7.1). The DoCCFS/UCD research project involved a smaller research population and did not collect demographic data about SUs. Given this, the recommendations from the report were to conduct the research on a broader scale and collect demographic information to provide context for data analysis.

The research experience with UCD highlighted the importance of partnering with ARs for the DoCCFS. After reflecting on the experience, the SMT understood that collaborating with ARs would ensure that future research would be undertaken in an evidence-based way and that such a partnership would bolster the DoCCFS opportunities to disseminate the findings of studies in academic journals. The DoCCFS SMT perceived research publications as the most effective way to evidence the complexity of the work undertaken by the staff within the organisation.

Table 7.1

The importance of implementing outcome measures research within the DoCCFS

"The focus of the UCD work was to try to find out if what we were doing was actually making a difference So..... we started to move towards trying to understand, firstly from a funding perspective was what we were doing making a difference and, secondly what did we need to do differently. The other thing I think.. really was trying to get (pause).... workers used to using outcome measures. So trying to get them not to just look at a case file but also having some kind of perspective on, you know, evaluating it in a more scientific way rather than just their own thoughts."

Participant – SMT Interviews

7.2.2 Ownership of the research data was important

Ownership relating to research data (including the ACE data) collected as part of the DoCCFS/TCD OMS was an important consideration for the organisation. To conduct the research, the SMT had to secure funding to facilitate the use and dissemination of the research data effectively to support the organisation's work. The SMT recognised that applying for funding through regular channels could restrict its autonomy. They did not want an external agency to claim ownership over the data. Due to this, the SMT wrote a funding proposal and submitted it to the Daughters of Charity (DoC), an international community of apostolic life within the catholic church, for consideration. Participants advised that the DoC established the DoCCFS, and it used to oversee its service provision. Due to this, they noted that staff had a positive perception of the contribution to and understanding of the organisation's work.

The SMT noted that the DoC had funded many of the organisation's previous initiatives. Submitting a funding proposal to the DoC was further motivated by the SMT's realisation that securing funding from them could assist with staff 'buy-in'. The SMT noted that the ethos and values within the organisation were established during the timeframe when the religious order played an active role in DoCCFS service delivery. The SMT described how many of the staff within the organisation were long-term employees and that the ethos and values of the organisation were things that they frequently identified as influencing their decision to maintain their employment with the DoCCFS. The SMT recognised that if these staff members understood that the DoC funded the research, they would be more inclined to view it as something worth implementing.

7.2.3 Implementation of the ACE survey was purposefully staggered

The DoCCFS SMT and ARs from TCD considered including the ACE survey as part of the OMS in 2016. The motivation behind its introduction was linked to the realisation that the survey could capture data that would evidence the complexity of the work that the FCs and ECDSCs were undertaking with SUs. In addition, implementing the survey was recognised as having the potential to support the organisation's applications for continued funding. Despite these factors, the SMT and ARs from TCD felt that introducing the survey as part of the OMS would be overwhelming for staff and that implementing it from the outset could lead to resistance regarding the OMS in general. As DoCCFS staff were unfamiliar with implementing research measures, the SMT and ARs adopted a phased approach to implementing the survey.

The first phase involved DoCCFS implementing the Significant Life Events Scale (SLES) as part of the OMS. The SLES was perceived as a softer version of the ACE survey and a good way to prepare staff for survey implementation. The outcome of the first phase validated the SMT and AR's initial perception as staff reported difficulty and expressed opposition to implementing the SLES questions. In recognition, the SMT and ARs decided they would need to implement a second phase. This phase involved undertaking preparatory work and training surrounding the implementation of the survey with staff.

7.2.4 Resistance to the ACE survey was predicted

The DoCCFS SMT predicted that there would be resistance to the ACE survey questions. Given that the DoCCFS staff were not accustomed to asking adult SUs about their retrospective childhood experiences and the experiences that their children were currently or had experienced, the SMT pre-empted resistance from staff. The SMT expected resistance to the survey would be grounded in not wanting to upset the SU and damage the relationship-building process. The SMT understood that although this resistance would be well-intentioned, it had to be addressed for successful survey implementation. They also anticipated more resistance from therapeutically trained staff. This expectation was validated when therapeutically trained staff, in particular, began to express resistance and reservations about asking the SLES question regarding adult SUs' educational attainment and financial situation. The SMT response to expected resistance was to adopt an understanding approach. They recognised that they would be less resistant if survey implementation were undertaken in collaboration with staff, and they could understand the benefits and motivation for including it in the OMS.

7.2.5 The potential impact on SUs was considered

The DoCCFS SMT considered the positive and negative implications of including the ACE survey in the OMS. In particular, this consideration period involved significant contemplation about the potential negative impact of implementing the survey with SUs. The SMT had initial reservations about labelling DoCCFS SUs and that the survey could evoke feelings of shame in them (please refer to interview extracts in Table 7.2). The SMT were confident that their collaboration with ARs from TCD would enable the DoCCFS to provide adequate staff training. The SMT was satisfied that they could deliver training that would equip staff to ask the survey questions in a manner that would reduce the possibility of evoking feelings of shame in SUs. They were also confident that they could collaborate with the ARs from TCD to ensure that the findings were framed in a way that did not stigmatise or label the DoCCFS SUs.

Table 7.2 Considerations of the potential negative impact on DoCCFS service users
"Recognising labelling was critical because that was something that we did not want to do and we always struggle with this. We don't want to represent families in a way that labels them as vulnerable." **Participant – SMT Interviews**
"You know, they could be from a family, and unfortunately, their parents could have died when they were two, and they had that adversity to cope with throughout their life, but that was no fault of theirs. So to be stigmatised by something that's completely outside of your control... I think it was important for us to be aware about stigmatisation and also shame. Shame has a massive impact." **Participant – SMT Interviews**

7.3 Implementation stage 2 – Installation of routine ACE inquiry

This section presents findings relevant to the DoCCFS experience of the tasks that needed to be addressed before routine ACE survey inquiry could be implemented throughout the organisation. These findings relate specifically to the identified implementation approach, structural supports, and resources required to ensure the execution of the survey as part of the OMS.

7.3.1 Anticipated resistance to the ACE survey influenced the installation approach

Another common theme emerging from the research relates to how the anticipated level of resistance from staff influenced the implementation approach to the initial installation of the survey. As the SMT and ARs from TCD perceived that there would be more resistance from staff with therapeutic training, a decision was made to commence the survey in the FCs first. As mentioned in chapter 1, the FCs, more so than the ECDSCs, had staff with therapeutic training. Due to this, it was felt that the FC staff would need to be convinced of the importance of implementing the survey and that this would take time, training, and effort. Data analysis from interviews with DoCCFS SMT and FCM participants determined that the consultation process during the initial installation of the survey was intensive. Both participant groups noted that staff within the FCs

expressed concerns about implementation. They recalled a consultation process to determine whether the survey would be given to SUs to self-complete or if the FWs would administer it by asking the questions. Despite their reservations about implementing the survey, both participant groups reported that FWs were adamant that they needed to ask the survey questions. The SMT and FCM participants attributed this stance to the FWs' motivation to ensure that SUs would have access to immediate support from them if they became upset.

The importance of consultation during the installation process of the ACE survey within the FCs was stressed by participants from all three groups; DoCCFS SMT, FCMs and FWs'. Before implementation, the consultation process also involved discussing other concerns that the FWs' had. These concerns related to issues such as ensuring they felt comfortable and equipped to ask the survey questions and the possibility that the survey questions could retraumatise SUs. In addition, there were also concerns about the potential negative impact of implementation on the therapeutic relationship and the probable increase in retrospective child abuse and welfare reports to statutory agencies. Data analysis from the FW focus groups determined that participants could easily recollect these discussions.

Additionally, they recalled that although they did not directly consult with the DoCCFS SMT and ARs, they were provided opportunities to query information via their FCMs. Furthermore, participants from the FWs focus groups stressed the vital role that Outcome Measures Champions played in the consultation process. Champions were individual staff members within each FC tasked with vigorously supporting and ensuring the OMS implementation. As part of their role, Outcome Measures Champions attended steering committee meetings with the DoCCFS SMT, ARs from TCD and FCMs. They often sought clarity regarding practical queries from staff members at the meetings and provided a voice for FWs with concerns.

Data analysis of the interviews with the DoCCFS SMT, ECDSMs, and the focus groups with ECDSWs indicates that consultation regarding the installation of the survey within the ECDSCs was less intense. Findings indicate that their approach differed as the SMT did not anticipate resistance from the ECDSCs. The SMT interview participants recalled consulting with the ECDSMs about implementing the survey as part of the OMS. They could not recount any significant resistance or objections. Participants from the SMT could not recall the consultation process with the ECDSCs as easily as the FCs. Those that could recall recollected that the only issue raised by the

ECDSMs was a preference relating to the practicalities of administering the survey. More specifically, the ECDSMs requested that the ACE survey, like the other OMS research measures, be self-completed by SUs. The ECDSMs provided a rationale for this request because the existing survey was self-completed. Since the outset of the OMS, the ECDSMs had given the surveys to SUs to self-complete because they did not have the time and resources to self-administer the survey. The ECDSMs also advised that they did not feel equipped to self-administer the survey to SUs as they were not therapeutically trained to ask the ACE questions or provide support regarding responses. The DoCCFS SMT and ARs from TCD agreed to this request. Findings indicate that the absence of notable resistance from the ECDSCs resulted in the SMT and ARs from TCD perceiving a lesser need for time, training, and support for the ECDSCs to ensure the installation of the survey questions as part of the OMS.

7.3.2 Buy-in from those asking ACE questions was viewed as paramount

Ensuring acceptance of survey implementation as a positive undertaking within the organisation was perceived as key to the installation process. In particular, the SMT and ARs from TCD attributed significant importance to securing 'buy-in' from staff within the FCs. Findings indicate that the rationale for this attribution was related to the anticipated level of resistance from therapeutically trained staff. Data analysis of the interviews with SMT participants indicates that there was a perception that the anticipated resistance from staff within the FCs was somewhat warranted. There was an understanding that the expected opposition would be linked to genuine concerns FWs had about the impact of survey implementation on DoCCFS SUs. A perception developed that the survey installation would be impeded if FWs' concerns were not addressed. In response to this perception, findings indicate that the SMT and ARs from TCD explored ways to address the concerns and promote the endorsement of survey implementation from FCMs and FWs. The need to demonstrate the value of the survey data to the organisation and its SUs and that implementation would not cause harm to SUs emerged as paramount. Due to this, both issues were incorporated as components in the ACE survey training approach for FCs. These components will be discussed more in-depth under other themes related to training within this chapter.

Although the SMT and ARs were optimistic that their approach to obtaining 'buy-in' would be successful concerning most workers, findings indicate that there was an expectation that a small contingent of staff would resist the survey implementation

for other reasons. These reasons were related to some feedback they had received about the OMS, more specifically, the dissatisfaction with having to administer research measures, the increase in paperwork and the negative impact it had on allocated time working with SUs. The SMT participants reported that although there was a willingness to address genuine concerns from staff, remonstrations of this nature would not be accepted as objections to survey implementation. Findings indicate a unanimous expectation between the DoCCFS SMT and ARs from TCD that staff would, when appropriate and despite resistance, ensure that ACE survey data was collected as part of the OMS.

7.3.3 ACE training and recollection differed depending on role

Findings indicate that training and recollection of it in FCs and ECDCSs differed depending on the ACE survey implementation role. Findings from the interviews with the SMT, FCMs, and focus groups with FWs indicate that those who completed the training found it easy to recollect. Furthermore, findings indicate that training was more intensive in the FCs. The reasoning provided for this was linked to the fact that FWs chose to self-administer the survey questions. Doing so appears to have resulted in the perceived need for more rigorous training. The initial survey training was one day long. It commenced with an educational component from the TCDARs (please refer to Appendix 7 for specific content). Following this, a member of staff from Dublin Safer Families (DSF), a targeted gender, sexual and domestic violence service within the DoCCFS service, provided an overview of the service's experience of implementing the survey. As DSF was the pilot service for ACE survey implementation within the DoCCFS, findings indicate that the SMT perceived that a first-hand account of a staff member's experience would be influential in achieving 'buy-in' from staff within the FCs. The training day ended with a practical workshop where members of the SMT, FCMs and FWs engaged in role plays and practised asking the survey questions.

Findings from interviews with SMT, FCM and the focus groups with FWs determined that participants felt that FWs' initial perception of the one-day training was positive. However, participants could not recall the exact content of the educational component. They did recollect that having access to the ARs to ask questions and voice their concerns about the implementation of the survey was helpful. Participants from the FCM interviews and FW focus groups emphasised the importance of the personality attributes of the ARs, such as being approachable, down to earth, and

kind during the training and installation process. Participants also noted two points during the training that reassured them that implementing the survey would not cause retraumatisation or negative implications for SUs. The first of these was identified as a statement by a TCD AR that findings from previous ACE survey implementation did not result in any reports of retraumatisation. The second was related to the helpfulness of the personal insights from the DSF staff member. Participants noted that hearing that there was nothing to worry about from a colleague was powerful.

Although the initial perception of training by staff within FCs was positive, findings infer that as the FCs approached the survey implementation date, both FCMs and FWs stressed the need for additional training. This need for additional training was related to discomfort and inexperience in asking the survey questions. For this reason, the initial implementation date was postponed. During the postponement period, FCMs decided to facilitate additional practical training within their centres. FCMs and some OMS Champions developed role plays and allocated time for staff to practice asking the survey questions. Findings indicate that these role plays were perceived as being beneficial to FWs.

Recollection of ACE implementation training indicated that this was not as easy for participants in the ECDSMs interviews and the ECDSWs focus groups (please see Table 7.3). The SMT confirmed that training did occur but that because the ECDS staff were not self-administering the survey, the training was less intensive. It incorporated input from one of the ARs from TCD and the use of the Welsh ACE-themed educational video (as discussed in chapter 3). Findings indicate that staff within the ECDS completed several ACE-themed training days in addition to this initial one. Overall, participants from both the ECDSM interviews and ECDSW focus groups reported that because they participated in frequent training that it was hard for them to recount meeting the AR from TCD.

When asked about ACE training within the ECDS, the participants from the ECDSWs focus groups frequently referenced child protection training with the DoCCFS CPM. Findings indicate that the CPM incorporated ACE education into the child protection training curriculum to ensure that the organisation became ACE-aware. Some participants also vividly recalled watching the ACE-themed film, ' *Resilience: The Biology of Stress and the Science of Hope*', previously discussed in chapter 2. After the ACE implementation training days, this film was screened for staff throughout the organisation. Only ECDSW focus group participants recalled it as part of training to

prepare DoCCFS staff for survey implementation. Other participant groups mentioned the video as being specific to the DoCCFS child protection training.

Table 7.3 Differences in recollections of DoCCFS ACE survey training
"I remember going to ACE training with (names academic researchers from TCD) in one of the airport hotels." **Participant, FW focus groups**
"I suppose for me it's funny that what we had was classified as training. It didn't seem enough for me and I suppose we all have different needs as workers and have different training and backgrounds, but I... I.. just felt that it wasn't enough training.... To, I feel tease that stuff out and I know some of it was through experience as well and maybe that's to do with training as well. You know you should go back after six months and have someone say how are you finding doing this, what is the experience, what is the learning and what can we do differently? How can we support you with that? It was more just there it is, go do it." **Participant, FW focus groups**
"I remember it, it was all of us together in a hotel near the airport." **Participant, FW focus groups**
"I remember yeah, there was a lot of family workers together... yeah they introduced the ACE and (names DSF worker) gave some information about how they found working with it and sort of reassured everybody. Yeah it was (names DSF worker) and (names academic researchers from TCD), and it was sort of a general discussion just about how people felt and just about some of the questions that people had." **Participant, FW focus groups**
"We did ACE training with the child protection manager; I don't remember training with anyone else." **Participant, ECDSW focus groups**
"I don't remember doing ACE training for a day. I remember the child protection manager played us a video about ACEs and gave us some information but I don't remember anyone else. We do so much training so it is hard to remember exactly." **Participant, ECDSW focus groups**

7.3.4 ACE training did not consider the potential impact on staff with ACEs

Findings indicate that even though the DoCCFS SMT and ARs deliberated on the impact of implementing the survey on SUs, they did not extend to considering the possible impact of survey implementation on staff members with a personal history of ACEs.

None of the participant groups identified this matter as being explored or addressed before implementation. Interestingly, this lack of consideration had implications concerning findings relating to some staff members' experiences with the survey installation process. Data analysis from all participant groups indicates that those who self-identified as having no history of ACEs reported that the survey implementation training and education had no emotional impact on them. On the contrary, participants who acknowledged that they had background ACEs reported that participating in some aspects of ACE training and education profoundly impacted them.

Findings demonstrate that participants with ACEs who were allowed to complete the ACE survey were impacted by doing so (please refer to interview extracts detailed in Table 7.4). Participants who acknowledged having personal experiences of adversities during childhood in two of the three ECDW focus groups spent significant time reflecting on their experiences of being given the option of completing a survey during training with the CPM. Data analysis indicates that only one participant group, the ECDSWs, could recall being provided with this option. Throughout these two focus groups, ECDSWs with ACEs kept returning to this experience and its impact on them. These workers spoke about the initial feeling of being afraid. They reported that even though they were assured that the survey was for their eyes only, reading the questions and realising they had encountered some of the experiences made them feel uneasy. These workers recalled feeling fearful that they would be asked to return it and that people would find out what had happened to them. Furthermore, findings indicate that realising their ACE score made them feel ashamed.

Findings further indicate that some ECDSWs reported that completing the survey made them question their childhoods. They described how it caused them to challenge their original perceptions. Before completing the survey, some participants noted that they had never perceived their experiences as abusive or traumatic. They recollected that these experiences were normal for the time and not different to other children's experiences. However, after reading the ACE questions, these participants realised this perception was skewed. They noted that this was difficult to process and brought up many emotions.

The impact, although profound, was not entirely negative for participants with disclosed histories of ACEs. Some participants noted that completing the survey had also made them think about the intergenerational transmission of ACEs. Findings indicate that the experience caused them to reflect on their parent's experiences.

Table 7.4 The impact of being asked to complete the ACE survey on ECDSWs
"Well because you don't really feel like you've had.. (PAUSE) thinking back say on my childhood. I don't think it was adverse or it was traumatic in any way but, when you go through those ACEs and you see that maybe there was a bit of alcohol abuse it makes you think maybe I did. You just never would have really thought about it I suppose until you see it." **Participant, ECDSW focus groups**
"Well personally when I found out my own, it did make me realise Jesus Christ, well obviously there was a lot of trauma in my life, but before I filled it in I wouldn't have thought that." **Participant, ECDSW focus groups**
"You know I had (names ACE score) and I could have went to drink, I could have went to drugs. I didn't, I chose not to, but I think a lot about it.. I think a lot of what happened to me after, it was down to my choices.." **Participant, ECDSW focus groups**
"And I would understand that more now from working here and the training, I wouldn't have before but I do now. It gave me an understanding of the reasoning behind what might be happening in families, you know the granny did it and now the mammy is doing it and the chances are that the child could. It also made me think that why a child behaves in a certain way could be linked. You know that's the way they were brought up so they don't know any different." **Participant, ECDSW focus groups**
"It's interesting because the things that answering the questions brought up for me... Emmm... I never would have realised and it kind of made me a bit more understanding of family situations. You know even though something seems small, it wouldn't seem like a big deal but actually it can have a big impact." **Participant, ECDSW focus groups**
"Because when we filled it out, I looked at it and thought oh god there are a couple of things in here that I don't want anyone to see... I didn't want anyone to see mine and even though I was told that no one would have to look at it, I was afraid that they would ask to." **Participant, ECDSW focus groups**

Participants reported that it evoked more empathetic feelings for them towards their parents. They recalled how completing the survey initiated thinking about how their ACEs had not been repeated in their children's lives, and it caused them to reflect on why this was the case. Completing the survey led to them considering the impact of their personal choices, experiences of positive adult relationships and how their involvement in community groups and sports had helped them. They

recalled intentional parenting choices and behaviours they had made and adopted in response to their own experiences, ensuring that their children did not encounter the same adversities. Participants noted that when they took these actions or made decisions, they were unaware of ACEs but knew they needed to stop the cycle. Findings determined that this period of reflection following the completion of the survey subsequently impacted how they viewed SUs. They recognised that parents could stop the intergenerational transmission of ACEs and that they could support them in doing so. Leading on from the findings covered within this section, the next part of this chapter will present the findings concerning the organisation's experience of the third phase of implementation of routine ACE inquiry within the DoCCFS.

7.4 Implementation stage 3 – Initial implementation of routine ACE inquiry

This section presents findings regarding the initial implementation of routine ACE inquiry within the DoCCFS. In particular, it encompasses findings specific to the organisation's initial implementation experience concerning the required administrative, skill development and motivational changes necessary to facilitate the execution of the ACE survey. In addition, this section details participants' perceptions of complex factors concerning the change process. These factors include staff willingness to implement routine ACE inquiry, feeling ill-equipped to implement the survey questions and the need for additional resources to support the implementation process.

7.4.1 Apprehension was primarily related to the impact on adult SUs

Findings relating to the initial implementation of the survey reveal that worker apprehension about the potential negative impact of asking the survey questions only related to adult SUs. Interestingly, findings indicate that although the apprehension was more prevalent in discussion within the focus groups with FWs, participant groups who were not tasked with asking adult SUs (parents/caregivers) the survey questions, FCMs, and ECDSWs, also expressed concerns. Concerns about the potential negative impact on children were not voiced. Findings from the FW focus groups indicate that workers spent significant time contemplating how to manage and minimise the potential upset during the initial implementation phase.

The initial implementation of the survey evoked other emotional reactions alongside apprehension in FWs. Findings from the focus groups with FWs indicate that the fear that survey questions could retraumatise adult SUs resulted in some workers experiencing anxiety, concern, and reluctance. Findings regarding FWs' ability to respond appropriately to SUs' potential distress in being asked survey questions were twofold. Firstly, FWs who had experience working therapeutically with adult SUs in previous roles noted feelings of frustration. This group of participants noted that they were willing to ask the survey questions but felt frustrated that the remit of their role obstructed them from providing the therapeutic input that could benefit SUs who disclosed significant ACEs or became distressed. FWs in this cohort noted that their role did not encompass providing adult therapy sessions in response to experiences of adversities or trauma during childhood. Some participants noted that they would like to do this work and felt it should have been considered or facilitated as part of survey implementation within the DoCCFS. Additionally, FWS in this group noted that these feelings intensified during the initial implementation phase when they realised that counselling supports for SUs who did experience distress or who had disclosed significant ACEs were not readily available and that there were financial barriers for SUs on low incomes in accessing them.

Secondly, some FWs who did not have previous experience working therapeutically with adult SUs or who did not have dual therapeutic training reported that they experienced feelings of inadequacy and uneasiness at times. These FWs described feeling ill-equipped. This cohort noted that being tasked with asking the ACE survey questions was aligned with a responsibility to ensure that adult SUs were not further harmed. Similarly to participants who had the experience of working therapeutically with adult SUs, they also affirmed that they were willing to ask the survey questions. They, however, differed in that they were unsure if it was fair to ask the adult SUs about their ACEs when they were not qualified or experienced in responding to any upset that doing so could cause.

7.4.2 Retrospective abuse questions were the biggest hurdle to overcome

Findings indicate that the issue of retrospective child abuse reporting resulted in significant apprehension and concern for staff within the DoCCFS. All participant cohorts raised retrospective reporting as an obstacle during implementation. Participants from the SMT and FCM interviews noted that FWs voiced the most concern

about the implications of reporting retrospective child maltreatment to statutory child protection and welfare services. Although all child maltreatment ACE questions were considered difficult, several participant groups identified the ACE survey question relating to adult SUs' experiences of CSA (please refer to Table 7.5) as the most challenging to ask. Participants from the DoCCFS SMT and FCM interviews affirmed that FWs raised this question persistently as the most challenging. FWs were overrepresented in this finding as they were the only participant group to ask the question directly. Participants from the FW focus group described difficulties with the terminology and content of the question. Some participants advised that they found the wording too descriptive and direct. They explained that as they were not used to asking this type of question, they felt embarrassed and uncomfortable. Additionally, some female FWs reported higher levels of awkwardness when asking male adult SUs the question.

Table 7.5 **ACE Survey - Childhood Sexual Abuse Question**
Did an adult or person at least 5 years older than you touch or fondle you, or have you touch their body in a sexual way? Or attempt to actually have oral, anal, or vaginal intercourse with you?

Although a yes response from adult SUs concerning childhood physical, sexual, and emotional abuse invoked mandatory reporting responsibilities for DoCCFS staff, participants primarily raised concerns with mandatory reporting obligations relating to their experiences regarding the ACE survey question about retrospective CSA. Findings indicate that concerns about mandatory reporting obligations emerged strongly during the initial implementation phase. These concerns were described as the realisation that reporting disclosures of adult SUs' experiences of child abuse to statutory child protection and welfare services could harm the FW's working relationship with adult SUs (please refer to Table 7.6). Additionally, participants from the FW focus groups noted that while they were more accustomed to mandatory reporting procedures regarding current child abuse and welfare concerns, they were not confident in explaining the input from statutory services concerning retrospective

disclosures. This unfamiliarity intensified feelings of discomfort when asking the question.

Interestingly, although the ECDSMs also played an active role in ACE survey implementation by giving the OMS to SUs (parents) and collecting it, the question regarding retrospective CSA did not emerge as an obstacle for them. Findings indicate that as the ECDSCs adopted a SU self-completion approach for the OMS, concerns about asking the questions or retrospective child abuse reporting were non-existent. Participants in the ECDSM interviews and ECDSW focus group expressed relief that they were not expected to ask the retrospective CSA question. Participants further advised that they appreciated not having to ask the ACE survey questions because, unlike their colleagues in the DoCCFS FCs, they were not qualified to respond to the potential distress experienced by adult SUs. Similarly to participants in the FC focus groups, participants recognised that asking adult SUs this type of question could cause upset.

Participants from the SMT noted that prior to ACE survey implementation, it was uncommon for staff within the DoCCFS to engage parents or caregivers in conversations about their experiences of CSA or other forms of child maltreatment during their childhoods. They affirmed that although staff were accustomed to mandatory reporting of child maltreatment concerning children in the ECDSCs and FCs, their experience of doing so for adults was limited. Participants described how staff within the ECDSCs and FCs had no hesitation in reporting child maltreatment as their primary goal was to protect children and access support for parents and caregivers who needed it. They noted that because the staff were unfamiliar with reporting retrospective disclosures of child maltreatment, they found it difficult to reconcile the need to report with potentially upsetting the parent or caregiver and damaging their therapeutic relationship. Although they understood that mandatory reporting was necessary to protect children, potentially upsetting the adult who had allegedly experienced childhood maltreatment was not something they were used to. Participants from the FW focus groups noted that although they had no issue reporting child protection and welfare concerns, they were wary of retrospective reporting because they were not always confident that their reports would help the parent or caregiver.

Table 7.6 Perceptions of the ACE survey question relating to CSA
"For me once they disclosed child sexual abuse it was to provide the space so that they could choose to talk about it or not. If they did then you were into a whole different thing of I have to put this into writing and put this forward.... Although I was told it was just for research then I had to deal with reporting it to a social work department. Sometimes..., the families were gone and you were there chasing down the report that an adult had put behind them, tried to forget because it was just too painful." **Participant, FW focus groups**
"The bit that was missing is that we are not an adult counselling service you know, when we had adults coming in disclosing retrospective abuse not only were we reporting on it, but we were referring it on. I suppose a lot of it was about thinking where can we look at referring it to, how are we going to support this family? If we weren't doing ACEs, how would we support this family who had told us that they had been sexually abused in their childhood." **Participant, FW focus groups**
"There were more challenges in terms of ACEs then other outcome measures. I think retrospective abuse, in particular, child sexual abuse and how workers should deal with that and the reporting of it... Ammm... so my understanding of it is... is that it did require an awful lot of input in the early stages, in particular in that, moral dilemma of asking very vulnerable people about that history and explaining to them honestly about what was going to happen." **Participant, SMT interviews**

7.4.3 Adult SUs could not always equate their experiences to adversities

Findings indicate that it became apparent during the initial implementation of the ACE survey that adult SUs sometimes found it difficult to equate their experiences during childhood to abuse, neglect, or household dysfunction (please see Table 7.7). Participants from the FW focus group recounted experiences whereby the adult SU would complete the ACE survey and verbalise that they did not realise that answers they had ticked yes to were considered adversities. Adult SUs on these occasions were recalled as advising that they had never considered the potential negative impact of their childhood experiences.

Additionally, participants from the FW focus groups observed that some adult SUs would answer no to all of the ACE survey questions but then recount childhood events that equated to child abuse, neglect, or household dysfunction. Although

participants from the ECDSW focus group did not ask the ACE survey questions directly, they did report that some adult SUs had approached them to discuss the questions. During these occasions, participants noted that these adult SUs were surprised that some of the questions were considered to represent child abuse, neglect, or household dysfunction because these were common in most families they knew growing up.

Table 7.7

Service users could not always equate their experiences as childhood adversities

"So what I found was when you asked a direct question you got a direct answer and I suppose the grey areas were when people didn't know that it was abuse or not. What was useful in the question was it was very specific, it asked if you were slapped or choked or punched and sometimes that was the trigger for people to go, yeah, actually that happened to me." **Participant, FW focus groups**
"I think that maybe they didn't equate the question to their experience, and I would have certainly found that with some of the parents that I'd worked with prior to the ACEs coming in. Even when we asked them the question, and they said no, that never happened to me, and I'd be like (lowers tone of voice) you told me that before it did, but of course, you'd never say it like that, but afterwards, I suppose, when I thought about it, they don't equate that question, which is such a stark question to their experience of what's happened in their life. And I think afterwards then that staff would have said the same. That maybe during the survey, they would have said no but then turned around and disclosed something later on, but I... I suppose I would have thought that they don't get it." **Participant, FCM interviews**

7.4.4 Implementing called for changes to resources and service delivery

Participants from the SMT and FCM interviews and the FWs focus groups described how ACE survey implementation within the FCs called for immediate changes to time resourcing (please refer to Table 7.8), service delivery, and staff supervision processes. Initial implementation of the ACE survey within the FCs elicited the need for additional resources. Due to apprehension surrounding implementing the ACE survey questions, as previously discussed in this chapter, participants reported that FWs needed to complete preparatory and reparatory work with adult SUs. Several participants from

the FW focus groups recalled feeling obligated to prepare the adult SU for the ACE survey questions. Participants stressed that they felt it was essential to ensure that the adult SU was aware of the nature of the questions that would be asked. They also stressed the importance of ensuring that the adult SU understood the FW's professional responsibilities relating to mandatory reporting if they answered yes to specific ACE survey questions. This additional work was highlighted by participants as requiring an essential prolongation of the usually expected working timeframe.

Participants advised that the negative impact of being asked the ACE survey questions took multiple forms. They further outlined these manifestations as adult SUs who, despite having no history of ACEs themselves, became upset at the idea that any other person would. They also reported observing distress and confusion from adult SUs whose completion of the ACE survey warranted a retrospective child abuse referral to statutory child protection and welfare services. Lastly, participants from the FW focus groups recalled adult SUs who became concerned and anxious when they realised their children were or had experienced similar ACEs. Extending the timeframe for working with families was also identified as necessary to repair any negative impact that asking the ACE survey questions might have.

Participants from the SMT and FCM interviews and the FW focus group reported that FCMs and FWs began to discuss how conversations about ACE survey implementation emerged in supervision sessions. Additionally, some participants reported that FW supervision began to include conversations about parent and child ACE scores. Although FCMs, unless they were doing direct work with SUs, were not tasked with asking the ACE survey questions, participants from the FW focus groups recalled how some FCMs began to ask questions about the families' ACE scores in supervision. Participants recalled that some FCMs encouraged them to consider high ACE scores in their work with families and the decisions they made throughout their engagement with families.

These participants perceived this change as positive as they felt it resulted in more flexibility from FCMs and the SMT in working timeframes with some families. They also noted that it helped FWs and FCMs approach work with families attending the service from a new perspective.

Table 7.8 The immediate impact of the ACE survey on allocated time working with families
"I listen.. nothing is rushed, and I remember one mother said, she couldn't believe the length of time I took with her, the length of time I listened to what she had to say. She talked about the difference when she had met somebody else, she felt that everything was just so rushed." **Participant, FW focus groups**
"No one ever left here distraught or that upset, we did get the time Emmm.. normally our meetings are an hour, but if that hour had to go over, then that's what had to be. I would never have a family member or a client leaving distressed." **Participant, FW focus groups**
"You'd get to the ACE part of the survey, and it's a whole other level, and I would have to stop and try to prepare the client as best you could for the experience that was about to happen. We were very much informed do that piece at the very start of the ACE part because then it doesn't count if you do it later." **Participant, FW focus groups**
"Workers would give people the time. They would sit them down and try to make them feel that they were in a space that was attentive to them... Ammm... and I think that workers in themselves that that would be part of the course, really for people, you know that if you are working here that the expectation is that (pause) yeah, that they would make the space, yeah that they were attentive, that they held it well." **Participant, FCM Interviews**
"We were aware that it was taking more time, and that was a huge issue, but the benefit of that was that the person if they did disclose, got an appropriate response and either they were told that they could stop and talk about it now, or we would set up another appointment for them to talk about. Workers also told them that we could signpost them to another service. My feeling about it, once it was introduced, was that those safeguards were put in place, and we were flexible with our timeframe." **Participant, FCM Interviews**

7.4.5 SU's socioeconomic status influenced the implementation

Findings indicate that once routine ACE survey inquiry had been fully implemented throughout the DoCCFS, staff began to recognise that a SU's socioeconomic profile could assist with or obstruct the process. Participants from the FW focus groups acknowledged that an adult SU's education and employment status began to influence their perception of how easy it would be to ask them the ACE survey questions. Some participants advised that those with higher educational attainment and professional

employment status were, at times, anticipated as being more likely to raise an issue with or decline to answer the ACE survey questions (please refer to Table 7.9).

Table 7.9 **Service user's socioeconomic status influenced FW implementation**
"So, for instance, I was working with a young boy whose mum was a (names a healthcare profession), and it didn't go down well with her. You know, people hear social care and family support and will think (names FC) is a place where their children are going to be taken from them, we get referrals from left, right and centre for all sorts. You've got the lady, the mother (healthcare professional), and then you've got the mother of ten whose had a really tough time of it growing up in her own life. I knew that it would be easier to get the ACE information from her than from the (healthcare professional). That lady's (healthcare professional) reaction was oh good god, why are you asking me this and no, that didn't happen to me, whereas the other woman was very open. It actually opened up a pandora's box for her in terms of what she's been through." **Participant, FW focus groups**
"Where I work is a socioeconomically disadvantaged area, now it is changing the dynamics like even in our centre we'd have a lot of parents who are professional sort of couples, you know their children are coming for support. With the ACE survey, you knew that those parents were more likely to raise an issue or refuse to complete the survey. They were harder to ask." **Participant, FW focus groups**

Comparatively, findings from the ECDSM interviews indicate a different experience. Data analysis determined that a perception had emerged that an adult SU's level of education attainment and profession positively influenced their willingness to self-complete the ACE survey questions. Participants attributed this to the fact that their education and professional status ensured that these adult SUs could fully comprehend the rationale behind and benefit of the questions to the ECDSC (Please refer to Table 7.10). Interestingly, the ECDW focus groups uncovered that ECDWs attributed more significance to certain socioeconomic factors in children's lives after completing ACE training. In particular, they acknowledged that before doing the ACE training, they did not appreciate that parental separation was considered an ACE, nor did they comprehend that the socioeconomic challenges associated with parental separation could potentially lead to negative outcomes for children. Findings indicate that participants from the ECDSWs immediately began to recognise how typical this

ACE was in their SU population. As a consequence, they became more mindful that a child may require extra attention because of parental separation.

Table 7.10 **Service user's socioeconomic status positively influenced the implementation of the ECDSCs**
"Before their children started in the centre, I had a morning with all of them. I told them about the ACE, and I said you are going to find some of these questions really difficult, and I explained why we would need to find that information. I found that the more educated parents who maybe had been to further education understood why we would be asking that questions, but the less educated ones were like, "I'm not fucking telling anyone that" **Participant, ECDSM interviews**
"Because of the area that we're in, we have a lot of blown-ins with affluence, and who have more education, we literally have children who are homeless, and their parent is in prison and then children who have university-educated parents with good jobs. The educated parents are more willing to answer the questions maybe because they are less likely to have encountered them." **Participant, ECDSM interviews**

7.5 Implementation stage 4 – Full operation of routine ACE inquiry

This portion of the chapter details findings about the organisation's experience when the ACE survey was fully implemented as part of the OMS. In particular, this section focuses on the perceived effectiveness of introducing routine ACE survey inquiry into the DoCCFS.

7.5.1 Implementation of the ACE survey was a positive experience for the DoCCFS

Implementing routine ACE inquiry throughout the DoCCFS was perceived as a positive experience by many participant groups. Participants from the SMT interviews affirmed that they did not regret implementation as it led to the organisation becoming more ACE-aware and responsive. Furthermore, they reported that ACE survey implementation helped the organisation to quantify and demonstrate the level of

complexity encountered. Similarly, participants from the ECDSM and FCM interviews reported that ACE survey implementation was positive for their respective centres. They also declared that they did not regret the organisation's decision to implement it. Despite this, participants stressed that they would like to know what would happen with the data. They asserted they would like tangible proof that their respective centres' hard work improved service provision. Participants from the FW focus groups acknowledged that despite the challenges, ACE survey implementation was mainly a positive experience for them. They noted that it assisted them in their work with SUs. Participants emphasised the importance of seeing proof that their contribution and that of their SUs would be used effectively to improve the work that the DoCCFS does. Similarly to participants from the ECDSM and FCM interviews, they also expressed the need for information about how the DoCCFS SMT and ARs from TCD would use the data.

Interestingly, participants from the ECDSW focus groups could not speak to whether the ACE survey implementation had been a positive experience for the DoCCFS. Participants attributed this to the fact that they were unaware of the precise rationale for introducing it in the first place. Furthermore, participants highlighted that as they had not administered the ACE survey questions or distributed the OMS to SUs for completion, their role in the process was more removed. Participants noted that they could not determine the success of the ACE survey implementation based on their limited role. They described this limited role as encompassing ACE training and inadvertent conversations that some of them had with adult SUs about their experiences of being asked to self-complete the ACE survey questions.

Findings indicate that inconsistent feedback about the ACE data findings and not knowing what the SMT and ARs from TCD intended to do with it during the implementation process was a notable criticism from some participant groups. Participants from the FW or ECDSW focus groups stressed that they did not understand what the ACE data was revealing or how it could be used to benefit their work. This realisation proved frustrating for participants as they reported that it made them question the benefit of implementing the ACE survey as part of the OMS. Participants stressed that this type of feedback should have been prioritised throughout implementation because doing so would have maintained staff motivation and engagement in the process. Some participants in the FC focus group noted that communication was more apparent and forthcoming when OMSs were not being

completed or when FWs raised concerns about implementing the ACE survey with specific families. This type of communication was not helpful as it did not demonstrate the importance or significance of the data collection process for workers across the DoCCFS.

7.5.2 Discomfort with administering the ACE survey questions dissipated over time

Albeit there were reports of initial discomfort with administering the ACE survey questions, findings indicate this uneasiness reduced over time. Participants from the SMT and FCM interviews and the FW focus groups noted that once asking the ACE survey questions became routine for FWs, most felt better equipped and more at ease when asking the questions, and this helped them react appropriately to adult SUs' responses. Participants from the FW focus groups noted that they developed new skills in timing and responding to potential adult service distress over time. Participants also reported that as implementation became embedded, their discomfort reduced because they started to recognise the value of asking the ACE survey questions in their work with SUs.

7.5.3 Data accuracy was a concern for workers

A concern surrounding the legitimacy of adult SUs' responses to the ACE survey questions was a finding that emerged from data analysis for several participant cohorts within the study (please refer to Table 7.11). Participants from the FCMs and FWs attributed this concern to realising that some adult SUs may feel obligated to complete the ACE survey questions. FWs, in particular, advised that they perceived that some SUs agreed to participate in research because they felt it necessary to obtain a service from the DoCCFS. Additionally, FWs reported that they recognised that some of the adult SUs may have completed the OMS and the ACE survey questions within it, not because they wanted to, but more so to 'help or repay' the FW for the assistance that they would provide. In these instances, FWs raised concerns about the ACE survey data's legitimacy because they questioned if the adult SUs meaningfully participated in providing accurate data.

Table 7.11 The perception that service users felt obligated to complete the ACE survey
"And I wonder too, even though you say it to the family it's voluntary and you don't have to do it.. because it's a free service, I wonder how many families feel obligated to have to do it... because it's a free service too you know so, even though you make it very clear to them. Because I think in my two years here that I have only had one family refuse and every other family has done and I wondered is it because they think I'll do it because my child is going to get A, B and C here." **Participant, FW focus groups**
"If I am being totally honest, a lot of mine did it because it's, like you say, a free service... Emmm... I... I expect that if they had the choice, they would have rather not done it, but they had a choice, and they did it. There was no force on them, you know." **Participant, FW focus groups**
"Even though you were talking through the questions and saying, look, it's really hard to answer this, and it's optional, but you know... you kind of look at the position of power in that dynamic as well; you know they're coming looking for a service. One woman said to me I did feel obliged to answer those questions because I wanted a service for my child, and it was free." **Participant, FW focus groups**

Participants from the ECDSW focus groups recalled conversations with adult SUs who would advise that although they had completed the ACE survey, they admitted that they had provided inaccurate answers (please refer to Table 7.12). Participants recalled that on these occasions, some SUs would acknowledge that it was the first time they had been asked the ACE survey questions and query why the ECDSCs needed information about their childhood experiences. Furthermore, participants recounted that SUs affirmed that they chose to provide inaccurate responses because they were concerned about the implications of disclosing such information resulting in possible social work involvement from statutory child protection and welfare services. As a result of these experiences, participants expressed scepticism about the accuracy of the DoCCFS ACE survey data. They noted that although adult SUs generally completed the ACE survey questions, they were not confident that these responses accurately represented the ACEs encountered by the SU population. Due to this perception, participants queried how valuable the ACE survey data would be to inform future service delivery within the DoCCFS.

Table 7.12 Concerns about ACE Survey Data Accuracy
"We had parents bringing it back saying "I'm not filling that in" or... "I lied on that", so.. you know." **Participant, ECDSW focus groups**
"We did the ACE training, so it makes us more understanding, not because we see the forms because its just a number. We never see the numbers, but we do eventually through speaking with the parents; that's where we learn this is what's going on... Daddy's in prison or whatever, and because we know the value of ACE, we're more understanding. We are not more understanding from the parents filling them in because a lot of them would tell you, "it's blank, or I lied." **Participant, ECDSW focus groups**

7.5.4 Concerns about SU retraumatisation were not legitimised

Data analysis of the SMT participant interviews indicates that there was no evidence to indicate that implementing the ACE survey as part of the OMS resulted in instances of retraumatisation for SUs. Initial concerns regarding the possibility that asking adult SUs the ACE survey questions could lead to retraumatisation were not supported during implementation. Despite initial staff anxiety and expressed concerns, participants advised that most SUs answered the ACE survey questions and were unaware of any post-completion concerns. Despite recollections of encountering adverse emotional responses from adult SUs who were asked the ACE survey questions, participants from the FW focus groups did not identify these experiences as retraumatising or raise retraumatisation as an experience they had encountered during implementation.

Furthermore, participants described the skills they developed and innovations they employed during the ACE survey implementation process as helping them to ensure that adult SUs were not retraumatised by their experience. This description was further validated by participants in the FCM interviews, who noted that although FWs had encountered challenging experiences with adult SUs during the implementation process, there was no suggestion that these experiences negatively impacted the SUs or the working relationship. Findings indicate that participants highlighted FWs' skills in managing these challenging situations so well that they did not cause any distress to

SUs that FWs could not respond to appropriately, nor did it impact their relationships with SUs.

7.5.5 Language of the ACE survey questions were identified as a barrier

Findings established a significant barrier to universal SU participation in DoCCFS ACE survey implementation. This barrier is related to the language of the ACE survey questions. Participants recognised that the ACE and OMS should be provided in multiple languages. They reported that they could not understand why the DoCCFS had only provided an English version. An interesting addendum to this finding was the rationale provided by some participant groups for the importance of doing so. Participants from both the ECDSM interviews and FW focus groups recalled the ACE training, which indicated that the DoCCFS ACE survey data would be used to inform service delivery. Participants noted that if all SUs could not complete the ACE survey, this objective would not be met, and the SUs who did not speak English as a first language would not be accounted for in future planning. Participants identified this as an injustice. In addition, some participant groups were critical of the wording of the ACE survey questions. Participants from the FW focus group advised that they had encountered adult SUs who did not understand the terminology contained within the questions. Participants from the ECDSM interviews reported similar instances when they had been approached by SUs who advised them that they had comprehension difficulties during their self-completion of the OMS.

7.5.6 New staff who arrived during implementation perceived immediate benefits

Staff that arrived after the initial implementation of the ACE survey perceived immediate benefits (please refer to Table 7.13). Participants from the FW focus groups who had not been part of the initial rollout phase or the ACE training by TCDARs were immediately receptive to ACE survey implementation.

Table 7.13 New staff member's perceptions of immediate ACE survey implementation benefits
"We did get a new staff member a couple of weeks ago, and I just asked them before coming down to meet you how do they find it, and they said that they have no problem with it; they like it. They said that they find the space and the time with service users, and they explore it further. It helps them get information." **Participant, FCM Interviews**
"I was just told ask these questions, tick that box. There was no explanation given to me as to why this was or why it should be done like this. For me, I was more or less informed to tick the boxes, but I would have taken more out of it. I would take a lot from it myself, and I got a lot of feedback for me from it, but that's because Emmm... I used it to my advantage for picking up information." **Participant, FW focus groups**
"I made it more of something because, for me, it was of huge benefit and the information I got from it was hugely important. So, I mean, over the time I have been doing it, I have been taking it seriously in terms of making sure that all my ACEs are up to speed and that they are being handed out because, initially, I wasn't told how important it is. Over time, I began to realise it is was very important, and I like to use it. You know, I have been told you have to have these ACE surveys done, and you have to give it back, but it wasn't explained to me at the beginning how important it was. At the beginning, I was just told it's a survey, go in and tick the boxes." **Participant, FW focus groups**

Participants noted that they had no idea of the rationale for survey implementation and that they had just been told to ask the questions and tick the boxes. According to participant descriptions, the experience was positive because asking adult SUs the ACE questions enabled them to build rapport. They further advised that implementing the ACE survey facilitated them in gathering information that focused their work quicker and enabled conversations that they would never have had otherwise. Findings indicate that these participants viewed the ACE survey as an intervention and a data collection tool and expressed gratitude that they had the opportunity to use it.

7.6 Conclusion

This chapter presented findings relating to the DoCCFS's experience of the first four stages of routine ACE survey implementation. In particular, the findings outlined the experience of the exploration and installation of routine ACE inquiry for the organisation and how initial and full implementation impacted service provision concerning resourcing and working relationships with SUs. Additionally, this chapter described findings relative to the differences in experiences of transitioning to routine ACE survey inquiry and interpretations by DoCCFS staff according to their implementation role and service remit.

The next chapter will present findings on the final two implementation stages of routine ACE inquiry within the DoCCFS. These final two stages relate to the organisation's innovation during the implementation process and the factors that emerged relating to the sustainability of routine ACE inquiry once it was fully implemented. The next chapter will also present findings relating to the advice the DoCCFS participants would offer to other social care organisations concerning introducing routine ACE inquiry.

Chapter 8

Qualitative Findings

Adaptation to, reflection on, and advice relating to ACE survey implementation

8.1 Introduction

This chapter will present findings about the final two implementation stages of routine ACE survey administration within the DoCCFS. Results relating to the fifth stage, organisation innovation, will detail adaptations that the DoCCFS executed following contemplation of their experiences during the first four implementation stages. The chapter will then outline findings about the process involved in the DoCCFS reflections on the sustainability of administering the ACE survey once fully implemented. Lastly, this chapter will report results on the advice that the DoCCFS would offer other social care organisations thinking about implementing routine ACE survey administration within their services.

8.2 Implementation stage 5 – Organisation innovation

This section will outline findings pertinent to the adaptations and innovations that DoCCFS Staff made once routine ACE survey administration had been implemented throughout the organisation. The results described are relative to changes that arose from the organisation's learning, skill development and observations acquired during the first four stages of implementation.

8.2.1 Staff made adaptations to both facilitate and avoid implementation

Findings indicate that once administering the ACE survey routinely had been implemented in the ECDSCs and FCs, DoCCFS staff began to make adaptations. Participants reported that such innovations were both to help facilitate the administration of the ACE survey and, at times, to avoid implementation. Findings relative to helping facilitation included staff not adhering to the suggested OMS format and adopting flexibility with the proposed timing of asking the ACE survey questions. Participants from the FCM interviews reported that although FWs were encouraged to follow the structure of the OMS, where the ACE survey was located in the middle of the

form, this format was inevitably not followed. Participants from the FCM interviews and the focus groups with FWs acknowledged that because the ACE questions were so different and required so much emphasis, FWs usually completed them separately from the other OMS questions.

During this adaptation process, findings revealed that FWs recognised the timing for asking the ACE survey questions as key. Some participants reported waiting until the end of the OMS to ask the ACE survey questions. Participants said doing so ensured that the possible distress of being asked the ACE survey questions would not preclude the SU from answering the other OMS questions. Moreover, they stressed that asking the ACE questions at the end provided FWs with time to build a tentative working relationship with the adult SU, which assisted them in preparing the SUs for the ACE survey questions.

Findings about staff innovations which facilitated avoidance of ACE survey implementation were evident in the DoCCFS FCs (please refer to Table 8.1). Some participants from the FW interviews acknowledged that once routine ACE survey administration had been fully implemented throughout the organisation and they encountered adverse reactions from adult SUs, they made adaptations to avoid completing the ACE survey where possible. These adaptations included over-emphasising that adult SUs did not have to complete the ACE survey questions and what would happen regarding mandatory reporting if adult SUs answered yes to any of the retrospective child abuse questions. Participants in the FW focus groups also admitted to giving the OMS to adult SUs to take away to read before completion. Participants who chose this approach noted that when they provided the survey, they would encourage the adult SU to review the ACE survey questions specifically. Findings indicate that these adaptations were related to FW's motivations to protect adult SUs from experiencing potential distress. Such adaptations reflected the FWs' experiences of being unable to access immediate counselling support for adult SUs who disclosed significant adversities during childhood.

Table 8.1 Examples of staff innovations to avoid ACE survey implementation
"I am one of those people who fights things until I am ok about it. If you tell me I have to do something I don't believe in, then I can't present it to the clients in a positive way. Because of that, I had quite a few refusals in the beginning, and you know… so that's why I think the whole training part, the understanding part, the whole end goal of this and how it's going to serve us as workers and the service in general that was missing for me, and it was so typical of the organisation. Here's another thing, we'll do it for a while and.. then it will fall apart, and it will be nothing anyway…. so it was really hard to warm to it as a tool." **Participant, FW focus groups**
"I reserved the right to be cautious. I suppose to really be careful about presenting it to people, and I (emphasises word) WASN'T keen because I did feel well… we don't, we're not allowed to support them, we're not there for that, we are being told that clearly but at the same time, it could be very triggering and in a way irresponsible." **Participant, FW focus groups**
"I think at the beginning I was (clears throat)… I felt, you know, well, a bit dubious about the whole thing. I just didn't agree with it, so I was very clear with clients about the type of questions that were in the survey, and I would give examples. I would be very clear about it. Clear about their right to say no, so, I did very few, I think five out of the whole time said yes they would do it, and I was happy with that." **Participant, FW focus groups**

Although there was no direct evidence of the ECDSC making adaptations to avoid implementation of the ACE survey, there was some indication that the ECDSMs made adaptations to ensure the completion of the survey by adult SUs. These innovations related to advising the adult SUs that they would not read the completed OMSs, including the ACE survey questions, and that the answers would remain confidential (please refer to Table 8.2). Several participants in the ECDSM interviews reported that they adhered to this and did not review or read the content of the OMS. Their rationale for doing so was that they believed that if the adult SUs thought they were reading the answers, they would be unwilling to complete the surveys. The ECDSMs reported that they understood the importance of collecting the data for the organisation and wanted to try their utmost to assist with this process. Findings indicate that these innovations had implications for mandatory reporting of retrospective and current child protection and welfare concerns. The ECDSMs' decision not to read the ACE survey responses resulted in the ECDSMs remaining unaware if

adult SUs had indicated that they experienced physical, sexual, or emotional abuse during childhood or if their children were experiencing or had experienced these adversities. Being oblivious to this information meant that the ECDSCs did not encounter the adverse reactions or difficulties associated with mandatory reporting that the FCs had.

Table 8.2 **Approach to reading ECDSC service user's ACEs who self-completed was different**
"I would always say to parents ", look, once it's given back, it's confidential; this is confidential information. I'm not going to read it at all; if you give it back to me, I'm not going to read the information in it because it's confidential." **Participant, ECDSM interviews**
"Yeah, I did look at them, but I more scanned them rather than read them to make sure that everything was ticked." **Participant, ECDSM interviews**
"Yeah, you know, I have to say that when they do come back, I don't look at them because I have told them that they are anonymous, and I would hate to think that I would look at it and I would find out something that I didn't know about a person. You know, not that it would change how I viewed them, that doesn't matter the majority of them, I would know what's going on, but Ehhh... I don't look at them; I only check that they have the right centre, the right date, and they have those which would be on the first page, but I never look at the ACE or anything like that." **Participant, ECDSM interviews**

8.2.2 Routine ACE survey administration led to changes in the FCs

Findings from the FCs indicate that routinely asking ACE survey questions had a multifaceted impact on practice for FWs. Interestingly results indicate that when participants were asked if implementation had led to changes in DoCCFS staff practice, the first response was primarily no. Despite this initial response, participants, particularly from the FCM interviews and FW focus groups, would then go on to describe changes that had occurred. Findings indicate that these participant groups perceived change as only relating to SMT decisions about funding allocation and developing programmes and interventions arising from the ACE survey data. Findings indicate that although participants described changes, they did not perceive these alterations to practice and approach as organisational innovation in response to administering the ACE survey.

The description of changes in FC service provision and practice approaches by participants in the FCM interviews included the positive impact that asking the ACE survey questions had on rapport building between FWs and adult SUs. Findings indicate that participants attributed the care and attention FWs demonstrated during the preparatory period to aiding this development. In addition, participants from the FCM interviews noted that ACE implementation led to FWs taking a broader view of SUs' circumstances. Participants recalled discussions with FWs about previous DoCCFS input with the SU and their families across generations. Findings indicate that the intergenerational engagement cycle with the DoCCFS and other services emerged as a new conversation topic. Participants reported that routine ACE survey administration initiated a process of FWs reflecting on how a parent's behaviour and circumstances could be linked to their past experiences. In addition, findings indicate that administering the ACE survey led to FWs consciously attempting to identify and recognise SUs' resilience. Participants from the FCM interviews noted that during supervision sessions, FWs started to remark about how well some SUs were doing despite their ACEs and broader experiences.

Findings indicate that FWs also started to educate SUs about the potential impact of ACEs. Participants from the FCM interviews acknowledged that although the decision to provide education by the FWs was motivated by their feeling the need to explain why the organisation wanted SUs to complete the survey, it inevitably enabled FWs to have a different type of conversation. Participants stressed that although FWs had always been equipped to and were having conversations about the impact of parenting on children, that routine ACE survey administration provided them with an opportunity to converse with SUs about how their experiences during childhood might be unknowingly impacting their parenting. It offered a direct way of having this conversation earlier in the relationship.

Findings from the FW focus groups indicate multiple changes to service provision and practice approaches arising from ACE survey implementation (please refer to Table 8.3). Participants from the FW focus groups reported that the ACE survey helped them identify when an adult SU was in crisis. The process of asking ACE survey questions opened the door to parents disclosing information about their past and current circumstances. Findings from the FW focus groups noted that they did not ask such direct questions about parents' histories before its implementation. Similarly to participants in the FCM interviews, participants indicated that asking the ACE survey

questions caused them to reflect on the intergenerational impact of ACEs on parenting and how difficulties and challenges experienced by families could be cyclical. Participants affirmed that this period of reflection motivated them to help the adult SU to see that they could intervene in these cycles to stop the same experiences from happening to their children.

Table 8.3 **The positive impact of ACE survey implementation on FW's approaches**
"I got to know my families initially so quickly because of the ACE survey, and that's how it turned out... yeah. I really built up a relationship with them, and they gave a lot back to me, which they didn't have to." **Participant, FW focus groups**
"I mean the parents; some parents would have delved back into their own life certainly a lot and would have looked at questions, for instance, like.. some parents... one parent would have come from a very difficult background, a lot of domestic abuse there, a lot of drugs, drink, and she came back after being asked the questions and said this really is why I am where I am now with my child because this is where I came from. We ended up having a really good discussion about that, so I found it great that way." **Participant, FW focus groups**
"Another way I suppose that it helped me was that I did have a foster mother and a child in care and Emmm... it was just really... having that information on ACE and having the score it really showed the complexity of the child's life and how at a young age all they'd experienced and I suppose for me in my work, well that.... just the value of having the space to offer the child and giving them something good and being able to share that with a foster parent, I felt that was very valuable." **Participant, FW focus groups**

FWs noted that before the ACE survey implementation, their primary focus of attention was assisting the family in the context of supporting the child or children. Findings indicate that introducing routine ACE survey administration altered this approach. Participants from the FW focus groups stated that they began offering emotional support to adult SUs impacted by the ACE questions. This support sometimes involved working with the parents more than the child, particularly when the child attended the FC individually for a specific programme and not for family support. When SUs appeared upset by the questions, FWs frequently called them to check in over the subsequent days.

8.2.3 ACE implementation training resulted in changes in the ECDSCs

Despite not being tasked with asking the ACE survey questions directly, findings from the ECDSM and ECDSW interviews indicate changes to service provision and practice approaches arising from ACE implementation training. Participants from the ECDSM interviews acknowledged that although some staff within the ECDS had previous knowledge of ACEs from background and external training, there was limited awareness of ACEs in the ECDSCs before DoCCFS implementation training. Regarding changes to ECDS service provision and practice approaches, participants described how ACE training had added a new perspective to home visits for ECDSWs. They explained how seeing where SUs lived and how they lived made ECDSWs think about how those factors impacted both child and parent behaviours. In particular, participants described how visiting parents living with several children in small or inappropriate accommodations after the ACE implementation training resulted in ECDSWs reflecting on how such difficulties would manifest in child behaviour and parenting practices. Findings indicate that participants were keen to assert that ECDSWs were responding to children's ACEs long before they had completed the ACE implementation training. Participants from the ECDSM interviews noted that although training helped provide a framework for understanding, much learning about ACEs occurs in ECDSWs' everyday engagement and responses to children's needs.

Participants from the ECDSW focus groups identified several changes to service provision and their practice approaches arising from ACE implementation training. Specifically, findings indicate that the training helped ECDSWs recognise that some children attending ECDSCs had encountered adversities and significant associated trauma. After completing the ACE training, they noted that they could easily recognise this by observing the children's behaviour. Despite being time-limited, they also became more observant of the possible occurrence of ACEs during their engagement with parents when they dropped their children off at the ECDSC or collected them. They started to notice if the parents seemed stressed or concerned and how engaged they were with their children. Findings indicate that participants in the ECDSW focus groups perceived ACE training as helping them to recognise and understand patterns of behaviour and challenges that kept re-emerging in SUs' lives. Participants noted that some staff within the ECDSCs had worked in the same setting for years and that since completing ACE training, conversations about SUs began to focus on how a child's parent may have encountered adversities similar to the ones

that the child was currently experiencing. Participants reported that these conversations were not negative and primarily focused on recognising the presence of the intergenerational transmission of adversities in the context of considering what the ECDS staff could do to intervene in the child's life.

Data analysis of the ECDSW focus groups highlighted how ACE implementation training caused participants to contemplate their opportunities to intervene in children's lives. Participants affirmed that ACE training had enabled them to recognise that they were some children's 'one good adult'. They noted that they saw this role as very important, and it motivated them to want to help and support children with ACEs. They recalled that the ACE implementation training had emphasised their need to have unconditional positive regard for children and be committed to wanting the best for them. Additionally, Participants highlighted their realisation that they were perceived differently from other professionals by adult SUs, which equipped them to intervene in an ACE-informed non-combative and collaborative way. They noted that some parents view the ECDSC as a creche and do not perceive ECDSWs as adversarial or a threat. They recognised that parents were much more open to their guidance than social workers. They identified this perception as being key to their discussion of the need to change parental behaviours to reduce the occurrence and impact of ACEs.

Findings indicate that ACE implementation training led to ECDSWs acknowledging the role that they were playing in addressing children's ACEs (please refer to Table 8.4). During ECDSW focus groups, participants recalled specific experiences when they had intervened in an ACE-informed manner with children. Interventions and actions described included conversing with parents about how these ACEs impacted their children, suggesting that parents seek counselling and parenting support, and reporting concerns to Tusla. Although participants stressed that they had always responded to children's ACEs before training, they reported that the urgency in doing so became more apparent after training. They recalled recognising when children were upset or their behaviour had changed and that they would try to ascertain what was happening when this occurred. Findings also indicate that ACE implementation training helped ECDSWs to become more conscious of social cues from adult SUs. Participants described that the ACE training made them take the time to recognise when a parent/caregiver might require support.

Table 8.4 Changes to ECDSW's approach arising from ACE implementation training
"We had a meeting with the parents because they openly told us that there was domestic violence in the house. When they told us that, we were honest and said that that was the reason why his behaviour was like that. We explained that what he was seeing was having such a huge impact on him. We started to tell them different ways to respond. Things like, when you're talking to him, don't be screaming at him. Go down to his level and explain the reason. We gave the example of the child trying to run out on the road, and we said, you know, explain to him how dangerous the road is and that you don't want anything to happen to him. Tell him you are holding his hand to keep him safe. When the dad started doing that and getting a positive reaction from him, he was shocked. We told him that it was because the child understood the reason why he needed to be safe crossing the road, but when you were dragging and shouting at him, he didn't. He was getting such criticism from them, and plus he was seeing the violence between them. Once they knew it was about their understanding, once they could understand that their behaviour was having a really traumatic impact on his behaviour. Then once they started doing little things, his behaviour started to change." **Participant, ECDSW focus groups**

Findings further indicate that ACE implementation training made ECDSWs recognise the untapped potential for the ECDSCs to intervene effectively in an ACE-informed way with children. Participants in the ECDSW focus groups reported how the training had led to a realisation that they could be doing a lot more work with parents and providing many more community-based groups that would inevitably reduce the prevalence and impact of ACEs. Participants stressed that they hoped that the ACE data provided by ECDS SUs would emphasise this potential to the SMT and that they would be provided opportunities to expand ECDS service provision to meet the needs that would come to light.

8.3 Implementation stage 6 – Sustainability of routine administration

This section outlines findings relative to the contemplation process of examining the sustainability of routine survey administration within the DoCCFS. In particular, the results pertain to staff reflections on how the challenges encountered during implementation influenced the perceived benefits of the survey and the decision to cease routine administration within the DoCCFS. During the data collection process, all

participant groups were asked if, after reflecting on their experiences of survey implementation, they had any advice for other social care organisations that were considering introducing routine survey administration. As these results relate to what participants felt would help other organisations successfully implement routine ACE administration, they are also included in this section.

8.3.1 Potential impact on staff should have been considered

The need to consider and respond to the impact of ACE survey implementation on staff tasked with asking the survey questions was a finding that emerged from several participant groups. The interviews with FCMs, in particular, highlighted observations regarding the need to account for and respond to the emotional impact of asking the survey questions on FWs. Participants reported that FWs' ACEs were not considered during the survey implementation. Despite this lack of consideration, participants said that due to the emotional impact on FWs they had observed, they began to provide space in supervision to allow FWs to discuss the implications of asking the survey questions on them. Participants reported that although they did not ask FWs if they had experienced adversities during childhood, they hoped that those who may have been impacted would use the opportunity to reflect on how their own experiences may be affecting their work. Comparatively, findings from the FW focus groups indicate that participants were not forthcoming about having experienced adversities during childhood. Unlike the ECDSW participants, no FW admitted to having ACEs. Some did note that asking the survey questions made them reflect on their childhoods but did not expand on exactly what they meant by this.

Findings indicate that participants from the FCM interviews recognised that asking the survey questions was difficult, and they empathised with the perception of some FWs that some of the questions were personal and intrusive. Furthermore, participants reported that some FWs expressed concern and anxiety about asking the survey questions from the outset of implementation and throughout. In recognising this, participants explained that they inevitably took on a pseudo counselling role to support FWs (please refer to Table 8.5). They offered them time and space to discuss any issues and made an effort to ensure that staff felt heard. Interestingly this concern for the emotional impact on FWs is further validated by the finding that participants from the FCM interviews focused primarily on the negative emotional effect on FWs in witnessing adult SUs' distress and not the adult SUs' distress. Participants described

how FWs became skilled in managing and responding to adult SU distress. Still, they frequently required support to process their own experiences after doing so.

Table 8.5

Example of support provided by FCMs to FWs after implementing the ACE survey

"You know, staff would come out of a room and say there's such sadness in that room with that client, and they may have to come up for an hour and talk to me or had a cup of tea or whatever... because they feel that, that client didn't really make the connection until they read those questions. They spoke about how when they made the connection, they were really upset and distressed in the room and then they spent a long time trying to deal with that. They talked about worrying about that client and how they might ring them later that day or talk to them to check how they are the next day. Sometimes they would be worried about that and think that the upset was because of what they had asked."

Participant, FCM interviews

Participants from the FW focus groups outlined the negative emotional impact of asking the survey questions. Findings indicate that they were largely unaware and unprepared for this impact. Some participants noted that asking ACE questions had brought up several negative emotions for them. Those impacted reported feeling drained and tired after encountering adult SUs who were upset or distressed by being asked the survey questions. They noted that they had often worried about these adult SUs and that it was not easy. Some participants advised that knowing that families had high ACE scores or that adult SUs had experienced abuse during childhood sometimes made them feel out of their depth in assisting them. Participants further noted that their role was to help the child, and knowing they could not do more or did not know how to assist was challenging. Findings indicate that the absence of self-care in ACE training was a deficit that negatively impacted FWs. Participants affirmed that ACE implementation training should have accounted for the likelihood that staff asking the survey questions would encounter negative emotions.

8.3.2 Several factors influenced the decision to end routine administration

At the outset of its introduction as part of the OMS, the DoCCFS SMT and academic ARs from TCD did not set an exact end date for implementing routine ACE survey administration. Findings indicate that two factors influenced the cessation period of

April 2020. These factors included, firstly, the impact of the COVID-19 social distancing measures on survey implementation. When social distancing measures were introduced, the findings indicated that adult SUs did not attend the FCs or ECDSCs in person. Due to this, FWs could not administer the ACE questions directly to the adult SUs, leading to concerns. Although findings indicate that some FWs attempted to implement the survey over the telephone, concerns arose about how appropriate this approach was if adult SUs became distressed by the questions. Similarly, ECDSMs reported that because adult SUs were not physically coming to the ECDSCs, they could not provide them with the ACE survey questions as part of the OMS.

Secondly, participants from the SMT interviews noted that despite there being no evidence of survey implementation retraumatising adult SUs, the reports of asking ACE questions risking FWs' therapeutic relationships with SUs persisted. Although participants from the SMT interviews reported having no evidence of adult SU complaints, they recognised that this message was consistently being repeated. Findings indicate that they realised this was something they would have to address regarding the sustainability of administering the survey. These results determined that a sustainability conversation ensued when participants from the SMT approached the ARs from TCD to advise them of the challenges posed by COVID-19 and the perceived negative impact on the therapeutic relationship. Participants reported that it was decided during this conversation that the time given to routine survey administration within the DoCCFS had been sufficient to collect enough data to provide a profile of the SU population. Findings indicate that the SMT felt confident that the ACE data collected would be sufficient to meet the original objectives of introducing routine administration of the survey.

8.3.3 Knowing how to use the ACE data effectively was not obvious at the end

A unanimous finding that emerged from data analysis of all participant groups was that there was no clear understanding of what the DoCCFS would do with the survey data. Participants stressed that ACE implementation training had not provided an overview of how social epidemiological data such as that collected by the survey could be used to inform social care service provision within a social care organisation. Discussion surrounding the ACE implementation training suggested that participants could not recall information about the motivation behind the first ACE study or how data collected in that study and subsequent ones were used to improve outcomes for SUs.

Although the SMT and TCDARs had described the motivation for survey implementation within the DoCCFS as supporting funding applications and informing service delivery, the practical steps in meeting these objectives remained unclear. Findings from the SMT interviews indicate that this lack of understanding related to being the first social care organisation internationally to implement routine survey administration. Participants reported that, unlike clinical settings that had implemented the survey, they had no services to compare to or to assist them in identifying what route they should take to use the data effectively.

8.3.4 Several factors need to be considered before implementation

Implementing the survey within a social care organisation requires consideration of several issues. Findings indicate that factors such as the organisation having a clear rationale for implementation and a plan for how the ACE data will be used were important. All participant groups stressed that social care organisations should be able to articulate why they want to implement the survey and what they intend to do with the ACE data to benefit the organisation (please refer to Table 8.6). This need for articulation was attributed to ensuring staff and SU participation in the implementation process.

Table 8.6 **Ensure that everyone knows the rationale for routine administration**
"Yeah, we need to be able to tell people what good is going to come out of it. By them doing it, will something good happen? What can we achieve from it? How can we use the information from this area to help people you know?" **Participant, FW focus groups**
Well, explain it to the staff first. We were not involved in asking the questions, so we do not understand really why the organisation was asking the ACE questions. I know managers need to, and they know what it's about, but not the staff. We don't know, and we should." **Participant ECDSW focus groups**
"Everyone needs to know the end goal, what is the point of it. We need to be able to say you're doing this and at the end of you doing it so we could or we will do X, Y and Z." **Participant, FW focus groups.**

Participants tasked with asking the survey questions, those from the FW focus groups, stressed the importance of organisations informing staff how they intended to use the ACE data before implementation. Participants noted that, at times, the challenges they encountered in implementing the survey were compounded by not knowing what good would arise from them asking the questions and potentially causing upset for adult SUs (please refer to Table 8.7).

The need for consistent consultation and collaboration between social care organisation management and workers relating to exploring, planning for, and implementing the ACE survey within the DoCCFS also emerged as consistent advice from the findings. Participants reported that having limited opportunities for consultation and collaboration specific to the survey data was disappointing. When reflecting on the DoCCFS experience, participants from the ECDSW focus groups noted that as they had not been tasked with asking the survey questions, they were inevitably unaware of important information relating to the rationale for implementation. Some noted that they felt excluded. In addition, some participants stressed that after completing ACE training as part of the implementation process, they had ideas about how the ECDSCs could change its service provision to intervene in and respond to children's ACEs. Participants from all groups noted that regardless of the survey implementation role, it was important that all staff within social care organisations are provided with opportunities for consultation and collaboration.

Table 8.7

The need for a clear plan for ACE data use

"I think when it was originally introduced as a piece of research, but then there was talk of it becoming..... that it would inform the work, but for me that never quite happened.... we were kind of told at the beginning this was just to collect data, but I think what happened was this isn't ok as a tool, just to collect data because you're talking about really sensitive information here where you are working and trying to develop a relationship with parents. You need to be able to provide that empathetic space, and when you are collecting data, you can't do that because you've got to be able to move on to the next question so that you can get it done. For us we kind of felt that we warmed to it, and we were waiting for ok once the research is collected, then they are going to use that information so that we can be better trained so that we can, be more trauma-informed and to be able to provide much more services Ehhh... Emmm... to the client, and that was going to make it all worthwhile for us... and now we are still waiting for the second part of it and thinking how is it going to change."

Participant, FCW focus groups

Findings suggest social care organisations should consult SUs before implementing routine survey administration. Participants from the ECDSM and FCM interviews and the ECDSW and FW focus groups acknowledged that the DoCCFS had not done this. Not consulting with SUs meant that staff within the organisation were more apprehensive about the possible negative impact of asking survey questions for SUs. The lack of SU perspectives resulted in staff within the DoCCFS anticipating that the survey questions would be upsetting for SUs and that implementing the survey would be difficult because of this expected distress. After reflecting on this, participants noted that asking SUs for their insights before implementation would have provided an understanding of their willingness to participate and inform DoCCFS on how they could implement the survey questions in a supportive way. Overall, participants affirmed the need for organisations to gauge SUs' opinions about the survey questions to inform the implementation process (please refer to Table 8.8).

Table 8.8

Ask for service user feedback before introducing routine administration

"We probably should have..... Emmm... I don't know why that was because we generally ask for feedback about everything else. It would have been interesting to know what they thought about the questions...."   **Participant, SMT interviews**
" I do not think that there was anything from the parent's point of view. I think, like for staff, that it was a fait acompli before we got to do any training, you know, we weren't involved in the process of deciding to do it, which was fine. I wouldn't expect to be. It wouldn't be my expertise or whatever, but it was sort of like the outcome measures were sorted out, and we had meetings to discuss why we were doing it with parents and where it came from, that type of thing, but, no I don't remember any, there was no discussion with the parents."   **Participant, ECDSM interviews**

Another factor that social care organisations require consideration of is the impact of routine survey inquiries on paperwork (please refer to Table 8.9).

Table 8.9 **Recognise that paperwork will increase**
"Emmm... I don't really know to be honest with you. Sometimes you're thinking (lowers the tone of voice), we have induction going on this week, and like the parents are coming in. To bring their child here for three hours of playschool, you have to (sound of papers rustling) fill in all of that. All that paperwork has to be signed off on, and that's only one section. Then they come, and they give me their PPS number, and I would have three other forms for them like that. One of them is six pages, another one is one page, the other one is two pages, and then they fill it in, and half the time you're saying (lowers the tone of voice) .. another fucking form. You know so many forms that have to be filled in to bring your child to playschool." ***Participant, ECDSM interviews***
"I think that you have to be prepared for an increase in SRFs because we did and are still having a few of them especially retrospective abuse that are coming up in the ACE, Emmm... obviously it's going to cause more paperwork, so be prepared for that, I think it's really important to have good systems in place." **Participant, SMT interviews**

Participants from the SMT, ECDSM and FCM interviews and the FW focus groups emphasised that inquiring about SUs' adversities during childhood resulted in additional paperwork. Findings indicate that it would be necessary for other social care organisations to both expect and plan for this increase.

8.3.5 Expect mandatory reporting to be an issue

The need for social care organisations to recognise that mandatory reporting of retrospective child abuse arising will be an issue also emerged as a finding. Participants from the SMT, FCM and FW interviews emphasised that asking SUs about their adversities during childhood would likely lead to an increase in retrospective reports to statutory child protection and welfare services. Given this expected increase, findings indicate that participants would advise other organisations to ensure that they provide appropriate training for staff surrounding mandatory reporting obligations (please refer to Table 8.10).

Table 8.10 The need to prepare staff for mandatory reporting
"I would say to one of the questions that you have around what advice would you have for people who are starting to use it, for me it was Emmm... right at the very beginning there was no explanation and there was talk of informed consent but I don't think that the consent highlighted clearly that you would be asked about retrospective abuse and that... the procedure that would have to follow from that because I had... right at the very beginning a difficult one with a man who said about retrospective abuse and he was furious about the fact that we had to you know Emmm... report that on and he hadn't... he had dealt with in his own way and his family and they had you know put that aside a very long time ago and there was a lot of repairing work that had to be done after and.. so its and what I learned from that was that you absolutely have to spend time going through exactly what the implications are of asking any of these questions and that wasn't explained to us at the beginning and I think that that was something that we had to learn by ourselves going along." **Participant, FW focus groups**

Participants also affirmed the need for social care management, in particular, to adopt an empathetic and understanding stance should concerns or resistance relating to mandatory reporting arise. Findings further indicate that social care organisations should expect more resistance to survey implementation from therapeutically trained staff. Should this occur, participants from the SMT suggested that social care organisations should consult with this cohort of staff to hear their reservations and work collaboratively to put systems in place to support implementation.

8.3.6 Training needs to be specific to staff implementation role and context

Participants affirmed the need for social care organisations to tailor ACE implementation to staff roles. Findings from the focus groups with FWs and ECDSWs and the interviews with FCMs and ECDSMs indicate that participants felt that deciding not to do so within the DoCCFS had negative implications (Please refer to Table 8.11).

Table 8.11 **Training material should be specific to the ACE survey implementation role**
"If a child is neglected and they are not being cared for or spoken to, explained, and they are just shouting and roaring and drinking, those branches stop growing, and you're actually looking at brain damage. A part of the ACE training should be what actually happens to the brain when a child is living in those circumstances because you can't have the same expectations of those children as a worker." **Participant ECDSM interviews**
"Yeah, training should include something around what can we do to support parents who are actively, you know… undergoing ACEs as an early years practitioner like.. what can we actually do, where's the line, do you know what I mean?" **Participant ECDSW focus groups**
"I think that you have to do a lot of training, support, awareness with staff, especially with staff that are very concerned about the impact on the therapeutic relationship with the child." **Participant, FCM interviews**
"Training should not just be about using it for research and not upsetting service users. It needs to look at the impact on staff as well. They are personal questions, and they're difficult to ask. Training needs to look at that, self-care, what can we do…." **Participant, FW focus groups**

In particular, participants stressed that assigned implementation tasks resulted in specific training needs. Participants from the FW focus groups emphasised that training should have included components on self-care, asking questions, understanding how best to respond to distress and how to explain the benefits of completing the ACE survey to the adult SU. The training emphasis for this participant group was primarily related to effectively responding to adult SUs' distress. Comparatively, participants from the ECDSW focus groups highlighted the importance of the training components relating to intervening in and responding to ACEs that children encountered. As ECDSWs were not tasked with asking the survey questions, their training needs were associated with integrating the ACE training into their work. Participants advised that although the training had highlighted ACEs as having the potential to impact a child's life negatively, it did not extend to equipping them with knowledge about how to counteract or alleviate these challenges.

Table 8.12 ACE Training material should be specific to the organisational location
Participant A: *"Because this is a totally different country to America and Americans with black people and that, there was, or I think that there still is a lot of racism there were I don't think that this country is the same as America, at least if you could see it in your own environment because even when we do our training, it's unrealistic some of the stuff."* ***Participant B:*** *"Yeah, they have a totally different way of talking and saying things; plus, we need a more recent video, not something from years ago."* ***Participant C:*** *"Yeah, because the Americans seem to be really old-fashioned, and some of the scenarios they do seem to be perfect, and you know that in real life, it's not going to work out like that."* **Participants, ECDSWs focus groups**

In addition to the need for ACE training to account for staff roles, participants from the ECDSW focus groups stressed the need to use training materials related to staff context and location. Understanding how to converse with SUs and intervene in children's ACEs in the country where the organisation is based was identified as an essential training component. Participants affirmed that using ACE educational videos from the USA was not helpful as they did not provide examples they could relate to their work environment (please refer to Table 8.12). Interestingly, participants who had been shown an ACE training video from a Welsh context noted that they found this helpful as they could understand the context. Participants advised that as people and the environment in Wales were similar to Ireland, the content covered in the video was easier for them to relate to and process for inclusion in their work.

8.3.7 The ACE survey should be adapted to reflect the SU population

Participants from the FCM, ECDSM interviews and the FW and ECDSW interviews affirmed that organisations should ensure that their choice of ACE survey questions captures the adversities experienced by their SU population (please refer to Table 8.13).

Table 8.13 The need for additional ACE survey questions
"I think that there was talk of the need to include homelessness as an ACE question, and given the number of families that are impacted by homelessness, I think that that would be an important one to add. I don't think that's going to go away anytime soon." **Participant, ECDSW focus groups**
"Families were experiencing more adversities than what was included on the ACE. We had a lot of Muslim families living in terrible accommodations. They had little money for clothes for the children and basic things. The ACE questions did not ask about those things." **Participant, ECDSW focus group**
"There are lots of other ACEs that the list did not include. Those things were also difficulties that families encountered that if we are going to use the survey to develop the service, we should have recorded them." **Participant, FW focus groups**

Findings reflect concern on behalf of participants that the survey questions implemented in the DoCCFS did not collect data representative of all challenges encountered during childhood. Specifically, participants observed that the survey did not have questions about homelessness, poverty, the impact of seeking asylum in Ireland, racism, discrimination, and experiences of chronic illness by the child or a family member. Findings indicate that if the organisation's rationale is to use the survey data to inform service delivery, they must include survey questions that reflect all of the childhood adversities that are or were encountered by the SU population.

8.3.8 Accept that Implementation is just the first phase of a change process

Participants from the SMT interviews accentuated the need for social care organisations to understand that routine ACE survey implementation was the first step in the ACE journey. Findings indicate that after reflecting on the DoCCFS experience, it became apparent that collecting the data was only the beginning and other organisations needed to know that there would be additional work. Findings indicate that as the journey towards effectively using ACE data to influence service provision was largely unchartered, social care organisations need to remain committed to the process. Participants acknowledged that not knowing how to proceed with the data was a complexity that the DoCCFS had not considered before implementation. Due to

this, the organisation was now entering a new phase of exploring options. Participants stressed that social care organisations should know this exploration required additional work and effort beyond the ACE data collection process.

8.4 Conclusion

This chapter presented findings about the organisation's innovations once routine administration of the ACE survey was fully operational within the DoCCFS. In particular, the chapter outlined findings relating to changes to service provision and staff approaches initiated by the implementation experience. The chapter then progressed to detail findings concerning the DoCCFS contemplation process surrounding the sustainability of routine ACE survey administration within the organisation. This chapter concluded with a description of the results of the advice that the DoCCFS would give to other social care organisations considering implementing the ACE survey.

Building on the qualitative findings relating to the DoCCFS experiences of the systematic ACE survey implementation process, the next chapter will present the quantitative results of this study. This presentation of quantitative findings will provide the reader with an insight into the ACEs experienced by the DoCCFS SU population. It will also use the qualitative data findings to illustrate continuities and discontinuities between the study's quantitative and qualitative results.

Chapter 9
Quantitative findings
DoCCFS ACE profiles

9.1 Introduction

This chapter will outline the quantitative results of this study. It will commence by providing an overview of demographic information relating to the DoCCFS SU population who completed the ACE surveys during the timeframe of this study. Once the demographic profile has been outlined, the chapter will proceed to outline the ACE profile of SUs who completed the DoCCFS surveys as part of the OMS in both the ECDSCs and the FCs.

9.2 Outcome Measure Survey demographics

As outlined in findings from chapter 7, one of the motivations for introducing the OMS within the DoCCFS was to look at SU outcomes in tandem with demographic information. The rationale for collecting demographic information about SUs was to provide a context for the results of the research measures implemented within the OMS. The first part of this chapter incorporates a similar rationale. It will provide demographic information about the children, parents, and caregivers who completed the OMSs, including the survey, during the study timeframe. Outlining this information is required to provide context for the ACE profile of the DoCCFS SU population related to this study and to adhere to the exploratory sequential design of the study.

9.2.1 Questions arising from exploratory sequential research design

As mentioned in chapter 5, this study implemented an exploratory sequential research design which called for the researcher to use the qualitative data findings to develop questions to consider during the quantitative data analysis phase (Creswell and Plano-Clark, 2018). The research questions which emerged from this process are outlined in Table 9.1. The rationale for the question about parents and caregivers and their children's experiences of child maltreatment relates to qualitative findings, which indicated that mandatory reporting of retrospective abuse was a consistent concern from the outset of implementing routine survey administration within the organisation and throughout the period of data collection. Participants also noted that the wording

of the ACE questions also caused them some discomfort. The quantitative data will therefore be examined to establish how often participants reported these experiences.

Table 9.1
Quantitative research questions arising from qualitative data analysis

1.	What was the frequency of parents and caregivers who indicated that they or their children had encountered child maltreatment, particularly childhood sexual abuse, within the ECDSCs and DoCCFSCs?
2.	What were the English literacy levels and nationality of adult parents and caregivers who completed the Outcome Measures Survey?
3.	How many ACE surveys were completed by adult parents and caregivers from Ireland compared to those from other nationalities?
4.	What was the level of educational attainment for parents who completed the ACE survey?
5.	Did the demographic information collected as part of the Outcome Measures Survey indicate that children attending the ECDSCs or DoCCFSCs may have encountered other childhood adversities, such as homelessness or poverty?
6.	What was the prevalence of parental separation and divorce as an ACE in ECDSCs?

The motivation for exploring SUs' English literacy level and nationality is twofold. As participants reported that completing the ACE survey by SUs who did not have English as their primary language was challenging, examination of the quantitative data will consider how many of the surveys were completed by this group. It will also clarify the nationality of those who completed the survey questions. Another question that emerged from the qualitative data was the need to establish the educational attainment level of parents who completed the survey. This question relates to the qualitative finding, which suggested that participants from the FW focus groups noted that SU's educational attainment and occupation influenced their implementation of the survey. In particular, participants noted that they anticipated more resistance to completing the survey by SUs with higher educational attainment. The rationale for considering the demographic information collected as part of the OMS emerged from workers' perceptions that the survey questions did not account for all adversities that the children attending the ECDSCs and DoCCFSCs were encountering. In particular, participants noted poverty and homelessness as adversities they frequently encountered within the SU population. The quantitative data will be examined to determine if the demographic information suggests SUs were experiencing significant financial hardship or living in insecure housing or homeless

accommodation. The last question arising from the exploratory sequential research design process relates to a qualitative data finding which emerged from the ECDSWs focus group. This finding related to the participant's observation that parental separation and divorce was the most prevalent ACE for children attending ECDSCs. Participants reported that the DoCCFS ACE training had caused them to recognise the need to provide additional support to children with this ACE. Given that the ECDSWs did not administer the ACE survey verbally, nor were they aware of children's ACE scores, it would be interesting to establish if the ACE data confirm participants' observations concerning the frequency of parental separation and divorce within the ECDSCs.

9.2.2 Total number of OMS completed

During the study timeframe, the OMS was given to 105 parents/caregivers from the ECDSCs to self-complete, and FWs administered it to 118 parents/caregivers from the FCs. The maximum number of surveys conducted by an ECDSC during the data collection period was 27, and the least amount was 15. The mean number of OMSs completed was 21, and the standard deviation was 5. Table 9.2 provides a breakdown of OMSs conducted by each ECDSC.

Table 9.2
Outcome Measure Surveys Completed in the ECDSCs

ECDSC ID	Frequency	Percentage
ECDSC - A	27	25.7
ECDSC - B	24	22.9
ECDSC - C	14	13.3
ECDSC – D	15	14.3
ECDSC - E	25	23.8
Total	**105**	**100.0**

Table 9.3 provides a similar breakdown for the FCs. The mean number of OMSs conducted within the FCs was 17, and the standard deviation was 8.

Table 9.3 Outcome Measure Surveys completed in the FCs		
FC ID	**Frequency**	**Percentage**
FC - A	6	5.1
FC - B	14	11.9
FC - C	26	22.0
FC – D	12	10.2
FC - E	25	21.2
FC - F	14	11.9
FC - G	21	17.8
Total	**118**	**100.0**

9.2.3 Child characteristics

Demographic information outlined within the ECDS completed OMSs (please refer to Table 9.4) indicates that the gender of children attending the centres was evenly split, with 49.5% male and 50.5% female.

Table 9.4 ECDSC Child Characteristics (N=105)			
		N	**%**
Gender (N=99)	Male Female	49 50	49.5 50.5
Age (N=100)	< 3 < 4 < 5 < 6 < 7	17 57 22 3 1	17 57 22 3 1
Nationality (N=98)	Irish Other	70 28	71.4 28.6

The children's ages ranged from 2 years and 10 months to 6 years and 10 months. The mean age of children whose parent or caregiver completed the OMS was 3 years and 6 months, with a standard deviation of 1 year and 6 months. The majority of children were between 3 to 4 years old. Irish (N=70/71.4%) was the prominent nationality of the children, with a smaller number of 28 (28.6%) recorded as having another nationality.

The child characteristics provided by parents and caregivers within the DoCCFS FCs (please refer to Table 9.5) indicate a higher population of male children and young people at 54.2% (N=64) than females at 45.8% (N=54). Comparatively, the age range of the children was broader than that of the ECDSCs. Children and young people attending the FCs had a minimum age of 2 years and 6 months and a maximum age of 18 years and 6 months. The mean age was 10 years and 6 months, with a standard deviation of 3 years and 6 months. The nationality of the children and young people relative to the surveys was markedly different from that of the ECDSCs, with 93% (N=107) recorded as Irish and only 7% identified as having another nationality.

Table 9.5
FC Child Characteristics (N=118)

		N	%
Gender (N=118)	Male	64	54.2
	Female	54	45.8
Age (N=118)	3-5	7	5.9
	5-7	9	7.7
	7-9	25	21
	9-11	21	17.8
	11-13	22	18.7
	13-15	18	6.8
	15-17	11	17.8
	17-19	5	4.2
Nationality (N=115)	Irish	107	93
	Other	8	7

9.2.4 Parent Characteristics

The characteristics of the parent or caregiver who completed the OMSs in the ECDSCs during the data collection period are illustrated in Table 9.6. Findings indicate that female parents and caregivers predominantly completed the surveys with a total of N=90 (93.8%). The age range of the parent and caregivers who completed the surveys were 22 to 46 years old. The mean age was 34 years, with a standard deviation of 5 and 7 months. Although English was the primary language for 60% (N=60) of the parents and caregivers who completed the survey, 40% (N=40) of the individuals did not speak English as a first language. Similarly, although 59% of parents and caregivers who completed the OMS in the ECDS identified Irish as their nationality, a sizeable 41% (N=41) of individuals provided another nationality. The marital status of parents and

caregivers in the ECDCS ranged from 23.2% (N=22) single, 20% (N=19) co-habiting, 51.6% (N=49) married, and 5.2% (N=5) separated or divorced.

Table 9.6
ECDSC Parent Characteristics (N=96)

		N	%
Gender (N=96)	Male	5	5.2
	Female	90	93.8
	Both	1	1.0
Age (N=92)	20-25	4	4.3
	25-30	18	19.6
	30-35	24	26.1
	35-40	28	30.4
	40-45	16	17.4
	45-50	2	2.2
English as the first language (N=100)	Yes	60	60
	No	40	40
Nationality (N=100)	Irish	59	59
	Other	41	41
Marital Status (N=)	Single	22	23.2
	Co-habiting	19	20
	Married	49	51.6
	Separated/Divorced	5	5.2

Table 9.7 outlines the characteristics of parents and caregivers who completed the OMS within the FCs. The age range for this cohort was higher than the ECDSCs, with the minimum age reported as 26 years and the maximum age as 57 years. Similarly to the gender findings for the ECDSCs, (N=107/93%), the gender of the parent or caregiver who completed the surveys in the FCs was predominantly female. The mean age range for parents and caregivers who completed the surveys was 40 years, and the standard deviation was 6 years and 7 months. Findings indicate that English was the primary language for 82.5% (N=94) of participants. Compared to the ECDSCs, Irish nationality was more prominent, 80.7% (N=92). Parents or caregivers who reported another nationality represented 19.3% (N=22). The marital status of most parents and caregivers who completed the survey was single (N=38/34.2%). It was followed by those who were married (N=30/27%), separated or divorced (N=20/18%), co-habiting (N=19/17.1%) and widowed (N=4/3.6%).

Table 9.7 FC Parent Characteristics (N=115)			
		N	%
Gender (N=)	Male	7	6.1
	Female	107	93.0
	Both	1	.9
Age (N=113)	25-30	8	7.1
	30-35	9	7.9
	35-40	36	31.9
	40-45	28	24.8
	45-50	21	18.6
	50-55	9	7.9
	55-60	2	1.8
English as the first language (N=114)	Yes	94	82.5
	No	20	17.5
Nationality (N=114)	Irish	92	80.7
	Other	22	19.3
Marital Status (N=111)	Single	38	34.2
	Co-habiting	19	17.1
	Married	30	27.0
	Separated/Divorced	20	18.0
	Widowed	4	3.6

9.2.5 Relationship of parent/caregiver to child

Results from the ECDSC OMS data indicate that all parents and caregivers (N=96) who answered the question about their relationship to the child on the survey were biological parents. (Please see Table 9.8)

Table 9.8 ECDSC - Relationship of parent/caregiver completing survey to child		
Relationship (N=96)	N	%
Biological parent	96	100

In contrast to the ECDSC findings, results from the FCs (Please refer to Table 9.9) indicate that although the majority of parents and caregivers (N=110/94.8%)who answered the question in the FCs were the child's biological parent, others specified their relationships to children as a foster parent (N=7/3.4%) and a relative or unrelated guardian (N=2/1.7%).

Table 9.9 FC - Relationship of parent/caregiver completing survey to child		
Relationship (N=116)	N	%
Biological parent	110	94.8
Foster parent	4	3.4
Relative or unrelated guardian	2	1.7

9.2.6 Parent level of educational attainment

One section of the OMS asked the parent or caregiver completing the survey to report their educational attainment and that of the child's other parent or caregiver. Results (Please refer to Table 9.10) indicate that educational attainment for parents and caregivers who completed the surveys in the ECDSC ranged from 1.1% (N=1) who had attended primary school or less to 13.8% (N=13) with a Postgraduate or Higher Degree.

Table 9.10 ECDSC - Parent level of educational attainment				
Attainment level	Parent 1 completing survey (N=94)	%	Parent 2 (N=54)	%
Primary School or less	1	1.1	1	1.9
Intermediate/Junior Certificate	6	6.4	16	29.6
Leaving Certificate or equivalent	31	33.0	13	24.1
Third Level Certificate or Diploma	35	37.2	13	24.1
Primary Degree	8	8.5	3	5.6
Postgraduate/Higher Degree	13	13.8	8	14.8

Most survey participants had a Third-Level qualification or above (59% / N=56). Information provided for the educational attainment level of the other parent was lower (N=54). From the information disclosed, results indicate that 1.9% (N=1) had a primary school education or less, and 14.8% had a Postgraduate or Higher Degree. In contrast to the results of the parents or caregivers who completed the surveys, results indicate that 55.6% (N=30) of the other parents or caregivers had a Leaving Certificate qualification or lower.

Results from the FCs (Please refer to Table 9.11) indicate that 5.3% (N=6) of parents or caregivers who completed the OMS had finished primary school or less. The percentage of individuals who obtained a Postgraduate or Higher Degree was 9.6% (N=11). Most parents or caregivers who completed the surveys had a Third Level Qualification or above (58.7% / N=67). Similarly to the ECDSC, the information provided for other parents and caregivers was lower (N=64). Results from the information disclosed indicate that 9.4% (N=6) had a primary school education or less, and 9.4% had a Postgraduate or Higher Degree. Similarly to the ECDSC, results concerning the other parents and caregivers in the FCs indicate that the majority had a Leaving Certificate Qualification or lower (57.8% / N=42).

Table 9.11
FC - Parent level of educational attainment

Attainment level	Parent 1 completing survey (N=114)	%	Parent 2 (N=64)	%
Primary School or less	6	5.3	6	9.4
Intermediate/Junior Certificate	21	18.4	21	32.8
Leaving Certificate or equivalent	20	17.5	15	23.4
Third Level Certificate or Diploma	44	38.6	8	12.5
Primary Degree	12	10.5	8	12.5
Postgraduate/Higher Degree	11	9.6	6	9.4

9.2.7 Parent literacy issues

There were two questions on the OMS concerning the literacy and English literacy level of the parent or caregiver completing the form. These questions were as follows:

- ***Can you read aloud to a child from a children's storybook?***
- ***Can you usually read and fill out forms that have to be dealt with in English?***

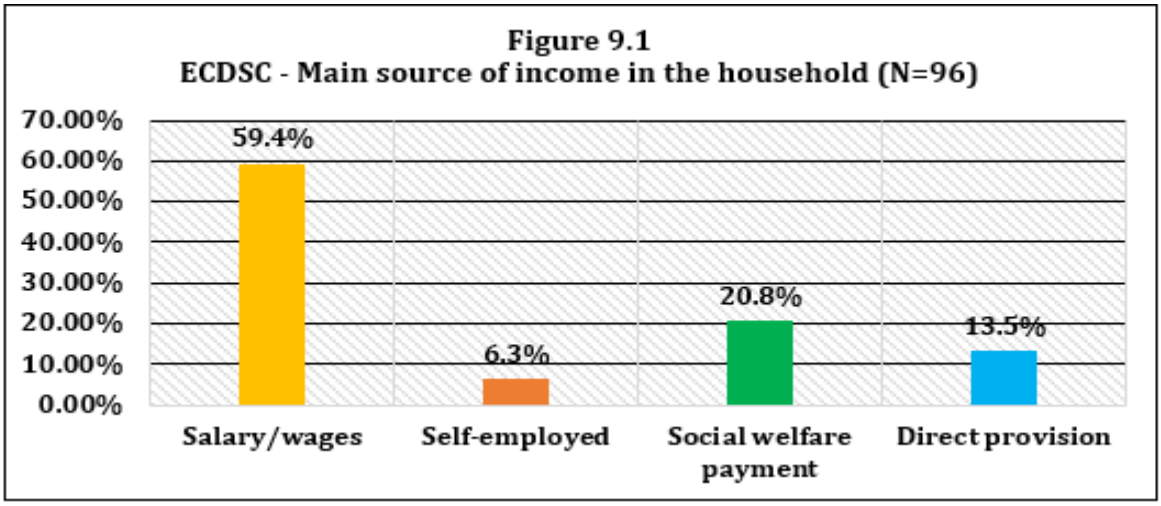
Results from both the ECDSCs and FCs indicate that most parents and caregivers who completed this study's OMS questions had no literacy difficulties. Results from the ECDSCs indicate that only 4% (N=4) reported literacy difficulties in response to the first question, and 2% (N=2) disclosed English comprehension and writing difficulties when reading and completing forms. Comparatively, both questions

yielded the same results in the FCs, with 98.2% (N=112) reporting no literacy difficulties concerning either question and 1.8% (N=2) noting literacy challenges regarding both questions.

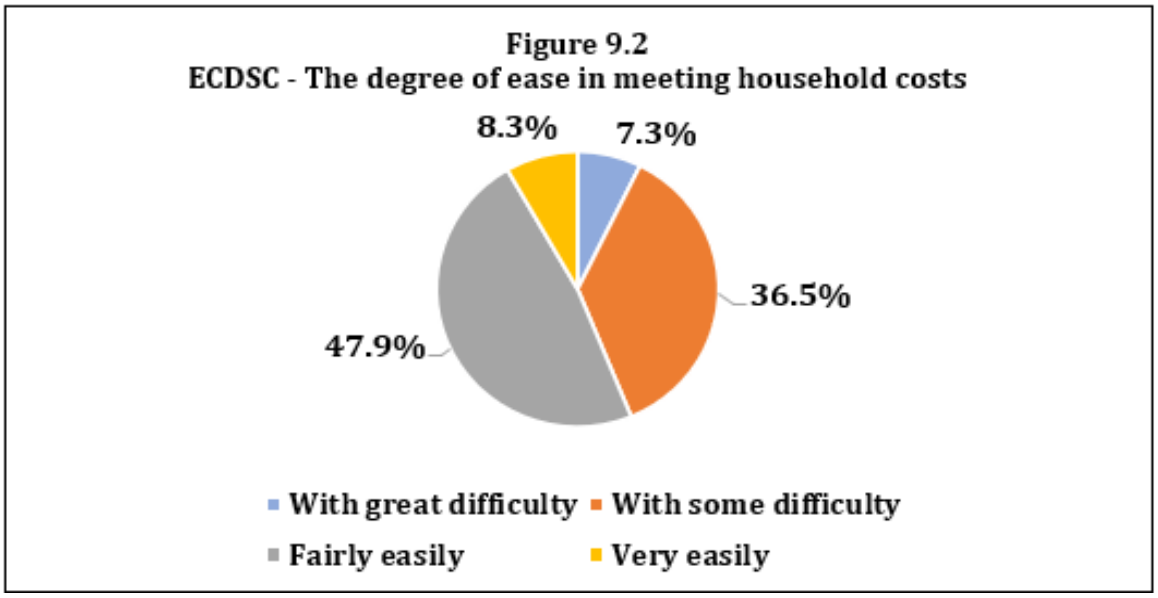
9.2.8 Main source of income in the household

Results from the question relating to ECDSCs families' primary source of income (Please refer to Figure 9.1) indicate that the majority, 59.4% (N=57) of the parents or caregivers who completed the OMS, were employed and received a salary. Self-employment represented the primary source of income for 6.3% (N=6). Social welfare payments were the income source for 20.8% (N=20), and the remaining 13.5% (N=13) outlined that they depended on the income provided under the direct provision scheme.

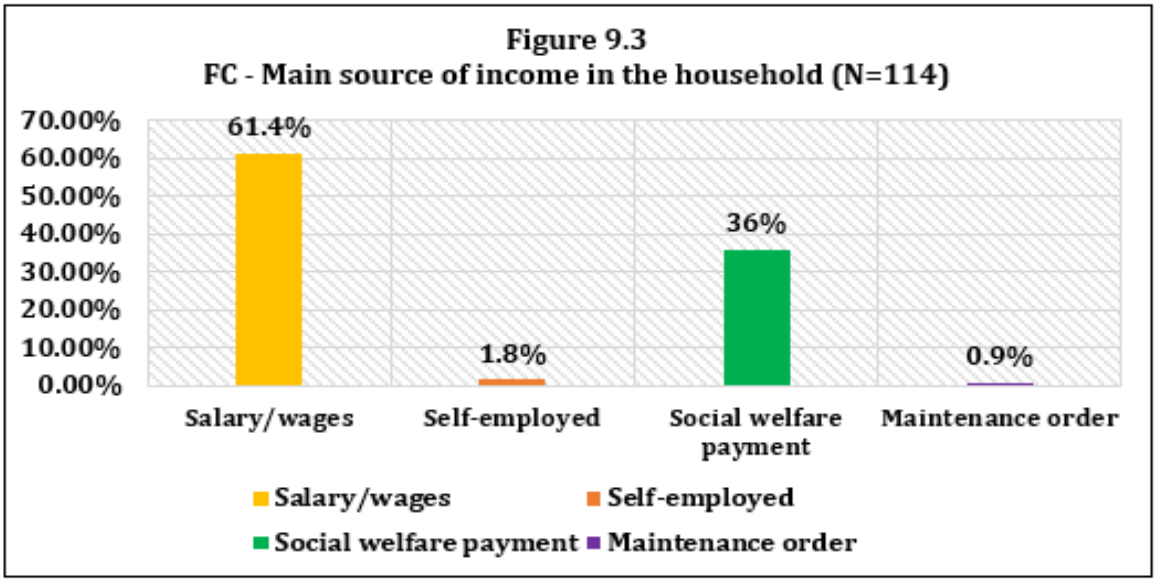
Figure 9.1
ECDSC - Main source of income in the household (N=96)



Results relating to the degree of ease in meeting household costs for parents or caregivers (Please see Figure 9.2) who completed the OMS in the ECDSCs indicate that 43.8% (N=42) reported experiencing difficulties. Of this percentage, 7.3% (N=7) indicated they encountered significant problems meeting household costs, while 36.5% (N=35) reported some challenges. Results illustrate that 7.9% (N=46) of parents and caregivers found it relatively easy to meet household costs. In comparison, the remaining 8% (N=8) indicated they encountered minimal issues in meeting household costs.



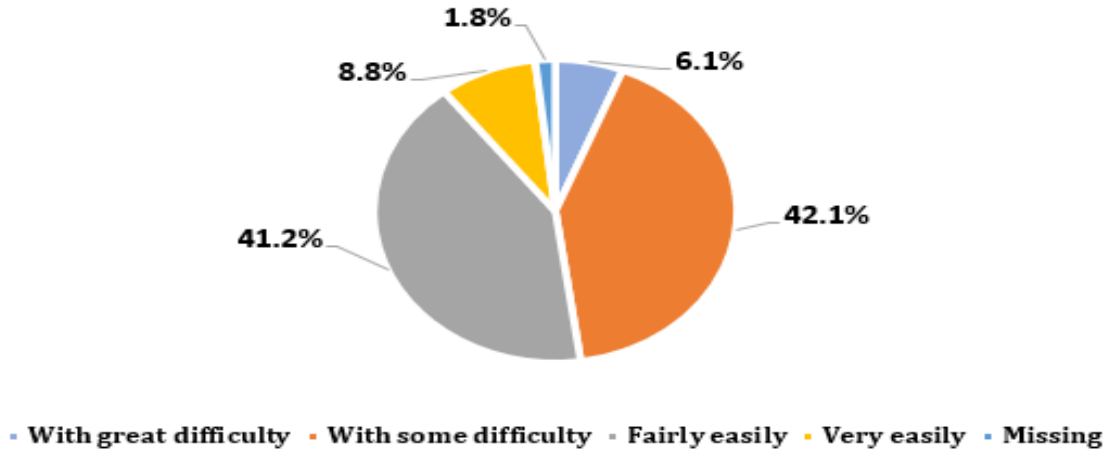
Similarly to the ECDSC results, the primary source of income for parents and caregivers who completed the OMS (Please see Figure 9.3) during the data collection period for this study was through paid salaried employment, with 61.4% (N=70) reporting relying on their wages to support the household. Compared to the ECDSC results, a smaller percentage of parents and caregivers identified self-employment as the household's primary income. The FC results indicate that 36% (N=41) of homes depended on social welfare payments, and 0.9% (N=1) relied upon a maintenance order as their primary source of income.



Results concerning difficulties in meeting household costs reported by parents and caregivers in the FCs are similar to that of the ECDSCs (Please refer to Figure 9.4).

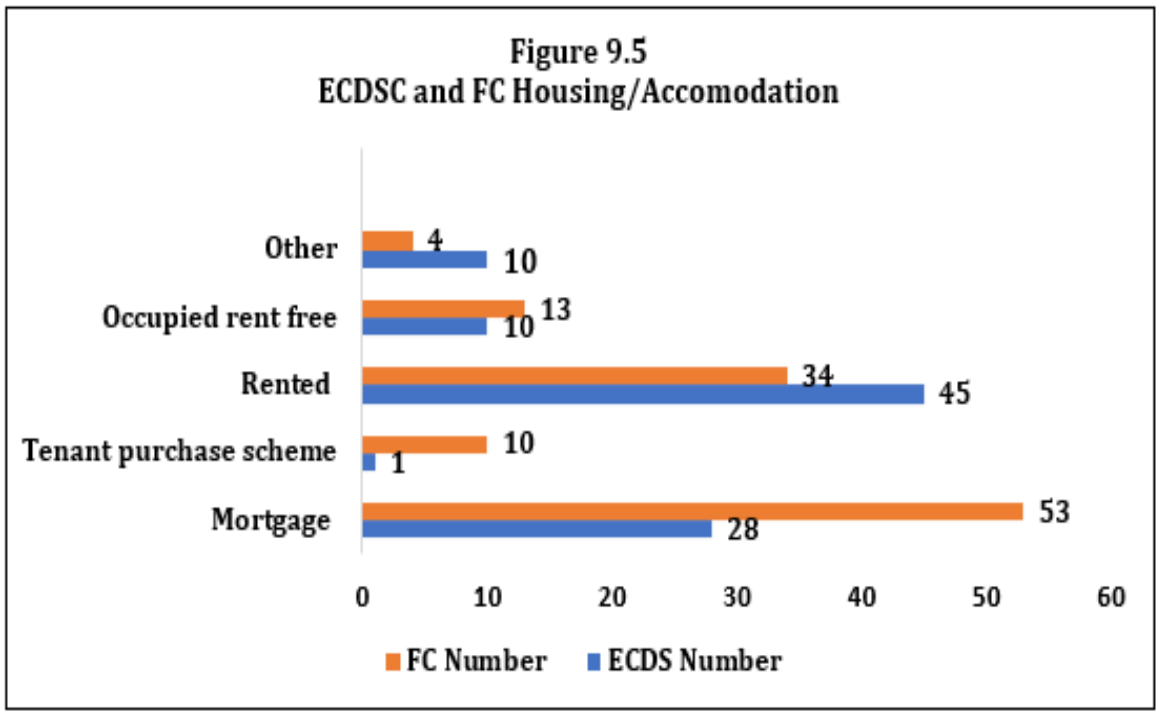
42.1% of the parents and caregivers (N=48) reported that they had encountered difficulties in financially supporting the household. 6.1% (N=7) reported experiencing great difficulty. Half of the parents and caregivers, 50% (N=57), indicated that they found it relatively easy to financially support their household, with 41.2% (N=47) stating that they found it relatively easy and the remaining 8.8% (N=10) reporting that it was very easy for them to do so.

Figure 9.4
FC - The degree of ease in meeting household costs



9.2.9 Accommodation

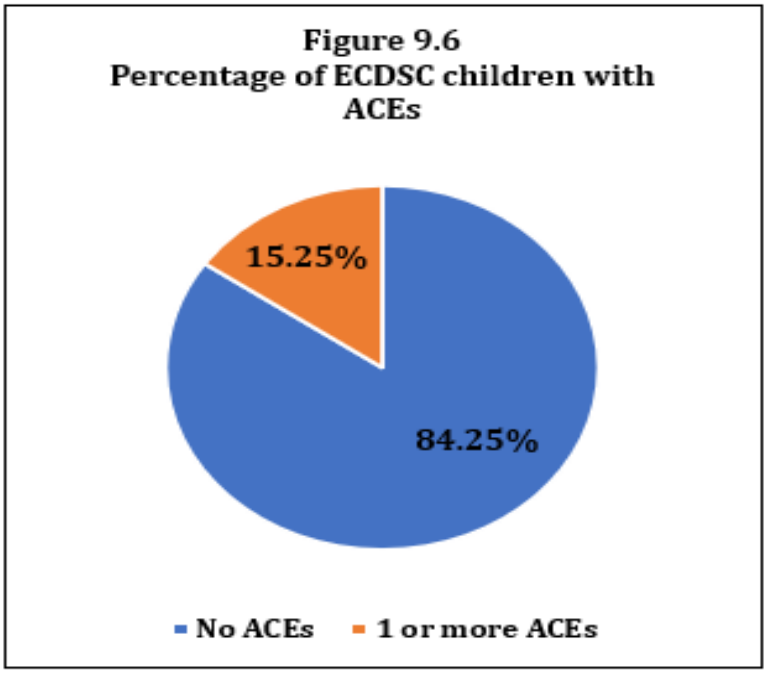
Results (Pease refer to Figure 9.5) from the completed ECDSC OMSs (N=94) indicate that the majority of parents and caregivers, 47.9% (N=45), lived in rented accommodation. Owner-occupied accommodation represented 29.8% (N=28) of the living situations for families availing of the service. The remaining parents and caregivers described their housing as occupied and free of rent (10.6% / N=10); purchasing a home from the local county council (1.1% / N=1) and other forms of accommodation such as living with family members or in direct provision (10.6% / N=10).



The housing situation for parents and caregivers (N=114) attending the FCs (Please refer to Figure 9.5) was different to the ECDSCs, with 46.5% (N=53) indicating that they lived in owner-occupied accommodation. Rental accommodation was shown as the accommodation for 29.8% (N=34). The remaining parents and caregivers outlined their accommodation as rent-free (11.4% / N=13), living in a rent-to-buy home from the county council and other housing types such as voluntary homeless accommodation and hostels (3.5% / N=4). The next section of this chapter will present the quantitative results specific to the ACE profiles of the parents and caregivers, as well as their children from the ECDSCs who completed the OMS during the data collection timeframe of this study.

9.3 ACE profiles of the ECDSCs

Results from the ACE surveys self-completed by parents and caregivers within the ECDSCs indicate that out of the 105 OMSs completed during the study timeframe, only 16 (15.2%) surveys (Please refer to Figure 9.6) indicated that children attending the centres had encountered ACEs; 84.25% (N=89) of children having no ACEs. The minimum number of ACEs recorded in the 16 surveys was 1, and the maximum was 4. The mean ACE score was 1.5, with a standard deviation of 0.89.



Children attending

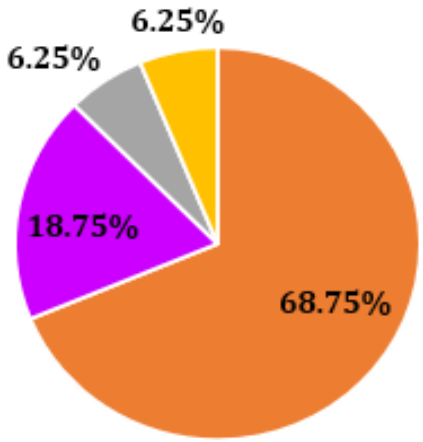
From the ACE data provided (Please refer to Table 9.12), four of the five ECDSCs had children attending that were impacted by childhood adversities.

Table 9.12
ECDSCs Child ACEs (N=16)

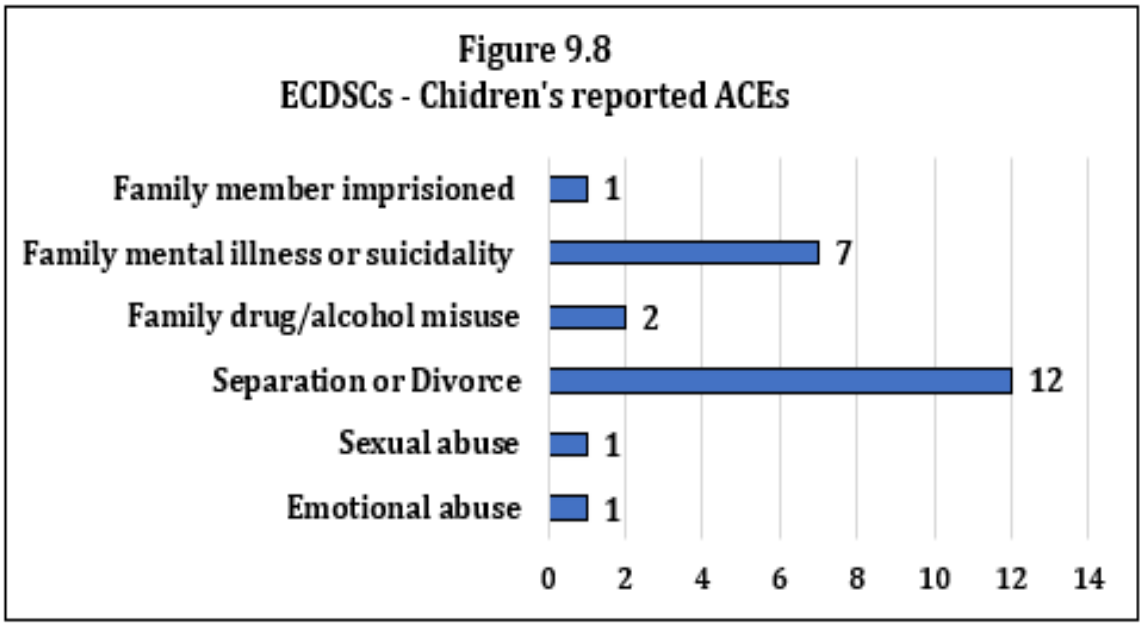
ECDS ID	1 ACE	2 ACEs	3 ACEs	4 ACEs
ECDSC - A	2	1	0	0
ECDSC – B				
ECDSC - C	3	2	0	0
ECDSC - D	4	0	0	0
ECDSC - E	2	3	1	1
Total (N=):	**11**	**3**	**1**	**1**
Percentage:	**68.75**	**18.75**	**6.25%**	**6.25%**

The OMSs for ECDSC-B had no ACEs indicated for any children attending during the study timeframe. An overview of the number of ACEs reported for children by parents and caregivers who completed the ACE survey is provided in Figure 9.7. Of the sixteen children with ACEs within the ECDSCs, 68.75% reported having one ACE (N=11). A smaller number, 18.75% (N=3), was identified as having encountered three ACEs. One child (6.25%) had experienced three of the outlined adversities. Similarly, a single child (6.25%) was outlined as having experienced four ACEs.

Figure 9.7
Number of ACEs reported for children attending the ECDSCs

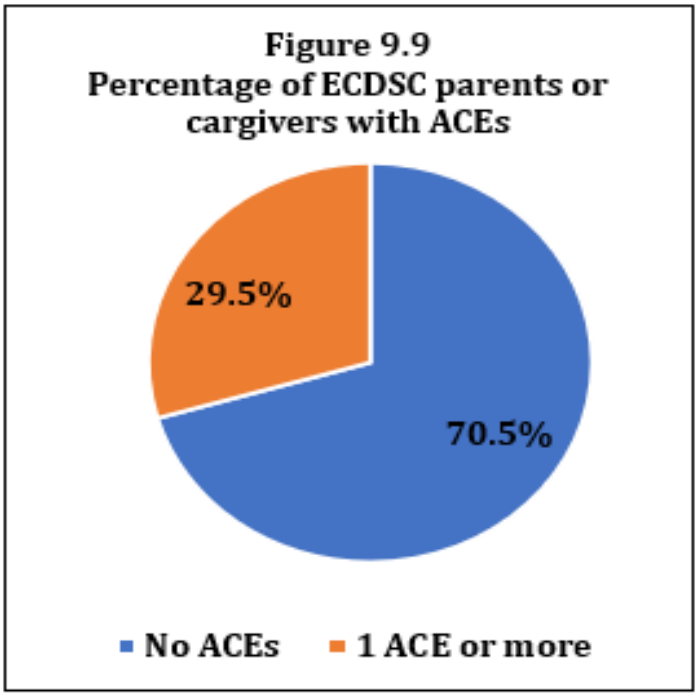


Results indicate that children reported encountering ACEs within the ECDS only experienced six of the eleven adversities (Please refer to Figure 9.8). The absent ACEs included physical abuse, physical and emotional neglect, witnessing domestic violence towards the parent or caregiver who completed the form and domestic violence towards the other parent or caregiver. Of the ACEs identified, the most frequent (N=12 / 75%) reported was having encountered parental separation or divorce. The second most reported ACE was familial depression, mental illness, or suicidality (N=6 / 37.5%). Living with a family member with a drug or alcohol misuse issue was reported for 2 (12.5%) children. One child (6.25%) was reported as having experienced a family member being imprisoned. Child abuse was an ACE for two children. One child experienced physical abuse, whilst the other was sexually abused.



Parent/caregiver of the child attending ECDSC

Of the 105 parents and caregivers who completed the ACE survey during the study timeframe, 29.5% (N=31) indicated that they had experienced adversities during childhood, whilst 79.5% (N=74) reported no ACEs (Please refer to Figure 9.9).



Of the 31 parents and caregivers who completed the survey, 64.5% (N=20) were Irish Nationals, and 35.5% (N=11) identified as of another nationality. Unlike the

adversities for children, results indicate that all five ECDSCs had parents and caregivers who responded yes to the ACE survey questions (Please see Table 9.13). The mean number of ACEs reported by parents and caregivers was 2.7, and the maximum was 9. The standard deviation for reported ACEs was 2.47.

Table 9.13
ECDSCs – ACEs of parent or caregiver who completed the Outcome Measures Survey (N=31)

ECDS ID	1 ACE	2 ACEs	3 ACEs	4 ACEs	5 ACEs	6 ACEs	7 ACEs	8 ACEs	9 ACEs
ECDSC - A	7	2	2	0	0	1	0	0	0
ECDSC – B	0	1	0	1	0	0	0	0	0
ECDSC – C	3	0	0	0	1	0	0	0	0
ECDSC – D	3	0	0	0	0	0	0	2	0
ECDSC – E	2	2	1	0	1	0	0	0	1
Total (N=):	**15**	**5**	**3**	**1**	**2**	**1**	**1**	**2**	**1**
Percentage:	**48.5**	**16**	**9.5**	**3.25**	**6.5**	**3.25**	**3.25**	**6.5**	**3.25**

Table 9.14 illustrates the number of Irish and non-Irish parents and caregivers who reported ACEs. The findings indicate that of the Irish parents and caregivers who completed the survey that 20% (N=4) had an ACE score of four or more. A much more significant percentage, 80% (N=4) of parents and caregivers who identified as non-Irish nationals, had an ACE score of 4 or more.

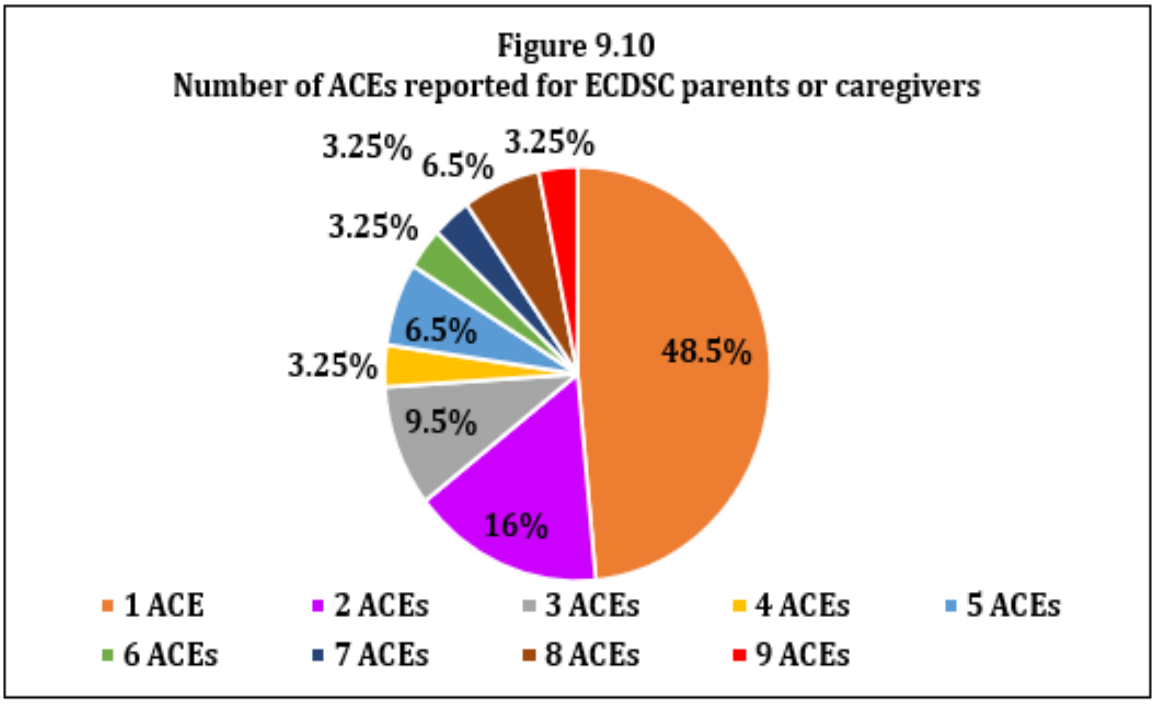
Table 9.14
ECDSCs – Number of ACEs reported by Irish and non-Irish parents or caregivers (N=31)

Nationality	1 ACE	2 ACEs	3 ACEs	4 ACEs	5 ACEs	6 ACEs	7 ACEs	8 ACEs	9 ACEs	Total:
Irish	10	4	2	1	1	1	0	0	1	= 20
Non-Irish	5	1	1	0	1	0	1	2	0	= 11

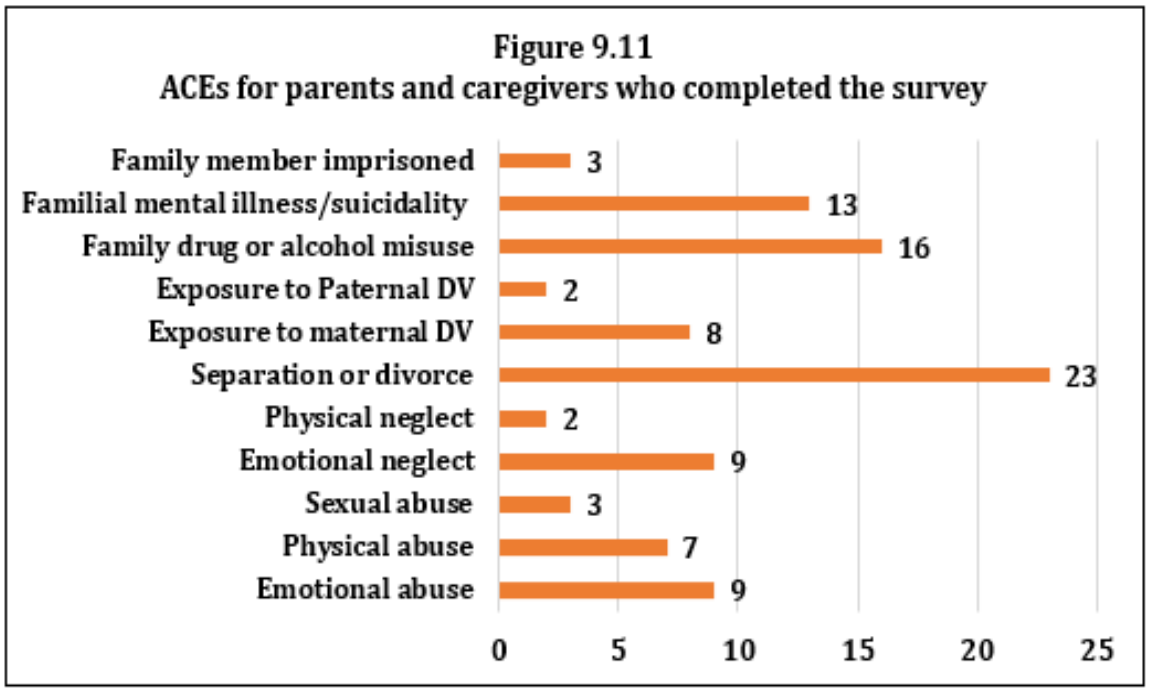
The number of ACEs for parents and caregivers is illustrated in Figure 9.10. Most frequently, parents and caregivers reported 1 ACE (48.5%/N=15), 16% (N=5) reported 2 ACEs, 9.5% (N=3) indicated that they had 3 ACEs, 6.5% (N=2) of parents

reported 5 ACEs, and 6.5% (N=2) experienced 8 adversities during childhood. The remaining 13% comprised 4 ACEs (3.25%/N=1), 6 ACEs (3.25%/N=1), 7 ACEs (3.25%/N=1) and 9 ACEs (3.25%/N=1).

Figure 9.10
Number of ACEs reported for ECDSC parents or caregivers

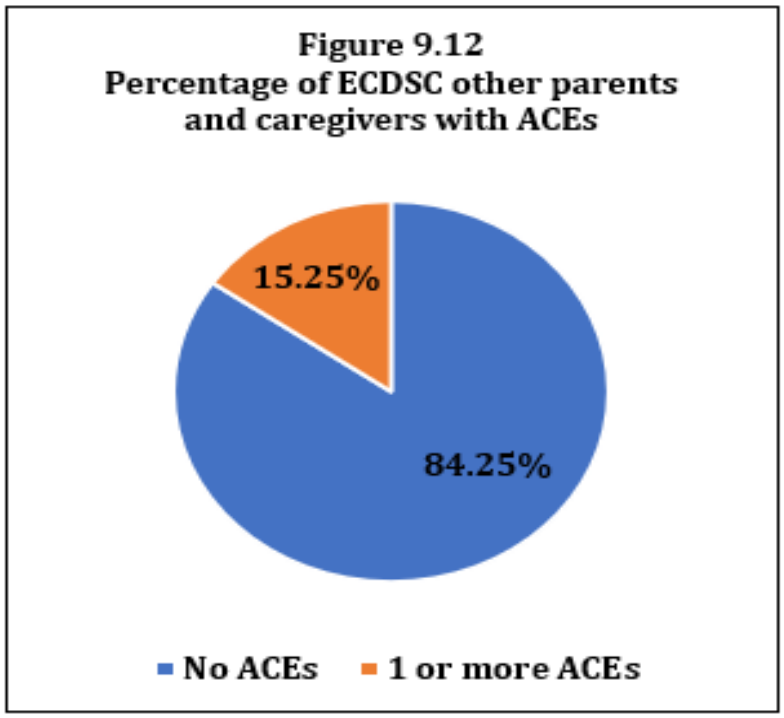


Compared with the ACE data provided for children attending the ECDSCs, all of the adversities included in the OMS were experienced by at least one parent or caregiver. An overview of the reported ACEs is provided in Table 9.11. The least common ACE reported by parents and caregivers was physical neglect (6.45%/N=2), and the most common adversity encountered was parental separation or divorce (74%/N=23). Retrospective child abuse was more prominent for parents and caregivers than child maltreatment for children attending the ECDSCs. Verbal abuse was the most prevalent (29%/N=9), closely followed by physical abuse (22.5%/N=7). Sexual abuse was reported by 3 (9.6%) of the parents and caregivers. Household adversities were the most common ACEs for this cohort. Parents and caregivers reported exposure to domestic violence towards their mothers or stepmother (26%/N=8) and fathers or stepfathers (6.45%/N=2). Familial depression, mental illness and suicidality during childhood were reported by 13 of the parents and caregivers. Growing up in a home where a family member had drug or alcohol misuse issues was also prevalent (51.5%/N=16). Lastly, the imprisonment of a family member during childhood was another adversity reported (9.6%/N=3).



Other parent/caregiver of the child attending

ACE data about the other parents and caregivers of children attending the ECDSCs during the data collection timeframe is much smaller (N=16). Although 15.25%(N=16)reported 1 ACE or more, 85.75%(N=89) of parents or caregivers did not indicate that they had ACEs (Please refer to Figure 9.12). Analysis of the ACE survey responses for the 16 other parents and caregivers illustrates a variance in reported ACEs (Please refer to Figure 9.13). These experiences range from 1 ACE (37.5%/N=6); 2 ACEs (18.75%/N=3); 3 ACEs (6.25%/N=1); 4 ACEs (18.75%/N=3); 8 ACEs (12/5%/N=2) and 9 ACEs (6.25%/N=1).



Results indicate that all the ECDSCs had other parents and guardians who experienced at least one adversity during childhood (Please refer to Table 9.15). Results from the information provided indicate that the other parents and caregivers had a mean ACE score of 3 and a maximum score of 9. The standard deviation for this cohort was

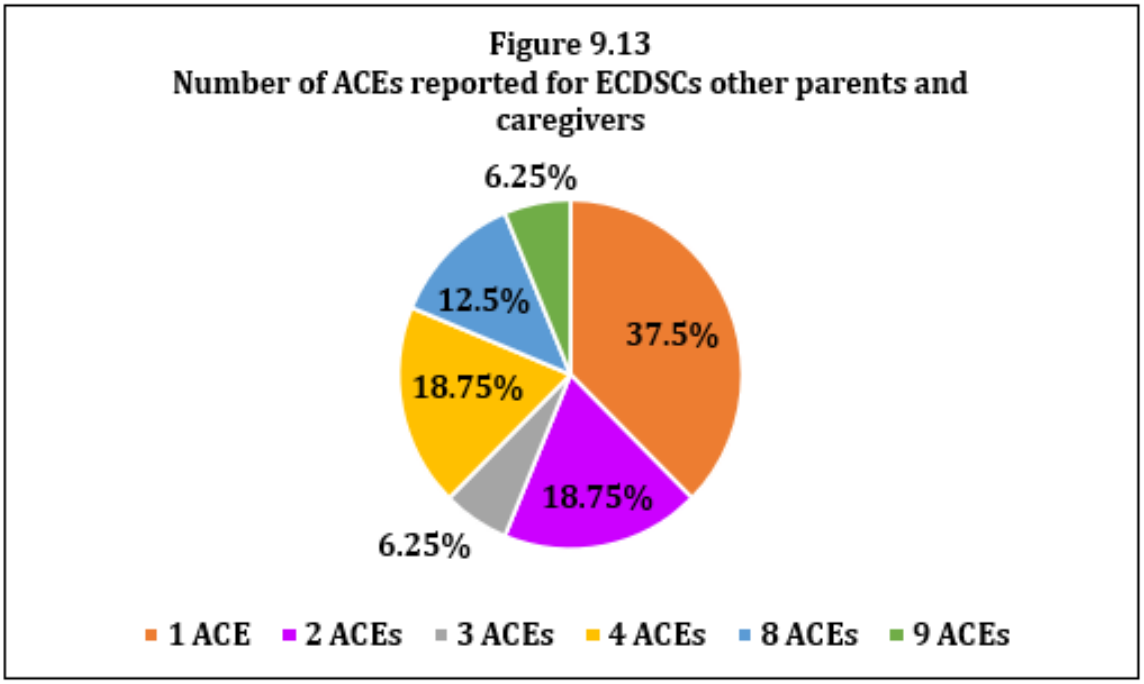
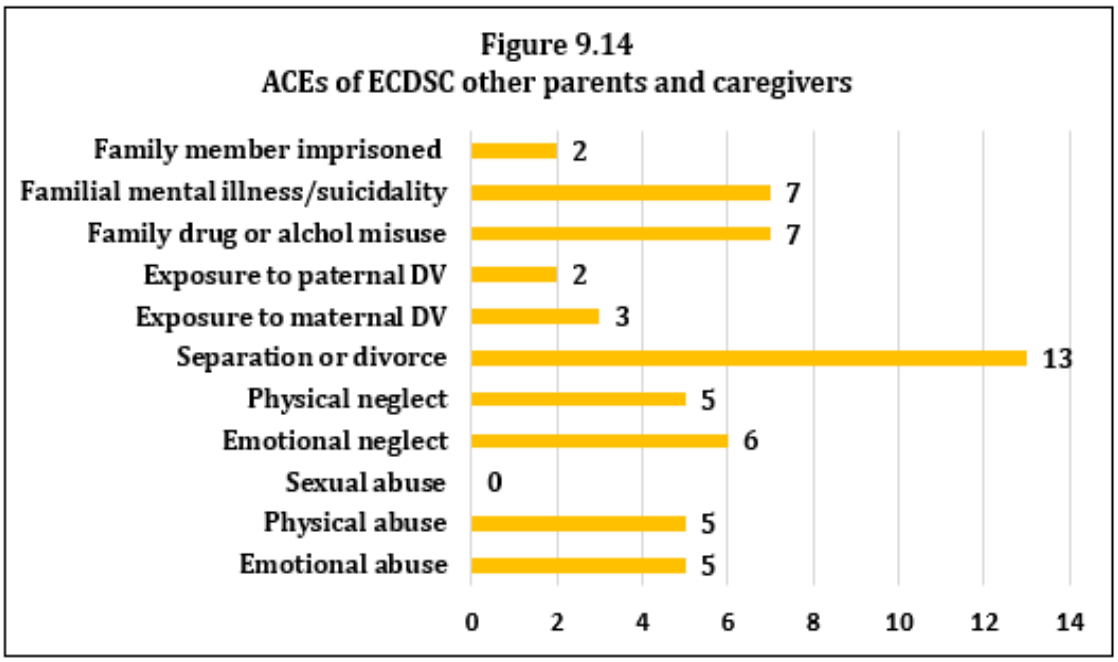


Table 9.15 ECDSCs – ACEs of the other parent and caregiver (N=16)						
ECDS ID	**1 ACE**	**2 ACEs**	**3 ACEs**	**4 ACEs**	**8 ACEs**	**9 ACEs**
ECDSC – A	2	1	0	2	2	1
ECDSC – B	1	0	1	0	0	0
ECDSC – C	1	0	0	1	0	0
ECDSC – D	1	0	0	0	0	0
ECDSC – E	1	2	0	0	0	0
Total (N=):	**6**	**3**	**1**	**3**	**2**	**1**
Percentage:	**37.5%**	**18.75%**	**6.25%**	**18.75%**	**12.5%**	**6.25%**

Similarly to the parents or caregivers who completed the OMS, the most prevalent category of ACEs encountered was adversities related to household dysfunction (Please refer to Figure 9.14). Parental separation and divorce was the most pervasive ACE (N=13/81.25%), followed by familial drug or alcohol abuse (N=7/43.75%) and depression, mental illness, and suicidality (N=7/43.75%). Other parents and caregivers also experienced imprisonment of a family member (N=2/12.5%) and exposure to domestic violence towards their mothers or stepmothers (N=3/18.75%) and their fathers or stepfathers (N=2/12.5%).

Figure 9.14
ACEs of ECDSC other parents and caregivers



Although there were reports of both childhood abuse and neglect, in contrast to results for the parents and caregivers who completed the OMS, which indicated that a small proportion had experienced sexual abuse as a child, there were no reports of this specific adversity.

ECDSC ACE survey results requiring mandatory reporting consideration

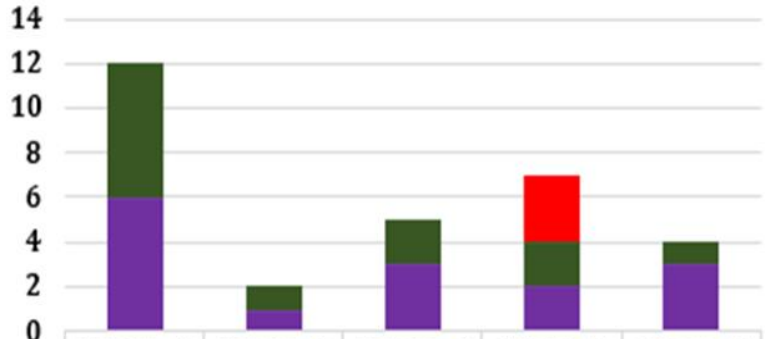
Given the qualitative findings outlined in chapters 7 and 8 of this thesis relating to retrospective child abuse and welfare reporting to statutory services, the rationale for providing these results is to provide information and context for the following discussion chapters. This section of the chapter will outline the results concerning ACE survey responses for both children and adults that required mandatory reporting consideration within the ECDSCs. Figure 9.15 illustrates the number of survey responses requiring mandatory child abuse and neglect reporting consideration during the study timeframe. In total, during the nine months, there were 2 ACE responses, one relating to child sexual abuse and the other to emotional abuse. As only two occasions required mandatory reporting considerations for current child abuse and neglect concerns during the timeframe, results indicate that only two of the five ECDSCs had to consider these concerns.

All ECDSCs experienced ACE survey responses that required retrospective child abuse mandatory reporting consideration (Please refer to Figure 9.16). The number of survey responses requiring retrospective child abuse consideration by ECDSC staff totalled 31. Of these 31 instances, 3 related to retrospective child sexual abuse, 12 were regarding retrospective physical abuse, and 16 were retrospective emotional abuse. Interestingly only one ECDSC had experienced positive survey responses to the retrospective child sexual abuse question. The four other centres did not encounter adults who indicated that they had encountered this adversity during childhood.

Figure 9.15
ECDSC - Breakdown of survey responses requiring current child abuse and neglect mandatory reporting consideration

	ECDSC - A	ECDSC - B	ECDSC - C	ECDSC -D	ECDSC - E
Emotional neglect child	0	0	0	0	0
Physical neglect child	0	0	0	0	0
Sexual abuse child	0	0	0	1	0
Physical abuse child	0	0	0	0	0
Emotional abuse child	0	0	0	0	1

Figure 9.16
ECDSCs - Breakdown of ACE survey responses requiring retrospective child abuse mandatory reporting consideration



	ECDSC - A	ECDSC - B	ECDSC - C	ECDSC - D	ECDSC - E
Retrospective sexual abuse	0	0	0	3	0
Retrospective physical abuse	6	1	2	2	1
Retrospective emotional abuse	6	1	3	2	3

The final section of this chapter will present the quantitative results specific to the ACE profiles of the parents and caregivers, as well as their children from the FCs who completed the OMS during the data collection timeframe of this study.

9.4 ACE profiles of the DoCCFS FCs

Results from the ACE surveys self-completed by parents and caregivers within the FCs indicate that out of the 118 OMSs completed during the study timeframe, 78 (66%) of the children attending the centres encountered ACEs (Please refer to Figure 9.17). This number is significantly higher than the results from the ECDSCs.

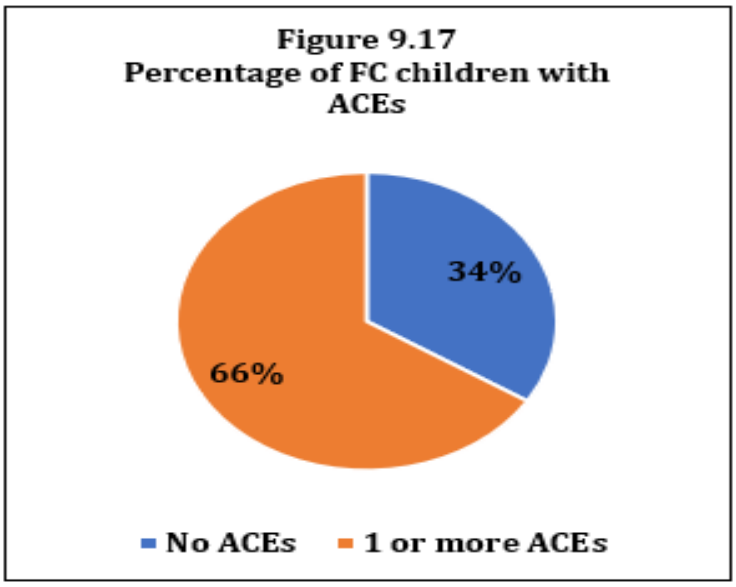


Figure 9.18 illustrates the range in the number of ACEs reported for children attending the FCs during the study timeframe. Of the children whose parents completed the OMSs, 30.8% (N=24) had 1 ACE, 25.6% were reported to have 2 ACEs, 14.1% (N=11) had 3 ACEs, 12.8% (N=10) had encountered 4 ACEs, 10.3% (N=8) were reported to have 5 ACEs and 6.4% (N=5) experienced 6 of the adversities covered by the ACE survey questions. Findings also indicate that all FCs supported children with reported ACEs during the study timeframe. The minimum number of ACEs recorded in these surveys was 1, and the maximum was 6 (Please refer to Table 9.16). The mean number of ACEs experienced by children within this cohort was 2.6, with a standard deviation of 1.5.

Figure 9.18
Number of reported ACEs for children attending the FCs

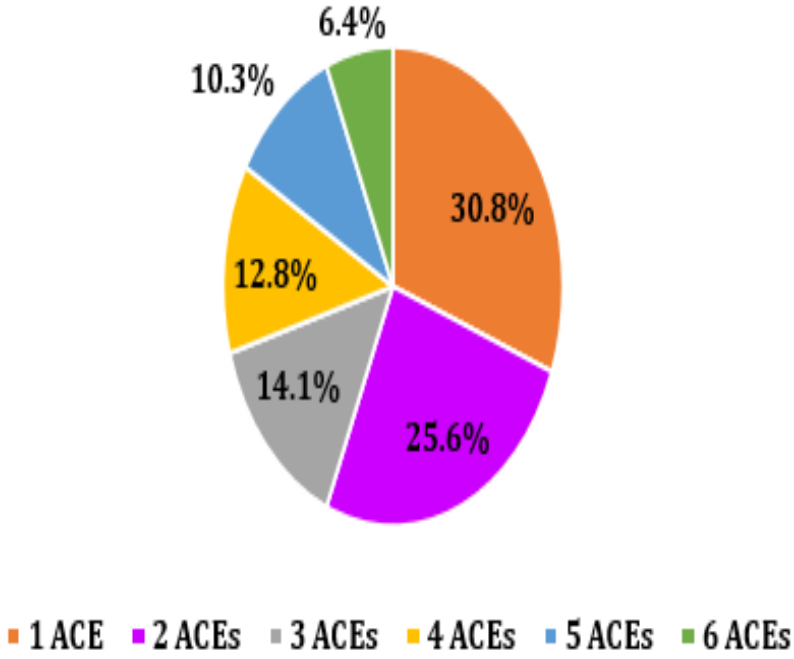


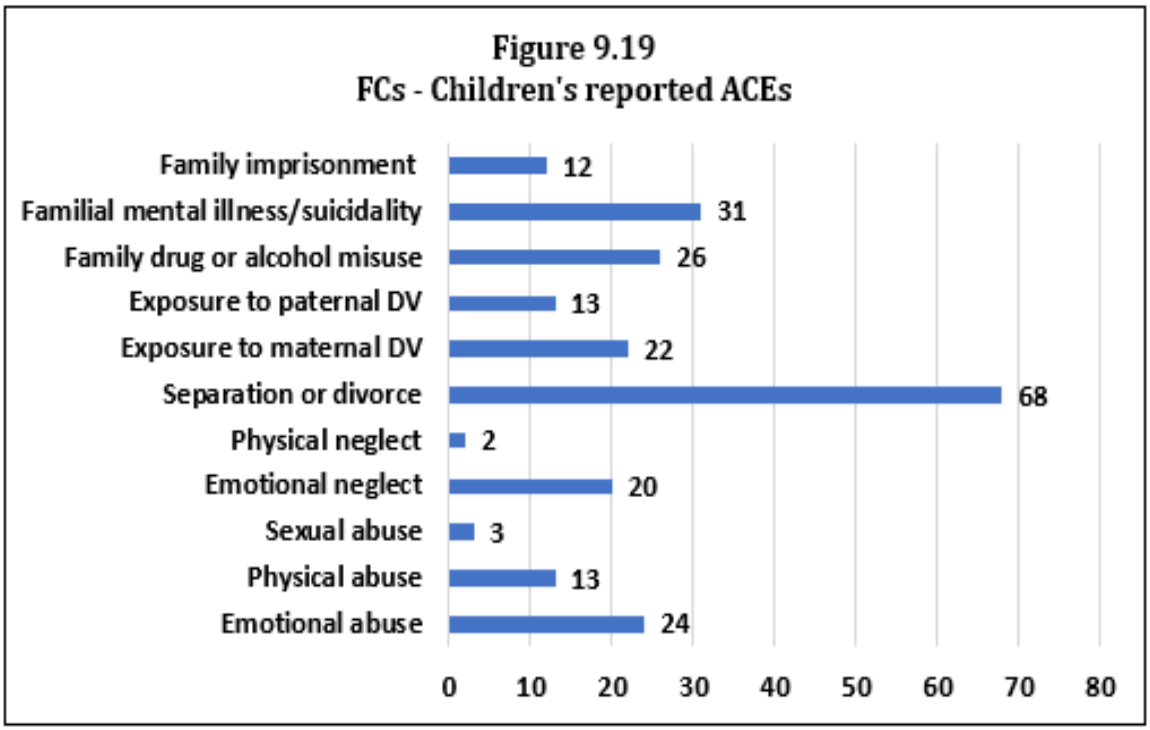
Table 9.16
FCs –Child ACEs (N=78)

ECDS ID	1 ACE	2 ACEs	3 ACEs	4 ACEs	5 ACEs	6 ACEs
FC – A	0	0	0	0	2	0
FC – B	6	2	1	1	1	1
FC – C	6	3	3	2	2	1
FC – D	3	2	1	2	1	1
FC – E	2	4	1	1	1	0
FC - F	6	2	1	1	0	0
FC - G	1	7	4	3	1	2
Total (N=):	**24**	**20**	**11**	**10**	**8**	**5**
Percentage:	**30.8**	**25.6**	**14.1**	**12.8**	**10.3**	**6.4**

Children attending

Results indicate that all ACE categories for children received a positive response from at least two parents or caregivers within the FCs (Please refer to Figure 9.19). The most prevalent adversity for children was parental separation or divorce (87%/N=68). The least common ACE was physical neglect (2.5%/N=2). Household dysfunction ACEs

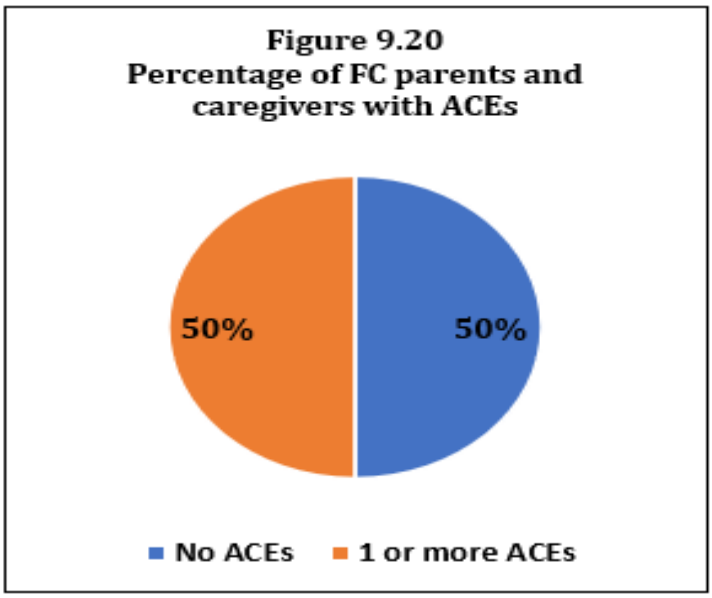
were the most pervasive ACE category, with 172 positive responses. Alongside parental separation and divorce, 39.7% (N=31) of parents and caregivers who completed the ACE survey questions ticked yes to their children growing up in a home with an adult who had depression, mental illness or expressed suicidal ideation. Living in a house with an adult with alcohol or drug misuse issues was indicated for 33.3% (N=26) of children. Exposure to domestic violence directed toward their mother or stepmother was reported for 28% (N=22) of children. Similarly, witnessing domestic violence towards fathers and stepfathers was also an adversity encountered by 16.6% (N=13) of children.



The least common ACE for children relating to household dysfunction was the imprisonment of a family member, 15.3% (N=12). Although less prevalent, experiences of child abuse were reported for children within this cohort. Parents and caregivers who completed the survey questions indicated that 30.7% (N=24) of children had been verbally abused, 16.6% (N=13) were physically abused, and 3.8% (N=3) had experienced sexual abuse. Although physical neglect was uncommon for this cohort of children, comparatively, results indicate that emotional neglect was experienced by 25.6% (N=20).

Parent/caregiver 1 of the child attending

Childhood adversities were experienced by 50% (N=59) of the parents and caregivers who completed the OMSs (Please refer to Figure 9.20).



Of that number, 74.5% (N=44) identified themselves as Irish, and the remaining 25.5% (N=15) were non-Irish nationals. The number of ACEs reported by the parents and caregivers (Please refer to Figure 9.21) who completed the ACE survey questions as part of the OMS ranged from those with 1 ACE (32.2%/N=19), 2 ACEs (22%/N=13), 3 ACEs (8.5%/N=5), 4 ACEs (13.6%/N=8), 5 ACEs (10.2%/N=6) and 8 ACEs (5%/N=3).

Results from the FCs indicate that the minimum number of ACEs reported by the 59 parents and caregivers was 1, and the maximum was 8 (Please refer to Table 9.17). This cohort's average number of ACEs was 2.9, and the standard deviation for the ACE score total was 2.03.

Figure 9.21
Number of ACEs reported by FC parents and caregivers

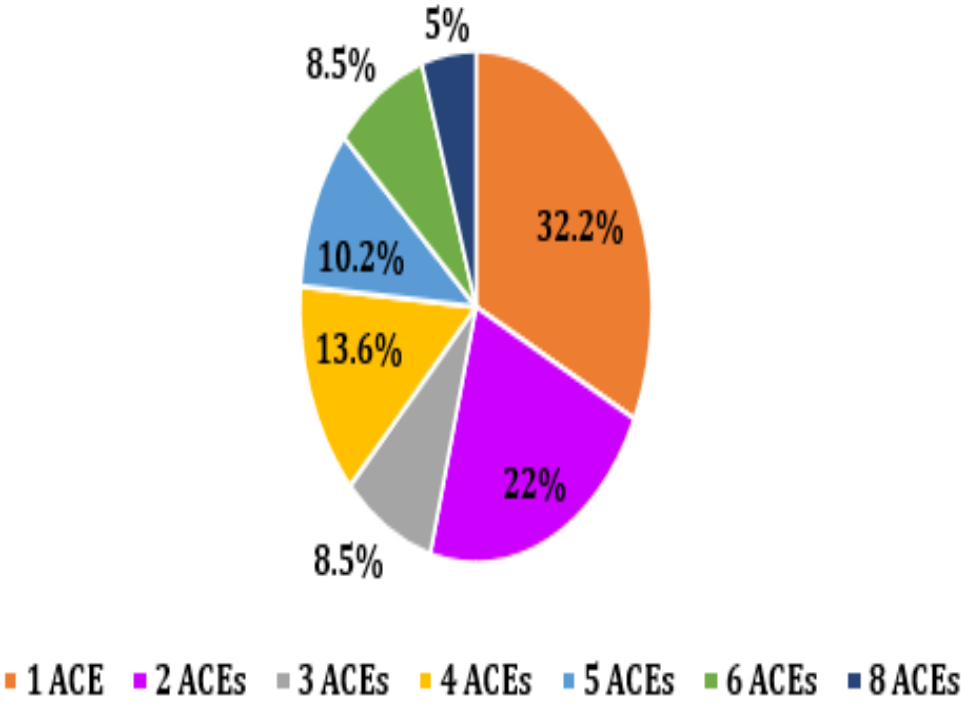


Table 9.17
FCs ACEs for the parents and caregivers who completed the Outcome Measures Survey (N=59)

ECDS ID	1 ACE	2 ACEs	3 ACEs	4 ACEs	5 ACEs	6 ACEs	8 ACEs
FC – A	1	0	1	0	0	0	0
FC – B	3	0	2	2	2	0	1
FC – C	1	5	1	0	1	1	0
FC – D	3	0	0	2	1	0	0
FC – E	4	2	1	2	1	1	1
FC – F	4	3	0	1	0	2	0
FC – G	3	3	0	1	1	1	1
Total (N):	**19**	**13**	**5**	**8**	**6**	**5**	**3**
Percentage:	**32.2**	**22**	**8.5**	**13.6**	**10.2**	**8.5**	**5**

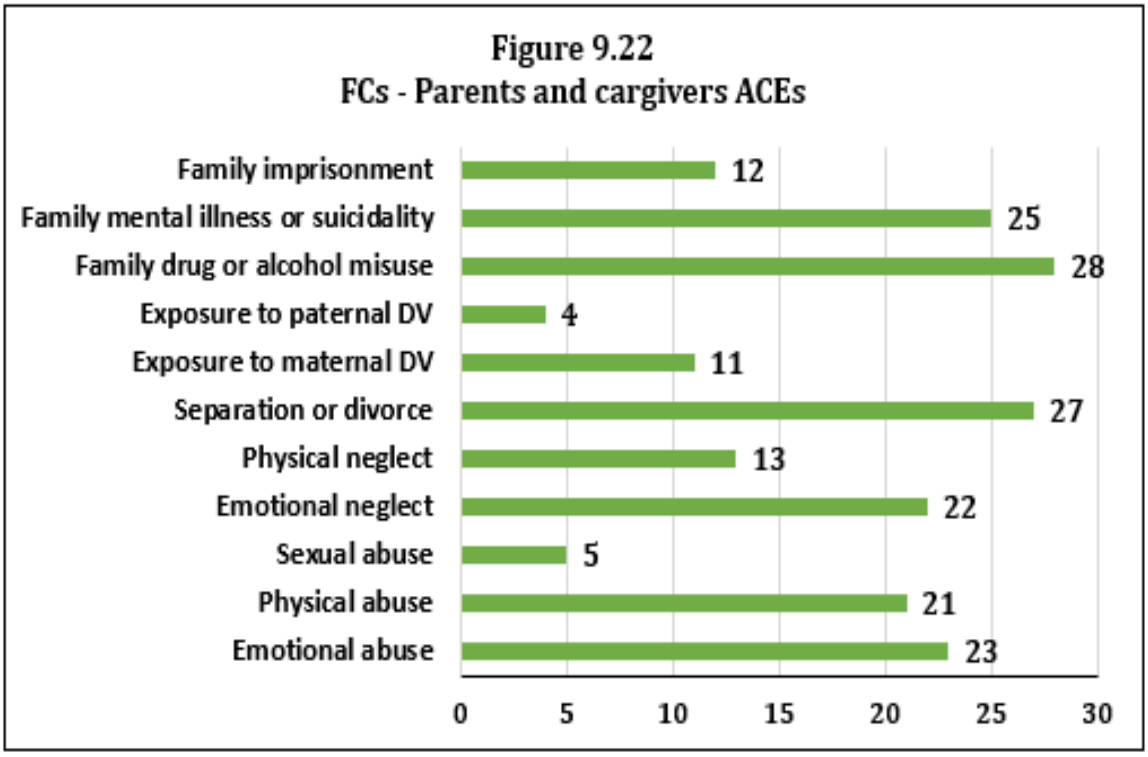
Table 9.18 illustrates the number of ACEs reported by Irish and non-Irish parents and caregivers who completed the ACE survey within the FCs. The findings indicate that 36% (N=16) of Irish parents and caregivers had an ACE score of four or

more. Of the parents and caregivers who identified as non-Irish nationals, 40% (N=6) had an ACE score of 4 or more.

Table 9.18
FCs – Number of ACEs reported by Irish and non-Irish parents or caregivers (N=59)

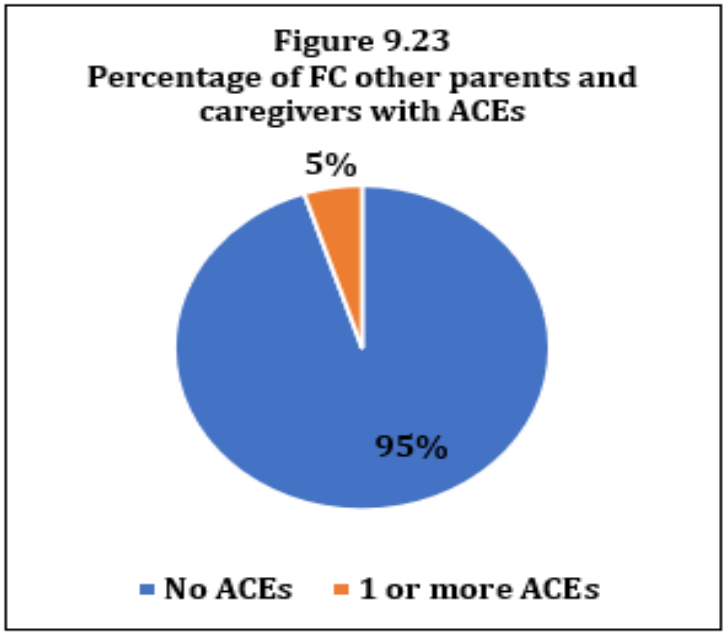
Nationality	1 ACE	2 ACEs	3 ACEs	4 ACEs	5 ACEs	6 ACEs	7 ACEs	8 ACEs	9 ACEs	Total:
Irish	15	10	3	5	4	4	0	3	0	= 44
Non-Irish	4	3	2	3	2	1	0	0	0	= 15

Positive responses to all eleven ACE survey questions were evident in the FC results (Please refer to Figure 9.22). The most common ACE category prevalent within the results from the FCs were adversities relating to household dysfunction. The most pervasive ACE reported by the parent and caregiver who completed the OMS was family drug or alcohol misuse (47.4%/N=28). The most uncommon ACE was exposure to domestic violence directed towards fathers or stepfathers (6.7%/N=4). Alongside experiences of familial drug and alcohol misuse and witnessing domestic violence towards fathers or stepfathers, parents and caregivers provided positive answers for survey questions about familial mental illness or suicidality (42.3%/N=25); a family member going to prison (20.3%/n=12) and exposure to domestic violence directed towards mothers and stepmothers (18.6%/N=11). Emotional abuse was experienced by 37.2% (N=22) of parents and caregivers. Physical neglect was experienced by 22% (N=13). Experiences of some form of childhood abuse were reported by 82.8% (N=48) of parents and caregivers. Of this percentage, 38.9% (23) indicated that they had been verbally abused, and 35.5% (N=21) reported experiences of physical abuse. A smaller number of 8.4% (N=5) specified that they had been sexually abused during childhood.



Other parents or caregivers of the children attending FCs

Of the 118 OMSs conducted within the FCs during the study timeframe, only 6 had information about the reported ACEs of the other parent or caregiver (Please refer to Figure 9.23). Of the 6 ACE surveys completed, the minimum number of adversities reported was 1, and the maximum was 9. The mean number of ACEs specified was 4.1, and the standard deviation for the ACE scores was 3.1.



Results indicate that only five participating FCs had survey data relating to other parents or caregivers (Table 9.19).

Table 9.19
FCs - ACEs for the other parent or caregiver (N=6)

FC ID	1 ACE	2 ACEs	4 ACEs	7 ACEs	9 ACEs
FC – A					
FC – B	0	0	0	1	0
FC – C					
FC – D	0	1	0	0	0
FC – E	1	0	1	0	0
FC – F	0	0	0	0	1
FC – G	0	1	0	0	0
Total (N):	**1**	**2**	**1**	**1**	**1**
Percentage:	**16.7**	**33.2**	**16.7**	**16.7**	**16.7**

The exact number of ACEs reported is outlined in Figure 9.24. Most other parents and caregivers were reported as having 2 ACEs (33.2%). 16.7% (N=1) experienced 1 ACE, 4 ACEs. 7 ACEs and 9 ACEs, respectively. Of the 6 ACE surveys completed, the minimum number of adversities reported was 1, and the maximum was 9. The mean number of ACEs specified was 4.1, and the standard deviation for the ACE scores was 3.1.

Figure 9.24
Number of ACEs reported by FC other parents and caregivers

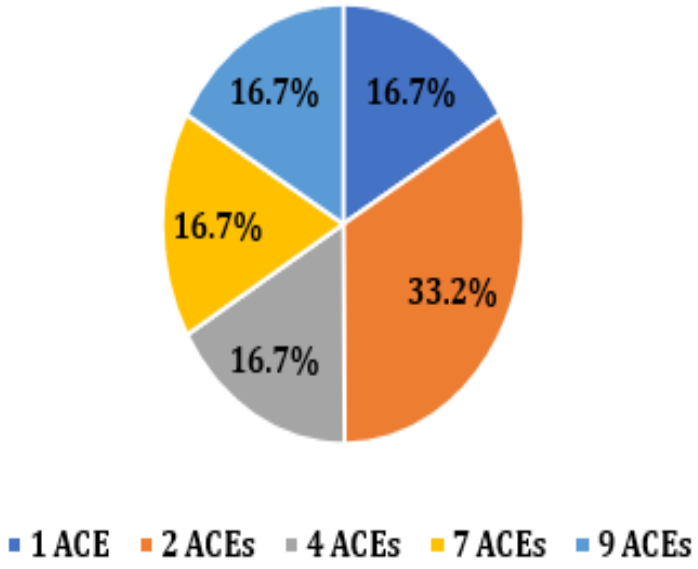
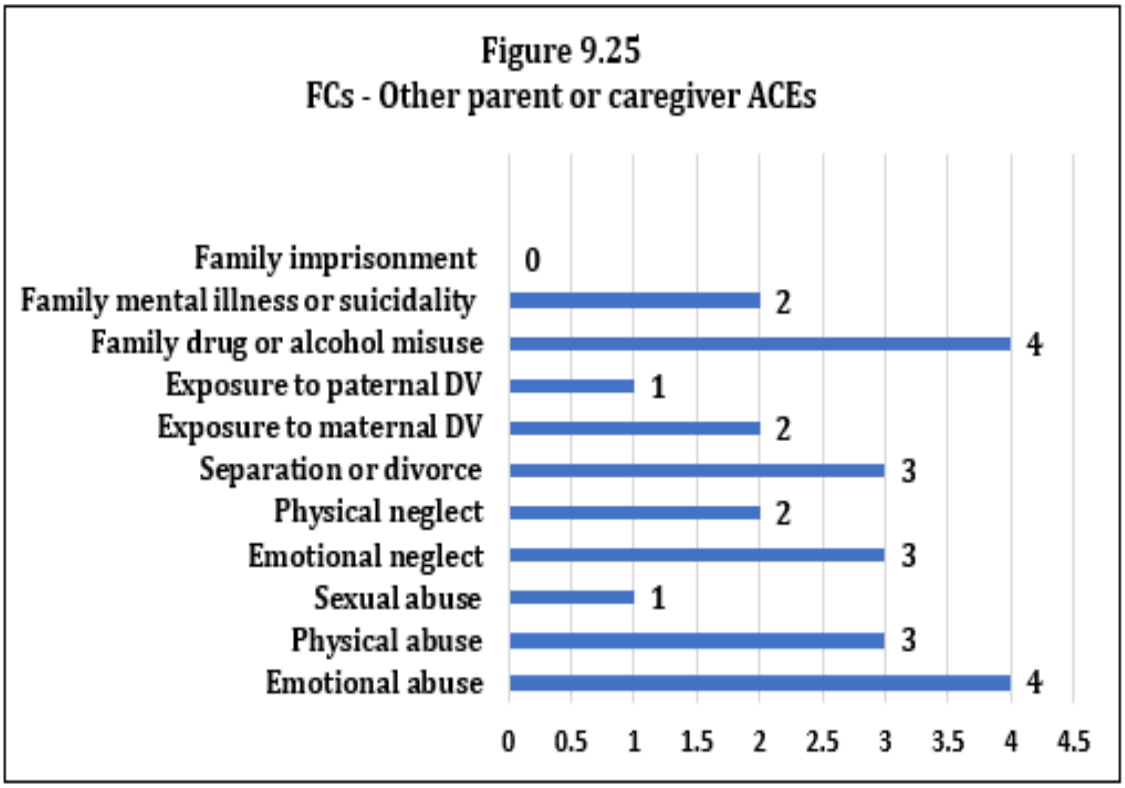


Figure 9.25 illustrates ACE data about other parents or caregivers. Data analysis determined that the most common ACEs reported for other parents or caregivers were family drug or alcohol misuse and verbal abuse (66.6%/N=4). 50% (N=3) of the cohort specified parental separation or divorce, emotional neglect, and physical abuse as adversities they had encountered during childhood. Familial mental illness or suicidality, witnessing domestic violence directed towards their mother or stepmother and physical neglect were ACEs for 33.3% (N=2) of the other parents and caregivers. The most uncommon ACEs reported were witnessing domestic violence towards a father or stepfather and CSA (16.6%/N=1). Results indicate that no other parent or caregiver was reported to have experienced imprisonment of a family member as an ACE.

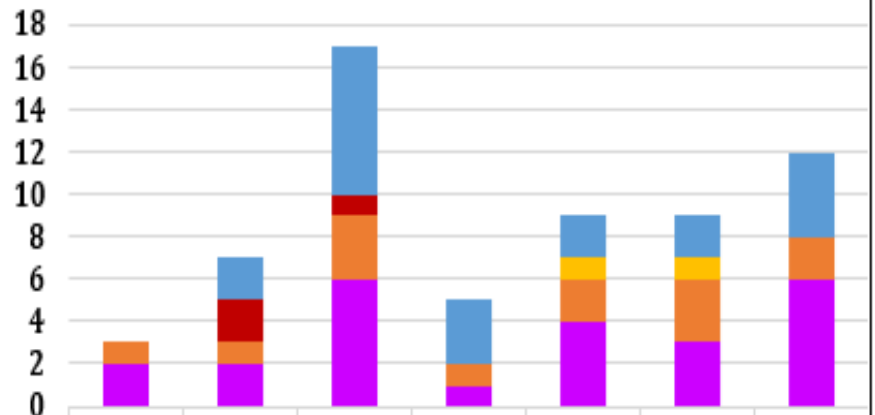


FC ACE survey results requiring mandatory reporting consideration

This section of the chapter will outline the results concerning ACE survey responses for both children and adults that required mandatory reporting consideration within the FCs. Results indicate that the number of ACE responses requiring current child abuse and neglect and retrospective mandatory reporting consideration is higher than that of the ECDSCs. Survey responses which evoked the need for mandatory reporting considerations concerning children attending the FCs totalled 62 (Please refer to Figure 9.26). Of these 62 survey responses, emotional abuse was the most frequently identified (N=24), with emotional neglect following this (N=20). Physical abuse accounted for 13 of the positive survey responses, with physical neglect representing a much smaller number at 2. Interestingly physical neglect and sexual abuse shared several commonalities. FCs E and F had positive survey responses for physical neglect, and FCs B and C encountered parents and caregivers who advised that their child had experienced sexual abuse. Both ACEs were lesser reported, with only three children reported as experiencing sexual abuse, and due to this, these ACEs were only encountered by FCWs in two FCs.

Figure 9.26

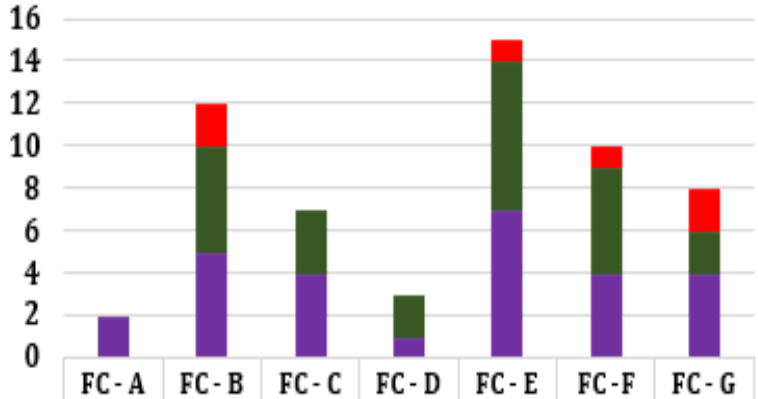
FCs - Breakdown of ACE survey responses requiring current child abuse or neglect mandantory reporting consideration



	FC-A	FC-B	FC-C	FC-D	FC-E	FC-F	FC-G
Emotional neglect child	0	2	7	3	2	2	4
Physical neglect child	0	0	0	0	1	1	0
Sexual abuse child	0	2	1	0	0	0	0
Physical abuse child	1	1	3	1	2	3	2
Emotional abuse child	2	2	6	1	4	3	6

FWs who asked the retrospective child abuse survey questions to and about parents and caregivers during the study timeframe encountered 57 instances that required mandatory reporting consideration (Please refer to Table 9.27). Most of these instances were related to survey responses which indicated retrospective emotional abuse (N27) followed by physical abuse (N=24). Retrospective child sexual abuse only accounted for 6 of the survey responses that required mandatory reporting considerations during the study data collection period. This result proves interesting as it indicates that only three of the seven FCs encountered adults who disclosed retrospective sexual abuse during the 9-month study timeframe. Three FCs did not require consideration of reporting for retrospective CSA.

Figure 9.27
FCs - Breakdown of ACE survey responses requiring retrospective child abuse mandatory reporting consideration



	FC - A	FC - B	FC - C	FC - D	FC - E	FC - F	FC - G
Retrospective sexual abuse	0	2	0	0	1	1	2
Retrospective physical abuse	0	5	3	2	7	5	2
Retrospective emotional abuse	2	5	4	1	7	4	4

9.5 Conclusion

This chapter outlined the quantitative results of the study. It commenced by detailing demographic information relating to the children and the parents and caregivers whose information was provided in response to the ACE survey questions during the study timeframe. This chapter also outlined the ACE profiles of these children and their parents and caregivers. In total, ACE profiles were described for 16 children, 31 parents and caregivers, and 16 other parents and caregivers in the ECDSCs and 78 children, 59 parents and caregivers and 6 other parents and caregivers within the FCs. The next chapter begins the discussion section of this thesis. It will focus on delving into the meaning, importance, and relevance of the results outlined in chapters 7, 8 and 9.

Chapter 10

Discussion of quantitative findings

How common were ACEs?

10.1 Introduction

The central aim of this study was to examine the introduction of routine administration of the ACE survey in a social care organisation from managers' and workers' perspectives. This chapter will critically examine the quantitative findings of the study. It will consider the meaning of the data and identify any correlations or discrepancies between the findings and existing literature. It will also compare the findings with existing literature to determine the overall significance of the study to the ACE evidence base. The chapter will commence with a discussion of the quantitative research data outlined in Chapter 9. The profile of DoCCFS SUs who completed the ACE survey during the data collection timeframe of the study will be compared and contrasted with similar ACE prevalence studies as identified in chapter 3.

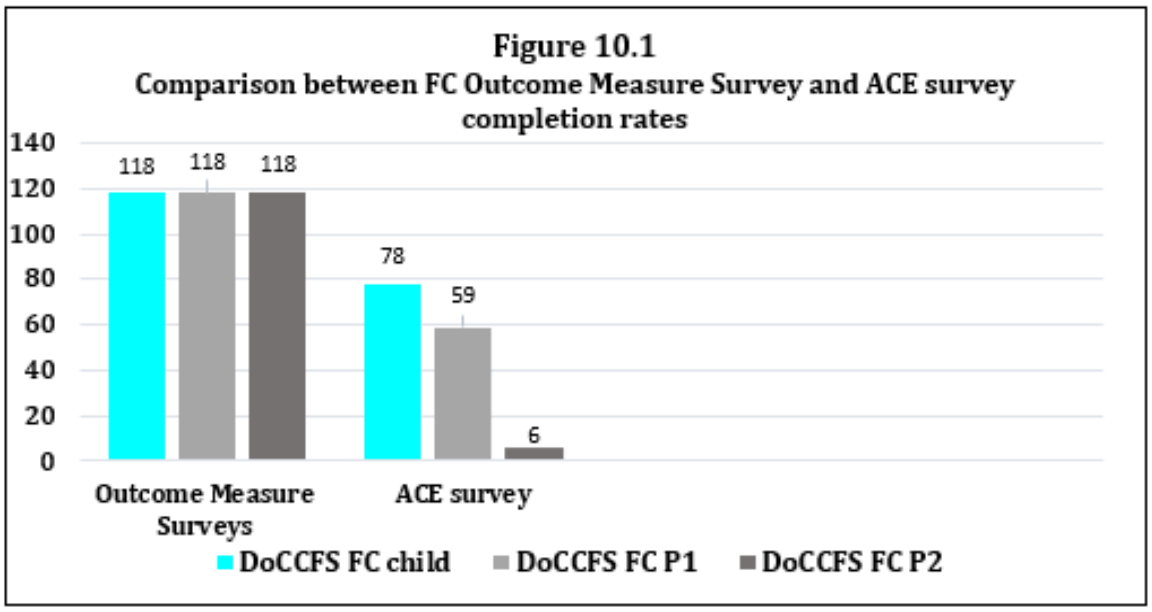
10.2 Comparison of the demographic profile of the DoCCFS SUs

As mentioned in chapter 2, the ACE survey measures have been criticised due to a perceived lack of generalisability (Steptoe et al., 2019). Due to the lack of consistency in the ACE measures implemented by researchers and the various approaches undertaken, there are difficulties in comparing the findings of data collected as part of the routine survey administration. Although this chapter discusses and considers the ACE study profiles of children and their parents and caregivers who completed the OMS during the timeframe of this study in tandem with other ACE population studies, there were no studies evident in the literature to provide an accurate comparison. Although the studies identified have commonalities, this chapter will highlight notable differences.

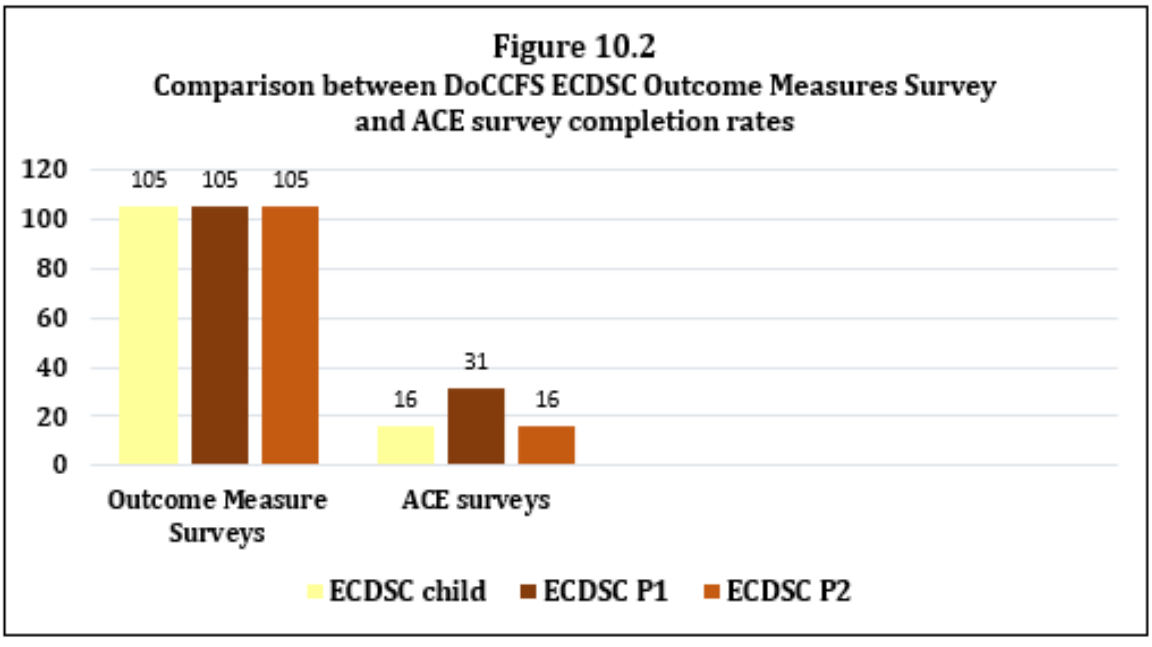
Number of ACE surveys completed

An interesting quantitative finding from this study relates to the differences in survey completion rates between the DoCCFS FCs (please refer to Figure 10.1) and the ECDSCs (please see Figure 10.2). Of the 118 OMSs completed within the DoCCFS FCs, there was

ACE data evident for 66% (N=78) of children and 50% (N=59) for parents and caregivers 1 (the adult who completed the survey with the FW).



Compared with the ECDSCs, the DoCCFS FCs had significantly higher completion rates for both the child and parent and caregiver 1. Of the 105 OMSs completed within the ECDSCs during the study timeframe, only 15.25% (N=16) had data entered concerning children's ACE scores and 29.5% (N=31) for the parent and caregiver 1.



It is important to acknowledge that there may be some marginal errors regarding survey responses. It is possible that the individual who completed the OMS survey, DoCCFS staff or SUs, left the survey data entry boxes empty rather than indicating that they had not encountered any ACEs. The lack of data may also be related to the FW or the parent and caregiver leaving the survey section blank because they decided not to complete it. Unfortunately, the OMS data did not account for individuals who declined to complete this survey section.

If not a data error, this higher completion rate could be attributed to the differences in approach implemented by each setting. The FCs verbally administered the OMS to SUs. The qualitative findings indicate that FWs spent considerable time administering the survey questions. On the other hand, the ECDSMs gave the OMS to SUs to self-complete. Due to this, it may have been more difficult for parents and caregivers within the FCs to decline to answer the ACE research questions. It is also possible that self-completion of the OMSs in the ECDSCs meant that parents and caregivers did not have the opportunity to ask questions about the rationale for asking them to complete the survey. Therefore this decreased their motivation to respond. This study found that verbally administering the survey results in higher completion rates. This finding is important as it suggests that social care organisations considering administering the survey need to account for completion rates depending on the approach they adopt. The fundamental differences in context between the two services could also account for the variations in completion rates. SUs attending the FCs could have been more motivated to complete the survey because they wanted and needed therapeutic support from the FWs administering it. Comparatively, those attending the ECDSCs were primarily doing so to access educational and developmental input for their children. Due to this, their motivation to complete the survey may not have been as strong as SUs attending the FCs.

The quantitative results from this study also indicate that the survey responses for the other parent or caregiver (the parent who did not self-complete it in the ECDSCs or have it verbally administered to them by FWs) were lacking. Of the 105 OMSs completed in the ECDSCs, only 15.25% (N=16) had data entered for the survey questions. The data entered in the FCs was even lower, with only 5.08% (N=6) of the OMSs having data about the other parent or caregiver's ACEs. This finding indicates that social care organisations should consider how viable it is to ask about both

parents' ACEs. It also suggests that asking parents or caregivers separately to complete the survey might be beneficial.

Gender of adults

There is a notable difference in the gender of adults who completed the survey within the DoCCFS compared to existing ACE population studies. The data indicated that the survey was completed by 90.7% of females and 5.9% of males in the DoCCFS FCs. Similarly, 85.7% of the survey respondents in the ECDSCs were female, with males representing just 4.8%. This finding is inconsistent with the gender breakdown of the Irish population reported by the Census 2016 data discussed in chapter 4. Although the findings indicated that from the age of 19 years or more that females were slightly higher per 1,000 males in most age categories, the difference was not as considerable (CSO, 2016a). Compared with ACE population studies, this higher proportion of female respondents could be related to the nature of the services provided by the DoCCFS. The gender breakdown of the Irish participant cohort in the study by McCutchen et al. (2022) examined if there were significant differences between the prevalence of ACEs and their relationship to mental health in Irish and USA research populations was more evenly split. Females represented 51%, and males made up 49% of participants. Similarly, both the Welsh ACE population study had research populations that were more gender-balanced. The Welsh study by Bellis et al. (2016) had 49.25% males and 50.25% females. The higher percentage of female participants in the DoCCFS cohort may be attributed to the other studies being population-based. Unlike the current study, the researchers used purposive sampling to recruit participants that reflected the gender balance of the Welsh and Irish populations.

Age of DoCCFS parents and caregivers who completed the ACE survey

The minimum age of the adults and caregivers who completed the ACE survey within the DoCCFS ECDSCs was 22 years. The maximum age was 46, and the mean age was 34. Parents and caregivers who completed the form in the FCs have a slightly higher minimum age of 22 years and a significantly higher maximum age of 57. The mean age of parents and caregivers was also slightly older at 40.5 years. These age differences correlate with the type of services offered by the DoCCFS. As the ECDSCs offer early childhood education, it is unsurprising that the age range of parents and caregivers was

lower than that of the FCs. Children and young people engaged with the FCs can be aged up to 18 years, so their parents would be expected to be older. Compared to the Welsh ACE study by Bellis et al. (2016), parents and caregivers who completed the survey within the DoCCFS were older. Most participants (30.4%) in the Welsh study were between 18 and 29. Again, this variation is more than likely related to the purposive sampling the Welsh study investigators implemented.

Gender of children

The gender profile of the children whose parent or caregiver completed the OMS within the DoCCFS was more balanced than those completed for parents and caregivers. Children whose parents completed the survey within the DoCCFS FCs were 54.2% male and 45.8% female. Within the ECDSCs, the gender breakdown of children was 49.5% male and 50.5% female. This gender profile, however, is unexpected as it differs from the population gender breakdown outlined in the 2016 census (CSO, 2016a). In all age categories up until the age of 19 years, there were fewer males than females reported. Although it is hard to generalise a rationale for this finding due to the lack of referral information to the DoCCFS, the increased number of male children attending the FCs may have been a result of parents seeking support for behaviour management issues relating to differences in how males and females manifest emotions or difficulties.

Age of children

The minimum age of children whose parent or caregiver completed the OMS within the ECDSCs was two years and ten months. The maximum age of children was six years and ten months, and the mean age was 3.5 years. The DoCCFS also had a low minimum age for children at two and a half years. The maximum age was significantly higher at eighteen and a half years. The mean age of children whose parents completed the DoCCFS OMS within the FCs was 10.5 years. Similarly to the age range of parents who completed the surveys, these variances in age can be attributed to the nature of the services provided. Given that the ECDSCs provide early childhood education, its age range was expected to be lower.

10.3 Differences in the DoCCFS ACE profiles and other populations

The ACE data collected in the current study is significantly smaller than the ACE population studies outlined in chapter 2. Therefore, the findings are difficult to compare accurately. Although the quantitative data cannot be accurately compared, the current study's findings established some consistencies and differences in the prevalence of ACEs reported for children, parents, and caregivers when considered in tandem with existing ACE research populations. Acknowledging these similarities and inconsistencies is crucial because they provide insights surrounding the ACE profiles of children, parents, and caregivers availing of social care organisations. The quantitative data findings of this study may be used to inform service provision for similar services.

10.3.1 Number of ACES reported by adults

As the current study was conducted in a social care organisation and there have been limited ACE prevalence studies undertaken in this type of setting (Ford et al. 2019), it is, however, important to compare the ACE profiles of parents and caregivers with what relevant existing ACE studies there are. Doing so will help to establish whether parents and caregivers availing of support or services for social care services have higher levels of ACEs. ACE prevalence data from the Welsh ACE study conducted by Bellis et al. (2016) to establish the prevalence of ACEs and the relationship between adversities during childhood and the adoption of subsequent health-risk behaviours in the Welsh adult population determined that 20% of participants within the study reported at least one ACE. In addition, the study findings found that 13% had experienced two to three ACEs, and 14% had experienced four or more childhood adversities. This study was undertaken with 2,028 adult participants (1,009 males and 1,019 females) aged 18-69 during a three-month period in 2015. The results of the national Scottish Health Survey (SHeS) by Mclean and Wilson (2019) indicate that 26% of the research population in Scotland had encountered one ACE, 31% reported two to three ACEs, and 26% indicated that they had experienced four or more adversities during their childhoods. Compared with existing ACE population studies, the findings indicate stark differences in the number of ACEs experienced by DoCCFS parents and caregivers (please refer to Table 10.1).

Table 10.1 Comparison of number of ACEs reported by DoCCFS parents or caregivers with other ACE research populations			
Research population	**1 ACE**	**2-3 ACEs**	**4+ ACEs**
DoCCFS ECDSC parent or caregiver 1 (N=105)	48.5%	25.5%	26%
DoCCFS ECDSC parent or caregiver 2 (N-16)	37.5%	25%	37.5%
DoCCFS FC parent or caregiver 1 (N=118)	32.2%	30.5%	37.3%
DoCCFS FC parent or caregiver 2 (N=6)	16.7%	33.2%	50.1%
Wales – Bellis et al. (2016) (N=2028)	20%	13%	14%
Scotland – McLean and Wilson (2020) (N=4903)	26%	31%	15%

DoCCFS parents and guardians have a higher prevalence of experiencing at least one ACE and an overall higher occurrence of a cumulative ACE score of four or more. Although there is no literature from a similar social care organisation to directly compare the finding to, this finding could correlate with the studies by Liu et al. (2021) and O'Malley, Devaney, and Millar (2022), which determined that adopting maladaptive coping strategies may lead to some individuals with ACEs being more inclined to come in contact with social care services. As the DoCCFS is a unique social care service offering both early childhood education and family support interventions, it is challenging to speculate why parents and caregivers generally reported higher ACE prevalence rates. As the OMS did not ask parents or caregivers about maladaptive coping strategies in response to their experiences of childhood adversities, this finding warrants further investigation.

10.3.2 Breakdown of ACEs reported by adults

Some interesting commonalities were identified in the DoCCFS parent and caregiver ACE profiles. These similarities are related to the fact that both ECDSC parent and caregiver cohorts reported parental separation and divorce as their most prevalent ACE (ECDSC P1= 81% / ECDSC P2 = 74%). They also reported household drug and alcohol abuse as their second most encountered adversity during childhood (ECDSC P1 = 43.75%/ ECDSC P2 = 51.5%). The FC parent and caregiver cohorts also shared a commonality in their most prevalent ACE, with 47.4% of parents and caregivers 1 and 66.6% of parents and caregivers 2 indicating that they had grown up in a household exposed to alcohol and drug misuse. These findings are interesting compared with the ACE profiles of children attending the DoCCFS during the study timeframe.

The ECDSC child ACE data indicates that parental separation and divorce were also the most prevalent ACE for children (75%). Exposure to household drug or alcohol misuse was among the three most reported ACEs for parents, caregivers and their children (12.5%). These findings indicate that both parents, caregivers and children experienced similar ACEs. However, the FC child ACE profile data somewhat contradicts the intergenerational transmission of ACEs. Although parents and caregivers reported exposure to alcohol and drug misuse within their childhood homes, the data indicated this was the fourth most prevalent ACE for children (33%). Given that the literature argues that ACEs can be passed down from generation to generation (Anderson et al., 2018; Hays-Grudo and Sheffield, 2020), these findings indicate that although intergenerational transmission may involve some direct repetition of ACEs, it also introduces new adversities. These new ACEs perhaps reflect the different pathways, as discussed in chapter 2, by which adversity and trauma in one generation may express themselves in another.

The ACE profile of DoCCFS ECDSC and FC parents and caregivers was consistent in some aspects with the existing ACE adult populations study findings. These similarities relate to the least reported ACEs. Table 10.2 provides a comparison of ACE prevalence between the participant cohorts. The least prevalent ACEs for all participant cohorts included experiences of CSA and growing up in a home where a household member was imprisoned. Despite the consistencies, the DoCCFS ACE profiles for parents and caregivers also had distinct differences. The data from the DoCCFS ECDSCs indicates that the three most reported ACEs for both parent and caregiver cohorts were in the ACE household dysfunction category. The FC data illustrate that two of the three most prevalent ACEs reported were in the household dysfunction category or related to one child maltreatment ACE - emotional abuse. Although this finding is somewhat consistent with the Welsh study by Bellis et al. (2016), they contradict some other studies. The studies in Ireland and Scotland (McCutchen et al. 2022; McLean and Wilson 2020) determined that two of the three most prevalent ACEs were in the child maltreatment ACE categories.

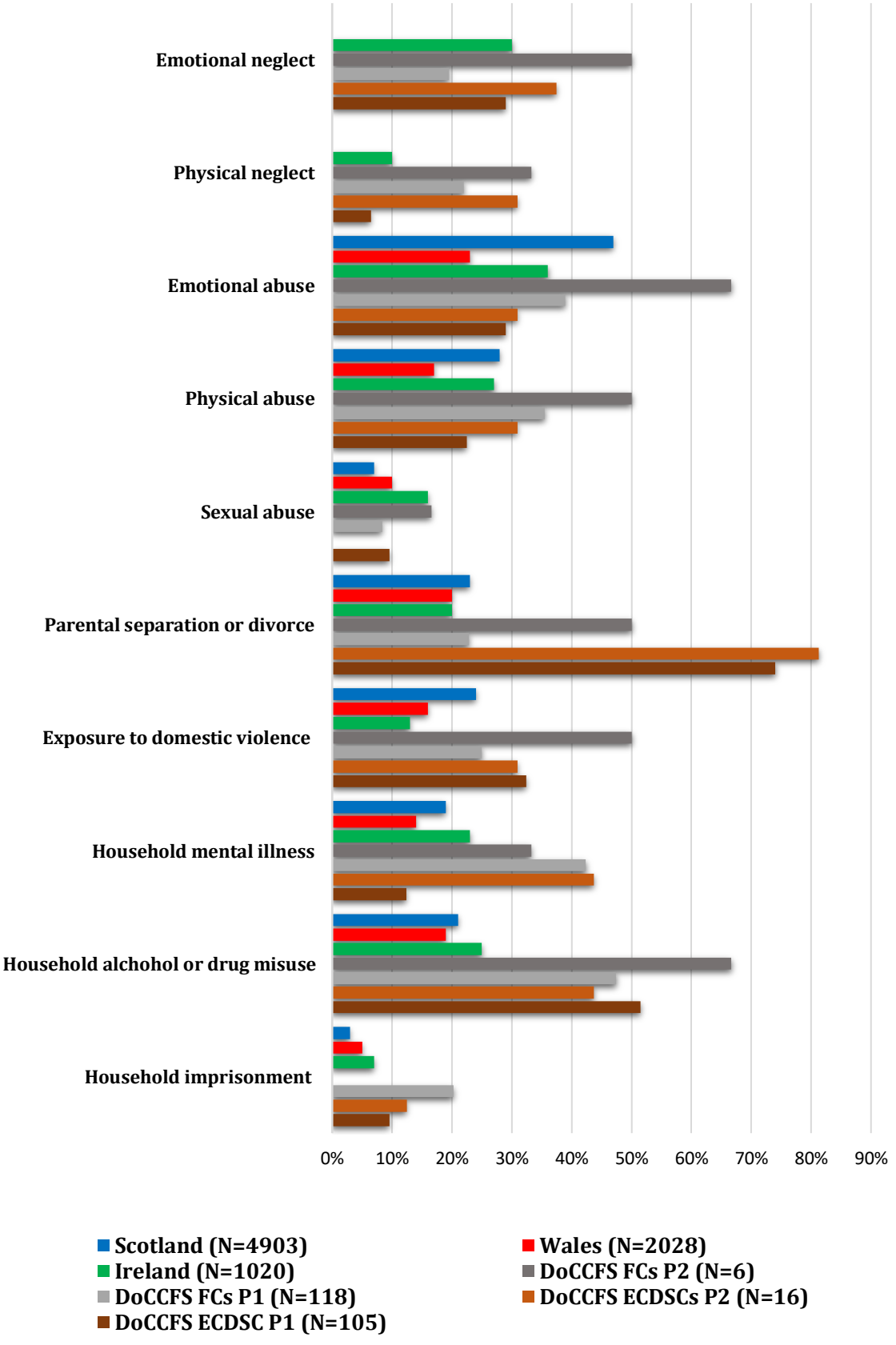
Table 10.2
Comparison of ACE prevalence between DoCCFS parents/caregivers with other adult studies
(ACEs ranked from most =1 to least = prevalent)

	ECDSC P1	ECDSC P2	FC P1	FC P2	Ireland	Wales	Scotland
Household imprisonment	6	7	8	10	10	8	8
Drug/alcohol misuse	2	2	1	1	4	3	5
Mental illness	3	6	2	7	5	6	6
Domestic violence	5	3	5	3	8	5	3
Separation/divorce	1	1	6	4	6	2	4
Child sexual abuse	[ii]	7	10	9	7	7	7
Physical abuse	5	5	4	5	3	4	2
Emotional abuse	5	4	3	2	1	1	1
Physical neglect	5	7	7	8	9	[iii]	
Emotional neglect	4	4	9	6	2		

Ireland = McCutchen et al. (2022); Wales = Bellis et al. (2016); Scotland = McLean and Wilson (2020)

Figure 10.3 visually compares DoCCFS adult SU ACE scores with other study populations. This illustration helps to emphasise some of the starkest differences between the Irish population study by McCutchen et al. (2022) and the DoCCFS data findings. Irish participants in the study by McCutchen et al. (2022) were a representative population sample. They were adults over 18 and did not reside in hospitals, nursing homes or prisons. The study's Irish participants (N=1020) were obtained using a survey research company. It is essential to highlight that the research population was much larger than the DoCCFS sample. Additionally, it is necessary to acknowledge that participants in the McCutchen et al. (2022) study were not parents or caregivers who completed the ACE survey whilst attending a social care service for early childhood education or support for their children's families. Interestingly the most common ACEs experienced by DoCCFS parents and caregivers, parental separation or divorce, exposure to domestic violence and household drug and alcohol misuse, were less prevalent in the Irish population sample (McCutchen et al., 2022). These differences emphasise the need for further investigation to determine whether the ACEs experienced by the parents and caregivers within the DoCCFS were indicative of their social issues and circumstances or if it is a consistent finding for adult SUs attending similar social care services.

Figure 10.3
Comparision of DoCCFS adult service user ACE scores with other populations



10.3.3 Number of ACEs reported for children

As mentioned in chapter 3, studies relating to child ACE population studies are lacking in Ireland, the UK and Europe. For this reason, the ACE profile of children attending the DoCCFS ECDSCs and FCs will be compared with the findings of studies in the USA. Direct comparisons are impossible due to the marked differences in research settings and populations. It is also important to highlight that direct comparison was also hampered by studies implementing different versions of the ACE survey. This challenge is consistent with one of the identified criticisms of the routine ACE enquiry (Steptoe et al., 2019).

Table 10.3 outlines the comparison between the cumulative ACE scores of children attending the DoCCFS ECDSCs and FCs with the ACE scores of studies undertaken with children in two studies in the USA (Crouch et al. 2019; Kerker et al. 2015) Crouch et al. (2019) conducted an ACE population study with children in the USA. This study aimed to examine the prevalence of ACEs for children and whether there was a correlation between ACEs and the child's socio-demographic characteristics. The study involved a cross-sectional analysis of data from an online and mail survey completed in 2016. This survey was called the National Survey of Children's Health (NSCH) and was conducted by the Data Resource Center for Child and Adolescent Health (DRC). The study used survey data provided by the parents of 45,287 children. Unfortunately, this study only provided a cumulative ACE score for children with four or more childhood adversities (17.7%). Eligibility inclusion for the study specified that parents or caregivers had to reside in a home with at least one child at the time they completed the survey (Crouch et al., 2019). The ACE research measures did not include questions about child maltreatment or neglect, nor did it offer outline cumulative scores for one, two, to three ACEs.

The second study, for comparison purposes, was completed by Kerker et al. (2015). Kerker et al. (2015) conducted a study using cross-sectional analysis of a nationally represented sample of children engaged with child welfare services in the USA. Using pre-existing data from the 2008-2009 wave of the National Survey of Child and Adolescent Well-being II survey, the study examined the prevalence of ACEs for parents and caregiver reports of 912 children aged 17-71 months who were not in out-of-home care. In addition to ACE prevalence, the study also set out to establish if there was a relationship between chronic medical conditions, mental health, social development, and ACEs for children engaged with the child welfare system. Results

determined that most children (98.1%) had at least one ACE. Of that percentage, 7.7% had one ACE, 39.9% had 2-3 ACEs, and 50.4% of parents and caregivers reported that their child had four or more ACEs.

Table 10.3
Comparison of the number of ACEs reported for DoCCFS children with other ACE research populations

Research population	1 ACE	2-3 ACEs	4+ ACEs
DoCCFS ECDSC children (N=16)	68.75%	25%	6.25%
DoCCFS FC children (N=78)	30.8%	39.7%	29.5%
USA – Crouch et al. (2019) (N=45,287)[iv]			17.7%
USA – Kerker et al. (2015) (N=912)	7.7%	39.9%	50.4%

The ACE data outlined in the Kerker et al. (2015) study relates to children engaged with child protection and welfare services in the USA, so it is hard to infer direct comparisons. The DoCCFS is not a child protection and welfare service. The families attending the DoCCFS ECDSCs and FCs were not availing of social work intervention. It is therefore not surprising that the DoCCFS ECDSC children (6.25%) and FC children (29.5%) were less likely to report a cumulative ACE score of four or more than those in the Kerker et al. (2015) study (50.4%). The quantitative findings of this study show that children attending the DoCCFS ECDSCs were less likely to have experienced more than one ACE, with 31.25% reporting two or more ACEs. The FC children were reported as having a higher prevalence of two or more ACEs (69.2%). It is essential to highlight that there was an age difference between the children in the ECDSCs and the FCs. The children in the ECDSCs may have had a lower cumulative ACE score because they had not been alive as long as the children in the FCs. The children from the Kerker et al. (2015) study had a high prevalence of two or more ACEs (90.3%). The Kerker et al. (2015) percentage is significantly higher than the DoCCFS. This finding is more than likely related to the fact that the children who completed the study attended child protection and welfare services for social work intervention.

The findings relating to the cumulative ACE scores within the DoCCFS are important for social care organisations as they indicate that ACEs reported for children differ depending on the service they are attending. These quantitative findings are significant because they infer that if social care organisations introduce routine ACE

survey administration to inform their service provision, the ACE data for their SU population would indicate differing needs in terms of ACE prevalence. A one size fits all approach to service development for various services within one organisation would not suffice.

10.3.4 Breakdown of ACEs reported for children

The ACE scores for children attending the DoCCFS ECDSCs and FCs differ significantly (please refer to Table 10.3).

Table 10.4
Comparison of ACE prevalence between DoCCFS children with other studies
(ACEs ranked from most =1 to least = prevalent. Similar scores = same percentage)[v]

	ECDSC child	FC child	Crouch et al. (2019)	Kerker et al. (2015)
Household imprisonment	4	8	4	8
Drug/alcohol misuse	3	4	2	6
Mental illness	2	3	3	8
Domestic violence		2	5	4
Separation/divorce	1	1	1	5
Child sexual abuse	4	9		9
Physical abuse	4	7		2
Emotional abuse	4	5		1
Physical neglect		10		3
Emotional neglect		6		7

The ACE data provided for the ECDSC children indicated that no children had been exposed to domestic violence within the family home, nor had they experienced physical or emotional neglect. The quantitative data findings for the FC children indicated that exposure to domestic violence was the second most prevalent ACE. Emotional neglect was the sixth most prevalent ACE. Although the data determined that children from the FCs had encountered physical neglect, it was the least prevalent of the ACEs reported.

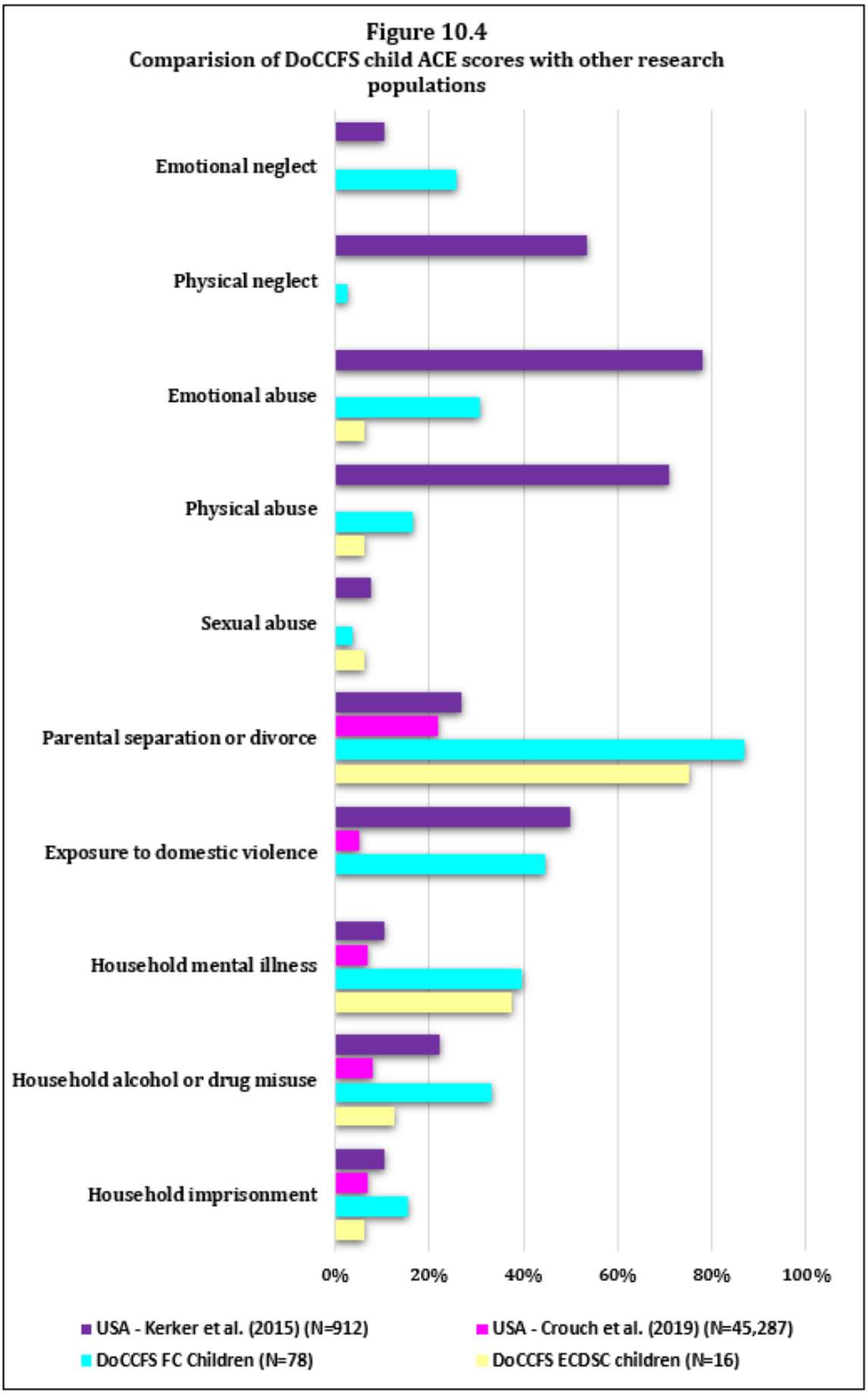
There were also some similarities evident between the DoCCFS ECDSC and FC children. These consistencies related to the fact that parental separation and divorce were the most prevalent ACE reported by both cohorts. Both cohorts reported that the three most prevalent ACEs were also related to ACEs from the household dysfunction category. Children from the DoCCFS ECDSCs were reported to have encountered parental separations and divorce (75%), household mental illness (37.5%) and

household alcohol or drug misuse (12.5%). The three most prevalent ACEs for the DoCCFS FC children were parental separation or divorce (87%), exposure to domestic violence (44.6%) and household mental illness (39.7%). These findings are consistent with those outlined in the study by Crouch et al. (2019) (Please refer to Table 10.4, which provides an illustrative comparison of DoCCFS child ACE scores with other research populations). It is important to reiterate that the ACE survey implemented in that study did not include child maltreatment ACE measures. It is, therefore, not possible to make direct comparisons or observations.

The DoCCFS findings are inconsistent with the findings of Kerker et al. (2015) study. The quantitative data from that study indicated that the three most prevalent ACEs experienced by children were related to child maltreatment. These ACEs were outlined as follows: Emotional abuse (78%), physical abuse (71%) and physical neglect (53.5%). These stark differences in quantitative data findings may be for several reasons. These reasons include the differences in population size and setting. The ACE data in the Kerker et al. (2015) study pertained to children attending child protection and services receiving social work intervention. It is therefore expected that these children would have higher rates of child maltreatment ACEs than other populations.

The quantitative data findings of this study about children's ACEs are significant because they indicate that the children attending the DoCCFS ECDSCs and FCs were more likely to encounter ACEs in the household dysfunction category. This finding indicates that if the DoCCFS plans to use the ACE data to improve service provision, it should specifically look at supports surrounding these childhood adversities.

Figure 10.4
Comparision of DoCCFS child ACE scores with other research populations



10.4 Conclusion

This chapter provided a discussion of the quantitative data findings of this study. The quantitative findings indicate that verbally administering the ACE survey yielded higher completion rates within the DoCCFS FCs. The study's quantitative findings indicate that ACEs were prevalent for children, parents and caregivers attending the DoCCFS. The top three ACEs experienced by DoCCFS children and parents and caregivers were those in the household dysfunction category. An interesting observation from comparing the current quantitative data with other adult ACE population studies was that it was difficult to make direct comparisons. These difficulties were related to differences in population sizes, settings, and ACE survey configurations. Overall, the discussion of quantitative data relating to the DoCCFS child ACE scores indicates that the DoCCFS should consider additional support and interventions relating to household dysfunction ACEs. The next chapter will discuss the qualitative findings in chapters 7 and 8 of this thesis concerning this study's first two research questions.

Chapter 11

Discussion of qualitative findings

The training and transition experiences.

11.1 Introduction

This chapter will deliberate on the qualitative findings in chapters 7 and 8 of this thesis concerning this study's first two research questions. These questions relate to whether the training provided by the DoCCFS prepared staff for the routine administration of the ACE survey and what the experience of transitioning to routine administration was like. The findings relating to these two questions will be contextualised within the existing literature to identify similarities and emphasise unexpected and new results. The chapter will also consider the meaning of the data and identify any correlations or discrepancies between the findings and existing literature. It will then compare the findings with existing literature to determine the overall significance of the study to the ACE evidence base. The qualitative discussion section of this chapter will be structured under the headings of the central research questions.

11.2 Did ACE training prepare managers and workers for routine administration of the ACE survey?

In order to answer the central research question, this study examined if the training provided by the DoCCFS to managers and workers within the ECDSCs and FCs prepared them to administer the survey. This study established that although some aspects of the training were helpful to workers, the ACE training provided by the DoCCFS was not substantive or sufficient for staff. Four themes emerged from data analysis which contributed to this finding. These themes included that training needed to be more specific to staff implementation role and context; ACE training did not consider the potential impact of professionals ACEs; ACE training and recollection differed according to the administration role, and the potential emotional impact on staff should have been considered. Each theme is described and considered in detail below.

11.2.1 Training needed to be specific to staff implementation roles and context

An important finding emerging from this study is that training to prepare staff to administer the ACE survey should be specific to worker role and context. Although this particular finding concerning training for administering the survey was not evident in the literature, it was apparent in studies about training for health and social care professionals. For example, a study by Surr and Gates (2017), which examined perceptions of effective dementia training for health and social care professionals, established that participants perceived the need for training to encompass information and skills that applied to their specific role and setting. Participants in this study outlined the importance of implementing role-plays relative to real-life practice scenarios for professionals. The current study participants from the FW focus groups reported that their training did not sufficiently equip them to administer the survey. They stressed that although they appreciated the role plays and found them helpful, the training curriculum should have been more extensive, practical, and related to them asking the survey questions and responding to SUs who exhibited distress. This finding is consistent with the literature, which emphasises the importance of practical training for staff in administering the survey (Selvaraj et al., 2019; Counts et al., 2017).

This finding is significant because it indicates that the training needs reported by FWs differed significantly from those indicated by ECDSWs. As identified in the literature, most studies relating to ACEs have been undertaken in clinical settings with healthcare professionals (Ford et al., 2019). Although these studies sometimes involved training surrounding multiple-disciplinary administration of the survey in clinical settings (Bora et al., 2022; Randall et al., 2020; Burke-Harris, 2018), they did not identify the need to tailor training to professional implementation roles or settings. On the contrary, the studies indicated that all disciplines and professions received the same training. Similarly, although they represent a smaller number, findings of studies in non-clinical settings (Morton and Curran, 2019; Lambert et al., 2017) did not highlight the need for specific training. The findings of this study indicate that training needs differed depending on whether staff were administering the survey or if they received training to increase their ACE awareness as part of the survey implementation process within the DoCCFS. As previously indicated, ECDSWs within the DoCCFS did not verbally administer the survey like FWs, nor were they assigned the role of giving

the survey to adult SUs for self-completion like the ECDSMs. Despite having no direct role in survey administration, ECDSWs attended ACE training as part of the DoCCFS survey implementation process. The training provided to ECDSWs by the DoCCFS and ARs from TCD relating to ACE survey administration was centred on providing information about ACEs and their potential negative impact across the lifespan. As the ECDSWs did not have an assigned role during survey implementation, participants from the ECDSWs' focus groups outlined that their training should have focused on intervening in and responding to children's ACEs. Participants explained that although the training helped them understand that ACE awareness was essential, they could not fathom why it had not described how they could integrate their acquired knowledge about ACEs into their work. This finding provides new insights surrounding the need for social care professionals to understand how they can implement ACE training into their work. It stresses the need for social care organisations to consider how administering the survey or increasing ACE awareness will transition into professional practice.

The current study's findings also provide unique insights surrounding using ACE-themed videos in preparing social care professionals to administer the survey. The literature indicates that ACE-themed videos are used in professional ACE training (Cork Education Support Centre, 2022; Trauma Matters Omaha, 2022; Children's Home Society of South Dakota, 2022). Despite this recognition, studies evaluating the effectiveness of these videos for training purposes were limited. The literature review for this thesis could only identify two studies which examined ACE videos, neither of which evaluated their use as training tools. The first was a study by Ford et al. (2021) which examined professionals' perceptions of a short-animated ACE film. This study explored the relationships between professional ACEs and their perceptions and attitudes about the film. The second study by Miller-Cribbs et al. (2020) assessed the video-based PATH training programme's use to address adversities during childhood with primary care medical students and occupational and physical therapy students. Although this study examined videos, these videos were role-play recorded by research participants as part of the PATH training programme. The study was not related to ACE-themed videos frequently implemented in professional training, such as the American film 'The Biology of Stress and the Science of Hope' (KPJR Films, 2020) or the ACE-themed videos developed by Wales (YouTube, 2022a), Scotland (YouTube, 2022b) and Northern Ireland (ESC Films, 2020).

This study established that the ACE-themed videos used in training professionals should be related to staff context and location. The ECDSW focus group participants were the only ones who recalled using videos as part of their DoCCFS training. Whilst FWs recalled seeing ACE-themed videos, these were not screened during their training. Participants from the ECDSW focus group explained that videos used in training should provide an understanding of how to converse with SUs and intervene in children's ACEs in the country where the social care organisation is based. Participants affirmed that using ACE educational videos from the USA was not helpful as they did not provide examples they could relate to in their work environment. Interestingly, participants who had been shown an ACE training video from a Welsh context noted that they found this helpful as they could understand the context. Participants advised that as people and the environment in Wales were similar to Ireland, the content covered in the video was easier for them to relate to and process for inclusion in their work. Participants from the ECDSWs emphasised the need to watch videos that provided them with practical insights about using ACE knowledge in their specific settings and familiar professional contexts. This finding is interesting because it indicates the need for social care organisations to consider and perhaps tailor the videos it shows to staff as part of training to prepare them to administer the survey.

11.2.2 ACE training did not consider the potential impact of professionals' ACEs

One of this study's most unexpected findings was that ACE training impacted staff who self-identified as having ACEs. During two of the three focus groups with ECDSWs, the impact of being asked to complete the ACE survey as part of training within the DoCCFS dominated the ensuing conversations. Participants with ACEs noted that being given the opportunity to complete the survey in a training session with the DoCCFS CPM made them feel afraid, uneasy, and ashamed. These participants attributed these feelings to the fear that other professionals would ask to see the responses they provided on the survey and know that they had encountered ACEs. Although participants reported that the DoCCFS CPM advised them that completing the survey was optional and strictly confidential, they noted that their concerns did not dissipate. Participants also reported feeling shocked that childhood experiences they had processed as being normative for children at that time in their area growing up were

considered adversities. This aspect of the finding is interesting as it correlates with one of the findings discussed later in this chapter. The finding in question concerns the perception of workers within the DoCCFS that SUs also could not always equate their childhood experiences with ACEs. This finding, relating to the negative emotions encountered by ECDSWs with ACEs, is stark compared to the experiences of participants within the current study who did not self-identify as having ACEs. These individuals reported that the training had no emotional impact on them whatsoever. Participants who did not self-identify as having ACEs could not recall being asked to complete the ACE survey during training.

This finding is unprecedented in the literature. Studies relating to professionals' experiences of being asked to self-complete the ACE survey were not evident in the literature. Unfortunately, the literature about administering the survey to SUs does not explain this finding as it does not extend to the impact on SUs when asked to self-complete the survey. The literature indicates that studies examining routine ACE enquiries have occurred with SUs in adult mental health, prenatal, housing and addiction services (Hillis et al., 2004; Dube et al., 2002; Larkin and Records, 2006; Read and Mayne, 2017) or; with parents of children in paediatric, primary care or family care hospital settings (Szilagyi et al., 2016; Brody et al., 2017; Kolta et al., 2018). The studies in these settings involved administering the survey by furnishing an envelope to adult SUs containing the survey and asking them to self-complete it (Selvaraj et al., 2019; Rose et al., 2016; Goldstein et al., 2019). Although adult SUs were asked to self-complete the survey, the literature does not expand to consider the emotional impact, if any, of self-completing it. It has not yet examined whether reading the questions alone, without the presence of a professional, can result in negative emotional implications. In addition, the literature indicates that most studies which implemented the survey did so to collect data for research purposes. These studies concentrated on routinely asking about ACEs; the prevalence of ACEs in specific populations; the types of health-risk behaviours adopted by research populations, the impact of routinely enquiring about ACEs on professionals and SUs, and identifying the types of adverse health outcomes that research populations experienced (Ford et al., 2019). In terms of this study, it is also important to highlight that the minority of studies implemented the self-completing envelope approach and that the literature which examined the emotional impact of survey administration on SUs focused on professionals verbally administering the survey. Generally, these studies determined

that SUs were open and receptive to being asked about their adversities during childhood (Edwards et al., 2007, Bethell et al., 2017; Counts et al., 2017). Literature concerning the impact of asking professionals to self-complete the survey as a mechanism to increase ACE awareness is absent within the literature.

This finding was unanticipated when developing the research questions as it was not evident in the literature. Interestingly, although the literature does not directly identify the impact of survey self-completion on professionals with ACEs, there are indications that professional ACEs have been emphasised as a consideration for health and social care organisations. The social work profession, in particular, has explored the impact of social work students' ACE scores on their learning and preparation for practice (Copeland, Howard, and Razuri, 2021; Lyter, 2021; Butler, Maguin and Carello, 2018). A study by Lyter (2021) to assess the extent of ACEs and resilience amongst social work students in a university in the USA determined that social work students had higher ACEs than students studying other subjects. Due to this, the author stressed the importance of social work training curriculums, including ACE education. The author indicates that this ACE training should include topics such as the potential impact of professional ACEs, post-traumatic growth, self-care, and developing coping skills to deal with work-related stress. Similarly, Grist and Caudle (2021) conducted a study which considered the relationship between professional-related burnout, personality traits, and ACEs in early childhood professionals in the USA and stressed that educational providers should recognise that early childhood educators may have elevated ACE scores compared with the general population. Brown et al. (2022) examined the possible correlation between therapists' positive and negative childhood experiences with experiences of compassion satisfaction, burnout, and STS in the USA. They determined that participants had elevated ACE scores. The authors of this study stressed that therapists should build awareness of how their childhood experiences may impact their professional practice.

Overall, this finding warrants further exploration. Given that the literature indicates that most SUs have interpreted being asked the questions as positive (Edwards et al., 2007; Bethell et al., 2017; Counts et al., 2017), it raises the question of whether professionals would also. The need for further investigation centres on determining whether professionals would experience the same emotional reactions if the survey were verbally administered to them. It also indicates the need to examine whether self-completion of the survey with professionals during training is

appropriate. The literature indicates that most ACE studies administered the survey to collect data for research purposes (Ford et al., 2019). The survey was administered to staff in the DoCCFS to bolster their ACE awareness and not to quantify or analyse their childhood adversities. Staff were advised that completing the survey was voluntary and strictly confidential. Despite this, the findings indicate that the option to self-complete the survey resonated negatively with them. The findings postulate that feelings of shame and apprehension for professionals may be more intense as disclosing one's ACE score in a work setting could be perceived as having undesirable consequences. This finding is significant because it indicates that social care organisations need to be aware that asking professionals about their ACEs to educate them about childhood adversities may not be perceived in the same way as asking for research purposes.

This study determined that even though being asked to complete the ACE survey resulted in negative emotions for ECDSWs with ACEs, it did not result in retraumatisation. This finding is consistent with the literature examining the impact of routine survey administration on SUs (Hardcastle and Bellis, 2019). Although ECDSWs experienced negative emotions such as fear, shame and uneasiness, the impact of being asked to complete the survey was not wholly negative. There were positive aspects. Participants with self-identified ACEs from the ECDSWs focus groups reported that completing the survey made them consider the intergenerational transmission of their childhood adversities. Although not related to the self-completion of the survey, this finding is consistent with the literature on SUs' experiences of routine ACE enquiry. An evaluation of a pilot routine ACE enquiry programme in a domestic violence service in Ireland by Morton and Curran (2019) also indicates that professionals reported that once SUs recognised that they had ACEs, they started to consider the intergenerational transmission effect. These implications included SUs recognising the positive aspects of parenting they had experienced. Some SUs would reflect on how their parents had tried to protect them from child maltreatment or exposure to other adversities. Participants in the study also noted that when SUs recognised that they had encountered ACEs and understood that they may have impacted their journey through life, they were less likely to engage in self-blaming. Participants described SUs as recognising their resilience and stressing the importance of improving the outcomes for their children.

In the current study, participants from the ECDSW focus groups who self-identified as having ACEs provided first-hand accounts of how completing the ACE survey had changed their perceptions of how they were parented and their parenting. This finding focuses on the personal and practice implications for professionals who self-complete the survey. Participants reported that completing the survey made them contemplate how their positive choices had reduced the potential negative implications of their ACEs on them and their children. Participants could identify the positive choices and experiences as their involvement in community groups and sports. In addition, they reported that completing the survey and training made them more empathetic towards their parents. It also helped them recognise the potential for the parents and caregivers of the children attending their ECDSC to stop the transmission of their ACEs. The participants described how the training had enabled them to acknowledge their potential and role in intervening in the intergenerational transmission of ACEs.

Although studies on the impact of knowing one's ACEs and the impact on professional practice were not evident in the literature, there was evidence that knowing one's ACEs could be positive for professionals during education programmes. The study's findings by Strait and Bolman (2017) affirmed that recognising and understanding one's ACEs, in conjunction with ACE and TIC education during professional training, could facilitate a better professional understanding of the impact of childhood adversities and trauma on SUs' lives. They affirmed that the results of their study are significant because it demonstrates that acknowledging personal ACEs can enable professionals to build better connections with patients through a scientific understanding of the impact of childhood adversities on their current difficulties. The current study finding adds depth to this by suggesting that the contemplation period following the completion of the survey resulted in increased motivation for participants with self-identified ACEs to explore the impact of childhood adversities on the families attending their ECDSC. It also suggests that although ECDSWs with self-identified ACEs reported that completing the survey resonated negatively with them, they also perceived personal and professional benefits.

11.2.3 ACE training and recollection differed according to role

This study found that the ACE training provided to staff members within the DoCCFS was not uniform. The data analysis conveyed significant differences in training

approaches and recollections depending on whether participants had attended the FC or the ECDSC training. Participants who attended the one-day FC training session with the TCDARs found it easier to recollect than those who participated in the ECDSC training. Most ECDSW focus group participants could not recall the training facilitated by the TCDARs. When asked about ACE training, ECDSWs referred to training provided by the CPM but generally could not recall the exact training content. They could only recollect watching the video, The Biology of Stress and Science of Hope and being asked to self-complete the ACE survey.

As FWs verbally administered the ACE survey, it is therefore not unexpected that the training provided to them by the DoCCFS differed from the ECDSWs. Although this finding is new, the literature explains why ECDSWs may have found it difficult to recollect the training. A study by Surr et al. (2020) which examined the barriers and facilitators to effective training for health and social care professionals, outlined that many factors influence participants' perceptions and recollections of training. The study determined that effective training must use interactive face-to-face learning and increase professional's knowledge and skills. Additionally, the study affirmed that training must incorporate opportunities to apply the learning in practice. The current study determined that the FW's recollections of training were of it being more intensive and practical than ECDSWs. FWs recalled their training implemented education about the first and subsequent ACE studies and explained how ACEs led to potentially adverse outcomes. A significant component of the training involved participants engaging in role plays. During these role-plays, FWs practised asking the survey questions and how they should respond to SU distress. Participants also had access to TCDARs to ask them questions and heard a first-hand account of survey administration within the DoCCFS DSF service from a colleague. The aspect of this finding relating to the importance of hearing a first-hand account from a colleague that administering the survey did not retraumatise SUs is significant. Although the literature indicated that retraumatisation was a significant barrier for professionals when administering the survey (Quigg, Wallis and Butler, 2018; McCrae et al., 2014), it did not extend to consider the benefits of inviting professionals who have administered the survey to speak with other professionals during training. This finding suggests that social care organisations considering introducing routine survey administration should invite practitioners who have lived experience implementing the survey to come and speak with professionals.

The FWs also noted how positive aspects of the trainer's personality were essential to their perception of and engagement in training provided by the DoCCFS. This finding is consistent with the literature. A study by Margiono and Hanafi (2020), which considered the relationship between trainers' personality characteristics and their impact on participants' perceptions of training effectiveness, determined that personality attributes were significant. The findings of this study determined that trainers' personalities were essential to ensure participant engagement in the learning processes. Trainers with pleasant personalities were found to develop positive learning relationships with participants, making them more open and motivated to learn. Similarly, a study by Ghosh et al. (2012), which considered how trainers' attributes resulted in more effective training, found that trainers participants perceived as being comfortable and knowledgeable about the training topic were better received. In addition, trainers who were warm, approachable, and open to answering questions were viewed as having a more positive rapport with professionals engaging in their training.

Since participants from that ECDSWs did not verbally administer the survey questions, their training did not incorporate practical application of implementing the survey, nor did it equip them with skills they could employ in everyday practice within the ECDSC. The fact that ECDSWs recalled watching the ACE-themed video as the main component of their DoCCFS training is interesting when considered in tandem with the earlier finding that they were the only cohort to remember watching ACE-themed videos during DoCCFS training. As discussed in this chapter, participants emphasised that videos implemented during training should be specific to their role and context and provide them with information and education about incorporating ACE knowledge into their professional practice. As the DoCCFS training did not provide ECDSWs with training materials or knowledge that they could transfer into their work, it is not unsurprising that it was more difficult for them to recollect the content. It is also unsurprising that they subsequently identified a deficit relating to a lack of applicability to their professional role and context concerning the ACE-themed video. This deficit in applicability may be why the ECDSWs were the only cohort to recall the ACE-themed video and critique it. Overall the ACE training was not memorable for ECDSWs because it did not relate to providing them with information that they could practically apply in their work. Although it increased their awareness of ACEs, it did not incorporate a practical component. This finding suggests the need for social care

organisations to ensure that the training they provide is practical and applicable to professional roles. It indicates that ACE awareness alone may not be sufficient for professionals and that social care organisations may need to train professionals on using ACE knowledge in their everyday working practices.

11.2.4 The potential emotional impact on staff should have been considered

The findings of this study indicate that the DoCCFS did not sufficiently consider or account for the potential negative emotional impact of administering the survey on FWs. Participants from the FW focus groups reported that verbally administering the survey to SUs had negative emotional implications for them. These emotions related to feeling drained and tired after observing distressed SUs. They also involved feeling concerned and anxious about the welfare of distressed SUs when they left. Participants affirmed that they could not understand why the ACE training provided by the DoCCFS to prepare them to administer the survey had not incorporated a component about professional self-care or regulating their emotional responses. Although the literature notes that routine ACE enquiry can cause fear and apprehension for professionals, it does not consider whether there should be training components to equip professionals to deal with these emotions.

Even though literature is lacking relating to this particular training issue concerning the administration of the ACE survey, there is some evidence to explain why FWs emphasised the need for a self-care component in training. Interestingly this literature relates to an issue of concern for DoCCFS that permeates throughout the findings of this study and will be discussed in greater detail at several points within this chapter. This concern relates to FWs' obligations to report instances of retrospective child maltreatment arising from responses to the survey by adult SUs. A study by Pellegrini et al. (2022), which examined the mandatory reporting experiences of psychologists in Ireland, conducted three focus groups with eighteen participants. Study participants were professionally qualified psychologists working for the national health service, the Health Service Executive in Ireland, who had been required under mandatory reporting legislation to report their client's current and retrospective experiences of child maltreatment. This study established that participants perceived that retrospective reporting, in particular, had the potential to damage the therapeutic relationship. They noted that adult clients would become upset and that participants found it challenging to feel comfortable with causing this distress. The findings of this

study determined that the requirement for mandatory reports had a profound impact on participants. Participants reported invoking maladaptive coping behaviours, such as avoidance and rumination, to regulate these emotions. They reported engaging in excessive contemplation and perceiving themselves as engaging in similar abusive behaviour to the client's experience of child maltreatment as they opened them to a situation where they felt powerless. Given that most FWs within the DoCCFS had dual therapeutic training, it is not unexpected that they could have experienced similar emotional responses. This finding is important because it affirms the need for social care organisations to include a component about self-care and emotional regulation skills for workers tasked with verbally administering the survey, especially in the context of a mandatory requirement to report retrospective child maltreatment.

11.3 What was the experience of transitioning to the routine administration of the ACE survey like for FCMs, ECDSMs, FWs and ECDSWs?

This section of the chapter relates to the second research question of this study. This question aimed to establish the experience of transitioning to routine survey administration for managers and staff within the DoCCFS ECDSCs and FCs. Several themes emerged within the findings, indicating that although the overall experience of transitioning was positive, it was also complex. The themes which evolved from the data indicated that aspects of the transition experience for managers and staff within the DoCCFS were practically and emotionally challenging. Therefore, the discussion of these themes will be subdivided into two headings, themes related to practical challenges and those related to emotional challenges.

11.3.1 Practical challenges

This study's findings established that the organisation considered several practical issues before including the survey in the OMS. This period of consideration constitutes new information for the ACE evidence base. The DoCCFS is a social care organisation. It is not a clinical setting. Identifying practical challenges that the DoCCFS encountered proves significant in light of the scoping literature review by Ford et al. (2019). This literature review examined the evidence base for routine ACE enquiry and determined that most ACE studies had been undertaken in clinical settings. The authors of this review established that the studies' focus in these settings concentrated on the clinical

enquiry process and health implications. Most of the studies centred on routinely asking about ACEs; the prevalence of ACEs in specific populations; the types of health-risk behaviours adopted by these populations; the impact of routinely enquiring about ACEs on professionals and SUs, and identifying the types of adverse health outcomes that these populations experience. The current study's findings indicate that the DoCCFS introduced the survey for different reasons. Integrating the ACE survey as part of the OMS was to gather data about SUs' ACEs so that the organisation could both evidence the complexity of its work and inform future service development. The DoCCFS SMT also believed that this evidence would inform funding applications. Unlike clinical settings, the DoCCFS did not have as clear a pathway for implementing the survey within the organisation. The findings from this study are significant because they provide new insights into one of the identified literature gaps, as outlined in chapter 3, relating to using the survey as a research tool in social care settings. This study provides an understanding of the practical issues that the DoCCFS encountered and responded to when implementing the survey in a social care setting.

The first practical issue indicated in the findings was the need for the DoCCFS SMT to consider how they would effectively disseminate the findings associated with the data collected as part of the OMS. As the rationale for implementing the OMS emanated from the organisations' previous collaboration with ARs from UCD, the DoCCFS SMT recognised the importance of partnering with a university to ensure that the data, including that collected as part of the ACE survey, would be collected and analysed effectively. The SMT were also confident that a partnership would increase the likelihood that the OMS data would lead to publications in academic journals. The SMT perceived publishing in academic journals as the most efficient way to emphasise and evidence the complexity of the work that the DoCCFS was undertaking with SUs. Although not yet evident in the literature concerning the survey, this finding is not surprising. McGrath (2016) asserts the importance of organisations ensuring that the results of research projects are broadly disseminated so that their conclusions and recommendations can benefit other professionals. The author explains that academic journals are the primary dissemination pathways for research conducted by organisations. ARs have also been identified as the primary submitters to academic journals (Hottentrot, Rose and Lawson, 2021). Given that the literature reviewed for this thesis suggested that research collaborations between professionals working in organisations and researchers can increase the potential of publishing articles in

academic journals (Mohajerzad, 2021), it is not surprising that the DoCCFS SMT identified this as an essential consideration.

The second practical issue evident in the findings was that the SMT determined that ensuring DoCCFS ownership of the data collected as part of the OMS was an important consideration. Participants from the SMT interviews reported that securing funding to implement the OMS required careful consideration. They noted that they understood that they needed to identify a funder that would allow the organisation to disseminate the research data effectively. The participants defined effective dissemination as facilitating the organisation to share the research data to secure funding to support the organisation's continued work. The organisation wanted to evidence the complexity of the work it provided to families to support future funding applications. As outlined in chapter 7, the SMT participants asserted that they recognised that regular funding channels would have presented barriers. Due to this, the DoCCFS made a funding application to the DoC As the DoC had a long history of positive engagement with the DoCCFS and provided funding for other research projects, the SMT felt they were the preferred funding source. The SMT participants noted that as they had previously funded research projects within the DoCCFS, they knew that the DoC would give due consideration to their research proposal and had sufficient confidence in the DoCCFS to facilitate the required autonomy over the research data. The SMT also noted that the pre-existing relationship between the DoC and the organisation meant that the DoCCFS staff would be more willing to engage in the OMS research project.

Although not evident as yet in the literature on administering the ACE survey, the need to clarify data ownership before organisations conduct research was apparent. McGrath (2016) explained that ownership of research data could hinder an organisation's dissemination of findings. McGrath (2016) stresses that an organisation must have autonomy over data to ensure it can control how and with whom the research results are shared. In addition, McGrath (2016) affirms that organisations should negotiate data ownership before conducting research projects. Given that the DoCCFS's motivation was to disseminate the findings of the Outcome Measures Research project, it is not surprising that the organisation understood the need to identify a funder that would facilitate autonomy to do so. An additional perspective offered by this finding to routine survey administration relates to the fact that the organisation recognised that the funding source could positively or negatively

influence staff buy-in. Participants from the DoCCFS SMT interviews noted that they were eager to secure funding from the DoC because doing so would positively impact staff willingness to engage in the Outcome Measures Research. This perception is not unexpected given that the literature suggests that a lack of buy-in to engage in change processes within an organisation can result in staff obstruction (Lau et al., 2016). The SMT recognised the importance of obtaining funding from a source that staff respected.

11.3.2 Buy-in from those asking ACE questions was viewed as paramount

Obtaining staff buy-in also emerged as the third practical consideration from the findings. This study found that ensuring staff buy-in was a pervasive factor from the outset of the survey implementation process. In particular, the need to ensure acceptance of ACE survey implementation from staff within the DoCCFS FCs was prioritised. As the FWs were the only staff within the DoCCFS tasked with asking the survey questions, the SMT understood that this cohort of staff would encounter the most challenges. This finding is not unexpected as it was highlighted as an essential consideration for organisations when engaging in a change process (Stein, Swerlick and Chokshi, 2020). Findings indicate that the SMT anticipated resistance from therapeutically trained FWs. Participants from the SMT interviews noted that they expected resistance from this cohort of workers because they understood that their training could make them more cognisant of and concerned about the potential distress caused by the survey administration to SUs. This finding is somewhat consistent with the literature, which indicates that professional resistance to administering the survey is expected and that professionals are more resistant to routine administration than SUs (Sziligyi et al., 2016; Anderson et al., 2015; Dube, 2018). This finding, however, adds a new perspective to studies examining survey administration. It indicates that professional resistance to the survey expands beyond studies which link resistance to professional anxiety associated with asking SUs about their ACEs and feeling ill-equipped to respond to any potential distress that enquiry may cause (Sziligyi et al., 2016; Anderson et al., 2015; Dube, 2018).

This study found that despite some FWs having therapeutic training that enabled them to respond to SU distress, they resisted the prospect of routine ACE survey administration and remained concerned about the potential negative impact on SUs throughout the implementation process. The findings of this study indicate that the resistance demonstrated by FWs within the DoCCFS appeared to be related to

feeling unsure about the benefits of the survey when weighed against potentially upsetting adult SUs. It also appeared to be connected to the fact that they felt that the therapeutic support required could not be facilitated as it was not part of the organisation's remit, and there were also time constraints. The literature provides a basis for understanding this aspect of the finding. Fuller et al. (2018) argue that for change to be successful, staff must identify the work purpose associated with the change. The authors define work purpose as staff understanding how the change in their work will benefit the organisation's purpose. Although the FWs understood the rationale for introducing the survey within the DoCCFS, this study determined a disconnect for participants from the FW focus groups between the rationale and how effective changes arising from the survey data would be developed or implemented. This lack of a clear pathway led to some FWs querying the benefits of potentially upsetting SUs, resulting in resistance and expressions of concern. Damian et al. (2017) argue that when planning change, organisations must consider the ability and willingness of staff to collaborate with the proposed change. Although there is an identified gap in the literature surrounding the routine administration of the ACE survey in social care settings (Ford et al., 2019), this finding indicates that the DoCCFS recognised that there would be resistance and spent time considering how it would obtain buy-in from FWs.

The expected resistance from therapeutically trained FWs resulted in the decision to stagger the implementation of routine ACE survey administration within the organisation. An interesting aspect concerning this finding was the decision by the DoCCFS SMT to transition staff to administering the survey after a period of them implementing the Stressful Life Events Schedule (SLES). As outlined in chapter 1, the SLES was one of the research measures included in the OMS. The SLES measures assess stressors in children's and adolescents' lives (Williamson et al., 2003). The findings of this study indicate that the DoCCFS SMT perceived the SLES as a softer version of the ACE survey and therefore identified it as an appropriate research instrument to prepare FWs for the implementation of the survey. The SLES required FWs to ask adult SUs about their children's exposure to several stressful life events. These events included whether their children had experienced the death of a close family member or friend, parental separation or divorce, moving house or country, being diagnosed with a severe illness or injury or having a family member diagnosed with the same, living in a foster home or residential care, family member with mental illness or

addiction issues, and conflict between parents. The findings of this study indicate that the SMT's initial perception of resistance to the ACE survey was reinforced when they heard the FWs' feedback about implementing the SLES. As the FWs noted that the research measures in the SLES were difficult to ask, the SMT understood that the routine survey administration training needed to be both practical and emotionally reassuring for FWs. In order to transition the FWs to routine administration of the survey, the SMT and ARs from TCD developed training that facilitated role plays and enabled FWs to hear accounts of ACE survey implementation from a staff member from the DoCCFS DSF service.

Participants from the SMT and FW interviews and the FWs focus groups acknowledged that although FWs initially perceived the one-day training as beneficial, staff anxiety persisted as the date for routine administration approached. In light of this, the FCMs recognised the need to introduce survey role plays into staff meetings and to focus on how FWs should administer the survey and how they could respond to potential distress. The findings further indicate that administering the survey within the DoCCFS required a third phase before the FWs started to administer the survey. The literature accounts for this persistent anxiety. Agboola and Salawu (2011) explain that initiating change within an organisation can require staff to acquire new or alter existing practice skills and approaches. The authors affirm that change can result in staff entering unchartered territories where they encounter unexpected challenges and obstacles. Therefore, it is not surprising that administering the survey evoked anxiety in FWs, which resulted in the need for additional training. Due to the lack of literature relating to survey implementation research in social care settings, this finding is significant because it demonstrates how a social care organisation like the DoCCFS may attempt to obtain buy-in from its staff. It is also interesting because it suggests that because the strategy of staggering ACE survey implementation by introducing the SLES failed, it enabled the SMT and TCDARs to identify specific training needs for social care staff in administering the survey.

11.3.3 The rationale for routine administration of the ACE survey was key

The findings of this study emphasise the importance of social care organisations establishing a clear rationale for asking staff to administer the ACE survey. It also affirms the need for social care organisations to communicate clearly and consistently with all staff members about the rationale. Although participants from the SMT

interviews appeared to clearly understand the rationale for integrating the survey into the OMS, the understanding was inconsistent in other participant groups. The ECDSWs, for example, noted that as they were not tasked with asking the survey questions, they did not know why the organisation was asking SUs about adversities during childhood. They further advised that communication with them about the DoCCFS integrating the survey as part of the ECDS OMSs did not occur. ECDSWs noted that this lack of communication resulted in obstacles for them. They noted that they found it challenging to advise adult SUs about why the ECDSCs were using the survey. Consistent communication with all staff during a change process emerged as an important consideration in the literature. A study by McCrae et al. (2014) exploring child welfare workers' reported willingness and readiness to engage in organisational change determined that consistent consultation and communication with all staff, regardless of their role or position, was essential to ensuring organisational buy-in during change processes.

By comparison, FWs knew the SMT's rationale for the ACE survey implementation. Participants from the FW focus groups reported that the rationale was related to demonstrating the complexity of the work the FCs were engaged in, bolstering funding opportunities and improving the services offered within FCs. However, findings indicate that they did not feel that the rationale was realistic, as information about how to transition ACE data to meet the objectives suggested by it was not readily available. FWs also noted that they could not clearly understand how the survey data could be used to bring about the changes suggested by the rationale. This uncertainty added to their concerns about the potential distress caused to SUs. Participants stressed that they found it challenging to justify upsetting SUs when they could not explain how answering the survey questions would benefit them. This attribution of importance to establishing a clear rationale is not unexpected, as the literature indicates that if an organisation wants to be successful in conducting research projects, it must first establish clear aims and objectives for the study (Thomas and Hodges, 2011). In their paper which examined the importance of creating a convincing rationale for research studies within organisations, Rojon and Saunders (2012) stressed the need for establishing a convincing rationale. The authors affirmed that providing a good rationale for a research study ensures that participants recognise the importance of conducting the research. They further suggest that a clear rationale

should outline how the study's results add to existing literature and how it will help improve professional practices relating to the research topic.

Establishing a clear rationale has also emerged as an essential consideration in survey implementation models. The REACh model developed by Quigg et al. (2018) outlines that the first stage of implementing routine ACE survey enquiry is establishing the organisation's motivation for considering routine administration. The findings of the current study are consistent with this recommendation. They determined that the rationale for survey implementation did, to some degree, influence workers' perceptions, motivations, and experiences during the administration process. Although the DoCCFS SMT had established a clear rationale for integrating the survey as part of the OMS, findings indicate that it was insufficient justification for staff within the organisation.

11.3.4 Some critical practical issues were not considered

Findings from the study indicate that the DoCCFS encountered unforeseen practical issues whilst implementing the survey. These issues related to the need to consult with SUs to obtain their perspectives about being asked to complete the survey, the need for consistent communication with staff beyond the training phase and the need to address the increase in paperwork from administering the survey. The data analysis for this study found that these practical issues emerged as either challenges or criticisms during the survey implementation process for the DoCCFS staff.

This study determined that staff within the DoCCFS attributed significant importance to social care organisations consulting SUs before implementing the survey. This perception appeared to be motivated by the need for reassurance from adult SUs that completing the survey questions would not cause them distress. Not consulting with SUs meant that staff within the organisation were more apprehensive about the possible negative impact of asking survey questions for SUs. Although this finding adds a new perspective to the survey implementation literature, it is not entirely unsurprising. In his book, which examined the resources and tactics for managing organisational change, Bevan (2011) argues that organisations must obtain feedback from stakeholders who will be most impacted before implementing any change. The author further argues that stakeholder opinions are essential and should be considered. Given the level of concern relating to SU's potential distress in administering the survey, it is unsurprising that staff within the DoCCFS identified

obtaining SU's perspectives as vital for social care organisations. The implications of this finding indicate the need for other social care organisations to consider introducing structured and proven formats for obtaining SU feedback prior to implementing routine survey enquiry. The literature outlined that organisations that used SU advisory boards to help inform service development and delivery reported positive results (Price and Feely, 2017; Rosenberg and Hillborg, 2016).

The need for consistent communication was not limited to the ECDSWs' lack of understanding of the rationale for integrating the survey within the DoCCFS. The findings also identified the need for consistent communication as a preference for FWs. Participants from the FW focus groups noted that they were disappointed by their lack of access to ARs after the DoCCFS training day. They further reported that they did not feel that they had adequate and consistent communication with the DoCCFS SMT about survey administration. Although the FWs reported that the OMS champions played a pivotal role in communicating on their behalf, they asserted that they preferred to communicate directly with the DoCCFS and ARs from TCD. This need for consistent communication is evident in the literature about ACE survey implementation models. The REACh model for implementing routine enquiry about ACEs in organisations developed by Quigg et al. (2018) specifies that implementation should include a follow-up and support stage. The authors describe this stage as engaging stakeholders within the organisation to ensure they understand their role in implementing routine ACE enquiry, ascertain how the implementation process is going, and provide staff with additional support if and when required.

Previous studies examining the routine administration of the survey have identified multiple practical obstacles. These obstacles include professionals feeling ill-equipped to administer the survey questions due to inadequate training and inability to provide support if SUs become distressed (Walsh, 2002; Follette et al., 1994). In addition, other obstacles include the negative impact of time constraints and the lack of available resources to offer SUs (Becker-Blease and Freyd., 2007; Kerker et al., 2015). The findings of this study identified another practical obstacle which was not evident in the literature, the increase in paperwork arising from survey administration. This finding may relate to the fact that the survey was integrated into a broader research document, the OMS. This document required SUs within the DoCCFS to answer questions concerning multiple research instruments and the survey. The possibility that this perception regarding the increase in paperwork is motivated by

integrating the survey into a broader research document proves significant. Integrating the survey into a broader research instrument requires those administering it to ask and record data for multiple surveys. It proves to be an important consideration for other social care organisations, as it suggests that they need to consider the paperwork associated with integrating the survey into a broader research survey as a potential barrier.

Another possible explanation for staff within the DoCCFS identifying increased paperwork as an obstacle could relate to times when staff submitted retrospective and current child maltreatment referrals to statutory child protection services as a result of administering the survey. The quantitative findings, however, do not adequately support this explanation. During the eight-month time frame for the current study, the ECDSCs encountered just two current and thirty retrospective positive child maltreatment responses to the survey. Even if all of these reports warranted referral to statutory child protection, they would only account for, on average, one referral weekly. Given that there are five ECDSCs, this would mean each centre only referred, on average, one case every five weeks. The quantitative findings from the FCs also indicate that the increase in paperwork during the study timeframe was unremarkable. Survey responses included sixty-two current and fifty-seven retrospective instances where referral to child protection services concerning child maltreatment needed to be considered. Even if all of these instances warranted referral to statutory child protection services, the increase in the paperwork was minimal at three to four referrals per week total for the entire seven FCs. This quantitative finding indicates that half of the centres did not encounter the need to submit any referrals at all.

11.3.5 Staff noted practical difficulties with the ACE survey questions

This study determined that DoCCFS staff encountered practical difficulties administering the survey questions. The first of these challenges was noted as the difficulties in administering the survey with SUs who were illiterate in English. As the OMS was in English, the study established that DoCCFS staff perceived this lack of accessibility as an injustice. This study's quantitative data results provide an interesting perspective as they indicate that Irish adult SUs predominantly completed the survey. The number of ACE surveys completed by non-Irish national parents and caregivers in the ECDSCs was 41% (n=41), and 17.5% (n=22) of the adult SUs who completed it in the FCs were not Irish. Similarly, the completion of the survey for non-

Irish children attending the DoCCFS during the study timeframe was lower than those completed for Irish children. Of the 115 parents or caregivers who completed the OMS in the ECDSCs, 28 indicated that their child was not Irish. Comparatively, the FCs had a much lower number of non-Irish children, with 8 parents or caregivers identifying their child as a non-Irish national. The number of children attending the ECDSCs may be higher due to the aggregated format of the data. One of the ECDSCs who participated in the current study was based in Mosney, a reception centre for refugees and asylum seekers. The fact that the ACE survey is predominantly administered in English was consistent in the literature, which suggested that survey implementation and subsequent research publications have emanated from countries where the primary spoken language is English (Hughes et al. 2017; Massetti et al. 2020). Even though the WHO has developed a version of the survey, which can be implemented in all countries (WHO, 2022), the literature indicated evidence of the survey being translated into different languages for non-English speaking research populations in predominantly English-speaking countries is also limited. Interestingly, a systematic literature review by Rariden et al. (2021), examining the perspectives of clinicians and patients regarding the feasibility and acceptability of ACE screening in the USA, determined that proficiency in English is one of the most consistent inclusion criteria for participants in ACE studies.

The observation by DoCCFS staff regarding the injustice of administering an English version of the survey is also consistent with existing literature. Squires, Sadarangani and Jones (2019) argue that researchers must consider and address a participant's language to ensure their voices are heard during the research process. In their paper describing best practices for implementing cross-language research with participants, they indicate that not considering this issue precludes participants from sharing vital information that could be used to inform service provision and policies (Squires, Sadarangani and Jones, 2019). This finding is significant as it offers new insights for the ACE evidence bases and reemphasises previous findings discussed within this chapter. The finding indicates that the rationale for introducing the survey was vital because it influenced staff perceptions during the survey administration process. Interestingly, this study determined that the perception of injustice relating to the English-only version of the survey stemmed from the staff's perception that some SUs' ACEs would not be considered during the organisation's development of new services arising from the survey data. FWs and ECDSMs noted that as part of the

rationale for survey implementation was to improve service provision, it was unacceptable that SUs who could not complete the survey due to English literacy difficulties would be excluded.

In addition, the findings of this study indicate that the wording of the survey questions was too complicated for some SUs to understand. Participants from the FW focus group advised that they had encountered adult SUs who did not understand the terminology contained within the questions. Participants from the ECDSW focus group reported similar instances when they had been approached by SUs who informed them that they had comprehension difficulties following their self-completion of the OMS. The perception of literacy as an obstacle is interesting when considered alongside this study's quantitative results. The quantitative results indicate that most parents and caregivers who completed the OMS questions within the ECDSCs and FCs during the study timeframe had no literacy difficulties. Results from the ECDSCs indicate that only 4% (N=4) reported literacy difficulties in response to the question related to whether they could read an English children's storybook aloud, and 2% (N=2) disclosed English comprehension and writing difficulties in response to the question about whether they could read and complete forms in English. These results indicate that during the study's eight-month timeframe, the OMS data indicates that only six SUs self-reported some literacy difficulties. Comparatively, quantitative results from the FCs, indicated that literacy difficulties were also not prevalent for 98.2% (N=112) of SUs. Only 1.8% (N=2) noted literacy challenges regarding both questions. The quantitative results for the FCs and ECDSCs do not support the perception that literacy difficulties were frequent or noticeable to DoCCFS staff. However, this finding could indicate that those with literacy difficulties or who did not speak English as a first language did not complete the survey. Therefore the information was not captured as part of the data collection process. The ECDSCs and FCs may have encountered multiple SUs who informed them that they could not complete the ACE survey as part of the OMS, and due to non-completion, this information was not captured in the data.

This study found that staff within the DoCCFS had concerns about the limited number of adversities the survey captured. Participants emphasised that the information collected was lacking because the survey questions did not collect data representative of all challenges encountered by DoCCFS SUs during childhood. Specifically, participants observed that the survey did not have questions about homelessness, poverty, the impact of seeking asylum in Ireland, racism, discrimination,

and experiences of chronic illness by the child or a family member. The quantitative findings of this study verify that these additional adversities may have been prevalent for children attending the DoCCFS FCs and ECDSCs. The data collected regarding families' financial means, in particular, indicates that a significant proportion of adult SUs who completed the OMS in the FCs encountered some degree of difficulty in meeting their financial obligations. When asked about the degree of ease in meeting their household costs, 42.1% (N=53) of adult SUs reported that they did so with some difficulty, and 6.1% (N=7) noted that they met their financial obligations with great difficulty. These findings are similar to those of the CSO SILC in 2022, which determined that 42% of the Irish population reported some degree of difficulty, and 5.6% reported great difficulty. This finding, therefore, may be indicative of the Irish economic climate (CSO, 2022a). In addition, 36% (N=41) of adult SUs reported being unemployed and financially dependent on social welfare benefits. Compared with the CSO 2016 census data, this level of unemployment is higher than expected, as the Irish population's unemployment level was reported to be 12.9% (CS0, 2022d). The socio-demographic data from the ECDSCs yielded similar results, with 36.5% (N=35) of parents and caregivers indicating difficulty meeting their household costs and 7.3% (N=7) reporting great difficulty doing so. Unemployment was lower for parents and caregivers within the ECDSCs, with 20.8% (N=20) noting that they were financially dependent on social welfare payments to meet household costs. Although experiencing financial difficulties does not necessarily mean that these families were living in poverty per se, it does suggest that asking families about whether their financial difficulties were impacting the families' well-being may have been helpful.

The quantitative data on children experiencing insecure housing or homelessness was not as stark. Only 10.6% (N=10) of ECDSC parents or caregivers indicated that their families lived with family members or in direct provision, and 3.5% (N=4) of FC adult SUs reported that their families were residing in voluntary homeless accommodations or hostels. Even though participants within the study reported that due to how common it was that homelessness should be considered as a question on the ACE survey for DoCCFS SUs, the data collected as part of the OMS might not indicate all the homelessness levels observed by staff within the DoCCFS, it is possible that the families experiencing homelessness did not complete the survey or chose not to disclose their accommodation type. Although the study's quantitative findings indicate that homelessness was not common for families attending the DoCCFS services during

the study's timeframe, it does suggest that some children did not have secure accommodation. It is, therefore, not surprising that DoCCFS staff highlighted the need to consider this as an ACE and to capture it as data so that it could be used to inform future service provision.

Overall this finding is not unexpected as it was evident as one of the criticisms of survey implementation in the literature. Kelly, Irving and Delpierre (2019) argue that the original and most of the subsequent ACE studies have not recognised the contribution of socioeconomic circumstances to adverse outcomes. They affirm that deprivation and poverty should be considered co-predictors alongside ACEs when developing public health policy to respond to and intervene in disease pathways. Similarly, Steptoe et al. (2019) argue that adversities are more complicated and diverse than those captured by the original ACE questions. The need for additional ACE research measures was also evident in a study by Merskey, Jancezewski and Topitez (2017). This study involved a sample of women (N=1,241) of lower socioeconomic status who availed of home-visiting support in the USA. As part of this study, the researchers implemented ten of the original survey questions alongside seven potential new ACE research measures to examine the prevalence of conventional and potential ACEs and their correlation with adverse health outcomes. Results from the study determined that the ten conventional ACEs were prevalent in the research population. Participants also endorsed the seven potential new survey measures. Mersky, Jancezewski and Topitez (2017) affirm that the study's results indicate that adversities during childhood are broader than those accounted for in the original ACE measures and that additional ACE measures should be developed and validated for use in subsequent studies.

Consistent with previous findings discussed in this chapter, this finding reiterates the significance of an organisation's rationale for implementing the survey for staff. Participants affirmed that because the DoCCFS's rationale was to use the survey data to inform service delivery, the staff grew concerned because it became apparent that the survey questions did not reflect the range of challenges encountered by the SU population. Although this finding is consistent with the literature, this study offers new insights into the ACE evidence base. It suggests that social care organisations should consider using additional ACE research measures and consult with staff about their perception of the most common ACEs experienced by SUs. Overall the practical obstacles experienced by DoCCFS staff with administering the survey

measures enforce the need for social care organisations to consider how their rationale for survey implementation will be perceived by staff. Social care organisations should contemplate whether and if the expectations indicated by their rationale could negatively impact staff perception.

11.3.6 There was an unanticipated end to the routine ACE survey administration

The current study's findings indicate the importance of organisations establishing a timeframe for administering the ACE survey. Although the first ACE study tracked participants for over twenty years (Prewitt, 2020), subsequent studies appear to focus on piloting routine ACE enquiry for a specific timeframe or collecting data about childhood adversities for new patients or SUs (Quigg, Wallis and Butler, 2019; Morton and Curran, 2019; Lambert et al., 2017). The literature further indicates that subsequent studies pertain to the results of administering the survey to gather data for time-constricted research projects (Bellis et al., 2016). As the DoCCFS introduced the survey as part of the OMS, the study determined that the SMT and TCDARs did not anticipate when they would stop administering it. As the OMS is a continuing research project, the DoCCFS's decision to cease survey administration was influenced by two factors. These factors included the impact of the COVID-19 social distancing measures on survey implementation and the persistent reports from FWs that administering the survey negatively impacted their therapeutic relationships with SUs.

Although the ACE evidence base does not include literature relating to the impact of COVID-19 on the administration of the ACE survey, the existing literature provides some understanding of the concern expressed by DoCCFS staff. When COVID-19 social distancing measures were introduced in Ireland, the findings of this study indicated that as adult SUs could not attend the FCs or ECDSCs in person, staff perceived this as a barrier in the DoCCFS administering the survey. A study examining Physician's ACE screening practices and knowledge in Canada by Maunder et al. (2020) found that one of the most prominent barriers to asking ACE questions was the physician's perception that it would cause distress for patients (McCrae et al., 2014). Participants from the SMT interviews noted that FWs, in particular, expressed such concerns. As the FWs could not administer the ACE questions in person to adult SUs and pick up on important body language cues which would enable them to provide

emotional support if they became distressed, they expressed reluctance. Although findings indicate that some FWs attempted to implement the survey over the telephone, concerns arose about how appropriate this approach was if adult SUs became distressed by the questions. Ford et al. (2019) identified one of the most pronounced barriers to ACE enquiry as occasions when professionals feel that they cannot provide emotional support to the SU should they become distressed. This finding is important because it suggests that apprehension concerning the distress that the survey may have caused resulted in staff within the DoCCFS attributing significant importance to administering the survey in person.

COVID-19 social distancing measures were not the only factor which led to the DoCCFS's decision to stop administering the survey; the SMT also highlighted the reported negative impact on FWs' therapeutic relationships with SUs as a precipitating factor. This finding is interesting because of the contradictions between reported FW experiences and concerns and the perception held by the SMT of the impact of routine ACE enquiry on the therapeutic rapport. This finding was not evident in the literature. The findings of a systematic literature review by Cibralic et al. (2022) examining the implementation of ACE screening in paediatric healthcare settings affirm that professionals in the study identified asking SUs about childhood adversities as strengthening the therapeutic alliance. Participants from the SMT interviews reported that although FWs asserted throughout the implementation process that administering the survey negatively impacted the therapeutic relationship with SUs, they had no evidence to support this. During the administration process, there were no reports of suspected SU retraumatisation, no SU had ever complained, and FWs' discomfort with administering the ACE survey questions appeared to have dissipated over time. This study determined that the SMT were perplexed by FWs' observations that routine administration negatively impacted the therapeutic rapport and understood that it was something they needed to consider if they were going to continue administering the survey.

This finding is important because it emphasises the need for further exploration to determine what constitutes a negative impact in therapeutic relationships. The findings also affirm the need for social care organisations to collaborate with therapeutically trained professionals before and during survey implementation to identify and respond to any challenges they encounter or to provide support.

11.4 Emotional challenges

Consistent with previous studies (Cibralic et al., 2022; Morton and Curran., 2019), this study determined that the introduction of administering the survey within the DoCCFS was a positive experience for the organisation. Participants from the SMT interviews affirmed that they did not regret implementation as it led to the organisation becoming more ACE-aware and responsive. Furthermore, they reported that ACE survey implementation helped the organisation to quantify and demonstrate the level of complexity encountered. Similarly, participants from the ECDSM and FCM interviews reported that survey implementation was positive for their respective centres. They also declared that they did not regret the organisation's decision to implement it. Despite this perception, and although participants from the FW and ECDSW interviews reported positive aspects surrounding the routine administration, they also reported that their experiences had evoked emotional challenges. The next section of this chapter will discuss the findings concerning the emotions experienced by DoCCFS staff members whilst transitioning to routine administration.

11.4.1 The potential impact on SUs was considered

This study established that before introducing routine administration of the survey within the DoCCFS, the SMT had initial reservations that doing so could label SUs or evoke feelings of shame in them. The study determined that after consideration, the SMT were confident that their collaboration with ARs from TCD would ensure that SUs would not be adversely impacted. The SMT were satisfied that they could deliver training that would equip staff to ask the survey questions in a manner that would reduce the possibility of evoking feelings of shame in SUs. They were also confident that they could collaborate with the ARs from TCD to ensure that the findings were framed in a way that did not stigmatise or label the DoCCFS SUs. The need for professionals to consider labelling SUs is evident in the literature. In particular, the literature focuses on the emergence of trauma-informed approaches in response to increased interest in the ACE evidence base. This literature indicated that professional interpretations of SU's experiences could result in unjust labelling (Khasnabis and Goldin, 2020). Professionals' perceptions and understanding of trauma were identified as having the potential to lead to them unfairly labelling SUs as distressed or vulnerable Lamphere, (2021). Reuben et al. (2016) stressed that when a professional labels

someone as traumatised, it can result in prejudices and cloud their judgement and responses.

The fact that some SUs experience shame in response to ACE enquiry was evident in the literature. Findings from a study by Mersky, Plummer-Lee, and Gilbert (2019) exploring client and provider discomfort with the survey in home visiting programmes in the USA offer a unique insight. This study asked home visitors to self-complete the ACE questionnaire. It also requested home visitors to ask clients the ACE questions. After both processes were complete, home visitors and clients were asked about their level of discomfort with the ACE questions. This study found that individuals with a history of CSA reported elevated rates of discomfort with the questions across both participant groups. The authors say this finding is consistent with research, which indicates that sexual abuse questions may evoke feelings of shame and distress in those who have experienced this type of abuse (Mersky, Plummer-Lee, and Gilbert, 2019). Although the literature indicates that adverse emotional implications for SUs can act as a barrier to survey implementation (Mersky, Plummer-Lee, and Gilbert, 2019; McCrae et al., 2014; Maunder et al., 2020), it does not extend to explaining what organisations can do to counteract this potential negative impact. The fact that this study established that the DoCCFS SMT considered the potential impact of the survey as resulting in unjust labelling of SUs or them feeling ashamed is a significant finding. The significance of this finding relates to the need for the DoCCFS to consider how it would ameliorate the possible negative emotional impact on SUs from administering the survey.

11.4.2 Apprehension was primarily related to the impact on adult SUs

The findings of this study indicate that worker apprehension about the potential negative impact of asking the survey questions only related to adult SUs. As adult SUs are usually tasked with answering the survey questions, it is not unsurprising that anticipated distress is relative to their experiences. This finding is not unexpected. The literature suggests that most subsequent ACE studies have centred on adult SUs' recollections of childhood adversities (Hillis et al., 2004; Dube et al., 2002; Larkin and Records, 2006). The literature further establishes that when the survey was administered to determine the ACEs of children and adolescents, it was common for parents or caregivers to complete the survey (Sziliagyi et al., 2016; Brody et al., 2017; Kolta et al., 2018). This study's findings offer important insights for social care

organisations considering introducing survey administration because it suggests that anticipating distress from adult SUs can result in workers shifting their attention from children to parents and caregivers. Participants from the FW focus groups indicated that they spent significant time contemplating how to manage and minimise the potential upset during the initial implementation phase. This finding warrants the need for further exploration. In circumstances where the ACE survey administration process negatively impacts an adult SU, it establishes the need to determine whether service delivery may be influenced by professionals' appreciation of the adult's distress or their ACE score. It would be important to determine whether this influence on service provision is beneficial in addressing the child and family's primary need for attending the service.

11.4.3 Adult SUs could not always equate their experiences to ACEs

Another significant emotional challenge emerging from this study is that staff within the DoCCFS reported that adult SUs could not always understand their experiences during childhood as adversities. Participants from the FW focus group recounted experiences whereby the adult SU would complete the survey and verbalise that they did not realise that answers they had ticked yes to were considered adversities. Additionally, participants from the FW focus groups observed that some adult SUs would answer no to all of the survey questions but then recount childhood events that equated to child abuse, neglect, or household dysfunction. Although participants from the ECDSW focus group did not ask the survey questions directly, they did report that some adult SUs had approached them to discuss the questions. During these occasions, participants noted that these adult SUs were surprised by some of the questions considered child abuse, neglect, or household dysfunction because they were common in most families they knew growing up. This finding is consistent with the literature; in their study involving a pilot routine ACE enquiry project in a domestic violence service in Ireland, Morton and Curran (2019) found that some SUs did not identify their experiences during childhood as adversities. The authors attributed these difficulties in perception to adult SUs' belief that their childhood experiences were socially and culturally normative. This finding is significant because of its consistency with the experiences reported by ECDSWs, as discussed earlier in this chapter. Participants from the ECDSWs focus groups who self-identified as encountering ACEs advised that

they also did not always identify their experiences as adversities. These participants felt surprised and embarrassed when they realised they were regarded as such.

11.4.4 Discomfort with administering the ACE survey dissipated over time

This study established that once FWs became accustomed to asking the ACE survey questions, they felt better equipped to react appropriately to adult SUs' responses. Although the findings discussed within the first part of this chapter established that discomfort with administering the survey was significant for DoCCFS, this study determined that this level of discomfort dissipated as time progressed. Participants from the FW focus groups noted that over time, they developed new skills regarding timing and responding to potential adult service distress. Participants also reported that as implementation became embedded, their discomfort reduced because they started to recognise the value of asking the survey questions in their work with SUs. This finding is not unexpected and has been reported by previous studies which examined survey implementation.

The literature suggests that once practitioners get into the habit of asking SUs about adversities during their childhoods, skills in administering the ACE research measures and signposting SUs to appropriate supports increase. The literature also affirms that health and social care practitioners perceive asking SUs about ACEs as beneficial to their practice and that it strengthens their rapport with SUs (Counts et al., 2017; Quigg, Wallis and Butler., 2018). The findings of a systematic literature review by Cibralic et al. (2022), examining the implementation of ACE screening in paediatric healthcare settings, established that professional ACE awareness and acceptability of screening for childhood adversities had steadily increased during the last decade. Morton and Curran (2019) found that implementing routine ACE enquiry within a domestic violence service was perceived as beneficial by professionals because it resulted in them slowing their practice responses down and providing time and space for SUs to process their experiences. Additionally, study participants noted that the disclosure of ACEs during survey implementation provided additional opportunities for SUs to discuss their experiences in subsequent meetings.

11.4.5 Data accuracy was a concern for workers

Although the literature includes critiques of the ACE survey relating to how multiple versions of the survey make generalising results difficult (Steptoe et al., 2019), literature relating to survey data accuracy was not evident in the literature. This data gap is surprising as this study established that data accuracy was a concern for DoCCFS staff. Participants from the FW focus groups expressed concerns that as SUs may have felt obliged to complete the survey, they may have provided incorrect responses on occasion.

Similarly, participants from the ECDSW focus groups recalled conversations with adult SUs who would advise that although they had completed the survey, they admitted that they had provided inaccurate answers. Furthermore, participants recounted that SUs affirmed that they chose to provide inaccurate responses because they were concerned about the implications of disclosing such information resulting in possible social work involvement from statutory child protection and welfare services. As a result of these experiences, participants expressed scepticism about the accuracy of the DoCCFS survey data. They noted that although adult SUs generally completed the survey questions, they were not confident that these responses accurately represented the ACEs encountered by the SU population. Due to this perception, participants queried how valuable the survey data would be to inform future service delivery within the DoCCFS.

Although literature relating to ACE survey administration does not consider data accuracy, there is evidence that it has been considered in research studies exploring adult SUs' retrospective experiences of child maltreatment. The literature suggests that shame can be a significant barrier to individuals indicating that they have experienced child maltreatment (Becker Blease and Freyd, 2007; Halvorsen, Solberg and Stige, 2020; Easton, 2013). A study by Halvorsen, Solberg and Stige (2020), which explored disclosure barriers relating to CSA by adults, found that fear of being stigmatised by others or being perceived differently were significant obstacles. In addition, participants (N=12) aged 18-57 indicated that disclosure of CSA was perceived as threatening because doing so put them at risk of not being perceived as normal and like everyone else. The literature suggests that it is not surprising that some SUs voiced concerns about completing the survey and admitted that they had provided incorrect responses. This finding is significant because it appears to be the first time that a study examining the administration of the survey has highlighted data

accuracy as a concern for professionals. This finding suggests that social care organisations may need to consider how they communicate with SUs about the ACE survey. The findings indicate that the shame associated with the experience of child maltreatment and concerns about referrals to statutory child protection services could lead to SUs not indicating that they encountered such childhood adversities. Social care organisations perhaps need to consider how they would address these issues for SUs to ensure that the data collected in the survey is correct.

11.5 Conclusion

This chapter discussed the findings of this study's first two research questions. In doing so, it determined that the study findings indicate that the training provided to staff within the DoCCFS to prepare them for routine ACE survey implementation was insufficient. Due to this inefficiency, the discussion concerning findings about what the transition to routine administration of the survey was like for the DoCCFS concluded that staff encountered several personal and professional practice implications arising from the implementation process. Although several of these challenges were interpreted by staff as obstacles and resulted in concerns, the study results indicate that despite this, staff within the organisation demonstrated a willingness to persevere with survey administration. The discussion in this chapter also highlighted the consistencies of the current study findings with existing literature and the new findings, which will add depth to the current ACE evidence base. The next chapter will discuss the qualitative findings in Chapters 7 and 8 of this thesis concerning the four final research questions.

Chapter 12

Discussion of qualitative findings

Understanding the overall impact

12.1 Introduction

This chapter will deliberate on the qualitative findings in chapters 7 and 8 of this thesis about the four final research questions. These findings will be contextualised within the existing literature to identify similarities and emphasise unexpected and new results. It will consider the meaning of the data and identify any correlations or discrepancies between the findings and existing literature. It will also compare the findings with existing literature to determine the overall significance of the study to the ACE evidence base. The qualitative discussion section of this chapter will be structured under the headings of the central research questions.

12.2 To what extent and in what ways did routine administration of the ACE survey impact both FWs' / ECDSWs' relationships with SUs?

This chapter section will discuss the findings concerning the third research question. This question examined to what extent and how ACE survey administration impacted FWs' and ECDSWs' relationships with SUs. Overall this study determined that administering the survey impacted the relationships between FWs, ECDSWs and SUs. The findings also conveyed that the impact on workers' relationships with SUs was both positive and negative. Some favourable aspects indicated included staff facilitating longer working timeframes with SUs; this provided additional opportunities for rapport building and enabled professionals to focus their work with SUs. Some of the negative aspects of the findings relate to workers feeling embarrassed and uncomfortable during the survey implementation and needing to complete both preparatory and reparatory work to counteract potential SU distress in response to the survey questions. The impact of administering the survey on workers' relationships with SUs was differential and, similarly to other findings discussed previously within this chapter, depended on context and implementation role. The main themes concerning this research question are outlined and will be discussed in detail below.

12.2.1 Retrospective child abuse questions were the biggest hurdle to overcome

The findings of this study determined that several participant groups identified the survey question relating to adult SUs' experiences of CSA as the most difficult to ask. Participants noted that the terminology was too descriptive and direct, and some reported feeling embarrassed when asking questions. FWs, in particular, acknowledged discomfort with asking this question. This finding is significant because it establishes that some DoCCFS experienced discomfort whilst administering the survey, which may have impacted their relationship with the SU. Findings from a study by Mersky, Plummer-Lee, and Gilbert (2019) exploring client and provider discomfort with the survey in home visiting programmes in the USA established that clients reported more discomfort with the survey when the home visitor reported any level of discomfort. The findings of this study affirmed that if a professional felt uncomfortable with the survey questions, this discomfort may impact their implementation of the survey. Unfortunately, the ACE evidence base does not yet account for professional discomfort with the ACE question about CSA. This lack of literature is surprising given that Dr Felitti admitted that during the first ACE study, thirty of his staff transferred out of his department to avoid asking patients about their CSA experiences specifically (Felitti et al., 2019). Despite the lack of literature relating to the ACE CSA question, there is evidence of studies examining professional discomfort with administering the survey questions as a collective research instrument (Mersky, Plummer-Lee, and Gilbert, 2019; Clark and Jones, 2022). These findings note that participants felt discomfort with administering the survey but do not identify the CSA ACE question in particular.

Although the ACE evidence base does not provide literature to account for or explain this finding, there was some evidence to suggest that questions relating to child sexual abuse may result in discomfort for professionals (Schomerus et al., 2021; Leder et al., 1999; Nixon and Quinlan, 2022). A study by Nixon and Quinlan (2022), with psychologists in Australia exploring professional discomfort when inquiring about sexual abuse histories, found that most participants were uncomfortable asking clients (adults, adolescents, and children) about sexual abuse. Participants described the manifestation of this discomfort as shutting down clients who started to disclose, becoming anxious when the matter of sexual abuse came up, asking sexual abuse

questions more quickly, and becoming more detached during sessions with their clients. Additionally, a study by Leder et al. (1999) with pediatric physicians adds weight to these findings. This study examined the factors that motivate pediatric physicians to query sexual abuse, enquiry barriers, and case management approach and determined that sexual abuse enquiry was directly related to the level of discomfort and training physicians received. Participants in the study reported difficulties with sexual abuse terminology. They noted that they felt uncomfortable using the term' sexual abuse' and often needed to change the words to reduce their discomfort. Some words they identified as alternatives to 'sexual abuse' were colloquial and included asking clients if they had been touched in their 'private parts', 'down there' and 'between their legs'. The study established that many participants encountered challenges using the correct sexual abuse terminology when discussing sexual abuse with families. The fact that FWs acknowledged discomfort with asking the ACE question relating to CSA, particularly, is a noteworthy finding in the study because it indicates that there may be a need to account for this occurrence in professional training. Social care organisations considering administering the survey may need to counteract staff embarrassment with the ACE CSA survey question terminology. This finding warrants further exploration to determine whether the discomfort experienced by FWs was linked to asking SUs whether they had experienced CSA or was associated with the specific terminology used within the survey question. It could be the case that because FWs were unaccustomed to using this terminology, this increased their experiences of discomfort.

12.2.2 Expect mandatory reporting to be an issue

Mandatory reporting obligations permeate several study findings. The most pervasive finding of the current study relates overwhelmingly to the apprehension and discomfort that DoCCFS professionals experienced concerning the mandatory reporting responsibilities arising from SU's survey responses within the organisation. This finding is consistent with the literature, which determined that asking SUs about ACEs can result in mandatory reporting obligations for professionals (Goodyear-Smith, 2012; Baker et al., 2021). All participant groups recognised that mandatory reporting concerning adult experiences of retrospective child maltreatment represented a significant issue throughout all stages of the implementation process.

The apprehension and concern about mandatory reporting appear to have been exacerbated by the fact that before the DoCCFS introduced the survey, its staff were unfamiliar with retrospective child abuse reporting. The study determined that FWs rarely had the cause or occasion to converse with parents about their childhood maltreatment experiences. Due to this, staff were not accustomed to the negative emotional reactions associated with retrospective reporting exhibited by SUs and encountered by themselves. Although the findings affirm that DoCCFS were acquainted with mandatory reporting of current child welfare and abuse concerns and had no hesitation in making such reports, the study found that retrospective reporting was perceived and experienced differently. Findings indicate that reporting current child protection and welfare concerns were recognised as helpful for children and families, but the benefits of retrospective reporting were not as clear. Although staff submitted retrospective reports, they found it difficult to reconcile meeting their mandatory reporting obligations with upsetting parents and caregivers who disclosed traumatic experiences of child maltreatment. The study established that FWs also found it difficult to see the benefits of asking the child maltreatment survey questions and potentially upsetting SUs when they could not fully understand how the survey data would be used to improve the service. This lack of understanding created a disconnect between the requirement to ask and the unclear benefit of asking, which exacerbated their concerns.

Given this, one of the recommendations of staff within the DoCCFS for other social care organisations considering routinely administering the survey was that they should expect mandatory reporting obligations to be an issue. Staff emphasised the need for organisations to account for the challenges posed by mandatory reporting properly via the provision of adequate training and consistent staff support. This aspect of the finding is also evident in the literature, as studies have indicated that professionals must be adequately trained (Goodyear-Smith, 2018) and feel supported to administer the survey (Goldman, 2010). This finding reinforces the recommendations of other studies, which call for all professionals to have continuous professional development to assist them in reporting their mandatory reporting responsibilities (Baker et al., 2021; Alvarez, 2004).

Intriguingly, although the qualitative findings indicate that mandatory reporting was a significant concern for staff within the DoCCFS, the quantitative findings do not indicate excessive instances which required retrospective reporting

consideration during the study timeframe. During the eight-month timeframe of the survey, 30 parents and caregivers from the ECDSCs indicated that they had experienced retrospective child maltreatment. Of these 30 parents and caregivers, 15 reported emotional abuse, 12 reported physical abuse, and 3 reported sexual abuse.

It is not surprising that FW's concerns related predominantly to mandatory reporting as they were the only participant group who had to administer the survey verbally. The literature indicates that mandatory reporting of retrospective child maltreatment is a contentious issue for therapeutically trained professionals (Romme and Kirk, 2021; Pellegrini et al., 2022). A study by Pellegrini et al. (2022) which examined the mandatory reporting experiences of psychologists in Ireland, established that participants perceived retrospective child maltreatment reporting as more challenging than children-related concerns. Participants in this study believed that retrospective reporting damaged their therapeutic relationships with adult SUs, as reporting their disclosure of child maltreatment left them feeling powerless and betrayed. Participants also recounted that mandatory reporting of adult disclosures of child maltreatment frequently resulted in adult SUs becoming angry and aggressive towards them or inevitably disengaging from the therapeutic relationship. The literature suggests that the contention experienced by professionals related to retrospective child abuse reporting is connected to the feeling that it may not always be in the best interest of the adult SU (Pellegrini et al., 2022). Although professionals recognise the need to report instances of child abuse to protect other children, they note that the immediacy aligned with mandated reporting leaves them unable to provide the appropriate support to adult SUs after they disclose child maltreatment. Romme and Kirk (2021) conducted a study with humanistic integrative counselling supervisors in Ireland to examine the ethical dilemmas involved in retrospective child maltreatment reporting to statutory services. The study conducted qualitative interviews with five research participants who supervised therapists. The results established that retrospective disclosures were unsettling for the therapists they supervised. Participants described how the legal obligation associated with mandatory reported left therapists unable to offer their clients the time to process their disclosures. As mandatory reporting obligations stipulate that therapists must report retrospective disclosures as soon as is practicable, this resulted in therapists feeling pressured. Participants reported that it was challenging to balance the request for

practicable reporting with the time they would like to give their clients to explore their disclosure of child maltreatment and its impact on their lives (Romme and Kirk, 2021).

Although this finding is somewhat consistent with the literature, it provides a novel perspective to the ACE evidence base. It was unexpected that this study established that participants from the FW focus groups primarily raised concerns with mandatory reporting obligations relating to adult SUs, indicating that they had encountered retrospective CSA. Interestingly the quantitative findings do not support this qualitative finding as they indicate that only four of the seven participating centres encountered six adult SUs in total during the eight-month timeframe who reported having experienced CSA. Given the low numbers of retrospective CSA referrals arising from the survey during the timeframe, it is perhaps surprising that this emerged as a theme for FWs. This finding could be because the six FWs who were required to mandatory report retrospective CSA from the survey were overrepresented in the focus groups or other participants in the focus groups engaged in retrospective CSA reporting during the timeframe prior to the study data collection period. It is also possible that the six FWs who had to make mandatory reports shared their experiences with their colleagues. It is possible that if the accounts that they shared of their experiences were not favourable, and they perceived a negative impact on their working relationships with SUs. In that case, hearing about their experiences could have increased other FWs' apprehensiveness and concerns surrounding retrospective CSA reporting.

12.2.3 Implementation called for changes to resources and service delivery

The findings of this study established that introducing the ACE survey into the DoCCFS elicited the need for additional resources in the FCs. Participants from the SMT and FCM interviews and the FWs focus groups described how survey implementation within the FCs called for immediate changes to time resourcing, service delivery, and staff supervision processes. The apprehension surrounding mandatory reporting also correlated with this finding, as participants reported that FWs needed to complete preparatory and reparatory work with adult SUs. This additional work was highlighted by participants as requiring an essential prolongation of the usually expected working timeframe. This finding is consistent with the literature, which indicates that professionals spend time informing SUs about their mandatory reporting obligations

to reduce the possibility of SU distress. Furthermore, studies suggest that professionals also spend considerable time repairing relationships where SUs exhibit distress (Pellegrini et al., 2022, Bean, Softas-Nall, and Mahoney, 2011). A study by Tufford and Lee (2020) with social workers in Canada provides unique insights. This study examined what participants did to repair their relationships with SUs after reporting child maltreatment concerns to statutory child protection services. Findings from the study determined that the relationship repair strategies included offering additional appointments and contacting the SUs by telephone to offer support.

A surprising aspect of this finding relates to data from the SMT and FCM interviews and the FW focus groups, which indicated that the survey became a consistent discussion topic for FCMs and FWs during professional supervision sessions. This finding was not evident in the literature about previous survey implementation studies. Therefore, this study's findings are significant because they demonstrate that routinely administering the survey within the DoCCFS led to alterations in supervision sessions for staff. Participants from the FW focus groups recalled how some FCMs began to ask questions about the families' ACE scores in supervision and to consider them as a factor in the service provided by FWs. Participants from the FCM interviews reported that some FWs expressed concern and anxiety about asking the survey questions from the outset of implementation and throughout. In recognising this, participants explained that they inevitably took on a pseudo counselling role to support FWs. They offered them time and space to discuss any issues and made an effort to ensure that staff felt heard.

Although the ACE evidence base fails to account for this finding, literature on professional supervision within health and social care organisations provides some basis for understanding. In their book, which examined supervision as a collaborative process in health and social care services, Austin and Hopkins (2004) describe how anxiety is common for professionals within organisations who adopt a learning approach and implement innovations. The authors affirm that organisations can mitigate professional apprehension and anxiety by providing appropriate support to professionals. They outline these supports as training, ensuring precise and consistent communication between organisational management and professionals, group support and supervision. According to Austin and Hopkins (2004), supervisors in learning organisations within the health and social care sector often take on a mentorship role for staff. In addition, the authors describe how supervisors often

provide emotional support and guidance for staff when they are emotionally impacted by the work associated with new learning.

This finding suggests that social care organisations should recognise the importance of staff having access to supervision if they want to introduce routine administration of the survey. Supervision for FWs was in place prior to the DoCCFS introducing routine survey administration. The findings suggest that accessing emotional support from FCMs helped FWs navigate the challenges they encountered concerning their oral administration of the survey with adult SUs.

12.2.4 SUs socioeconomic status influenced the implementation

The findings of this study offer a different perspective surrounding how SU's socioeconomic status influenced the DoCCFS staff's implementation of the survey. Participants from the FW focus groups acknowledged that their perception of ease of implementation differed according to the adult SU's education and employment status. Some participants advised that those with higher educational attainment and professional employment status were, at times, anticipated as being more likely to raise an issue with or decline to answer the survey questions. Comparatively, findings from the ECDSM interviews indicate a different experience. Their responses indicated that a perception had emerged that adult SU's with higher levels of education attainment and employment status positively influenced their willingness to self-complete the survey questions. Participants attributed this to the fact that SU's education and professional status ensured that they could fully comprehend the rationale behind and benefit of the questions on the survey.

To further interrogate this qualitative finding, the quantitative data was analysed and considered to ascertain if there were differences between the educational attainment and employment statuses of parents and caregivers attending the ECDSCs and adult SUs attending the FCs who completed the OMS during the study timeframe. The quantitative findings conveyed that 92.5% (N=87) of parents and caregivers who completed the survey within the ECDSCs had completed the Leaving Certificate or higher. The level of educational attainment was slightly lower for the FCs, with 76.2% (N=87) of adult SUs reporting that they had a Leaving Certificate or had progressed to third-level education. Most parents were employed in the ECDSCs (65.7%) and FCs (63.2%). Given this finding, it is perplexing why the FWs and ECDSMs reported differing experiences and perceptions. FWs may have perceived more resistance

related to adult SUs' educational attainment and employment status because, unlike the ECDSMs, they had to administer the survey questions verbally. As FWs had to engage parents in completing the survey, they understandably would have had to answer queries and concerns that arose. ECDSMs, on the other hand, did not have to participate in these conversations. They handed the survey to parents and caregivers to self-complete and advised them that their responses would be strictly private and confidential and that they did not have to complete the ACE survey if they did not wish to.

The literature also does not account for this finding. There were no studies identified in the literature concerning how adult SUs' educational attainment and employment status influence professional approaches to ACE survey implementation. This finding from the current study is significant because it indicates that professionals' perceptions of parents' educational attainment and employment status can be seen as both a positive and negative predictor of their willingness to administer the survey. The finding warrants further investigation to determine if this is common for professionals in other social care organisations. It also suggests the need to consider how and why professional perceptions of anticipated reactions from adult SUs may impact the administration of the survey within a social care organisation. It is possible that professionals' perceptions of adult SU's educational and employment status could be influential in determining the level of apprehension surrounding survey administration and the implementation approach.

Another aspect of this finding is that ECDSWs attributed more significance to certain socioeconomic factors in children's lives after completing ACE training. In particular, they acknowledged that before doing the ACE training, they did not understand that parental separation was considered an ACE, nor did they comprehend that the socioeconomic challenges associated with parental separation could potentially lead to adverse outcomes for children. Findings indicate that participants from the ECDSWs immediately began to recognise how typical this ACE was in their SU population. They became more mindful that a child may require extra attention because of parental separation. The quantitative findings of this study confirm that even though the ECDSWs did not administer the survey or have any access to the data collected, their observation was accurate. The majority of children (75%, N=12) whose parents or caregivers completed the survey during the study timeframe had encountered parental separation or divorce. This finding is important because it

demonstrates how the training ECDSWs received led to them recognising the need to provide extra support to children whose parents were separated or divorced. This finding emphasises the need to examine what types of supports professionals provide when observing this ACE, what they do to intervene, and whether their interventions are effective.

12.2.5 Concerns about SU retraumatisation were not legitimised

This study determined that during the implementation process of the ACE survey within the DoCCFS, there was no indication that SUs who were asked to self-complete the survey in the ECDSCs or answered the questions posed to them by FWs, experienced retraumatisation as a result. Furthermore, participants described the skills they developed and innovations they implemented during the survey implementation process as helping them to ensure that adult SUs were not retraumatised by their experience. Findings highlighted FWs' skills in managing these challenging situations so well that they did not cause a level of distress to SUs that FWs could not respond to appropriately, nor did it impact their relationships with SUs. This finding was not unexpected, as retraumatisation is not evident in the literature on other survey implementation studies. Studies examining SUs' perspectives on being asked about ACEs consistently report that they are generally positive about the experience (Edwards et al., 2007; Bethell et al., 2017; Counts et al., 2017). Studies indicate that SUs view professional ACE enquiry as a demonstration on behalf of the practitioner that they care and are interested to hear about their lives (Woods-Jaeger, Cho, and Goggin., 2018; Felitti et al., 1998; WHO, 2018; Burke-Harris, 2018; Kolta et al., 2018).

Counts et al. (2017) completed a pilot study involving home visitors who implemented an ACE and trauma-informed approach in the USA. Results from this study indicated that SUs felt that being asked about ACEs enabled them to build rapport with practitioners and to feel safe and secure in engaging in the interventions offered. Counts et al. (2017) further determined that being asked about ACEs enabled SUs to understand their childhood adversities' impact on their lives and encouraged them to lessen the consequences for their children. This finding affirms that concerns about SU retraumatisation were not validated during the survey implementation. This finding may be reassuring to other social care organisations considering implementing the survey within their services.

12.2.6 New staff who arrived during implementation perceived immediate benefits

Another unexpected finding from this study was that new staff who arrived during the ACE survey implementation process perceived immediate benefits and were more complimentary concerning the benefits of administering the survey. Participants from the FW focus groups that had not been part of the initial rollout phase or the ACE training by TCDARs were immediately receptive to survey implementation. Participants noted that they had no idea of the rationale for survey implementation and that they had just been told to ask the questions and tick the boxes. According to participant descriptions, the experience was positive because asking adult SUs the ACE questions enabled them to build rapport. They further advised that implementing the survey facilitated them in gathering information that focused their work quicker and to have conversations that they would never have had otherwise. Findings indicate that these participants viewed the survey as an intervention and a data collection tool and expressed gratitude that they had the opportunity to use it. Although this specific finding is not evident in the literature, aspects of it were. Morton and Curran's (2019) study, which examined social care professionals' experiences of routine ACE enquiry, established that participants identified several benefits to asking SUs about their ACEs. These benefits included the perception that the survey gave them a structured opportunity to engage SUs in discussing their childhood adversities. It was helpful because it validated their professional intuition. Participants described this experience as recognising prior to survey enquiry that a SU may have encountered childhood adversity from their demeanour but not having the confidence or cause to explore this intuitive perception with them.

The literature also indicated that organisational changes could prove more difficult for experienced staff members. Agboola and Salawu (2011) state that initiating change within an organisation can alter behaviour and redefine work procedures and relationships. The authors note that it can result in the need to acquire or alter new and existing practice skills. Change can force staff within the organisation into unchartered territories where they encounter unprecedented problems and obstacles. If the organisational change conflicts with normal expectations, the authors argue that this naturally evokes reactions from staff. Given that the behaviour and expectations of new employees are not as embedded, they are often unaffected by the change and are

usually more responsive and less resistant to it. New staff members may have been more optimistic about survey administration within the FCs because it allowed them to obtain information and engage SUs in rapport building. Participants in the FW focus groups who identified themselves as new staff members reported that administering the ACE survey helped them to gather information and focus their interventions. These participants' experiences possibly differed because, unlike FWs whom the DoCCFS employed prior to survey implementation, they did not have recollections of relationship building with SUs to compare the impact.

12.3 What impact did the existing differences between the services provided by the DoCCFS ECDSCs and FCs have on how the ACE survey was implemented and interpreted by workers?

This study's fourth research question considered if the differences between the ECDSCs and FCs impacted how the survey was implemented and interpreted by workers. This study found that there were differences in implementation and interpretation. These variations related to two themes which emerged from the qualitative data, (a) the adaptations that staff made to both facilitate and avoid implementation in the FCs and (b) how the implementation of the survey within the ECDSCs led to new interpretations of the educational curriculum by ECDSWs. This finding will be examined using these themes as headings below.

12.3.1 Staff made adaptations to both facilitate and avoid implementation

The study established that after the initial implementation period, a proportion of FWs adapted their approach to ensure that SUs would be willing to complete the survey and reduce the risk of being distressed. These adaptations included adopting a flexible approach to the timing and format of administering the survey. Participants reported that they did not adhere to the suggested format of the OMS. This format placed the survey in the middle of the document, and participants explained that they did not adhere to this. Usually, they did not introduce the survey questions until after they had completed the rest of the OMS. Most participants explained that as they got used to administering the survey, they became accustomed to identifying the right time to ask SUs the questions. The right time was defined by participants as the point in relationship building with the SU when they felt that they had built sufficient rapport

to prepare them for the survey. This finding is unsurprising as other studies have reported similar professional adaptations (Counts et al., 2017). As described in chapter 4, one of these studies examined the REACh implementation approach for routine ACE enquiry. Quigg et al. (2018) determined that once professionals became accustomed to administering the survey, their skills in asking the ACE survey questions improved. Similarly, Morton and Curran's (2019) study, which examined a pilot routine ACE enquiry project within a domestic violence service in Ireland, found that professionals stressed the importance of timing for implementing the survey. Furthermore, the findings of this study emphasised that professionals felt that the right timing for implementation depended on the professional having built enough rapport with the SU to ensure that they could respond appropriately if the survey resulted in distress for them.

As discussed in this chapter, this study found that mandatory reporting represented a significant barrier to the routine administration of the survey within the DoCCFS. Interestingly this finding suggests a possible correlation between the need for mandatory reporting and ECDSMs making adaptations to facilitate survey completion by SUs and possibly motivating FWs to avoid survey administration within the FCs. Although there was no direct evidence of ECDSMs making adaptations to avoid survey implementation, some indicated that they made a change to ensure the completion of the survey. This change related to them assuring parents they would not read the completed surveys as they were strictly confidential. Adopting this change meant parents who completed the survey were guaranteed that the ECDSMs would remain unaware of whether they answered yes to any of the questions requiring mandatory reporting to statutory child protection and welfare services. This finding is not surprising when considered in light of the findings from a study by Alvarez et al. (2004), which explored professional deterrents to the mandated reporting of child abuse. This study indicated that professionals were resistant to mandated reporting for several reasons. These reasons were related to a lack of knowledge and training, the risk of negative implications for SUs arising from reports, the professional's negative perception of statutory child protection and welfare services and the potential negative impact of professional reporting on the relationship with the SU. Therefore, it is not unthinkable that, given these deterrents, professionals would be motivated to avoid mandatory reporting. Unlike the FWs, the ECDSMs did not verbally administer the survey questions to parents attending the ECDSCs. Instead, the parents were given

the survey to self-complete. This approach, alongside the assurance of not reading the surveys once completed, resulted in ECDSMs not having to report current or retrospective child maltreatment concerns to statutory child protection and welfare services. Although the ECDSMs asserted that their rationale for this adaptation was to ensure that the parents completed the survey, it could be hypothesised that the ECDSMs adopted this behaviour to reduce the likelihood that they would be required to mandatory report. A possible explanation for this behaviour was outlined in chapter 4. Agboola and Salawu (2012) noted that resistance during organisational change occurs when staff are forced into unchartered territories where they encounter unprecedented obstacles. Given that the ECDSMs acknowledged feeling ill-equipped to ask SUs about their ACEs and to respond to possible distress, it is not surprising that they found ways to avoid instances where they would have to engage in these conversations because of mandatory reporting.

Mandatory reporting may also have motivated adaptations by FWs. This study determined that once routine administration had been implemented within the DoCCFS, FWs reported making adaptations to avoid administering the survey with SUs. The literature suggests that workers can engage in obstructive behaviours during periods of change within organisations when their feelings of fear, anger and apprehension are not validated, and support to counteract these feelings is not implemented (Zietsma et al., 2019). Participants noted that they started to avoid administering the survey when they encountered negative emotional responses from SUs and realised they could not access immediate counselling support to assist such individuals. Interestingly, and as previously discussed within this chapter, these emotive responses from SUs were generally related to retrospective abuse disclosures, which required mandatory reporting. The obstructive behaviour reported by participants included over-emphasising the likelihood of mandatory reporting relating to retrospective and current child abuse disclosures to statutory services and repeatedly advising SUs that they did not have to answer the survey questions.

Although professional avoidance relating to mandatory reporting arising from ACE enquiry is not evident in the literature, there is some indication that discomfort with administering the survey, in general, can result in professionals avoiding asking SUs about their childhood adversities. In their paper entitled, '*Walking Children Through a Minefield: How Professionals Experience Exploring Adverse Childhood Experiences*', Albaek et al. (2018) provide a detailed examination of the reservations

held by professionals working in child and adolescent health and well-being services when enquiring about ACEs. Albaek et al. (2018) determined that when professionals experienced significant emotional discomfort with routine ACE enquiry, this discomfort led to them adopting avoidance behaviours regarding administering the survey. The emotional discomfort identified by the authors as contributing to these avoidant behaviours was the feeling of being ill-equipped to respond to ACE disclosures and the fear that asking about ACEs would cause further hurt to the child. This finding has implications for social care organisations because it emphasises the need to provide staff with training that could help them manage their emotions so that they can support the SU and navigate the mandated reporting process when necessary.

12.4 What impact, if any, did routine administration of the ACE survey have on the pathways of care experienced by SUs?

The fifth research question of this study set out to determine if ACE survey administration had any impact on the pathways of care experienced by SUs. The study established that routinely administering the survey led to changes in service provision by staff within the FCs and that the training provided as part of the implementation process within the DoCCFS also led to changes in approach for staff within the ECDSCs. This finding is presented and discussed below using these themes as headings.

12.4.1 Routine ACE inquiry led to changes in the FCs

Although this study identified changes in service provision within the FCs, it was unexpected that when first asked if there had been any changes to service provision within the FCs arising from survey administration, the participants' immediate response was no. It was also remarkable that, despite this affirmation, participants would then describe how implementing the survey with SUs had led to changes that impacted the pathways of care SUs received. Interestingly, the rationale articulated by the SMT and TCDARs for implementing the survey appears to have set the parameters for measuring change for staff within the FCs. Findings indicate that participants' perceptions of changes from administering the survey were restricted to whether increased funding for the DoCCFS had been obtained and if it had led to the development of new programmes and interventions. Although this finding concerning survey implementation is new, the literature on organisation change presented in

chapter 4 provides some understanding of its occurrence. In his book examining the resources and tactics for managing organisational change, Bevan (2011) stressed that before implementing change, an organisation must provide a clear justification and purpose for implementing the change. He postulates that providing a clear rationale enables workers to understand and participate in the process.

Given that staff within the FCs were advised that the rationale for administering the survey was to increase funding possibilities and to use the ACE data to improve the services provided by the DoCCFS, it is not surprising that their perception of changes explicitly related to these objectives. Although staff within the FCs described changes to their practice and approaches arising from survey administration, these changes did not align with what they had been told to expect. Bevan (2011) adds further insight into this finding by explaining that successful organisational change requires introducing systems to measure the change and track its progress. Although the DoCCFS OMS met this objective by tracking the progress of children and families attending the FCs, the organisations' systems did not extend to tracking the changes to service provision by staff from administering the ACE survey within the FCs. Due to this, minor changes to professional practice and service provision arising from the routine ACE enquiry seem to have been interpreted as necessary to ensure implementation rather than recognised as being innovative.

Some of the changes to the care pathways experienced by SUs arising from survey administration within the DoCCFS FCs correspond with those outlined in the existing literature. Participants' observation that administering the survey enabled them to build rapport with SUs mirrors the findings of other studies by Counts et al. (2017) and Quigg, Wallis and Butler (2018). These studies determined that health and social care practitioners perceived that asking SUs about ACEs benefited their practice and strengthened their rapport with SUs. The current study adds depth to this finding as participants further noted that the preparatory work they felt they had to do before administering the survey resulted in them building relationships with the SUs. This change in approach by FWs in response to survey implementation also correlates with the identified challenges arising from mandatory reporting obligations. Since FWs anticipated that SUs might become distressed if a referral to statutory child protection services was required, it is unsurprising that they afforded SUs extra time to prepare them for this.

Additional changes described by staff within the FCs also mirror the findings of the study by Morton and Curran (2019), as outlined in chapter 4. This study examined a pilot routine ACE enquiry project within a domestic violence service in Ireland. Morton and Curran (2019) found that administering the survey gave professionals a structured opportunity to engage SUs in conversations about their childhoods. Participants from the current study made a similar observation but developed this point by affirming that administering the survey enabled them to have new and helpful conversations with SUs. This study determined that talking about ACEs with SUs provided new opportunities for exploration relating to the impact that childhood adversities may have had on past and current difficulties. These conversations assisted the FWs in directing their work to meet families' needs better. This finding partially addresses a gap in existing literature identified by Ford et al. (2019) in their scoping literature review, which examined the evidence base for routine ACE enquiry. This gap relates to a lack of research considering how professionals respond to ACE disclosures. The current study determined that FWs within the DoCCFS responded by allowing SUs to talk about their experiences and reflect on their significance regarding their current issues. This study also found that educating SUs about ACEs as a precursive measure before administering the survey provided an unexpected catalyst for them to talk about their childhood adversities and recognise their impact on their current parenting. This study adds further depth to the findings of Morton and Curran (2019), with participants reporting that once SUs could make the connection between the impact of ACEs and the difficulties they encountered, they were more receptive to searching for and recognising their resilience in the face of challenges they had encountered arising from their childhood adversities,

Another component of this finding that was missing from the literature was related to reports by FWs that administering the survey resulted in them reflecting on the intergenerational transmission of SUs' ACEs. Participants in the FW focus groups reported seeing ACEs as a cyclical experience for families. This recognition motivated them to converse with adult SUs about the importance of change and intervention to stop this repetition. Although not found in the literature, this finding is not entirely unexpected. Studies relating to SUs' perspectives about survey administration intimate that completing the survey also caused them to contemplate intergenerational transmission. A study by Woods-Jaeger, Cho, and Goggin (2018), which examined parents' perceptions of the intergenerational transmission of childhood adversities,

determined that completing the survey resulted in SUs recognising that their parents had encountered similar ACEs to their own and affirming that FWs within the DoCCFS also noted that administering the survey assisted SUs in recognising the intergenerational transmission of ACEs and understanding the scope for preventative intervention. After recognising this, the study participants affirmed that it motivated them to try to reduce the likelihood that their ACEs would be transferred to their children. The current study adds depth to this finding by providing professional insights that address one of the other identified gaps in the literature, as outlined in chapter 4. This gap related to whether the routine survey administration enabled professionals to understand better or explore the impact of SUs' ACEs in terms of their needs or presenting problems (Ford et al., 2019). This finding indicates that it did assist FWs in engaging parents in conversations about the intergenerational transmission of ACEs. It also motivated them to raise the importance of stopping the cycle with SUs.

As emphasised in the literature review, there were significant gaps in the literature relating to routine administration of the survey in social care settings (Ford et al., 2019). As the current study is the first to explore survey administration from managers' and worker perspectives within a social care organisation offering family support and intervention, it is unsurprising that some aspects of the findings are unprecedented in the literature. One of these relates to participants' reports that administering the survey enabled them to identify when families were in crisis more quickly. Participants noted that the structured nature of the survey enabled them to converse with SUs they had never engaged in before. They noted that participants were responsive to being asked and, as a result, were more forthcoming when identifying past and current challenges. This willingness to disclose information enabled FWs to provide timely crisis intervention for families. This finding is interesting as it indicates that administering the survey questions can provide valuable opportunities for social care professionals to recognise when families are encountering difficulties and to offer immediate intervention.

An additional aspect of the finding that was not evident in the literature relates to participants' reports that administering the ACE survey caused them to shift their focus from centring their work on the child to being more attentive to the adult parent or caregiver. Participants noted that when they encountered adult SUs who became distressed after disclosing child maltreatment during their childhoods, FWs would shift their focus away from the current issues impacting the child to addressing the

distress. Again, there appears to be a correlation between this aspect of the finding and the reported distress caused for SUs by mandatory reporting of retrospective child abuse. As some of the FWs within the DoCCFS have therapeutic qualifications (DoCCFS, 2023), their therapeutic training may have contributed to this shift in focus. As specified in chapter 3, the current study is one of the first to consider therapeutically trained social care professionals' survey administration experiences.

Although this finding is unique, the study by Romme and Kirk (2021), as outlined in chapter 4, provides a basis for understanding this shift. Romme and Kirk (2021) conducted a study with humanistic integrative counselling supervisors in Ireland, which examined ethical dilemmas encountered by therapists concerning retrospective child maltreatment reporting to statutory services. This study determined that the legal requirement to report retrospective child maltreatment caused therapists to feel pressured and impacted their ability to provide the support they felt was necessary. Participants in this study noted that therapists' preferred professional response to disclosures of retrospective child maltreatment was to stop and provide their clients with time to explore their disclosures and the impact of such experiences on their lives. That the FWs redirected attention from the child to providing emotional support to the adult parent or caregiver post-disclosure of retrospective child maltreatment is not surprising and may be due to their professional training. Ultimately, this finding warrants further exploration to determine whether this change in focus was beneficial for the child or adversely impacted the service provided to families during their engagement with the DoCCFS FCs.

12.4.2 ACE implementation training resulted in changes in the ECDSCs

This study determined that although the ECDSCs did not administer the ACE survey verbally like the FCs, the ACE training provided as part of routine administration impacted service provision. This finding is not entirely surprising. The literature suggests that ECDSWs may be best placed to recognise and intervene in childhood adversities. The study by Eismann et al. (2020), which examined the feasibility of the Strengthening Families intervention in helping childcare providers support families with ACEs, stressed that the regular contact professionals working with children have with families provide them with vital opportunities to intervene. Consistent interaction with children and their parents as part of their role provides these professionals opportunities to shape a child's cognitive, emotional, and social development. The

authors further argue that regular contact results in these professionals quickly recognising families experiencing stress and its negative impact on children (Eismann et al., 2020). It is, therefore, not unexpected that an increase in ACE awareness would result in changes within the ECDSCs.

The changes identified by this study were most apparent in the approach adopted by ECDSWs following ACE education. Participants reported that the increase in ACE awareness arising from the training provided by DoCCFS to prepare the ECDSCs for survey administration had practical implications for them. In particular, participants noted that the increased ACE awareness gave them new insights when completing daily tasks. Participants affirmed that they started to understand that they had been unknowingly intervening in children's ACEs, and they became more motivated to do so upon recognising this. They stressed that they began recognising that some children within the ECDSCs had significant ACEs. In addition, ECDSWs advised that learning about ACEs helped them recognise and support children encountering multiple adversities. Participants reported that this increased ACE awareness made them more observant of parental interactions with children when they dropped their children off or collected them from the ECDSCs. They noted that this observation provided them with opportunities to engage with the parents to intervene when they perceived the need to do so. These observations are atypical in ACE research and are important because they partially fill the gap in the literature on how ACE training impacts professional practice and perceptions of early childhood educators. Although there is literature on the impact of early childhood educators' ACEs on their work (Grist and Caudle, 2021; Hubel et al., 2020), no studies have considered the impact of training to prepare professionals as part of the introduction of survey administration on service provision within early childhood education settings. ECDSWs reported that ACE training rather than the survey administration resulted in increased awareness for them concerning the intergenerational transmission of ACEs. Participants further noted that as some had worked in the same ECDSC for significant periods, they had observed intergenerational transmission patterns within families attending the ECDSCs. This finding is also new.

Although the literature suggests that completing the survey results in SUs recognising the intergenerational transmission of ACEs (Morton and Curran, 2019), there is a gap relating to whether professionals who complete ACE training without administering the survey make similar observations. Given the impact that the ACE

training had on ECDSW participants with ACEs, as previously discussed within this chapter, it is possible that contemplating the role of intergenerational transmission concerning their childhood adversities may have resulted in them being more cognisant of this in others.

Another novel aspect of this finding was that participants reported that the ACE training helped them to recognise that they provided positive adult relationships to children under their care. The literature suggests that children having consistent positive interactions with adults outside their families represents a counter ACE (Crandall et al., 2019). These interactions provide children with opportunities to build resilience so they can withstand and overcome the negative impact of their ACEs (Brown et al., 2022). Participants emphasised that the training introduced them to the importance of positive adult relationships for children. They emphasised that acquiring this information assisted them in recognising their potential significance in intervening in children's ACEs. It also motivated them to think about what else they could do to help. This finding indicates that ACE training resulted in ECDSWs identifying their importance and potential contribution to intervening in the lives of children with ACEs.

12.5 To what extent was ACE data used to inform service delivery?

This study's sixth and final research question was to determine the extent to which the DoCCFS OMS data, including the ACE survey data, was used to inform service delivery within the FCs and ECDSCs. This study determined that the ACE data collected as part of the DoCCFS OMS has not yet been used to inform service delivery. Interestingly one of the most consistent findings across all participant groups within the current study was that there was no clear understanding of what the organisation would do with the survey data. Participants noted that although they understood how the survey could inform service provision within a healthcare setting, they did not know how it could be implemented effectively to inform service provision in a social care organisation. This finding is not unexpected, as the literature suggests that the majority of the ACE studies have been completed in health care rather than social care settings (Albaek et al., 2018; Sun et al., 2017; Duke and Borrowsky., 2018; Hillis et al., 2004; Szilagyi et al., 2016). It is, therefore, not surprising that participants in the current study had a limited understanding of how ACE survey data could inform service delivery within the organisation.

This study also offers a new perspective to the ACE evidence base from participants from the SMT interviews. This perspective relates to the participants' suggestion that social care organisations must recognise that routine survey administration is only the first phase of a change process. Participants stressed that social care organisations must commit to a continuous process if they consider implementing routine survey administration. Participants explained that this continuous process would involve them searching for ways that the survey data might inform service development. The literature provides some insights regarding this. In his book examining the resources and tactics for managing organisational change, Bevan (2012) stresses that there must be effective leadership at the management level to implement change successfully. He explains that effective leadership ensures that the organisation remains committed to the change process and that when problems are encountered, the organisation is equipped to find a way to navigate these difficulties. This finding indicates that the DoCCFS remains committed to using the survey data to inform service delivery while recognising that engaging in this process will require additional time and effort.

12.6 Conclusion

This chapter discussed the findings of the final four questions of this study. The discussion indicated that this study determined that the routine administration of the ACE survey within the DoCCFS impacted staff relationships with SUs. In particular, the impact of asking SUs the retrospective child maltreatment ACE questions and mandatory reporting presented as pervasive considerations in staff relationships with SUs in multiple findings. This chapter further established that there were differences in how the ACE survey was implemented and interpreted by workers within the DoCCFS ECDSCs and FCs. These differences were most apparent regarding the adaptations invoked to facilitate and avoid the routine administration of the ACE survey. Mandatory reporting emerged as a significant factor in this finding also. This chapter determined that despite encountering challenges, the routine administration of the ACE survey within the DoCCFS positively impacted the pathway of care experienced by SUs. The discussion within this chapter established that despite findings which indicated that routine administration resulted in changes to service development in terms of staff professional practice, these alterations were not apparent to the organisation. Additionally, this chapter determined that due to the lack

of comparative research in other social care organisations, the DoCCFS remains unaware of how to intentionally use ACE data to inform service development. The next chapter will outline the conclusion of this study. It will summarise the study's main findings, acknowledge its limitations and outline its recommendations.

Chapter 13
Conclusions and Recommendations

13.1 Introduction

This chapter outlines the conclusion of this study. It outlines the answer to the research question. The chapter also provides an overview of the current study's contribution to the existing literature and identifies areas for further research arising from its findings. In addition, this chapter provides a model of implementation for other social care organisations considering introducing routine ACE survey administration.

13.2 Answering the research question

The current study examined the introduction of routine administration of the survey in a social care organisation from manager and workers' perspectives. The findings conclude that although the overall experience of routine survey administration was perceived as positive for the social care organisation, the implementation process resulted in practical and emotional challenges for staff. The study determined that the rationale for implementing routine ACE enquiry was a key determinant for how staff responded to routine ACE survey administration within the DoCCFS. The rationale for introducing survey administration by the DoCCFS SMT and TCDARs was related to capturing data relating to the complexity of the work undertaken by the social care organisation and using it to support funding applications. As the organisation did not introduce survey administration for service development purposes, this negatively impacted staff interpretations and responses to the implementation process. In particular, the potential mandatory reporting obligations arising from survey administration emerged as a significant barrier and concern for staff. Due to a lack of clarity surrounding the benefits of administration to improve service development, staff found it difficult to reconcile potentially upsetting SUs. The study determined that although staff persisted with survey administration, some continued expressing concern and resistance. The study established that staff perceived that their input should be interpreted by SUs as supportive and helpful and not synonymous with administering a survey that could result in emotional distress. Despite this perception by staff, the study did not establish that routine administration of the ACE survey had led to significant emotional distress for SUs. On the contrary, the study determined that

the prospect of upsetting SUs was enough to motivate resistance to survey implementation for staff.

The study established that the transition of using a social epidemiological research survey in a social care setting was not linear. Unlike clinical settings, where there is evidence of how ACE survey data informs service delivery, the DoCCFS did not have examples to draw upon. As emphasised in the literature review, there were significant gaps in the literature relating to routine administration of the ACE survey in social care settings (Ford et al., 2019). As the current study is the first to explore routine administration of the ACE survey from managers' and worker perspectives within a social care organisation offering family support and intervention, it is unsurprising that some aspects of the findings are unprecedented in the literature. Although the DoCCFS introduced routine administration of the ACE survey and collected data, the organisation did not monitor how the implementation changed staff practices or influenced service development. This study determined that although these alterations were not apparent to DoCCFS staff, they emerged within the study findings. Routine administration of the survey impacted staff emotionally and practically, resulting in changes in how they engaged with SUs. This study established that social care organisations considering introducing routine ACE enquiry should monitor alterations to practice responses and service development during the implementation process. They also need to be innovative in finding ways to use survey data to purposefully inform service development.

13.3 Statement of research contribution

This study contributes to existing research by validating other study findings as well as introducing new findings. The study found that ACEs were common within the DoCCFS SU population and that introducing routine administration of the survey was an overall positive experience for staff. This study reaffirmed the findings of previous studies, which determined that asking SUs about their ACEs can help to build rapport, recognise SU's resilience and identify the need to break the intergenerational transmission of childhood adversities within families.

This study makes a significant contribution to research with its determination that translating ACE data into informing social care service delivery remains a work in progress. The study also extends the limited research on routine administration of the survey within a social care organisation. This study is among the first to examine the

introduction of routine administration of the survey in a social care organisation from manager and worker perspectives. The study, therefore, makes a significant contribution to the ACE evidence base as it provides research findings to inform the specific considerations that social care organisations should contemplate before introducing routine administration of the survey. It also provides findings relating to staff training and implementation experiences within the DoCCFS, highlighting that social care organisations need to be considerate of their approach in both regards. The findings of this study emphasise the need for the ACE evidence base to expand to provide examples for social care organisations to be able to translate research data in ways that inform the interventions and services they provide. A significant contribution of this study is the implementation model developed in response to the findings. This model is based on the findings of this study and is designed to help social care organisations considering introducing routine administration of the ACEs survey. Depending on the context and with some minor alterations, the model can also be implemented to introduce other research instruments.

13.4 Routine administration of the ACE survey implementation model for social care organisations

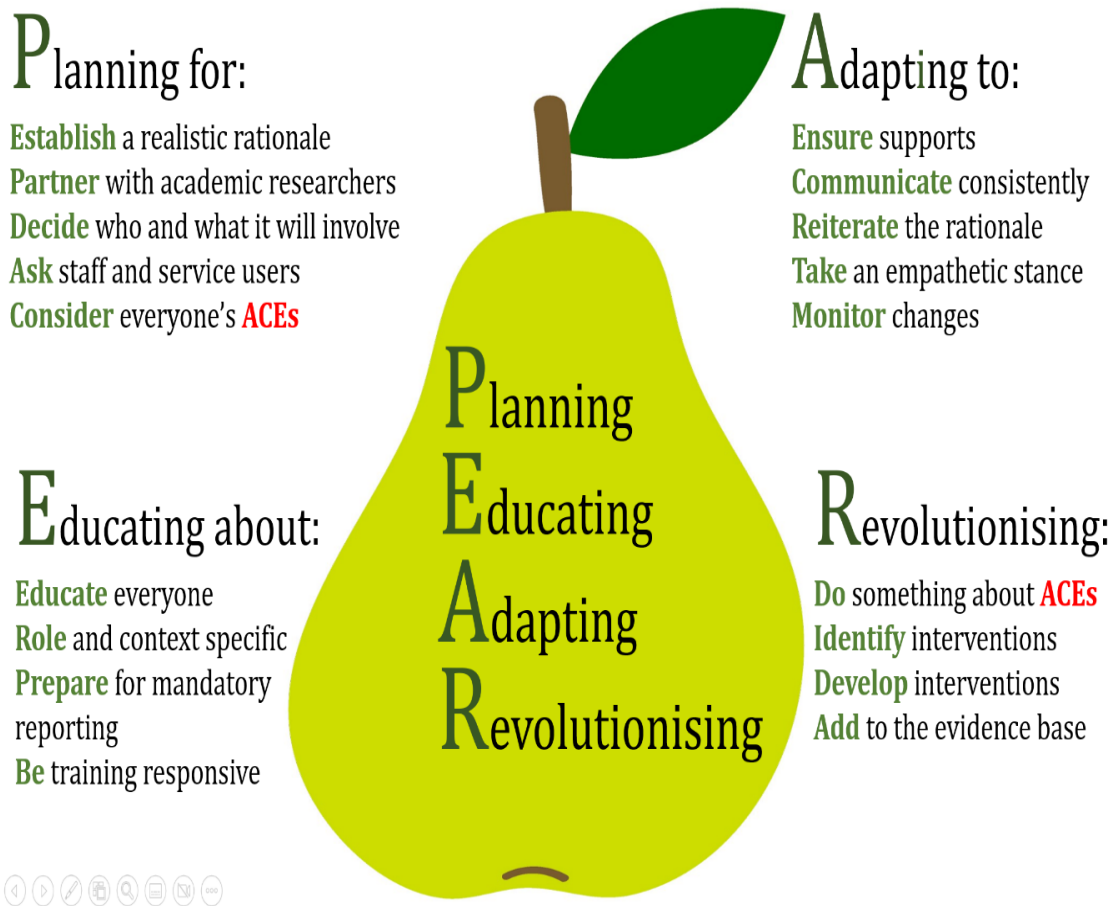
This study's findings have been utilised to inform the development of an implementation model, which might usefully be employed to inform the work of other social care organisations. Figure 13.1 illustrates this implementation model. The model is titled PEAR. This acronym encompasses four implementation phases: Planning for, Educating about, Adapting to the routine administration of the survey, and Revolutionising the social care organisation after doing so.

Phase 1: Planning for routine administration of the ACE survey

The first phase of this implementation model relates to planning for the routine administration of the ACE survey within the social care organisation. During this initial phase, the organisation should ***establish a realistic rationale*** for introducing routine administration. As the current study determined that the rationale is a key determinant of staff motivation in administering the survey, the organisation must set realistic objectives to coincide with the rationale. The organisation needs to identify why it wants to ask its SU about their ACEs and what it intends to do with the data. The

organisation should review the existing ACE literature to identify how ACE data informs social care service provision or interventions. Given that the data is limited, the organisation should examine how social care organisations have implemented data from non-ACE-related survey studies and ascertain if they can adapt these approaches to using the ACE data.

Figure 13.1
PEAR social care implementation model for the routine administration of the ACE survey



This phase of the implementation model also recommends that the social care organisation ***partner with ARs***. Engaging in this type of collaboration will assist the organisation in creating a standardised research instrument to incorporate the survey. The ARs can also provide some assistance and guidance surrounding the practicalities of administering the survey. The social care organisation should also ***decide who and what*** the routine survey administration will involve. As part of this phase, it must consider whether it will ask SUs to self-complete the survey, administer it orally, or

combine both. Once this has been established, the organisation should identify specific implementation roles for staff and define these clearly. The social care organisation should consult with staff and SUs about its vision for the routine administration of the survey. It needs ***to ask staff and SUs*** what they think before progressing with implementation. During this phase, staff and SUs must know each other's perspectives on survey implementation. There should be an open dialogue between all stakeholders, and the social care organisation should listen and respond to concerns meaningfully and constructively. This consultation may result in the need to clarify information about routine survey administration. The social care organisation can revert to ARs for guidance and input if this occurs.

An important component of the first implementation phase under this model is the need for social care organisations to ***consider everyone's ACEs***. Before introducing routine survey administration, social care organisations must proactively consider how the implementation process may impact staff and SUs with ACEs. This contemplation process may determine a need to educate staff and SUs about the probabilistic nature of ACEs, factors that help to ameliorate the potential negative impact and how they will benefit from the introduction of routine survey administration. The social care organisation should also consider how it will respond to any potential negative emotional implications experienced by staff or SUs.

Phase 2: Educating about routine administration of the ACE survey

The second phase encompasses the training component of the implementation model and focuses on educating staff and SUs about the ACE survey. Primarily this phase emphasises the need to ***educate everyone about ACEs***, the rationale for the social care organisation introducing routine administration of the survey, the staff's specific role in survey implementation and how the data collected as part of the survey will benefit the organisation. The study's findings emphasise the need for social care organisations to ensure that their training is ***role and context-specific.*** The training provided by the social care organisation should equip staff with an understanding of how to administer the survey and how they can integrate ACE knowledge into their professional practice. Staff tasked with orally administering the survey should receive training relating to asking the survey questions, supporting the SU if they become distressed, self-care and regulating their emotions when they encounter the SU upset or angry. Whether staff are administering the survey orally or otherwise, if they receive ACE education as part

of the organisation introducing the survey, they should be provided with examples of how to use their newly acquired knowledge. To assist organisations with this, ARs could identify validated ACE-ameliorating interventions or approaches from the literature that services can adopt. This phase also stresses the need for SUs to be educated about ACEs and how their participation in the survey will help the social care organisation improve its services. Providing SUs with this information should equip them to make an informed decision about completing the survey and may increase survey response rates.

This phase of the implementation model affirms the need to ***prepare for mandatory reporting.*** Social care organisations must recognise that mandatory reporting could represent a significant barrier to introducing routine administration of the survey. In doing so, it must provide training that increases staff understanding and confidence in meeting their obligations. The social care organisation should determine how accustomed its staff are to making current and retrospective child maltreatment reports to statutory services. Once they have established the experience level, training should be provided to equip staff to understand, comprehend and manage these occurrences. If mandatory reporting is uncommon for staff, then the organisation may need to provide multiple training sessions and support throughout the implementation process. Overall this phase stresses the need for social care organisations to be ***training responsive.*** During the implementation process, difficulties may arise, and social care organisations may need to provide additional training or guidance to support staff or SUs.

Phase 3: Adapting to routine administration of the ACE survey

The third phase of the implementation model relates to the social care organisation adapting to routine administration of the ACE survey. During this phase, the social care organisation should ***ensure supports*** are available to staff if they have concerns or queries while administering the survey. This support could be regular supervision or facilitating open dialogue within the social care organisation so that staff can ***communicate consistently*** about their concerns and obtain constructive and supportive feedback and guidance. This phase of the implementation process also stresses the need to ***reiterate the rationale*** for the routine survey administration. Given that there may be a time lapse between the first consultation with staff and SUs about the social care organisation introducing the survey, reminding them of the

objectives of doing so should reiterate the benefits of doing so and sustain their endorsement of the process. This phase also reminds the social care organisation of the need *to* ***take an empathetic stance*** in response to staff resistance or concerns. The study's findings determined that routine survey administration had negative emotional implications for staff within the DoCCFS. The staff were concerned about the welfare of SUs, and much of their resistance related to them not wanting to cause unnecessary distress or upset. Social care organisations should therefore try to understand staff perspectives and work collaboratively during this phase to resolve any issues. The last part of this implementation phase relates to the need for the social care organisation to ***monitor changes*** associated with service provision and professional practice arising from survey implementation. Although the current study determined that there is a lack of evidence to guide how survey data can be transitioned into informing social care service provision, it also uncovered immediate changes from implementing the survey. As the DoCCFS did not expect these changes, it did not note them or identify them as significant. This phase of the implementation model recommends that other social care organisations actively record their observations about any such changes.

Phase 4: Revolutionising the social care organisation in response

The last phase of this implementation model requires the social care organisation to be innovative. This phase focuses on identifying ways in which survey data can be used effectively by the social care organisation ***to do something about ACEs***. Social care organisations considering introducing routine administration of the survey should identify how they will respond to the ACE data findings of their SU populations. They must be proactive in this regard. During this phase, social care organisations should ***identify interventions*** from the ACE evidence base that their services could implement in response to its data findings. An example of this would be introducing an ACE ameliorating intervention for parental separation and divorce in response to this being the most prevalent ACE reported by social care organisations' SU population. During this phase, the social care organisation could also ***develop interventions*** in collaboration with ARs in response to its SU ACE profile. Developing an intervention could also assist the social care organisation to ***add to the ACE evidence base***. Although the survey is primarily a research tool used predominantly in clinical settings (Ford et al. 2019), this study determined that social care organisations also use the survey to

identify SUs with higher ACE scores. Due to this, social care organisations must conduct ACE research on how their services help mitigate and respond to the negative social, emotional, and behavioural outcomes associated with childhood adversities. The ACE evidence base needs social care organisations to contribute research and learning from their experiences, survey implementation and subsequent data use in service provision and development.

13.5 Limitations of the study

This study has several limitations. The findings are subjective to the case study research design, and the potential for replication is consequently restricted. As the study set out to address a gap in literature relating to social care professionals' perspectives of ACE survey implementation, there was limited comparable literature available.

The study did not examine SU's thoughts, feelings or perceptions concerning the routine administration of the ACE survey. Although the findings indicate no evidence of SU retraumatisation or complaints, the researcher cannot be sure this was the reality. It is possible that SUs were distressed and that the apprehension and concerns reported by participants within the study directly related to their observations of this distress.

13.6 Recommendations for future research

The current study identified the need for further research in the following areas.

These include the need to:

- Examination of ACE score profiles in other social care organisations
- Explore the impact of staff ACEs on their perceptions of ACE training or routine administration of the survey
- Examine whether ACE educational training materials are more effective when tailored to specific staff roles and context
- Ascertain the need for separate ACE training depending on the survey administration role within organisations

- Examine whether mandatory reporting of retrospective CSA and child maltreatment is an implementation obstacle for other social care organisations
- Investigate how data collected using research instruments such as the ACE survey can be implemented to inform social care service provision
- Ascertain social care SU's perspectives on being asked to answer the ACE survey questions

13.7 Conclusion

This chapter provided the conclusion of this study. The study determined that the although the introduction of routine administration of the ACE survey had an immediate impact on the professional practice of staff within the DoCCFS, that understanding how to use the ACE survey data to purposefully inform service development remains a work in progress. At the outset of the study, the researcher believed that the ACE survey could offer social care organisations the opportunity to quantify their work and enable them to prevent ACEs and intervene when they occur. The researcher also expected that the study would identify some barriers to implementation but that, overall, the organisation would perceive routine administration as beneficial. After four and a half years of reading about the ACE evidence base, conducting the study, collecting the data and analysing it, the researcher now appreciates how naïve she was. The researcher did not understand the complexities of asking social care professionals to administer a survey which involved asking adult SUs about childhood adversities. Although the researcher appreciated that routine ACE enquiry might be uncomfortable for staff who were not accustomed to asking the questions, she did not recognise how important it would be for DoCCFS staff to have a clear understanding of how routine ACE enquiry would benefit the SUs. The journey to discovering this was a revelation.

This study determined the importance of researchers considering organisational factors when introducing research instruments or innovations within a social care organisation. If the entire organisation does not clearly understand and endorse the change, then the study established that this could lead to implementation obstacles. The study provides unprecedented findings that will assist social care organisations in introducing routine ACE enquiry and developing pathways for using survey data to inform service provision and improve the lives and outcomes of SUs.

Most importantly, the study provides social care organisations with the PEAR implementation model for doing so.

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Appendices

Appendix 1

List of Questions – CEO Semi-Structured Interview

Why did you introduce routine outcome measures?

What resources were needed to introduce routine outcome measures across the service?

What was the rationale for DoCCFS introducing routine administration of the Adverse Childhood Experience (ACE) survey?

Did the organisation adopt different approaches to ACE survey implementation within the ECDS centres and the family centres? If yes, what were the differences and why were they required?

What is your experience of introducing routine administration of the ACE survey? What worked well, what has not worked so well?

What is your opinion about the training provided to prepare the service for the routine administration of the ACE survey, do you think that the training provided was useful / beneficial and was there any aspects that did not work so well?

Were there any variations in the training provided to the family centres and the ECDS centres? If yes, what where these variations and why did they occur?

Did you encounter any barriers in introducing routine administration of the ACE survey in the organisation, if yes, can you describe these barriers?

Can you highlight anything within the DoCCFS that you perceived as making the introduction of routine administration of the ACE survey easier?

What role, if any, do you think organisational culture had in the introduction of routine administration of the ACE survey within the DoCCFS?

Did anything happen during the implementation process of routine ACE survey administration that was unexpected? If yes, can you describe what happened?

Did the implementation process of the ACE survey and response to it, differ between ECDS centres and family centres? Can you explain your answer?

Has anything changed within the DoCCFS since the introduction of routine administration of the ACE survey, if yes can you tell me more about these changes?

Have these changes been negative or positive for the organisation?

The DoCCFS stopped using the ACE survey as part of the outcome measures during this study, what motivated the decision to stop routine administration?

What is the general feedback that you have received from service users about being asked about adversities?

What is the general feedback that you have received from family workers about asking service users about their adversities?

What feedback have you received from the ECDS managers about giving the ACE survey to parents to self-complete?

Do you think that asking service users about adversities improves the service that DoCCFS provides? If so, in what ways?

Can you think of anyways that DoCCFS can improve the process of routine administration of the ACE survey?

What advice would you give to other social care organisations who are considering introducing routine administration of the ACE survey?

Appendix 2

List of Questions – SMT Semi-Structured Interviews

Why did you introduce routine outcome measures?

What resources were needed to introduce routine outcome measures across the service?

What was the rationale for DoCCFS introducing routine administration of the Adverse Childhood Experience International Questionnaire (ACE-IQ)?

What is your experience of introducing routine administration of the ACE-IQ?

What is your opinion about the training provided to prepare the service for the routine administration of the ACE-IQ, do you think that the training provided was useful / beneficial?

Did you encounter any barriers in introducing routine administration of the ACE-IQ in the organisation, if yes, can you describe these barriers?

Do you think that a family worker's, manager or acting managers professional training or background influences how they interpret and implement the ACE-IQ?

Can you highlight anything within the DoCCFS that you perceived as making the introduction of routine administration of the ACE-IQ easier?

What role, if any, do you think organisation culture had in the introduction of routine administration of the ACE-IQ within the DoCCFS?

Has anything changed within the DoCCFS since the introduction of routine administration of the ACE-IQ, if yes can you tell me more about these changes?

Has your interpretation or perception of service delivery within the DoCCFS changed in anyway since the introduction of routine ACE inquiry? Can you explain your answer?

Have these changes been negative or positive for the organisation?

What is the general feedback that you have received from service users about being asked about adversities?

What is the general feedback that you have received from family centres about asking service users about their adversities?

In what ways does asking service users about adversities improve the service that DoCCFS provides?

Can you think of anyways that DoCCFS can improve the process of routine administration of the ACE-IQ?

What advice would you give to other social care organisations who are considering introducing routine administration of the ACE-IQ?

Appendix 3

List of Questions – FCMs Semi-Structured Interviews

What is your understanding of the rationale behind DoCCFS introducing routine administration of the Adverse Childhood Experience International Questionnaire (ACE-IQ)?

What is your experience of introducing routine administration of the ACE-IQ?

What is your opinion about the training provided to prepare the service for the routine administration of the ACE-IQ, do you think that the training provided was useful / beneficial for family workers?

Did you encounter any barriers in introducing routine administration of the ACE-IQ in your centre?

Can you tell me how outcome measures are managed in your centre, for example what systems are to monitor returns?

Can you highlight anything within your centre or DoCCFS that made the introduction of routine administration of the ACE-IQ easier?

What role, if any, do you think organisation culture had in the introduction of routine administration of the ACE-IQ within the DoCCFS?

Has anything changed within the family centre that you manage or DoCCFS service provision since the introduction of routine administration of the ACE-IQ, if yes can you tell me more about these changes?

Have these changes been negative or positive for the organisation?

Do you think that family worker professional training or background has any impact on their interpretation or implementation of the ACE questions? If yes, can you explain your answer.

How has introduction of the ACE-IQ changed your role or perception within the organisation?

What is the general feedback that you have received from service users about being asked about adversities?

What is the general feedback that you have received from family workers about asking service users about their adversities?

How does asking service users about adversities improve the service that DoCCFS provides?

Has the introduction of the ACE impacted on your centres approach to work?

Can you think of anyways that DoCCFS can improve the process of routine administration of the ACE-IQ?

What advice would you give to other social care organisations who are considering introducing routine administration of the ACE-IQ?

Appendix 4

List of Questions – ECDSMs Semi-Structured Interviews

What is your understanding of the rationale behind DoCCFS introducing routine administration of the Adverse Childhood Experience International Questionnaire (ACE-IQ)?

What is your experience of introducing routine administration of the ACE-IQ?

What is your opinion about the training provided to prepare the service for the routine administration of the ACE-IQ, do you think that the training provided was useful / beneficial for family or early years workers?

Did you encounter any barriers in introducing routine administration of the ACE-IQ in your ECDS / family centre?

Can you tell me how outcome measures are managed in your centre, for example how are parents asked the ACE questions, what systems are to monitor returns, etc...?

Can you highlight anything within your ECDS or DoCCFS that made the introduction of routine administration of the ACE-IQ easier?

What role, if any, do you think organisation culture had in the introduction of routine administration of the ACE-IQ within your ECDS?

Has anything changed within the ECDS / family centre that you manage or DoCCFS service provision since the introduction of routine administration of the ACE-IQ, if yes can you tell me more about these changes?

Have these changes been negative or positive for the organisation?

Do you think that a workers professional training or background has any impact on their interpretation or implementation of the ACE questions? If yes, can you explain your answer.

How has introduction of the ACE-IQ changed your role or perception within the organisation?

What is the general feedback that you have received from parents about being asked about adversities?

What is the general feedback that you have received from family / early years workers about asking parents about their adversities?

How does asking parents about adversities improve the service that the DoCCFS ECDS / family centres provide?

Has the introduction of the ACE impacted on your ECDS approach to work?

The ACE questions are no longer included in the outcome measures, do you think that this is a good or a bad thing for your ECDS and the DoCCFS?

Can you think of anyways that DoCCFS can improve the process of routine administration of the ACE-IQ?

What advice would you give to other social care organisations who are considering introducing routine administration of the ACE-IQ?

Appendix 5

List of Questions – FWs Focus Groups

What is your understanding of the rationale behind DoCCFS introducing routine administration of the Adverse Childhood Experience International Questionnaire (ACE-IQ)?

What is your experience of introducing routine administration of the Adverse Childhood Experience International Questionnaire in DoCCFS?

What is your opinion about the training provided to prepare the service for the routine administration of the ACE-IQ, do you think that the training provided was useful / beneficial for family workers?

Do you think that a family workers professional background or training influences their interpretation or implementation of the ACE-IQ? Can you explain your answer?

Did you encounter any barriers in introducing routine administration of the ACE-IQ in your work, if yes can you tell me more about these barriers?

Can you highlight anything within your centre or DoCCFS that made the introduction of routine administration of the ACE-IQ in your role easier?

What role, if any, do you think organisation culture had in the introduction of routine administration of the ACE-IQ within the family centre where you work and within DoCCFS in general?

Has anything changed within the family centre where you work or within your practice since the introduction of routine administration of the ACE-IQ, if yes can you tell me more about these changes?

Have these changes been negative or positive for you as family workers and for the organisation?

What is the general feedback that you have received from service users about being asked about adversities?

Does asking service users about adversities impact on your working relationship with them, if yes, can you describe in what way it impacts?

Has your practice changed since asking service users about their ACEs, can you explain your answer?

How has the introduction of routine administration of the ACE-IQ as part of your practice in DoCCFS impacted on you in anyway?

How does asking service users about adversities improve the service that DoCCFS provides?

What advice would you give to other social care organisations who are considering introducing routine administration of the ACE-IQ?

Appendix 6

List of Questions – ECDSWs Focus Groups

What is your understanding of the rationale behind DoCCFS ECDS introducing routine administration of the Adverse Childhood Experience International Questionnaire (ACE-IQ)?

What is your experience of introducing routine administration of the Adverse Childhood Experience International Questionnaire in your ECDS?

What is your opinion about the training provided to prepare the service for the routine administration of the ACE-IQ, do you think that the training provided was useful / beneficial for early years workers?

Do you think an ECDS workers professional background or training influences their interpretation or implementation of the ACE-IQ? Can you explain your answer?

Did you encounter any barriers in introducing routine administration of the ACE-IQ in your work, if yes can you tell me more about these barriers?

Can you highlight anything within your ECDS or the DoCCFS that made the introduction of routine administration of the ACE-IQ in your role easier?

What role, if any, do you think organisation culture had in the introduction of routine administration of the ACE-IQ within the ECDS where you work and within DoCCFS in general?

Has anything changed within the ECDS where you work or within your practice since the introduction of routine administration of the ACE-IQ, if yes can you tell me more about these changes?

Have these changes been negative or positive for the you as early years workers and for the organisation?

What is the general feedback that you have received from service users about being asked about adversities?

Can you describe the process that your ECDS follows when it comes to the ACE survey questions?

Does asking parents about adversities impact on your relationship with them or their children, if yes, can you describe in what way it impacts?

Has your practice changed since service have been asked to answer ACE questions, can you explain your answer?

How has the introduction of routine administration of the ACE-IQ as part of your practice in the DoCCFS ECDS impacted on you in anyway?

Does service users being asked ACE questions improve the service that DoCCFS ECDS provides?

Can you think of anyways that DoCCFS ECDS can improve the process of routine administration of the ACE-IQ?

The ACE questions are no longer part of the ECDS outcome measures, do you think that this is a good or a bad thing?

What advice would you give other professionals or organisations who are considering introducing routine administration of the ACE-IQ?

Appendix 7

Adverse Childhood Experiences

Trevor Spratt and Lorraine Swords
Trinity Research in Childhood Centre
Trinity College Dublin

1

Knowing our past is key to our present: The ACE study

Why did middle class Americans drop out of a weight loss programme? 'Dr Felitti collected the life histories of those who left the programme, asking questions such as, "What weight were you when you got married?" and "At what age did you first have sex?" During one interview, he misspoke, asking the patient what weight she had been when she first had sex. When she replied, "About 45 pounds", he asked her to repeat herself. She did so, adding, "I was 5 at the time. It was my father". A week later, another patient volunteered similar information and Dr Felitti began to ask the question at all interviews: 65 of the next 120 patients said that they had been subject to childhood sexual abuse.'
Dr Lian McGavock

2

Adverse Childhood Experiences

- 10 item questionnaire on areas of abuse and family dysfunction experienced in the first 18 years of life.
- A majority of the population have an ACE score of 1 or more.
- The higher their score, so increases an individuals probability of experiencing a range of poorer than average health and social outcomes over their life-course.
- The mechanisms for translation include physiological embedding of trauma, distorted psychological processing, risk taking behaviours and detrimental health choices.

3

What's My ACE Score?

- ***Prior to your 18th birthday:***
- 1. Did a parent or other adult in the household **often or very often**…
- Swear at you, insult you, put you down, or humiliate you?
- **or**
- Act in a way that made you afraid that you might be physically hurt?
- Yes No If yes enter 1
- 2. Did a parent or other adult in the household **often or very often**…
- Push, grab, slap, or throw something at you?
- **or**
- **Ever** hit you so hard that you had marks or were injured?
- Yes No If yes enter 1
- 3. Did an adult or person at least 5 years older than you **ever**…
- Touch or fondle you or have you touch their body in a sexual way?
- **or**
- Attempt or actually have oral, anal, or vaginal intercourse with you?
- Yes No If yes enter 1

4

What's My ACE Score?

- 4. Did you **often or very often** feel that …
- No one in your family loved you or thought you were important or special?
- **or**
- Your family didn't look out for each other, feel close to each other, or support each other?
- Yes No If yes enter 1
- 5. Did you **often or very often** feel that …
- You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
- **or**
- Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
- Yes No If yes enter 1
- 6. Was a biological parent **ever** lost to you through divorced, abandonment, or other reason ?
- Yes No If yes enter 1

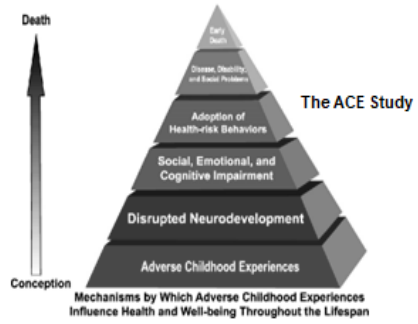
5

What's My ACE Score?

- 7. Was your mother or stepmother:
- **Often or very often** pushed, grabbed, slapped, or had something thrown at her?
- **or**
- **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard?
- **or**
- **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
- Yes No If yes enter 1
- 8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
- Yes No If yes enter 1
- 9. Was a household member depressed or mentally ill or did a household member attempt suicide?
- Yes No If yes enter 1
- 10. Did a household member go to prison?
- Yes No If yes enter 1
- **Now add up your "Yes" answers: _____ This is your ACE Score**

6

The impact of Adverse Childhood Experiences



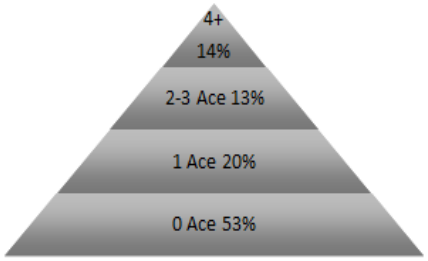
7

Prevalence of ACEs in the original study

ACE Score	Prevalence
0	48%
1	25%
2	13%
3	7%
4 or more	7%

8

ACE scores in Wales



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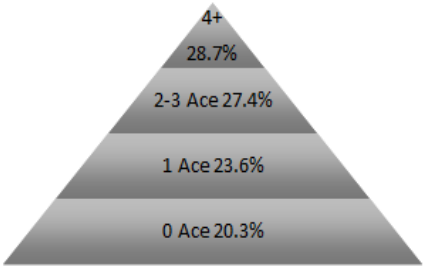
Ace scores in Saudi Arabia



10

Adverse childhood experiences in young adults in 8 eastern European countries – Bellis et al.

- **Physical abuse** – average 18.6% (range 6.9% Rep of Macedonia to 41% Albania)
- **Problematic use of alcohol by household member** - 16.4% (6.4% Turkey to 30.3% Latvia)
- **Domestic violence towards mother** 14.6% (1.4% Rep of Macedonia to 30% Albania)
- **Parents separated or divorced** - 14.1% (3.8% Rep of Macedonia to 42.3% Latvia)
- **Emotional neglect** - 11.8% (7.4% Montenegro to 18.4% Russian Federation)
- **Depressed or suicidal household member** 10.0% (5.6% Montenegro to Latvia)
- **Emotional abuse** - 8.0% (2.9% Russian Federation to 26.5% Albania)
- **Sexual abuse** - 7.5% (3.5% Lithuania to 19.1% Albania)
- **Household member incarcerated** 5.3% (2.3% Romania to 8.3% Latvia/Turkey)
- **Drug abuse by household member** 2.6% (1.4% Russia to 4.8% Latvia)

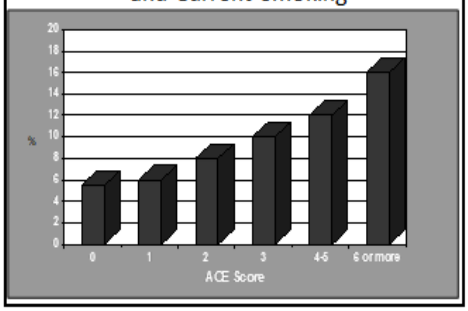
11

ACE surveys in England and Wales

England	Wales
• Physical abuse – 18.6%	• Physical abuse – 17%
• Sexual abuse – 7.5%	• Sexual abuse – 10%
• Domestic Violence – 14.6%	• Domestic Violence – 16%
• Loss of parent – 14.1%	• Loss of parent – 20%
• Emotional neglect – 11.8%	• Emotional neglect – 11.8%
• Depressed/suicidal – 10.0%	• Depressed/suicidal – 23%
• Alcoholic – 16.4%	• Alcoholic – 14%
• Incarcerated – 5.3%	• Incarcerated – 5%
• Street drug user – 2.6%	• Street drug user – 5%

12

Adverse Childhood Experiences and Current Smoking



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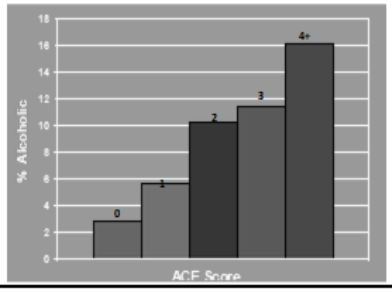
Childhood Experiences and Adult Alcoholism



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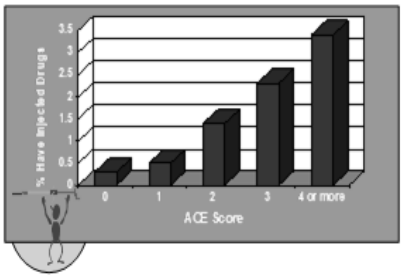
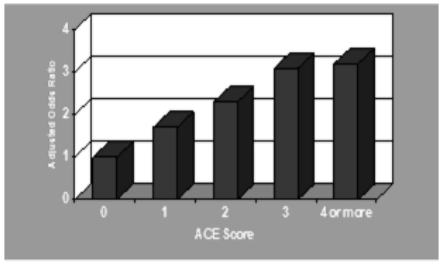
ACE Score and Intravenous Drug Use



15

Adverse Childhood Experiences and Likelihood of > 50 Sexual Partners



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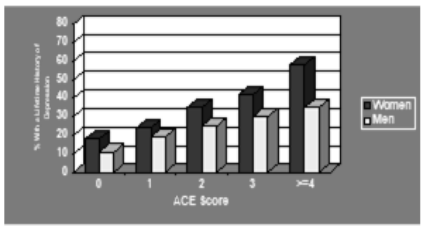
Impact upon physical health

When compared to those who have an ACE score of zero, those with a score of 4 or more are:

- 4 times more likely to develop type 2 diabetes
- 3 times more likely to develop respiratory disease
- 3 times more likely to develop heart disease

17

Childhood Experiences Underlie Chronic Depression



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Pattern recognition

'In all cases the pattern has been the same – the greater the number of adverse experiences in childhood, the greater the likelihood of health problems in later life.'

Center on the Developing Child at Harvard University

19

Prevalence of ACEs in a university population: Associations with Social Services contact

- 765 respondents
- Those with 4+ ACEs were over 23 times more likely than peers with 0 ACEs to have social services contact

Ace Score	Number	%
0	336	44
1	162	21
2	104	14
3	67	9
4+	95	12

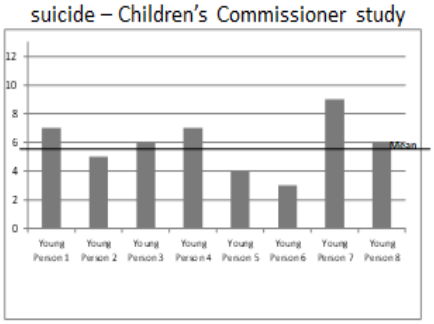
20

Witnessing Domestic Violence and ACE scores

- Of the 68 (9%) students who reported witnessing domestic violence, 92% report at least two additional ACEs and 82% report at least three additional ACEs (score of 4 or more).
- Following a pilot study an additional question on male directed abuse was added, 25 students reported this(3.3%); 43 female directed (5.7%).
- 42% also reported contact with social services.
- In a UK study Stanley and colleagues found that in 83% of cases referred because of DV the family either received a letter only or no further action.

21

Number of adversities recorded in cases of suicide – Children's Commissioner study



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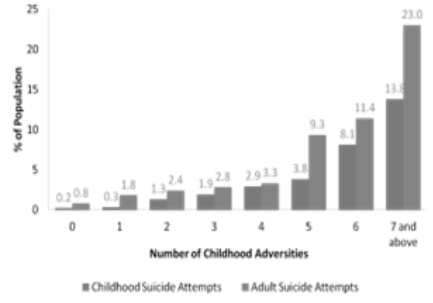
Number of childhood adversities and subsequent suicide attempts in childhood and adulthood



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Adversities noted in interviews with children caring for parents

Table 1 Research participants, ACE question categorisation and scores

ACE questions:	1	2	3	4	5	6	7	8	9	10
1 Alana (b)	-	-	-	1	1	1	-	1	1	-
2 Ben (b)	-	-	-	-	-	-	-	-	1	-
3 Beth (g)	-	-	-	-	-	1	-	-	1	-
4 Carol (g)	-	-	-	-	-	1	-	-	1	-
5 Catherine (m)	1	1	-	1	-	1	1	-	1	-
6 David (b)	-	-	-	-	-	-	-	-	1	-
7 Elizabeth (m)	-	-	-	-	-	-	-	-	-	-
8 Emma (m)	-	-	-	-	-	-	-	-	-	-
9 Eve (b)	-	-	-	-	-	-	-	-	1	-
10 Grace (b)	1	1	-	-	-	-	-	-	1	-
11 Jennifer (g)	1	-	-	-	-	1	-	-	-	-
12 Lena (b)	-	-	-	-	-	1	-	-	-	-
13 Lesley (m)	-	-	-	-	-	-	-	-	-	-
14 Lisa (m)	-	-	-	-	1	1	-	1	1	-
15 Michael (m)	-	-	-	-	-	1	-	1	1	-
16 Nichola (b)	-	-	-	-	-	-	-	-	1	-
17 Oliver (m)	-	-	-	-	-	-	-	-	-	-
18 Orla (g)	-	-	-	-	-	1	-	-	1	-
19 Rachel (b)	-	-	-	-	-	-	-	-	1	-
20 Rosemary (b)	-	-	-	-	-	-	-	-	1	-
21 Sarah (g)	1	-	-	-	-	-	-	-	1	-
22 Zoe (m)	-	-	-	-	-	1	-	1	1	-

24

Transmission: Wales – compared with people with 0 ACEs, those with 4+ were:

- 4 times more likely to be a high risk drinker
- 6 times more likely to have had or caused a teenage pregnancy
- 6 times more likely to smoke tobacco or E cigs
- 11 times more likely to have smoked cannabis
- 14 times more likely to be a violence victim in last 12 months
- 15 times more likely to have committed violence in last 12 months
- 16 times more likely to have used crack cocaine or heroin
- 20 times more likely to have been incarcerated

31

Preventing intergenerational transmission

http://www.aces.me.uk/in-wales/

32

Two questions from David Finkelhor

- 1. What the effective interventions and responses we need to have in place for effective ACE screening? Is it ethical and justified to screen for conditions when proper treatment cannot be assured?
- 2. What are the potential negative outcomes and costs to screening that need to be buffered in any effective screening regime? Increase in referrals to Tusla resulting in more investigations, flooding the system and not resulting in effective services?

33

Test criterion - Finkelhor

'The initial criteria for deciding among screening approaches should be the degree to which differently screened groups get access to, complete and derive any benefit from the intervention.'

34

ACE awareness in Spokane High School

Challenge: One third of the class had ACE scores of 4+. Best predictor of health, attendance and behaviour. Education success related more to ACE score than family income.

Intervention: Staff informed about the impact of ACEs and they helped pupils focus on building resiliency and developmental skills, promoted relationships with care-givers (attachment) and encouraged self regulation by sharing emotional experiences.

Results: 75% less fights, 83% drop in suspensions (from 798 to 135) and improved graduation rates.

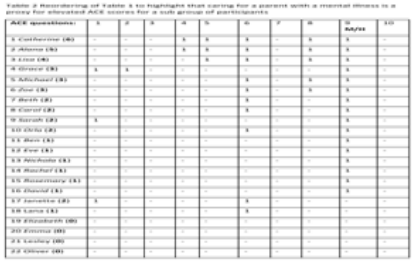
35

Coping with ACEs

Mark Bellis

36

Caring for a parent with a mental illness signifies higher ACE scores



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DoCs Children referred by Standard Report Form in the 'welfare' category

Delores Carroll

In most of these cases further SRFs were submitted involving some of the other categories of abuse, such as emotional, physical, sexual and neglect. Of the 36 cases surveyed, only 8 cases scored below 4. The large majority of these children had ACE scores at what me might term clinical levels. In population studies only around 15% of respondents have scores in excess of 4, in this group of children using DoCs services, 89% had scores of 4 or more, in fact considerably more, the mean score being 5.86. Incredibly almost half the children (49%) had scores at the very highest level of 8+

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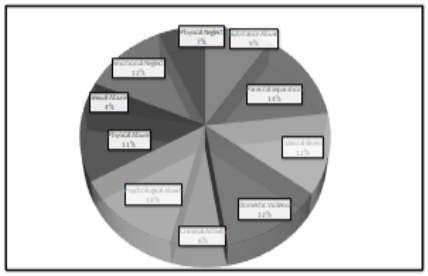
ACE profile of DoCs SRF children



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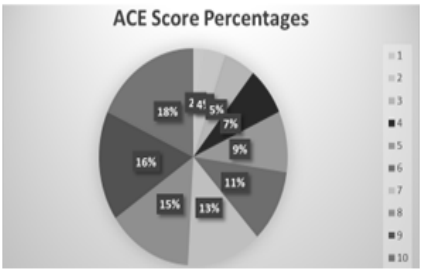
ACE scores of DoCs SRF children



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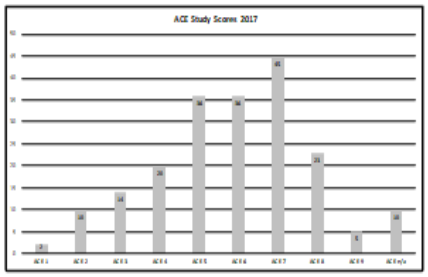
ACE profile of Mothers using DoCs services with children subject to SRFs



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Comment

These data demonstrate that reasons for referral to DoCs may only indicate the tip of an ACE iceberg, for both parents and children. So to the category of 'Welfare' for children who are the subject of SRFs, covers a multitude of additional categories of abuse and adverse family circumstances. Such profound intergenerational damage is unlikely to be halted without the provision of long term therapeutic help.

30

Buffering effect for high ACE score: One positive and sustained relationship with an adult

- Question for adults with ACE scores of 4+. 'As a child was there an adult you trusted and could talk to about your problems?'
- Of those who responded '**always**' 8% reported problem drinking, 12% use of cocaine and heroin and 12% had been imprisoned.
- Of those who responded '**never**' 21% reported problem drinking, 21% use of cocaine and heroin and 41% had been imprisoned.

ACE Resilience Survey 2017, Mark Bellis, unpublished data

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