Case Studies	
Title	Pennine Lancashire ACE Framework
Brief summary	A paradigm shift is needed across Pennine Lancashire to ensure a coordinated population approach to reduce children's exposure to adverse childhood experiences (ACEs) and, to prevent or mitigate the consequences of ACEs. This ACE Framework will ensure that this is achieved by providing the direction, vision and support needed for the emergence of an ACE Movement.
Background and context of initiatives	Blackburn with Darwen has been driving the ACE agenda for a number of years. It was the first area in the UK to undertake a population-based ACE survey, which identified the prevalence of ACEs across the Borough and identified the poor health and social outcomes in adulthood. The population study has since been repeated in England and Wales, both of which found similar results to Blackburn with Darwen. ACEs are common and endemic. Almost half (46%) of adults living across the Borough have suffered at least one ACE, with 12% of adults in Blackburn with Darwen having suffered four or more ACEs (Bellis et al., 2013). This study showed that the more ACEs people experience, the greater the risk of a wide range of health-harming behaviours and diseases as an adult. The impact on poor health and social outcomes is so evident, and with our own local findings, the ACE agenda must be considered within all communities and across all sectors. Failing to address ACEs is expensive. In 2014, the estimated impact of social costs and lost earnings associated with child maltreatment was $5.8 trillion in the USA alone. Dr Robert Anda,

	co-author of the original ACEs study, describes ACEs as *'chronic'* and *'insidious'* with their impact passing from generation to generation via epigenetic inheritance and he states that ACEs '*are the single greatest unaddressed public health threat facing our nation today.'* It is, however, possible to prevent or reduce the consequences of ACEs in those that have already experienced them. Over 14,000 people worldwide are part of a growing social movement to address ACEs, mainly in America thus far but with an increasing number being based across the UK. The movement arose in response to a public health study conducted by Kaiser Permanente and the Centres for Disease Control and Prevention (Felitti and Anda, 1998), which identified a range of stressful or traumatic experiences that children can be exposed to whilst growing up. The ACEs[1] range from experiences that directly harm a child (such as physical, verbal or sexual abuse, and physical or emotional neglect) to those that affect the environment in which a child grows up (including parental separation, domestic violence, mental illness, alcohol abuse, drug use or incarceration). The ACE study found a strong dose-response relationship between these ten ACEs and the adult onset of chronic disease (diabetes, heart disease, etc.) and negative health and social behaviours (smoking, alcoholism, violence, incarceration etc.). Similar findings have been found in Blackburn with Darwen, England and Wales, as well as across Europe. Through this whole system and cultural change programme in developing 'ACE informed communities' and 'ACE informed

[1] Please refer to Appendix A for the full definition of ACEs

	organisations' we intend to: 1. Prevent ACEs from occurring across the population via a universal approach. 2. Prevent ACEs from occurring in high risk individuals, families and communities via a targeted approach. 3. Prevent the re-occurrence of ACEs for those people who have experienced ACEs. 4. Prevent or mitigate the consequences for those people who have experienced ACEs. 5. Decrease the population prevalence of ACEs and reduce the population's average ACE score by 1.
Rationale	This large-scale change programme will enable cultural change across our organisations and within our communities so that conversations become strength-based and resilience focussed through the perspective and understanding of ACEs, and where ACEs can be prevented by building resilient, nurturing communities, families and individuals. It is important that childhood adversity does not remain hidden, is not considered a social taboo and is not about shame or blame. This approach sits alongside the emerging neuroscience of the impact of childhood adversity and the mechanisms of association. We will take a population approach to enable a downward shift in ACE incidence and prevalence, through both universal and targeted approaches. We will support, develop and align interventions that are from an ACE perspective so that we become ACE-aware and where communities, organisations, services and interventions are ACE-informed. A public health approach will be adopted to reduce children's

	exposure to ACEs. It is well evidenced that safe, stable and nurturing relationships (SSNRs) have positive impacts on a broad range of health problems and on the development of skills that will help children and their families. Other key programmes also have positive impacts, such as: the healthy child programme; parenting programmes; intimate personal violence prevention programmes; social support for parents; home visitation to pregnant women and families with new-borns; mental illness and substance misuse services; preschool and school enrichment and income support for low income families. This list is not exhaustive and there is not one simple solution. Further, the ACE agenda is still relatively new and, to date, we have not yet tested propositions that use childhood adversity concepts as central tools. The complexity of preventing ACEs lends itself to adopting the ecological model, where strategies and changes are required at all levels. The ecological model considers the complex interplay between individual, interpersonal, organisational, community and public policy. It allows us to understand the range of factors that put people at risk of being exposed to ACEs, protect them for experiencing such adversity and to mitigate the impact of ACEs. The components within the ecological model overlap, thereby demonstrating how factors at one level influence factors at another level. Further, to sustain prevention efforts over time, it is important to act across multiple levels of the model at the same time and to consider the primary, secondary and tertiary prevention aspects. Adopting such a model would support a coherent set of principles to guide ACE prevention and mitigation, align ACE principles alongside existing interventions, and become a mechanism for determining gaps in strategies to guide new service

		development (Blodgett, 2009).
Implementation	**Supporting Factors**	Strategic Support and Agreement Incorporated into the integrated health and care agenda locally Proactive, innovative and passionate workforce
	Challenging Factors	No additional finances No national direction across government
Process	**Key actions taken**	Agreement into key strategies and policies at local level. Multi agency group established. Clear governance and accountability
	Timescales	
Resources		Within existing resources
Outcomes (and Efficacy)		As above: 1. Prevent ACEs from occurring across the population via a universal approach. 2. Prevent ACEs from occurring in high risk individuals, families and communities via a targeted approach. 3. Prevent the re-occurrence of ACEs for those people who have experienced ACEs. 4. Prevent or mitigate the consequences for those people who have experienced ACEs. 5. Decrease the population prevalence of ACEs and reduce the population's average ACE score by 1.
Transferability		Population and targeted approach – so transferable across populations.
Further information		
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