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COVID-19 should be considered an Adverse Childhood Experience (ACE)

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Growing up with Adverse Childhood Experiences (ACEs) such as abuse, neglect, community violence, and homelessness, or growing up in a household where adults are experiencing mental health issues or harmful alcohol or drug use, has been shown to have long-lasting effects on people's lives. This is why the identification and prevention of ACEs and supporting children and adults affected has become a priority for government. Frontline organization practitioners are being encouraged to ask "what happened to you?" rather than "what is wrong with you?" (Centre for Health Care Strategies, 2016). The emphasis is on a personal experience and individual interpretation of an event(s). With COVID-19 being experienced so differently by different groups of people, we argue that the COVID-19 pandemic should be treated as an ACE, which could have short- and/or long-term impacts on a range of health and life outcomes. However, as with the existing dangers of ACE enquiry (Bateson, McManus, & Johnson, 2019), we must remember it is not the ACE itself, but the perception and experience of the ACE which is key.

What are ACEs?

Adverse childhood experiences were first identified by Felitti et al. (1998), who explored the relationships between experiences of trauma in childhood and detrimental effects on health outcomes later on in life. There are 10 main categories of ACE: physical, emotional, and sexual abuse, physical and emotional neglect, parental abandonment, parental imprisonment, mental illness, domestic violence, and substance misuse (Public Health Scotland, 2020). Experiencing ACEs without supportive/protective factors to mitigate their effects, can impact on well-being and mental health and is often correlated with health-harming behaviours that can lead to long-term consequences such as increased risk of diabetes, heart disease, and cancer (Bellis et al., 2016). These non-communicable diseases reportedly kill 41 million people a year (World Health Organisation, 2018). Felitti also found a correlation between ACEs and poor educational outcomes, higher unemployment, and increased involvement with the criminal justice system. A recent report by Jones et al. (2020) found that violence costs the economic health system an estimated £46.6 million just in short-term consequences.

Adverse childhood experiences often co-occur (Hughes et al., 2017), with the two most common ACEs from the 21st century being those related to alcohol and substance misuse (Finkelhor, 2020), both of which have been exacerbated due to the COVID-19 pandemic and lockdown restrictions (Public Health England, 2020; Yougov Poll, 2020). While this paints a bleak picture, it is crucial to remember that ACEs are a risk factor and not a predetermined fate. Experiencing an ACE does not necessarily lead to poor outcomes. Adverse childhood experiences are not inevitable nor do they determine a child's future destiny (Burke, 2020). Furthermore, if we understand the potential impact of an ACE we can take action. By considering COVID-19 as an ACE in its own right, we hope to raise awareness of potentially harmful effects, both short- and long-term, as a result of the COVID-19 pandemic and its restrictive measures. Moreover, we advocate that, as with all experiences of childhood adversity, this calls for understanding the individual and personal experience and responding with a trauma-informed approach to support children and families.

International impact of ACEs

Research has been carried out throughout the world, providing a variety of statistics on ACEs. It has been reported that, within North America, ACEs cost the economy US$748 million (America's Health Rankings, 2020). Across the globe, Kezelman et al. (2015) estimate the cost of unresolved childhood trauma in Australia at AU$9.1 billion. The World Health Organisation (2019) notes that ACEs cost North America and Europe US$1.3 trillion dollars a year. In response to this, money is being invested in support for those who have experienced ACEs. Kaiser Permanente, a network of health care providers in the United States and founder of the ground-breaking 1998 ACE study, has recently invested £2.75 million in research in the prevention and reduction of ACEs (Kaiser Permanente, 2019). The ACEs movement has been expanding massively, evidenced by the worldwide network ACEs Connection, which has over 40,000 members and advocates for trauma-informed resources based on a growing body of science.

Within the United Kingdom, all countries have shown a commitment to tackling ACEs (Public Health Scotland,

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2020; Department for Health and Social Care, 2018; Bellis et al., 2016; Safeguarding Board for Northern Ireland, 2018), and the ACE movement is continuing to evolve. There are various tools used to capture the prevalence of ACEs, such as The World Health Organisation's international questionnaire (n.d.), resulting in ACE scores. Whilst it is positive to recognize potential trauma a person has experienced, it is important to remember that the narrative must go deeper and that experience is not accurately reflected simply in a score (Hambrick et al., 2019).

How can COVID-19 be an ACE when the whole world has experienced it?

Our whole argument since working on the adoption of ACEs within the criminal justice system (see Early Action Together, 2018) has been warning about the simplification of the model that allows practitioners to use ACEs as a checklist. In our paper discussing the misuse of ACEs (Bateson et al., 2019), we warned about organizations that were either refusing or including an individual for treatment, intervention, or service based on the number of ACEs they checked. However, like COVID-19, it is not the presence of the ACE but the personal experience we need to focus on.

We have all experienced the effects of the COVID-19 pandemic one way or another. Lots of families have talked about the great positives of COVID-19 in theirs and their children's lives, such as spending more time together and "strengthening family bonds" (Clayton & Potter, 2020). A recent article also highlighted additional positives, such as embracing a much more dynamic and less routine-based lifestyle with our families (Pope, 2020). Then there are those families that have had to balance full-time jobs with children at home (Craig & Churchill, 2020). Some parents have stated that they have seen changes in their children's behaviour, agreeing that this has worsened in lockdown (University of Oxford, 2020). The knock-on effect of this can be increased screen time due to isolation at home, with parents at home working and providing reduced levels of supervision of their children's online activities and engagement. The World Health Organisation (2020) has warned this could lead to increases in sedentary lifestyle, changes in mood and behaviour, and, of course, the risk of being exposed to harmful content, exploitation, and cyberbullying.

The impact of lockdown is diverse, but while most people will recover from the challenges posed by the COVID-19 pandemic, the assumption cannot be made that all children will simply "bounce back."

The danger surrounding COVID-19 is that we may consider that *everyone* has been adversely affected by COVID-19 and that, therefore, any changes in behaviour, mood, physical appearance, emotions, an so on are just a natural consequence of COVID-19 and the social restrictions that we all had to abide by. Thinking this way is simply wrong. It assumes that there was an equal playing field prior to COVID-19 and ignores the protective factors, often taken for granted, in place for some children (Madigan et al., 2018). These include stable attachments (Stacy, 2006) and strong relationships (Bright, 2017) with loving extended family or friends, as well as permanent and secure accommodation. It also implies a life free from the horrors of hunger, domestic abuse, parental long-term unemployment, mental illness, and substance misuse. If these protective factors were absent before, there is a strong possibility that the situation is deteriorating rapidly, as evidenced by the Office of National Statistics (2020) reporting increased unemployment, increased risky alcohol consumption (Public Health England, 2020), and increased referrals for urgent mental health cases (Royal College of Psychiatrists, 2020). In addition to this are the national spikes in domestic abuse cases: the *Telegraph* newspaper reported an increase of 54% in women needing emergency accommodation in July alone and an 800% increase in calls to Refuge's National Domestic Abuse Helpline (Davies, 2020). Are we expecting children from these chaotic households to have experienced the same ups and downs of lockdown as those who have regular and sustained protective/supportive factors? And let's remember, the restrictions are far from over.

What are the benefits of including COVID-19 as an ACE?

It is well known that many organizations have now bought into the concept of trauma-informed practice. The College of Policing (2018), England's National Health Service (2019), Trauma Informed Schools UK (2020), and Criminal Justice agencies (Papamichael, 2019) have all come to the conclusion that considering ACEs is an essential component when dealing with people, often vulnerable, on a daily basis. These organizations are spending thousands on trauma-informed training and are no doubt already talking about COVID-19, but are they considering this as a traumatic, individualized experience?

CONCLUSION

Our point has always been that the simplification of ACEs could be the potential downfall of the concept. The frequency, severity, chronicity, and type of ACE, along with such factors as the age of the child and other socio-demographic factors, will vary the impact of each ACE experience (Bateson et al., 2019). It is likely that, upon returning to schools, teachers will have witnessed changes in the behaviour of children who have experienced trauma as a result of the lockdown. Welcome guidance has already begun to be circulated by Merseyside Violence Reduction Partnership (2020) and Lancashire Violence Reduction Unit (2020) to assist schools in recognizing the potential signs of trauma.

Adverse childhood experiences can affect people either directly or indirectly. The same is true for COVID-19. In a world where we look to be informed by evidence and are "guided by science," the ACE-awareness movement needs to become mainstream and consider a variety of adverse experiences, such as the COVID-19 pandemic. If individuals are aware of the impact of ACEs and their relevance to COVID-19, they are more likely to be empowered to make decisions for themselves and their families. The pandemic has impacted upon all children, but not all children will have experienced COVID-19 as an ACE.

Adopting COVID-19 into the ACEs framework will encourage practitioners to ask the question "how was lockdown for you?" Simply pausing to consider the varied impact of COVID-19 and basing next steps in decision-making on *their* experience, not on *our assumptions* of their experience, can be the difference between making people safe and allowing them to continue to be harmed.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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