Voices of those with lived experiences of homelessness and adversity in Wales:

Informing prevention and response

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Executive Summary

Homelessness is a serious societal and complex public health issue, that is an indicator of fundamental breakdown in a person's life, with wide-ranging causes and consequences, including ill-health.

We know a great deal about individual, familial, and structural causes of homelessness and yet it still persists and is projected to rise. Efforts to reduce homelessness have so far focused on crisis prevention, with little attention paid to early intervention and primary prevention. Dealing with homelessness is complicated as it involves not only identifying and implementing effective solutions to support people, but also addressing these multiple complex personal and structural causes that can occur throughout the life course; including those experienced in early childhood such as Adverse Childhood Experiences (ACEs), and other associated risk factors such as poverty.

This study aimed to explore the relationship between adversity in childhood and later risk of homelessness, as well as to explore perceptions of the opportunities for early intervention. This work is key to understanding the role of ACEs in life-pathways that lead to homelessness. It will also help understanding with regards to how early support

centred around childhood adversity, for both children and adults, could be used to help prevent homelessness and reduce health and social inequities.

Findings and recommendations for early intervention and preventative action

Around **one in 14 (7%) of the Welsh adult general population reported lived experience of homelessness**, and those who reported **four or more ACEs were 16 times more likely to report lived experience of homelessness** at some point in their adult lives.

This suggests that by reducing or preventing adversity experienced by the child, this may help reduce future vulnerability by mitigating negative health and social outcomes in the adult, including homelessness. Participants with lived experience of homelessness discussed developing maladaptive coping behaviours in teenage years, or earlier, in response to the adversity they were experiencing, that continued into adulthood and contributed to their homelessness. Resilience assets are known to be protective against ACEs, and here we found that those with lived experience of homelessness had lower Childhood Resilience Levels compared to those without homelessness experiences.

We also found that the likelihood of reporting homelessness **reduced from 16 to 8.1** times for those with four or more ACEs in the presence of Childhood Resilience Levels,

suggesting that **childhood resilience assets have a moderating effect by protecting against ACEs leading to homelessness** outcomes in

adults. Participants described how **belonging to a community** (religious or school), having a **trusted relationship** with a stable adult, and **supportive teachers** seeing beyond the presenting behaviour helped them to cope. Participants described being in contact with multiple services both throughout childhood and later as adults experiencing homelessness, and that **barriers to support** included not being listened to, fear of the consequences, lack of trust, not seeing the person behind the presenting behaviour, and the child not recognising their experiences as adversity.

The views of service providers supported participants' experiences and insights of key opportunities for early intervention.

Considerations for further action:

1. **Capacity** needs to be built into services across sectors in order to take a multi-agency, trauma-informed approach to the vulnerable child or adult, to better support the individual by developing sustainable trusted relationships, and by improved communication skills and better listening so that appropriate interventions can take place and supportive pathways followed. Community and family should also be recognised as key assets to supporting the vulnerable individual, and capacity promoted in these support systems as well as in services.

2. To use **awareness** of the impact of adversity in childhood on later vulnerability in adults, including homelessness, so that all services that come into contact with children and young people are better informed to identify those at-risk from adversity in their household, and for services to work together to provide better support for the child and for adults and parents who are struggling to ensure early prevention.

3. Better addressing the **support needs** of both child and adult vulnerable populations that have been impacted by ACEs, by seeing the person underneath and listening to them rather than focusing on the presenting behaviour. Ensuring that support and provision of services are culturally and environmentally supportive of individuals with ACEs, and barriers to access to health and social support minimised.

4. Support **early years' settings** to work in a trauma-informed way and to recognise vulnerability in the child, and to ensure that early intervention is multi-agency and centred around supporting the child and their family. Support for the vulnerable child should continue over time as they transition from primary to secondary school, and to prevent the impact that barriers to education could have on health and social inequities.

5. Recognise the value that teachers, support workers, and community support systems play in early intervention and in providing a **holistic system of support** for the child (e.g. Team Around the Family Approach), with the focus on taking a trauma-informed approach to vulnerability and building a trusted and constant relationship with the child.

6. Public bodies need to take a **Children's Rights Approach** to supporting children at-risk from adversity. Empower the child and improve awareness of the Rights of the Child among children, through helping them to recognise what is normal and acceptable and what is not, to communicate their experiences effectively and understand how they can access support, and to build resilience skills to mitigate the impact of ACEs and prevent future homelessness.

This study supports the need to think about homelessness in a different way and to consider action to reduce and prevent homelessness, through early identification and action to prevent and mitigate ACEs in vulnerable children and young people. As well as supporting vulnerable adults who find themselves homeless, by strengthening understanding of adversity in childhood as a cause of health and social inequities and a barrier to services supporting those who find themselves homelessness.

1.0 Background

Homelessness is a serious societal issue that can cause deterioration of physical and mental health (1), and is caused by a combination and accumulation of factors including lack of housing affordability, life disadvantage, and traumatic life events, including those experienced in early childhood. There is growing evidence to suggest that adversity experienced in childhood can lead to vulnerability in adulthood, impact health and life chances, and contribute to adverse housing outcomes (2–8).

Good quality housing and sense of belonging is fundamental to good health and wellbeing. Having a home is a basic need and a stabilising factor that brings benefits to health from access to employment and education (9), and reduces health inequalities - a key public health priority. Inadequate housing, including homelessness, is known to directly and indirectly affect physical, social, and mental health (10,11).

1.1 Homelessness as a public health concern

Homelessness is an indicator of a fundamental breakdown in a person's life (12) and can be **chronic, episodic**, or **transitional** (situational) (13,14). Homelessness can be defined as having either a lack of adequate housing to which individuals have personal access, or living in housing below a minimum adequacy standard (15). This includes both street homeless, or **rough sleepers**, but also the **hidden homeless** with temporary living arrangements i.e. 'sofa surfing' or living in Bed and Breakfasts (B&Bs) (12,14,16,17). Therefore, measures of the extent of homelessness and lack of reliable data is likely to underestimate the extent of homelessness and the impact on societal health (17,18).

Homelessness is caused and maintained by a wide range of **structural** (macro-level) and **individual** (micro-level) factors interacting (19–21). Structural factors include a lack of affordable housing, unemployment, and changes in social support. Individual factors include life histories or disadvantage, and life events (1,22,23) such as breakdowns in family relationships (16). The risk of homelessness is higher for those leaving institutional environments, such as the care system and prison (24,25).

Homelessness is a complex and persistent public health issue (17,26), and an extreme form of social exclusion (13,27) with homeless people experiencing considerable health inequities (27), with ill-health both a cause and consequence of homelessness (28). For example, ill-health may contribute to job loss or relationship breakdown, which in turn can result in homelessness. Once homeless, a person's health and wellbeing deteriorates and is far poorer than that of the general population (1,24,28,29), and the homeless population has a high proportion of **multiple health issues** with bidirectional processes underlying the link to homelessness, including mental health problems, physical illness, or substance misuse problems (12,30,31). Homeless individuals are four times more likely to use Accident and Emergency services (A&E) than the general population, and this over-representation in unscheduled care costs the NHS eight times more than the general population (29,32,33), moreover there are barriers to access to healthcare for this population (17,34). Excess mortality in this population is significantly higher than in the general population (27,33,35). A great deal is known about the individual and structural causes of homelessness, and yet homelessness persists and is projected to increase (36).

Dealing with homelessness is complicated as it involves not only identifying and implementing effective solutions to support people, but also addressing the **multiple complex causes** (19). Homelessness in countries with advanced welfare systems is concentrated around people with psychosocial vulnerabilities (13), as well as poverty and other social inequities likely to be contributing factors (13,18,21,31,37).

1.2 The link between childhood disadvantage and later homelessness

Homelessness in youths and adults is one of the negative effects that has been associated with adversity in childhood (8,38,39), where homelessness in adults is more likely amongst those who have experienced a history of childhood adversity and poverty (21,23,26,30,31,40,41). In particular, homelessness in adulthood has been associated with individual risk factors experienced in childhood such as parental addiction, domestic violence (DV), and living in social housing or local authority care as a child (23). Family relationship problems and lack of support networks are common amongst teenagers and young adults who find themselves homeless (42). Many of these adversities are recognised collectively as **Adverse Childhood Experiences** (ACEs) - stressful experiences that children can be **directly** or **indirectly** exposed to while growing up (2). ACEs include: childhood abuse (physical, sexual or emotional); family breakdown; exposure to domestic violence; or living in a household affected by substance misuse, mental illness, or where someone is incarcerated (2); and emotional and physical neglect (43). ACEs are interrelated, so if one ACE is reported this increases the chance of reporting at least one more (2,44,45).

Grouping them collectively as ACEs has been found to provide a better assessment of the breadth of childhood adversity and the relationship with health and social issues, irrespective of the potential for relative effects of individual ACEs and different combinations (5). The national Welsh ACE study found that 14% of adults had experienced four or more ACEs (46).

There has been growing evidence in the past two decades that exposure to ACEs early in life has long-term impacts on health, wellbeing, and behavioural issues (2–4,44,47) and that many of these conditions and outcomes could have been alleviated if toxic stress caused by ACEs was addressed in childhood (48–51). Understanding ACEs in different populations (e.g. patients in health settings, social care, schools) could help to improve our understanding of the underlying causes of health issues or behaviour, as well as enable better-informed intervention options to reduce their effects (5). A systematic review found that ACEs are risk factors for many health conditions in adults, but the associations were particularly strong for violence, substance misuse, problematic alcohol use, and mental illness (5), which are also factors associated with homelessness (42). The systematic review also highlighted a consistency between studies, in the links between exposure to multiple ACEs and poor health, despite variations in type and extent of exposure (5). Homelessness is a late emerging symptom in those experiencing deep social exclusions, including institutional care (prison, local authority care, mental health hospitals/wards), substance misuse (drug, alcohol, solvent/gas), or participation in street culture activities (begging, street drinking, survival shoplifting, sex work) (41). With ACE-prevalence extremely high in this population, suggesting that homelessness is a symptom of a life-pathway that is influenced by a range of known variables (52). Where exposure to social disadvantage in childhood leads to being less likely to adapt successfully and more likely to adopt unhealthy coping behaviours (53).

Individuals with 'lifetime homelessness' (see Section 2.0) in a study from the USA had experienced **higher rates of all childhood adversities**; 85% of women and 77% of men with lifetime homelessness had experienced at least one adversity (1). Other research from the USA has shown that in the homeless population, 87% reported at least one ACE, and 53% reported four or more ACEs (7). Half reported parental loss, emotional neglect, living with a substance abuser, and emotional abuse as a child, with the ACEs significantly correlated with one another (7). A survey of rough sleepers in Wales by Shelter Cymru found that nearly everyone disclosed multiple ACEs and recognised the impact these ACEs had had on them as adults (6).

1.3 Can resilience help mitigate between ACEs and homelessness?

Resilience is a combination of **internal and external assets** that help an individual to cope with or thrive when faced with adversity; these include secure attachment with a trusted adult and later in adolescence peer-relationships, adaptive learning, problem-solving, engaging with others, having self-valued competences, and feeling valued by society (54). **Resilience is seen as protective against ACEs**. An association between resilience factors in childhood and not going on to develop adverse health and social outcomes from exposure to ACEs suggests there is a protective effect (43,46,55,56). The availability of **social support networks** may be protective against homelessness in those who are at-risk, although this can be put under strain by stressors associated with poverty (20,21).

1.4 Preventing homelessness through early intervention

Wales is leading the way on preventing homelessness through the pioneering Housing (Wales) Act 2014, which has shown that a legal right to assistance is an effective driver for change (57). However there is not equality in service outcomes, with some of the most challenging and socially vulnerable households (e.g. single people, prison leavers) not always being entitled to support (57), and with most interventions limited to private rented sector tenancy access support and crisis (eviction) prevention (57). The solutions for homelessness is not just removing the absence of a home - homelessness is a more complex social and public health phenomenon beyond bricks and mortar and understanding the social element is key to prevention (26). Work between Public Health Wales and housing partners has been undertaken to reduce the chance of vulnerable tenants becoming homeless through training social housing staff to look at tenants through an ACE-lens and help them access support and prevent evictions through taking a trauma-informed approach to ACEs (58). A trauma-informed approach would include understanding of ACEs, an environment of physical and emotional safety, and a strengths-based approach to services (58).

Improving our understanding of adversity in childhood and the path to homelessness will help to provide a foundation for public health to work together with other sectors to reduce homelessness in Wales through preventing or lessening the impact of ACEs (59). Preventing adversity from ACEs and supporting the needs of vulnerable populations has the potential to prevent the threat of evictions and homelessness, through greater understanding of trauma and its impacts on the life-path (58). Understanding some of the individual factors that cause homelessness, the influence that these factors had on the life-path leading to homelessness, and how these individual factors impact the individual accessing support from services, would provide insight on how to intervene earlier to prevent homelessness and how to overcome barriers to supporting those who find themselves homeless.

2.0 Methodology

This study aimed to explore the relationship between adversity in childhood and later risk of homelessness, as well as to explore the key opportunities for early intervention. ACE-prevalence and the relationship between ACEs and homelessness was explored through a) analysis of an existing dataset and b) qualitative semi-structured interviews with individuals with experience of homelessness (n=27), as well as service providers (n=16).

2.1 ACE and Resilience survey

The Public Health Wales 2017 ACE and Resilience survey data was analysed in order to understand associations between ACEs and homelessness in Wales. Analyses included bivariate analyses using chi-squared and logistic regression to examine independent relationships between homelessness and exposures, including ACEs, controlling for socio-demographic characteristics (age, deprivation, gender, and ethnicity). Statistical analysis of the data was undertaken using IBM SPSS Statistics for Windows, Version 24.0.

The study design was a cross-sectional retrospective national Welsh survey that took place during four months in 2017, using a stratified random probability sampling methodology. Data collection was face-to-face doorstep interviews at the homes of respondents by trained interviewers and is described in detail in Hughes et al. (2018) (46). The final sample size for analysis was n=2497 (58.5% response rate from the households contacted).

The outcome of interest, adult lifetime homelessness, was measured by asking respondents *'Since the age of 18, has there been a time in your life when you considered yourself homeless?'* with a dichotomous (yes/no) response. Unless specified, the full sample was used in all analyses; where specified the data was adjusted (weighted) to reflect the Welsh national population (46).

The primary exposure variable was the ACE Count. ACEs experienced under the age of 18 were measured retrospectively using standardised questions from the validated Centers for Disease Control and Prevention short ACE tool (43). Eleven ACEs were measured (*childhood abuse*: 1) physical, 2) sexual and 3) emotional; *neglect*: 4) physical and 5) emotional; 6) parental separation or divorce; 7) exposure to domestic violence; and living in a household affected by 8) alcohol misuse, 9) drug use, 10) mental illness, or 11) where someone is incarcerated) (43). The individual ACEs were summed and categorised into an ACE Count variable for respondents reporting 0, 1, 2-3, and ≥4 ACEs for use as an independent variable for analysis, allowing a cumulative measure of exposure to ACEs and comparability to other research (43).

Secondary variables were childhood resilience and absence from school. Childhood resilience (<18 years old) was measured retrospectively using an established resilience tool, the Child and Youth Resilience Measure (CYRM-12)(60), and analysed individually, and by categorising into three levels - low (≤6), medium (6-9) and high (≥9) Childhood Resilience Levels (46). An additional childhood resilience asset related to resilience and ACEs was included - access to a trusted adult in childhood (55). Retrospective secondary school absenteeism was categorised as never/rare, 5-10 times per year, 11-20 times per year, or more than 20 times per year. Models were adjusted for the a priori selected socio-demographic covariates of age, deprivation, gender, and ethnicity.

2.2 Qualitative interviews

Semi-structured interviews took place in two groups, service users and service providers, to understand the pathways to homelessness from an ACE-perspective and explore opportunities for early intervention to prevent homelessness. Topics were informed by the literature and from expert input. For service users, themes included discussion of ACEs prompted by an infograph, home and school life, events leading to housing transitions including homelessness as an adult, and how services could work differently. For service providers, topics included the relationship between ACEs and homelessness, and how different services could intervene earlier to mitigate and prevent

homelessness. Each interview took on average 40 minutes. Informed consent was obtained from all participants, and ethical approval was obtained through Cardiff University and NHS research permissions gained through IRAS (Project 247731). Interviews were transcribed, anonymised (pseudonyms used), coded and analysed (using a qualitative data analysis (QDA) software package, ATLAS.ti, Version 7.5.15). General themes were identified through thematic analyses.

Face-to-face interviews of service users (self-identifying as homeless, or previously homeless in the South Wales area, and accessing homelessness services (n=27)) took place between August 2018 and January 2019. Three sub-groups were purposively recruited through homelessness services in South Wales – young adults (aged 18-24) (n=9), adults with children (n=10), and single adults (n=8). In total nine males and 18 females were interviewed. A small incentive was given to service users for taking part in the interview (£10 gift voucher). Where requested by participants, support workers could be present during the interview, and this occurred in four cases.

The types of service providers interviewed were informed by the qualitative interviews with service users, in order to reflect a range of services that people had been in touch with throughout their lives.

These included:

- Primary School: wellbeing and additional learning needs (n=1)
- Secondary School: assistant head (n=1)
- Primary Care: GP with special interest in Vulnerable Groups (n=1)
- Health Board: Inequalities/Partnerships, Housing and Mental Health (n=2)
- Department of Work and Pensions: drug and alcohol dependency, supporting employment opportunities (n=4)
- Clinical psychology: work in mental health wards/psychiatric hospitals and research (n=1)
- Social Work: Children and Families (n=1)
- Housing Organisations (n=2)
- Homelessness Charities (n=2)
- Youth Services (n=1)

The roles of those people interviewed ranged from Chief Executives to front line service delivery staff from organisations across Wales, covering both strategic and operational perspectives. The interviews took place face-to-face or by telephone between November 2018 and February 2019.

3.0 Results

3.1 ACE and Resilience survey

Within the populations sampled, 6.6% reported lived experience of homelessness. When weighted to reflect the Welsh national adult population **the proportion of those with lived experience of homelessness in the population increased to 7.0%**. Socio-demographics are summarised in Table 1.

Table 1: Characteristics of those with lived experience of homelessness

Characteristics of sample	Lived experience of homelessness % (n)		χ^2 (p)	OR (95% CI)	p
	No	**Yes**			
Full sample (unweighted)	93.4 (2333/2497)	6.6 (164/2497)			
Full sample (weighted)[a]	93.0 (1864/2005)	7.0 (141/2005)			
Gender					
Male	45.1 (1052/2333)	48.8 (80/164)	0.841 (0.359)	Ref	
Female	54.9 (1281/2333)	51.2 (84/164)		1.160 (0.85, 1.59)	0.359
Age group (years)					
60-69	24.9 (566/2270)	6.1 (10/164)	36.859 (0.000)	Ref	
50-59	18.5 (419/2270)	19.5 (32/164)		4.072 (1.97, 8.42)	0.000
40-49	19.8 (450/2270)	31.1 (51/164)		5.552 (2.75, 11.21)	0.000
30-39	18.4 (418/2270)	25.0 (41/164)		6.415 (3.22, 12.78)	0.000
18-29	18.4 (417/2270)	18.3 (30/164)		3.758 (1.83, 7.72)	0.000
Deprivation quintile					
1 (least)	19.4 (453/2333)	9.1 (15/164)	36.893 (0.000)	Ref	
2	21.3 (496/2333)	16.5 (27/164)		1.644 (0.86, 3.13)	0.130
3	25.5 (595/2333)	19.5 (32/164)		1.624 (0.87, 3.04)	0.128
4	18.9 (440/2333)	25.0 (41/164)		2.814 (1.54, 5.16)	0.001
5 (most)	15.0 (349/2333)	29.9 (49/164)		4.240 (2.40, 7.69)	0.000
Ethnicity					
White	96.4 (2250/2333)	95.7 (157/164)	0.223 (0.637)	Ref	
Other	3.6 (83/2333)	4.3 (7/164)		1.209 (0.55, 2.66)	0.637

OR: Odds ratio of reporting lived experience of homelessness for socio-demographic characteristics

[a] Weighted to national Welsh population (n=2005) using mid-2015 population estimates for Lower Super Output Areas (LSOAs) by sex, age group and deprivation quintile.

Males and females were equally likely to report experiencing homelessness in our sample. The oldest age group was least likely to report homelessness. Compared to the 60-69 age group, individuals aged 30-39 years were 6.4 times more likely to report lived experience of homelessness, and individuals aged 40-49 years were 5.5 times more likely to report lived experience of homelessness. Compared to those living in the least deprived areas, those living in the most deprived areas in Wales were 4.2 times more likely to report lived experience of homelessness, as measured by the Welsh Index of Multiple Deprivation (WIMD) (61).

3.1.1 Relationship between ACEs and experiencing homelessness

Compared with those with no ACEs, individuals with **four or more ACEs** were **16.0 times more likely** to report experiencing homelessness (Table 2). As the ACE Count increased, the prevalence of homelessness increased. More than half (54.0%) of those without lived experience of homelessness reported no ACEs at all, **compared to just 13.4% of those with lived experience of homelessness.** In contrast, while 10.8% of those without lived experience of homelessness reported having **four or**

more ACEs, this increased to 50.0% of those with lived experience of homelessness.

A significant association between ACEs and experiencing homelessness was evident for each specific type of ACE, with the strongest associations for physical neglect (AOR 8.0), physical abuse (AOR 7.0) and sexual abuse (AOR 7.1), followed by emotional neglect (AOR 6.9), verbal abuse (AOR 5.3) and domestic violence in the home (AOR 5.2) (Table 2).

3.1.2 Relationship between childhood resilience and experiencing homelessness

The relationship between childhood resilience assets and lived experience of homelessness as an adult was explored (Table 3). Compared to those with low Childhood Resilience Levels, individuals with medium Childhood Resilience Levels were 2.8 times

less likely (1/0.360) to report lived experience of homelessness, and individuals with high Childhood Resilience Levels were 10.9 times less likely (1/0.092) to report lived experience of homelessness. 72.6% of those without lived experience of homelessness reported **high Childhood Resilience Levels**, compared to just **28.2% of those with lived experience of homelessness.**

A significant association between childhood resilience and lived experience of homelessness was evident for each individual type of childhood resilience asset, with the strongest association being having a **supportive family** (AOR 0.112), followed by **belonging to the school community** (AOR 0.178), and **solving problems** (AOR 0.184).

Compared to those without a trusted adult, individuals with a **trusted adult** were 4.1 times less likely (1/0.243) to report lived experience of homelessness.

3.1.3 School absence and experiencing homelessness

The relationship between absence from school and lived experience of homelessness as an adult was explored (Table 3). Compared to those who were rarely or never absent from school, those with frequent absences from school were 7.5 times more likely to report lived experience of homelessness.

Table 2: Prevalence of Adverse Childhood Experiences (ACEs) experienced among those with lived experience of homelessness

Characteristics of sample	Lived experience of homelessness % (n)		χ² (p)	OR (95% CI)	p	AOR (95% CI)	p
	No	**Yes**					
ACE Count							
0	54.0 (1259/2333)	13.4 (22/164)	240.090 (0.000)	Ref		Ref	
1	19.7 (460/2333)	11.0 (18/164)		2.239 (1.19, 4.21)	0.012	2.180 (1.15, 4.12)	0.016
2-3	15.5 (361/2333)	25.6 (42/164)		6.658 (3.92, 11.30)	0.000	5.904 (3.46, 10.09)	0.000
4 or more	10.8 (253/2333)	50.0 (82/164)		18.548 (11.37, 30.26)	0.000	16.039 (9.73, 26.43)	0.000
Individual ACEs							
Verbal abuse	17.1 (400/2333)	55.5 (91/164)	142.602 (0.000)	6.024 (4.35, 8.35)	0.000	5.261 (3.77, 7.34)	0.000
Physical abuse	13.0 (304/2333)	53.0 (87/164)	185.806 (0.000)	7.541 (5.42, 10.48)	0.000	7.027 (5.00, 9.87)	0.000
Sexual abuse	5.9 (138/2333)	28.0 (46/164)	109.905 (0.000)	6.198 (4.23, 9.08)	0.000	7.108 (4.69, 10.78)	0.000
Parental separation	21.5 (502/2332)	53.7 (88/164)	87.643 (0.000)	4.221 (3.06, 5.83)	0.000	3.736 (2.65, 5.27)	0.000
Mental illness	15.3 (358/2333)	42.1 (69/164)	77.218 (0.000)	4.007 (2.88, 5.57)	0.000	3.786 (2.69, 5.34)	0.000
Domestic Violence	14.4 (335/2333)	48.8 (80/164)	131.009 (0.000)	5.680 (4.10, 7.88)	0.000	5.176 (3.69, 7.26)	0.000
Alcohol abuse	11.3 (263/2333)	31.7 (52/164)	58.040 (0.000)	3.654 (2.57, 5.20)	0.000	3.255 (2.26, 4.69)	0.000
Incarceration	3.3 (78/2333)	12.8 (21/164)	36.026 (0.000)	4.246 (2.55, 7.08)	0.000	3.404 (2.01, 5.77)	0.000
Drug Abuse	4.5 (106/2333)	18.9 (31/164)	55.512 (0.000)	4.658 (3.00, 7.24)	0.000	3.517 (2.22, 5.56)	0.000
Physical Neglect	3.0 (69/2333)	20.1 (33/164)	115.220 (0.000)	8.266 (5.27, 12.97)	0.000	8.004 (4.98, 12.87)	0.000
Emotional Neglect	6.0 (140/2333)	29.9 (49/164)	124.867 (0.000)	6.674 (4.59, 9.716)	0.000	6.865 (4.63, 10.19)	0.000

OR: Odds ratio of reporting lived experience of homelessness for ACEs

AOR: adjusted for age, deprivation, gender, ethnicity

Table 3: Prevalence of childhood resilience assets experienced among those with lived experience of homelessness

Characteristics of sample	Lived experience of homelessness % (n)		χ² (p)	OR (95% CI)	p	AOR (95% CI)	p
	No	Yes					
Individual childhood resilience assets							
Respect others	89.0 (2070/2326)	61.0 (100/164)	107.381 (0.000)	0.193 (0.14, 0.27)	0.000	0.214 (0.16, 0.30)	0.000
Education important	75.2 (1745/2322)	43.6 (71/163)	77.268 (0.000)	0.255 (0.19, 0.35)	0.000	0.270 (0.20, 0.38)	0.000
Engaged with parents	85.9 (2000/2329)	54.3 (89/164)	112.704 (0.000)	0.195 (0.15, 0.27)	0.000	0.215 (0.16, 0.30)	0.000
Complete things	85.6 (1995/2331)	64.4 (105/163)	51.320 (0.000)	0.305 (0.22, 0.43)	0.000	0.337 (0.24, 0.48)	0.000
Solve problems	94.1 (2190/2328)	70.7 (116/164)	120.843 (0.000)	0.152 (0.11, 0.22)	0.000	0.184 (0.13, 0.27)	0.000
Community help	67.7 (1577/2328)	39.0 (64/164)	56.181 (0.000)	0.305 (0.23, 0.42)	0.000	0.313 (0.23, 0.44)	0.000
School community belonging	75.7 (1764/2330)	34.8 (57/164)	130.414 (0.000)	0.171 (0.13, 0.24)	0.000	0.178 (0.13, 0.25)	0.000
Supportive family	92.8 (2159/2327)	58.3 (95/163)	211.305 (0.000)	0.109 (0.08, 0.15)	0.000	0.112 (0.08, 0.16)	0.000
Supportive friends	88.8 (2068/2328)	62.2 (102/164)	96.608 (0.000)	0.207 (0.15, 0.29)	0.000	0.227 (0.16, 0.32)	0.000
Treated fairly	88.1 (2050/2328)	55.5 (91/164)	134.308 (0.000)	0.169 (0.13, 0.24)	0.000	0.196 (0.14, 0.28)	0.000
Given opportunities	81.6 (1900/2328)	46.3 (76/164)	116.102 (0.000)	0.195 (0.15, 0.27)	0.000	0.205 (0.15, 0.29)	0.000
Culturally engaged	81.6 (1899/2326)	51.2 (84/164)	87.442 (0.000)	0.236 (0.18, 0.33)	0.000	0.258 (0.19, 0.36)	0.000
Childhood Resilience Levels (CYRM-12)							
Low	8.7 (203/2326)	41.7 (68/163)	205.381 (0.000)	Ref		Ref	
Medium	18.7 (435/2326)	30.1 (49/163)		0.336 (0.23, 0.50)	0.000	0.360 (0.27, 0.55)	0.000
High	72.6 (1688/2326)	28.2 (46/163)		0.081 (0.06, 0.12)	0.000	0.092 (0.07, 0.14)	0.000
Childhood resilience asset (additional)							
Trusted adult available	79.6 (1842/2315)	48.2 (79/164)	86.555 (0.000)	0.239 (0.18, 0.33)	0.000	0.243 (0.18, 0.34)	0.000
Absence from school							
Rare/never	60.5 (1407/2327)	26.5 (43/162)	156.875 (0.000)	Ref		Ref	
5-10 times per year	21.6 (503/2327)	20.4 (33/162)		2.147 (1.35, 3.42)	0.001	2.036 (1.27, 3.26)	0.003
11-20 times per year	8.0 (185/2327)	11.7 (19/162)		3.361 (1.92, 5.89)	0.000	2.859 (1.62, 5.06)	0.000
< 20 times per year	10.0 (232/2327)	41.4 (67/162)		9.450 (6.29, 14.2)	0.000	7.518 (4.94, 11.45)	0.000

OR: Odds ratio of reporting lived experience of homelessness for childhood resilience assets

AOR: adjusted for age, deprivation, gender, ethnicity

3.1.4 Childhood resilience assets moderating experiencing homelessness

Logistic regression modelling was applied to understand whether Childhood Resilience Levels would moderate the relationship between ACE Count and lived experience of homelessness (Table 4).

Table 4: Relationship between lifetime homelessness, ACEs, and childhood resilience assets among those with lived experience of homelessness

Characteristics of sample	AOR (95% CI)	p
ACE Count		
0	Ref	
1	1.945 (1.02, 3.70)	0.042
2-3	4.180 (2.41, 7.26)	0.000
4 or more	8.073 (4.68, 13.93)	0.000

AOR: adjusted for age, deprivation, gender, ethnicity, Childhood Resilience Levels (CYRM-12)

We saw earlier that compared with those with no ACEs, individuals with four or more ACEs were 16.0 times more likely to report experiencing homelessness (Table 2). The likelihood of lived experience of homelessness **reduced from 16.0 to 8.1 times** for those with four or more ACEs in the presence of Childhood Resilience Levels, suggesting that **childhood resilience assets have a moderating effect protecting against ACEs leading to lived experience of homelessness** as adults (Table 4).

3.2 Qualitative interviews

3.2.1 Service users

ACEs were experienced throughout childhood by some participants and were often frequent, and for other participants or for particular ACEs these started or stopped during periods of transition, for example as a result of changes in their family life such as parents separating. ACEs were often interrelated and cumulative. Pseudonyms are used throughout the illustrative quotes.

3.2.1.1 Childhood trauma and Adverse Childhood Experiences (ACEs)

Participants were asked whether it is acceptable for services to talk to them about ACEs. Three of the service users responded negatively, five responded that it would depend on how the individual felt at the time and what was asked, and 70% responded positively that that they felt it was acceptable. They felt that framing their negative childhood experiences as 'ACEs' was a **helpful tool to aid communication and remove barriers.**

Participants were asked about the number of ACEs they had experienced. Their response, together with other information provided during the interview, was collated (Table 5). All of the 27 participants had experienced **at least one ACE**, and 78% experienced four or more ACEs. Of the individual ACEs disclosed, sexual abuse (22%) and incarceration (33%) were the least commonly experienced ACEs; and physical abuse (59%), alcohol abuse (57%), domestic violence (70%), and parental separation (74%) most commonly experienced.

Table 5: ACEs experienced by participants

	n (%)
ACE Count	
0-1	0
1	1 (3.7)
2-3	5 (18.5)
4+	21 (77.8)
ACE type*	
Sexual Abuse	6 (22.2)
Incarceration	9 (33.3)
Drug Abuse	11 (40.7)
Emotional Neglect	12 (44.4)
Physical Neglect	13 (48.1)
Mental Illness	13 (48.1)
Emotional Abuse	15 (55.6)
Physical Abuse	16 (59.3)
Alcohol Abuse	18 (66.7)
Domestic Violence	19 (70.4)
Parental Separation	20 (74.1)

* ordered by prevalence

3.2.1.2 Childhood and resilience

Participants were asked to describe what their childhood was like. Many of the stories encompassed the child **experiencing and normalising ACEs** and not having a stable upbringing with a healthy adult role model who was physically and emotionally present. Rather they had to take on adult-responsibilities and care for themselves or siblings from a young age, as well as having felt a lack of stability and belonging/rejection. Participants described being stigmatised, having unstable housing, a lack of boundaries, and being exposed to high levels of ACEs from a young age, often leading to the child copying the behaviour and adopting harmful behaviours themselves (e.g. taking drugs or drinking).

My mum never sheltered me from anything, that's why I grew up way too quickly... I was always there... I knew how to be an adult before I was an adult because I was never sent out of the room... I could probably tell you about most drugs by the age of ten. (Aisha)

My mum, physically bit me all over my body, and I got taken off her. And got taken into foster care, for a year, I think it was. Then I got put back with her, because she went into [name removed] mental hospital. And, yeah, just got worse from there... the same sort of cycle over and over again. (Harper)

Many of the participants described their childhood family life as **noticeably different** to that of their friends or peers, describing how the other families were more stable, and children were provided with food and a bed, clean clothes, and days out. One participant described her own home life as a 'nightmare' compared to her peers, and they began to realise when they got a little older that their home life was different to the lives of their peers, leaving them upset and wanting a 'normal' life.

I was about 10. I started realising not everybody was getting hit every day … seeing the police at your house every day wasn't normal … or drugs being in your house, that wasn't normal. (Sofia)

Most participants stated they had **no happy recollections** of childhood, that they had to 'grow up' at a premature age, that they preferred not to think about their childhoods, or that they had unhappy memories linked to the ACEs they experienced or being taken into foster care.

I have got no memories of my childhood that were good… It was all dark and violence…constant violence… at the age of five I left my childhood behind. (Blake)

Participants adopted different ways to **cope or build resilience** as children. Coping mechanisms included: being drawn to **religion**, which provided a sense of belonging and stability; being drawn to friends with stable home lives; **stability** was provided for some by wider family, friends, friends' families, and for some their foster carers where a stable, **trusted relationship** was created. **Self-motivation** or a drive for education and bettering themselves or moving away from their family's ways, was described by some participants.

I started going to church [aged 14]… I felt like I belonged there, like [I] belonged somewhere…if I didn't go to church, then I probably would have been on the street, because my friend took me in … they kind of saved me, if you get me. (Madison)

[I] think it was more seeing how my family was, and knowing that I don't want to be living in poverty for the rest of my life…And, well, actually I just knew from my family there's no… they don't care about my education so I may as well just care about it myself and then just isolate myself from them. (Reggie)

3.2.1.3 Childhood response: maladaptive behaviour

As participants became teenagers they described many different responses to the difficulties they were experiencing at home. Maladaptive responses included:

Being overly-independent: From a young age or taking on the responsibility for younger relatives and not telling anyone what was going on; getting into relationships quickly or to escape the situation they were in (e.g. foster care), repeating **unhealthy relationship patterns** observed in parents, getting pregnant quickly.

I went into things [relationships] a bit quickly, had little respect for myself. And I don't think I was taught that respect at home. (Aisha)

Self-medicating: With alcohol or drugs (in some cases supplied by adult family members, or dealing drugs). Participants discussed **self-harm** and **suicidal** ideation, **violence** and **criminal** behaviour, and **staying out** or **running away** from home, and **rebelling** against all rules. Participants described this as their way of coping with the tension in their home lives, and blocking things out, and this behaviour often started at a young age (beginning of secondary school or earlier).

My way of coping is when I left the school I turned to drugs… as I grew older my mum wasn't very nice to me, and my way of dealing with things was taking drugs. (Alice)

I was drinking, toking [started before age 10], just smoking a lot, getting into fights. Vandalism. Theft. Destroying public property. Fires. Arson. (Blake)

During childhood a great deal of time is spent in the school environment, and most participants described having **difficulties in school** (concentrating, emotionally, bullying, and hanging around with the 'wrong crowd', not caring about

consequences) linked to not feeling safe/instability at home, feeling tearful, anger, a feeling of having no hope, feeling ashamed/anxiety. This led to not coping academically, and poor school attendance. Relationships were used to try to escape the home, some copied behaviour observed at home, for example, promiscuity or being a teenage parent.

When I was with foster carers or my grandad I was good as gold. The school seen a massive [negative] change in my behaviour when I was living at home with my mum... Because I used to think that, the more that I was naughty in school, and got into trouble, the more likely I was to be taken away from my mum. (Harper)

Childhood housing transitions: Participants often discussed unstable childhood living arrangements, and many leaving their homes to live on their own a few years before they reached 18 years old. In some cases, children were sent to live with family members informally because their parents felt unable or unwilling to keep them at home, and in others one of the parents left the family home and often stopped their relationship with their child for a period. Some children/teenagers would find alternative accommodation to avoid being at home, or because they would have periods of being kicked out of the family home - either sleeping rough, sofa surfing (often with much older friends/adults/the 'wrong crowd'), find supported accommodation for young people, or get into intimate relationships with older adults in order to have somewhere to stay.

I would always try and let go from my parents' and I would just try and avoid it as much as possible, so I'd [aged 14+] always be sleeping with [older] guys just to... have their house for the night.. two, three nights a week. (Reggie)

A number of participants had spent parts of, or much of, their childhood in foster care, with carers or wider family, with both positive and negative experiences. Relationships with foster carers were often described as difficult, with some participants experiencing multiple placements during their time in care as a result.

Primary school education: During primary school, most participants discussed a more positive attitude towards going to school and education, but that this often changed during their teenage years. There was an increasing awareness of feeling different to their peers because of the difficulties they were experiencing at home, and awareness of stigma as a result of the physical impacts of neglect or abuse (e.g. bruising, head lice, being unkempt, or going without).

During primary school, positive feelings about school appeared to be determined by **regular attendance and stability** that could be hampered by the extent to which parents encouraged attendance or changing schools (e.g. travellers or frequently moving in and out of foster care placements). Some participants recalled teacher's negative attitudes towards them. One participant described experiencing fear from a young age that her parents would not be there when she returned from school.

Secondary school education: During secondary education, one participant described how she started in the top sets and was very academically capable, but that slowly her peers started commenting on her social background, this combined with difficulties at home and absent parenting, led to her becoming demotivated and angry, acting out in school and having fraught relationships with teachers, and leaving school with minimal qualifications. She reflected that her behaviour, *"might have subconsciously just been a cry for attention"*. (Aisha)

Even now, I'm capable, but... in high school, I think my mouth just got in the way of that and I suppose I was always kind of just angry at something... I did enjoy it [school]... didn't go on the knock often. Didn't usually have to, to be honest, I'd just kind of get sent out.... If I did come in in a positive mood, they thought I was being very sarcastic. And it just kind of made me think, do you know what, I'll just go back to being myself. (Aisha)

Many participants described displaying challenging behaviour at school, including not going to or leaving class, drinking and taking drugs, or rebelling and trying to get a reaction from teachers through

behaviour and words. Several participants similarly mentioned how difficulties in secondary school often began after the first year or two, and were often caused by an **increase in difficulties at home** (e.g. parent's drinking), making it difficult to concentrate.

I was in high sets ... I was in set 1 when I first went there ... and then slowly ... I think by about year nine, I was ... no, about half way through year eight, I was problematic then...It's important that you do it [school], but at the time you don't care ... you've got bigger emotional things going on rather than worrying about school and education. (Rose)

Participants faced interrelated challenges both in **school** and at **home**. **School-challenges** were caused by factors such as bullying, not fitting in or feeling that they did not belong (being a loner, being unkempt, being a foster child), frequently changing schools, multiple exclusions or expulsions, lack of ambition/fatalism, lack of encouragement from school, lack of positive engagement from parents, acting out behaviour, getting involved with the 'wrong crowd'. **Home-challenges** were caused by factors such as unstable living arrangements and difficult relationships/trauma - either in the family home or foster care - meaning that nearly all participants left school before the age of 18 with **minimal qualifications**, and in some cases illiterate. One participant described how there was no respite for her or a safe place, as she was bullied in school and home life was traumatic.

3.2.1.4 Childhood interaction with services

During childhood, participants had been in contact with a number of different services. Universally participants had been in contact with primary and secondary school teachers. Others had varying involvement with counsellors/psychiatrists, the NHS, youth workers, social services, police, youth offending services, and educational welfare officers. Trusted relationships with supportive adults that understood the child's circumstances and underlying reasons for their behaviour, was seen as beneficial in childhood.

Supportive teachers: Supportive teachers were seen as a huge asset by participants. Some reflected that this was particularly the case if teachers saw potential in the student. Supportive teachers were described as being able to 'see something in them' **beyond their behaviour**, not casting them off, understanding the child and the reasons for their behaviour, and being easy to talk to by spending time with the child and building up trust. In some cases teachers were going as far as ensuring participants were able to get to school by picking them up from home and giving them a lift. As well as undertaking house visits, and interacting with social services. One participant described a teacher paying for her prom dress that would otherwise have been unaffordable for the child.

They did understand that I had a difficult... home life. I think I'm quite lucky that I did have a bit of intelligence, because they tend to... cut you some slack, because I think they know you have potential whereas if you don't, they just kind of just give up on you completely. (Aisha)

Counselling: Some participants had received counselling in school, or were referred for psychiatric treatment for their behaviour. Counselling in schools tended to be described as 'brief' or a 'few months'. Some participants would open up and tell their counsellor what was going on in their lives, and for others it was more difficult to open up about their home lives and rather it was seen as a 'free hour' off class. Only one participant spoke about the counselling being helpful.

NHS: A small number of participants discussed interacting with the NHS as children in relation to ACEs. This was linked to their behaviour, self-harming, and because of social services concerns.

She [mother] went to the doctors and said I was really, really bad and everything else. So they give me Ritalin tablets. But I never used to take them. She used to keep them in the cupboard and stuff. But I think that was just an excuse to keep me off school. (Harper)

Youth workers: A few participants were involved with youth workers in their teens, accessed through school or youth clubs. Youth workers would be involved with the children because of their behaviour, and to help them deal with anger and difficulties at home, providing support through talking to the children and through activities. One participant felt that although he got on well with his youth workers there was also a degree of feeling that he was being rewarded for bad behaviour by being taken on group days out. When a trusted relationship was built with a youth worker, who the participant felt had lived experience of what the participant was going through, this support was perceived as more positive than traditional services.

It was like a support worker who'd meet with me every week [for a few years] to ask me what's going on … I just think it was because I was a teenager going through a hard time… I used to love my worker… She would be my go-between. If I wasn't happy with so and so, she would fight my case for me. (Rose)

Social services: Many of the participants were involved with social services, either because of concerns about their childhood families, if they had been taken into care (foster care or care homes), or as later teens when the relationship with their parents or foster carers started breaking down, resulting in the risk of youth homelessness.

One participant described having had 32 different foster care placements, or *"every year a different social worker"* (Harper). This was a common experience among participants who described going into multiple care homes in different areas, or going in and out of foster care from a young age. Participants described feeling different to their peers, being bullied because of being in care, carers only being in it for the job not the children, foster carers not being equipped or willing to deal with their behaviour, or being labelled a 'problem child'. However, in other cases participants remembered having a positive relationship with their foster carers or family support workers. Some participants described how even if social services were contacted because of concerns, there was a sense of frustration if it did not reach their threshold for action, or if it took many years for social services to listen and take action.

My grandad raised concerns about my dad sexually abusing me when I was four, right? And it took them until I was 13 to actually listen and do something about it. (Harper)

Police: Several of the participants described how the police had been involved directly and indirectly during their childhoods. Police would be called to the homes to deal with family members (e.g. drugs, domestic violence, criminal behaviour, being reported by neighbours), with actual or threatened abuse to the child, or because of the child's behaviour (e.g. running away from home or foster care, affrays, criminal behaviour). Some recalled the police attending their homes so frequently that they still remembered a particular officer's name; or conversely how when the police arrived they were hidden out of the way, or police officers not talking to them on their own. One participant described how their family member would 'beat him with a belt' for bringing the police to the door.

The police were called, because he [step-father] threatened us. He was going to chuck acid on our face and bury us under the patio. He chucked paint all over the car. He'd storm in the house, he took all our food out of the fridge and chucked it up the garden, stamped, stamped on all of it. He took our toothbrushes, toothpaste, destroyed them. They were called and he was threatening on the phone, so she recorded him. But there was nothing they could do. Because they said there wasn't enough evidence. The police were called, yeah, but social services were never involved, no. (Bea)

We were put in a bedroom…with the door closed and my mum would just speak to them [police] by the door. And we were told that they just wanted to speak to her about something else that had happened, and we've got to stay quiet … because the police are very harsh and they didn't like kids and stuff. (Sofia)

Youth Offending Services (YOS): A few participants had been involved with YOS and would see their YOS worker weekly for a fixed period, and be sent on courses or taken places, or have weekly drug tests. The relationship with YOS tended to be described as functional and brief.

I went to jail at 14 …. I was under … youth offender team… she used to come and see me every week and take me somewhere. Court and stuff like that. It is where I got all my grants and all that. But I'd only see them once a week. (Dan)

3.2.1.5 Barriers to the child's interaction with services

Participants described several barriers to interacting with services.

Disempowered child (not being heard):
Participants described how as children they often lacked awareness that the ACEs in their home lives were not normal (i.e. experienced by their peers). As they entered their teens they became more aware of social services but were often scared that involving them would make the situation worse rather than help. Some described how no one ever asked them about their home lives even if signs of ACEs were present (e.g. neglect, bruising or acting out behaviour), or that no one listened to the child about what they actually wanted (e.g. placing them back with their parents, or forcing them to have contact), or the child feeling that the service was not on their side supporting them.

You're a child at the end of the day. And you know your stepdad's being nasty to you, but you don't really know, do you? And unless you talk about it… I think it needs to be set from a young age… what's right and what's not. What to look out for and what's not… normal… (Bea)

Fear of consequences (keeping secrets):
Participants described how they would refuse to open up to services, because they were told by their parents not to discuss what was happening at home to people outside, or they described fear of getting

their parents into trouble. Other reasons given were fear of their parents or of services, parents physically keeping children away from services (i.e. telling the child to stay upstairs), or parents warning the children not to talk to services. The participants feared the impact that talking to services might have, of not being believed, or their maladaptive coping mechanism was shutting down and not sharing information with anyone.

I just kept it to myself. Just didn't think… nobody [psychologist] was really interested, so, just kept it to myself… I just felt that… nobody would believe me, you know, because my mum didn't believe… so I thought… nobody else is going to believe me. (Jessica)

Fear within family: Participants' families could be a barrier to the child's interaction with services. Participants described parents stating that the child was lying for attention or making things up, being present when the service was talking to the child, or by interfering with services (e.g. by getting close to the foster carers and manipulating the system, encouraging their child to misbehave for foster carers, or making up the child's illnesses to a GP to keep the child off school). Some participants described services that were there to support the family, bypassing the child in favour of the adult.

I was really, really scared 'cause my dad and [step-mother] they always used to say… she's lying for attention. (Amelia)

Because I could see my mum in the background, I was too scared to say anything in front of her. (Sofia)

Lack of trust: Participants described how a lack of trust between the child and the service could break down the relationship to the point where the child would not behave, let alone open up or cooperate.

I'm big on my trust so if I don't like you, I don't like you, if I do like you well happy days...[name of social worker removed] and I just clicked ... and ... obviously I complied, and I gave her respect and I got a lot more out of it. But obviously, I didn't like [name of social worker removed] at all, so I was just a little cow to her 'cause I just didn't like her and I just didn't trust her. (Amelia)

Poor relationship with services: Participants described challenges in the relationship between the child and services in terms of no one caring or asking/understanding why the child was behaving in the way they were (what the child was going through), being cast off and not given the time of day/being negatively biased towards the child, trying to overtake the role of the parent, not being listened to or believed, thinking that the child was just being attention-seeking, and considering additional challenges such as homosexuality or culture/ethnic diversity.

I just felt let down by everyone and everything. (Madison)

I tried telling my high school something small, and they were just like, oh, you're just using this as an excuse so you can get out of lessons. (Reggie)

3.2.1.6 Services doing things differently in childhood

Participants were asked what they thought services could have done differently in their childhoods.

Awareness and support: Several participants felt that children themselves need to be taught how they can access support to deal with the ACEs they are experiencing. There needs to be awareness raising and education aimed at children about ACEs, and to normalise being able to tell someone if something adverse is happening at home. Better

guidance and support for children is needed on how to stay on path and to think about their futures when this is lacking from their families (e.g. the importance of education, staying out of trouble). Participants felt that children should have better access to mental health support to help them cope with the impact of ACEs.

It's important for them to know. To recognise the signs and stuff…. I think...there needs to be...a lot more educat[ion] and there needs to be a lot more aware[ness], and there needs to be a lot more support groups out there. (Bea)

Noticing the signs: Participants suggested that services generally need to be more able to recognise the signs that children are not coping well, and to take children more seriously when concerns are raised rather than dismiss this as attention-seeking or lying.

I think if someone just sat down and just asked what ... was going on, then it would have ended up a lot better than what situation I'm in now. I wouldn't be here now. (Chloe)

Changing parental behaviour: Participants felt that parents were the source of learned bad habits, of not protecting their children, letting them grow up too quickly, or not being a good example or teaching them how to create a positive future. Services could do more to support parenting and intervene to help parents when they are struggling, so that children would not experience adversity or be placed into foster care. A challenge for many parents is the fear of involving social services and there is nothing in-between such as a support worker that could have a role in checking in with families to see how they are coping.

Just general support ... I think a lot of people are probably scared ... when you've got kids involved because of social services…. even if there was something ... in between ... like we have here with support workers, where they could go out and just check how things are. (Seth)

The role of schools (and nurseries):
Schools were highlighted as key to supporting children because this is where children are spending a large amount of their time and where teachers have the opportunity to get to know the child and observe how they are developing. This would be more challenging for children who are changing school frequently (e.g. travellers). Teachers or specific workers should be able to identify signs of problems, such as non-attendance, parents frequently being late picking up a child, appearance, and behaviour/mannerisms. Some participants felt that the schools must have been aware, or been able to pick up on what the child was going through at home. There should be a pathway created to investigate concerns (e.g. getting social services in to talk to the child) out of the home environment because this might be an unsafe place for the child.

The school would see how I acted ... and see how I was dressed... they surely could have thought well, this is not how a child's meant to be looked after... even if I wouldn't tell them nothing, they still would have seen some signs of... do you get what I mean? (Amelia)

The role of social services: Participants felt that there was a lack of proper support for them when they were taken into care, rather they were expected to *"just go there and be happy" (Chloe)*, with their *"brand new family"*, although several participants were acutely aware of being treated differently both in school (e.g. bullying) and within their foster families.

There were challenges around how the children were taken into care, whether this happened quickly enough and how to help the child access social services support if concerns were identified, and services not listening to the child or the child

being re-placed with their dysfunctional families after having been in care. Children who were taken into care because of the adversity they had experienced, described how both foster carers and schools were not equipped to cope with their behaviours.

She [support worker] could have stayed. Because as I grew up she became the only positive role model in my life, and when she left it just went downhill. (Madison)

I wish, when social services took me away... that they wouldn't have put me back... because I wouldn't have gone through hardly of the stuff I've been through, if they didn't put me back. (Harper)

3.2.1.7 Perceived impact of childhood on life and later homelessness as adults

Participants reflected on the impact they perceived their childhood had on their lives and later homelessness experiences.

Creating resilience: Some participants felt that growing up with ACEs had provided them with a sense of personal strength, and wanting to do things differently in terms of a better life, and making sure their children received the emotional support that they had been lacking.

Following footsteps: Others felt that their lives had followed a similar pattern in terms of repeating the patterns they experienced in childhood, particularly of getting into violent relationships.

I ended up going into a relationship with domestic violence, so it probably was ... Because you think it's normal, don't you? But it's not normal. (Lili)

Reactive behaviours: That participants had adopted as teenagers such as drinking or taking drugs and acting out behaviour, being unable to get an education, criminal behaviour, feeling stigmatised and not having a sense of belonging, trust issues, and effects on mental health and wellbeing - all contributed to homelessness.

As I grew older my mum wasn't very nice to me, and my way of dealing with things was taking drugs. (Alice)

Like my behaviour, the way I act, the way I am like. The things I do when I go out and that, it's just I think if I had a stable home and a stable upbringing I think I could have been completely different. (Amelia)

I can't do certain jobs now because of my criminal record, violence and that. (Dan)

I've grown up thinking I don't belong. (Efa)

I do have a trust issue. I have done for most of my life. (Jacob)

Everyone has got so many different complex needs. I was very dismissive of, when I was growing up, you'd see someone rough sleeping, and you'd walk by and you'd think well, it's their fault. And having gone through it, and seeing what's gone on in the past with my life, it's not, you know. No. (Seth)

3.2.1.8 Adult homelessness experiences

Homelessness varied from one or more experiences of DV refuges both with and without children, repeated use of night shelters, living in temporary accommodations (bedsits, B&Bs, shared accommodation), entering a series of unstable housing situations due to inability to cope or thrive, street homelessness (also camping out in woods or other rural locations) lasting months to years, sofa surfing/temporarily living with various family members, friends, or wider acquaintances - *"dossing from place to place"* (Bea), and leaving the care system with no family support.

Causes of adult housing transitions included a complex interplay between structural and individual factors. **Structural causes** included job loss, leaving the care system, losing the current home whilst in rehabilitation or prison (prisoners no longer automatically have priority need for homelessness – see Section 1.4), financial illiteracy, and loss of social benefits. **Individual factors** described included breakdown of intimate and family relationships, leaving abusive and violent relationships with partners or family members, the emotional impact of bereavement, and leaving or being kicked out of a family home. Other individual factors included consequences of maladaptive behaviour, such as escalation of alcohol abuse and drug habits, mental health issues, avoiding other residents in temporary accommodation taking drugs, trying to isolate self, trauma/bereavement, arson and destruction of home, and cuckooing (drug gangs taking over the home of a vulnerable person); all leading to an inability to cope with maintaining a home.

She [niece] was offering dealers…. drug dealers in my home, and I… it ended up that I was in the bedroom and she [niece] was in the living room with all these… coming back and forth dealing drugs and things like that. And I just lost control. And then, I was walking down the square and beat up by one of them [dealers]. Badly too, he kicked me to the floor and he was kicking me in the face, in the head. (Sara)

3.2.1.9 Adult resilience capacity

As adults, the things that helped participants cope were an extension of the same sources of resilience that they experienced in childhood, and included **religion**, **social relationships**, improved relationships with **childhood families**, strength gained from their **experiences**. Other sources of strength were having **children**, whether they were currently living with the participants or not.

... I know I've got to be, be strong and I've got to protect the child- the children. Now I've got to protect this baby. Otherwise, they'll end up taking it away from me. (Efa)

For some, talking to **support workers** was seen as positive, **if** they were seen as trusted, supportive, easy to talk to, non-threatening, and able to understand or relate to the experiences of the participant, and as independent from the participant's social circle.

I've only opened up to two people. Two people that work here now, but only one person who knows everything. And that's only because I gained confidence to speak to them. (Sofia)

Some participants reflected that being able to **support others** would help them cope with the effects of their own challenging childhood experiences.

I wanted to do something that I felt was rewarding, and I wanted to, well I still do, I want to go in a career which involves mental health, and so I thought it would be good experience [volunteering at a mental health charity], and, I don't know, I guess it was just kind of like a coping mechanism. Like, if I'm making people, or trying at least, to help people with their mental health, then maybe I can have some hope to help myself with my own. (Reggie)

3.2.1.10 Destabilising behaviour: adult response

Response behaviour used by participants to deal with their housing situation and difficulties coping as adults were described.

Unhealthy relationships: included having brief (one-night stands) and longer relationships in order to maintain a roof over their heads, and breakdown of relationships with family, and difficulties coping with rules and authority.

I ended up moving in with him straight away. We'd only been together two, three months... it was like a safety net... And then...[DV]. (Efa)

Cycles of self-medicating with alcohol use and drug-taking:

I was doing it [drinking and drugs] to block everything out, what I was going through. (Efa)

At the time, I really didn't care what anybody thought about me. At the end of the day I was waking up in the morning, when really I wanted to sleep [and] lock myself away, and I ended up going to sleep absolutely [drunk] out of my head. (Kai)

Mental health: cycles of mental health issues and suicidal ideation/mental breakdowns.

I ended up moving out because I got really bad depression, and I went back to my mum's house and I started selling and taking drugs again. (Ava)

I couldn't handle it, I needed help. I was just thinking of stupid stuff and that [suicide], I just couldn't... being out on the street, it was winter time and that, and my mother wasn't talking to me, no one was talking to me. (Logan)

Self-isolating: and having to distance self from previous friends to avoid returning to drug use.

I'm trying to distance myself from friends, cos they still go out. They live the party lifestyle, and I don't wanna be going back down that road. (Efa)

3.2.1.11 Adult interaction with services

Participants had engaged with a wide range of different services depending on their situation and complexity of their needs. These included:

- alcohol and substance misuse services (outpatient, residential, detox)
- psychiatric hospitals, mental health services and charities, counselling therapy, bereavement counselling
- GPs, hospitals
- council housing teams, supporting people services, social services (adult) and social services (child), family support services, information hubs, citizens advice
- trained staff at supported accommodation services, homelessness night shelters, street homelessness outreach teams, homelessness charities – including support workers/peer mentors
- volunteering and courses, anger management classes, support/skills building for care leavers, victim and DV support services
- police
- prison and probation services, third sector support for prisoner's families

One participant described how support from, and a trusted relationship with, her child's nursery teacher helped her access services to escape DV.

A big enabler to providing help was being able to provide the right support as soon as the participant felt ready to engage with the service, and not withdrawing support because it is initially rejected.

Spoke to the right people. Had the right support at the right time. And had what I needed... That's literally what helped me. That's what saved me in the end. (Cole)

3.2.1.12 Barriers to adult's interaction with services

Although there are multiple services that participants engaged with, many different barriers existed. These included:

- not being ready to accept support, trust issues, fear of not being believed, lack of relatability, not wanting to show emotions, not being heard
- not knowing how to access services or which services are out there and misinformation
- long waiting lists, services not following up actions, discharging from services when the participant does not feel ready, reluctance to engage with services/ask for help (e.g. travellers, family culture, experience), not being able to access services (due to distance, mental health issues, service type e.g. group therapy), delays getting diagnosis or support for mental health issues
- problems with finances and benefits, lack of literacy
- participants not understanding what was wrong with them, reluctance to take medication
- being housed away from family, lack of local connection (council homelessness services), having to cut family/social ties to engage with services (DV refuge)
- negative perception of temporary accommodation, temporary accommodation full of older adults/full of drug takers, re-traumatisation from other residents in temporary accommodation

3.2.1.13 Services doing things differently

When asked what services could do differently, participants felt that talking about their ACEs or homelessness to people who were able to understand and relate to what participants had gone through would help. Participants felt that

services needed to be able to deliver the support they promised, whether it is prosecuting an abuser, or ensuring that support (e.g. counselling) is available without long waiting lists. Also, services need to be able to better identify when someone is behaving in a way that indicates that they need support.

I think I was quite good at hiding it. Hiding the grief that I was bottling up. I mean, everyone always thought I was like the life and soul of the party. (Seth)

3.2.2 Service providers

Services coming into contact with children experiencing ACEs, or adults displaying the health and social impacts of ACEs from their upbringing, reflected on the relationship between ACEs and homelessness and early intervention.

3.2.2.1 Reflections on ACEs amongst service users and consequences

Service users characterised as having ACEs were frequently coming into contact with the service providers interviewed. Service users accessing homelessness services were described as:

They've all had really horrific childhoods. (Provider 2)

One service provider working as a wellbeing lead in a primary school compared the ACE questionnaire with existing information they had from their work with families:

We've looked at the ACE questionnaire with … some knowledge of our families that we work with, and around about 75 percent of our families have experienced one ACE, and about 35% of our families have experienced four or more ACEs…and that's just information that we know about. There's a good number of the children … that we deal with that have got eight or nine of the ACEs. (Provider 6)

Similarly, in secondary school those children who need more intense support are also more likely to have a number of ACEs:

What we find is … the majority of children that we do support, more intensely, would normally have a number of ACEs. (Provider 9)

Service providers also described other risk factors that impact children and exacerbate ACEs, these include poverty, unemployment, living in areas of high deprivation, and family relationship breakdown leading to housing challenges for young people.

Service providers described the consequences of ACEs and the lack of a safe and secure childhood for their service users.

Some of the young people who've been in the looked after system that come, are referred to us, more have had 40 or 50 different placements, and perhaps 40 different schools. So, although that's not an ACE, I think that's indicative of the impact that ACEs will have on them. (Provider 13)

The impacts of ACEs on children were described as including poor general physical and mental health, poor wellbeing, and low self-esteem. As well as behavioural issues and risk-taking behaviours, poor attachment, non-attendance at school, poor educational attainment or underperformance, getting involved with the 'wrong crowd', and being drawn into health harming behaviour.

A lot of our children are identified with ACEs, do tend to go to … medical appointments more often. (Provider 6)

There's quite a link, or correlation between poor attendance and number of ACEs. I would say there's also a direct correlation between poor mental health and number of ACEs. (Provider 9)

There's a direct link between the number of ACEs, and the amount of sort of [trauma] that these children carry around, so often in school it presents as the fight or the flight notion, so

they can become quite challenging in school and harder to reach and harder to engage. Which makes them more likely then, not to achieve their potential. (Provider 9)

There may also be an inability to create healthy and meaningful relationships, with frequent family relationship breakdowns. These issues are exacerbated by poverty and financial challenges such as fines for parents for a child's non-attendance at school, family financial deprivation, and food and fuel poverty. Service providers described ACEs and the impacts being intergenerational:

You'll know sometimes if they've got drug issues, the parents have had drug issues, and then, obviously, it's been passed down... and the children that we're now dealing with have got the same issues. (Provider 3)

As they grow older, the trauma and lack of resilience can lead to complex socioemotional and medical challenges that can contribute to homelessness, including: **financial** (employment, money management), **behaviour** (anger/violence, alcohol and drug misuse, criminality, sex-for-rent, entrenched behaviour, institutional care), **health** (poor mental health, repeated hospital admissions), **relationships** (challenges around boundaries and behaviours, risk of exploitation and unhealthy relationships, feeling alienated from society/social isolation, lack of positive peer/family support and social network), and **coping** (maintaining accommodation, ability to tolerate stress and distress, raised barriers and challenges around accessing services, lack of life skills, mistrust in the establishment).

I think it's absolutely huge [impact of ACEs on events leading to homelessness]... It's the foundation blocks, isn't it really? ... It completely affects their ability to make decisions, life

choices, and I think, even more crucially, affects their ability to create and maintain relationships. (Provider 11)

I think it has a massive effect... They often have very low self-esteem... very low self-confidence, they don't believe that they're any good. Nobody's told them that they're any good... It has a massive impact on their ability to thrive as individuals, to move forward with their lives. (Provider 13)

Service users were described as having a high prevalence of ACEs associated with physical health or mental health problems, and risk-taking behaviour. Service providers described service users with ACEs and other complex trauma who quite often also had learning disabilities and other challenges.

We're seeing people who have failed to engage mainstream mental health services, either because of systemic issues or because they don't have an address, or because they've just not been able to navigate and access the systems to get the support that they need. We're seeing a really high level of dual diagnosis symptoms, so people turning to substances to self-medicate to cope with their adverse childhood experiences. And just not having the distress tolerance skills to hold those emotions while they access support and go through the systems, so it's a significant barrier to people accessing homeless support services, as well as a reason for people becoming homeless in the first place. (Provider 7)

ACEs were felt to impact a person's ability to plan or respond to a challenge in a logical way. Instead:

They tend to sort of bury their heads in the sand... we don't really get involved until it is that crisis point. (Provider 2)

3.2.2.2 Acceptability of talking about ACEs

The frontline services interviewed tended to feel that it was not only acceptable but positive to talk about ACEs, whereas those services who had less direct contact or were not working in a supportive, ongoing role, were more reticent. Reasons given in favour of talking about ACEs included, transparency and creating an honest, trusting relationship with service users, empowering service users, helping them to understand and be more conscious of the impacts of ACEs on behaviour and to make decisions.

Lots of the parents are quite supportive of that fact … it's like a light bulb moment for them, it's, oh this is the reason why this is happening to my family. (Provider 6)

Making them aware of ACEs … would serve them, would help them, give them the resource to understand themselves better. (Provider 4)

Concerns included that ACEs were not part the roles and responsibilities of the organisation, any discussion about ACEs should not be a tick box exercise, there is the potential to create a culture of guilt or labelling/stigmatising people, and worrying about adding to the individual's trauma or re-traumatising them. Service providers identified that the discussion should be properly facilitated within a trusted relationship where there was time for appropriate support to be put into place.

3.2.2.3 Responding to people through an ACE-lens

It was felt that a universal trauma-informed approach to all service users, or a 'code of conduct for professionals around ACEs', would be beneficial.

You respond in a trauma-informed way to somebody [who] hasn't actually experienced trauma, well it's not going to be detrimental. So I just think maybe it's just something we need to just embed within practice. (Provider 12)

Service providers described a trauma-informed approach to service users that included increased access to therapeutic, psychologically-informed/restorative environments, responding to need, and the importance of relationships and not being affected by the power-dynamics between service user and services. Service providers reflected that this made a difference to the way service users behaved towards services.

Service providers felt that traditional models of services (e.g. general practice, job centre, homelessness services) are not always fit for purpose for vulnerable people. For example, an individual with complex needs such as mental health problems or homelessness being penalised for missing appointments or being banned from services, a 'revolving door' model of care, or complexities/barriers and inflexibility around accessing a service. Service users may not engage with services because of rejecting authority or statutory services as a result of their ACEs.

We offer an open door policy with no … criteria and we have a really non-judgemental, friendly environment … people in the community judge this cohort. And actually what we found, by taking all that away and having this open door, very sort of different environment, we've had no hostility, no aggression. So although it's there, I think a lot of that is about frustrations that they're experiencing that they can't access services, they feel they're not getting the help they need, and so as a result, they become frustrated and they get cross, understandably, because they're being treated quite badly. (Provider 2)

Service providers highlighted the importance of creating support through building the confidence and trust of service users to access available provisions. Through better understanding of what service users want from services and improved physical design to make the environment more welcoming. Also by focusing on an asset-based philosophy to help service users better use the resources and strengths they have, through improved self-awareness.

An example of a streamlined, holistic, joined-up model of care that has been used within a community care hub to support a traumatised or vulnerable individual effectively was described by a service provider. This consisted of bringing together social care and health services under one roof, together with volunteers, and ensuring professional groups did not wear ID badges, with no appointments needed and no penalties for not adhering to appointments. The hub created a care-navigator role where front line staff, some of whom were trained peers, were able to link service users with the right services, and ensured a friendly, supportive community where service users did not feel intimidated by services and professionals.

And I think it's because you listen to them and actually take an interest. Nobody ever has before. No one's ever explained to them...or believed that they can do things and believed that they can - they're as good as any of us. (Provider 3)

Overwhelmingly, service providers felt that ACEs were 'everybody's responsibility', and that the problem cannot be fixed by one service or by services working in silos. Information about an individual needs to be shared in multi-agency working, and access to help should not be blocked by eligibility criteria, or lack of budgets. Universally, service providers identified that professionals working in services need to be trained (within the job, and during formal training), so that they were more aware and better able to cope with those affected by ACEs and trauma. Improved education and training would help professionals understand the causes of ACEs and to have a holistic picture of the individual's current needs as well as aspirations, rather than focusing and responding to presenting problems, which were often the consequence of underlying issues - such as distorted expectations, anger, blurred boundaries, or lack of trust; as well as heightened psychological distress.

Actually, if you asked that question, "what's happened to you?", it just changes your whole perception, you know, about somebody and what their needs are. And I think that was really quite powerful really. (Provider 2)

People's inability to engage with you as a provider, is greatly affected by the fact that that individual hasn't understood how all their experiences have brought them to be the person that they are now. (Provider 10)

We face a lot of anger sometimes... we also see like a real blurring of boundaries in the client's mind....we're working from a position of mistrust, and then trying to turn that into a trusting, boundaried, respectful relationship, whereas with somebody who hasn't got ACEs, you're kind of starting from zero. (Provider 7)

Some service providers felt there is also a need for clinical supervision and support for staff who are dealing with the impact of ACEs in service users, particularly, as a proportion of staff will also be impacted by their own ACEs leading to a risk of re-traumatisation, as well as the direct impact of those ACEs. One service provider conducted an ACE survey amongst staff and found that just under 50% had also experienced four or more ACEs, highlighting potential re-traumatisation of staff when dealing with service users with ACEs.

Service providers felt that as well as ACEs being every service's responsibility, further, every child is every adult's responsibility and there is a need for greater awareness raising among the general public and common understanding that everyone is in recovery from trauma of some kind, leading to greater empathy and reduced stigma.

Our common human bond is that we're all in recovery from a trauma of some kind, and I think that's where we get our common understanding and that's where we'll increase empathy and reduce stigma for the people we support. (Provider 7)

3.2.2.4 Early intervention – challenges and solutions

There are challenges around preventative work and providing support, with a lack of resources and long waiting lists, and services being shut down, meaning that often by the time children and families reach services (e.g. social services) they are already reaching crisis point. Therefore children who are entering the care system and may not have had access to preventative support, such as respite and family centres offering parenting programmes and one-to-one work. With long waiting lists for support and a lack of preventative care, accessing suitable support for what is likely to be a fluctuating problem with fluctuating support needs (i.e. crises are likely to re-emerge if not dealt with) becomes challenging. Vulnerable individuals and families may struggle to access the services available and to understand how to navigate resources provided for support. Examples provided to address such issues included a 'care navigator role' that links the individual or family to services and provides support.

Like that care navigator role of being… they're put in touch with her straight away, as soon as there's a concern identified, and actually, she then links them to all the services and supports them. (Provider 2)

'Early Help' was also described as supportive for families where a safeguarding issue has been raised, that has a multi-agency team that links with the family and undertake preventative, early intervention work. Another example is a 'Wellbeing Officer' that can support families to access services, where GPs or primary care have concerns.

There's a project that one of the clusters is trying which is proving really successful where they're working with a CAMHS officer and she's… basically has a role as a family… wellbeing officer I think they've called her. So she's… basically is put in touch with any family that GPs or primary care team have concerns about, and that's proving to be really successful. (Provider 2)

Overwhelmingly, service providers felt that ACEs are a societal problem that needs a community response, and is a multi-agency responsibility where all services that come into contact with someone with a vulnerability have a duty of care.

It's about how we wrap around individuals, not deal with them in isolation. (Provider 5)

Service providers felt that it is important that services work together, share information between agencies and as the child progresses through their life (i.e. transitions between primary and secondary school), and are all dealing with ACEs in the same way. Also to remove barriers to early intervention, such as changing organisational culture, eligibility for interventions under current funding streams, and changing the current commissioning structure in Wales so funding is attached to projects and programmes, rather than organisations.

The way commissioning currently takes place, it's basically dog-eat-dog. So voluntary sector organisations are all fighting for the same pot of money, and I think that's really… really destructive really to good partnership working. (Provider 2)

One service provider suggested that because so many services are trying to deal with the impact of ACEs in so many different ways that Ministers need to align portfolios, particularly around health, criminal justice, and housing. This could bring together cohesive plans and funding streams to enable prioritisation and coordination of services, for example by creating a designated homelessness and mental health pathway with incorporated learning disability support, rather than passing individuals from 'pillar to post'.

If we just brought that together cohesively, we could do something really significant. (Provider 7)

We want to collaborate on a level that's never been seen before. But actually we don't have the backing of the responsible authorities who are constantly just pitching us against each other. Who pays for that? Well, actually it's the person on the street with their ACEs. (Provider 7)

Some service providers described that they are observing the second, or third generation of the same cycle happening. Service providers felt that putting in support to break the cycle of ACEs should start from universal services at the bottom, for example, during the First 1000 Days from when antenatal services (midwives) first develop a contact with parents, and questions could be asked about their childhood experiences.

It would be down to those services that engage… with families and children in the first instance… the first 1000 days of life… you would involve maternity services, you would involve the various aspects of children's services in particular. But I think also, you shouldn't pigeon-hole to just… the health contribution. It's got to be that broader, multi-agency approach. (Provider 5)

Other services that were described as having early contact with children are health visitors, school nurses, and children's social services, and Child and Adolescent Mental Health Services (CAMHS).

Unless we address that [causation], all we're going to carry on doing is dealing with the symptoms and patching up. So how do we take things upstream? How do we provide services earlier in the life course, so that we're addressing the ACEs as and when they're happening… not as a consequence of. (Provider 5)

However, service providers felt that accessing children's social services was found to be difficult outside of emergencies because of organisational pressures, even though:

Some parents out there are crying out for support. (Provider 6)

One service provider described a greater need for support for children in the care system with greater efforts to repair the damage caused by ACEs.

It's… quite dangerous to feel that because somebody's in care, that there is a safety net, because there really isn't. Not all the time, and people do actually really slip through that net. (Provider 12)

The education system was seen as critical by service providers for early identification and prevention of ACEs as that is where contact between services and children is greatest. Similarly, an example given by a service provider from the USA was of children accessing paediatrics presenting with health problems being taken through the ACE checklist and there is a triage with social services and counselling services. One service provider described a school in the USA where an ACE-informed approach had been taken into the classroom and students taught what ACEs are, how they should be treated at home, and being given a safe space to talk about current issues and problems in their home lives. Another service provider described how discussion around ACEs had taken place in a Year Six cohort in Wales.

We talked about what ACEs were, but in a very positive way, and we talked about supporting children and making them more resilient. (Provider 9)

It needs to start in primary school… I worked with a young girl who had been very violently physically and sexually abused by her own parents from a young age….there was nothing to compare it to, so she assumed that was happening to everybody. (Provider 10)

We do nursery visits as well, home visits, we can identify quite soon, if children are living with ACEs. But it takes a long time then to get services in place, and sometimes when they're in year, you know, they're in year six, and you're only just managing to get services in place. (Provider 6)

However, service providers felt that schools need to be part of a multi-agency approach to early prevention, rather than be expected to provide the service on their own. Service providers suggested resources that would help schools have a trauma-informed approach including employing specialists such as DV and mental health workers, greater numbers of adults who can take a non-teaching role of 'trusted adult' with the capacity to provide time and support, and providing toolkits for children to help themselves such as mindfulness and relaxation.

We need to understand an awful lot more about those that are viewed as being disruptive in school, or those who have just been non-attaining. … There are ways to give you a different experience of what it's like to be valued, and not to be in traumatic relationships, and not to necessarily to have to turn to substances in order to manage any difficult feelings. But actually to respect your experience up to now, but actually to be able to say … that doesn't have to be what the rest of it is going to look like. (Provider 10)

Service providers highlighted the importance of ensuring that support remains, information is shared, and the child is monitored as the child transitions between services. For example, as a child in care transitions from children's to adult social services, particularly if specialist support is needed such as mental health, that may not be as available in adult services.

The sharing of information throughout the child's life, from early years, would be incredibly useful for us because we put early intervention in, even though a child wasn't actually displaying behaviours we could just monitor them and keep them on track. (Provider 9)

Cuts in youth provision were seen as significant:

If youth workers are the significant adults for quite a lot of these young people with ACEs, what did we expect to happen [related to increases in violence and stabbings], when we cut that really valuable provision? … I think we've thrown the baby out with the bathwater with austerity. Those services I don't think have been valued enough. (Provider 7)

Service providers felt that supporting young people and adults who have been affected by ACEs is less about prevention and more about supporting them to deal with the consequences:

Services aren't just about listening, but sometimes they're about reflecting back. It's about you know, changing a person's view of what happened to them before, to give them that strength and power to then go on and have a different life to the life that they've got right now. (Provider 10)

Providing support for adults in order to prevent homelessness and other adverse outcomes, includes empowering the individual and helping people manage their trauma.

It's, almost identifying right and wrong and giving them the power to say, this is wrong, this happens in my life and it's not acceptable…. You can still actually do very meaningful work to help them take back control of it, rather than, you know, you can't wipe these things out, but you can certainly help them to manage them differently. (Provider 10)

Community support was also seen as important, particularly for people who have become homeless as a result of their ACEs, as well as peer support and enabling people to speak to others who have been through the same kind of trauma.

If you don't belong to a mainstream community, people seek to belong to something else, and that's when we get … these sub-cultures forming, and that's when people become entrenched… At least you belong somewhere, and that's what people are seeking ultimately. Comfort, belonging and identity. A purpose. ACEs just, it just knocks the floor out of those things, where they had no foundation to build those things on. (Provider 7)

4.0 Discussion and Conclusion

4.1 The role of ACEs and resilience in homelessness

Around one in 14 (7%) of the Welsh adult general population reported lived experience of homelessness. Similarly, previous UK studies have estimated homelessness to be 5% in Scotland, 2001-07, 2010 (21), 6% in England, Scotland and Wales, 2000 (21), and 9% in England, 2012 (21). Research between 1999 and 2003 found the rate for lifetime prevalence of homelessness in the UK was 8% for rough sleeping and this increased to 14% when homelessness specified rough sleeping and precarious housing such as sofa surfing (62). Measures of the extent of homelessness can be complicated and also contribute to an underestimation of the real problem (18). Hidden homelessness is a likely cause for under-reporting homelessness, which is also likely the case in this research, as homelessness was not defined in the ACE and Resilience survey, suggesting the 'real' prevalence in Wales may actually be higher than seven per cent. The survey was conducted at participant's place of residence, which would automatically exclude those living in temporary or unstable housing situations, or those likely to opt out because of other structural and individual level factors likely to be related to homelessness, or premature mortality linked to homelessness (35), again leading to under-reporting.

An **'area poverty effect'** was seen where those who live in the more deprived areas in Wales are more likely to report lived experience of homelessness, probably in part due to the complexity of the interrelated structural and individual level factors involved in homelessness. In line with previous studies, homelessness in Wales does not appear to have gender differences (21) and older age groups are less likely to report homelessness (40,41). Recent data from England and Wales show that the mean age of mortality in the homeless population is 32 years younger in men and 39 years younger in women compared to general population figures (35); as well as homeless populations experiencing extreme health inequities compared to the general population (27).

We found that those who reported four or more ACEs were **16 times more likely** to report lived experience of homelessness at some point in their adult lives. Individuals who experienced neglect,

physical abuse, or general household dysfunction in childhood have previously been found to be more likely to experience homelessness as adults (20,45). Most of the evidence on ACEs and homelessness comes from the USA. In one study from the USA, individuals with 'lifetime homelessness' (having ever experienced homelessness lasting more than one month) were seen to have experienced higher rates of each childhood adversity compared with individuals without lifetime homelessness (1). They found that 85% of women and 77% of men with lifetime homelessness had experienced any (one or more) adverse childhood event (1), which compares to our results where we found **87% of those reporting lived experience of homelessness had experienced at least one ACE, and 50% reported four or more ACEs**. This is comparable to another study from the USA that found that in the homeless population, 87% reported having experienced at least one ACE, and 59% reported four or more ACEs (7). This suggests that **by reducing or preventing adversity experienced by the child, this may reduce vulnerability in the individual, and mitigate negative health and social outcomes in the adult that includes homelessness**.

Studies suggest that **ACEs are more common in the homeless population** compared to the general population (7), and this is supported by our interviews where **every single participant** reported at least one ACE and **78% experienced four or more ACEs**. Similar numbers were reported by Llamau in a survey of young service users in Cardiff (63). Parental loss, parental addiction, domestic violence, and living in social housing or local authority care as a child, child sexual abuse, and physical/emotional abuse and neglect are all correlated risk factors associated with homelessness in adulthood (7,23,39,40,64–66).

Many of the participants of our study had **spent time in care** during their childhood, because of the ACEs they had experienced in their family home, with both positive and negative experiences of the care system. One study from the USA found that events that lead to the child being separated from their home or a parent (being placed in care, incarceration, ordered to leave home, running away) were associated with homelessness, likely as proxy indicators of **family dysfunction** and **individual problems** (31). Similarly, a UK study found strong

associations between homelessness and a range of support and behavioural issues experienced in teenage years, including ever being in care, not living with both parents, and mother's mental health (21).

Those who find themselves homeless often have prior **minimal social support** available, often due to loss or conflict (37). This was also seen in those interviewed who described breakdown of intimate and family relationships, leaving abusive relationships, and bereavement. Family relationship problems and lack of support networks are common amongst teenagers and young adults who find themselves homeless (42). Subsequently, during adulthood, homelessness is connected to unemployment, crime, addiction and mental health problems (42); all factors that are also found to have **strong associations with ACEs** (5). Studies of homeless women reveal ACEs and later lifetime patterns of abuse, likely caused by **inability to form and maintain relationships** limiting their social support (20). A range of health and support needs and behavioural issues, particularly in adolescence, have been seen to contribute to the risks of homelessness in young adulthood (21).

In our interviews, reactive, **maladaptive coping behaviours** started in teenage years or earlier, in response to a chaotic home life. These included being over-independent at a young age, repeating unhealthy relationship patterns, self-medicating, self-harm and suicidal ideation, violence and criminal behaviour, staying out/ running away, and not being able to cope with rules. This led to not **coping academically and poor school attendance**, particularly in secondary education where challenges being faced by the child in their home lives combined with conflict in school caused by their displays
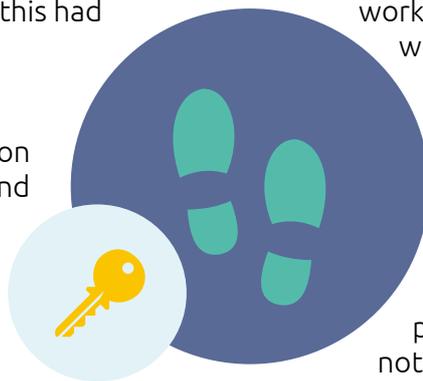
of challenging behaviour, bullying, or frequently changing schools schools, led nearly all participants to leave school with minimal qualifications, or in some cases illiterate. Participants reflected that these maladaptive behaviours and lack of education, or repeating patterns experienced in childhood, all contributed to later homelessness. Further **destabilising behaviours** were described by participants in adulthood that included unhealthy relationships, self-medicating, mental health issues, and self-isolation. A high degree of overlap has been found between homelessness and deep social exclusion; homelessness is the most common form of exclusion (98%) (67). Previous studies suggest that the most complex forms of homelessness are associated with childhood trauma, with temporal sequencing showing that substance misuse and mental health problems tend to predate homelessness and later adverse life events (41). The interviews suggest for many participants that a clear life-path to homelessness can be seen, where the ACEs they have experienced lead to maladaptive coping behaviours in teenage years and further destabilising behaviour in adulthood, resulting in homelessness. Further, participants felt their chaotic and difficult childhoods had had an impact leading to homelessness.

The national Welsh ACE study found that childhood resilience assets were linked to better outcomes in those who had experienced ACEs (43). We found that when you look for the presence of **high Childhood Resilience Levels** these were found in 73% of the general population compared to **only 28% of those who reported lived experience of homelessness**. We also found the likelihood of reporting homelessness **reduced from 16 to 8.1 times** for those with four or more ACEs in the presence of Childhood Resilience Levels, suggesting that childhood resilience assets have a moderating effect **protecting against ACEs** in childhood leading to homelessness outcomes in adults.

A supportive and loving relationship and secure attachment with a parent or family member is among the most

powerful resilience processes in childhood and adolescence, supporting good psychological functioning and healthy development (52,68–70). Regularly attending school was also seen to be protective. The national Welsh ACE study found that school absenteeism increased with ACE Counts (43), however, it is likely that **school attendance is protective** against homelessness both by being **related to many of the individual childhood resilience assets** but also by mitigating some of the later **structural and individual level factors** involved in homelessness. Participation in school and education helps to prevent homelessness outcomes (21); particularly as education is likely to be disrupted because of ACEs (43). This is supported by the interviews where participants reflected that they had difficulties in school directly linked to their ACEs and that they felt that this had contributed to their homelessness.

Childhood adversity and conflicted relationships may affect the formation of secure attachment in childhood and learnt reciprocity that is needed for healthy development and achievement of autonomy and intimacy as an adult (20,52). The presence of resilience assets in childhood and later in adult life is likely to have a protective effect against the presence of adversity in a child's life and help support positive life outcomes. This study found that solving problems, belonging to the school community and having a supportive family were most strongly suggestive of better outcomes for preventing homelessness. **Children cope better** if they have **resilience skills** and are adaptive learners and problem-solvers, engage with other people, and have competence that they themselves value, and feelings of being valued by society (70). The national Welsh ACE study found the childhood resilience assets that were important for improving childhood health were different (43), suggesting that different resilience assets may be protective against different health and social outcomes, and at different stages during the life course. Participants interviewed reflected that coping and resilience building as children and continuing into adulthood included **belonging to a religious community**, being part of a **supportive school community**, stability provided by others, safe and trusted relationships, and self-

motivation. Participants interviewed frequently described having a **trusted, stable relationship with an adult** as a positive asset in their otherwise chaotic childhoods. This stability could be provided by range of adults in lieu of a healthy relationship with their parents, that included wider family, friends/peers, friends' families, and supportive teachers that could see **beyond the presenting behaviour**. Participants described being more receptive to interactions with their teachers in primary school, whereas by secondary school signs of maladaptive behaviour frequently started that included being absent from school more regularly or being less receptive to authority figures. These maladaptive behaviours were described as barriers to interactions with teachers, with even academically strong children being unable to attain their potential. Foster carers, youth workers, counsellors, and support workers were described as **less helpful when the relationship was temporary or not supportive or trusting, or when the focus was on addressing the negative behaviour of the child, rather than supporting the underlying causes or building a trusted relationship**. Participants often described distrust of police and social workers, or that they were not being listened to by these services. A barrier to building trusting relationships included **fear of the consequences** of getting involved with the service and of the family's reactions to the child liaising with the service.

Resilience can be learned and developed over a life course (71,72). Adults have had years to develop coping skills that are likely to have become habitual and there may be resilience processes distinct to adults and older people (73). Having positive relationships with peers, mentors, and supportive partners can have resilience-promoting effects (68,69). Building resilience in the early years can help when facing adversity in childhood and later life (46,74), and emotional wellbeing as a child is an important determinant of adult wellbeing (75). The move away from relying on a supportive family to also needing supportive friends as the individual leaves childhood is in line with the literature (68,69). As adults, those interviewed described building resilience through religion, social relationships and wanting to support others, improved relationships with childhood families, wanting to make changes

for their own children, and trusted relationships with services.

> **Consideration for action: Capacity** needs to be built into services across sectors in order to take a multi-agency, trauma-informed approach to the vulnerable child or adult, to better support the individual by developing sustainable trusted relationships, and by improved communication skills and better listening so that appropriate interventions can take place and supportive pathways followed. Community and family should also be recognised as key assets to supporting the vulnerable individual, and capacity promoted in these support systems as well as in services.

Those interviewed described being involved with various services through their childhood but were universally in contact with **primary and secondary school** teachers, and **supportive teachers** were seen as a huge asset. Children were also often involved with social services and the police because of their chaotic home lives.

4.2 Early intervention and where systems are failing

Although Wales is leading the way on preventing homelessness through the Housing (Wales) Act 2014, some of the most challenging households continue to be failed (57). There is a need to dismantle the processes through which services contribute to life-trajectories into homelessness, particularly in childhood. For example, the literature and our interviews suggest there is increased risk of later homelessness, from a child's entry into the care system, their experiences whilst in care, and transitions from care (8). Interviews with service providers suggested that services need to work better together, and to better share information between agencies and through life-transitions.

There is a growing awareness

of the impacts of ACEs, both on individuals and the impact on services and resources, and the value of trauma-informed interventions and yet there is a paucity of evidence of the cumulative effect of adversity in childhood, specifically prevalence of ACEs, and the relationship with homelessness. Given the likely association between ACEs and homelessness, awareness of the impact of adversity in childhood on vulnerability in adults could help to inform how early intervention and prevention could be used to prevent homelessness/crisis being reached; supporting an integrated, preventative approach using collective resources and different services working together (59).

Intervening at the earliest stage when children are identified as at-risk is critical to positive outcomes for the individual in the short and long-term, in terms of preventing homelessness (8) and other adverse outcomes related to ACEs, including repeating unhealthy patterns experienced in their childhoods and continuing the intergenerational cycle of ACEs. This could be done by services providing support to parents who are struggling in order to help them change their behaviour, as well as to children, and better identifying children and young people who are at-risk of becoming homelessness so that early intervention efforts can be put into place (8).

> **Consideration for action:** To use **awareness** of the impact of adversity in childhood on later vulnerability in adults, including homelessness, so that all services that come into contact with children and young people are better informed to identify those at-risk from adversity in their household, and for services to work together to provide better support for the child and for adults and parents who are struggling to ensure early prevention.

Participants described the many services that they came into contact with in childhood and as adults. They suggested that there was scope for improved services through reducing barriers to engaging with services, as well as to consider whether traditional models of services remain fit for purpose for vulnerable people who often have complex needs and where providing support can be challenging. Responding to ACEs is the responsibility of all services, with a need for organisations to

understand and support people with ACEs and to **see the person not the behaviour**. Training should be more available so that services become more ACE-aware.

> **Consideration for action:** Better addressing the **support needs** of both child and adult vulnerable populations that have been impacted by ACEs, by seeing the person underneath and listening to them rather than focusing on the presenting behaviour. Ensuring that support and provision of services are culturally and environmentally supportive of individuals with ACEs, and barriers to access to health and social support minimised.

Particularly in **early years' settings** such as schools, nurseries, and children's social services where contact with vulnerable children is particularly high, there is opportunity to identify ACEs and build resilience in childhood that may moderate the impacts of ACEs and improve the individual's life chances and reduce health and social inequities.

> **Consideration for action:** Support **early years' settings** to work in a trauma-informed way and to recognise vulnerability in the child, and to ensure that early intervention is multi-agency and centred around supporting the child and their family. Support for the vulnerable child should continue over time as they transition from primary to secondary school, and to prevent the impact that barriers to education could have on health and social inequities.

Recognising the important role of supportive teachers, as well as the wider support systems including support workers and community support assets is key.

> **Consideration for action:** Recognise the value that teachers, support workers, and community support systems play in early intervention and in providing a **holistic system of support** for the child (e.g. Team Around the Family Approach), with the focus on taking a trauma-informed approach to vulnerability and building a trusted and constant relationship with the child.

Participants generally felt that framing their trauma as 'ACEs' was a useful tool to aid communication and remove barriers. Participants reflected that in their childhood they often lacked awareness that the ACEs in their home lives were not something children should expect to experience - rather they often 'normalised' their experiences. Participants also described having a fear of the consequences of speaking out, not being listened to, a culture of fear within the family, and a lack of trust in and poor relationship with services. **The United Nations Convention on the Rights of the Child (UNCRC)** outlines 42 rights that give children and young people what they need to grow up happily, healthily and safely, and has been transposed into Welsh domestic law (Rights of Children and Young Persons (Wales) Measure 2011) providing all public bodies with a legal duty to contribute towards the realisation of children's rights through a Children's Rights Approach (76). Helping children to communicate their experiences and recognise their rights would help to empower them.

> **Consideration for action:** Public bodies need to take a **Children's Rights Approach** to supporting children at-risk from adversity. Empower the child and improve awareness of the Rights of the Child among children, through helping them to recognise what is normal and acceptable and what is not, to communicate their experiences effectively and understand how they can access support, and to build resilience skills to mitigate the impact of ACEs and prevent future homelessness.

Conclusion

This study looks at the prevalence of ACEs at a population level through a retrospective, cross sectional study and is supported by qualitative interviews with a group of people with lived experiences of homelessness and service providers. The findings reflect wider evidence from the literature and supports the need to think about homelessness through actions to prevent the underlying causes of vulnerability that lead to homelessness. By considering action to reduce and prevent homelessness through early identification, and action to prevent and mitigate ACEs in vulnerable children and young people. As well as supporting vulnerable adults who find themselves homeless, by strengthening understanding of adversity in childhood as a cause of health and social inequities and a barrier to services supporting those who find themselves homelessness.

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Our Priorities 2018-2030

Working to Achieve a Healthier Future for Wales

Improving mental well-being and resilience

Promoting healthy behaviours

Influencing the wider determinants of health

Securing a **healthy future** for the next generation

Building and mobilising knowledge and **skills** to improve health and well-being across Wales

Supporting the development of a sustainable **health and care system focused on prevention** and early intervention

Protecting **the public** from infection and environmental threats to health

Our Values: Working together with trust and respect to make a difference

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

I think if someone just sat down and just asked what ... was going on, then it would have ended up a lot better than what situation I'm in now. I wouldn't be here now. (Chloe)