Adverse childhood experiences or adverse childhood socioeconomic conditions?

Published Online
May 15, 2018
http://dx.doi.org/10.1016/S2468-2667(18)30094-X

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If a child lives with an adult who has a mental health disorder or an alcohol-related illness, how does that affect the risk of emergency hospital admission for that child? In *The Lancet Public Health*, Shantini Paranjothy and colleagues[1] use the excellent record linkage system established in Wales to address this question, showing that these exposures independently increase the risk of childhood admission due to all causes, external causes and injury, and victimisation. A great strength of this study is the use of population data linkage across all children in Wales, with a research platform that is helping to address fundamental questions in child health. The study's findings, however, illustrate wider issues in the debate about policy implications of so-called adverse childhood experiences, which are worthy of closer examination. The authors frame their analysis in the context of the adverse childhood experiences agenda, suggesting that children living in families with mental disorders and alcohol misuse should be identified and appropriately supported, but is this interpretation of the data the most appropriate for policy?

Although it is clear from the study of Paranjothy and colleagues that family alcohol misuse and mental health problems are associated with worse outcomes for children in those families, the question remains as to the most appropriate public health response.[2] There is interest in identifying populations of children at risk of poor health outcomes to inform resource allocation and service planning,[3] and there are moves to screen children for adverse childhood experiences so that they can be referred to services in the hope that outcomes can be improved.[2] But if the purpose of the exercise is to identify children at risk of poor outcomes who might benefit from intervention, the study's findings suggest that childhood socioeconomic conditions and factors such as maternal smoking in pregnancy might be more useful as predictors.

Paranjothy and colleagues show that mental health problems and alcohol misuse in families are associated with increased risk of hospital admissions for the children, but there is less focus on other striking findings: that the effects are largest in deprived areas and in children whose mothers smoked during pregnancy. The main results show a 17% increase in the risk of all cause admission, 14% for injuries, and 55% for childhood victimisation for children living with families with parental mental disorders. There are similar associations for living with a household member who had had an alcohol-related hospital admission. There was no association between household alcohol misuse and all-cause admissions in children. The researchers go on to assess how the risk of admissions in children increases with combinations of each exposure (household mental disorder and alcohol misuse) with measures of socioeconomic conditions, family structure, and parental behaviour. For example, children born in the most disadvantaged areas to mothers aged younger than 18 years who smoked during pregnancy, living in a household where there is evidence of household mental disorder and alcohol misuse have a hazard ratio of 20 for victimisation-related hospital admissions, compared with the reference group of low risk children. This finding shows the importance of adverse socioeconomic conditions, raising a new set of policy implications, and has relevance for the broader debate on adverse childhood experiences.

The concept of adverse childhood experiences has considerably influenced policy,[4] but their definition is varied and has gradually expanded, increasingly to the detriment of the concept's utility.[5] The papers[5,6] that introduced the term focussed on the effect of experiences of trauma and abuse in children, either direct or indirect. These experiences included toxic exposures such as childhood psychological, physical, or sexual abuse[7]; domestic abuse and violence against the child's mother; and living with household members who had substance misuse disorders, were mentally ill or suicidal, or had been imprisoned in the past. The definition of adverse childhood experiences has since expanded to include in some analyses measures such as family instability and parental separation, low parental education, child poverty, parental unemployment, and lone parenthood.[5] This development has led to an unhelpful conflation of directly harmful risk factors, such as abuse, and measures of family structure and childhood socioeconomic conditions, which might be associated

with other risk factors for poor health. Lumping these concepts together as adverse childhood experiences is conceptually muddled, potentially stigmatising, and might lead to the importance of socioeconomic conditions being overlooked.

Our contention is that efforts to improve child health outcomes should focus on reducing modifiable socioeconomic inequalities, as well as early identification and appropriate intervention for children that have had adverse childhood experiences, which will vary widely depending on the specific exposure.[2,8] The concept of adverse childhood experiences has been a useful starting point for debates about investing in children's health, but it should not obscure the overarching idea of important, modifiable, determinants of child health.[9,10]

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DCT-R is funded by the MRC on a Clinician Scientist Fellowship (MR/P008577/1).

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