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Black People's Experiences of Being Asked About Adverse Childhood Experiences in the UK:
A Qualitative Study

Introduction

Adverse childhood experiences (ACEs) have been associated with several physical and mental health problems such as heart disease, cancer, increased likelihoods of obesity, hallucinations and depression (Brown et al., 2010; Chapman et al., 2004; Dong et al., 2004; Felitti et al., 1998; Whitfield et al., 2005). The original definition of ACEs includes physical, sexual and emotional abuse, parental neglect, parental mental illness or alcohol abuse, domestic violence, or parents not being present due to imprisonment, divorce or death (Felitti et al., 1998). There is a growing interest in enquiry about ACEs in health care, and there are discussions about using this to improve trauma-informed care (Department of Health, 2015; Home Office, 2015). A recent scoping review found limited literature providing health, wellbeing or service use outcomes from ACE enquiry, and little attention to the feasibility and acceptability of routine enquiry (Ford et al., 2019). Only three studies considered how acceptable ACE enquiry was to service users, two of which found qualitative evidence of acceptability for parents in paediatric clinics (Conn et al., 2018, & Flanagan et al., 2018) and one which found quantitative evidence of acceptability in primary care (Goldstein et al., 2017). To build on these studies, the current paper aims to gain an in-depth understanding of people's experiences in a variety of services, as well as their opinions on two different methods of asking about ACEs, which other studies have not incorporated.

Several health services across the UK have introduced routine enquiry about ACEs (Asmussen et al., 2020). In Lancashire routine enquiry of ACEs is implemented across several services (Quigg et al., 2018), NHS Health Scotland recently made ACE enquiry a top priority and spent £1.3 million on an ACE hub (NHS Scotland, 2019), and Public Health Wales has recently supported routine ACE enquiry (Hardcastle & Bellis, 2019). A pilot study in Wales reported that mothers found ACE questionnaires delivered by health visitors to be acceptable and important (Hardcastle & Bellis, 2019). However, the sample was not representative of the UK population with 99% of the sample identifying as White British. There is evidence that adult White British respondents are more likely to report ACEs than Indian or Pakistani respondents (Bellis et al., 2013). This could suggest that people with Indian or Pakistani heritage experience fewer ACEs, but it could also suggest that the ACE questionnaires are not sensitive in diverse samples. There may also be cultural reasons why people do not disclose trauma (Bellis et al., 2013).

Poverty has been found to increase the risk of children experiencing ACEs (Lacey et al., 2020). Black people* experience poverty through higher unemployment, lower wages and worse accommodation than White people (Equality and Human Rights Commission, 2016). Black children are also overrepresented in secure children's homes and young offender institutions and are more likely to be restrained in these institutions than White children (Bush, 2018). Reports from the UK show that Black people are ten times more likely than White people and three times more likely than Asian people, to be stopped and searched by police (Ministry of Justice, 2020). It is possible that these examples of structural racism would lead to higher numbers of ACEs for Black children and adults, although this has not yet been established in research in England (Bellis et al., 2014).

The charity Young Minds (Bush, 2018) have called for a new definition of ACEs, to include traumas that Black people may be more likely to experience, such as hate crimes, discrimination, racism and institutionalisation (Bush, 2018). Arguably, the existing definition of ACEs may partly underpin fewer minoritised people reporting ACEs. The calls for a broader definition have suggested including factors such as deprivation, sexism and disablism.

*Footnote: When referring to Black people, this paper will refer to people who have either self-identified as Black during recruitment, or people who other reports and research have referred to as Black. The researchers of this paper have referred to people with mixed heritage as Black, when the people in question have self-identified as Black. The researchers acknowledge that it is not always helpful to consider Black people as a homogenous group in research.

Black communities may have a different understanding of mental health and trauma than those of Eurocentric mental health services (Llewelyn & Murphy, 2014). Black men have reported predominantly seeing mental health problems as an "illness" that needed to be treated with medication (Myrie & Gannon, 2013). This is perhaps not surprising, given that Black service users are less likely than White service users to be offered psychological therapy (Harwood et al., 2023) and they report services are excessively medicating them (Department of Health, 2018). It is important to explore whether Black people feel comfortable disclosing ACEs to health professionals, particularly given Black people report experiencing overt racism when accessing services (Myrie & Gannon, 2013; Rabiee & Smith, 2014). Furthermore, the traumatic experience of racism may be cyclical, in the sense that common responses to distress have often been misinterpreted in Black people as aggressive, noncompliant or non-engaging (Carter et al., 2005), leading to less responsive care or a lack of support. This could make it even more difficult for Black people to obtain help, as they may feel disclosing traumatic experiences will not help them.

Most ACEs research has been conducted with assumptions of White, middle-class experiences, and has missed experiences such as being discriminated against or living in an unsafe neighbourhood (Cronholm et al., 2015). Cronholm et al. (2015) recruited an ethnically and socio-economically diverse sample and found that when these experiences, as well as experiencing bullying, living in foster care and witnessing violence, were included, 13.9% of people who had not reported ACEs on the original checklist, reported ACEs on the extended checklist.

The current study aims to expand on existing research, by providing an in-depth qualitative exploration of Black people's experiences of being asked about ACEs and provide perspectives on practice. The study also aims to hear participants experiences of an adapted version of a questionnaire for ACEs already used as part of a UK government-funded pilot project, which asks questions based on the originally defined ACEs (Quigg et al., 2018). We also sought perspectives on using the above-mentioned expanded definition of ACEs (Bush, 2018), in order to understand preferences regarding how to be asked about ACEs and which ACEs ought to be addressed.

The research objectives are:

Primary objective:

- To explore the experiences of Black people of being asked about ACEs in mental health settings.

Secondary objectives:

- To explore the perspectives of Black people on being asked about ACEs with a commonly used ACE questionnaire.
- To understand the perspectives of Black people on how services should be asking about ACEs.

Method

Design and Procedure

This study used a qualitative methodology, with a reflexive thematic analysis approach (Braun & Clarke, 2019), which allows for themes and patterns to be established from the data (Braun & Clarke, 2006; Braun & Clarke, 2019). The study employed a Lived Experience Consultant, who also works as a Racial Equity Consultant and Trainer, and is a co-author (JM). She identifies as a racialised (Black) woman of Jamaican heritage. She consulted throughout the research process, co-conducted interviews, and had reflective conversations with the first author. Ethical approval for the study was obtained.

A semi-structured interview was used to gather information. Participants were asked to share their perspective on an ACE questionnaire (Quigg et al., 2018). The participants were also asked for their perspective on the Young Minds definition of ACEs (Bush, 2018).

The interviewers aimed to ensure participants felt safe, particularly as it was possible that the doctoral student (first author, EHS) could be seen to represent the long history of racist and harmful practice provided by majority White mental health professionals (Jackson, 2002). Participants were given the option of being interviewed by the doctoral student only, or by the doctoral student and the Lived Experience Consultant (JM). This was to ensure that any participants that may feel uncomfortable speaking with a White interviewer only, could still participate. The participants' preferences are included in Table 1. The interviews were audio recorded and transcribed. Transcribing was done by the first author. The shortest interview was 57 minutes and the longest interview was 103 minutes.

Participants

Participants were people over the age of 18 who identify as Black, and who reported being asked about their own adverse childhood experiences in a mental health or counselling service in the UK where people are commonly asked about childhood experiences.

Participants were asked to complete a Qualtrics screening survey to assess this. People were excluded for interview if they were unable to speak English or unable take part in an online call.

Thirteen people responded to the survey of which ten were interviewed, one person was not eligible because they had not been asked about adverse childhood experiences, and two people did not attend the interview.

Table 1. shows demographics and interview preference for each participant who was interviewed. Pseudonyms were used, and some participants chose their own pseudonyms.

Table 1. *Participant demographics and interview preference*

Pseudonym	Age bracket	Gender	Ethnicity*	Interview preference
Grace	18-30	Female	Mixed Black and White heritage	EHS
Anaya	18-30	Female	Black African	EHS
June	31-50	Female	Black Caribbean	EHS, JM
Chantelle	18-30	Female	Black Jew	EHS, JM
Peter	31-50	Male	Black Caribbean	EHS
Samantha	51-70	Female	Black Caribbean	EHS, JM
O.	31-50	Female	Black Caribbean	EHS, JM
Denise	31-50	Female	Mixed Black and White heritage	EHS
Bonnie	31-50	Female	Black Caribbean	EHS
Janet	31-50	Female	Black Caribbean	EHS, JM

**Each participant has defined their own ethnicity, and the researcher has reported this verbatim.*

The participants were recruited through Twitter and other online channels. A flyer was posted together with a link for the survey. An information sheet and consent form were added to the survey. Potential participants were asked to complete this before proceeding.

Analysis

As described, the analysis conducted was a reflexive thematic analysis (Braun & Clarke, 2019; Terry et al., 2017) using Nvivo software. The epistemological approach taken was critical realist (Willig, 2013), which assumes that data does not "mirror" reality but needs to be interpreted for underlying structures to be understood. It encourages context and mechanisms, such as social or psychological factors, to be considered in these interpretations.

The analysis followed the six steps proposed by Braun & Clarke (2019). Firstly, the researcher familiarised themselves with the data by re-reading transcripts and making notes of initial observations in their reflexive diary (see below for description). The researcher then generated codes in Nvivo for any features of the data that could help answer the research question. The codes were then organised into broader patterns of meaning, which constituted the initial themes. The researcher used lists and reflexive diary entries rather than conceptual maps for this stage. The themes were then reviewed, and they were checked against the dataset and changed when appropriate. The themes were then defined and named.

Reflexivity

The first author aimed for cultural humility throughout the process, which involves understanding other people's experiences within their cultural context, as well as working to understand how their own environment has shaped their assumptions, biases and values

(Kumagai & Lypson, 2009). To aid transparency and allow readers to understand the author who analysed the data process, the first author has included a statement about themselves. The first author was a clinical psychology doctoral student while doing the analysis, and she is a White woman who has lived in the UK for ten years. She considers herself to have had a relatively privileged upbringing. She acknowledges the importance of continued education about race and racism, and she has made a particular effort to educate herself on Black people's experiences through reading, discussion and reflection both before and during the writing of this paper. The first author will often understand people's experiences through a social justice lens. This meant that she would particularly notice when participants were talking about systemic issues, and this will likely have translated into the analysis and theme creation. She also acknowledges that a White person might not be able to fully understand the experiences of Black people, and she nonetheless hopes that she has managed to represent the views and experiences of the people who were interviewed, particularly aided by the crucial involvement of the Lived Experience Consultant.

Results

The analysis produced four themes, two of which also comprised of several subthemes (see Table 2 below).

Table 2.

Themes and subthemes with pseudonyms of participants who contributed to each.

Themes		Subthemes
Lack of trust and safety as individual and systemic	Distrust in the clinician	*Grace, June, Chantelle, Peter, Samantha, O., Denise, Bonnie, Janet.* *"Um I suppose when you meet somebody - you are going to share intimate information about myself with somebody,… I am looking for all those signs, those nuances of whether this person is trustworthy or they have the emotional capacity to handle what I am coming with." (Samantha)* *"… it's about trust, I wouldn't trust them." (Denise)*
	Distrust in the system	*Grace, Chantelle, Peter, O., Denise, Bonnie.* *"But yeah, there's just not enough trust full stop I think. I mean, I am not the spokesperson for Black people, but I have no trust or faith in the system…"* *(Denise)* *"Well, you just feel like it'll be used against you. You feel like, it'll lead to some kind of like diagnosis or coercion, maybe a meds review (laughter). So it won't be beneficial to reveal too much information." (Peter)*

	Racism in healthcare	*Grace, Anaya, June, Chantelle, Denise, Janet.* *"Um when all my friends who aren't Black, are able to tell me that they've like got a scan or something for something they have gone to the GP once for, I have gone like four time or five times, and even when I turn up for the scan for something, it's the wrong part of my back, it's just like (pause). And my White male boyfriend will get listened to at the doctor's really quickly, and it just leaves me to conclude, it just leads me to that conclusion when I read the statistics, of being Black and female, and medical bias and research bias." (Grace)* *"… I would be conscious of how could this information be used in a racist way… Racism constantly changes it's face and the way it impacts our community is constantly changing. I wouldn't even want to give you that information so that someone could make use of it in a way that was going to be harmful." (Denise)*
	Keeping safe	*Grace, Anaya, June, Chantelle, Peter, Samantha, O., Denise, Bonnie, Janet.*

		"I think for me, it is about really being clear, you know, I'll mention one thing and see how the conversation goes, you know, see the expression on their face, how they react." (Peter) *"…(the therapist) made me feel like there were some things I couldn't talk about or that would be misunderstood. Because the things I had spoken about weren't as significant to me, they had been mishandled in my opinion, I didn't feel safe enough to explore any deeper." (Bonnie)*
It's the person, not the questions	Being heard and understood	*Grace, Anaya, June, Chantelle, Peter, Samantha, O., Denise, Bonnie, Janet.* *"I think rather than the questions, it was me developing trust with her, that's what enabled me to speak about the experiences." (Samantha)* *"It feels like I have given something precious of myself, that I feel should be handled delicately, and you know, if you give someone something precious to look at you expect them to have the same kind of endearment towards that thing, and look at it and handle it, not just look at it and hand it back, kind of thing or, take it and then go that's difficult, and hand it back." (June)*

	Similarity and difference	*Grace, Anaya, June, Chantelle, Peter, O., Denise, Bonnie, Janet.* *"… we also had some similarities on how we understand religion, … and he said he identified with a lot of the stuff I was saying in terms of how I saw myself and how that impacted my life growing up… those things made me feel, okay he is not a Black guy, he is not from the Caribbean, but … he seems to have understood some aspects of me." (Janet)* *"The psychologist I saw, was White, middle class man, and although he was very intelligent, … I did feel like he was out of sync." (June)*
Engaged client, 'hard to reach' clinician?		*Grace, Anaya, June, Chantelle, Peter, Samantha, O., Denise, Bonnie, Janet.* *"I mean, it's not about shying away from [talking about ACEs], because it is significant and important and we need to talk about these things, so that people can thrive and develop their potential." (Samantha)* *"But they (therapists) have no practical, or I would stretch to say in some cases human understanding, of how to talk to somebody who have had an abusive childhood. It's almost like they start shutting down themselves." (Chantelle)*
People are not tick-boxes		*Grace, Anaya, June, Chantelle, Peter, Samantha, O., Denise, Bonnie, Janet.*

	“It’s not necessarily the amount of times [you experience trauma], it is the impact that it has on you - it could be just once, but it could scar you for a lifetime.” (Samantha) *“… people from African and Caribbean backgrounds, parents discipline in a physical way… and I don’t know how that can be communicated, or clearly within this questionnaire…I would feel that was a misrepresentation, like my answers are not accurate…” (Anaya)*

Lack of trust and safety as individual and systemic

The concepts of trust and safety seemed to be a crucial part of understanding what needs to be considered when services are asking about adverse childhood experiences.

Distrust in the clinician. Firstly, having trust in the person that is asking about ACEs, appeared to be an important factor in deciding whether the questions could be answered safely.

For several participants, whether a clinician could be trusted with their ACEs was related to the level of competence and expertise they felt was needed to hear people's traumas, and also to what the clinician's responses would be if there was trauma that needed addressing:

> *"Because I just, I see the GP as more about the physical body. They're not there for emotional support really are they. And what, and how they would fix that if, if I were to answer that question it would be about medicating more so…" (June)*

For some participants, the decision of whether to trust someone came down to the personality and approachability of the clinician. Questions about childhood trauma could be personal and vulnerable, and it seemed important that there is a positive connection with the person asking. Most participants said they would not trust their GP with answers to an ACE questionnaire.

Distrust in the system. Several participants mentioned the importance of containment and feeling cared for when being asked about ACEs, and these factors might not only be important in an individual relationship, but also on a systems-level. It might be difficult to trust a service when you feel you have to fight to get the support you need, and participants talked about distrust in the medical profession in general.

It was suggested that not feeling safe due to institutionalised racism needs to be considered, as it affects how willing and able people are to provide information to all services:

> *"…they have consistently shown me that they don't care about Black people…. You can't expect people who you have disregarded and left in the gutter for so long, to then trust you with really personal information that can potentially be used against them." (Denise)*

The idea that information given through ACEs questions can be used against a person was repeated by a few participants. Some people were concerned that services may abuse the information they provided. This tallies with the current situation for Black men in mental health institutions, where they are more likely to be seen as "aggressive" and more likely to be sectioned compared to people who are not Black (Care Quality Commission, 2010).

Racism in healthcare. Several people gave examples of direct or indirect racism impacting on their access to and involvement in, health services. This may be underpinned by experiences of the NHS, both historical abuses, but also current issues such as Black women being more likely to die in childbirth (ClearView Insights, 2020). Several examples of being treated differently than White peers in the health system were given.

As noted above, one of the reasons it is important to consider structural racism when asking about ACEs, is that it might influence how likely someone will be to trust the service with the information required when asked about ACEs.

Some participants also discussed feeling that the questions they were asked and the care they were given, were informed by racial stereotypes. Sometimes this was experienced as clinicians not appearing to understand the context of someone's childhood experiences, and sometimes it was through the clinician directing the conversation towards certain aspects of ACEs:

> *"I would often be like, ... , can we talk about the things that are going on, and a lot of the times I'd get pried about my absent father…. who is Black as well, so I think there might have been a stereotype there somewhere, but yeah." (Grace)*

Keeping safe. Participants described considering whether a person or situation would be safe enough for them to disclose ACEs. Several people talked about this being with someone or somewhere that feels comfortable, where there is enough time, and where appropriate responses are given. Some people described that the decision of how much to disclose was made partly based on assessing whether it was appropriate:

> *"…if somebody says, well tell me about what happened - I have to feel several things: is this an appropriate question, has this come from an appropriate person, do I feel safe to share this information with this person? So you can ask the question, but you are not necessarily going to get the answer that you're looking for, or the information that you are hoping for." (Samantha)*

The idea that people would not answer ACE questions if they did not feel comfortable in a situation, was repeated by several participants. Several people also described the importance of receiving a human and compassionate response when they disclosed difficult parts of their childhood, and some people would gauge reactions to disclosures to decide whether it would be safe to answer questions about ACEs. Some people described having taken the chance to disclose something personal, but then realising it was not a safe space after all, and choosing not to divulge any more information. Lastly, several participants talked about a fear of negative consequences for others, if they talked about their ACEs. Some people feared others would be upset if they knew, and some people were worried about the judgement of others:

> *"Just feeling judged, them being judged or me making them look bad, I really didn't want that." (Janet)*

It's the Person, not the Questions

Throughout the interviews, most people talked a lot about the importance of having a good relationship with the person asking the questions about adverse childhood experiences.

Being heard and understood. Several participants highlighted how building a relationship where it feels comfortable to discuss ACEs takes both time, and the clinician to be willing to understand the client. Most participants described that they had at some point experienced positive therapeutic relationships where they had felt heard and understood when talking about ACEs:

> *"… it made me feel like someone was caring about me and where I was coming from and wanted to kind of understand the full picture." (Peter)*

Participants often remembered the feeling they got from the relationship with the clinician better than they remembered specific questions.

Several participants talked about the importance of the clinician asking about ACEs having a cultural awareness and understanding. For some people, it was easier to feel seen when they did not have to explain their culture to the clinician before answering questions, and for some people, there was also a sense of threat if the clinician did not have a cultural understanding:

> *"... I guess in Western culture, I guess because of the culture, British culture, there's lots of things that are seen as wrong in terms of upbringing practices that I knew was part of my culture, but that I didn't feel safe to explore with a therapist that didn't have the understanding." (Bonnie)*

An aspect of being asked about ACEs that was mentioned repeatedly by many participants, was the importance of the clinician taking the time to see the individual and respect that sharing ACEs can feel like a significant personal disclosure.

Similarity and difference. Several people commented on perceived similarity or difference with the person asking them about ACEs. Many people felt that having some level of similarity with the clinician was helping the therapeutic relationship, as they did not need to explain themselves to the therapist or worry about not being understood.

This did not necessarily need to be ethnicity. A couple of the participants highlighted instead the importance of seeing a clinician that identified as gay, as *"the dynamics of those [same-sex] relationships are very different to heterosexual relationships, and those nuances have to be appreciated very differently" (Bonnie).* Some people described having benefitted from seeing a Black clinician, and a few participants explained that they had initially thought that seeing a Black clinician would help the relationship, but then did not feel they were able to connect with them after all.

"I just don't want to be that stereotype saying oh, if my therapist was Black they would have understood more… [it] can make it easier for people to have therapy if they're the same culture, but it can also work the opposite as well." (June)

There was no consensus on which personal characteristics might make it easier to feel connected to a clinician, but some participants mentioned that cultural awareness and open-mindedness from the clinician could help mitigate most differences.

Engaged client, 'hard-to-reach' clinician?

Black people are still under-represented in mental health services and are therefore sometimes given the labels "hard to reach" or "disengaged" by practitioners (Ouro-Gnao, 2020). However, these assumptions are not supported by the data in this study. Every participant in the study said that their childhood experiences were relevant to who they were as adults. Several participants also described themselves as open and ready to talk, and many participants described talking about ACEs in the right setting as a helpful experience – which might all be indicators of being an "engaged client". There was a general view that talking about ACEs is important.

Whilst some research talks about the stigma of getting mental health support and talking about difficulties as something shameful (Myrie & Gannon, 2013), this was not emphasised in this study, and instead there were a few examples of how family had been supportive:

"…my dad and family encouraged me [to speak with a professional], and said it is important to talk." (Denise)

Most participants did emphasise that it can be both "*nerve-wracking"* and "*exposing" (O.)* to talk about ACEs, even when they were motivated to do so. Participants particularly highlighted the importance of being in the right setting with an empathic and human clinician because the conversations about ACEs are difficult. Everyone in the study had talked to someone about ACEs, which supports the idea that they were engaged clients and willing to talk. However, most people stated that there would be situations where they would not answer questions about ACEs. This would not be attributable to "disengagement" or being "hard to reach", but to setting appropriate boundaries when they do not feel comfortable with the clinician or the setting. It was implied that the clinician might be the person that was "hard to reach" for the client. Clinicians were sometimes described as not able to cope with hearing ACEs.

And there were also descriptions of clinicians being too far removed from the clients to understand:

> *"…no disrespect, but if you are working and coming from a good family, a good upbringing, you go to work and yes you hear some bad stuff, but you go back to your life. Whereas the reality on the streets is very different." (Peter)*

In some cases, the clinicians themselves admitted they were going to be "hard to reach", by stating outright that they did not understand the clients:

> *"… I think maybe because it didn't feel, and the therapist said as well, that he couldn't understand everything that I was trying to talk to him about." (Janet)*

People are not Tick-Boxes

When participants were shown the ACE questionnaire during the interview, most people initially said it felt *"fine" (Anaya)* or *"okay" (O.)* to provide the researcher with the answers to the questionnaire. However, when going into more detail, it became clear the participants had issues with the questionnaire:

> *"I wouldn't feel that's an appropriate way to touch such a sensitive topic…. fill this in, tick-boxes, I'm not so sure about that." (Samantha)*

Many participants found that the questionnaire was not clear, and that there were several questions that could be easily misunderstood. Several participants noted that using tick-boxes for ACEs could be seen as both bureaucratic and imprecise.

> *"… needing to feel like I need to fit into like this box, because I'd get treatment if I tick this box." (Grace)*

Many participants also brought up the cultural practice of physically disciplining children, which would be counted as an ACE on the questionnaire. Participants were somewhat divided in whether they felt it was a traumatic experience or not to have been hit as children, but several participants mentioned that they would not continue the practice with their own children. However, participants agreed that the ACE questionnaire was not sensitive to this issue

Most participants also felt that important context would be missed by the ACE questionnaire, which could lead to clinicians making the wrong conclusions:

> *"It is all about the context…. And I think that on the face of it, it can look really bad. Yeah, it leaves me apprehensive that people won't know the context, because it is much deeper." (Denise)*

Participants were also shown an expanded definition of ACEs for comparison, and all participants identified one or more ACEs that they had experienced in this definition, that was not covered by the questionnaire. Several participants described feeling that the expanded definition was *"more inclusive." (O.).* However, one person noted that it might be burdensome to *"rack up more ACEs." (Bonnie).* Most participants stated that they preferred the expanded definition, although two participants explained that they would prefer to be asked using a questionnaire - which supports the overarching idea, that there is no one-size-fits-all solution to asking about ACEs.

Discussion

This study aimed to understand Black people's perspectives on ACEs enquiry, using a qualitative reflexive thematic analysis. Four overarching themes were established: *Lack of trust and safety as individual and systemic; It's the person, not the questions; Engaged client, 'hard-to-reach' clinician?* and *People are not tick-boxes.* The themes are discussed below to consider how the current study relates to and extends existing knowledge.

This study suggests that trust and safety are particularly important factors when people are asked to disclose ACEs. An American study found that African Americans were less likely than White Americans to trust the health service, due to experiencing higher levels of racial discrimination (Armstrong et al., 2013). A recent UK report found that 60% of Black people believed their health is not as equally protected in the NHS as the health of White people, and this number was even higher for Black women, with 78% believing their health is not equally protected according to a report commissioned for the UK parliament (ClearView Insights, 2020). Given the fact that the NHS has not set any targets to end known disparities, such as Black women being five times more likely to die in childbirth than White women, these numbers are unsurprising (ClearView Insights, 2020). Considering this, it might be that trust and safety are important to Black people when interacting with health services, because they might not have the benefit of a baseline level of trust in the system.

The findings are also consistent with the literature on importance of the therapeutic relationship (Lambert & Barley, 2001). It is possible clinicians judged the ACE questionnaire as less likely to trigger adverse reactions than interventions or extended therapy and assumed that it does not require the same level of relationship-building. However, this study shows that disclosing ACEs can be difficult for several reasons, and that people will not disclose unless they feel it is a reasonably comfortable situation in which to do so. It therefore seems likely that the qualities that are needed to build a positive therapeutic relationship, are also highly relevant when asking about ACEs.

Previous research supports the findings of the current study – that people do wish to talk, but it is important to do this in a compassionate, open way. One US mixed-methods study with 46% African American participants, suggested that participants found ACE enquiry helpful and normalising (Chandler et al., 2018). This study did not, however, use the ACE questionnaire (Felitti et al., 1998), but instead used an interview protocol that asked people to talk about their childhood, and then followed this up with a compassionate response and discussion. Another study also emphasises importance of clinicians being non-judgemental, building trust, and providing choice during ACE enquiry (Chokshi et al., 2020), which again is consistent with current findings.

The final theme of *People are not tick-boxes* diverges from the pattern of findings in existing quantitative research on ACE enquiry. Hardcastle and Bellis (2019) found that 85% of participants thought an ACE questionnaire was acceptable, and 91% were very or somewhat comfortable with filling out an ACE questionnaire in an American study (Flanagan et al., 2018). Participants in the current study also stated that it was acceptable to be asked about ACEs with the questionnaire initially. However, when following up on this they reported difficulties with the questionnaire and situations in which they would be uncomfortable filling it out. The quantitative approaches used in previous research might not have captured these nuances in people's responses. However, participants in the current study were all generally in favour of being asked about ACEs, which corresponds with the other research presented.

Strengths and Limitations

It was a strength that a Lived Experience Consultant was employed, as they could use their empathic understanding to keep the focus on the most important parts of the research and keep the questions grounded in real-life situations, as well as being crucial in reaching participants to recruit (Videmsek, 2017)

It was a further strength that the study did not attempt to group together several minoritised people's experiences. The study recognised the particular difficulties Black people meet in the health system, and therefore saw the importance of highlighting Black people's experiences.

It is a potential limitation of the study that there were fewer participants who identified as being Black African or from mixed heritage. There were also more people in the 31-50 years old age bracket than others. Furthermore, the study was only able to recruit one male participant. Future research would benefit from recruiting a wider diversity of participants. It is possible that the difficulties in recruiting Black men and Black African people is due to both these groups being less likely to seek mental health support, which may make it less likely they have been asked about ACEs (Myrie & Gannon, 2013; Devonport, 2022).

Many of the current participants had been asked about ACEs in therapeutic settings, as routine enquiry of ACEs is not yet widespread practice outside of therapeutic environments. Therefore, future research ought to conduct qualitative research with people who have been through the ACE enquiry process in other settings.

Implications for Practice and Research

This study highlights in several ways that dismantling institutional racism, including working to rebuild trust in the health system by providing equal levels of care to everyone should be considered a crucial part of routine ACE enquiry in trauma-informed practice (McIntosh, 2019). ACE enquiry cannot be seen as a standalone issue, and the whole system in which these questions are asked needs to be considered. To improve the sense of trust and safety in the shorter term and on a smaller scale, each individual clinician and service ought to make sure their rationales for asking people about ACEs are clear to both themselves and to the clients being asked to provide this information. They also ought to be clear on how this information will be used, as well as if and why this will be beneficial for the client's care. It is also recommended that clients are offered a choice in whether and how this information is taken and stored.

Another means of improving trust and safety could be matching clients to assessors on ethnicity. For example, in one qualitative study in the United States Black participants stated they would prefer to see a Black therapist; and others explained that they would feel a White clinician would be too far removed from their culture to be helpful (Thompson et al., 2004). However, meta-analyses have not found consistent evidence for improved engagement or outcomes when matching therapists and clients (Cabral & Smith, 2011; Shin et al., 2005). The participants in the US study also commented that some Black therapists may become elitist due to their profession, and that they would therefore be as unhelpful as a White therapist (Thompson et al., 2004). This links to the idea presented in the current paper that it is sometimes the clinicians that are perceived to be hard to reach, rather than the clients. Working towards a greater representation of economic, social and ethnic backgrounds in mental health professionals might go some way to addressing this. One participant in the current study also noted cultural similarity may not always be beneficial, highlighting the need for client choice.

Another aspect of helping people feel safe is ensuring the presence of a clinician who has the knowledge and resources to respond appropriately to other people's experiences of trauma. This is important to consider for roll-out, perhaps particularly in non-therapeutic services. The results from this study show a reluctance from Black people to discuss ACEs with for example GPs and other professionals who they do not feel have the required therapeutic skills to administer ACE questions. High quality staff training for all staff groups will be essential in supporting clients. There should also be satisfactory options for further support for clients. Providing supervision for staff that ask about ACEs will also be important to support them in understanding their own reactions to clients' experiences. If they are given the time and space to consider their own reactions, they might be able to more easily respond in ways that help the client feel safe and heard. Other research has suggested that asking about ACEs has not led to a large increase in referrals or support (Hardcastle & Bellis, 2019). However, this might not be because it is not needed, but because clients do not feel there is an option for further support or because clients felt the clinician did not have enough expertise to address it.

Based on the responses from the participants in this study, alternatives to using the ACE questionnaire should be considered. Ideally, people ought to be given the choice of how and if they would like to talk about their ACEs. A truly trauma-informed approach understands that individual needs should be accommodated whenever possible (Homes &

Grandison, 2021), and that this should be prioritised over the easier option of gathering data in the same way from every client.

When considering the themes, they appear to overlap to a large extent with trauma-informed practice principles – particularly those regarding safety, trust and choice (Homes & Grandison, 2021). It might therefore be beneficial for services to consider delivering ACE enquiry according to trauma informed principles, which might include allowing time for a therapeutic relationship to build between the clinician and client before ACE questions are asked.

As for national or local policies on ACE enquiry, this study recommends that giving people a choice of whether to disclose ACEs, in which way they choose to disclose it, and to whom, is included in guidelines for ACE enquiry rollout. Furthermore, writing policies with clarity and transparency on how the data will be used to the benefit of the client, appears essential.

Lastly, whilst the current paper focused on Black people's experiences of being asked about ACEs, it is possible that the themes and recommendations would apply to a larger population. The lack of trust and safety for example, might also be experienced by people who have had traumatic childhoods, or those who have been let down by the benefits system or the asylum system and therefore find it hard to rely on public services.

Future qualitative research that considers the experiences of the above groups, is recommended. It would also be useful to understand the experiences of people from other minoritised groups. Qualitative research that aims to understand the experiences of people who have been asked about ACEs using questionnaires in a range of services, could help further inform practice. Future quantitative research could ask about acceptability of ACE questionnaires compared to other methods of asking about ACEs, rather than only asking about acceptability of questionnaires. It might also be important to capture people’s reasons for not answering ACEs questions when feasibility studies are conducted.

Conclusion

Participants reported that it is important to be asked about ACEs, but that it needs to be done by a clinician that can build up trust with the client, within a system that can be trusted by the client, and in a way that allows the client to feel safe and heard. Participants generally preferred an expanded definition of ACEs. This study highlighted the need for services to understand the wider context in which ACEs questions are asked, and adapt their approach accordingly.

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