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INSIGHT SERIES

Mitigating the Impact of Adverse Childhood Experiences

Emily McIlmurray

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Acknowledgement of Country

Anglicare Southern Queensland acknowledges Aboriginal and Torres Strait Islander peoples as the first Australians and recognises their culture, history, diversity, and deep connection to the land. We acknowledge the Traditional Owners and Custodians of the land on which our service was founded and on which our sites are operating today.

We pay our respects to Aboriginal and Torres Strait Islander Elders both past and present, who have influenced and supported Anglicare Southern Queensland on its journey thus far. We also extend that respect to our Aboriginal and Torres Strait Islander staff, clients and partners (past, present and future) and we hope we can work together to build a service that values and respects our First Nations people.

We acknowledge the past and present injustices that First Nations people have endured and seek to understand and reconcile these histories as foundational to moving forward together in unity.

Anglicare is committed to being more culturally responsive and inclusive of Aboriginal and Torres Strait Islander people and we are committed to embedding cultural capabilities across all facets of the organisation.

About Anglicare Southern Queensland

Anglicare Southern Queensland (Anglicare) has responded to the needs of our community through more than 150 years of delivering innovative, quality care services. More than 3,000 Anglicare staff and volunteers operate across southern Queensland and in Townsville. Our comprehensive, integrated range of community services includes community aged care; residential aged care; and community support programs, including youth justice, child safety, disability support, counselling and education, mental health, homelessness, and chronic conditions. Our services are designed to 'wrap around' clients in a comprehensive way, recognising their health needs but also addressing the social needs which contribute to wellness.

About the Insight Series

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The Anglicare Southern Queensland Insight Series is a new series written by Anglicare staff, for Anglicare staff, and for those with an interest in Anglicare's core areas of work. Based on research, essays in the Insight Series share ideas, encourage dialogue, and generate feedback on issues related to Anglicare's key areas of service delivery and organisational operations.

The Insight Series is edited by the Research, Evaluation & Advocacy team within the Mission Research & Advocacy portfolio.

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Cover image

Crowd on Busy Street. Urban Life, 5 December 2024. Credit: Carlos Castilla, Shutterstock.

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Acronyms

ACEs	Adverse Childhood Experiences
ECD	Early Childhood Development
SDH	Social Determinants of Health

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Contents

Introduction

The Australian Child Maltreatment Study (Haslam et al., 2023) found that 62.2% of the Australian population have experienced childhood maltreatment inclusive of physical abuse, sexual abuse, emotional abuse, neglect, and exposure to domestic and family violence, with 25.4% of young people aged between 16 and 24 experiencing three to five types of maltreatment. This landmark study highlights the proliferation of maltreatment, trauma, and Adverse Childhood Experiences (ACEs) across the Australian population (Cowgill & Knol, 2023; Haslam et al., 2023; Portwood et al., 2023). The Australian Child Maltreatment Study's findings of young people experiencing multiple ACEs during childhood significantly contributes to the impact of the Social Determinants of Health (SDH) and outcomes across the lifespan (Haslam et al., 2023; Islam, 2024; Likhar et al., 2022; Watts & Hodgson, 2023). There are numerous SDH including education, employment, food security, access to housing, structural conflict, and working life conditions.

This essay will critically examine the intersection of ACEs with the specific SDH relating to Early Childhood Development (ECD) and social inclusion for children, discussing the longer-term impacts on the health and wellbeing of non-Indigenous people as compared to First Nations people in Australia. It will also discuss the importance of creating opportunities for Protective and Compensatory Experiences and prosocial place-based experiences, for social inclusion and supporting recovery from ACEs for First Nations children in the context of their families and communities (Karatekin et al., 2023). Finally, this essay will discuss the role of social workers in co-creating the conditions for the provision of Protective and Compensatory Experiences through their practice with First Nations children, families, and communities, working towards lifelong positive health outcomes (Atikison, 2002; Karatekin et al., 2023; Meldrum et al., 2022).

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are childhood experiences that are complex, variable, and interconnected with social inequities. These experiences have enduring lifelong impacts on health and wellbeing, including long-term biological and neurological impacts, toxic and chronic cumulative stress, and escalation in risk over time (Cowgill & Knol, 2023; Moore et al., 2015; Tshanbangu, 2018; Van der Kolk, 2014; Waite & Ryan, 2020).

On a macro level, ACEs are viewed as a global health issue requiring holistic responses to disrupt the socioeconomic drivers of health inequities across communities and cultures (Karatekin et al., 2023; Waite & Ryan, 2020). They influence inequities in health outcomes across multiple layers of our community, including the socioeconomic, political and cultural context of governance and policy; dominant culture and social norms or values; daily living conditions in communities; and the accumulation of individual health-related factors such as knowledge, attitudes and beliefs (Gabrielli et al., 2023; Karatekin et al., 2023). On a meso or group level, ACEs are a gateway to identifying the resources needed for contextualised social change and implementation of health care and/or social services, correlated to predicted health and wellbeing outcomes (Gabrielli et al., 2023; Karatekin et al., 2023). On a micro or individual level, more investment in research and evaluation is required to establish validated ACEs screening and assessment tools which safely translate into other cultural contexts (Gatwiri et al., 2021; Karatekin et al., 2023; Meldrum et al., 2022).

The Australian Child Maltreatment Study highlights the pervasive nature of ACEs in Australia, revealing that patterns of ACEs and intergenerational trauma lead to long term detrimental impacts on health and wellbeing (Haslam et al., 2024). The conservative findings of the Australian Child Maltreatment Study revealed that ACEs are strongly correlated with severe behavioural and mental health disorders such as major depressive disorder, generalised anxiety disorder, severe alcohol use disorder, and post-traumatic stress disorder, with 48% of participants who reported ACEs meeting the criteria for at least one mental health disorder as compared to 21.6%

who did not (Haslam et al., 2023, p. 24). Specifically, young people aged 16 to 24 who reported ACEs were 2.9 times more likely to have at least one mental health disorder which further impact capacity to participate in life events across the lifespan such as education, relationships, and employment (Haslam et al., 2023, p. 27)

Social Determinants of Health

Social Determinants of Health (SDH) are the elements in a person's life or context that cause positive and/or negative impacts on health outcomes and/or alter the risk and likelihood of disease. These are socially constructed, determined, and conditioned, and can be altered by social policy (Cantos-Egea et al., 2023; Islam, 2024; Likhar et al., 2022; Moore et al., 2015). There are three dimensions of SDH including socioeconomic and political contexts, individual socioeconomic position within society, and individual attributes (Rahman et al., 2024; Tan, 2022). Various SDH also interact and intersect, such as income and social protection or education and job security; therefore, SDH have the potential to impact various people, groups, communities and nations differently (Likhar et al., 2022; Salzer, 2021). Improved research and resourcing in community programs is required to adequately understand and address SDH for positive impact and outcomes (Hatton et al., 2024; Islam, 2024).

Early Childhood Development (ECD) is a SDH that focuses on the foundational healthy physical, biological, social, emotional, linguistic and cognitive development of children from birth to age six, which promote health and wellbeing across the lifespan (Likhar et al., 2022; Littleton & Reader, 2022; Van Eyk et al., 2023). In Australia, health and wellbeing outcomes for children follow a social gradient and linear relationship informed by the socioeconomic status of the family into which the child is born (Islam, 2024; Likhar et al., 2022). Inequitable access to quality services perpetuates and concentrates inequities during ECD, leading to lifelong detrimental impacts in health and wellbeing, and vice versa (Islam, 2024; Moore et al., 2015; Portwood et al., 2023; Webster, 2022). Research demonstrates that addressing this systemic failure during ECD requires multi-faceted and multi-dimensional responses across the community, inclusive of evidence-based programs for creating inclusive environments and strong communities, where investment in high quality ECD leads to improved outcomes into adulthood (Cowgill & Knol, 2023; Gabrielli et al., 2023; Moore et al., 2015; Webster, 2022).

Government policy in Australia has consistently focused on the acute and siloed care of illness and disease and has subsequently neglected to adequately invest in ECD as a foundational SDH for long term health and wellbeing, leading to perpetually poor outcomes for lower socioeconomic groups (Cowgill & Knol, 2023; Gabrielli et al., 2023; Hatton et al., 2024; Littleton & Reader, 2022). First Nations children are persistently the most vulnerable and overrepresented cohort across all areas of SDH – including ECD – and therefore consistently have the poorest health and wellbeing outcomes in the community (AIHW, 2024; Meldrum et al., 2022; Moore et al., 2015; NIAA, 2025). While various national strategies focus on ECD – such as supporting the first 1000 days, equitable access to quality education, targeting the workplace as an environment where parents can access healthy food and exercise, and increasing access to stable and affordable housing – there has been minimal evidence of action, implementation, or impact of these policies (AIHW, 2024; Littleton & Reader, 2022; Malvaso et al., 2022; Meldrum et al., 2022; NIAA, 2025; Van Eyk et al., 2023).

Social inclusion is a SDH that determines the ability of an individual and/or a group to participate in various aspects of life, such as access to services, connectedness, belonging, citizenship and rights, but is also determined by that individual or group's birthright and social standing (Salzer, 2021; Tan, 2022). As a key variable that directly and indirectly impacts immediate and long-term health, wellbeing, and/or illness, social inclusion has also been historically defined in contrast to social exclusion, being the lack of social protections and exclusion from social, economic and cultural spheres (Cantos-Egea, et al., 2023; Petrakis & Lethborg, 2022; Rahman et al., 2024; Tan, 2022). On a micro level, social inclusion centres around participation, connectedness, belonging, citizenship and rights. On a meso level, social inclusion centres around group characteristics or values, socioeconomic status, living conditions, and shared group identities such as race or sexual orientation. On a macro or systems level,

social inclusion centres around poverty, gender and workforce equality, and increasing equity across communities or nations (Cantos-Egea, et al., 2023; Rahman et al., 2024; Tan, 2022). Indicators and outcomes of social inclusion within a community are presence, participation, altered identities (from pathology to person) and benefits within physical, mental and cognitive health (Cantos-Egea, et al., 2023; Salzer, 2021; Tan, 2022).

The intersection of social inclusion and ACEs often reveals multiple forms of oppression and social exclusion, which perpetuate poor health and wellbeing outcomes for certain groups and identities (Islam, 2024; Petrakis & Lethborg, 2022; Watts & Hodgson; 2023). There is a strong correlation between people and groups in society who hold power, privilege and status, and those who do not, whereby lower socioeconomic and marginalised groups also experience social exclusion leading to poor health and wellbeing outcomes (Islam, 2024; Salzer, 2024; Tan & Liamputtong, 2022; Watts & Hodgson; 2023). Understanding the importance of social inclusion and positive ECD for children regardless of their ACEs history impacts longer-term outcomes for health and wellness across the lifespan, by providing access to protective factors and prosocial relationships for recovery and healing from trauma (Islam, 2024; Tshabangu, 2018; Van der Kolk, 2014; Webster, 2022).

Cultural Determinants of Health

Cultural Determinants of Health must also be considered when analysing the impacts of ACEs and SDH, especially for First Nations Australians. Understanding the impacts of systemic racism, colonisation, oppression, and pathologisation of First Nations people leads to an understanding of health inequities and perpetuation of poor health outcomes (AIHW, 2024; Gatwiri et al., 2021; NIAA, 2025; Olson et al., 2021; Watts & Hodgson 2023). For First Nations people, the impacts of colonisation and systemic racism on SDH and Cultural Determinants of Health include reduced service accessibility, increased stress levels and subsequent engagement in risk taking behaviour, chronic disease, and reduced life expectancy (Gatwiri et al., 2021; Gibson et al., 2021; Meldrum et al., 2022; O'Donnell & MacDougall, 2016). Connection to Country – inclusive of community, language, cultural protocols and kinship ties – is integral to the health, wellbeing and resilience of First Nations people (Gatwiri et al., 2021; Gibson et al., 2021; Malvaso et al., 2022; Meldrum et al., 2022).

People with ACEs in their history experience interrupted ECD which detrimentally impacts their brain development and subsequent developmental delay and behavioural impacts (Haslam et al., 2023; Islam, 2024; Van der Kolk, 2014). Children involved with social services have statistically higher rates of ACEs and therefore higher risk and likelihood of maladjustment in adulthood, inclusive of poor mental health (Islam, 2024). Their experience of social discrimination or exclusion then perpetuates the impact of their trauma. Research suggests, however, that the experience of people with ACEs is not as pronounced and profound as that of First Nations people (AIHW, 2024; NIAA, 2025; O'Donnell & MacDougall, 2016). Many will also hold more power and privilege in society as compared to First Nations people; therefore, the impact is not as severe and support services and intervention for recovery and healing are more accessible and available (Hatton et al., 2024; O'Donnell & MacDougall, 2016; Olson et al., 2021).

First Nations people with ACEs in their history also experience interrupted ECD with the same impacts, as well as higher rates of mental health, non-suicidal self-injury and suicide, chronic health conditions, and shorter life expectancy (Haslam et al., 2023; Islam, 2024; Meldrum et al., 2022; NIAA, 2025; O'Donnell & MacDougall, 2016). Additionally, First Nations people often experience Cultural Determinants of Health whereby their social experiences and health outcomes are impacted by their lower socioeconomic status, race, class, cultural context, and intergenerational trauma (Atkinson, 2002; Meldrum et al., 2022; Olson et al., 2021). Due to the ongoing impact of colonisation on the wellbeing of First Nations people, tools for screening wellbeing are largely culturally inappropriate because they have been developed using a western colonial lens (Meldrum et al., 2022; Olson et al., 2021).

First Nations people who have ACEs in their childhood history also experience increased rates of complex and entrenched social exclusion, discrimination, marginalisation, oppression and racism, inclusive of the health system and/or health professionals (Gatwiri et al., 2021; O'Donnell & MacDougall, 2016; Olson et al., 2021). This further perpetuates the detrimental impact of their trauma. While cultural identities and determinants of health can be both positive and negative, socially constructed systemic racism and violence is pervasive in Australia. This continues cycles of intergenerational trauma and poor health outcomes for First Nations people (AIHW, 2024; O'Donnell & MacDougall, 2016; NIAA, 2025; Olson et al., 2021; Petrakis & Lethborg, 2018).

Individual Impact and the Role of Social Work

Social workers can play various roles in recovery from ACEs and promoting the health and wellbeing of First Nations people. While ACEs can provide a gateway to identifying the resources needed for an intervention or implementation of a service, this should not replace rigorous professional assessment and evaluation (Cowgill & Knol, 2023; Gabrielli et al., 2023; Portwood et al., 2023).

At a macro level, social workers can challenge and disrupt entrenched whiteness and racism in health care policies and systems, address socioeconomic, political and cultural contexts, address inequities in daily living conditions, and promote cultural safety for not only decolonising, but indigenising health care practices (Gabrielli et al., 2023; Gatwiri et al., 2021; Hatton et al., 2024). Interventions focused on foundational socioeconomic factors, with a focus on improving community health, have a greater long-term impact as they reach broader segments of the community and are strong indicators or predictors for health outcomes across cultures (Hatton et al., 2024; Rahman et al., 2024). Understanding the health and wellbeing of First Nations people within their cultural context requires an understanding of the physical, emotional, spiritual, social and cultural wellbeing of the entire community, viewing an individual as part of a collective whole, centring First Nations communities for person-led decision making (Atkinson, 2002; Hatton et al., 2024; Meldrum et al., 2022).

A social worker can support children to recover from ACEs with a focus on ECD and social inclusion, by co-creating opportunities for Protective and Compensatory Experiences for children and their communities as early as possible where maltreatment and trauma has been experienced (Hatton et al., 2024; Karatekin et al., 2023; Rahman et. al, 2024; Tan & Liamputtong, 2022; Webster, 2022). Working collaboratively with families and communities to establish prosocial structures where Protective and Compensatory Experiences can occur can create opportunities for children to experience safety and stability in relationships, psychoeducation for building positive relationship and self-care skills within the community and disrupting intergenerational trauma (Meldrum et al., 2022; Waite & Ryan, 2020).

Collaborating with First Nations communities to co-create Protective and Compensatory Experiences for children who have experienced trauma in the context of their family and community draws on the strengths of their cultural identities and protocols of knowing, being and doing, and creates the conditions for collective healing (Atkinson, 2002; Gibson et al., 2021; Meldrum et al., 2022; O'Donnell & MacDougall, 2016). Working with community Elders creates the conditions for self-determination, agency, voice and choice, which leads to the facilitation of Protective and Compensatory Experiences, and healing that are culturally responsive and safe (Gibson et al., 2021; Meldrum et al., 2022).

Conclusion

By understanding the pervasive and widespread nature of ACEs, and the systemic inequities in SDH and Cultural Determinants of Health in Australia, social workers can agitate for change through micro, meso, and macro advocacy. Specifically, social workers can focus on working towards policy change alongside early intervention and prevention work. This research-informed approach has the potential to change the long-term trajectory of the lives and health outcomes for the most vulnerable and marginalised children in the community.

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