Adverse Childhood Experiences in Maine II: Knowledge, Action, and Future Directions

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Research conducted by:
Sue Mackey Andrews, MS, Leslie A. Forstadt, PhD, Erik Hood, MS, & Mark Rains, PhD

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Background

This report is produced for the Maine Resilience Building Network (MRBN), a statewide network founded in 2012. Prior to the MRBN's founding, a research project was conducted in 2010 in the form of a survey sent out by the Maine Children's Growth Council Health Accountability Team. The 2010 survey was sent to a convenience sample of Maine practitioners in mental health, education, medicine, and other disciplines. Participants (n = 352) shared their understanding of Adverse Childhood Experiences (ACEs) and the ACE Study. They shared how they work with ACEs and resilience professionally, and levels of intervention throughout the state. The results of the study were used to determine needs related to ACEs education and training.

As a result of recommendations from the study, the MRBN was founded, and several training and educational resources were developed to educate about ACEs.

The MRBN is a statewide network of individuals working in a variety of settings and the goals of the network are to:

1. Engage in broad conversations about ACEs and resilience
2. Increase participation in the MRBN
3. Become a clearinghouse for ACEs information and educational resources
4. Seek funding to support projects at the local level
5. Collect additional data

As part an evaluation of the MRBN, in 2014 a follow-up research project was designed to understand practitioner knowledge about ACEs and their effects, and the impact of the MRBN.

Participants

Demographics.

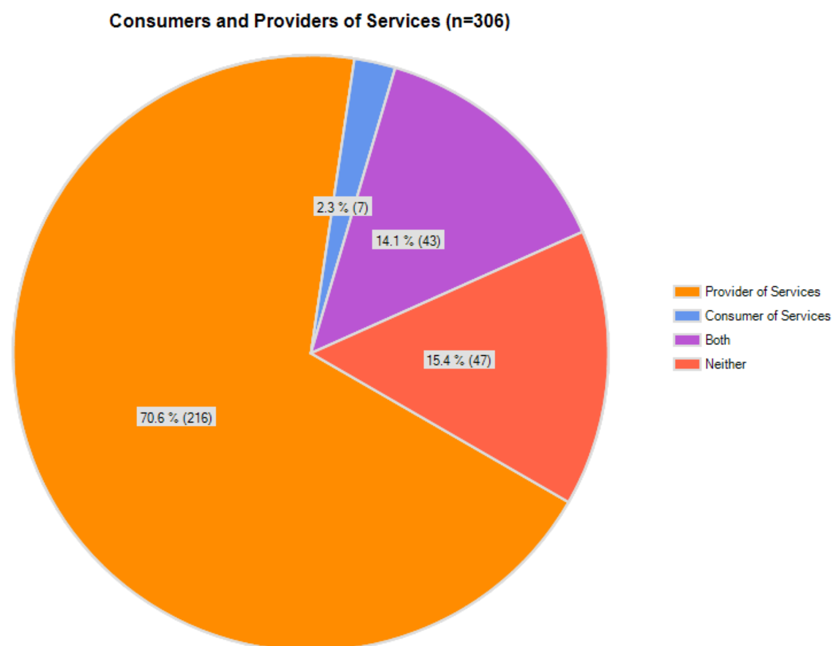
The 2014 survey was completed by three hundred and six individuals (n = 306) from a variety of disciplines. The participants were 79.3% female, 97.7% white, and ranged in age from 20 years to over 80 years of age, with the most responses (19.1%) coming from respondents between the

ages of 56-60. Some questions had more responses than others, resulting in variance in the numbers of participants (n) throughout this report.

Provider or Consumer.

When asked if they were a provider or consumer of services, some respondents (n = 47) answered they were "neither" a provider nor consumer, and they did not complete the remainder of the survey. As seen in Figure A, the majority (71%, n = 216) of respondents described themselves as providers, and less than 15% (14.1%, n = 43) described themselves as both a provider and consumer. For those reporting they were providers, 92% indicated their work involved or addressed early childhood experiences, trauma, infant mental health, or issues with adults related to early childhood trauma.

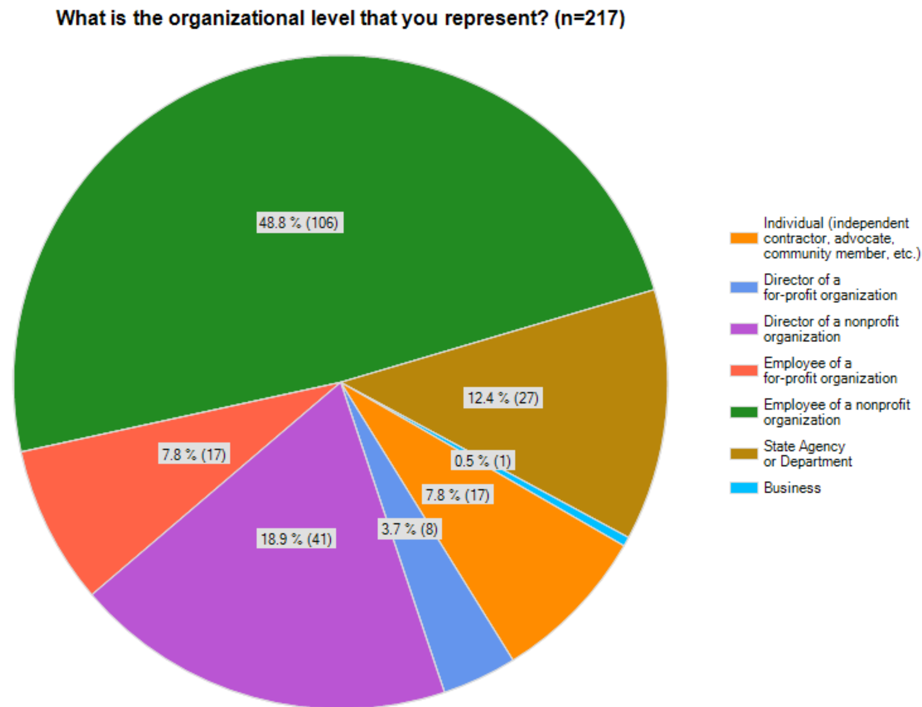
Figure A. Consumers and Providers of Services (n = 306)



Organizational Level.

Figure B illustrates the organizational level that was represented by respondents. Over half of respondents (67.7%) were employees of a nonprofit organization, which included serving as director. The remaining respondents worked independently or were advocates, members of the business sector, or worked in the state department/government.

Figure B.



Focus Area.

Survey participants were asked to self-identify their focus area(s), and could select more than one. The most popular response was "mental health," selected by 46% of respondents (n = 98). In contrast, the most popular response to this question in the 2010 survey was "early care and education," 64.4% (n = 147). In the current survey, 25% of respondents (n = 53) were from the field of early care and education. This change reflects the random nature of convenience sampling, and the network that MRBN has created with respect to who received the survey in 2014 compared to recipients in 2010.

Years of Experience.

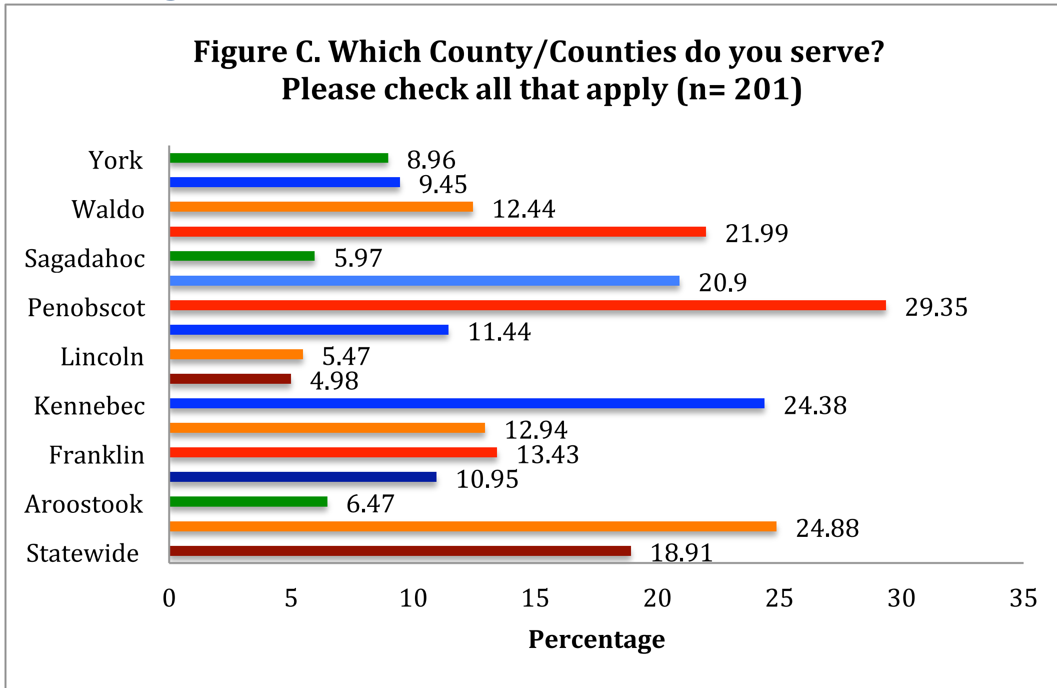
In response to the question, "how long have you been doing work that is affected by early childhood experiences, trauma, infant mental health, or issues with adults that relate to early childhood trauma?" there was a wide range of years of experience. The average was 16.9 years

(compared to the 2010 average of 17.4 years), and the range was one year to 43 years. Over one quarter of the respondents, (28%, n = 64) worked in their field for over 25 years.

County Served.

As seen in Figure C, respondents served all 16 counties in Maine, and 18.9% reported statewide responsibilities. The greatest number of responses to this question included Androscoggin, Penobscot, Piscataquis, and Somerset counties (all greater than 20%).

Knowledge about ACEs



When asked, "Do you know about the Adverse Childhood Experiences (ACEs) Study," 81.1% knew about the study, compared to 41.8% four years ago, the results are in Table 1.

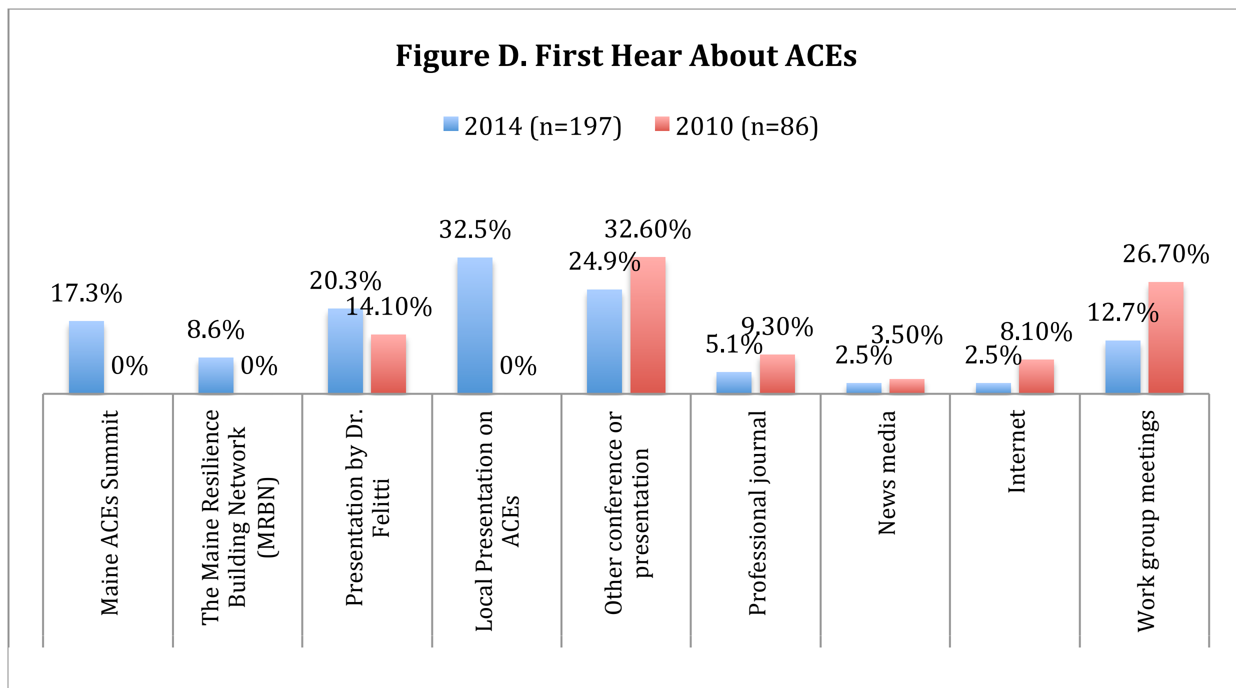
Table 1. Knowledge of ACEs Study

	2010	2014
Yes	41.8 (n=105)	81.1% (n=197)
No	47% (n=118)	12.3% (n=30)
Unsure	28 (11.2%)	6.6% (n=16)

Among those who had heard of the study, the Internet, news media, and professional journals were among the least popular sources of information. In 2014, many respondents reported learning about the study from presentations by one of the study's authors, Dr. Felitti. The MRBN coordinated multiple speaking engagements around the state for Dr. Felitti in 2013.

In the current survey, the following sources of information were not present at the time of the 2010 survey: "local ACEs presentations" and "ACEs Summits," and the "Maine Resilience

Building Network," which is why the 2010 data is 0% for these items. Over 30% of respondents first learned about ACEs from these, which suggests that the implementation MRBN and the trainings are shifting how people are exposed to ACEs information. More people reported exposure to ACEs information through formalized gatherings in 2014 compared to 2010. In 2010, the majority of learning opportunities were more informal in nature (eg., work group meetings, internet, professional journals, other conferences or presentations).



Importance of ACEs.

When asked how educated and how important it is for the general public to be educated about the effects of early experiences on child well-being and adult outcomes, the response patterns were similar in both 2014 and 2010. As seen in Table 2, there is a perception by respondents that the general population is "somewhat educated" or "not educated."

Table 2. Education of the General Population

	Very educated		Educated		Somewhat educated		Not educated	
	2010	2014	2010	2014	2010	2014	2010	2014
How educated is the general population about ACEs?	0	1.8% (n=4)	1.7% (n=4)	.4% (n=1)	48.7% (n=116)	54.6% (n=124)	49.6% (n=188)	43.2% (n=98)

Despite this perceived lack of general education, respondents felt that it is important for the public to be educated about ACEs. As seen in Table 3, almost 75% responded it's "very important" for the general public to be educated about ACEs, an increase from 71% in 2010.

Table 3. Importance of Education for the General Public

	Very important		Important		Somewhat important		Not important	
	2010	2014	2010	2014	2010	2014	2010	2014
How important is it for the general public to be educated about ACEs?	71% (n=171)	74.5% (n=169)	24.1% (n=58)	22.5% (n=51)	5% (n=12)	2.6% (n=6)	0	.44% (n=1)

Effect of ACEs Awareness.

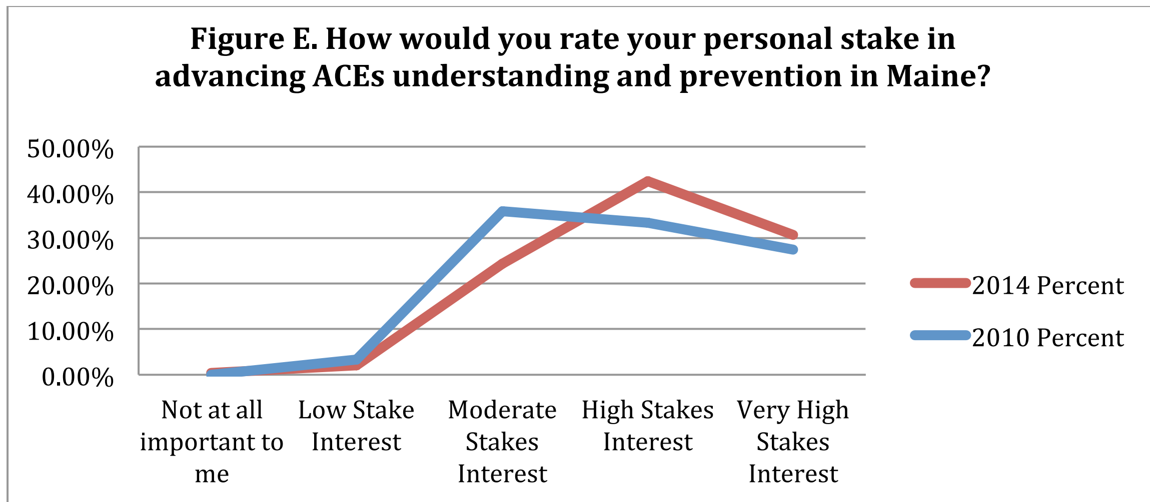
Having an awareness of the ACEs study impacted the lenses through which providers viewed their work. Respondents were asked, "In what ways has learning about the ACEs study affected your work?" in an open-response format. The most common responses were grouped in the theme of providing context to client interactions. Knowing the impact of ACEs increased providers "compassion quotient" as one respondent put it and provided a framework for better understanding client behavior.

Future Investment in Advancing ACEs Education

Stakes.

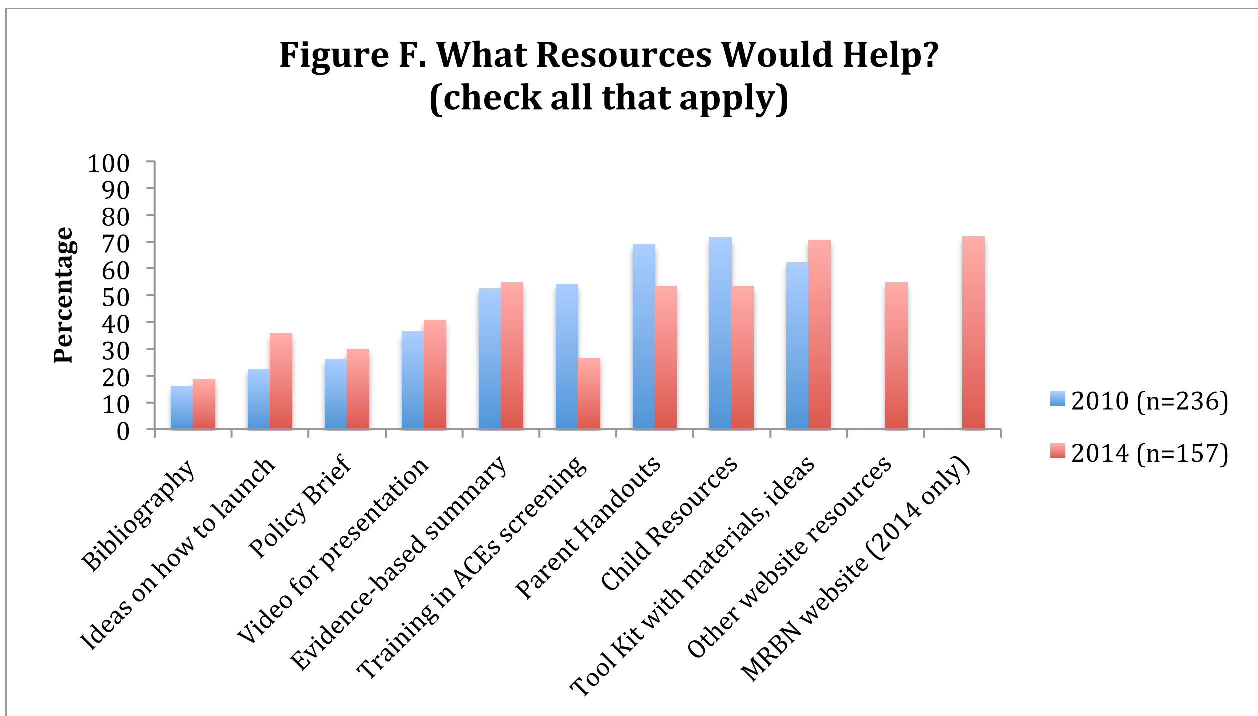
Participants were asked to rate their "personal stake in advancing ACEs understanding and prevention in Maine," and the average personal stake was higher in 2014 compared to 2010. As

Figure E illustrates, 42% of 2014 respondents had a high stakes interest compared to 33% in 2010.



Needs.

When asked what resources they needed to best support their ACEs-related work, responses showed a similar pattern to 2010. Figure F illustrates the responses. Respondents wanted a toolkit, handouts, and resources to use in their own presentations or client interactions.



In 2010, the feedback was put to use. A web site was developed for MRBN (www.maineaces.org) that included a comprehensive toolkit with resources for parents, children, policymakers, and community members. For 70% of respondents in 2014, the toolkit is still perceived as an important resource. The MRBN website (72%), and other websites like ACEs Connection (54.8%), are also viewed as very useful resources. In 2016, the MRBN website will be redesigned and updated, further meeting the needs of parents, children, policymakers, and community members.

Anticipated Resistance.

Respondents were asked to described in an open-ended formant, "what resistance do you expect from…" different organizational stakeholders. Common anticipated resistance from "Service Providers" included: concerns with access to appropriate training or feeling unable to appropriately address the issue because of a lack of training. Respondents also thought that service providers would balk at the increase in time for services when they were already overwhelmed.

Anticipated resistance from "Organizations" included: the need for increased funding, the need to make changes to complex systems, and the absence of currently available resources. In other words, respondents thought that organizations would hesitate given the need to create new and costly (in both time and money) systematic changes.

Respondents expected anticipated resistance from the "Community/Environment" given a current lack of general awareness/understanding of ACEs impact. They also believed that the cost associated with ACEs related changes would create community/environment resistance.

The MRBN's Impact

The 2010 report was completed for the Maine Children's Growth Council Health Accountability Team. In it, recommendations were made in the following categories:

- resource development,
- training and support of clinicians,
- screening for risk and resilience,

- collaborative service network, and
- public education campaign

One way to address all of these categories was to develop a collaborative service network that could develop resources, bring providers together, and educate the public. As a result, the MRBN was formed. In the most recent survey, among both MRBN members *and* non-members, the MRBN was viewed highly as a source for learning about ACEs (76.3% of members, 50% of non-members).

Website.

The MRBN website is viewed as a helpful resource to provide public education. In the most recent survey, 50.4% of respondents familiar with MRBN found the website helped them to be more effective, and 61.8% of actual MRBN members felt the same. In contrast, 41.4% of non-members found the website helpful, and among those who were unfamiliar with or "not sure if they knew of" MRBN, only 5.9% found it useful.

This suggests that once people know about MRBN, the website is used and shared. People appear to know about MRBN before they find the website, rather than learning about MRBN through the website. Thus, efforts made to increase MRBN awareness would likely increase the use of its invaluable resources.

Educational events.

One of the goals of the network is to educate about ACEs. In 2014, 34% of survey respondents learned about them from organized ACEs Summits. The Summits are a direct result of MRBN and did not exist prior to MRBN's formation. Among MRBN non-members, local presentations about ACEs were a significantly higher source of information for learning about ACEs than for members (45.3% of non-members compared to 20.6% of members, $p = .05$). The reverse was true for presentations by Dr. Felitti: members were more familiar with his work than non-members as a way to learn about ACEs. MRBN is responsible for organizing the Summits and for promoting the work of Dr. Felitti, as well as bringing him to Maine on multiple occasions for professional development opportunities.

Respondents to the 2010 and 2014 surveys wanted more in-depth training beyond ACEs introductory material like that provided by the local presentations and the Summits. This need has been addressed by offering a second level of training.

Services.

Survey respondents were asked about the types of activities they had participated in the past, types of activities they were presently engaged in, and the types of activities they anticipated participating in the future. Respondents selected from: providing direct services, grant writing, developing programs, partnering with other progrms, evaluating services, funding programs and services, or do training/conferences. Overall, significantly more members of MRBN than non-members participated in some of the activities ($p = .05$), both in the past and in current/future time.

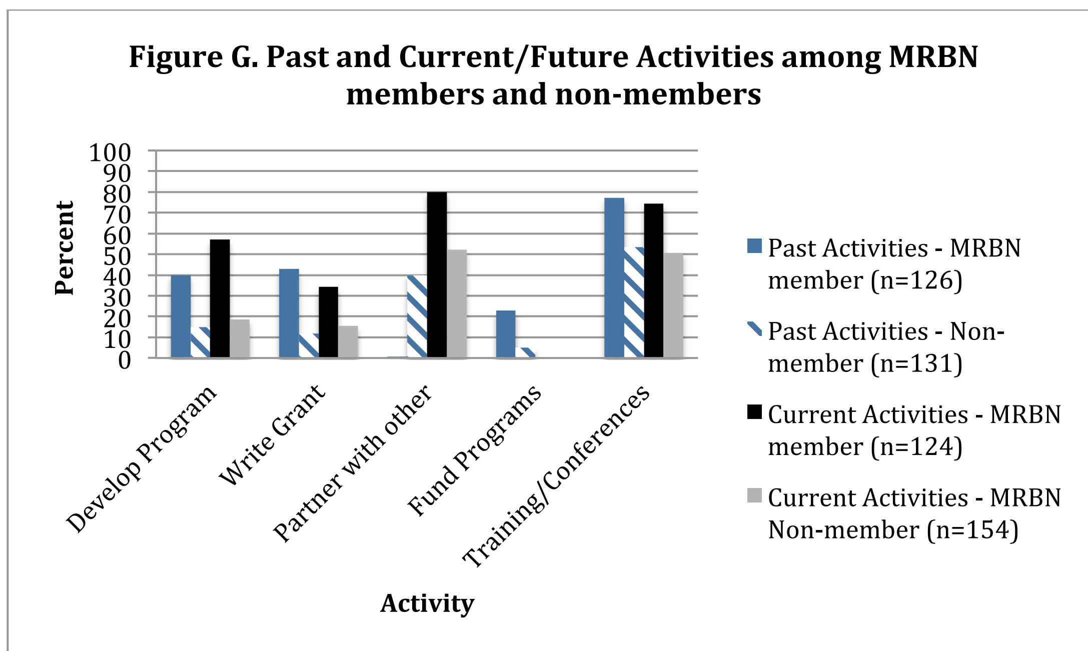
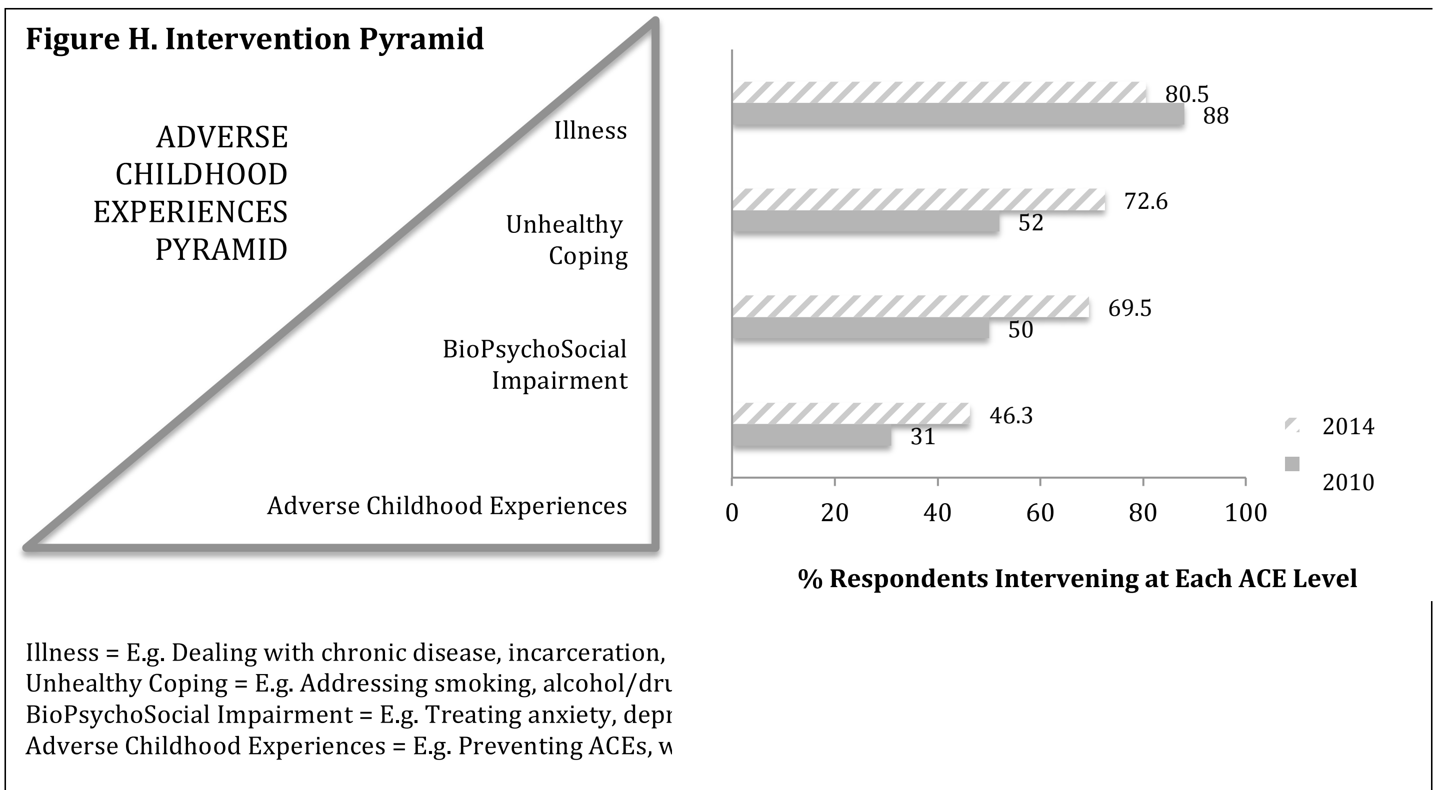


Figure G. Past and Current/Future Activities among MRBN members and non-members

Respondents were also asked about specific services they provide that "build or support resilience and protective factors." Members of MRBN were more likely to provide resilience support to communities than their non-member counterparts (66% compared to 35%) and were more likely to provide mentoring as well (49% compared to 27%). Among all respondents, 37.4% said that opportunities for training in the ACEs survey had made them more effective at their jobs.

The survey did not ask how the survey was being used, whether formally or informally, but the training did have an impact to increase perceived effectiveness.

The ACEs Pyramid in Figure H illustrates various levels that Adverse Childhood Experiences manifest, and the ways that providers intervene. Respondents to both the 2010 and 2014 surveys were asked: "at what level of ACE do you intervene?" They responded with as many levels that were relevant to their work. The levels included: ACEs, BioPsychoSocial Impairment, Unhealthy Coping, and Illness. Intervention on all levels, except Illness, increased from 2010 to 2014. For Illness, it was above 80% for both survey years.



Toolkit.

Since the 2010 survey, a toolkit of resources was developed and housed on the MRBN website. The toolkit provides links to articles, videos, research, and more in one location. In the most recent survey, when asked what types of resources respondents wanted, the toolkit remained the number one resource desired.

Future efforts

Moving forward from this update of ACEs in Maine, there are multiple efforts that will continue locally and statewide.

- Meetings - As a Network, the MRBN will continue to grow in membership, conduct regular meetings, and maintain the website. More efforts will be extended to offer the meetings with video or other remote technologies so that members from farther away can attend.
- Trainings – As trainings continue, the Summits and the more in-depth trainings will continue to be offered. In addition, some community members will have the opportunity to become trained to offer basic ACEs education through a program called *ACEs Interface*, developed by Dr. Robert Anda, co-author of the ACE Study.

Knowledge about the impact and effect of ACEs appears to be growing among providers. Providers also appear to increasingly realize their personal stake in advancing ACEs understanding and prevention throughout Maine. Providing a platform for engaging people in regular conversations about ACEs is important for current and continued progress. This is where MRBN's impact over the last four years is clear. It successfully organized and formalized the dissemination of ACEs information through its website and educational events. Those who are aware of and participate in MRBN recognize it as an invaluable resource. More people are familiar with the ACEs study compared to 2010 and utilize MRBN for needed resources and further training. This survey validates the importance of such a network and highlights the need for continued organization and effort.