Working with Adverse Childhood Experiences: Maine's History, Present and Future

Executive Summary for the Maine Children's Growth Council

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Introduction

This report details the results of a statewide survey contracted by the Health Accountability Team (HAT) of the Maine Children's Growth Council (MCGC). The survey's focus was to learn more about the prevention and intervention work happening in Maine about Adverse Childhood Experiences (ACEs) as defined in the Adverse Childhood Experiences Study (ACE Study). [1]

Background

The ACE Study began in the mid 1990's to explore the relationship between childhood experiences and adult health and behavior outcomes. A research team from the Kaiser-Permanente Health Plan and the US Centers for Disease Control and Prevention (CDC-P) mailed a voluntary survey to over 13,000 people receiving health assessments within the Kaiser-Permanente Health Plan in San Diego, CA. Approximately 9508 surveys were returned.

The research team identified eight Adverse Childhood Experiences *(physical abuse, emotional abuse, sexual abuse, and experience of parental domestic violence, substance abuse, incarceration, mental illness, and separation/bereavement)* and found that they cumulatively increase the risk of many of the causes of premature death and illness, either through maladaptive coping behavioral or physical impairment *(e.g. attempted suicide, injected drug use, alcohol abuse, illicit drug use, depression, chronic bronchitis, sexually transmitted disease, chronic smoking, cancer, obesity, high blood pressure, etc.).*

Applying the odds ratios from the ACE Study to Maine children in foster care * estimated that, *if they received no intervention and their adverse experiences continued to bother them,* then *unnecessarily (i.e. over and above the average rate for these problems),* per thousand children:

20+ would become obese
40+ would attempt suicide
40+ would have employment problems
70+ would engage in illicit drug use
80+ would have unwanted pregnancies
100+ would become depressed

**www.infantmentalhealth.org/newsletter/acestudy.html*

A second wave of the study sampled 13,000 more respondents, brought the number of ACE categories to ten with the addition of *physical and emotional neglect*, and increased the number of surveys in the research database to over 17,000. A series of studies have focused on one or both samples.[2]

Why the ACE Study matters

The impacts of childhood adversity on adult outcomes and the cumulative effects of multiple ACEs on children and adults have profound public health and societal implications. The findings of the ACE Study generate research and clinical questions (see FAQs, Appendix C) that are important for clinicians, policymakers, and the general population to explore, such as:

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[1] Felitti, VJ, Anda, RF, Nordenberg, D, Williamson, DF, Spitz, AM, Edwards, V, Koss, MP, Marks, JS. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The ACE Study. *American Journal of Preventive Medicine, 14,* 245-258.

[2] http://www.cdc.gov/ace/outcomes.htm

- How does early stress lead to a variety of negative behavioral and physical health outcomes in adulthood and how does cumulative stress exposure significantly increase this risk?
- How can illness outcomes be prevented and wellness outcomes be promoted?

The current survey and participants

Professionals were surveyed or interviewed in the summer of 2011. These professionals work in early care and education, public health, child welfare, home-visiting, mental health, law enforcement, corrections, clergy, primary care, parent advocacy, public policy, and business, etc. They responded to questions about the status and impact of knowledge, education, prevention, and intervention related to ACEs. Over 300 respondents across the state from a variety of service areas, types of practice, and degree of knowledge about the ACE Study and the effects of traumatic stress, completed the on-line survey or focused interview.

This sample does not represent all professionals in Maine, but it provides rich descriptive information and recommendations for program planning and further information gathering. Due to the sensitive nature of the topic and the extensive scope of the survey, the sample was not designed to include youth or parent consumers directly. Child and family advocates were surveyed or interviewed and a follow-up survey with consumers will be recommended.

Building on a strong foundation

Maine has a long history of addressing traumatic stress and its outcomes beginning in the 1980's [see Timeline, Appendix A]. By 2006, addressing ACEs in public policy and clinical practice had emerged as one of three priorities of the Governor's Children's Cabinet and this interest continues within the Maine Children's Growth Council. Despite the long history, there is still a perceived lack of knowledge among the general public.

How do people know about the ACE Study?

Although nearly all thought that it was "important" or "very important" for them and for the general population to understand the effect of traumatic early experiences on child well-being and adult outcomes, within this sample less than half of the respondents knew about the actual ACE Study. For those who knew about the ACE Study, they learned about it through work group meetings and conference presentations; 25% of them were introduced to the study in the past year.

What is currently being done with work related to ACEs?

Professionals work with age groups across the lifespan, from expectant parents to grandparents who are caring for their children's children. Most focus on childhood adversity, such as preventing ACEs by working with parents, managing child safety, counseling families under stress, etc. Many provide training and education. About half work with symptoms of impairment from ACEs and half address unhealthy strategies that individuals use to cope with ACEs. Nearly a third intervene at the level of illness or negative life outcomes resulting from unhealthy coping such as health problems, substance abuse, attachment issues, and more.

Is enough being done?

No. Respondents asked for more investment, priority setting, and increased public education about ACEs. The top priorities for developing prevention and intervention activities include:

- Preparing resources and handouts for children, youth and parents
- Developing "tool-kits" of professional and educational materials
- Providing training in ACE screening measures and piloting how they would be used
- Summarizing the evidence base for ACE-related services (see FAQs, Appendix C)
- Increasing public education and dissemination strategies
- Supporting professionals including clinical supervision

Building on strengths

Providers and agencies have a strong base of collaboration and cross-referral on which to build. Respondents emphasized that developing ACE-related services (e.g. screening, referral, intervention, prevention, etc.) could lead to improved knowledge, skills and tools for providers, enabling them to:

- Better engage children and families about trauma, resulting in improved coping and parenting
- Improve coordination, cost-effectiveness, and outcomes among service providers
- Move beyond focusing on illness to focusing on wellness
- Contribute to well -being within communities and to return on government and private investment

Anticipating concerns

Respondents anticipated that children and parents would have greater concerns about how ACE information would be shared and used, than about the potential experience of discomfort (e.g. facing pain, shame, stigma) completing an ACE questionnaire. They also raised logistical issues about how services would be funded.

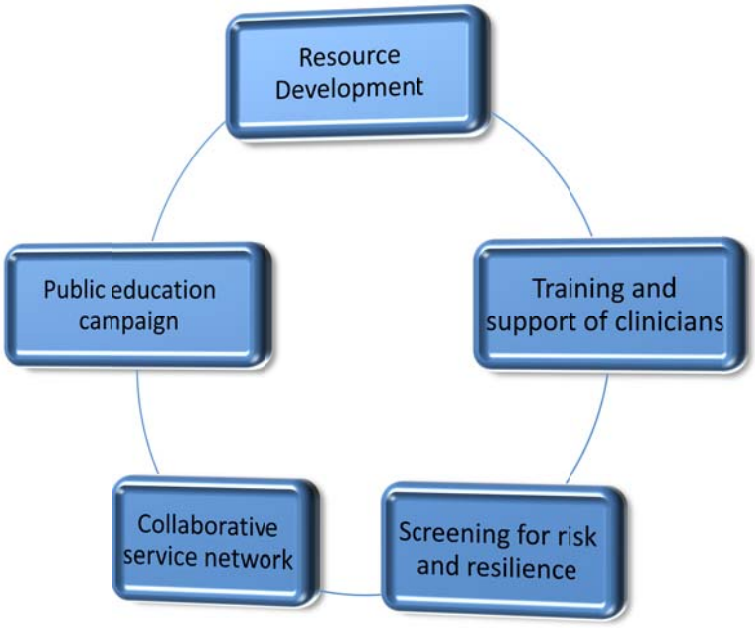
Next steps

Opportunities exist within HAT/ACEs field sites (See Appendix D) and related projects to move from the conceptual to the practical level by pilot testing resources and implementing recommendations. For example, holding focus groups to guide development of parent/community education resources and implementing screenings in primary care practices that link to child behavioral health consultation and community resources.

Recommendations from the Health Accountability Team

Investment in pilot-testing risk/resilience screenings, building preventive intervention networks, developing a toolkit of resources and supporting clinicians in using them, and disseminating public education could yield valuable returns; transforming service systems, increasing individual and community well-being, and reducing the emotional and financial costs of unresolved childhood adversities.

The HAT recommends a broad approach with multiple possible starting points, and encourages collaboration with other subcommittees of the MCGC.



Specific recommendations include:

- Continue the HAT project with focus groups and pilot group activities to develop resources
- Integrate HAT resources and messages with the MCGC Communications Committee
- List specific resource toolkit materials and groups to collaborate with on development (e.g. EAP programs, early childhood consultants, primary care, protective services, OCFS trauma-informed systems, etc.)
- Invest private funds toward an innovative screening/intervention pilot project
- Invest in a roundtable forum of current implementation of ACEs
- Explore opportunities to incorporate ACE screening and service planning to enhance existing services, such home-visiting, primary care, employee assistance, juvenile justice, child welfare, mental health, and prevention of suicide, smoking, drug use, etc

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