Overview

- Background leading to study
- Research question
- Prior research
- Study design
- Results
- Conclusion
- Implications
Background leading to study

- ACEs and Sanctuary Model
- Informal ACEs surveys of Sanctuary Model training participants
- Increasing research on prevalence of ACEs in general population (e.g., Behavioral Risk Factor Surveillance System)
- Increasing research on VT, STS and compassion fatigue among social workers
- Importance of conducting formal exploratory study

Research question

- What is the prevalence of ACEs among child service providers?
- Are there differences in ACEs by gender, type of position (direct/indirect), race or age?
Prior research

- ACEs study (Dube et al., 2001)
  - 63.9% of respondents have 1+ ACEs
  - 14.5% have 4+ ACEs
- Social service providers
  - Primarily social work students
  - Link between early trauma and social work career (Black, Jeffreys & Hartley, 1993; Rompf & Royse, 1994)
- Helping professionals can experience VT, STS and compassion fatigue (Knight, 2010)

Study design

- Exploratory, cross-sectional study
- Voluntary child welfare agency in Northeast
- Agency provides residential, day treatment and schooling for children with histories of trauma, and mental health and community services
Measures

- ACE questionnaire (Dube et al., 2004)
  - Depressed/Mentally Ill household member,
    Humiliation/Physical Threat by household member, Substance
    Abusing household member, Parental Loss through divorce or
    abandonment, Sexual Abuse, Physical Abuse, Lack of Support,
    Domestic Violence, Incarceration, Neglect
  - The number of “yes” responses to each category is added to
    create ACE score; 10 categories

- Violence against the respondent’s mother was
  changed to any parent figure to elicit domestic
  violence experience

Data collection

- E-mail introducing study from Executive
  Director
- E-mail with informed consent and link to
  SurveyMonkey survey April 2011
- One reminder e-mail
- 3 weeks
Sample characteristics

- 94 out of 360 employees (26%)
- 79.1% female, 20.9% male
- 59.8% direct care, 40.2% indirect care
- 65.9% white (not Hisp), 17.6% Hispanic, 7.7% Black (not Hisp), 5.5% Asian/PI, 3.3% Mixed
- Age range: 22 to 68 with average of 39

Analysis

- Descriptive
  - ACE Score
  - Prevalence of each ACE category
- Correlational analysis
  - Age and ACE Score
- Independent samples t-test
  - ACE Score and gender, position, race (White/Non)
Results – ACE Score

Results – ACE Category
Results

- Correlational analysis
  - No significant association between age and ACE score; \( r = -0.001, p = 0.991 \)
- Independent-samples \( t \)-tests
  - No differences in ACE score by type of position held \( t(84) = 0.32, p = 0.75 \), as was the case with gender \( t(48.49) = -1.34, p = 0.19 \), and race \( t(84) = 1.07, p = 0.29 \)

Findings

- Suggests high prevalence of ACEs among workers in an agency serving children with histories of trauma
- \( \sim 70\% \) of employees had at least one ACE; nearly 16\% reported 4+
- ACEs more prevalent in this sample than original ACE study (Dube et al., 2001)
- Higher prevalence of family mental illness and emotional abuse among agency staff (Dong et al., 2004)
Limitations

- Cross-sectional, retrospective design
- Single agency
- Reliance on self-report
- Somewhat low response rate (26%)

Conclusion

- Study helps us understand ACE characteristics among child service providers
- Future research could explore ACE prevalence among other types of social service providers
- Integrating knowledge about resilience suggests opportunity to create restorative organizational cultures
- Qualitative research could explore provider perspectives on elements of restorative cultures that reduce STS, VT and compassion fatigue
- Article to be published in *Families in Society*
Policy & Program Implications

- ACE research as a policy advocacy tool
- Behavioral Risk Factor Surveillance Survey (BRFSS)
- Fragmented service silos vs. comprehensive, integrated services

Restorative Integral Support

**Individual**
- Support strengths
- Mobilize resilience & recovery
- Enhance coping skills
- Resolve trauma
- Restore development
- Build other life skills
- “Evidence-based behavioral practices” (i.e. CBT)
- Medical model
- Body-oriented interventions
- Physical exercise

**Collective**
- Social networks
- Therapeutic milieu
- Peer supports
- Culture of Recovery and Transformation
- Policies and procedures
- Infrastructure
- Recovery-oriented systems of care
- Systems Transformation
RIS & Coalitions

New York example:
The HEARTS Initiative
- a coalition of well-established Capital Region service providers
- strengthening social networks within and across agencies
  - Includes & supports Sanctuary as well as other approaches

RIS: Key elements

- Raise staff awareness of ACEs
- Integrate resilience and recovery knowledge
- Engage staff in organizational development
  - Best practices, values, culture, systems
- Support staff self-care
- Policy advocacy
- Team-based research partnerships
- Leadership as key
Recovery & Transformation

“Some of the healthiest people I know are those who have had to heal from the most challenging situations, and in the process, have gained insight and wisdom far beyond what a ‘comfortable’ life would ordinarily provoke.”

- Joan Borysenko, Fire in the Soul

References

References cont’d


Thank you and Questions?

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