



# Iowa's Community-Based Child Abuse Prevention Response to the Adverse Childhood Experiences Study

*Prepared for*  
Prevent Child Abuse Iowa

*by*  
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It is our sincere hope that their contributions will help strengthen the current landscape of child abuse prevention and community empowerment.

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## Introduction

In 1998, the Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998)<sup>1</sup> surveyed over 17,000 people and found a strong relationship between exposure to trauma during childhood and many risk factors for health and social problems later in life. For example, people exposed to childhood trauma had a far greater incidence of attempted suicide and excess alcohol consumption; they also had a higher incidence of depression, heart disease, obesity and the use of illicit drugs. The ACEs study findings offer a compelling testament to the effects of abuse, neglect and other adverse experiences that children experience on those same people in later life.

Today, it is estimated that three million children and adolescents in the United States are exposed to serious traumatic events each year (Hamblen et al., 2012; Hamblen, Barnett, & Norris, 2012).<sup>2,3</sup> Since its original findings, the ACEs study has been used around the nation as a platform to educate and inform a broad range of audiences about the importance of promoting safe and nurturing environments for all children. It is a topic that has effectively influenced families and community providers across sectors by illustrating the cumulative impact of adverse experiences, regardless of perspective. The ACEs study connects health professionals, social service providers, law enforcement and the judicial system and even business owners because there is room for everyone to play a part in either promoting factors that protect children or reducing risks, directly or indirectly. The findings of the ACEs study are convincing and many efforts are underway to act on those findings across a multitude of arenas. Examples are demonstrated by developing evidence-based treatments and best practices to address ACEs, designing trauma-informed services and changing the way that entire service delivery systems operate.

## Iowa's Approach

Prevent Child Abuse Iowa (PCA Iowa) is a non-profit organization that uses three types of strategies to prevent child abuse—assistance, advocacy and awareness. In 2013, PCA Iowa launched the Community-Based Child Abuse Prevention Response (CBPR) to ACEs project in an effort to engage communities systematically to support local child abuse prevention efforts using the results of the ACEs study as a unifying motivator. The Community-Based Prevention Response's theory is that if people understand where, along a readiness continuum, a community is in terms of responding to child abuse, and if they possess compelling research tools to illustrate the adverse consequences of childhood abuse and neglect, they will be in a better position to promote actionable prevention messages than if either or both of those conditions were not present.

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<sup>1</sup> Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, 14(4), 245-258.

<sup>2</sup> Hamblen, J. L., Barnett, E. R., Hermann, B. A., & Schnurr, P. P. (2012). 28 PTSD Treatment Research: An Overview and Evaluation. *The Oxford Handbook of Traumatic Stress Disorders*, 415.

<sup>3</sup> Hamblen, J. L., Barnett, E., & Norris, F. H. (2012). 17 Long-Term Mental Health Treatment for Adult Disaster Survivors. *Behavioral health response to disasters*, 301.

PCA Iowa viewed the CBPR framework as a natural platform for distributing the ACEs study results. With support from Mid-Iowa Health Foundation and the Principal Financial Group Foundation, Inc. PCA Iowa selected six communities, from a field of 19, to disseminate the ACEs message. The first teams were located in Dallas, Henry, Jones, Linn, Pottawattamie and Scott counties. PCA Iowa challenged each participating community to examine closely the base-level knowledge, attitudes and behaviors of its members in an effort to align its ACEs messaging with the subsequent goals and action plans.

PCA Iowa staff prepared these communities to implement a CBPR by thoroughly orienting each group to the framework for social change and the process for carrying out a community readiness assessment, complete with the background materials and theory supporting the process. Staff began by facilitating a series of structured meetings and trainings, helping the six sites to participate firsthand in the community readiness assessment and analysis of results, followed by development of their own unique action plans. PCA Iowa has continued to provide individualized technical assistance to those sites during the past year by requesting status updates, sharing resources, reviewing materials and brainstorming solutions to local challenges as they arise.

With support from the Iowa Department of Public Health, PCA Iowa provided funding and assistance for four more sites in November of 2014. Though the process has changed slightly based on lessons learned from the first group of grantees, the focus continues to be on using the ACEs study findings to increase public awareness and commitment to child abuse prevention.

### *Purpose of this Report*

The purpose of this report is to share findings obtained through a year-long evaluation performed by Hornby Zeller Associates, Inc. (HZA) whose focus primarily was the efforts of the original six sites. The evaluation aimed to learn how ACEs can be used effectively to promote child abuse prevention messaging using the CBPR approach both throughout Iowa and, by inference, to a broader national audience. The evaluation results can assist other communities to mount effective child abuse prevention campaigns using ACEs as a key component of the messaging. The remainder of the report is organized into the following sections:

- **Methodology**, which describes the evaluation questions, what information was collected and how it was analyzed;
- **Description of the Program** (and local sites), to lend greater context to the discussion of results;
- **Findings**, which examine the CBPR process, how ACEs has been disseminated and the preliminary outcomes observed; and
- **Conclusion**, which shares the lessons learned through this innovative initiative.



## Methodology

By examining the six initial communities that implemented the CBPR model, the evaluators determined how effective the project was in communicating the prevention messages. Of particular interest was how the findings from the ACEs study were used to advance child abuse prevention and what appeared to be the most useful and credible approaches across the six sites. Specifically, the evaluation questions addressed in this report are below:

- 1) Is ACEs a useful tool in promoting child abuse prevention in the community?
- 2) What audiences are particularly interested in ACEs?
- 3) What messages are most important to each type of audience?
- 4) What methods are particularly effective in motivating various audiences to become involved?
- 5) What networks can be tapped to maximize the dissemination of information?
- 6) Looking across the six to ten agencies, what lessons can be generalized to other communities that will help them motivate a stronger child abuse prevention response?

## Data Collection and Analysis

HZA employed the following data collection and analysis methods to answer the evaluation questions.

**Review of Documents:** HZA reviewed meeting minutes, group presentations and other materials provided to the local CBPR Teams. In addition, HZA staff reviewed the action plans developed for each local site as well as any other documents provided, including handouts, fact sheets, training curricula, presentations, websites and social media.

**Training Attendance:** HZA staff attended the CBPR training in November 2014, intended to orient the second round of sites to the project. HZA staff spoke with representatives from each new location and learned more about their plans. In addition, HZA observed one day-long “action planning” meeting facilitated by PCA Iowa with one of the newly funded communities to better understand the CBPR process as it related to this project.

**Site Visits:** Two HZA staff visited five of the six original communities in March 2015 to obtain a better understanding of what had been accomplished, how the readiness assessment was used, what prevention activities were targeted, how the planned activities differed from what actually occurred and why. One community had difficulty arranging the site visit, and a telephone interview was conducted instead.

**Community Stakeholder Survey:** A survey of stakeholders in the six selected communities was conducted in March and April 2015 to obtain feedback about the prevention efforts. The survey was web-based and the local CBPR Teams invited community stakeholders to participate. The brief survey asked about the respondents’ understanding of ACEs, the types of formats used to convey the information, how often they had contact with the local CBPR Teams, the extent to which they believed that ACEs was an effective framework by which to discuss child abuse prevention, and their level of agreement that child abuse prevention

services were needed in their communities. A series of open-ended questions solicited feedback about which messages resonated and asked for examples of how the information has potentially changed their own work or that of their organization. The complete survey can be found in the Appendix.

In total, 38 individuals provided usable responses to the community survey (two indicated they had not heard of ACEs and were therefore excluded). The respondents represented all six funded communities, with the community response ranging from three surveys to nine. The majority of respondents were female (87%) and the average age was 42.

## *Analysis*

Because of the nature of the CBPR assessment approach, developing a comparable domain score and determining whether a community had “advanced” on that score was not feasible without fully replicating the community readiness assessment process. Instead, HZA reviewed each site’s action plan and determined the degree to which the goals and outcomes were achieved based on our review of the site’s documents and the face to face interviews conducted at each site. In this manner, HZA was able to determine whether any demonstrable progress had been made within each community on the CBPR domain areas they had selected as the target of their respective action plans.

The results of the site visits were also themed by two HZA staff in accordance with the evaluation questions to determine the progress made within each community, what contributed to success and the lessons learned along the way. In addition, the survey results were analyzed using simple descriptive statistics to glean a broader community-based perspective of the effectiveness of ACEs and prevention messaging within the CBPR approach.

By examining the six initial communities who implemented the CBPR model, evaluators determined how effective the project was in communicating prevention messages.



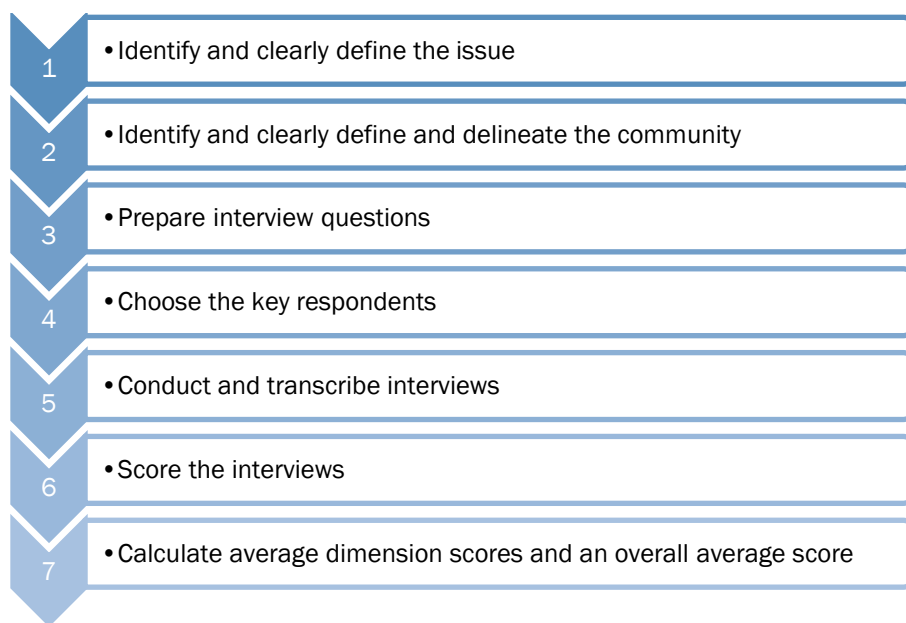
## Description of the Program

### CBPR Process

PCA Iowa provided each local CBPR Team with an overall framework for developing and implementing the project, as well as tools, training, and technical support. Each team received a local readiness assessment report and developed a response, or action plan, that was appropriate for its community. All six sites were encouraged, in turn, to provide mutual support for each other.

The initial training and technical assistance in late 2013 consisted of a webinar and a day-long training to provide a framework for the readiness assessment process. The workshop was used to share theories of community change, discuss best practices for social messaging and marketing, and review the expectations for conducting the readiness assessment. The community readiness assessment employed a model developed by the Tri-Ethnic Center at Colorado State University to guide prevention efforts at the individual community level. According to the Tri-Ethnic Center, the steps in the Community Readiness Assessment process are as follows.

**Figure 1.**  
**Community Readiness Assessment Steps**



Following this model, PCA Iowa prepared interview questions and worked with each local CBPR Team to identify four to six respondents in each community to be interviewed.<sup>4</sup> Each local CBPR Team was then assigned to interview community representatives for another team and the responses were recorded by a third-party service. PCA Iowa analyzed the

<sup>4</sup> For more information about Iowa's approach and for examples of the actual Community Readiness Assessments completed, go to <http://www.pcaiowa.org/programs/cbpr-to-aces/>

results and provided a community readiness assessment report for each community that showcased the community readiness level in six areas: efforts, knowledge of efforts, leadership, climate, knowledge of the issue and resources. A detailed description of the community readiness assessment concepts and scoring can be found in Appendix A.

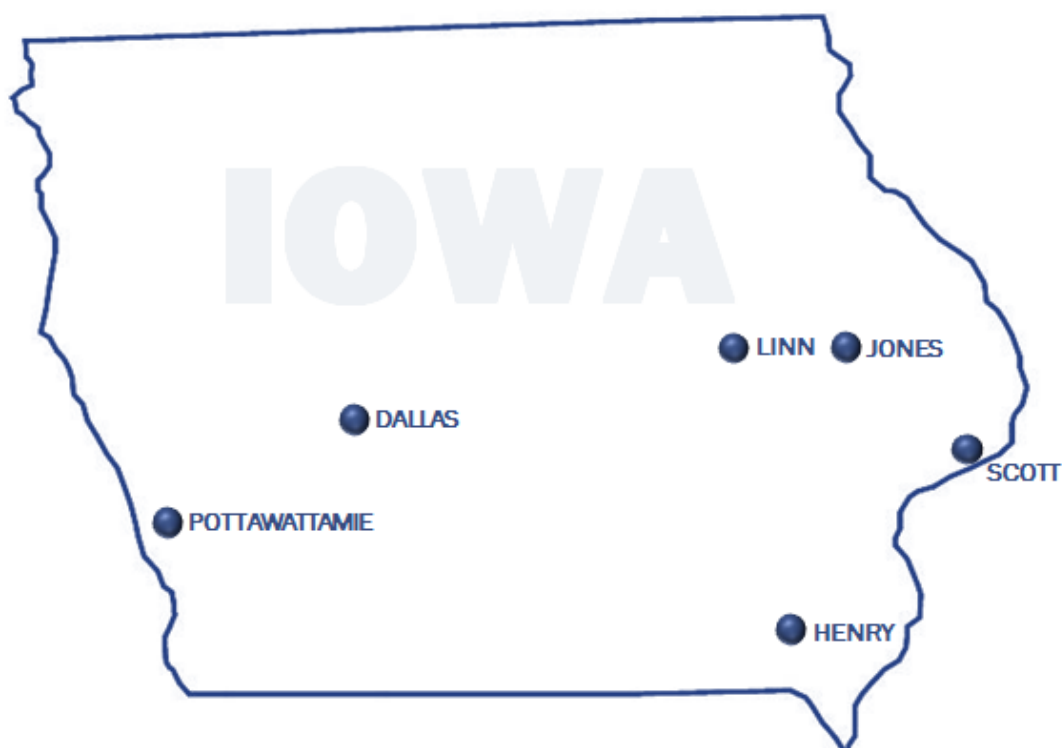
In March 2014, PCA Iowa hosted a day-and-a-half-long workshop where it presented the readiness assessment scores and helped the local CBPR Teams process the findings. The session also walked the CBPR Teams through the steps of creating an action plan. PCA Iowa staff subsequently visited each team to help them to complete their action plans and began checking in with project members in September 2014 to see what they had accomplished over the summer. Staff members have continued checking in with the sites regularly over the past year, providing guidance and linking them to resources.

### *Description of the CBPR Teams*

Local CBPR Teams were selected from different geographic and demographic areas in Iowa, with consideration of their range of content area knowledge, background and skills represented in each group. The team members' existing connections to child abuse prevention efforts in their communities, and evidence of broader community support for the project were also considered.

The image here shows the original six counties in Iowa: Dallas, Henry, Jones, Linn, Pottawattamie and Scott. A brief overview of each follows.

Figure 2.  
Iowa's Community-Based Child Abuse Prevention Response to ACEs:  
Funded Communities, 2013–2104



## *Dallas County*

Located in the center of the state, not far from Des Moines, the Dallas County team selected one rural area, Redfield, hoping to work with the city government and eventually the school district, and one urban area, Waukee, the fastest growing city in the nation, targeting the school district as well as a young leaders group. Originally this project had a team of four but lost one representative and is implementing activities under the leadership of three members. These members represent different service sectors (early childhood, juvenile justice and clinical mental health), though all have a mission related to supporting families and preventing abuse. The project now falls under a larger community effort called the Generation Wellness Coalition. The readiness assessment showed fairly low scores across all domains, indicating vague awareness of issues related to prevention. The action plan focused on engaging leaders and raising awareness of prevention resources across the two distinct locations by writing articles, meeting with local leadership and developing an on-line prevention resources toolkit.

## *Henry County*

Henry County is small and rural, home to an older and strongly working-class community. The Mount Pleasant readiness assessment showed the community to be in the stage of vague awareness in climate, indicating a need to educate its members on the benefit of taking a prevention approach versus the current stance of reacting when problems occur. This project has a very small team with few hours available to work on the CBPR efforts, with the most active member coming from the area's Child Abuse Prevention Council. The action plan originally targeted members of the Healthy Henry County Communities (a community-wide coalition), the school district and the local chapter of a human resources professional association. Later in the process, they focused solely on the members of the community coalition and have recently turned efforts towards family practice staff and the local Early Childhood Initiative's Parent Council.

## *Jones County*

A fairly rural community located on the eastern side of Iowa, Anamosa in Jones County is adjacent to another CBPR site (in Linn County). The readiness assessment showed some of the lowest scores in community climate and knowledge of the issue, allowing the team many opportunities to educate both leadership and direct service providers across disciplines since they have had very little exposure to the ACEs study. The team has three members who are very connected to various sectors in the community including: education, law enforcement, medical providers, and faith-based organizations. The Jones County Community Partnerships for Protecting Children (CPPC) has become a solid resource to the various sectors; however, they do not have the time and resources to reach all areas that they would like.



## *Linn County*

The project in Linn County had a unique focus on a specific neighborhood: the Taylor Neighborhood, initially, because members had a personal connection there and they wanted to address the existing hardship following a devastating flood. This area's readiness scores were lowest in community climate and resources, but they also struggled with leadership and knowledge of efforts. Through natural partnerships between the neighborhood school, the United Way and Public Health, the plan involved building community leadership and infrastructure to support local activities rather than targeting community members (e.g., parents) to address the community climate and exposure to the concept of prevention. The Taylor Area Neighborhood Association (TANA), the United Way and the Community Action Network (CAN) are crucial partners in moving the efforts forward, though with a loss of leadership and challenges outside of the project with the TANA, the team has had to revisit the best ways to reach the target audience and develop connections with school personnel.

## *Pottawattamie County*

This project is in Council Bluffs in Pottawattamie County, which is located in the southwest corner of Iowa. As a result, they have the opportunity to connect with the Nebraska-based Boys Town organization (through Lutheran Family Services), yet they also struggle with families moving back and forth between states. The team here is small, working on the prevention project through two specific professional affiliations: the faith-based and social services sectors. The readiness assessment scores for Council Bluffs were relatively high across the domains, with the lowest scores in community climate (vague awareness) and knowledge of the issue (preplanning). Leadership seems to be on board with prevention messaging and activities; however, the community level of engagement needs focus. The plan seeks to educate and empower human service professionals and faith leaders to understand ACEs and work directly within the community to reduce risk factors. This team has worked to shift the perspective so that all members view prevention as their collective responsibility.

## *Scott County*

This project is located in the middle of the Quad Cities area on the Mississippi River between Iowa and Illinois. The community has the benefit of many existing partners in prevention under the Eastern Iowa–Western Illinois Trauma-Informed Care Consortium and the Child Abuse Prevention Advisory Council of the Child Abuse Council, to name just two. The readiness assessment for this area showed lowest scores in community climate and knowledge of issues despite the numerous programs in place under the aforementioned



Consortium. This team acknowledged that there is a difference in perception between what providers and higher-level professionals know about ACEs and prevention and what families and parents know. This project, carried out by three members representing the non-profit, mental health services, early education, and child abuse prevention sectors, has focused on promoting concrete and appealing messages directly to parents through social media and print materials designed with the audience in mind.

## Findings

The local CBPR Teams across the six original communities have built upon their existing programs (which include multiple service sectors) not only to promote awareness of ACEs, but also to use the information learned from the formal Community Readiness Assessment. For example, the teams designed activities, events, presentations and ad campaigns to shift the way communities think about child abuse and neglect. Based on the evaluation results, these messages have been well-received by all six communities and CBPR Teams have been successful in adapting the original materials made available to them by groups such as PCA Iowa and the Central Iowa 360 Steering Committee so that the messages are suitable for the anticipated audiences.

### *CBPR Process*

The original six CBPR Teams reported at length about the CBPR process, describing from their perspectives what was helpful, informative and what could be changed in the future. Despite suggesting some ways to improve the process, the participants in CBPR projects overwhelmingly agreed that the framework and technical assistance were invaluable factors in their local successes. Below is a summary of the teams' feedback.

### *Training and Support*

As previously described, PCA Iowa provided every CBPR Team with extensive technical assistance that took the form of in-person training (both in large group settings and on-site), templates, action planning and regular telephone calls. This support continued into the second year, once the action plans were developed, and PCA Iowa helped connect local teams to resources and materials and brainstormed solutions to local challenges. Indeed, CBPR Team members felt supported by the PCA Iowa staff and were appreciative for the thorough review and careful consideration of each step in the CBPR component of the project.

However, some teams talked about how the training was much more extensive and time consuming than they had initially expected. While they acknowledged that a thorough introduction was necessary, some felt overwhelmed by the breadth of information. Others hoped to have a more concrete work plan by the end of the second workshop. One team suggested providing an example of a work plan and/or a template to use during this session so that teams could leave with some concrete ideas on paper. For the second group, PCA Iowa shortened the training sessions and added more in-person TA to the site-specific action planning meetings.

### *Community Readiness Assessment*

The Community Readiness Assessment reports were very useful to all local CBPR Teams to help them see how far along their targeted community was in terms of awareness and knowledge of child abuse prevention. The results can be seen in Table 1, with the average scores shown for each readiness domain (ranging from a score of one, meaning “no



awareness,” to nine, meaning “high community ownership”). A full explanation of the scoring and domains can be found in Appendix A.

**Table 1.**  
**Community Readiness Assessment Scores**

	Dallas	Henry	Jones	Linn	Pott.	Scott
Community Efforts	3.5	7.3	4.5	6.0	7.6	5.6
Community Knowledge of Efforts	3.8	3.3	2.7*	3.1	5.3	3.7
Leadership	3.3*	3.3	2.5	3.1	5.9	4.0
Community Climate	4.1	2.3*	1.8	2.7*	3.5*	2.4
Community Knowledge of Issue	3.8	2.5*	2.2*	3.7*	4.5*	3.4*
Resources Related to the Issue	3.2*	3.8	2.3	2.7	4.7	3.5*

*\*Targeted by action plan. 1 = no awareness; 9 = high community ownership*

The six sites generally believed that the results were accurate and helped the teams determine where best to focus their efforts. Many shared how the report showed them that their community was often lower in terms of understanding ACEs than the teams had thought before the assessment. Others spoke about how having information that was specific to their community was helpful to initiate conversations about the project, particularly when they talked about child abuse prevention outside of the local agencies already dedicated to the issue. Some noted that community members responded well to the concrete definitions and ratings used in the assessment model. They described the final report as being “professional,” “polished,” “extremely useful,” and “very helpful in solidifying what we were thinking about our community’s perceptions of ACEs.” In short, the Community Readiness Assessment process helped ensure that the action plans were feasible and met the community at the appropriate level of readiness.

The process of partnering with another team to complete the required key stakeholder interviews for the needs assessment generated less positive feedback. Participants shared that some teams had greater capacity to conduct the interviews than others, and in some instances, this may have led to inconsistent results. They also reported that the interview participants found the protocol confusing and repetitive because it asked questions about ACEs on one hand and then questions about child abuse prevention on the other; participants perceived this as being asked the same questions twice. In response to this feedback, PCA Iowa changed the process and protocol for the Community Readiness Assessment being implemented with the second group of sites funded this past year by having a third party collect and score the interviews. The interview protocol was also modified to focus exclusively on child abuse prevention instead of ACEs, with the latter reserved for messaging.



### *Action Plans and Subsequent Changes*

Based on the results of the Community Readiness Assessment, each community selected one or two domain areas to address with their action plans, as well as targeted audiences and proposed messages. The plans outlined each action step that the local CBPR Team intended to take to achieve their set goals and measurable objectives. PCA Iowa provided a three-hour technical assistance site visit to each local CBPR Team to help develop the action plans according to the CBPR framework.

After about nine months of implementation, however, every local CBPR Team had adjusted its original action plan. Some sites acknowledged that their initial plans were overly ambitious (that is, too many audiences, communities or activities) and needed to be scaled back. Others faced unexpected circumstances that resulted in changes, such as staff turnover, shifting community conditions and leadership changes. One team lost two members, while another needed to rethink its target audience when an important community collaborator faced its own significant challenges and shifted its priorities away from ACEs messaging. In other instances, the local CBPR Teams realized that their initial plans were simply not feasible once they started to connect with their target audience. For example, one team had to accommodate the logistics of the local school training schedule, which meant extending its original timeline.

By Spring 2015, most of the changes had been smoothed out and all of the local CBPR Teams were able to demonstrate progress towards their goals (discussed later in this report). However, most reported that three to five years was a more realistic timeframe than two in which to get the work done, particularly when trying to find additional resources, staffing or funding to sustain and support the work.

Most CBPR Teams reported that three to five years was a more realistic timeframe than two in which to get the work done, particularly when trying to find additional resources, staffing or funding to sustain and support the work.



The following section describes who was targeted, how ACEs was used to advance the child abuse prevention message, and what appeared to be the most useful and credible approaches across the six sites.

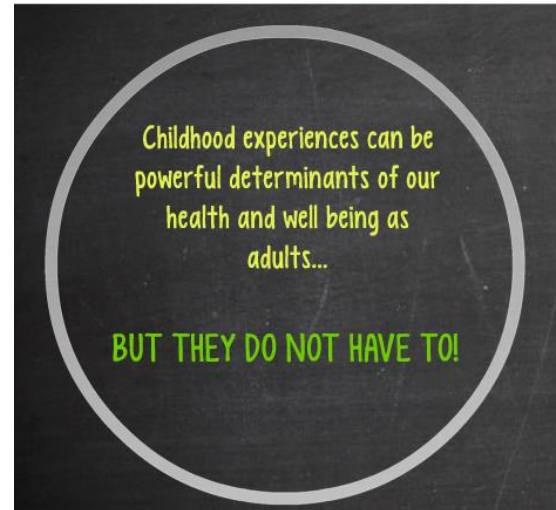
Across all the targeted audiences, the local CBPR Teams focused on sharing the core ACEs information and prevention messages. This was a result of the readiness assessments, which generally showed that the communities had little or vague awareness and were in need of basic information. Regardless of the audience, the teams found that simple messages and concrete information were important, as was including data and statistics specific to Iowa and the local community (rather than national data). In particular, local and Iowa-specific data about ACEs (e.g., Central Iowa ACEs Steering Committee study, mapping, and local survey results) was a powerful tool to engage the community.

Percent of county population with ACE score of 2 or more

County	Percent of county population with ACE score of 2 or more
LYON	29
OSCEOLA	
DICKINSON	31
EMMET	46
WINNEBAGO	28
WORTH	
MITCHELL	26
HOWARD	28
WINNECHEE	30
ALLAMAKEE	21
SKUNK	22
OBRIEN	16
CLAY	48
PALO ALTO	
WASSUTH	21
HAWKCOCK	
Cerro Gordo	36
FLOYD	25
CHICKASAW	19
PLYMOUTH	31
CHEROKEE	46
BUENA VISTA	35
POCAHONTAS	33
HAMBOLEDT	42
WRIGHT	28
PRAIRIE	50
BUTLER	28
BREMER	32
FAYETTE	42
CLAYTON	21
WOODBURY	37
IDA	20
SAC	32
CALHOUN	36
WEBSTER	31
HAMILTON	27
HARDY	34
GRUNDY	18
BLACK HAWK	38
BUCHANAN	24
DELAWARE	34
DUBUQUE	23
MONROE	24
CRAWFORD	40
CARROLL	31
GREENE	21
BOONE	30
STORY	36
MARSHALL	34
TAMA	31
BENTON	29
LINN	42
JONES	37
JACKSON	31
HARRISON	31
SHELBY	40
AUDUBON	
GUTHRIE	39
DALLAS	37
POLK	42
JASPER	39
POWESHIEK	40
IOWA	28
JOHNSON	38
CEDAR	26
CLINTON	36
POTTAWATTAMIE	41
CASS	27
ADAIR	22
MADISON	39
WARREN	41
MARION	34
MAHASKA	43
KEOKUK	21
VA SHINGTON	31
MILLS	15
MONTGOMERY	42
ADAMS	
UNION	44
CLARKE	27
LUCAS	11
WINNIE	51
VIA PELLO	31
JEFFERSON	31
HENRY	24
DESMOINES	41
FREMONT	61
PAGE	21
TAYLOR	27
RINGGOLD	
DECATUR	34
WYTHE	40
APPANOOSE	41
DAVIS	12
VAN BUREN	20
LEE	27
LOUISA	32
MUSCATINE	50
SCOTT	41

Both the local CBPR Teams and the community stakeholder respondents revealed that ACEs broadened the conversation about child abuse in a way that made child abuse an accessible and recognizable topic within the community, not just limited to community organizations

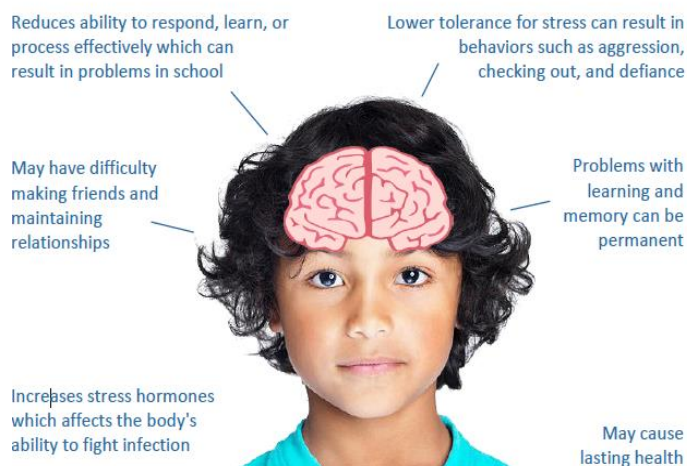
and service providers. Some expressed this as a new realization that child abuse is more prevalent than one might think. Others described how ACEs provided them with a new way to talk about child abuse and neglect, which moved it away from extreme images and negative connotations to a context of family stressors (such as substance abuse, mental health, physical health and financial instability). Another team described how they were reaching out to community civic groups (e.g., local Eagles Club, Rotary) and using ACEs to frame food drives and other community support efforts as ways to support families, reduce stressors and prevent child abuse and neglect. This shift allowed the individuals receiving the information to recognize the potential for child abuse and neglect within their own communities, and to identify solutions and community supports in a socially-acceptable way.



Every local CBPR Team talked about how important it was to include information about resiliency and to leave each group feeling empowered to make a difference in the resiliency of children in their community. Similarly, among community survey respondents, the most prevailing message that “stuck” with them was the negative impact of adverse childhood experiences across the lifespan, and the importance of not only preventing those experiences but also countering their effects. Indeed, multiple local teams and survey respondents referred to the organization promoting the phrase “resilience trumps ACEs” when talking about positive messaging.<sup>5</sup> As one person noted, *“If you only talk about protective factors, they don’t get it. Until you frame it as ACEs. They really go hand-in-hand.”*

### How do ACEs affect health?

**Through stress.** Frequent or prolonged exposure to ACEs can create toxic stress which can damage the developing brain of a child and affect overall health.



### Distribution Mechanisms

The local CBPR Teams used a variety of contacts and approaches to distribute the ACEs messages. These included handouts with attractive, simple images and few words; social media (including Facebook and blogs); videos; and in-person training or presentations. According to the community stakeholders, the most frequent methods for hearing about the local ACEs work were committee meetings (50%), followed by one-on-one conversations and fact sheets (both 45%), in-person training (39%) and social media (21%). This varied by

<sup>5</sup> From [www.resiliencetrumpsACEs.org](http://www.resiliencetrumpsACEs.org) © 2015 Children’s Resilience Initiative, Teri Barila, Walla Walla WA.

community, however. Each local CBPR Team tapped into a local network that was a unique combination of professional providers, community members and in some cases, youth. No single communication method appeared more effective with any particular group than others. Instead, local CBPR Teams reported the greatest success when they had in-person contact coupled with informational handouts and takeaway materials, tailored to the interests of the target group. All noted that attractive, colorful handouts with simple information had the most impact on their audiences.

### *Target Audiences*

The six original sites targeted a wide range of local audiences. The most popular group by far was educators (early education, schools and administrators), who were initially targeted in four of the six sites. This was followed by law enforcement professionals and local neighborhood or community groups. The remaining audiences were more unique to one or two communities and included the faith-based community, local leadership/government, young parents and human services professionals.

For most of the sites, the target audiences were selected due to their influence within the community and with the hope that they would open the door to sharing messages with others. A few local CBPR Teams looked at where other efforts related to ACEs or child abuse prevention were already in place in their communities and tried to fill the gaps by selecting a group that was not yet engaged. Indeed, the community survey respondents represented all these sectors in a similar way, including education (42%), non-profit organizations (37%), social service providers (16%), health/medical professionals (13%), youth-serving organizations (11%) and business leaders (11%).

The local CBPR Teams often tailored the focus of the ACEs and prevention messages and supplemental documents to particular target audiences. To modify their messages, some CBPR Teams reached out to one or two members of their target audiences before

presenting to a larger group to explore what themes and concepts might resonate best.



For example, medical providers and educators responded to the concrete information about brain science and child development, and teachers wanted information about creating resilient communities in their classrooms. One local CBPR Team noted that older males seemed to respond positively to the facts and evidence that ACEs provided to the concept of prevention.



Unlike professionals and service providers, family and community members responded more emotionally by considering the information within the context of their own lives and wanted to know concretely how they could help children and families in their own community build resiliency. One team working closely with parents found that the order in which adverse experiences were presented was important. That is, if the first two items listed were more extreme, parents were likely to disregard the entire list.

As a result, they re-ordered the list of experiences to start with more common issues (see below). Many local CBPR Teams provided examples of resilience-building, such as reaching out to a parent in need or engaging with children and youth in the community.

**CHILDHOOD TRAUMA CAN INCLUDE**

- Loss of a parent to divorce, abandonment or death
- Household substance abuse
- Caregiver treated violently
- Household mental illness
- Incarceration of parent
- Emotional neglect
- Physical neglect
- Emotional abuse
- Sexual abuse
- Physical abuse

trauma

## ***The Resiliency Wheel***



**25 WAYS**  
You can improve your community and protect kids

**GET INVOLVED.**  
Be an active community member. Connections make all the difference.

**Become a foster parent.**

**SUPPORT PARENTS**  
Tell a parent how much you admire them.

**BE THERE FOR FRIENDS AND FAMILY**  
• Offer to babysit a friend's child for a night.  
• Ask your nephew about his soccer game.  
• Ask a friend for coffee, and ask "how are you doing?"

**Get to know your neighbors.**  
Rake a neighbor's yard.  
Cook a meal for a neighbor.

**Eat dinner as a family.**  
Create family traditions.

**Praise and encourage children.**  
Talk about your child's feelings often.

**Compliment a positive child/adult interaction.**  
**Establish safety rules.**  
Purchase your child a book on body safety.

**Be a mentor.**  
Be a positive role model.  
Ask for help.

**BE THE BEST PARENT YOU CAN BE.**  
Ask other experts for advice.

**DIAL 911**  
if a child is in immediate danger.

**REPORT** any suspicions of child abuse or neglect.  
**1.800.4.A.CHILD**  
NATIONAL HOTLINE  
IOWA 1.800.362.2178  
ILLINOIS 1.800.252.2873

**GIVE** Donate to local child abuse prevention efforts.

EASTERN IOWA - WESTERN ILLINOIS  
**Trauma-Informed Care**  
CONSORTIUM

A PARTNERSHIP WITH



[www.famres.org](http://www.famres.org)

[www.childabuseqc.org](http://www.childabuseqc.org)

## *Initial Impact and Outcomes*

Although the longer-term outcomes associated with this project will take more years to manifest in a measurable way, local CBPR Teams and community stakeholders provided preliminary information about the observed impact within their respective communities. These accounts are summarized below. Similarly, the interim steps achieved to date are discussed with the understanding that these accomplishments move Iowa closer toward the goals of positively impacting state-level policy, resources and fiscal support for child abuse prevention. However, a challenge expressed by more than one local CBPR Team was knowing when they had reached the desired outcomes. Some described the entire project's goals as lofty while others felt they were unclear about what change they were really intended to effect. *"What are we moving towards? How do we know we are meeting our goals? What is the outcome?"*

## *Community-Level Impact*

To date there have been positive changes at the community level, beginning with the awareness of how adverse experiences in childhood contribute to poor health outcomes later. This work is ongoing; CBPR Teams have described the need to solicit (or maintain) involvement from those in leadership positions in each sector to continue the momentum. Also, now that general awareness is increasing, some key informants talked about the need to address some of the other domain areas in the readiness assessment model, particularly building more community resources and sharing information about existing efforts.

Over the past few months, teams have been expanding their messages to more audiences, sharing information among various service sectors, and using the ACEs conversation to provide concrete suggestions for how each community member can promote familial and individual protective factors such as resilience and social support. CBPR Teams that involved early childhood and mental health service providers described how these groups experienced affirmation and relief that concepts that were once taboo to discuss are now more common; likewise, these professionals working directly with children and families recognize that this is an effective way of addressing many challenges they see. Some expressed that the information is lingering within their organization and influencing how they view the children and families they serve. One survey respondent wrote, *"Information from the presentation continues to be discussed in our facility."* Other organizational representatives reported making efforts to integrate ACEs education and resiliency into their services and work with clients, and that it is becoming a more natural part of their dialogue and future planning.

The teams talked about how awareness of the impact of ACEs for other sectors is gradually increasing as well. Law enforcement, medical professionals and representatives from the faith communities are examples of providers that have begun absorbing the messages from these efforts, contributing to a community-level change in the way services are delivered. One local CBPR Team shared how a school resource officer changed his response to working with a student: *"[He] is at the table now, and he said 'I wonder what is going at home?' He would not have gone that way one year ago."* Many teams reported that this effort has changed the way providers talk about abuse and has introduced community conversations that once were reserved for private discussion. For example, one person stated, *"No one*

wants to see child abuse or maltreatment, but we don't always know what to do or step in. Now we have some better tools so that we can prevent abuse and maltreatment from happening.” Another saw the potential for linking child abuse prevention to local substance abuse prevention efforts in the future. Multiple community survey respondents shared that they are now sharing the information with others and are supporting parents and children differently.

Table 2 on page 19 summarizes the progress observed within the six local CBPR Teams in the context of the community readiness domains, based on information compiled from telephone calls, site visits, interviews and the community key stakeholder survey. The table shows the community readiness domains targeted by the local action plan, as well as a progress rating that ranges from slight (primarily planning and outreach) to significant (implementation/expansion and evidence of behavior changes). The table shows that most of the efforts focused on the domain of promoting community knowledge of the issue with the second most frequent on community climate. No one focused on community efforts (*i.e.*, efforts, programs and policies) specifically. There was also most progress in increasing community knowledge of ACEs, with two out of five who had significant progress and two others having moderate progress. Only one community worked on the leadership domain and made only slight progress.

### ***Importance of Project Staffing and Resources***

Overall, local CBPR Teams found greater success when multiple sectors and organizations were involved in their efforts, rather than having the efforts driven or led by one agency. Project management and follow through were easier when local CBPR Teams had at least three collaborators who met regularly (at least once per month) and represented multiple service sectors (*e.g.*, Community Partnerships for Protecting Children, prevention councils, early childhood providers, mental health services). Teams often slowed down when they lost a team member, particularly when that individual had provided a natural connection to the community upon which the project had relied. Local CBPR teams that had multiple objectives found it the most difficult to regroup after the loss of a team member.

## **Conveyors of ACEs Messaging**

*In addition to those responsible for leading efforts,  
a list of natural community partners is emerging,  
including but not limited to:*

**Early Childhood Educators  
Public Health Services  
First Five  
United Way  
Youth Coalitions  
Law Enforcement Leadership  
Public School Administration  
Local Government Leadership  
Service Provider Directors  
Faith Leadership  
Colleges**

The most successful teams tended to have paid staff designated to work on the CBPR project, either as part of their regular positions, or with significant support from their organizations. Those teams built upon all team members' natural connections with the targeted community and tapped into the existing prevention infrastructure. Also noteworthy, the communities with the most diverse array of distribution methods reported by community stakeholders included local teams that reported having greater staff capacity. Conversely, the local CBPR teams without natural connections or designated staff reported having to find creative ways to justify their time spent on this project during working hours. As one interviewee stated, *"We ended up dropping the other audience...We just didn't have the right connections to get in there."*

Finally, shifting local conditions beyond the control of the CBPR Team impacted some teams' progress, whether it was a new school administration, county politics or the loss of a partner organization. Again, those who were more connected with the target community and had dedicated staff time were able to respond quickly and leverage those resources to overcome the challenges that arose.

### *State-Level Outcomes*

At this point, it is difficult to gauge the longer-term, state-level impacts of this project, specifically, in terms of policy changes, resources or fiscal support for prevention. However, to address the ongoing challenge of identifying one compelling public message about ACEs, PCA Iowa has partnered with three other coalitions—Central Iowa ACEs Steering Committee, Trauma Informed Care Project, and Developing Brain Group—to create a shared and compelling public message about early childhood brain development, trauma, and the community's role in responding.

The result of this collaboration is Iowa's new *Connections Matter* campaign. The goal is to provide organizations and communities with common language, messages and materials to grow the movement so that Iowans receive the same message across multiple sources and venues. The message is broader than just prevention. The website ([www.connectionsmatter.org](http://www.connectionsmatter.org)) will provide a toolkit and a train-the-presenter workshop for any advocates wishing to carry this initiative into their communities. The group is working with a known expert, Linda Chamberlain, to develop the curriculum on brain science, relationships and community role in overcoming trauma. The new resources will be used by all four of the new CBPR sites, and will be available to any of the six original sites as well.





Table 2. Community Readiness Assessment: Observed Progress on Target Domains

Domain	Dallas	Henry	Jones	Linn	Pottawattamie	Scott
Community Efforts						
Community Knowledge of Efforts			<b>Significant ↑</b> <i>Connected with First Five (early detection &amp; referral system) at local pediatric clinic, developed local resource guide.</i>			
Leadership	<b>Slight ↗</b> <i>One-on-one conversations with leadership (e.g., mayor), planned, structured follow up conversation after Iowa ACEs summit.</i>					
Community Climate		<b>Slight ↗</b> <i>Evidence of community members sharing information, better understanding of prevention approach.</i>		<b>Slight ↗</b> <i>Shared information at local Healthy Family Night and on "Parents Like Us" Facebook page, planning local "Taylor Talks."</i>	<b>Slight ↗</b> <i>Plans to train faith-based volunteer corps to be better equipped to respond to members &amp; to bring message into neighborhoods.</i>	
Community Knowledge of Issue		<b>Moderate ↑</b> <i>Presentations to local health coalition, requests for training from other sectors (e.g., local military families, parent council), evidence of community members sharing information.</i>	<b>Significant ↑</b> <i>Presentations to 50 school personnel (more scheduled) and local coalition with 30 members, progress towards training law enforcement and reaching community groups.</i>	<b>Moderate ↑</b> <i>Present at community meetings, held key stakeholder focus group, sharing with community and school leadership, training planned.</i>	<b>Slight ↗</b> <i>Engaged social work students to have targeted one-on-one conversations with local professionals, reaching out to local community members, plans for presenting at local Human Services Advisory Council.</i>	<b>Significant ↑</b> <i>"Now What?" parenting blog launched to share resources and information, regularly updated with increasing participation.</i>
Resources Related to the Issue	<b>Moderate ↑</b> <i>Generation Wellness coalition and website, public service video message, and Resource Toolkit launched August 2015.</i>					<b>Significant ↑</b> <i>"Now What?" parenting blog launched to share resources and information, regularly updated with increasing participation.</i>

After two years, PCA Iowa's experiment with using the Community-Based Child Abuse Prevention Response as a way to frame the dissemination of the Adverse Childhood Experiences Study results has proved successful, both in terms of distributing the message effectively, and in terms of reframing child abuse prevention messages into something more relatable to the broader community.



## Conclusions and Lessons Learned

After two years, PCA Iowa's experiment with using the Community-Based Child Abuse Prevention Response as a way to frame the dissemination of the Adverse Childhood Experiences Study results has proved successful, both in terms of distributing the message effectively, and in terms of reframing child abuse prevention messages into something more relatable to the broader community.

ACEs research appeals to multiple sectors of the community. It provides recognizable examples of adversity (e.g., mental illness, substance abuse, parental separation) which can be related to many personal experiences and areas of professional expertise. In turn, this allows community members to talk more openly and comfortably about different aspects of child abuse prevention. Information about promoting protective factors, such as social support and resiliency, is critical to include when talking about ACEs in the context of prevention; for example, knowing how to provide social support and promote resilience empowers community members to do something about child abuse.

Overall, the local CBPR Teams appear to be advancing their community readiness to address child abuse prevention as a result of the work, albeit more slowly than they originally thought. Many factors in the local context have influenced the success and the speed at which it has occurred. Contributing to success were the levels of community leadership buy-in, the ability to connect with the existing community infrastructure, and the opportunity to involve multiple sectors. Conversely, local CBPR Teams struggled when there were too few staff on the team or limited resources to implement the action plans, when there were significant changes in teams or key stakeholders, or when community providers were overwhelmed by other work.

## Next Steps

To keep up the momentum locally, the six original local CBPR Teams should continue presenting information and distributing materials within their respective communities, using their local networks to bring the messages to an ever wider cross-section of the community. They should continue implementing their action plans, making adjustments as necessary to ensure that the plans are feasible and taking into account the lessons learned thus far (see below). The local CBPR sites might also consider what other natural partners and stakeholders they should bring into the work, possibly forming a more formalized leadership group so that the original team members are not the only ones responsible for the work. All the sites, old and new, should utilize the new *Connections Matter* tools when the materials are appropriate for the target audience.

## Lessons Learned

**Start small and break the work into phases.** CBPR Teams who chose multiple action plans shared that this was difficult to do well with limited time and funds. When planning action steps, specific activities and small steps kept teams focused, as did specifying each person's role, concrete task and target timeframe for each team member.

**The “lead” agency for the project should be selected strategically.** The lead agency represents the project to the community. Some potential audiences may have preconceived ideas about an organization’s mission, purpose or services, especially when youth and families are targeted (e.g., perceptions of United Way versus county public health agency). Moreover, a lead agency that is already active in the community makes it easier to use designated staff time to support the project, rather than asking a team member to add a new responsibilities to an existing workload.

**Customize ACEs messages to the audience receiving the information.** Here again, it is helpful to have multi-sector representation as those providers will likely have an understanding of the field as well as existing professional connections to develop a network. Consulting with representatives from a particular sector before providing information to that sector helps to a) learn about what will resonate with the audience, and b) tailor information appropriately. Using local data, or at least Iowa-specific data, enhances the message.

**Highlight the existing strengths and resources in each community.** Include specifics on how to promote protective factors rather than information that is too general or generic. Successful projects incorporated specific actions and what providers and/or families could do to contribute to reducing child abuse and neglect, ranging from getting to know parents in the neighborhood through regular events, to helping a stressed parent by providing child care, to sharing in experiences through a facilitated support group.

**Ensure ACEs messages appeal to all families and avoid stereotyping certain families as needing support.** When initiating a discussion about the ACEs, be mindful of the order that the experiences are presented. Starting with those that are more common (e.g., loss of parent due to separation, depression, etc.) keeps adverse experiences relatable and presents examples as more common than not. This conscious re-framing of the messages ensures that the audience maintains an open mind to accepting the reality in their own lives, rather than dismissing the events as not relevant, or feeling guarded against sharing information for fear of being labeled or judged.

**Use multiple communication strategies and repeated interactions with groups and individuals and ask them to bring the information back to their own networks.** In-person contact (including presentations, trainings and one-on-one conversations) were reinforced by subsequent conversations, sharing information using different strategies (e.g., face-to-face, email, blogs and videos) and tangible materials such as rack cards or flyers.

**Develop attractive materials with information relevant to the locality.** Common ways to share the ACEs information include succinct fact sheets, brief and attractive handouts, presentations designed with the audience in mind, websites, social media and blogs. Materials that work best include infographics such as those shared in this report, accompanied with short, factual statements that simplify the complexities of ACEs. Materials that work effectively are colorful, appealing and easy to pass along to others in the community; having a variety of options available promotes the messages more widely.

## Appendix A: Community Readiness Assessment Definitions

### Dimensions of Community Readiness

Dimension	Description
Community Efforts	To what extent are there efforts, programs, and policies that address the issue?
Community Knowledge of the Efforts	To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?
Leadership	To what extent are appointed leaders and influential community members supportive of the issue?
Community Climate	What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?
Community Knowledge about the Issue	To what extent do community members know about the causes of the problem, consequences, and how it impacts your community?
Resources Related to the Issue	To what extent are local resources—people, time, money, space, etc.—available to support efforts?

## Stages of Community Readiness (Scores)

Stage	Description
1. No Awareness	Issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).
2. Denial/Resistance	At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.
3. Vague Awareness	Most feel that there is a local concern, but there is no immediate motivation to do anything about it.
4. Preplanning	There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.
5. Preparation	Active leaders begin planning in earnest. Community offers modest support of efforts.
6. Initiation	Enough information is available to justify efforts. Activities are underway.
7. Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced.
8. Confirmation/Expansion	Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
9. High Level of Community Ownership	Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

## Appendix B: Data Collection Instruments

### Iowa Community-based Prevention Response to ACEs Site Visit Protocol March 30–April 2, 2014

5 min	<b>Introductions</b> <i>Review agenda. Note it is flexible and we will check in periodically to see if you want to switch gears or move things around. However, given limited time we will also try to keep us on track.</i>
10 min	<b>Evaluation Recap &amp; Today's Focus</b> <i>Review the evaluation questions and purpose, today's focus, and what we hope to get out of today (our "result.")</i>  <u>Community Survey Update</u> <i>Review the community survey, current # of responses, who was invited, other questions.</i>
50 min	<b>Progress and Structured Interview</b> <i>See attached questions; include site-specific details/follow-up.</i>
20 min	<b>Site Specific Materials and Sharing</b> <i>What resources have been developed?</i>  <i>Review documents, presentations, messages etc. Tour venues as appropriate. Observe environmental factors, e.g., urban/rural, hub or not, connected to another agency (what sort of agency), etc.</i>  <i>How are partners connected?</i>
5 min	<b>Wrap Up &amp; Next Steps</b>





## ***CBPR Team Structured Interview Protocol***

When we last spoke, *[INSERT SITE SPECIFIC UPDATES]*. What has happened since that time? Has your process or plan changed at all? How?

- ☐ *Little to no change*                      ☐ *Moderate changes*                      ☐ *Significant changes*

If yes, why do you think that is?

What has been the impact of those changes?

- ☐ *Little impact*                      ☐ *Moderate impact*                      ☐ *Significant impact*  
☐ *Generally negative*                      ☐ *Neutral*                      ☐ *Generally positive*

Who are your target audiences? What messages have really resonated with them?

- |  |  |
|--|--|
| <input type="checkbox"/> <i>Business</i>                 | <input type="checkbox"/> <i>Local Government</i>           |
| <input type="checkbox"/> <i>Civic Organization</i>       | <input type="checkbox"/> <i>Media</i>                      |
| <input type="checkbox"/> <i>Education</i>                | <input type="checkbox"/> <i>Not-For-Profit</i>             |
| <input type="checkbox"/> <i>Faith-based Organization</i> | <input type="checkbox"/> <i>Social Services-related</i>    |
| <input type="checkbox"/> <i>Health/Medical</i>           | <input type="checkbox"/> <i>Youth Serving Organization</i> |
| <input type="checkbox"/> <i>Law Enforcement</i>          | <input type="checkbox"/> <i>Other, please describe:</i>    |

What methods of communication have worked **best**? In your experience are some methods more effective with certain groups (e.g., conversations with police)?

- ☐ Fact sheet/informational handout
- ☐ In-person training
- ☐ Committee meeting
- ☐ Webinar training
- ☐ Report
- ☐ One-on-one conversation
- ☐ Social media
- ☐ Other, please describe:

Are there gaps in community understanding at this point? What are they and what are your plans for addressing them?

In your opinion, is ACEs an effective way to talk about child abuse prevention? Please explain your answer.

- ☐ *Disagree*                      ☐ *Somewhat agree*                      ☐ *Strongly agree*

To what degree do you believe sharing ACEs information has led to meaningful changes in the target community? How about in the future? Please explain your answer and provide examples.

- ☐ *Little to no change*                      ☐ *Moderate changes*                      ☐ *Significant changes*

What aspect(s) of your project do you think can be replicated by others?

Who have been your most important connections that allowed you to move forward with this work? How have they helped?

- |  |  |
|--|--|
| <input type="checkbox"/> <i>Business</i>                 | <input type="checkbox"/> <i>Local Government</i>           |
| <input type="checkbox"/> <i>Civic Organization</i>       | <input type="checkbox"/> <i>Media</i>                      |
| <input type="checkbox"/> <i>Education</i>                | <input type="checkbox"/> <i>Not-For-Profit</i>             |
| <input type="checkbox"/> <i>Faith-based Organization</i> | <input type="checkbox"/> <i>Social Services-related</i>    |
| <input type="checkbox"/> <i>Health/Medical</i>           | <input type="checkbox"/> <i>Youth Serving Organization</i> |
| <input type="checkbox"/> <i>Law Enforcement</i>          | <input type="checkbox"/> <i>Other, please describe:</i>    |

Who would you like to see at the table in the future?

- |  |  |
|--|--|
| <input type="checkbox"/> <i>Business</i>                 | <input type="checkbox"/> <i>Local Government</i>           |
| <input type="checkbox"/> <i>Civic Organization</i>       | <input type="checkbox"/> <i>Media</i>                      |
| <input type="checkbox"/> <i>Education</i>                | <input type="checkbox"/> <i>Not-For-Profit</i>             |
| <input type="checkbox"/> <i>Faith-based Organization</i> | <input type="checkbox"/> <i>Social Services-related</i>    |
| <input type="checkbox"/> <i>Health/Medical</i>           | <input type="checkbox"/> <i>Youth Serving Organization</i> |
| <input type="checkbox"/> <i>Law Enforcement</i>          | <input type="checkbox"/> <i>Other, please describe:</i>    |

If you had to do this all over again, what would you do differently? The same?

Do you have anything else to add?

## ***Iowa Child Abuse Prevention Response to ACEs Community Survey 2015***

The Community-Based Child Abuse Prevention Response to ACEs project seeks to raise awareness of child abuse prevention and the ACEs study in targeted Iowa communities. You were identified as a person who has received information about child abuse prevention and the Adverse Childhood Experiences Study (ACEs) from one of these community-based initiatives. The goal of this survey is to get feedback from those who have had first-hand experience with The Community-Based Child Abuse Prevention Response to ACEs project so that we may improve this work across the state.

1. Before you continue, where have you been exposed to this work?

- |  |   |
|--|---|
| <input type="checkbox"/> Scott County  | <input type="checkbox"/> Jones County         |
| <input type="checkbox"/> Dallas County | <input type="checkbox"/> Henry County         |
| <input type="checkbox"/> Linn County   | <input type="checkbox"/> Pottawattamie County |

You have identified **[Insert selection to Q1]**. The local efforts for this project are being undertaken by the following individuals and organizations:

**[Insert primary contacts and their affiliations based on Q1.]**

For the purpose of this survey, consider the activities of these individuals and organizations when the survey refers to the “*prevention response to ACEs project*.” We are looking for honest feedback and your participation is voluntary.

2. Do you know about the Adverse Childhood Experience Study (ACEs)?

- ☐ Yes
- ☐ No **[If NO, survey is saved and brings up “thank you” page].**

3. Did you first hear about ACEs from the *prevention response to ACEs project* in your community?

- ☐ Yes
- ☐ No, I already knew about ACEs
- ☐ No, I did not hear about this study from them
- ☐ Not sure

4. How did you receive information from the *prevention response to ACEs project* about child abuse prevention and/or ACEs?

- ☐ Fact sheet/informational handout
- ☐ In-person training
- ☐ Committee meeting
- ☐ Webinar training
- ☐ Report
- ☐ One-on-one conversation
- ☐ Social media
- ☐ Other, please describe:

5. In the past year, how often did you have contact with the *prevention response to ACEs project* in your community?

- ☐ More than once a week      ☐ Weekly      ☐ Monthly  
☐ Quarterly      ☐ Once or twice in the year      ☐ No contact this year

6. Looking at the list below, did you participate in any of the activities connected with the *prevention response to ACEs project* in the past year?

	Yes	No	Don't know
a. Participated in a <i>Community Readiness Assessment</i>			
b. Connected through social media (e.g., Facebook)			
c. Received materials from them			
d. Participated in their presentation or a training event			
e. Participated in joint meeting, taskforce, coalition			
g. Shared information with them			
i. Co-sponsored or co-facilitated an activity or event			
j. Sent funds to the project			
k. Volunteered or provided volunteers			
l. Other (explain):			

7. Based on the information received from this project, how likely are you to agree or disagree with the following statements?

	Agree	Somewhat Agree	Somewhat Disagree	Disagree	No Opinion
a. I am more aware of ACEs and their impact as a result of this particular project.					
b. The information has helped me to better understand child abuse prevention.					
c. ACEs prevention efforts are highly visible in my community.					
d. Sharing ACEs information is an effective way to talk about <i>child abuse prevention</i> .					
e. Sharing ACEs information is an effective way to talk about <i>resiliency</i> .					
f. Raising awareness about ACEs and child abuse prevention will lead to meaningful changes in my community.					
g. There is a need for child abuse prevention services in my community.					

8. What information about the ACEs study and child abuse prevention do you remember most from the *prevention response to ACEs project* in your community?
9. What do you, or your organization, do differently as a result of the ACEs and child abuse prevention information that is being shared in your community?

8a. What else do you think *could* be done?

10. In your community, what do you feel are the barriers to collaborating or coordinating to prevent child abuse and neglect?
11. Do you have anything else to add about the *prevention response to ACEs* efforts in your community?

**Some questions about you.** So that we can better understand the responses provided to this survey, we are collecting some information about you. These questions are entirely voluntary.

12. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other

14. How old are you? \_\_\_\_\_

15. What best describes your professional role? (Select all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Business                 | <input type="checkbox"/> Local Government           |
| <input type="checkbox"/> Civic Organization       | <input type="checkbox"/> Media                      |
| <input type="checkbox"/> Education                | <input type="checkbox"/> Not-For-Profit             |
| <input type="checkbox"/> Faith-based Organization | <input type="checkbox"/> Social Services-related    |
| <input type="checkbox"/> Health/Medical           | <input type="checkbox"/> Youth Serving Organization |
| <input type="checkbox"/> Law Enforcement          | <input type="checkbox"/> Other, please describe:    |

***Thank you for your participation.***

*Your feedback will help us thoroughly evaluate the effectiveness of the  
Community-Based Prevention Response to ACEs Project.*