Addressing ACEs in Arkansas

A Legislative and Stakeholder Analysis of ACEs in Arkansas

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Executive Summary

The Arkansas Foundation for Medical Care (AFMC) is a nonprofit organization that engages health care providers and beneficiaries in all settings to improve overall health and consumers' experience of care at a reduced cost. AFMC accomplishes this through information technology, education, outreach, data analysis, medical case review and marketing/communications service (AFMC, 2018).

In accomplishing these goals, AFMC serves as the backbone organization to the Arkansas ACEs/Resilience workgroup. The workgroup, made up of 180 members from over 90 organizations and government agencies, works to create awareness about adverse childhood experiences (ACEs), advocates for systematic and policy change, and offers technical assistance to varied agencies, private organizations, and the general public.

AFMC has made great strides in improving overall health and consumer experience. However, a clear-cut framework for the provision of trauma-informed care remains elusive, making it difficult to tackle issues concerning ACEs. ACEs have have long-lasting impacts, and if left unaddressed, may be detrimental across the course of people's lives.

This project analyzes approaches proposed or adopted by other states, organizations, and key stakeholders aimed at mitigating the effects of ACEs and examines their applicability in the State of Arkansas. This report sheds light on the activities of stakeholders and measures by the selected states in the fight against the long-term effects of ACEs by seeking answers to the following questions:

- What stakeholders are missing from AFMC's work regarding ACEs?
- What potential do faith-based organizations (FBOs) have in Arkansas' work on ACEs?
- How have other states approached work focused on ACEs?
- How can Arkansas replicate strategies from other states in addressing ACEs?
- What legislation has been proposed or enacted in other states addressing ACEs?

The research led to the following findings:

- Stakeholder gaps among the public, parents, and frontline service providers emphasize the need to engage the public to raise ACEs awareness among community members.
- Churches and other faith-based organizations, which have access to vulnerable populations, can be a great tool in raising awareness, educating, and involving the general public in the implementation of trauma-informed care.
- States with no statewide initiative or legislation may have local and individual initiatives in addressing ACEs related issues and providing trauma-informed care.

These findings reveal available resources that could be harnessed to develop a framework for the implementation of trauma-informed care models in Arkansas. Based on these findings, the research team makes the following recommendations:

- Improvement in the coordination of communication with stakeholders and the general public to build awareness about the ACEs/Resilience Workgroup and its aims.
- Development of trauma-informed training for FBO staff and volunteers using non-threatening language, familiar analogies, and a positive message of hope to teach a trauma informed care approach for serving vulnerable populations.
- Amendment of legislation to incorporate trauma-informed care, particularly in the area of criminal justice, which allows mental health professionals and law enforcement officers to collaborate in responding to emergencies.
- Amendment of legislation to require CSUs and mental health courts to incorporate ACEs training and take a trauma-informed approach in treating participants.

Introduction

Arkansas Landscape

Arkansas is currently ranked highest in the nation for the number of children with two or more ACEs (State ACEs Action, 2018). Almost thirty percent of Arkansas's children are believed to have experienced two or more ACEs (State ACEs Action, 2018). Furthermore, it is estimated that 436,237 Arkansas adults aged 18 and older, roughly 19% of the population, have experienced four or more ACEs (Johnson, 2016). However, mapping the prevalence of ACEs by county does not reveal any discernible patterns (Johnson, 2016).

To address the issue of ACEs in Arkansas, the Arkansas Foundation for Medical Care (AFMC) and the Arkansas Department of Health created an ACEs/Resilience workgroup (State ACEs Action, 2018). The workgroup is a cross-sector collaboration representing organizations across the public, private, and nonprofit sectors, with approximately 180 individuals from more than 90 organizations. Many of the members of the workgroup work in education, health, and other sectors with the capacity of addressing ACEs (State ACEs Connection, 2018; Medley, 2016). Currently, no other local initiatives exist in Arkansas, and no legislation has been proposed (State ACEs Connection, 2018).

However, the Arkansas Department of Health's 2016-2019 Strategic Plan includes addressing ACEs, explicitly increasing data and awareness, and increasing the number of organizations using an ADH-developed toolkit for ACEs education (Medley, 2016). The Department of Health also conducts community outreach and faith-based outreach (Medley, 2016). Although there are many individual, quasi-trauma informed initiatives across the state, the landscape remains fragmented, and the ACEs Workgroup is moving towards a more holistic and unified approach to addressing ACEs in Arkansas.

The Challenge

Adverse Childhood Experiences (ACEs) have a significant negative impact on the lives of children. ACEs include emotional abuse and neglect, physical abuse and neglect, sexual abuse, violent treatment of mothers, household substance abuse, household mental illness, parental separation or divorce, and incarceration of a household member (SAMHSA, 2018). ACEs affect people in all areas of life including their career, social relationships, and most importantly, their health (Mersky et al., 2013). ACEs influence adolescent cognitive development, altering youths' response to stress (Hillis et al, 2004) and potentially affecting their immune system (Danese & McEwen, 2012). ACEs' severity stems from the fact that the effects may only manifest later on in life, which may complicate treatment (Macnaught, 2017).

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACEs) study is one of the largest investigations of childhood abuse and neglect and its impact on health and well-being. This study, involving over 17,000 participants, reported at least two thirds of participants have experienced one adverse experience and 20% experienced three or more ACEs (CDC, 1998). Physical abuse was found to be the most commonly experienced childhood adversity. The study

also found that women experienced ACEs more than men (CDC, 1998). Victims mostly suffer more than one form of ACE with almost 40% of participants experiencing two or more. Additionally, 12.5% of the study's sample experienced four or more ACEs (CDC, 1998).

Childhood trauma leads to lifelong chronic illness (Nakazawa, 2016). According to the CDC-Kaiser Permanente ACEs study, people reported to have experienced four categories of childhood adversity are twice as likely to be diagnosed with cancer and depression as adults. The study also showed that as the number of ACEs increases so does the risk for sexually transmitted diseases, financial stress, poor academic achievement, suicide attempts, and liver disease, among other illnesses (CDC, 1998).

The effect of childhood toxic stress also transcends the individuals who directly experience it, and ACEs have both implicit and explicit economic costs. Research has shown that the physical and mental health conditions caused by childhood toxic stress reduce productivity later in life (Shern et al, 2014). According to the CDC, ACEs also result in increased taxpayer costs for health care, child welfare, special education, and criminal justice (Baglivio et al, 2014). The CDC estimates the lifetime cost associated with child maltreatment to be $124 billion (Fang et al., 2012).

Arkansas' efforts to assist children who are victims of ACEs are in their infancy stages. This report recommends a path for developing the Arkansas ACEs effort and draws on practices and legislation proposed or adopted by selected states. A stakeholder analysis also informs the recommendations. This report addresses the following questions:

- What stakeholders are missing from AFMC's work regarding ACEs?
- What potential do faith-based organizations have in Arkansas' work on ACEs?
- How have other states approached work focused on ACEs?
- How can Arkansas replicate strategies from other states in addressing ACEs?
- What legislation has been proposed or enacted in other states addressing ACEs?

The stakeholder analysis involved the identification of relevant stakeholders in devising a model to provide care to people with ACEs. An essential step in finding solutions to any problem is identifying the people it affects as well as the people with the potential to effect change.

This report also draws on strategies other states have adopted in handling cases of ACEs and makes recommendations based on their applicability in Arkansas' climate. By highlighting similarities and drawing distinctions, applicable recommendations in dealing with ACEs cases are included within this document. As part of the state comparison, a legislative component involved the analysis of laws and provisions other states have proposed or enacted in addressing ACEs and implementing trauma-informed care models.

Interviews with experts and leaders of faith-based organizations, nonprofit organizations, senior government officials and other relevant stakeholders within and outside Arkansas, informed this analysis and guided its recommendations.

Collective Impact

"Collective Impact" provides a framework to address deeply entrenched and complex social problems (Kania & Kramer, 2011). Kania and Kramer (2011) identified the following five key elements in Collective Impact, all of which are addressed by the ACEs/Resilience Workgroup:

1. *Having a common agenda*: ACEs and Trauma Informed Care is the common agenda that binds all members of the workgroup.
2. *Measuring results consistently*: Creation of the data sub-group facilitates data collection, analysis, and evaluation of efforts.
3. *Conducting mutually reinforcing activities*: As part of their job description or otherwise, all workgroup members tackle the challenge of improving Arkansas' ACEs score in different ways.
4. *Continuous Communication:* This is achieved through the distribution of newsletters by AFMC; and the communication subgroup.
5. *Back-bone organization*: AFMC serves in this capacity for the ACEs/Resilience Workgroup

The Collective Impact (CI) approach can be used to make significant improvements in a community. Kania and Kramer (2011) believe "that there is no other way society will achieve large-scale progress against the urgent and complex problems of our time, unless a collective impact approach becomes the accepted way of doing business" (cited in Butterworth, 2016, p. 19).

Kania and Kramer (2015) argue that CI unfolds along three stages of activity: formation of a governing structure, creation of a backbone organization, and sustainment of action. Moreover, the following three conditions contribute to the success of any CI project: a sense of crisis or urgency, adequate funding, and a prominent champion for the cause (Hanleybrown, Kania & Kramer, 2012).

By having major organizations involved in the workgroup (especially those in the Central Arkansas region) and having the workgroup championing for change in one voice, the three conditions for success of a CI initiative are fulfilled. Furthermore, the three stages of activity (formation of a governing structure in the form of the workgroup, AFMC being the backbone organization, and plans for a sustainable action plan) are also in line with the model. A steering committee member, expressed it perfectly stating, "The workgroup is going in the right direction but going through the growing pains of workgroup collaboration" (personal communication, 2017).

Nevertheless, the CI model has its pitfalls as well, which AFMC should be aware of in these nascent stages of building their own working model for Arkansas. Dr. Wolff, a nationally recognized consultant on coalition building and community development, argued that although the CI model brings about an increased focus on metamorphic changes via coalition building; at the same time, it gets many things wrong about collaboration (Wolff, 2016). For instance, Wolff (2016) states that CI models many times fail to include policy and systems changes as integral

and deliberate outcomes of the partnership's work; are based on the assumption that most coalitions have access to adequate funding for their projects; and are grounded in an over reliance on a few selected successful cases. Given that research on the effectiveness and implications of implementing a CI model is inconclusive, AFMC needs to continue its thoughtfulness at every step in its use of CI for its ACEs improvement initiative.

Methods of Analysis

Though many states have initiatives and have developed frameworks to address ACEs collectively, the efforts in Arkansas are in the developmental stages. The Arkansas ACEs/Resilience Workgroup has yet to adopt a framework for advancing its efforts publicly, organizationally, and legislatively. The success of a particular approach in another state or city does not guarantee success in Arkansas. The research teams, therefore, employed two forms of analysis: a stakeholder analysis of the Arkansas ACEs/Resilience Workgroup and a comparative case study of state and city ACEs initiatives and frameworks.

The principle behind conducting a stakeholder analysis is to identify the relevant individuals and organizations whose interests in the project need to be considered, while also understanding why those interests need to be considered, and who may potentially be left out (Crosby, 1992). The research team conducted interviews with 42 Arkansas ACEs/Resilience Workgroup members to assess the gaps in representation, identify potential new stakeholders, and develop a plan for engaging current stakeholders.

The research team also conducted a comparative case study of state and city initiatives concerning ACEs. According to Kaarbo and Beasley (1999), a case study "often uses a number of techniques for gathering information- from interviews to surveys to content analysis" (p. 373). Researchers looked at eight state initiatives and two city initiatives, conducted five interviews with key stakeholders, and analyzed literature published on each initiative. Kentucky, Mississippi, Missouri, Montana, North Carolina, Oklahoma, South Carolina, and Tennessee were targeted for this study due to their proximity, socio-economic makeup, demographic resemblance, or similarities in terms of population percentage with two or more ACEs relative to Arkansas'.

Stakeholder Analysis

The research team sought to schedule interviews with all current members of the Arkansas ACEs/Resilience Workgroup. Priority was placed on the steering committee members, followed by the engaged members or those who regularly attend meetings, and finally on less engaged members or those who do not attend meetings nor have any direct communication with leadership. Since it was not possible to interview every member of the workgroup, the sector and focus of members were taken into consideration in scheduling interviews to provide a representative view of the workgroup.

The team interviewed 42 workgroup members from the public, private, and nonprofit sectors. The research team conducted semi-structured interviews guided by three central questions, and several follow-up questions to provide the most useful information.

A full list of interview questions can be found in Appendix A Table A1. The first interview question, "What is your interest in/involvement with ACEs?" along with its sub-questions, provided a landscape of the workgroup's current members, their organizations, goals, and any potential conflicts of interest.

The second interview question, "What do you expect of this workgroup?" targets immediate and long-term expectations of the workgroup and assesses its work thus far. These questions give a deeper insight into members' attitudes and perceptions of the Arkansas ACEs/Resilience Workgroup. Responses to these questions provide AFMC with an idea of the direction the workgroup is headed and whether there is the need for reevaluation of goals.

The third interview question, "Are you familiar with collective impact?" addresses the collaborative process, and if and how members are participating in the workgroup's current state. Its sub-questions highlight what actions members are already taking to create awareness among their peers and the public and how they may already be working with others to implement trauma-informed care models to address ACEs. Members were also asked if they could name five people who are not already involved with the workgroup but would either be interested in getting involved or could be a beneficial resource for the workgroup. A list of these recommendations can be found in Appendix E.

The research team conducted interviews by phone, in-person, and via email. Interviewers made three attempts to contact members and only the view of respondents is captured in the stakeholder interview analysis. The permission of interviewees was sought before the interview was recorded and later transcribed. Responses collected by email served as written records of those interviews.

As with other research techniques, there are certain disadvantages associated with conducting interviews. Certain "measurement errors" could include response and non-response rates affecting the representativeness of the data collected, misinterpretation of information, or bias in reporting certain data points (Bleich & Pekkanen 2013). Despite efforts in making the data as representative of the workgroup as possible, it's possibly representative only of those who participate more frequently in the workgroup and are more connected. Bias in responses denies AFMC a clear and comprehensive understanding of the current workgroup disposition.

To minimize selection bias, members who declined interviews were encouraged to 1) reconsider and allow their unique perspective to be heard, 2) answer any of the questions they were willing to answer via email, and 3) explain why they declined the interview. While measures were taken to prevent misconstrued data in this report, including audio recordings and written notes taken by interviewers, Bleich and Pekkanen remind us that, "as with quantitative data, it is impossible for qualitative researchers to achieve complete reliability" (2013, p. 89).

Comparative Study

The research team conducted a state comparative study to investigate trauma informed care models, and initiatives prioritized by other states concerning ACEs. The research team used three major approaches in the comparative case study: state-by-state document review and analysis, interviews with individuals at organizations with ongoing work regarding ACEs, and state legislative analysis.

The state-by-state comparative analysis provided the majority of the research team's content for comparison. After reviewing national, regional, state and local level data regarding ACEs-based work initiated across the country, the research team decided to focus on states with similar demographics, proportion of children with two or more ACEs, or regional connection to Arkansas. This study prioritized content analysis of documents including policy briefs and state reports on ACEs, reviews of state agency websites, and media reports. The research team also contacted ACEs-related organizations via phone or email to communicate directly with people regarding their ACEs-related work in other states.

The twelve questions for these interviews are grouped in three categories, focusing on what shaped their respective organizations' work concerning ACEs, in what ways they interacted with others stakeholders regarding this work, and what state and legislative implications have arisen from their work with ACEs. The goal for this component of the study is to identify what has worked for other groups in the past, and methods suitable for AFMC to navigate potential opportunities and challenges as Arkansas builds on this work.

Faith-based Analysis

To further investigate the role of FBOs in ACEs education, the research team gathered data through semi-structured interviews with faith leaders from Oklahoma and Montana. These states were selected because FBO leaders were highly involved and played important roles in ACEs efforts. Interviewees were selected from the ACEs Connection Faith Based Community Network and the contact referrals supplied by interviewees. Five people were interviewed from churches, government organizations and nonprofits. The interview questions were formulated to uncover opportunities and challenges in involving FBOs in the ACEs efforts that could be generalized to Arkansas. The interviews were conducted by phone and recorded by concurrent notes. The contact information of interviewees can be found in Appendix A.

Because all the faith leaders interviewed were Christians, there is a skew to the data presented and the material cannot accurately represent an interfaith or broader world faiths perspective. African American churches were not represented among the interviewees. Further effort should be given to incorporate other world faiths and minority churches/faith communities.

Legislative Analysis

The final component of the state-by-state comparison is the analysis of legislation in the selected states. The team studied proposals related to ACEs and trauma-informed care and included information on the current status of this legislation. The research team also examined the political makeup of the states studied. The team focused on states that were most similar to

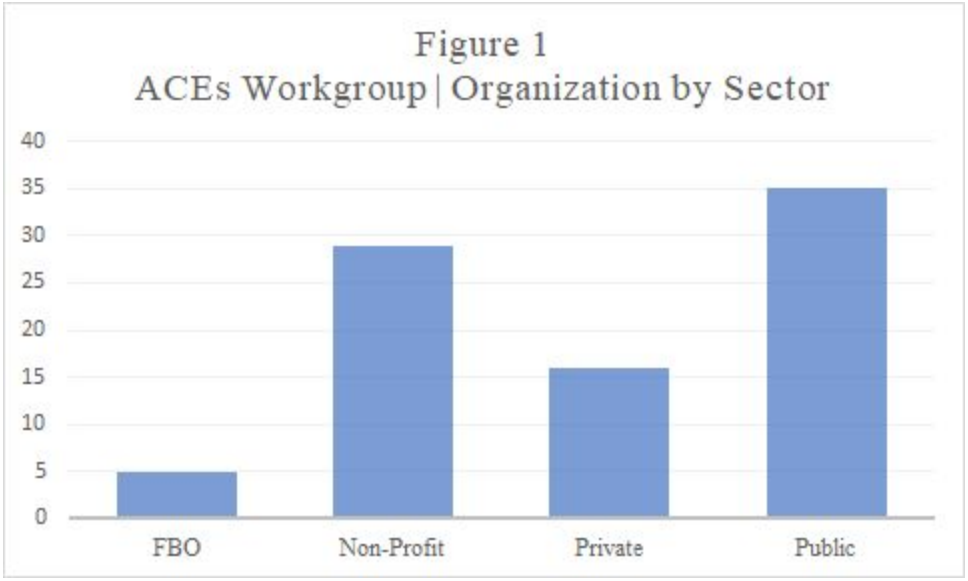
Arkansas to identify legislative proposals that would be most palatable for the Arkansas General Assembly. The research team also included an analysis of the political landscape of Arkansas in the upcoming election and a study of the most recent legislations passed in Arkansas suggesting Arkansas' readiness in implementing ACEs legislation.

Key Findings

Current Workgroup Analysis

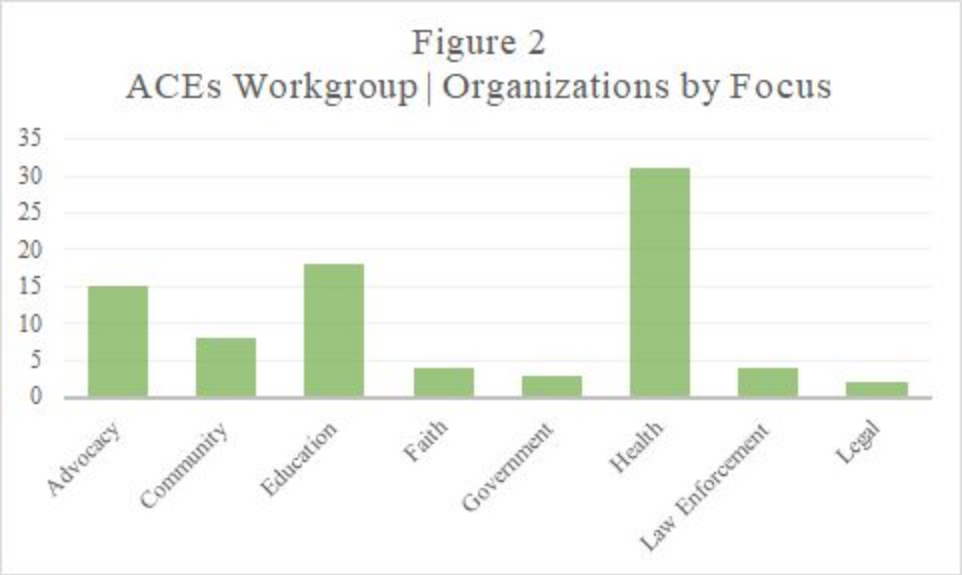
An analysis of current Arkansas ACEs/Resilience Workgroup members was conducted to determine the composition of organizations already involved. The workgroup is comprised of organizations from four sectors: Public, Private, Nonprofit and Faith-Based Organizations (FBOs). Because of the unique culture of FBOs, and their access to families and vulnerable populations, they were examined separately from other nonprofits. FBOs are service-oriented and assist those in need as an intrinsic cultural value. Many survivors of traumatic experiences find comfort or solidarity in the faith community and may already be seeking out their resources. Thus, their relevance as a key stakeholder group for this study.

Figure 1 illustrates the number of organizations in the workgroup by sector. Forty-one percent of the organizations involved are public institutions, including state and city agencies, public hospitals, universities, and K-12 schools. Nonprofit organizations make up the second largest group constituting 34%, private institutions follow with 19%, and faith-based organizations represent the remaining 6%.

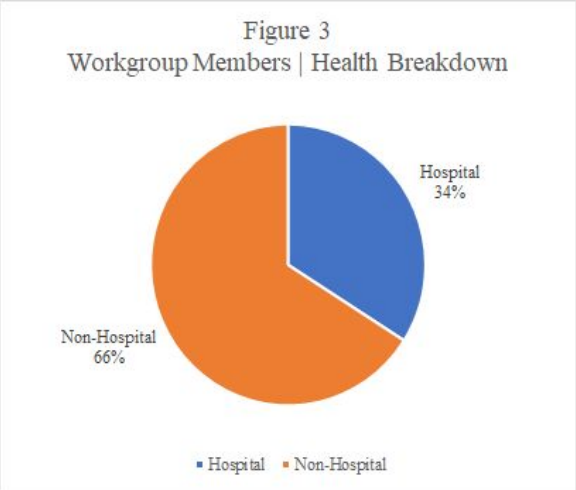


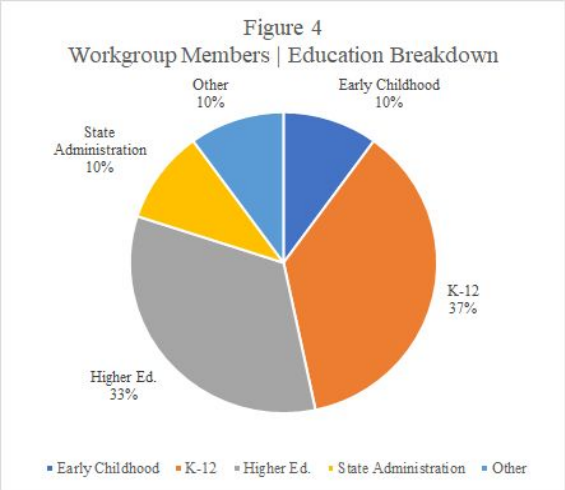
Workgroup organizations were also divided into the following focus areas: Advocacy, Community, Education, Faith, Government, Health, Law Enforcement and Legal. As depicted in

Figure 2, health-related organizations make up 36% of the total workgroup. Education came in second, constituting 21%. Legal, Government, Faith-Based and Law Enforcement professions are the least represented with each comprising less than five percent of the current organizations in the workgroup.



The two largest focus areas were examined more closely and analyzed by number of individuals as shown in Figures 3 and 4. Of those who work for health-related organizations, roughly one-third (34%) work for hospitals; the majority of those who work for hospitals are employed by the University of Arkansas for Medical Sciences (75%). Those working at non-hospitals are represented mostly by the Arkansas Department of Health along with various non-profit, grant-funded, and private health initiatives or practices. Although representation and input from these institutions are imperative, their presence does not diminish the need for representation from other organizations serving Arkansans.





Members associated with educational organizations were broken down into five categories as depicted in Figure 4 above: Early Childhood, K-12, Higher Education, State Administration and Other. K-12 educators (37%) and Higher Education (33%) have the largest representation while the remaining three categories each have 10 percent representation in the workgroup education focus. While representatives from higher education may be able to provide a foundation for research on the effects of ACEs, those who work in early childhood education are considered frontline organizations working directly with children impacted by ACEs and could provide significant insight.

These findings revealed where gaps in representation may exist in the overall makeup of the ACEs/Resilience workgroup. From these findings, the research team was able to make recommendations as to what types of organizations could be beneficial for AFMC to pursue.

Workgroup Interviews

Interview responses were compiled and analyzed for themes, commonalities and points of interest. Three main themes emerged from our analysis: communication and engagement, workgroup expectations, and workgroup representation.

<u>Communication & Engagement</u>

To gauge interest and engagement levels, interviewees were asked about the weekly emails sent out by AFMC. The majority of respondents confirmed they read the emails and found them useful, and approximately 30% confirmed that they forward the AFMC emails to others. Those who agreed that the emails were useful reported that they could utilize the emails to increase the awareness of ACEs-based issues and the workgroup activities through forwarding to volunteers, staff, and board members. Members also reported finding the information provided useful when writing grants.

Interviewees were also asked about their particular individual or organizational interests or involvement regarding ACEs. Two major themes emerged, comprising 41% of responses. First, the need to spread awareness of ACEs across the state to those in every occupation working directly with children - i.e. nurses, teachers, coaches, parents, and physicians. Second, the need to improve the physical and mental health services already provided to children to help them build resilience to ACEs. The remaining respondents suggested encouraging good parenting skills; focusing on women's health, particularly during pregnancy; and focusing on ACEs in prisons and how they may be used to better understand criminal justice as reasons why they are interested or involved in the ACEs initiative.

Several interviewees expressed disappointment and frustration because they believed their specific area of focus would be incorporated into the larger ACEs effort, but was not. They felt that the group stayed so broad in focus that their areas of interest were given too little attention. Though these focus areas must be seen as a component of the larger effort and not the only concern to be addressed, engaging with workgroup members through focus on their initial areas of interest could be an effective way of engaging members who are less active and drawing them into the collective effort.

Workgroup Expectations

Interviewees expressed short-term and long-term expectations for the workgroup. Most respondents (41%) indicated creating awareness of ACEs in children, adults, and specifically, first responders, was their primary expectation. Others implied that increasing representation across fields in the workgroup and collaborating with businesses and policy leaders was an expectation. Other expectations included passing a policy that sets a standard for public and private businesses in dealing with ACEs; increasing the involvement of current stakeholders through workshops and other volunteer opportunities; and finding funding to support the workgroup's efforts. These expectations are well suited to the AR Workgoup's position and stage of development.

Workgroup Representation

While a wide variety of organizations embodies the current workgroup, certain sectors are overrepresented, leaving gaps in representation from other fields. Of those interviewed, 21% indicated that the workgroup was missing policy leaders and politicians; 18% mentioned parents and community members; 15% mentioned representatives from law enforcement, first responders, and the judicial system were missing; and 12% indicated that FBOs should be added. The Department of Education and mental health providers were also mentioned as being beneficial, yet underrepresented, contributors to the workgroup. Though it was not mentioned by interviewees, the research team identified the Latinx community as another underrepresented group.

Interviewees were asked if they perceived any conflicts of interest within the workgroup. Of those interviewed, 27% responded they did. Though responses varied, the consensus was that

members are still operating in silos with their goals and vision limited by organizational context that could prevent potential progress from the group as a whole. This could also stand as a challenge for implementing the Collective Impact model.

Faith Based Organizations as Underutilized Stakeholders

Though FBOs make up nearly half (7,500+ out of approximately 14,000) of the NPOs in Arkansas, only six FBOs are represented in the Arkansas ACEs/Resilience Workgroup. The existing workgroup members from FBOs have contributed through providing spaces for ACEs events and bringing their voice and view to workgroup meetings. However, many of the resources FBOs can offer remains untapped. FBOs played a crucial role in addressing ACEs in other states such as Oklahoma and Montana and have the potential to play a similar role in Arkansas. FBOs are not only underrepresented, they are underutilized as a resource for reaching the community and providing Trauma-Informed Care. The culture of FBOs offers unique benefits and challenges highlighted in this section.

Access and Responsibility

A recurring theme, mentioned by four interviewees (9%), within the Arkansas ACEs/Resilience Workgroup was that of access. Many professionals who can offer expertise and resources to children, families, and adults experiencing long-term effects of ACEs lack access to those affected. Workgroup and FBO interview respondents indicated how a child may tell his/her youth minister or bible school teacher things about their home life yet would not open up to a caseworker. Adults may share personal trials they may not share with medical practitioners with their faith community (personal communication, March 20, 2018).

Churches and other faith communities often have outreach and service programs to address the needs of the poor, homeless, and other vulnerable populations. This places faith practitioners and communities at the forefront with regards to serving vulnerable populations, but those interactions can be harmful if they are not well-informed (personal communication, March 20, 2018). It is essential that pastors, rabbis, imams, religious leaders, staff, and volunteers receive trauma-informed training so that they may adequately address ACEs, trauma, and their effects.

Religiosity in Arkansas

According to the University of Arkansas for Medical Science's (UAMS) Faith-Academic Initiatives for Transforming Health (FAITH) Network (2017), 74% of people living in Arkansas claim religion is "very important in their lives" and 50% attend church at least once a week. As of 2017, there were over 7,500 religious congregations, excluding faith-based service organizations and charitable clinics, in the State of Arkansas.

Considering the prevalence and importance of faith and FBOs in the State, this network could be an important tool for the workgroup in raising awareness, educating, and involving the

general public in ACEs work. The real expansive grassroots level changes the workgroup wishes to see are not possible until ACEs awareness and information moves beyond professionals to the public, utilizing the natural networks and gatherings of community members.

Value of Spirituality in Trauma-Informed Care

A growing body of mental health studies show that spirituality can play an important protective role for adults and children who have experienced trauma (Dervic, Grunebaum, Burke, Mann, & Oquendo, 2006; Gall, Basque, Damasceno-Scott, & Vardy, 2007; Gillum, Sullivan, & Bybee, 2006; Kaslow et al., 2003; Moreira-Almeida, Net, & Koenig, 2006; Wong, Rew, & Slaikeu, 2006; Yoon & Lee, 2007). One study found that spirituality plays an important role in the psychological healing and personal empowerment vulnerable populations experience in the post-trauma period. These studies underline the need for spirituality to be incorporated in trauma-informed practice and holistic care (Hipolito, et al., 2014).

Though religious organizations and faith communities are not always a part of one's spiritual journey, church attendance is a weekly practice for half of Arkansans surveyed by UAMS (Research, Evaluation and Social Solutions, Inc., 2017). These studies report that one reason spirituality becomes an important part of healing is that, during the post-trauma period, people turn to faith communities and practitioners as they seek to find meaning in their experiences (Hipolito, et al., 2014).

Opportunities

Interviews among the ACEs/Resilience Workgroup revealed that some members (9%) utilized faith-based community networks in their work with ACEs and others (12%) named FBOs among the organizations that should be included in the ACEs effort. One reason for this is that faith communities are service-oriented. Whether they feel responsible for caring for others because they are fulfilling a religious responsibility or they feel called to service, care for others is a value that is held high in faith communities. Many faith-based 501(c)(3) organizations are incorporated to reach people in need because of this cultural value. Thus, FBOs are filling the gap left by cuts in government funding in many fields of service (Cnaan & An, 2015). Many churches are becoming more socially-aware and justice-driven. One interviewee suggested that social justice focused service is this generation’s approach to charitable care (personal communication, March 20, 2018).

Faith communities also place immense focus on family and have programs for children, adolescents, parents, and expectant parents. Few other organizations can provide such a broad outreach to the family audience. More and more, fostering and adoption are en vogue among church groups (Tam, 2017). This perfectly positions churches to provide education on ACEs and preventative and responsive care principles such as good parenting, protective emotional support, and self-care. Providing ACEs education to both adults, especially parents, and children can help prevent ACEs rather than just responding to their impacts. This type of holistic care is necessary to facilitate lasting change.

Challenges

Though there are many reasons for the ACEs/Resilience Workgroup to collaborate with FBOs, there are several challenges that deserve consideration. Many FBOs are reluctant to collaborate with government and social services organizations believing that such connections could lead to mission drift or compromised values (Tam, 2017). Clear communication of how trauma-informed care is central to the mission of serving vulnerable populations and emphasis on the importance of FBOs' voice as stakeholders can ease some of these concerns. At times, FBOs have proved important government partners in the ACEs effort, such as in Oklahoma where the Office of Faith‑Based and Community Initiatives and the Oklahoma Department of Human Services State Coordinator for Faith Engagement (a position which has since been terminated) played a vital role in the development of reentry, child abuse prevention, and teen pregnancy prevention programs (personal communication, March 26, 2018; Oklahoma Interagency Child Abuse Prevention Task Force, 2014; Central Oklahoma Teen Pregnancy Prevention Collaboration, 2015).

One of the problems of communicating the causes and long-term effects of ACEs is that people, parents in particular, become defensive. People who have perpetuated poor coping and parenting skills may assume blame, feel guilt, and choose to turn away rather than face hard truths (personal communication, March 3, 2018). Much of these can be avoided by taking an asset-based rather than deficiency-based approach to ACEs education (personal communication, February 27, 2018). This includes careful communication emphasizing the strengths and opportunities, not just mistakes and damages. Church culture, like many other cultures, tends to be reactive rather than preventative. Parenting styles that are inherited, ingrained, culturally accepted, and defended by faith practitioners are difficult to challenge, let alone, change. This is where one must fight fire with fire; using scripture, religious analogies, maxims, and shared values can go a long way (personal communication, February 27-March 3, 2018). A primer to using religious language in ACEs education is included in Appendix B.

State-by-State Comparison

The state comparison and legislative analysis examined the same eight states. Based on conversations with AFMC, one area of focus for this analysis included states geographically contiguous to Arkansas (Mississippi, Missouri, Tennessee, and Oklahoma). Several of the states chosen (Kentucky, Mississippi, Missouri, and Oklahoma) have high records of ACEs. In addition, the state comparison included Southern states with initiatives in which AFMC showed an interest, not only because of the geographic proximity and cultural similarity, but also because these states have initiatives that are recognized as exemplary in addressing ACEs (North Carolina, South Carolina). The state comparison included Montana because the involvement of faith-based organizations was important to ACEs work in the state, and provides a unique context in the broader picture of ACEs work in Montana. Conversations with AFMC revealed that the organization was concerned about passing legislation in Arkansas due to the makeup of

its legislature. Accordingly, the state comparison includes only states with similar legislative landscapes.

Kentucky

Kentucky currently ranks 43rd in the United States for the lowest percentage of children with ACEs score of two or more; 26.9 percent of its children experience two or more ACEs (State ACEs Action: Kentucky State Profile, 2018).

Currently, Kentucky does not have a statewide initiative or any statewide legislation (State ACEs Action: Kentucky State Profile, 2018). However, Louisville, KY, has a local initiative known as Building Resilient Children and Families (BOUNCE) (State ACEs Connection, Kentucky Profile, 2018). The Foundation for a Healthy Kentucky created BOUNCE in 2012 (City of Louisville, Office of Safe Neighborhoods, n.d.). BOUNCE uses the Center for Disease Control and Prevention (CDC) Whole School, Whole Community, Whole Child Coordinated School Model to implement a trauma-informed resiliency model in the Jefferson County Public Schools (State ACEs Action: Kentucky State Profile, 2018). The Whole School, Whole Community, Whole Child Coordinated School Model is part of the CDC coordinated school health approach (CDC, 2018). The CDC developed the model with ASCD (formerly the Association for Supervision and Curriculum Development), and key stakeholders from healthcare, public health, school health, and education to create a model focused on the long-term development of children, rather than merely academic achievement (CDC, 2018). This involvement of key leaders in the various fields is similar to the makeup of the Arkansas workgroup; the CDC mentions that the participation of key leaders helped create a unified and collaborative approach (CDC, 2018). The model focuses on social and emotional climate, physical environment, community involvement, and family engagement (CDC, 2018). In 2017, the National Association of Chronic Disease Directors, using CDC funding, published a guide to implementing the Whole School, Whole Community, Whole Child Model, (CDC, 2018). All public school employees in Jefferson County, Kentucky receive the training (BOUNCE Louisville, 2016).

Approximately twenty community partners participate in BOUNCE (BOUNCE Louisville, 2016). The BOUNCE coalition partners include Metro United Way, Jefferson County Public Schools, KentuckyOne Health, Louisville Metro Department of Public Health and Wellness, YMCA of Greater Louisville, and the University of Louisville School of Public Health and Information Services. These participants broadly mirror the current AR ACEs Workgroup.

In addition, the Center on Trauma and Children at the University of Kentucky conducts trauma-informed care training for public school staff and other community partners. The Child and Adolescent Trauma Treatment and Training Institute is a university collaboration housed at the Center on Trauma and Children. The training institute disseminates information on trauma-informed, evidence-based practices to schools and other advocacy groups across the state (University of Kentucky, n.d.). Furthermore, the Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities facilitates a trauma-informed care steering committee.

Mississippi

As of 2018, 27.2 percent of children in Mississippi experience two or more ACEs, ranking it 45th in the U.S. (State ACEs Action: Mississippi State Profile, 2018). However,, Mississippi has limited experience working with ACEs. Through the Department of Mental Health and the State Department of Health, Mississippi has created a starting point for incorporating ACEs into state and local dialogue opportunities. The majority of Mississippi's work with ACEs stems from the Substance Abuse and Mental Health Services Administration (SAMHSA) block grants funding. The grant allows the Department of Mental Health in Mississippi to engage mental health providers, their 14 community mental health centers, and their freestanding sites in collaborative trauma-focused (CBT) and Sparks trainings. With the support of the National Child Traumatic Stress Network, Mississippi became the first state to organize a trauma-focused cognitive behavioral (TF-CBT) learning collaborative (State ACEs Action: Mississippi State Profile, 2018). Because of this collaboration and other trauma-informed based considerations, Mississippi's mental health centers and providers must now provide initial mandatory trauma screening upon the intake process (J. Chapman, personal communication, April 9, 2018).

For the last four years, Mississippi has hosted a Trauma Informed Care Conference and has conducted trauma care trainings for 9,000 entities (State ACEs Action: Mississippi State Profile, 2018). This conference, which brings together over 600 persons, allows for stakeholders across the state to submit proposals for and present on topics relating to trauma and ACEs (J. Chapman, personal communication, April 9, 2018). Each year, the work around ACEs expands; for the upcoming conference, presenters will be discussing trauma and its impact on the elderly and hospice workers and the Mississippi Emergency Management Agency (MEMA) will present on the relationship between disasters, like Hurricane Katrina, and resulting trauma (J. Chapman, personal communication, April 9, 2018).

Over 480 TB-CBT therapists can be found in Mississippi currently, and service providers of youth and children mental health services throughout the state have been trained on trauma-specific interventions (State ACEs Action: Mississippi State Profile, 2018). Through legislation proposed last year (SB 2798), Senator Blackmon acknowledged the impact ACEs have in increasing the risk of medical, mental, and social problems and called for the creation of a statewide mental health summit. The bill did not make its way out of the committee. Yet, other pieces of legislations that relate to ACEs, concerning suicide and bullying, have shared recent legislative success (J. Chapman, personal communication, April 9, 2018).

Missouri

As of 2018, 27.2 percent of children in MO experience two or more ACEs, ranking Missouri 46th among U.S. states (State ACEs Action: Missouri State Profile, 2018). There are many different programs combating ACEs in Missouri, but the two well-known initiatives are Alive and Well and the Missouri Prevention Partners. Alive and Well is a community wide effort

in St. Louis, Missouri, that focuses on reducing stress and trauma impacts on health (Alive and Well STL, 2018). One way St. Louis reaches out to people is through a 15-minute radio segment by Bethany Johnson-Javois. She runs a "two-million-dollar nonprofit that brings personal stories from community members, celebrating regional successes in improving health, and challenging people to make health a priority in their lives and the community" (Javois, 2018). One of the main purposes of this community initiative is to inform those in St. Louis about the negative effects of stress on people's development and its impact on their lives (Alive and Well STL, 2018). Alive and Well also strives to educate the people of St. Louis on how to respond to individuals' stress and trauma (Alive and Well STL, 2018).

The Missouri Prevention Partners (MPP) is a "collaboration of statewide public and private non-profit organizations that all have an interest in and statewide perspective of child abuse and its prevention" (Children's Trust Fund, 2016). The MPP has a vision of "providing leadership to trauma informed organizations to reduce child abuse and neglect by strengthening families and communities" (Children Trust Fund, 2016). Missouri has 22 prevention partners including funders who aim to make a difference for the people in Missouri like Children's Trust Fund; government agencies like the departments of corrections, public safety, mental health, social services and elementary and secondary education; nonprofit organizations focusing on child positive outcomes like Missouri Child Care Resource and Referral Network, Missouri KidsFirst, Missouri Head Start – State Collaboration Office, and Missouri Juvenile Justice Association; parent organizations like ParentLink; and local partnerships like St. Louis Family Community Partnership and Kansas City Child Abuse Roundtable Coalition among others. (Missouri Prevention Partners, 2016).

Montana

As of 2018, 26.1 percent of children in Montana experience two or more ACEs, ranking it 40th in the U.S. (State ACEs Action: Montana State Profile, 2018). ChildWise Institute, a nonprofit focused on child trauma and health, pushed the ACEs effort in Montana by joining forces with state partners to present an Annual ACE Study Summit. In preparation for these summits, ChildWise Institute reached out to healthcare providers, mental health professionals, educators, early childhood education professionals, juvenile justice professionals, officers of the Court, chemical dependency and rehabilitation counselors and professionals, human resource directors and professionals, workforce development professionals, policy makers, parents, foster parents, early childcare professionals, corporate and small business executives, non-profit leaders, and philanthropists. Professionals attending these summits could claim the lectures as credits towards their POST, CEU, OPI, or nursing contact hours (ChildWise Institute, 2014; Elevate Montana, 2016; Health Federation of Philadelphia, 2017).

The discussions and connections that came out of these early summits led to the formation of Elevate Montana, a project of ChildWise Institute, the backbone organization of the Montana ACEs Initiative, to reduce the number of ACEs among children in Montana and create resilient communities. Elevate Montana was awarded substantial grants through the Health Federation of Philadelphia and the Robert Wood Johnson Foundation to launch community-

based pilot programs employing "trauma-informed approaches and resilience-building strategies" in Wolf Point, Kalispell, Missoula, and Helena (Elevate Montana, 2016).

Together with ACE Interface, ChildWise developed the ACE Master Training Program to send more than 20 trainers out to raise awareness, educate, and actively address the effects of toxic stress in children throughout the state. As a result, Montana completed its first all-staff, school district-wide, training in 2015. The film *Paper Tigers*, documenting the process and effects of one alternative school in Washington adopting a Trauma-Informed approach, was screened multiple times to raise community awareness. The local faith community in Helena was responsive, and several church and FBO leaders began efforts to educate their staff and congregations about ACEs and take a trauma-informed approach to ministry and counseling (personal communication, March 20, 2018; Elevate Montana, 2016; Health Federation of Philadelphia, 2017).

North Carolina

North Carolina has made strong and clear strides towards incorporating ACEs into their state and local level work. As of 2018, 23.8 percent of children in NC experience two or more ACEs, ranking North Carolina 30th among U.S. states (State ACEs Action: North Carolina State Profile, 2018). Some of the most robust community-level work in NC comes from the Mobilizing Action for Resilient Communities (MARC) in Buncombe County. MARC has provided grants and funding for local and community groups to build capacity and help them connect and collaborate with government entities and social service agencies (MARC, 2018). In 2017, with funding support from Buncombe County, they provided 14 awards to groups like the Father to Father Empowerment Project, which works with men for a 12-week period on issues relating to ethics, parenting, anger, trauma, and relationships (MARC, 2018).

Other local and regional groups in NC have prioritized ACEs as well. In Raleigh, a chapter of the Prevent Child Abuse North Carolina has prioritized education on ACEs screening the documentary *Resilience* to over 1,500 people statewide (State ACEs Action: North Carolina State Profile, 2018). In Durham, Duke University's Center for Child and Family Policy works with local school systems and child services agencies to support ways to acknowledge ACEs in youth and treat them accordingly (State ACEs Action: North Carolina State Profile, 2018). Additionally, the state's Division of Medical Assistance is working to embed trauma-informed content into mental health conversations while the state's Department of Public Safety/Division of Juvenile Justice has begun addressing trauma in their assessments, treatments, practices, and policies of youth within their Youth Development and Youth Detention Centers (State ACEs Action: North Carolina State Profile, 2018).

At the state level, North Carolina recently adopted legislation that creates a Child Well Being Transformation Council, charged with ensuring collaboration, coordination and communication among agencies that provide services to children (H.B. 630, 2017-2018 Reg. Sess. (N.C. 2017)). The appointees for the council will be in place by July 2018. The Council's design includes members from various departments and agencies including Department of Health and Human Services, Department of Public Safety and programs such as Guardian ad

Litem program, Disability Rights NC, all convened to assess and monitor child-serving institutions and determine opportunities for greater collaboration, communication, and cooperation among publicly funded state agencies (H.B. 630, 2017-2018 Reg. Sess. (N.C. 2017)).

Oklahoma

At 21.7%, Oklahoma ranks 42nd in the United States for percentage of children with ACEs score of two or more (State ACEs Action: Oklahoma State Profile, 2018). Oklahoma does not currently have any statewide initiatives or cross-sector regional, city, or county initiatives addressing ACEs and trauma-informed care (State ACEs Action: Oklahoma State Profile, 2018). However, individual organizations in Oklahoma are addressing ACEs in various ways (State ACEs Action: Oklahoma State Profile, 2018).

A five-year grant from the National Institutes of Health created the Center for Integrative Research on Childhood Adversity in Tulsa. The center's goal is to "develop sustainable prevention and intervention strategies to interrupt the cycle of generational trauma and toxic stress" (State ACEs Action: Oklahoma State Profile, 2018). Other organizations involved in the project include the OSU Center for Health Sciences, University of Oklahoma-Tulsa, and the Laureate Institute for Brain Research (State ACEs Action: Oklahoma State Profile, 2018).

The Potts Family Foundation has shown multiple screenings of the *Resilience* documentary, which led to an interest in forming a state trauma-resilience initiative, although no initiative exists yet (State ACEs Action: Oklahoma State Profile, 2018). Additionally, the foundation created a legislative caucus addressing early childhood issues (State ACEs Action: Oklahoma State Profile, 2018).

The Oklahoma State Department of Health launched the Lemonade for Life project in 2017 (State ACEs Action: Oklahoma State Profile, 2018). Lemonade for Life is a train-the-trainer program that trains home visit workers to address ACEs in at least five home visits (State ACEs Action: Oklahoma State Profile, 2018). The State Department of Health works with the University of Kansas Center on Public Partnerships and Research, the University of Oklahoma Center on Child Abuse and Neglect, and the Cherokee Nation (Oklahoma State Department of Health, 2017). The program is funded through a federal grant from the Maternal, Infant, and Early Childhood Home Visiting program (Oklahoma State Department of Health, 2017). Home visit workers have been trained in Oklahoma and Tulsa counties (Oklahoma State Department of Health, 2017).

South Carolina

As of 2018, 25.3 percent of children in SC experience two or more ACEs, ranking it 38th among U.S. states and the District of Columbia (State ACEs Action: South Carolina State Profile, 2018). South Carolina's burgeoning work regarding ACEs is led in part by the Children's Trust of South Carolina, an organization that manages the South Carolina ACEs Initiative. This group leverages as train-the-trainer model to help equip community members and

other stakeholders with the tools necessary to educate additional community members regarding ACEs and their greater implications.

The Children's Trust of South Carolina operates through the lens of four main components: Know, Learn, Plan, and Advocate. The Know phase emphasizes helping community members understand ACEs and cultivating data disaggregated on the county level regarding ACEs (A. Srivastav Bussells, personal communication, March 20, 2018). In the Learn phase, they have worked to train over 70 ACE Interface Master Trainers from different sectors on how to discuss and implement ACEs data and strategies into their communities (A. Srivastav Bussells, personal communication, March 20, 2018). These trainings cover an overview of ACEs, ACEs data from South Carolina, and early childhood brain development among other topics (A. Srivastav Bussells, personal communication, March 20, 2018). In the Plan and Advocate phases, the Children's Trust of SC is working on a convention framework and provides planning tools and resources to other groups while working to effect change via state policy that integrates ACEs research and reform practices (A. Srivastav Bussells, personal communication, March 20, 2018).

In addition, through the Pee Dee Resiliency Project, the Children's Trust of South Carolina support holistic programs in eight elementary schools in the Pee Dee area of SC on health, education, and mental health issues and their relationship to ACEs promoting practices such as mindfulness (State ACEs Action: South Carolina State Profile, 2018).

Tennessee

Tennessee had no organized ACEs effort before 2014, and at 24.6 percent ranks 34th of states where children experience two or more ACEs. In May 2014, Tennessee started a collaboration among Baptist Memorial Hospital for Women, Porter-Leath, and the ACE Task Force of Shelby County Tennessee. The 40-member task force, commissioned by the Public Health Management Corporation, conducted a telephone survey to assess the prevalence of ACEs in Shelby County. (State ACEs Action: Tennessee State Profile, 2018). Following the survey, the task force analysed the data and developed a course of action to prevent ACEs in Tennessee (State ACEs Action: Tennessee State Profile, 2018).

As a result of the survey, in 2015 the Building Strong Brains: ACE's Initiative was started to promote awareness regarding ACEs through intervention and prevention policies and practices (Daughtery & Poudel, 2017). The Building Strong Brains campaign is a statewide ACEs effort that seeks to ensure that people living in Tennessee have the supports and resources in the years to come from different public and private institutions interested in preventing and mitigating ACEs (Daughtery & Poudel, 2017). Building Strong Brains also encourages government and private organizations to work together to create innovative practices and provide resources for the strengthening of families' social and emotional health, the enhancement of community safety, and the reduction of toxic stress' impact on youth (Peck, n.d.). For such practices to be implemented adults, especially those who work with children, such as teachers, lawyers, and judges, need to stop asking "what is wrong with you?" and start asking children "what happened to you?" (Peck, n.d.).

Overall, our state-by-state comparison revealed the fragmented, and in some cases, locally nuanced initiatives targeting ACEs and the implementation of trauma informed care models. Whereas some states, for example Oklahoma, have no statewide initiatives, others, such as Tennessee, have grounded their initiatives in response to data driven assessment of the local environment. Table 1. Summarizes the state-by-state comparison.

Table 1: State-by-State Comparison

States	KY	MS	MO	MT	NC	OK	SC	TN
2 or More ACEs (%)	26.9	27.1	27.2	26.1	23.8	26.6	25.3	24.6
State Rank	43rd	45th	46th	40th	30th	42nd	38th	34th
Statewide Initiative	No	Yes	Yes	Yes	Yes	No	Yes	Yes
Example Funding Source(s)	Foundation for a Healthy Kentucky	Assortment of Federal Grant Funds	Children's Trust Fund	U.S. Department of Health and Human Services; Health Federation of Philadelphia; Robert Wood Johnson Foundation	General Assembly of NC; waive employment mandate for IAFT parents		U.S. Health and Human Services; BlueCross of BlueShield of South Carolina Foundation; The Duke Endowment; S.C. Department of Social Services	Building Strong Brains; TN General Assembly as allocated by Governor Haslem
Estimated Total Funding	~3 million	Unclear	~1.4 million	~1.5 million	Unclear		Federal, State, and Local funding~15 million	~2.5 million
Leading ACEs Organizing Groups or Orgs	Foundation for a Healthy Kentucky, Kentucky Department of Behavioral Health, Development and Intellectual Disabilities	Trauma Informed Care Conference; Trauma-focused cognitive behavioral learning collaborative; Training and Teaching	Missouri Prevention Partners (statewide), Alive and Well	Elevate Montana (statewide), ChildWise Institute, ACE Interface, the Alliance	North Carolina Child Well Being Transformation Council (statewide), MARC (Buncombe County), Prevent Child Abuse NC, Duke's Center for Child and	Currently there is no state initiative and no cross-sector initiative at the city, county or regional level	Children's Trust of SC (statewide)	TN ACEs Initiative (Statewide), Building Strong Brains

					Family Policy			
Strategies	Implementing trauma resiliency model for Jefferson County Public Schools (JCPS); Improving the knowledge and skills of providers of out-of-school (OST) programming	Trainings on trauma-specific interventions for service providers; education on trauma-informed care	Trauma prevention; trauma and stress management; mental health education	ACE Master Trainer Program (awareness program), trauma-informed/ resilience-building community pilot programs	Local and Community Granting; Education through Resilience documentary: regional work with child services agencies and local school systems; trauma-informed content in mental health trainings	Training the trainer (Lemonade for Life); developing sustainable prevention and intervention strategies (Center for Integrative Research on Childhood Adversity)	Education through trainings of community-based trainers on ACEs; holistic education programs in schools	Promote culture change in early childhood based environments

Themes across States

The research conducted for this study is largely exploratory and descriptive. However several themes emerged from the cross state comparison. One theme refers to the coordinated and collaborative approach of both nonprofit and state actors to address ACEs. In all of the states examined, state agencies and nonprofit groups were involved in ACEs work and initiatives, in either the same program or across different, but coordinated programs. In some states, universities and colleges were intimately involved in ACEs initiatives, in addition to state agencies. It is unclear if the collaborating partners engaged in a process evaluation to determine the effectiveness of the collaborative effort, or, of the collaboration itself.

A second theme is the lack of consistency across states in addressing ACEs and the prevalence of localized ACEs initiatives in cities or regions (see below for City Spotlights on Walla Walla, Washington, and Philadelphia, Pennsylvania). Alive and Well in St. Louis, BOUNCE Louisville, and MARC in Buncombe County, North Carolina, offer examples of regional efforts to address ACEs. These and local efforts in MI, KY, SC work to highlight the potential for local efforts and knowledge in generating positive outcomes regarding ACEs. This study does not assert a preference for regional or more localized efforts to address ACEs. Thus further research needs to be done to determine if a regional, state wide or more localized effort would be more effective in the Arkansan context.

Two themes emerged around education. First the use of programs to educate professionals who work with populations vulnerable to ACEs. The Lemonade for Life program in Oklahoma is one example; the program trains home visits workers to address ACEs. Another

example is the South Carolina ACE Interface Master Trainers. The other theme in education is educating the public about ACEs. One common way this is done across states is through screenings of *Resilience* and *Paper Tigers*. Building on the education theme, understanding the current context on the ground regarding the public's ACEs education and awareness cannot be overstated. For instance, three exemplary cases - Philadelphia, PA; Shelby County, TN; and Walla Walla, WA conducted surveys to assess ACEs knowledge and awareness prior to launching their initiatives.

Finally, a theme emerged about the limited number of members involved in the local initiatives when comparing states and city initiatives. The Walla Walla Community Resilience Initiative (discussed below), the Philadelphia ACEs Task Force, and BOUNCE Louisville all have around twenty members in the workgroup; the Arkansas ACEs/Resilience workgroup is much larger. The collaboration literature suggests numerous reasons for limited membership participation, including time, resource, and network constraints. An analysis of specific city initiatives may reveal the factors that influence membership relative to the Arkansas ACEs/Resilience workgroup.

City Spotlights

Walla Walla, Washington

The Walla Walla, Washington, Community Resilience Initiative began in 2008 when Dr. Rob Anda visited Walla Walla to give a presentation to the Walla Walla County Community Network (CRI, 2017). After a start-up grant of $40,000 from the Donald and Virginia Sherwood Trust and a three-year, $130,000 grant from the Bill and Melinda Gates Foundation, the organization conducted a citywide ACEs survey and launched its website (Stevens, 2014). The group officially launched in February 2010 (Stevens, 2014). It consisted of 25 members and two facilitators, with the goals of raising awareness of ACEs and brain development, fostering resilience, and educating the community (Stevens, 2014). The number of members is of particular note considering the much larger size of the AFMC workgroup.

The mission of CRI is "mobilizing the community through dialogue to radically reduce the number of adverse childhood experiences while building resilience and a more effective service delivery system" (CRI, 2017). CRI created a model of a thriving community that includes human development, learning and skill building, economic stability and opportunity, safety, health, and sense of belonging (CRI, 2017). CRI also educates the community on ACEs and its effects (MARC). Furthermore, the documentary *Paper Tigers* is based on Walla Walla's Lincoln High School, which completely changed its discipline practices after its principal attended a presentation on trauma and ACEs (MARC).

Philadelphia, Pennsylvania

The Philadelphia ACEs Task Force began meeting in 2012 (MARC). The Institute for Safe Families convened 24 organizations in Philadelphia, including the major colleges and

universities with medical schools or other health programs (Philadelphia ACE Project, 2016). As with Walla Walla, the number of organizations involved is interesting considering the much larger Arkansas ACEs/Resilience workgroup. In 2013, the Task Force conducted the Philadelphia Expanded ACE Study (Philadelphia Project, ACE Research Committee, 2016). The expanded study asked survey participants about community-level adversities particular to an urban area, including living in foster care, bullying, experiencing racism or discrimination, and feeling unsafe in your neighborhood (Philadelphia Project, ACE Research Committee, 2016).

In 2014, the Health Federation of Philadelphia took over the task force (Philadelphia ACE Project, 2016). The Health Federation of Philadelphia supports a network of community health centers, as well as a base of public and private organizations delivering services to vulnerable populations (Health Federation of Philadelphia, n.d.). The Health Federation is funded through grants and contracts from government organizations and private foundations, member dues, and fees for specific services to organizations, like training (Health Federation of Philadelphia, n.d.). The Health Federation and the task force identified four priorities of the group: 1) educating the community about ACEs; 2) understanding what interventions were currently in place in Philadelphia; 3) preparing the workforce, including ACEs training in medical schools and other graduate programs (law, education, social work, counseling); and 4) using Philadelphia's Expanded ACE Study to increase understanding of community-level adversity (Philadelphia ACE Project, 2016; MARC). Currently, the Philadelphia ACEs project receives support and staffing from the Scattergood Foundation (Philadelphia ACE Project, 2016). The project has four distinct workgroups, each focusing on one of these four priorities (Philadelphia ACE Project, 2016).

City Comparison

While Walla Walla's ACEs work began in 2008 with grant funding (CRI, 2017), Philadelphia's ACEs work began through the Institute of Safe Families in 2012 (Philadelphia ACE Project, 2016). Both groups conducted surveys in the region addressing ACEs; however, Philadelphia's survey focused on community-level adversities particular to the urban environment (Philadelphia Project, ACE Research Committee, 2016; Stevens, 2014). In addition, the two ACEs initiatives have a similar structure. Walla Walla's initiative consists of members and a few facilitators (Stevens, 2014); Philadelphia's initiative is a task force with facilitation through the Health Federation of Philadelphia (Health Federation of Philadelphia, n.d.).

Legislative Initiatives in Other States

The second component of the state-by-state comparison included researching whether states considered in this study have proposed and/or implemented any legislation concerning ACEs or trauma-informed care. Most of the states are currently considering legislation, but have not yet enacted any at the time of this report. Of the legislation proposed, states have largely focused their efforts on education or establishing a task force to start studying ACEs. Two states, Missouri and Tennessee, are considering multiple measures addressing ACEs or

trauma-informed care. The legislative component of this study also includes a prediction of the political outlook in Arkansas given the impending 2018 election, and an assessment of the types of measures that could be proposed in Arkansas in future legislative sessions.

Kentucky

The Kentucky General Assembly is currently in session. The House is composed of 37 Democrats, 63 Republicans, and there is one vacant seat, and the Senate is composed of 11 Democrats and 27 Republicans. (Kentucky General Assembly). Representative Will Coursey, a Democrat from the southwestern corner of Kentucky, has proposed House Bill 604, which would establish a program for developing trauma-informed care schools. (Kentucky Legislature; H.B. 604, 2018 Reg. Sess. (Ky. 2018)). Under H.B. 604, schools are directed to hire mental health professionals; create trauma-informed teams; and train teachers, staff, and administration how to recognize trauma in students and provide appropriate interventions and strategies. (H.B. 604, 2018 Reg. Sess. (Ky. 2018)). The goal is to have one mental health professional, such as a licensed physician, a licensed psychiatrist, a psychologist, a psychiatric mental health nurse practitioner, a licensed clinical social worker, or a professional counselor, per 1,500 students by the 2019-2020 school year (H.B. 604, 2018 Reg. Sess. (Ky. 2018). The new law would implement trauma-informed principles developed by the Substance Abuse and Mental Health Services Administration. (H.B. 604, 2018 Reg. Sess. (Ky. 2018).

Mississippi

The Mississippi Legislature has a Republican majority, with 33 Republicans and 19 Democrats in the Senate and 73 Republicans and 48 Democrats in the House. (Mississippi State Legislature). Senator Barbara Blackmon (D) sponsored S.B. 2339, which would create a Mental Health Summit comprised of 29 high-level state and local public officials. (Mississippi State Legislature; S.B. 2339, 2018 Reg. Sess. (Ms. 2018)). The Mental Health Summit would be directed to conduct a study aimed at finding ways to improve mental health for children and the elderly. (S.B. 2339, 2018 Reg. Sess. (Ms. 2018)). With regard to helping children, S.B. 2339 specifically takes into account ACEs and how they can have an impact on adult medical, mental, and social problems. (S.B. 2339, 2018 Reg. Sess. (Ms. 2018)). To date, Senator Blackmon has had no success establishing the Mental Health Summit; S.B. 2339 died in committee. (S.B. 2339, 2018 Reg. Sess. (Ms. 2018)).

Missouri

As in the other states legislatures examined for this study, a Republican majority governs the Missouri legislature. In the House, there are 46 Democrats, 111 Republicans, and 6 vacant seats; in the Senate, there are 9 Democrats, 24 Republicans, and 1 vacancy (Missouri General Assembly). Missouri is the only state considered in this study that has already enacted trauma-informed legislation. Policymakers in Missouri have been working towards

implementing trauma-informed approaches for several years and have been spurred by devastating events unique to the state, such as the police officer shooting of Michael Brown in Ferguson in 2014 and the violent E-F5 tornado that devastated Joplin in 2011 (Ballentine, 2016). In 2016, the legislature passed S.B. 638, which repealed, amended, and added several sections of the Missouri code concerning elementary and secondary education. (S.B. 638, 98th Leg., Second Reg. Sess. (Mo. 2016)). S.B. 638 was sponsored by Republican State Senator, Jeanie Riddle (Senator Jeanie Riddle). Part of the act added sections 161.1050 and 161.1055, which have become known as the Trauma Informed Schools Initiative. (S.B. 638, 98th Leg., Second Reg. Sess. (Mo. 2016)).

Section 161.1055 established the Trauma-Informed Schools Pilot Program. (Mo. Rev. Stat. § 161.1055 (2016)). The department of elementary and secondary education ("DESE") was required to select five schools based on very specific criteria, such as geographic location and population of the school district. (Mo. Rev. Stat. § 161.1055 (2016). DESE was then required to train the administrators and teachers of the five schools on the trauma-informed approach, provide the five schools funding to implement the approach, and closely monitor the progress of the five schools in becoming trauma-informed schools, providing further assistance if necessary. (Mo. Rev. Stat. § 161.1055 (2016)). DESE is required to submit a report on the results of the pilot program to the General Assembly by December 31, 2019 (Mo. Rev. Stat. § 161.1055 (2016)). Section 161.1055 also established a Trauma-Informed Pilot Program Fund. (Mo. Rev. Stat. § 161.1055 (2016)). Section 161.1055 became effective on August 28, 2016, and expires when the report is due. (Mo. Rev. Stat. § 161.1055 (2016)).

Section 161.1050, which became effective July 1, 2017, requires DESE to provide information to all schools, offer training to all schools, and develop a website regarding the trauma-informed approach. (Mo. Rev. Stat. § 161.1050 (2016)). Every school district is required to provide the website to parents before October 1, each school year. (Mo. Rev. Stat. § 161.1050 (2016)). Furthermore, the legislature defined "trauma-informed approach" as one "that involves understanding and responding to the symptoms of chronic interpersonal trauma and traumatic stress across the lifespan." (Mo. Rev. Stat. § 161.1050(5)(1) (2016)). The fiscal impact statement for SB 638 indicated that the pilot program and the overall initiative would include expenses for building a website, purchasing equipment for developing and implementing the training, hiring one full time staff person, and funding for the schools participating in the program; however, the fiscal impact statement did not state how much these expenses were expected be (Wilson, 2016). The legislature allocated $200,000 to the pilot-program, but the governor withheld the funds as part of a plan to address a looming budget deficit (Ballentine, 2016; Erikson, 2017). (For more information, see appendix F).

Montana

The Montana Legislature is a Republican majority with 41 Democrats and 59 Republicans in the House and 18 Democrats and 32 Republicans in the Senate. (Montana State Legislature). In 2015, Representative Jessica Karjala (D) sponsored House Bill 589, which would have required state agencies to focus on prevention and reduction of ACEs. (H.B. 589,

64th Reg. Sess. (Mt. 2015)). Furthermore, H.B. 589 would have mandated the funding of evidence-based pilot projects that educate communities about ACEs, increase community capacity for responding to ACEs, or prevent or reduce ACEs. (H.B. 589, 64th Reg. Sess. (Mt. 2015)). H.B. 589 failed, and a revised version of the bill, H.B. 264, sponsored again by Representative Jessica Karjala (D), was presented to Montana's 65th Legislature. (H.B. 264, 65th Reg. Sess. (Mt. 2017)). That bill also died in committee. (H.B. 264, 65th Reg. Sess. (Mt. 2017)).

Some legislation aimed at vulnerable populations, such as H.B. 118, sponsored by Representative Jennifer Eck (D) in 2017 to address Suicide, has included the effects of toxic stress outlined in the ACEs study and has passed. (H.B. 118, 65th Reg. Sess. (Mt. 2017)). S.B. 298, which addressed child abuse and was sponsored by Senator Jonathan Windy Boy (D) in 2013, also used the ACEs study to show the physical effects abuse can have on children throughout their lives and the fiscal effects this has on Montana; however, the bill died in committee (H.B. 298, 63th Reg. Sess. (Mt. 2013)). (See appendix F).

North Carolina

The North Carolina Legislature is comprised of 45 Democrats and 75 Republicans in the House and 14 Democrats and 35 Republicans in the Senate. (North Carolina General Assembly). In 2017, Representative Brian Turner (D) proposed House Bill 725, which passed in the House and remains on the Rules and Operations Committee agenda in the Senate. (Representative Brian Turner; Rules and Operations of the Senate). H.B. 725 is relatively unique compared to other legislative initiatives in this report because it does not seek to create a task force or implement a program incorporating ACEs or trauma-informed care models. Instead, H.B. 725 directs the Department of Public Instruction (the "Department") alone to "study and make recommendations regarding the funding structures in place to provide mental health support in public schools." (H.B. 1517, 2017-2018 Reg. Sess. (N.C. 2017)). Furthermore, H.B. 725 does not exactly instruct the Department to consider ACEs statistics, but instead, requires the Department to include "the advisability of tying mental health support to a particular measure" such as "survey information and physical examinations similar to the Adverse Childhood Experiences (ACEs) score." (H.B. 1517, 2017-2018 Reg. Sess. (N.C. 2017)).

Oklahoma

Similar to the other legislatures on which this study focuses, Oklahoma's legislature is comprised of a Republican majority in both houses, with a total of 8 Democrats and 40 Republicans in the Senate and 28 Democrats, 71 Republicans, and 2 vacancies in the House. (Oklahoma State Legislature). Co-Sponsors Representative Carol Bush (R) and Senator AJ Griffin (R) have proposed Senate Bill 1517, which would create the Task Force on Trauma-Informed Care in Oklahoma. (S.B. 1517, 56th Leg., Second Sess. (Okla. 2018)). The Task Force would be comprised of 17 members from various agencies representing a range of sectors, such as health care, education, law enforcement, and law. (S.B. 1517, 56th Leg., Second

Sess. (Okla. 2018)). Though the bill does not require participation from any specific nonprofit organization, the Task Force must include "one member who is an employee or designee of an Oklahoma organization that advocates on behalf of children." (S.B. 1517, 56th Leg., Second Sess. (Okla. 2018)). The Task Force would be responsible for collecting data, conducting studies, and recommending best practices and evidence-based models to help "children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma, especially adverse childhood experiences." (S.B. 1517, 56th Leg., Second Sess. (Okla. 2018)). The fiscal analysis of S.B. 1517 suggested that the Task Force will not have any "fiscal implications to the state." (Johnson, 2018).

South Carolina

There are no legislative initiatives in South Carolina as of this writing.

Tennessee

The Tennessee General Assembly also has a Republican majority, with 74 Republicans and 25 Democrats in the House and 28 Republicans and 5 Democrats in the Senate. (Tennessee General Assembly). Representative Raumesh Akbari (D) and Senator Becky Duncan Massey (R) introduced Senate Bill 197/House Bill 274 ("S.B. 197"). (S.B. 197, 110th Gen. Assembly, 2018 Reg. Sess. (Tenn. 2018)). Unlike the other bills considered in this study, it concerns sentencing procedures for juvenile offenders. (S.B. 197, 110th Gen. Assembly, 2018 Reg. Sess. (Tenn. 2018)). If passed, S.B. 197 will require courts to consider "trauma history, including any adverse childhood experiences" as a possible mitigating circumstance before the court can issue a sentence for a person who was less than 18 years of age at the time of the offense and was tried and convicted as an adult. (S.B. 197, 110th Gen. Assembly, 2018 Reg. Sess. (Tenn. 2018)). "The proposed legislation does not create any new cases or impact sentencing of cases, [it] . . . alters the release date for some . . . inmates." (Lee, 2017). In fact, the fiscal review committee estimates that S.B. 197 will result in approximately five inmates per year being released early. (Lee, 2017). Though the fiscal review committee does not expect to see any measurable savings for many years, it expects S.B. 197 to decrease state incarceration costs by almost $3 million by fiscal year 2050-2051. (Lee, 2017). (See appendix F).

Table 2 below, summarizes the legislation discussed.

Table 2: Legislative Initiatives	
KY	H.B. 604 would establish a trauma-informed initiative in schools.
MS	S.B. 2339 proposes the institution of a Mental Health Summit (a task force) primarily composed of high level public officials.
MO	S.B. 638 establishes the Trauma-Informed Schools Initiative

MT	H.B. 509 addresses suicide among Native American youths. The ACE Study was referenced to show the life shortening effects of ACEs and how suicide of a family member affects children.
NC	H.B. 725 directs the Department of Public Instruction to "study and make recommendations regarding the funding structures in place to provide mental health support in public schools."
OK	S.B. 1517 passed Senate and sent to House on 3/12/2018, would create a task force on trauma-informed care to make recommendations to the legislature.
SC	No legislative initiatives at this time.
TN	S.B. 197 includes trauma history and ACEs as a possible mitigating factor for sentencing of minors. S.B. 552 creates a pilot program for victims of sex trafficking.

Arkansas In Perspective: 2018 General Election Outlook in Arkansas

The Arkansas General Assembly is comprised of a majority of Republicans. Currently in the Senate, there are 9 Democrats, 23 Republicans, and 3 vacancies; in the House, there are 24 Democrats, 75 Republicans, and 1 vacancy. (Arkansas General Assembly). Though 2018 is an election year, the composition of the Arkansas General Assembly is not likely to change significantly. In the Senate, there are only 20 seats on the ballot, and of the 20 seats up for election, only 9 are truly contested (seven additional seats are contested, but only in the primaries) (Tolbert & Baldwin, 2018). Even if Democrats win all 9 contested seats, which is unlikely because 8 of the contested districts are currently held by Republicans, there still will be 18 Republicans in the Senate (Arkansas District Finder).

In the House, all 100 seats are on the ballot, but only 44 of those seats are contested. The remaining 56 seats are either uncontested or only contested in the primaries, so at a minimum there will be 42 Republicans and 14 Democrats in the House. (Tolbert & Baldwin, 2018). In order to get a majority in the House, therefore, Democrats need to win 37 of the 44 seats, while Republicans need only win 9. Because 34 of these seats are currently held by Republicans, it would be very difficult for Democrats to win a large enough percentage of them to take control of the House (Arkansas District Finder).

There are four candidates from the two major parties running for Governor, including two Democrats and two Republicans. (Tolbert & Baldwin, 2018). The Democrats are Jared Henderson, a Harvard-educated medical professional who has experience working for NASA, and Leticia Sanders, a hairdresser from Maumelle (Jared Henderson for Governor; Brock, 2018). The Republicans include Jan Morgan, a journalist and small business owner, and the incumbent Governor Asa Hutchinson. (Jan Morgan for Governor; Asa Hutchinson for Governor). Governor Hutchinson will likely win re-election. He enjoys a 63% approval rating, and is the third-most popular governor in the country (Easley, 2017). If Governor Hutchinson wins re-election, it would likely be beneficial for the implementation of ACEs or trauma-informed care initiatives. Governor Hutchinson has already given an inclination towards his support for such measures after he issued a proclamation announcing October 13, 2017 as ACEs Awareness and Action Day in Arkansas. (Stevens, 2017). If one of the Democratic candidates were to win, AFMC

would likely find either candidate to be supportive of ACEs and trauma-informed initiatives because both have named health care and education as priorities for their administrations.

Recent Legislative Initiatives in Arkansas

A number of measures have been passed in the last legislative session that suggests that the time is ripe for Arkansas to consider new means of confronting trauma and mental illness resulting from ACEs. For example, the Arkansas General Assembly passed Act 539, known as the Fair Sentencing for Minors Act of 2017. (2017 Ark. Acts 539, Section 1). The legislative intent of the act states that the "General Assembly acknowledges and recognizes that minors are constitutionally different from adults," and furthermore, because of emerging brain and behavioral development science, Arkansas is following other states, such as Texas, Kansas, Kentucky, West Virginia, and others, by eliminating life without parole as a sentencing option for minors. (2017 Ark. Acts 539, Section 2).

The most relevant section of Act 539 contemplates administering a comprehensive mental health evaluation on a minor convicted of capital murder or murder in the first degree. (2017 Ark. Acts 539, Section 8). The mental evaluation has to include information about the minor such as: family interviews, prenatal history, developmental history, medical history, history of treatment for substance abuse, and a psychological evaluation. (2017 Ark. Acts 539, Section 8). Tennessee is currently considering legislation that would contemplate ACEs as a mitigating factor in the sentencing of juveniles. (S.B. 197, 110th Gen. Assembly, 2018 Reg. Sess. (Tenn. 2018)). The two bills are very similar in subject matter. It would be the perfect opportunity for AFMC to reach out to Senator Missy Irvin (R), the primary sponsor of Act 539, and request an amendment to the legislation adding a line like that in Tennessee's SB 197 to the mental evaluation for convicted minors in Arkansas. SB 197 states that, with respect to a juvenile tried and convicted as an adult, "the court shall consider the following mitigating circumstances . . . trauma history, including any adverse childhood experiences." (S.B. 197, 110th Gen. Assembly, 2018 Reg. Sess. (Tenn. 2018)). Arkansas could add a similar sentence concerning the types of information gathered in a mental evaluation.

Moreover, the Arkansas Legislature passed Act 423, which, among other things, provides for the establishment of crisis intervention teams. (2017 Ark. Acts 423, Section 36). Basically, if someone is found to be in danger of hurting him or herself or another person and he or she suffers from a "behavioral health impairment mental disability, mental illness, or other permanent or temporary behavioral health or mental impairment," the person can be diverted to a crisis stabilization unit ("CSU") to receive emergency psychiatric services instead of being arrested and sent to jail. (2017 Ark. Acts 423, Section 36). Act 423 is designed to get law enforcement and medical professionals to work together to help people receive necessary medical treatment, reduce the likelihood they will commit a crime, and overall reduce the inmate population. (2017 Ark. Acts 423, Section 36). This is another great opportunity to amend existing legislation to incorporate ACEs and trauma-informed care into legislation. Act 423 could easily be amended to require law enforcement and medical professionals to consider ACEs in the provision of services to those treated at a CSU. On the other hand, Act 423 delegates

rulemaking authority to the Department of Human Services ("DHS") in order to implement the provisions concerning CSUs (2017 Ark. Acts 423, Section 36). Instead of going to the legislature, the workgroup could reach out to DHS to suggest that ACEs and trauma-informed care approaches be included in the rules DHS promulgates. What is more, Governor Hutchinson has already earmarked $6 million to establish four, sixteen-bed CSU facilities in Craighead, Pulaski, Sebastian, and Washington Counties (Miller, 2017).

Finally, the General Assembly enacted Act 506, which creates a framework for developing mental health specialty courts for adjudicating someone who has already committed a crime and who suffers from mental illness (2017 Ark. Acts 506, Section 1). If program participants complete all the requirements and receive all the treatment recommended, the mental health specialty court is authorized to dismiss their cases and seal the records (2017 Ark. Acts 506, Section 1). The act lists several goals for the mental health court program, which would be a good place to add that ACEs should be considered in the treatment of participants (2017 Ark. Acts 506, Section 1). Act 506 also suggests that a judicial district that establishes a mental health court should develop an implementation manual with assistance from DHS, ADH, the Department of Community Correction, the Administrative Office of the Courts, and any other organization with expertise in mental health conditions (2017 Ark. Acts 506, Section 1). Such language opens the door for the AFMC work group to have a role in developing a trauma-informed approach to mental health court adjudication and treatment.

Recommendations

Guided by the state comparison and the stakeholder analysis, the research team has developed the following recommendations for the Arkansas ACEs/Resilience Workgroup. The recommendations fall under four categories: Raising ACEs Awareness, External Education and Development, Internal Development, and Legislative Approach. Each category includes specific action items that can be leveraged by the Arkansas ACEs/Resilience Workgroup to advance their work.

Raising ACEs Awareness

Communication

The workgroup should create a communications sub-group to craft communications for targeted audiences and streamlining of internal communications. The cross-cutting impact of ACEs on life outcomes has been well documented (Bethell, Newacheck, Hawes & Halfon, 2014). However, there is an urgent need to translate existing knowledge into nonprofessional terms for the general populous. The role of the communications sub-group would be to provide the link between the workgroup and general population. Forty-eight percent of the stakeholders interviewed said they used the newsletters sent out by AFMC for increasing awareness about ACEs amongst peers and others who could benefit. One interviewee, who was linked to the education sector, said that the teachers who were newly informed about ACEs and their

long-term effects felt “helpless”. With the help of creative people in the communications sub-group, infographics and pamphlets could be produced, targeting different groups (like educators, mental-health practitioners, family medicine doctors) to help provide such teachers/others who expressed helplessness, with tangible steps to take in their classrooms.

The creation of uniform educational material to be used by both public and private organizations was also suggested by people interviewed. Using data already collected, the communications sub-group could work to create easily comprehensible materials and content. Showing documentaries, such as Resilience and Paper Tigers, could serve as an entry point into communities and stakeholder groups with limited exposure to information regarding ACEs. Legislators AFMC hopes to involve in the initiative may also benefit from gathering to watch these documentaries and engage around ACEs work in a non-partisan fashion.

Twenty percent of the interviewees cited schedule conflicts as the main reason for not being able to attend meetings. Therefore, by having the communications sub-group distribute the minutes of the meetings, the subgroup could play another role benefitting members who are not able to attend meetings due to their busy schedules. Creating a group whose sole purpose would be to improve internal and external communications could really help the ACE initiative in Arkansas. It would also be the job of this sub-group to follow up with designation of tasks decided in all sub-groups, further helping in accountability of the group.

External Education and Development

There are very diverse stakeholders among the AFMC workgroup devoted to statewide education on ACEs. This provides a strong opportunity for the Workgroup to present ACEs and their greater implications to groups throughout Pulaski County and beyond.

Train the Trainers

Arkansas can adopt the train a trainer approach where people can be trained to subsequently enlighten people in the homes they visit. Through a training of trainers program that targets formalizing a base of ACEs trainers and educators, AFMC can introduce ACEs to new and potential stakeholders, connect with neighborhoods and communities throughout Arkansas, and build strategic partnerships within communities and across the state to enhance work around ACEs.

The state comparison provides resources and examples that can be used and/or replicated for training efforts. South Carolina’s Master Trainer program has trained over 70 Master Trainers who focus on ACEs and trauma-related effects on youth. Their organization has offered over 167 trainings on child neglect, abuse, and trauma-related effects across South Carolina for 5,500 people through 2017 (Children’s Trust of South Carolina, 2017). South Carolina’s Children Trust of South Carolina is the licensee of the ACEs Interface (www.aceinterface.com), which provides training modules, content, and resources around ACEs for all interested stakeholders as well as Master Trainer Education (ACE Interface, 2018). Using and/or adapting this interface to serve Arkansas residents could help with AFMC’s efforts to raise the state’s overall knowledge regarding ACEs and trauma-informed practices and procedures.

Professional Development

Many of the groups that AFMC would like to engage have professional conferences. For example, all attorneys in the State of Arkansas are required to attend at least 12 hours of Continuing Legal Education per year to maintain licensure. AFMC could create a template version of a Continuing Legal Education presentation that could be modified for specific circumstances, such as conferences of prosecutors, judges, attorneys ad litem, or criminal defense attorneys. In addition to presenting to groups likely to be interested in ACEs, workgroup members could present continuing education type presentations to broader groups; for example, a member of the workgroup could present a continuing education presentation hour at the Arkansas Bar Association yearly meeting or a monthly meeting of the Arkansas Association of Women Lawyers.

Social workers are required to complete 48 hours of continuing education every two years. AFMC could also create a template version of a social work continuing education presentation to be modified for various social work conferences or individual meetings.

AFMC and the workgroup should reach out to the Arkansas Department of Community Corrections to determine what kind of training might be useful for their employees. The Department of Community Correction provides staff for probation, parole, various specialty courts (drug courts, veterans' courts, mental health courts), as well as community correction centers.

School counselors, along with teachers, are on the frontline when it comes to our students. The Arkansas School Counselor Association provides professional development for its members and holds an annual conference each summer. They work closely with the Arkansas Department of Education (ADE) in developing state counseling standards. Getting this group involved could lead to updated practices across multiple ADE divisions.

Internal Development

Strategic Stakeholder Inclusion

As awareness of ACEs increases, the workgroup will need to develop a strategic plan to fill in the gaps of underrepresented sectors within the group. Partner identification and recruitment is key to building influence within the workgroup. The research uncovered some fundamental partnerships in other states that could be highly beneficial to AFMC's work.

Mississippi, for instance, found that youths who experience ACEs and enter one of their agencies as a client are often treated at another agency at some point in their experience. For example, a youth who interacts with child services stands a greater chance of being impacted by the justice system or alternative education environments (personal communication, 2017). In acknowledgement of this, education, justice system-based, mental health, child services, homeless centers, etc. have not only been engaged as partners in their work but have received training as it relates to trauma and procedures to meet the whole child (personal communication, 2018). It is recommended that these partnerships, if not currently involved, be added to the current stakeholder basis at AFMC. Additionally, a group of first ladies of state governors have

expressed interest in advocating for policies that relate to ACEs (personal communication, 2018). Having the support of Arkansas' first lady in this group and AFMC could help facilitate legislative efforts on ACEs.

Primary care physicians have direct communication with families affected by ACE trauma such as parents, children, expectant parents, guardians and adoptive parents who are eager to assess their children and learn about building resilience. Employees of family shelters such as Our House, Dorcas House, Women in Transition and DHS-Center for Youth and Family to name a few would add to the workgroup to address the needs of families experiencing trauma. Programs such as Youth Home and Children's Home have the employees who have experience with women and children who have an ACE score and can bring vital knowledge to the workgroup.

Additionally, underrepresentation has been identified within the legal sector among law enforcement, CASA, DHS, and lawyers who work with many clients experiencing trauma. In addition to lawyers and law enforcement representation from those who work in the prison system and re-entry needs a stronger presence. Other community members to pursue are school counselors, teachers, and superintendents that can start implementing a trauma-informed model in the classroom.

There is an underrepresentation of ethnic and racial minorities within the Workgroup. Thus, the Workgroup should reach out to agencies which serve minority groups such as Seis Puentes which serves the Latinx community in Central Arkansas. All groups face trauma, but minority groups experience trauma at higher rates, especially when the potential for a language barrier are added (Slopen, et al., 2016).

Faith Based Organizations

Among the stakeholders considered, FBOs offer the greatest potential of reaching and raising awareness among affected children, parents, and the general public. To raise ACEs awareness in faith communities, the workgroup should continue screening informational films, adopt curriculum like "Bruised Reeds and Smoldering Wicks" and invite congregation members and the community at large to attend. The importance of familiarizing the public with ACEs, their effects, means of prevention and support cannot be overstated, and faith communities provide a convenient access point to community members.

To build on this awareness, the workgroup should enlist the help of the faith-based leaders, ministers and other religious leaders in the workgroup to focus on a trauma-informed and mental/behavioral health friendly preaching and ministry approach (see tools and links in Appendix B) to build trauma-informed and mental/behavioral healthy congregations. This would not only educate faith communities about ACEs, but also break down the mental health stigma existing in many communities. Special focus should be placed on reaching minority faith groups and ethnic churches, such as African American and Latino Churches. These groups are underrepresented, and their perspective could bring a unique view and approach to the AR Workgroup.

Many churches already require background checks and/or training for staff and volunteers who work with minors; adding ACEs/Trauma Informed training as a requirement

could better ensure faith communities are safe places for vulnerable populations to find resources and relationships. Seminaries could also be encouraged to include or require ACEs/Trauma-Informed training in their education plan to ensure ministers provide the best possible care. FBOs that require standardized ACEs/Trauma-Informed Care trainings for staff and volunteers could put on their web and social media pages that they are Trauma-Informed. A list of trauma mental/behavioral health friendly, Trauma-Informed faith communities could be provided as a resource to counselors and mental health providers as a resource for patients who desire to include spirituality as an aspect of their holistic care. Faith community leaders could be provided a list of trauma-informed ACEs trained mental health professions to whom their members could be referred. This would encourage faith leaders and mental/behavioral health leader to work as partners and provide well-rounded services for holistic care.

Legislative Approach

Two states, Oklahoma and Mississippi, have proposed creating task forces. It is not recommended that Arkansas follow that approach because the AFMC workgroup already acts like a task force, and has already conducted or has access to any necessary research concerning ACEs. Arkansas is beyond this step. What is more, Governor Hutchinson recently announced a plan to reorganize the state government by reducing the number of cabinet level agencies by fifty percent (Brawner, 2018). Though his focus is on major agencies at this time, he has mentioned that all 200 boards and commissions will be part of the reform effort (Brawner, 2018). Given this development, it seems unlikely that there will be an appetite for the creation of new task forces.

Two states, Missouri and Kentucky, have proposed trauma-informed care models in schools. Missouri is the only state that has already enacted its trauma-informed schools initiative. Arkansas is not as advanced in considering ACE's as Missouri. Missouri has been contemplating ACEs proposals since 2011 and has been propelled forward by deeply traumatic events, such as the tornado in Joplin and the shooting of Michael Brown in Ferguson. Moreover, Governor Hutchinson is proposing major budget cuts in for fiscal year 2019, which makes it less likely that a new initiative, such as the Trauma-Informed Schools Initiative in Missouri, requiring the establishment and funding for a pilot program, a website, and training, as well as a roll-out to all elementary and secondary schools, would receive the requisite funds to operate (see Brawner, 2018).

One state, Tennessee, has proposed legislation incorporating ACEs in the criminal justice context. Arkansas has already proposed quasi-trauma informed legislation in a similar context to the Tennessee legislation, and that would be an excellent option for amending legislation to expressly incorporate ACEs and trauma-informed care. For example, in the 2017 legislative session, the Arkansas General Assembly passed legislation authorizing the creation of crisis stabilization units ("CSUs") and mental health courts (2017 Ark. Acts 423; 2017 Ark. Acts 506). The General Assembly also enacted legislation authorizing comprehensive mental health evaluations for minors convicted of capital murder or murder in the first degree. (2017 Ark. Acts 539). It is recommended that AFMC reach out to legislators who proposed Acts 423, 506, and 539 to ask them to consider amending the legislation to require CSUs and mental health courts to

add that the training and treatment delivered to participants include ACEs or a trauma-informed approach. Again, the most similar case is in Tennessee, where the legislature is currently considering SB 197, which would contemplate ACEs as a mitigating factor in the sentencing of juveniles. SB 197 contains only a one-line sentence about ACEs, which would be easy to add to existing legislation in Arkansas.

Furthermore, with CSUs, there is also an opportunity to work with the Department of Human Services to promulgate rules related to ACEs and trauma-informed care because the legislature delegated rulemaking authority to DHS. (2017 Ark. Acts 423). By taking this route, AFMC could avoid proposing legislation altogether. However, one downside to rulemaking is that the public notice and comment period can be time consuming.

Not only does the subject matter of recent Arkansas legislation comport with ACEs science and trauma-informed care, but it also would be prudent to consider amending existing legislation because funding has already been appropriated for these new programs. For example, Governor Hutchinson has already earmarked $6 million toward the establishment of four crisis stabilization units in Arkansas (Millar, 2017).

Ultimately, regardless of whether AFMC would instead pursue legislation to implement trauma-informed schools or focus on existing measures in the criminal justice system, last year the Governor proclaimed October 13, 2017, as ACEs Awareness and Action Day in Arkansas. (Stevens, 2017). Given that Governor Hutchinson and First Lady Susan Hutchinson have already expressed an interest in ACEs and trauma-informed care, it likely would be easy to reach out to them to get their support on any proposed amendments to legislation.

Conclusion

Arkansas is currently ranked highest in the nation for the number of children with two or more ACEs, with approximately thirty percent of Arkansas' children believed to have experienced two or more ACEs. The Arkansas Foundation for Medical Care and the Arkansas ACEs/Resilience workgroup continue to make strides toward improving ACEs outcomes for Arkansans.

The research team at UA Little Rock (MPA and Nonprofit candidates) after a thorough analysis of stakeholders, legislations and initiatives in and outside Arkansas, recommend AFMC and the Arkansas/Resilient workgroup to work to fill in gaps in the AFMC workgroup, engage stakeholders by improving communication and education and incorporate successful or feasible trauma-informed care models from other states.

These efforts will help AFMC achieve its goals to increase awareness of ACEs and implement ACEs initiatives in Arkansas thereby mitigating the long-term effects of ACEs on Arkansans and its greater implication on the economy of the United States.

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