CECIL J. PICARD CENTER FOR CHILD DEVELOPMENT & LIFELONG LEARNING

A View from the Field: Awareness, Activities, and Approaches for Addressing Adverse Childhood Experiences (ACEs) in Louisiana

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UNIVERSITY of LOUISIANA LAFAYETTE

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A View from the Field: Awareness, Activities, Approaches for Addressing Adverse Childhood Experiences in Louisiana (*AAA for Addressing ACEs*) study represents the collaborative efforts of several groups committed to addressing the impact of adverse childhood experiences in Louisiana:

Louisiana ACE Initiative. The Louisiana ACE Initiative includes agencies representing child health/mental health, welfare, advocacy, child abuse and prevention, education and research institutions and nonprofits who are committed to education, research, family and community engagement, and advocacy about ACEs, including prevention of and resilience to the negative effects of adversity. The ACE Initiative Survey Advisory Committee contributed to survey development and distribution, review, and dissemination of the report.

Louisiana Early Trauma Task Force (LA ETTF). The LA ETTF aims to identify the needs, develop a model to address the needs, and support the dissemination of evidence-based approaches and treatments for young children and their families who have experienced trauma. The LA ETTF is under the auspices of the Early Trauma Treatment Network (ETTN), a Category II Center in the National Child Traumatic Stress Network funded by the Substance Abuse Mental Health Services Administration. The grant was awarded to Dr. Alicia Lieberman at University of California San Francisco Medical Center and includes three collaborating sites at Boston University Medical Center, Louisiana State University Health Science Center and Tulane University School of Medicine. The goals of ETTN are training, development and building capacity in the infant and early childhood field with a main goal being dissemination of the evidence-based treatment, Child-Parent Psychotherapy. For Louisiana, the objective is to further the national goal by improving families' access to information about child development, early education, and mental health services. Comprising faculty from LSU Health Sciences Center Department of Psychiatry, Tulane University Department of Psychiatry/Child Psychiatry, and the Picard Center/College of Nursing of the University of Louisiana at Lafayette, the ETTF members contributed expertise in infant/early childhood mental health and trauma-informed mental health practices to the development of the survey, analysis of findings, development of the report, and dissemination of findings.

Picard Center and College of Nursing and Allied Health Professions, University of Louisiana at Lafayette. Faculty and staff from the Picard Center and College of Nursing took the lead on developing and analyzing the results of the survey, including conducting and analyzing the key informant interviews, creating a resource list of services aimed at prevention and intervention of ACEs in Louisiana, development of the report, and dissemination of findings.

Results of the survey will inform planning and activities of the ACE Initiative, the ETTF, and will inform research and program initiatives at the Picard Center and College of Nursing.

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EXECUTIVE SUMMARY

The landmark Adverse Childhood Experiences (ACE) study, co-sponsored by the Centers for Disease Control and the Kaiser Permanente Managed Care Consortium in San Diego, CA (Felitti et al., 1998) demonstrated that cumulative adversity in childhood is associated with significant long-term consequences for adult health and well-being. The "ACE Study" findings have been replicated in numerous studies and the research has underscored the urgent need to accelerate focus on preventing all types of early adverse experiences, as well as developing interventions that mitigate effects, especially for young children already exposed.

Using a broad, cross-sector online survey that reached over 900 professionals and included interviews with 20 key informants from across service sectors, the *A View from the Field: Awareness, Activities and Approaches for Addressing ACEs* (*AAA for ACEs)* study sought to assess the penetration of ACE education, advocacy, and trauma-informed approaches in Louisiana. The study addressed three specific questions:

1. ***What is the saturation of ACEs education and awareness in Louisiana?***

ACE education and information has reached every region of the state. Respondents were representative of the racial/ethnic mix of Louisiana citizens, and professional disciplines represented a wide range of child and family service professionals including direct service providers, home visitors, supervisors and consultants, administrators, community advocates, educators, and researchers. Across disciplines, respondents perceived ACE education as highly valued, relevant, and beneficial to service recipients, staff, programs, and communities. However, slightly more than half of the respondents indicated they had only basic, introductory knowledge and/or did not know how to apply the knowledge; slightly less than half reported having a good grasp of information and were beginning or regularly applying the content. There was consistent recognition of the need for more ACE education for both the public and for professionals throughout the state.

2. ***What are the trauma-informed prevention and intervention activities in Louisiana, including research and advocacy?***

Direct service providers described a wide range of clinical trauma-related services and activities, with screening and referral most frequently endorsed, but many of the identified approaches were not specifically evidence-based to address the impact of trauma. Notably, few of the mental health respondents indicated they were fully trained, confident, or actively using specific, trauma-focused, evidence-based therapies for young children. Nevertheless, there is great interest among all direct service providers to deepen and expand knowledge and skills for addressing ACEs and trauma.

The vast majority of administrators, program managers, and agency directors reported their programs engage in a variety of ACE and trauma-related services, including direct services, advocacy, education for professionals, community education, research and program evaluation, and spiritual support. Similar to direct service providers, administrators believed that ACE-related knowledge has a positive impact on their agency or program activities, but often felt they did not have enough knowledge of "what to do" and/or lacked the resources to implement activities.

Similarly, the majority of advocacy and community development professionals indicated that their communities were at least somewhat interested or already had ACE-related activities underway, and they

perceived a number of potential benefits to community knowledge of ACEs. However, they too indicated that lack of resources, lack of clarity about what to do, as well as other issues with higher priorities as barriers to more active community uptake of ACE knowledge.

We did not reach a large number of university or medical school faculty, likely a limitation of the sampling approach of the survey. While those who responded believed incorporating ACE information into curricula was important, the low response rate also suggests that penetration of ACE education in undergraduate and graduate programs may be limited. In addition, few of these respondents indicated they were involved with ACE-related research.

3. ***What are gaps, needs, and priorities for ACE education and prevention and intervention activities?***

Although the survey reached a wide range of professionals, few represented law enforcement, business, and faith-based communities. This likely reflects the recruitment process, but also suggests gaps in groups who may benefit from and be interested in ACE-related education.

Barriers to providing ACE education, services, and activities were not surprising: insufficient funding, insufficient referral resources, and insufficient expertise in evidence-based, trauma-informed services. Respondents expressed the need for tools, materials, and strategies for providing education to professionals as well as families and communities. Additionally, respondents identified the need for better awareness of how communities are incorporating ACE-related activities, access to or development of community data regarding trauma and ACEs, and web-based resources for statewide ACE-related services and activities.

The three most frequently endorsed top priorities for ACE education and interventions included trauma-informed approaches in schools, education for providers/professionals, and prevention services (such as home visiting). Specific trauma-informed approaches were identified as needed in every child-serving system, as well as the need to address basics such as housing, food, and health care. Additional priorities included trauma-informed health care services, improved inter-agency collaboration and communication, and better research on ACEs/trauma in Louisiana.

In addition to the needs and priorities identified in the survey, key informants identified the need for policies and procedures at the program and system levels that recognize the effects of trauma and do not undo trauma-informed treatment efforts (for example, it was noted that the “zero tolerance” policies implemented in many schools not only ignore understanding of the individual child, but can replicate traumatic experiences in some cases). The importance of adequately supporting professionals who work in systems of high trauma-exposure was noted. The transmission of ACE information needs to consider the social and community contexts, and the importance of including the voices of parents and those directly affected by trauma in ACE education and activities were emphasized. The perennial challenge of ensuring long-term planning and commitment to the needs of children and families also were high priorities of the key informants.

The most important implications are:

1. ACE knowledge is highly valued; education and intervention efforts are taking place at every level, from individual and family work to programs, institutions and systems.
2. Nevertheless, across systems, there is a high desire and great need for additional knowledge and education about what to do regarding ACE recognition, prevention, and intervention.
3. Given the very limited availability of trauma-informed, evidence-based mental health services for children and families, there is an urgent need not only for greater availability of knowledgeable and skilled mental health professionals, but also to understand better the barriers to training and implementing evidence-based practices.
4. Similarly, there is a dearth of mental health and other professionals who are prepared to address the needs of young children and their families who have been exposed to ACEs. As young children are particularly vulnerable to the effects of ACEs and trauma, evidence-based, trauma-informed services can provide the first line of prevention and buffer the impact of trauma. If Louisiana is interested in long-term prevention, such services should be a priority for educational and training efforts.
5. Efforts are being made at the state Medicaid Care Organization (MCO) level to improve reimbursement for and availability of evidence-based therapies; adequate reimbursement is an important barrier to development of adequate numbers of providers and service availability.
6. Education efforts should expand to target professionals and systems that, based on this survey, may be under-represented, such as physicians, law enforcement, the business community, and faith-based organizations.
7. Knowledge of the scope and effects of adversity continues to grow; ACE education must include up-to-date findings, including controversies, such as whether to screen for ACEs in service and educational settings.
8. ACE education should be incorporated into undergraduate and graduate programs so that professionals have at least introductory knowledge and skills as they enter the workforce.
9. Parental needs regarding ACEs include service recognition of how ACEs impact their health and ability to care for children; education to help parents be aware of ACE prevention and to be appropriately responsive to the effects of ACEs in their children; and enlisting parents, including those who have been impacted by childhood adversity, in advocacy efforts and involving them in delivering ACE education and messaging.
10. ACE messaging must consider the social and community contexts and needs to maximize effective education and amelioration efforts.
11. ACE education fosters a language and framework for cross-systems understanding and collaboration, and there is high need and interest for better communication between and among agencies and service providers.
12. Systems and state-level leadership, policy, and plans were identified as needed for direction and prioritization of ACE and trauma-related activities.
13. Caring for those affected by trauma is hard work; the importance of supporting and uplifting caregivers/professionals providing such services is necessary to avoid burnout and compassion fatigue.
14. Louisiana-focused research is needed to determine the scope and effects of ACEs on Louisiana's citizens, as well as to identify and develop new, evidence-based practices for prevention, and intervention for individuals and communities.

This first study to examine ACE education and activities in Louisiana demonstrates a palpable momentum to take seriously the impact of trauma on children, and a strong desire to do what is

needed to prevent the long-term effects of ACEs and trauma. Survey methodology has some significant limitations, including inability to know who did not respond, not reaching relevant populations, and a somewhat limited ability to delve deeper into the activities, needs, and perspectives of respondents. However, the findings of this report provide an important snapshot of Louisiana's ACE-related activities, and we hope will stimulate continued efforts and commitment to "move the needle" on Louisiana's poor health and social circumstances.

SECTION 1

INTRODUCTION & RATIONALE FOR THE STUDY

Decades of research document that many types of environmental exposures to events early in life produce negative outcomes many years later. One clear finding from this research is that exposure to multiple risk factors predicts more severe adverse developmental consequences compared to single risk factor exposure. The surprising discovery is that long-term adverse outcomes are better predicted by the total number, rather than the specific nature of risk exposures. This well-replicated finding has become known as the cumulative risk model (Rutter, 1979; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987).

The best-known cumulative risk study is the Kaiser-CDC ACE study (ACEs; Felitti et al., 1998), which has drawn considerable attention to the importance of early experiences by investigators, policy makers and educators. In this landmark study, co-sponsored by the Centers for Disease Control and Prevention (CDC) in Atlanta, GA and the Kaiser-Permanente Managed Care Consortium in San Diego, CA, over 17,000 adult members of the Kaiser-Permanente system were mailed questionnaires and asked to recall experiences of abuse, neglect, and exposure to forms of household dysfunction prior to 18 years of age. The results were synthesized into 10 different types of adverse childhood experiences (ACEs): physical, emotional and sexual abuse, physical and emotional neglect, mother treated violently, household substance abuse, household mental illness, parental separation or divorce, and incarceration of household member (Felitti et al., 1998). Within this relatively advantaged population, experiences of adversity in childhood were common. However, the most important finding was a "dose-response" relationship between the number of adversities experienced in childhood with a vast array of health problems. Adults who experienced four or more childhood adversities were significantly more at risk for smoking, severe obesity, physical inactivity, alcoholism and substance abuse, depressed mood, suicide attempts, sexually transmitted infections, as well as the presence of diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease, and self-ratings of poor health (Felitti et al., 1998; Kerker et al., 2015. A recent systematic review and meta-analysis demonstrated similar findings (Hughes et al., 2017), and because of their pervasive effects, ACEs are considered a "hidden burden on health" (Felitti et al., 1998).

While longitudinal studies have not been done directly linking ACEs to Louisiana's health outcomes, it is notable that the long-term effects of ACEs are associated with many conditions that contribute to Louisiana's poor health rankings. For example, according to America's Health Rankings (2018a), Louisiana is the least healthy of all 50 states and ranks 45th in obesity, 46th in cardiovascular deaths and premature deaths, 47th in diabetes and frequent mental distress, and 48th in smoking. Louisiana has the third highest rate of syphilis and second highest rates of chlamydia and gonorrhea in the U.S. and outlying areas (Centers for Disease Control and Prevention, 2018b); Louisiana ranks 3rd in AIDS and 4th in HIV case rates (Centers for Disease Control and Prevention, 2018a). Similarly, low birth weight and infant mortality have been associated with ACEs (Smith, Gotman & Yonkers, 2016), and Louisiana also ranks poorly on those outcomes, including low birthweight and infant mortality (Louisiana ranks 49th and 46th, respectively) (America's Health Rankings, 2018b).

Importantly, we now recognize that other adverse experiences beyond the original 10 have been shown to have similar effects (Chronholm et al., 2015). Given that Louisiana's population in general has more economic and social risks than the study population of the original Kaiser-CDC ACE study, it is likely that the relationship between adversity and health outcomes may be stronger in Louisiana. For example, Louisiana is ranked 3rd in the U.S. of the largest per capita number of children (birth to 17 years) who have

experienced two or more ACEs (28.2% vs 21.7% U.S. average) (America's Health Rankings, 2018b). In this study, the definition of ACEs was slightly broader than in the Kaiser-CDC study, and included socioeconomic hardship, parental separation or divorce, lived with someone who had an alcohol or drug problem, victim or witness of neighborhood violence, lived with someone who was mentally ill or suicidal, domestic violence witness, parent served time in jail, treated or judged unfairly due to race/ethnicity, and death of parent (America's Health Rankings, 2018b).

Relevant to this report, studies demonstrate the proximal effects of exposure to ACEs in young children, including maternal ACEs and young children's adaptation (see Table 1, below). These studies demonstrate that adverse experiences in mothers and other environmental risks are associated with biological effects in their offspring. For example, mothers' prenatal reports of her own adverse experiences predicted telomere length in placental tissue and across infancy, as well as being associated with impaired stress response at 4 months and externalizing behavior problems at 18 months (Esteves et al., 2020; Jones et al., 2019).

Table 1. Cumulative Risk Studies in Young Children

Study	Who was studied	Risk exposures	Outcomes
Kerker et al. (2015)	18-71 month olds who were involved in the child welfare system for suspected or actual abuse.	10 ACEs from the Kaiser Permanente Study.	98.1% experienced at least one ACE in childhood with average age of 3.6 years. For each additional ACE reported, 21% increase in the odds of having a chronic medical condition, 32% increased odds of having a behavior problem, and a 77% increased odds of a low socialization score on developmental assessment.
Jimenez et al. (2016)	1001 5-year-olds recruited as part of the Fragile Families and Child Well-being Study, a U.S. urban birth cohort.	9/10 Kaiser Permanente Study ACEs (emotional and physical neglect were combined).	$\geq$ 3 ACEs more likely to have below average language and literacy skills and math skills, poor emergent literacy skills, attention problems, social problems, and aggression.
Madigan et al. (2017)	501 infants recruited in Hamilton and Toronto, Ontario, as part of the Kids, Families, Places Study.	Mother mental illness, drug/alcohol problem, father mental illness, father drug/alcohol problem, parent went to jail, non-intact family, experienced sexual abuse, experienced physical abuse, witnessed inter-parental verbal abuse, witnessed inter-parental physical abuse.	Four or more adverse childhood experiences in mothers were related to a 2-fold increased risk of biomedical risk and 5-fold increase in psychosocial risk. There was a linear association between number of adverse childhood experiences and extent of biomedical and psychosocial risk.
Racine et al. (2018)	1994 women who were recruited in pregnancy and their	10 ACEs from the Kaiser Permanente Study.	Mothers who experienced more adversity in childhood experienced more health risks in

	12-month-old infants, who were part of a prospective, longitudinal cohort.		pregnancy and, in turn, had infants who were born with more infant health risks, which were associated with poorer developmental outcomes at 12 months.
Wallander et al. (2019)	6156 diverse children from the Growing Up in New Zealand Study.	Risk exposures assessed prenatally, at 9 months and 2 years: Mothers' depression, low health, smoking, young age, single status, low education, financial stress, unemployment, receiving govt benefit; public housing. overcrowded housing; neighborhood deprivation.	Children exposed to one or more risks in the first two years of life (52.5% of sample) were significantly more likely to exhibit problem behaviors at 4.5 years. Of children exposed to 4 or more risks at all 3 ages, 44% had problem behaviors in the clinical range.
Jones et al. (2019)	68 mothers recruited during pregnancy and reassessed with their 4-month-old infants.	10 ACEs from the Kaiser Permanente Study.	Higher maternal ACE score significantly predicted shorter placental telomere length and infant autonomic stress reactivity and recovery moderated the relation between ACE score and infant stress response.
Esteves et al. (2020)	155 mothers recruited in pregnancy and infants followed 4-18 months.	10 ACEs from the Kaiser Permanente Study.	Higher maternal ACE scores were associated with shorter infant telomere length across infancy and higher infant externalizing behaviors at 18 months. In infants whose mothers reported higher ACEs, greater telomere length attrition predicted higher externalizing problems, even after accounting for maternal postnatal depression and prenatal maternal stress.

Recognition that trauma can have immediate as well as lasting impact on physical, social, emotional, and spiritual well-being (Substance Abuse and Mental Health Services Administration, SAMHSA, p. 7), the research has underscored the urgent need to accelerate focus on preventing all types of early adverse experiences, as well as developing interventions that mitigate effects in young children already exposed. *Trauma-informed care* describes approaches that can be incorporated into programs, organizations, and systems that reflect an understanding of the impact of trauma. Trauma-informed care recognizes the signs and symptoms of trauma that may manifest in clients, families, staff, and others involved in the system, responds by integrating such knowledge into policies, procedures, and practices, and seeks to prevent re-traumatization (SAMHSA, p. 9). This does not mean that all programs must diagnose and treat trauma; however, using trauma-informed approaches can result in more effective services to clients. In addition, there is a growing number of evidence-based, trauma-specific assessment and treatment interventions

to address problems in specific populations (for examples see SAMHSA's evidence-based resource center, https://www.samhsa.gov/ebp-resource-center; National Child Traumatic Stress Network, nctsn.org; Centers for Disease Control and Prevention, https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/resources.html).

As a result of the burgeoning ACE and trauma-related research, a number of states are undertaking broad educational efforts and developing partnerships and collaborations to develop, connect and align resources across health, mental health, educational, child welfare, legal/juvenile justice, and legislative arenas (for examples, see case studies at https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/resources.html).

LOUISIANA'S EDUCATION & ADVOCACY EFFORTS

The Louisiana ACE Initiative began in 2014 as a group of organizations striving to increase communication and education about ACEs. Comprising agencies representing child health and mental health, welfare, advocacy, child abuse prevention, education and research institutions, and nonprofits, the initiative's mission is to serve as a "catalyst for efforts to recognize, prevent, and address the impact of adverse childhood experiences on children and families" via encouragement of research, education, family and community engagement, and advocacy (ACE Initiative Bylaws, 2016).

The Louisiana ACE Educator Program was created in 2015 through a partnership between the Louisiana Department of Health's Bureau of Family Health and the Tulane Institute of Infant and Early Childhood Mental Health, with support of the Louisiana ACE Initiative. Since the initial ACE Interface® (2015) training in September 2015 until this survey was undertaken in Spring/Summer 2018, more than 50 ACE Educators (professionals across sectors including juvenile justice, education, social work, child welfare, and health) had given presentations to more than 4,000 Louisianans. As a result of these efforts, Louisiana is experiencing a rapid increase in ACE knowledge and activities, yet there does not exist a full understanding of the impact of those activities.

The Louisiana Early Trauma Task Force (ETTF) was developed in 2016 to identify needs and propose solutions to bridge the multiple systems in Louisiana working with young children and families who may have experienced trauma. The purpose of the task force is to develop a model of collaboration to help meet the needs of children who have experienced adversity and trauma statewide. The model will be disseminated nationally and can be used as a framework for meeting the needs of young children around the country who have experienced trauma. The Task Force is led by Paula D. Zeanah, PhD, RN of the University of Louisiana, Lafayette and ETTN partners Amy Dickson, PsyD and Joy D. Osofsky, PhD of LSU Health Sciences Center, and Julie Larrieu, PhD and Charles Zeanah, MD of Tulane University.

It is important to note that evidence-based approaches for preventing and addressing the effects of ACEs and other trauma are still developing (Forman-Hoffman et al., 2013a; Forman-Hoffman et al., 2013b; Georgetown University Center for Child and Human Development, National Technical Center for Children's Mental Health, http://gucchdtacenter.georgetown.edu/TraumaInformedCare/Module8.html), but a number of evidence-based treatments have been identified (National Child Traumatic Stress Network, nctsn.org; California Evidence-Based Clearinghouse for Child Welfare, https://www.cebc4cw.org/registry/topic-areas). In Louisiana, a number of efforts have sought to build mental health professionals' skills in evidence-based practices that address trauma in children and families, including Child-Parent Psychotherapy (Lieberman, Ghosh-Ippen, & Van Horn, 2015; Ghosh-Ippen, Toth, Manly, & Lieberman, 2018), Trauma-Focused Cognitive Behavior Therapy for Preschoolers

(Scheeringa, 2016), Parent-Child Interaction Therapy (Eyberg, 2008); Triple-P Parenting (Nowak & Heinrichs, 2008), Attachment and Bio-Behavioral Catch-up (ABC, Dozier & Bernard, 2017); Cognitive Behavioral Therapy In Schools (CBITS, Jaycox, Langley & Hoover, 2018); Trust-Based Relational Intervention (TBRI, Purvis, Cross, Dansereau & Parris, 2013); and Circle of Security (Marvin, Cooper, Hoffman & Powell, 2002). Given the efforts in ACE education and advocacy and dissemination of trauma-informed treatment approaches, we were interested in assessing the current state of knowledge, activities and efforts in Louisiana.

PURPOSE OF STUDY

Using a broad, cross-sector online survey and key informant interviews, the *Awareness, Activities and Approaches for Addressing ACEs* sought to assess the penetration of ACE education and trauma-informed approaches in Louisiana.

We addressed the following specific questions:

1. What is the saturation of ACEs education and awareness in Louisiana?
2. What are trauma-informed prevention and intervention activities in Louisiana, including research and advocacy?
3. What are gaps and needs for ACE education and prevention and intervention activities?

In this report, the approaches and findings of this study are presented in separate sections. Section 2 describes the methods and findings of the Cross-Sector Online Survey; Section 3 describes the methods and findings of key informant interviews; Section 4 summarizes the overall findings of this study, provides a snapshot of recent activities, and makes recommendations for sustainability and growth in ACE-related prevention and intervention activities. Appendix A includes a summary of Evidence-Based Trauma-Informed Therapies for Young Children available in Louisiana and Appendix B outlines Resources for Services and Activities in Louisiana.

This report can serve as a resource to inform and facilitate communication, collaboration, and coordination of ACE and trauma-related education, prevention, research, and advocacy in Louisiana.

SECTION 2

CROSS-SECTOR ONLINE SURVEY

Methods

Sample

Members of the ACE Initiative and Early Trauma Treatment Task Force, along with University of Louisiana Picard Center/College of Nursing staff and faculty, created a purposive sample, targeting potential participants representing the sectors of health and mental health, early care and education, primary and secondary education, child welfare, juvenile justice, law enforcement, community education and support services, parent education and home visiting programs, child and family advocates, legislators, clergy and religious community, and ACE educators. This list included but was not limited to individuals who participated in various educational programs related to ACEs or trauma-informed interventions. The initial list was augmented by recommendations of participants to identify additional qualified participants (snowball or chain sampling). Purposive and snowball sampling are not considered scientifically drawn or necessarily representative of the target population (Noy, 2008). However, when the target population is such a small proportion of any usable sampling frame that it becomes unlikely to randomly draw qualified participants, purposive techniques become the best possible alternative, especially in primarily qualitative projects (Palinkas et al., 2015). Our goal was for the survey to reach at least 500 professionals.

Measures

A two-part online survey, based on a similar survey conducted by Forstadt and Rains (2011), was developed to capture a wide range of activities and perspectives of ACE-related activities and efforts across Louisiana (Andrews, Forstadt, Hood, & Rains, 2016). Part 1 of the survey focused on ACE knowledge, needs, perspectives, and recommendations, and was aimed at a wide range of professionals who serve children and families and were interested and invested in addressing ACEs in Louisiana. Several branching questions allowed the most information to be obtained with the fewest questions. First, respondents were simply asked if they were ACEs knowledgeable. If the respondent did not know ACEs, they were directed to the end of the survey to complete questions answered by everyone – demographic, geographic, and attitude measures. The second major branch involved their area of work (direct service providers; program and agency administrators; community education and advocacy professionals; university faculty and researchers). Sets of questions were designed specifically for each type of potential respondent. After the service specific questions, all respondents were directed to the general questions at the end of Part 1. Anonymity of responses was maintained in Part 1. The measure was piloted with approximately 10 respondents and edits were made for clarity. The average completion time was less than 12 minutes.

After completing Part 1, respondents were invited to participate in Part 2 of the survey, which requested respondents to share information about their programs or activities that could be incorporated into a resource map for ACE and trauma-related services in Louisiana. If the participants agreed and were authorized to provide public information, they were redirected to a separate survey disconnected from Part 1. Information gathered from Part 1 and Part 2 were not linked.

Solicitation of Participation and Distribution of the Survey

Identified individuals were notified by an informative email and asked to participate in the survey. In addition, email notifications about the survey were sent to leaders in state agencies including the Office of Public Health Bureau of Family Health, Office of Behavioral Health, Department of Education,

Department of Children and Family Services, and Office of Juvenile Justice, with the request that they distribute the survey to appropriate professionals within their programs. A link to the survey was included in the initial email requests. To increase the number of respondents, initial participants were asked to pass on the survey to others engaged in ACE activities. This "snowball" approach maintains a purposive model and increases the likelihood of wider inclusiveness of the respondent pool (Biernacki & Waldorf, 1981). Within 10 days of the initial email request, a reminder email was sent to those who had not responded. We planned for the data collection to be completed within one month, but because the snowball approach successfully increased participation, the survey period was extended an additional two weeks. A combination of survey security system, filtering questions, and email filtering reduced the redundant responses. Because we did not know exactly how many potential participants received the survey, we do not know the return rate. The team anticipated 500 respondents and received 981, suggesting strong interest in the subject matter.

Consent, Confidentiality, and Security

UL Lafayette served as the primary approving IRB for this project, and IRB approvals also were obtained from the LSU Health Sciences Center, Tulane School of Medicine, and the Louisiana Office of Public Health. The email invitation to participate in the study provided information about the IRB approvals and confidentiality. Specifically, potential participants were notified that responses to Part 1 of the survey were anonymous and confidential. At the end of Part 1, survey respondents were asked if they were willing to provide contact information about their agency or service for the purpose of resource development (Part 2). If the respondent agreed, agency or personal contact information was collected in a separate survey. A combination of survey security system, filtering questions, and email filtering reduced the redundant responses.

Data Analysis

Initial descriptive data from the survey were provided by Survey Monkey with additional data manipulation and visualization using Excel (Microsoft Office365). Based on information collected in Part 2 (public information), the organizational data was developed as a resource directory (Appendix B).

Results

Sample Description

Of the 981 professionals initially responding to the survey, nine actively declined to participate, and 44 dropped from the survey before answering the first question, leaving a total of 928 respondents who provided at least some information. All respondents were asked if and how they first learned about ACEs. As shown in Figure 1, 77% of participants had some knowledge of ACEs. The respondents learned about ACEs from a variety of sources, primarily work-related in-service education or professional programs specifically on ACEs (45%), professional communications such as journals or newsletters (9.4%), and community

Figure 1. How did you first learn about ACEs?

education programs (3.6%). Only a few learned through mass media (1.3%), and 5.8% could not recall the initial source of information. Fewer than 10% of respondents indicated they learned about ACEs through other means, including graduate or college classes and research, work-related programs and professional conferences. Only 1% had heard of ACEs from conversations with professional colleagues or from an email. In comments, several respondents stated they had learned of ACEs on their own, from Facebook, or from previous work experience, including experiences working with Dr. Anda or Dr. Felitti. We do not know how many of these respondents participated in the ACE Interface educational programs. Notably, 215 (23%) of respondents indicated they did not know about ACEs. Therefore, to ensure that those answering survey questions were similarly informed about ACEs (vs, for example, an informal knowledge of childhood adversity), those who did not know about ACEs at all were skipped to the demographic questions placed at the end of the survey.

Similarly, when asked specifically if they knew about the original Kaiser Permanente ACE study, fewer than half said they were familiar with it (45%, N=412). Those who did not know about the original ACE study were skipped from the questions specifically about the study but were included in all subsequent questions.

Demographic characteristics of the sample. Questions about the demographic, geographic, and professional characteristics of the sample were available for all to answer at the end of the survey. Although the ACE survey sampling procedure did not presume a demographically representative sample, we wanted to determine how close the penetration of ACE knowledge reflected the demographics of Louisiana. As shown in Table 2, respondents represented every region of the state, and by comparison, the percent of respondents from each region roughly paralleled the percent of Louisiana's population in each region.

Table 2. Survey Participants by Region in Louisiana

Region	% Responses	% of State Population
1: Greater New Orleans Region	27.0%	19%
2: Capital Area Region	13.2%	15%
3: Houma/Thibodeaux Region	6.3%	9%
4: Acadiana Region	13.4%	12%
5: Lake Charles Area Region	10.9%	6%
6: Alexandria Region	8.8%	7%
7: Shreveport/Bossier Region	7.4%	12%
8: Monroe Region	9.0%	8%
9: Northshore Region	13.1%	12%
10: Statewide (not identified as working within a particular region)	7.72%	N/A

Similarly, the race/ethnicity of respondents was similar to that of Louisiana, as shown in Table 3.

Table 3. Race/Ethnicity of Survey Respondents

Race/ethnicity	Survey Respondents	Louisiana Residents (Suburban Stats 2018)
Caucasian/non-Hispanic white	68%	62%
African American	28%	32%
Hispanic/Latino	3 %	4%
Asian	1%	1%
Other	2.8%	1%

Together, these findings indicate that the survey respondents were roughly representative of statewide demographics, with some over-representation of respondents from the New Orleans and Lake Charles regions, and some under-representation from the Houma/Thibodeaux and Shreveport/Bossier regions.

Professional representation of respondents. Given the emphasis on ACE education efforts across the state, we wanted to assess the types of professionals and service types that have received the education. The findings presented in Table 4 suggest that health and mental health professionals have been the most frequent recipients of ACE-related education.

Table 4. Professional Disciplines Represented

Profession	N	% of Sample
Social work	222	33.3%
Nursing	151	20.6%
Psychologists/Licensed Professional Counselors	66	9.0%
Teacher/Early care provider	63	8%
Physician	25	3.4%
Business	17	2.3%
Law enforcement	12	1.6%
Faith-based	8	1.0%
Other	168	22.9%

Over 20% of respondents identified as “other.” Self-identifications of professional discipline included public health and health education, law and juvenile probation, family and client advocacy including Court Appointed Special Advocate (CASA), early child care and education, K-12 educators and administrators, clerical and program administrators, university professors and researchers, graduate students, nonprofit agencies and funders, as well as dietitians/nutritionists, pharmacists, media and communications professionals, librarians, coroner’s office professional, cancer support, substance abuse and behavioral health professionals, as well as retired professionals and volunteers. The low percentage of physicians, business, law enforcement, education, and faith-based respondents likely reflects survey distribution and also suggests these are service groups that may benefit from more ACE educational development.

As shown in Table 5, professionals who provide direct health and mental health services to children and families, and infant and early childhood home visiting and consultation professionals, made up more than 55% of those who responded. In addition, 25% of the respondents served in administrative roles, and 14%

served in community advocacy roles and presumably were in positions to effect change in their programs, organizations and communities.

Table 5. Respondents by Service Type

Service Type	Responses%	N (643)
Direct Health or Mental Health Services	28.46%	183
Administration/Management	25.35%	163
Advocacy/Community Education/Support	14.31%	92
Home Visiting	12.60%	81
Consultation	10.11%	65
PreK-12 Teacher/Provider	4.04%	26
University/Medical School Faculty	3.73%	24
Researcher	1.4%	9

Clients served. As shown in Table 6, the professionals responding to this survey served primarily children and families. Vulnerable populations served included foster families, LGBTQ, and military families.

Table 6. Clients Served by Age & Specialized Population

Answer Choices	Responses (%)	N (718)
Preschool (ages 3-4)	60.03%	431
High School (ages 14-18)	60.03%	431
Infants (ages 0-2)	58.08%	417
Families	57.24%	411
Middle School (ages 9-13)	55.29%	397
Primary Grades (ages 5-8)	53.48%	384
Parents/Expecting Parents	51.25%	368
Foster Families	38.72%	278
Adults Not in College	37.05%	266
College (18+)	33.70%	242
LGBTQ	26.32%	189
Service Members/Family	20.89%	150

General Knowledge of ACEs and Impact on Work Activities

Of those respondents who indicated they had at least some knowledge of ACEs, we wanted to know how they rated their level of knowledge as well as their impression of the importance of ACE information. Slightly more than half of respondents indicated they had basic, introductory knowledge (40%) or that they were aware of the research findings but did not know how to apply the knowledge (14.8%). Another 31% rated themselves as having a good grasp of the information and were beginning to apply the research, and 14% indicated they had strong knowledge which they regularly applied to their work. The vast majority of respondents felt the ACEs information is important to their own work (85.4%), to other similar professionals (87.5%), and the information is useful for the general public (81.1%).

ACE and Trauma-Informed Prevention and Intervention Activities in Specific Service Sectors

Given that different service sectors may use or incorporate ACE-related information and activities in different ways, we wanted to get a better understanding of the efforts and challenges of professionals representing various service sectors. Questions directed to specific service sectors were only completed

by those who identified with the sector, including direct service providers, administrators, community advocates, university faculty, and researchers.

Direct service providers, supervisors and consultants. We combined the responses of direct service providers (e.g., nurses, social workers, physicians, early childcare providers), supervisors, home visitors, and consultants in order to get a perspective from those who provide face-to-face services to children and families. As shown in Table 7, respondents reported engaging in services that included screening and referral (most common) to medical observation and interventions, psychotherapy, and community education. Involvement with the legal/justice systems and research were lowest rated, but this likely reflects the professional orientation of the respondents. Some respondents provided more than one type of service, so the total percentage is greater than 100%. In comments, several respondents added other activities, including education for prevention of child sexual abuse, nutrition education, maternal child health education, educational classroom observations, and past history of being a foster parent.

Table 7. ACE-Related Activities by Direct Service Providers

Answer Choices	Responses (%)	N (322)
Referral for health or mental health assessment or intervention	62.73%	202
Screening for trauma or stress	54.04%	174
Education about impact of adversity/trauma/stress to clients/families	50.31%	162
Intervention (e.g., therapy, consultation, skill-building)	48.14%	155
Support resilience factors (e.g., self-esteem, choices, empowerment, aspirations, etc.)	42.24%	136
Education/training for professionals	31.37%	101
Formal assessment for trauma, stress, or adversity	27.33%	88
Education/training for community members	18.63%	60
Medical/observation/intervention	17.39%	56
Trauma-informed classroom policies or practices	9.63%	31
Legal/justice/public safety	5.28%	17
Other	4.97%	16
Research or program evaluation (related to ACEs or trauma)	2.17%	7

Direct service respondents identified a number of benefits to providing ACE-informed services for children and families, including increased self-awareness/personal improvement (65.3%), increased willingness of clients to obtain needed services or support (48.2%), and improved relationships with other providers or service agencies (40.3%). Comments in the "other" category included consumers gaining increased understanding of the relationship between ACEs and primary health care, better DCFS (child protection) outcomes, and diagnosing Developmental Trauma Disorder (DTD). Only 10% indicated there were no benefits to providing ACE-related services, but no comments were made by those who made this choice.

Service providers identified barriers to providing ACE-related services both for clients as well as for themselves. As shown in Table 8, some barriers were similar for clients and providers: lack of resources and referral options, and lack of knowledge about what to do. Resistance to change, discomfort when being asked about ACEs, and logistical issues or difficulty accessing services were rated as more problematic for clients, and paperwork was rated as more problematic for professionals.

Table 8. Barriers to Providing ACE-related Services Identified by Direct Service Providers

Barrier	For Clients	For Service Providers	Total Respondents
Resources (time, money, staff)	69.76% 143	69.76% 143	205
Lack of referral sources	74.03% 134	62.43% 113	181
Lack of knowledge/know-how	64.42% 105	68.71% 112	163
Resistance to change	74.47% 117	50.33% 77	153
Discomfort when asking ACE questions	68.63% 70	54.90% 56	102
Paperwork/documentation	38.95% 37	83.16% 79	95
Logistical issues (transportation, access)	70.21% 66	57.45% 54	94
None	73.44% 47	62.50% 40	64

Mental health providers. Of the overall group of 322 direct service providers, 305 participants endorsed that they provide some type of mental health services. Of these, 92 identified as mental health professionals who provide trauma-specific care to children and families. As seen in Figure 2, the mental health professionals provide an array of general psychotherapy aimed at individuals and families, with Cognitive Behavioral Therapy (CBT) and family therapy being most common.

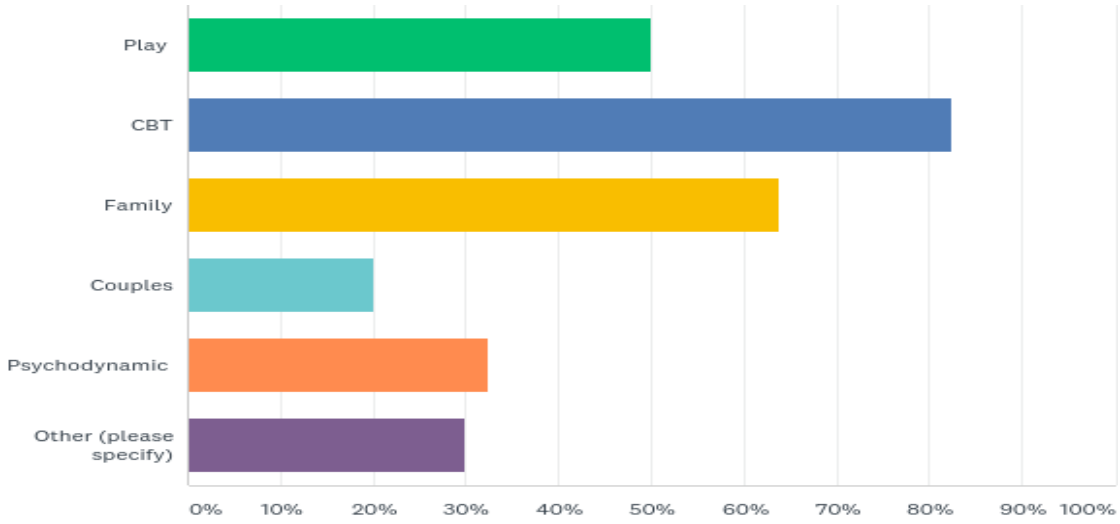

Figure 2. General Psychotherapy Approaches Provided by Mental Health Professionals

In addition to the general types of therapy listed, some respondents noted that they provided group therapy, Christian counseling, substance abuse counseling, school counseling, person-centered therapy, Acceptance and Commitment Therapy (ACT), solution-focused therapy, anthetic therapy, Eye Movement

Desensitization and Reprocessing (EMDR) therapy, motivational interviewing, mindfulness, and case management.

These treatments and approaches are often used or integrated into treatment of child behavioral or parent-child problems, but they are not necessarily specifically aimed at the unique needs of young children and their parents who have been affected by trauma. We next asked mental health professionals to rate their experiences with several trauma-focused, evidence-based therapies (EBT's) aimed at children age six years and below (Table 9). Each of the therapies listed in Table 8 requires specialized training of varying intensity, and training for most of the listed EBT's is available in Louisiana (for more information on these therapies, see Appendix A.) If the respondent had no training or experience with a particular therapy, they could skip these questions; some respondents may be trained in more than one EBT.

Table 9. Experience, Confidence, and Use of Evidence-Based Therapies (N=74)

Type of Therapy	Some Training	Completed Training	Confidence	Frequent Use
Attachment and Biobehavioral Catch-Up (ABC)	5	6	4	1
Child-Parent Psychotherapy (CPP)	12	12	10	5
Circle of Security (Parent Education)	8	8	12	6
Circle of Security (Therapy)	4	2	3	1
Cognitive Behavioral Therapy in Schools (CBITS)	10	12	16	10
Parent-Child Interaction Therapy (PCIT)	20	13	14	10
Trauma-Focused CBT (TF-CBT)	18	39	44	17
Triple-P Parenting	4	7	5	1
Trust-Based Relational Intervention (TBRI)	10	1	4	5

As can be seen, few of the respondents indicated they had completed these specialized trainings. Trauma-Focused CBT (TF-CBT; N=57) had the highest numbers of some or completed training, followed by Parent-Child Interaction Therapy (PCIT; N=33), Cognitive Behavioral Therapy in Schools (CBITS; N=22), and Child-Parent Psychotherapy (CPP; N=24).

Mental health professionals also were given the opportunity to describe the types of knowledge, training, skills, perspectives and theoretical frameworks they found most useful for working with children and families impacted by trauma, and respondents provided a wide range of approaches. In addition to the trauma-focused approaches listed in this survey, they included, more generally, cognitive behavioral therapy, individual and group therapy, art and play therapies, and skill and solution-based approaches , as well as specific therapies including EMDR, the Nurturing Parenting Program, short-term psychodynamic therapy, and dialectical behavior therapy (DBT). Strengths-based perspectives, knowledge about brain development, attachment theory, positive parenting and relationship-focused methods, family systems and family development, mentalization and mindfulness were identified as useful content areas for trauma-focused clinical work. A number of respondents recognized the need for better knowledge of ACEs and complex trauma when working with children and families affected by trauma.

Finally, these mental health professionals were asked what additional tools, skills, information and resources would help them better serve children. Again, we received a range of comments. Training, or additional training, in specific therapies including EMDR, CBT, TBRI, Theraplay, PCIT, TF-CBT, Circle of

Security, Conscious Discipline, and Functional Family Therapy were identified most frequently. Additionally, respondents included therapies that are "less deficit focused and more resilience focused," parenting classes and training for parents who have experienced trauma; more trauma-focused treatments ("all that you listed"); training on brain development; refresher and review courses; and art therapy and play therapy training. Several respondents stated "more resources" are needed such as parenting classes, after school programs and programs to use in school for K-4 students; direct services for opioid treatment and medication management; wrap-around services; more training in diagnosis of trauma-related conditions including complex trauma, chronic trauma, and psychosis. The mental health professionals also advocated for better collaboration between agencies, and the need for "all teachers, early child development, school counselors, mental health counselors" to be trained in ACEs and trauma-informed practices.

Overall, the responses of the mental health professionals suggested that they encounter and work with children and families exposed to trauma, but the level of skills and experience, especially with evidence-based therapies aimed at young children, are limited. Therapeutic approaches most likely reflect professional orientation, opportunities for learning and refining skills with EBT's, and priorities and limitations within the service setting.

Administrators, program managers, agency directors. We wanted to know how administrators perceived the import, activities, benefits and challenges of ACE-related information for their program or agency. Of the 144 administrator respondents, 74.2% indicated that understanding the effects of ACEs was essential or important (22.4%). Administrators endorsed a number of ACE and trauma-related services provided by their programs, including direct services (86.5%), advocacy (80.6%), education for professionals (79.6%), community education (76.2%), research or program evaluation (66.2%), and spiritual support (61.7%). Administrators also identified benefits to providing ACE-related services and activities, shown on Table 10.

Table 10. Administrators' Perceptions of the Benefits of Providing ACE-Related Services & Activities

ANSWER CHOICES	RESPONSES	
Better staff development	74.31%	107
Incorporation of trauma-informed approaches	71.53%	103
Improved services/outcomes	81.25%	117
Improved coordination and collaboration with other agencies, services, and organizations	64.58%	93
Improved relations with clients	71.53%	103
Other (please specify)	2.78%	4
Total Respondents: 144		

In their comments, one administrator stated he/she was aware of research about ACEs but had not yet implemented any changes; another commented that ACEs "forces the work to primary prevention."

As shown in Table 11, the administrators endorsed barriers to developing and implementing ACE-related services. While a number of barriers were endorsed, there was more agreement about benefits than barriers. Lack of information about impact of ACEs and how to respond were the highest rated barriers. Consistent with the high value placed on the importance of ACE education, lack of programmatic fit and other activities being higher priority were among the lowest rated, though still substantial, barriers. Additional barriers included lack of agency capacity to treat trauma, especially with non-English speaking

clients or those who do not have insurance. One administrator noted a need for a "no excuses" attitude to get the work accomplished, and a couple of others noted they were not sure of advantages or barriers.

Table 11. Barriers to Developing & Implementing Services as Identified by Administrators

ANSWER CHOICES	RESPONSES	
Lack of information about the impact of trauma or ACEs	57.64%	83
Lack of clarity about how to respond	51.39%	74
Implementation costs/funding, sustainability	47.22%	68
Lack of support for staff (education/training, consultation, supervision, space)	43.06%	62
Lack of staff	38.19%	55
Resistance to change	37.50%	54
Other activities are more urgent/higher priorities	31.25%	45
Collaboration or coordination challenges	28.47%	41
Perception of lack of "fit" with organizational values or activities	26.39%	38
Other (please specify)	4.86%	7
Total Respondents: 144		

Advocacy and community development professionals. As community investment and connectedness are considered core approaches for addressing ACEs (ACE Interface, 2015; Hall, Porter, L., Longhi, D., Becker-Green, J., & Dreyfus, S., 2012; Wilkins, Tsao, Hertz, Davis, & Klevens, 2014), we asked professionals who identified their role primarily as providing community education, advocacy, or support (N=92) about their perceptions of community readiness for ACE education. Although we did not ask how they assessed readiness, it appears that many believe their communities have at least some interest or willingness to learn about ACEs and very few felt there was little or no interest (Figure 3, below).

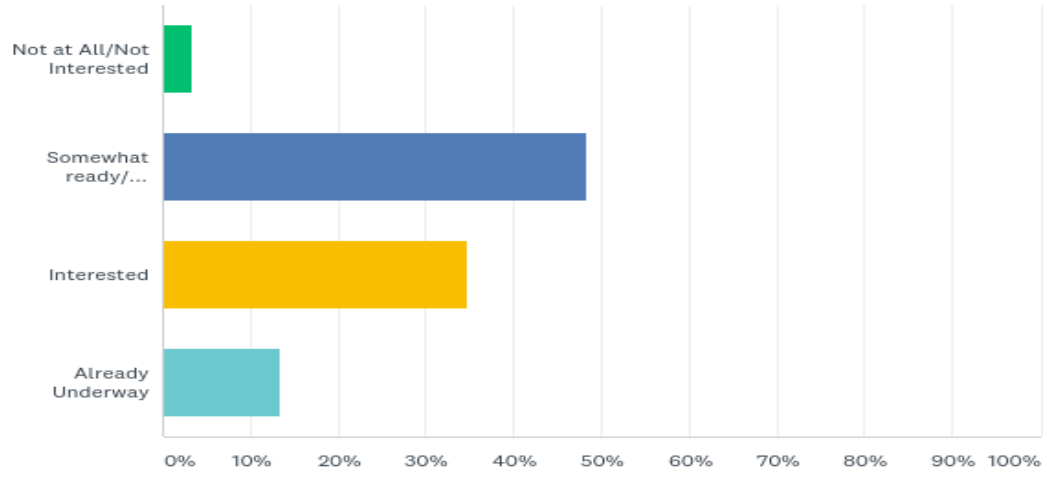

Figure 3. Advocates' Perceptions of Community Readiness for ACE Education

Advocates perceived there could be a number of benefits for communities regarding ACE education, ranging from better recognition of the impact of trauma on community health and the potential for breaking cycles of violence and illness to increased support for preventive health efforts and decreased costs of services (Table 12). Respondents commented that there could be many positive effects, better recognition of the impact of trauma on children's behaviors, and policy changes.

Table 12. Community Development Professionals' Perceived Benefits of Communities from ACE Education

ANSWER CHOICES	RESPONSES	
Better understanding of impact of trauma and ACEs on community health	74.44%	67
Breaking the cycles of violence and illness	71.11%	64
Increased support for preventative community health efforts	57.78%	52
Improved health and mental health	53.33%	48
Increased capacity of the "village" to care about all community members	40.00%	36
Safer neighborhoods	30.00%	27
Decreased costs of intensive health, social, and educational services	21.11%	19
Other (please specify)	3.33%	3
Total Respondents: 90		

Similar to other groups of respondents, barriers identified by community professionals included lack of knowledge about ACEs (71.1%), lack of funding and community resources (each at 52.2%), lack of clarity about how to address ACEs at the community level (35.6%), other issues with higher priority (31.1%) and perceived lack of fit with community needs or values (23.3%). One respondent commented "people struggle to think in terms of systems and how individual actions contribute to systemic changes."

University and medical school educators and researchers. In addition to professional development and community education, we were also interested in determining if ACE education is included in pre-professional or graduate educational programs. Given the survey approach, we did not reach a large number of university or medical school faculty. Of those that did respond (N=24), most (70%) reported regularly incorporating ACE-related content into their courses, and 25% indicated they included the content sometimes. Goals for this education ranged from a basic introduction of ACEs to preparing students with sufficient knowledge to work with clients/families, systems and communities to address ACEs (Table 13).

Table 13. ACE Education Goals of University Educators

ANSWER CHOICES	RESPONSES	
Introductory knowledge of impact of trauma/ACEs on children/families	60.87%	14
Prepare students/learners with sufficient working knowledge/skills to identify the impact of trauma/ACEs on children/families	69.57%	16
Prepare students/learners with sufficient knowledge and skills to assess and treat the impact of ACEs/trauma on children/families	52.17%	12
Prepare students/learners with sufficient knowledge to collaborate with other professionals in the prevention and amelioration of ACEs/trauma on children and families within systems and communities	47.83%	11
Other (please specify)	13.04%	3
Total Respondents: 23		

Three comments highlighted additional, broader goals for the incorporation of ACE information into course content: increased understanding of ACEs in the general public, making the world a safer and more loving place, and "to educate any and all people about the importance of childhood experiences."

Few researchers participated in this survey, a limitation of the sampling approach, and the responses suggest there is limited research currently underway in Louisiana regarding ACEs, though there are plans for research across all of the listed priorities (Table 14).

Table 14. Current & Planned ACE-Related Research

Research Priorities	CurrentResearch	Planned Research
Identification and screening approaches for trauma	1	2
Development/implementation of resources for children and families	2	1
Development/implementation of assessment and treatment approaches	0	3
Prevalence of ACEs in specific populations	0	2
Outcome studies	1	3
Cost-effectiveness studies	0	2

There were no additional suggestions or comments about research needs or activities. We asked both educators and researchers about their specific needs and resources related to ACEs and trauma. As shown in Table 15, the strongest need is for educators and researchers to be knowledgeable about ACEs (84%); while the majority indicated that resources are available (71%), availability of appropriate training was the lowest rated need (54.8%). Notably, most indicated they had networked with other ACE-informed professionals (80.65%).

Table 15. Resources Needed for University Educators & Researchers

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Educators/researchers need to be knowledgeable.	0.00% 0	3.23% 1	12.90% 4	19.5% 6	64.52% 20	31
I am confident that I can incorporate content in my courses or research.	3.23% 1	9.68% 3	19.35% 6	25.81% 8	41.94% 13	31
I feel I have the time to incorporate content.	6.45% 2	9.68% 3	19.35% 6	32.26% 10	32.26% 10	31
I have networked with ACE-informed professionals.	3.23% 1	6.45% 2	9.68% 3	32.26% 10	48.39% 15	31
Resources are available.	0.00% 0	3.23% 1	25.81% 8	35.48% 11	35.48% 11	31
Appropriate training is available.	9.68% 3	3.23% 1	32.26% 10	22.58% 7	32.26% 10	31

Perceived Needs and Priorities for Future Development of ACE Resources and Activities

We asked all respondents about what they perceived as needs and priorities for future development of ACE-related prevention and interventions. First, we asked about the general resources and support that would be most useful in providing trauma and ACE-related services. Using a forced choice format, respondents could choose as many of the choices as they felt applicable. As shown in Table 16, there was

Table 16. Resources & Support Perceived as Most Useful to Provide Trauma- and ACE-Related Services

ANSWER CHOICES	RESPONSES	
Staff development/training in evidence-based practices	62.14%	320
Partnerships with other agencies/programs/organizations	51.55%	317
Funding	53.98%	278
Incorporate trauma-informed approaches or programming	53.59%	276
Trauma-informed policies	45.83%	236
Reflective supervision/consultation	31.65%	163
Evaluation of services	31.65%	163
Other (please specify)	7.38%	38
Total Respondents: 515		

strong interest in additional training/education regarding ACEs, as well as partnerships for collaboration with other agencies/professionals. Evaluation of services and reflective supervision and consultation were the least frequently endorsed, but still captured almost a third of respondents. Respondents added a number of other ideas that reflected training/education as well as service needs: more ACE and trauma-related education focusing on neurobiology of trauma and impact on adults; more mental health providers in general and those with specialized evidence-based training; more time; better assessment procedures and protocols for assessing ACEs; expanding ACEs to include other forms of trauma, and increased awareness of community resources.

Next, we asked what specific types of tools, materials, or strategies would be useful for developing or implementing the improvements based on the previous question. Again, respondents were asked to check all that they felt would be helpful (Table 17). While educational materials were most frequently endorsed, respondents recognized the need for a wide range of information, data, and policy support.

Table 17. Priorities for ACE Resource Development

ANSWER CHOICES	RESPONSES	
Educational materials for professionals (e.g., PowerPoint, videos, handouts, etc.)	68.71%	358
Educational materials for families and communities (e.g., PowerPoint, videos, handouts, etc.)	68.14%	355
Ideas on how to launch and sustain services	55.47%	289
Data for my community regarding trauma or ACEs	54.32%	283
Web-based resources for statewide ACE-related services and activities	52.21%	272
Summaries of evidence-based prevention or intervention approaches	46.45%	242
Policy/legislative briefs	35.12%	183
N/A	4.99%	26
Total Respondents: 521		

Finally, given the many ways to address ACEs and limited resources, we asked respondents to identify their top three priorities. As shown in Table 18, approximately half the respondents ranked trauma-informed approaches in schools, education for professionals, and prevention services as highest priorities. Interestingly, better research and data on ACEs and trauma for children and adults in Louisiana was rated lowest among the choices offered.

Table 18. Priorities for ACE-Related Approaches

ANSWER CHOICES	RESPONSES	
Trauma-informed approaches in schools	51.92%	271
Education for providers/professionals	51.34%	268
Prevention services (e.g., home-visiting, parent education, etc.)	48.66%	254
Education for communities	41.38%	216
Trauma-informed approaches in child welfare/juvenile justice	39.85%	208
Better resources to address basic needs (e.g., housing, food, transportation)	37.55%	196
Trauma-informed approaches for mental health services	32.38%	169
Trauma-informed approaches for healthcare services	23.75%	124
Improved interagency communication/collaboration	21.46%	112
Better research/data on ACEs and trauma for children and adults in Louisiana	13.79%	72
Other (please specify)	2.87%	15
Total Respondents: 522		

In comments, some respondents stated all listed resources were needed, and that it was too hard to prioritize. Others added priorities including getting parents more involved, education (about ACEs) for anyone receiving services, more referral services and more "qualified" professionals, including more compassion in services. Emphasis was also placed on the need for trauma-informed services in schools, funding, including ability to better address basic needs; and continued education and data to inform program decisions and policy.

SUMMARY OF SURVEY RESULTS

This is the first known state-wide survey conducted in Louisiana to assess ACE awareness, education and practices among a broad cross-sector of professionals. The survey was designed to answer three questions: (a) What is the saturation of ACEs education and awareness in Louisiana? (b) What are the trauma-informed prevention and intervention activities in Louisiana, including research and advocacy? and, (c) What are gaps and needs for ACE education and prevention and intervention activities?

The number and quickness of responses to the survey demonstrated a strong interest in the topic of ACEs. Using targeted purposive and snowballing sampling, the goal for this research was to yield 500 responses from professionals. The actual number of responses was nearly double the goal, with 981 individuals responding. Although the sampling technique was not targeted to a representative sample, the participants generally reflected the demographic and geographic characteristics of the population of Louisiana. Similarly, the representation of professional groups within the participants was similar to group membership within the state. Important to understanding the current state of ACEs in Louisiana, information was received from every region of the state and from most disciplines that conduct ACE-related work.

In terms of ACE education and awareness in Louisiana, participants strongly endorsed the importance of ACE knowledge for both professionals and communities. However, when describing themselves, the respondents reported varying degrees of knowledge and ability to confidently apply their knowledge and the research to their work.

Among the various service sector groups, there were both unique and common activities reported. With respect to trauma-informed prevention and intervention activities in Louisiana, participants identifying as

direct service providers most commonly cited screening and referral. However, this sector also was involved in community education, medical interventions, and therapy. Mental health professionals reported the use of a wide variety of approaches to address trauma; most frequently reported included Cognitive Behavioral Therapy (CBT), family therapy, and play therapy. It is important to note that these widely used therapies may or may not focus specifically on trauma symptoms. As there have been a number of efforts to provide training in trauma-focused, evidence-based therapies for young children and their caregivers in Louisiana, mental health professionals also were asked to rate their experiences with several trauma-focused, evidence-based therapies (EBT's) aimed at children age six years and below. Notably, few mental health professionals had completed training or acknowledged significant experience or confidence when using trauma-focused evidence-based therapies for young children. Of those therapies, most frequently used were Trauma-Focused CBT, Parent-Child Interaction Therapy, Cognitive Behavioral Therapy in Schools, and Child-Parent Psychotherapy. Across mental health and other direct service providers, there was great interest in gaining more skills and knowledge in trauma-informed assessment and treatment approaches.

The majority of the participants from the administrator service sector strongly endorsed the importance of understanding the effect of ACEs was essential or important to their programs. Collectively, they reported their programs were engaged in a variety of ACE and trauma-related activities including direct service, education for professionals and communities, research, program evaluation, spiritual support and advocacy.

Participants identifying primarily as advocacy or community development professionals reported providing education and support in their advocacy activities. They perhaps have the most direct knowledge of community readiness and engagement. Nearly 80% of the respondents reported their communities were interested or engaged in ACE-related activities.

Because the number of university and medical school educators and researchers participating in the survey was limited, the information shared by these two groups needs to be considered through this narrow lens. However, nearly all responding educators reported incorporating ACE-related content in their courses, with majority doing so on a regular basis. Similarly, based on the reports of a small sub-sample of respondents, there is limited research currently underway in Louisiana regarding ACEs.

The third overarching question in the survey was identifying the gaps, needs, and priorities for ACE education and prevention and intervention activities. All respondents were asked to identify the top three priorities to address ACEs and trauma in Louisiana's children and families. The three most frequently endorsed top priorities included trauma-informed approaches in schools, education for providers/professionals, prevention services (such as home visiting), and education for communities. Participants reported that specific trauma-informed approaches were needed in every child-serving system, as well as the need to address basic needs such as housing and food. Although deemed important, the lowest priorities were for trauma-informed health care services, improved inter-agency collaboration and communication, and better research on ACEs/trauma in Louisiana. Comments, however, suggested that respondents often had difficulty choosing the top three, and some indicated "all are important." Specific priorities for resource development included staff development/training in evidence-based practices, partnerships with other agencies/organizations, funding, incorporating trauma-informed approaches or programming, developing trauma-informed policies, reflective supervision/consultation, and evaluation of services. Given that respondents from all service sectors rated trauma-informed services in schools and prevention services in the top three priorities suggests that there is recognition of the importance of development of services and resources across systems and levels of intervention.

There is a clear interest in developing ACE awareness and activities within the state of Louisiana. Results from the survey suggest major considerations in moving forward should include expansion of awareness of ACEs, not only within service sectors, but also to the general public; increased opportunities for additional training in trauma-related approaches; additional support and resource development; collaborative partnerships at multiple levels; and expansion of screening activities.

The results from the survey provide a broad overview of what is known and needed related to ACEs in Louisiana from the perspective of a sample of those individuals working directly or indirectly with people affected by ACEs. To deepen the knowledge about the state of ACE-related awareness, activities and initiatives in Louisiana, key informant interviews were conducted with 20 identified leaders from across the state representing a range of service-sectors. Their unique perspectives contribute to an expanded understanding of the strengths and areas of opportunities in developing and improving a response to ACEs. Section 3 of this report focuses on their experiences.

SECTION 3

KEY INFORMANT INTERVIEWS

While the survey gave us a broad perspective of the penetration of ACE knowledge and activities in Louisiana, we wanted to gain a deeper knowledge and understanding of the impact of ACE education on services, needs, and activities in child and family-serving sectors. Thus, we conducted key informant interviews with local and state leaders across Louisiana.

Methods

Sample

Approximately 25 individuals were identified, based on their recognition and reputation as ACE thought leaders and advocates, as potential key informants by the members of the ACE Initiative and Early Trauma Treatment Taskforce, along with Picard/College of Nursing staff and faculty. We sought representation from all 9 regions of the state, and leaders in health, mental health, public health, education, community advocacy, child protection, and juvenile justice. The initial group of potential interviewees was contacted by an informative email explaining the project and requesting their participation. They were informed that the interviews would be recorded and would not be confidential; once they responded to the email and agreed to participate, a time was determined to conduct the interview via a web-based meeting program (www.gotomeeting.com) that allowed voice recording of the interviews. During the interviews, some of the interviewees suggested other key individuals engaged in implementing/promoting ACE training and screening within their communities or agencies, and they were also invited to participate. In total, 20 interviews were conducted from May 1, 2018 through September 14, 2018 (Table 19).

Interview Instrument. A semi-structured interview was developed by the authors with questions intended to gain a deeper understanding of the ACE-related activities taking place across the state. We elicited leaders' perspectives on the challenges, resources needed, and important partners and stakeholders that could enable incorporation of ACE and trauma prevention and intervention. The interviews were conducted by two of the primary authors of this report, Dr. Jeanne Cartier and Dr. Paula Zeanah. Each interview lasted approximately one hour. All interviews were voice recorded. The recordings were transcribed and returned to the interviewees to allow for checking of accuracy and editing.

Analysis. Analysis of key informant interviews provided a qualitative dimension to research findings. Content analysis of each interview was conducted by each author separately, and included evaluation of consistent issues, themes, and perceptions that are relevant to ACE education and trauma-informed practices.

Table 19. Key Informants

Name	Region	Sector
Gina Bergeron, LCSW-BACS Executive Director Family Resource Center for Region 3 (Lafourche, Terrebonne, St. Mary, Assumption and Lower St. Martin parishes).	3	Social Services
Dr. James Bueche Deputy Secretary, Office of Juvenile Justice	Statewide	Juvenile Justice
Sue Catchings Administrator at Our Lady of the Lake Children's Hospital responsible for school health programs serving 90 schools in East Baton Rouge parish including seven school-based health centers, mobile medical	2	School-based health

and mental health units for 10 schools, and the school nurse program.		
Paulette Carter, MPH, LCSW President and CEO of the Children's Bureau of New Orleans, a community mental health program.	1	Child mental health
Lynn Clark, PhD Executive Director of the Children's Coalition for Northeast Louisiana	8	Community development and advocacy
Tammy DiBartolo Outreach Youth Services Coordinator for Rapides Parish Library. The parish library system has 10 library branches.	6	Community library services
Judge Blair Edwards District Judge/Juvenile Judge of the 21st Judicial District serving Tangipahoa, Livingston, St. Helena Parishes	9	Juvenile justice
Mary Margaret Gleason, MD Professor of Psychiatry and Pediatrics, Tulane University School of Medicine	1 and 4	Child Psychiatry and Pediatrics
Stewart Gordon, MD Chief Medical Officer, Louisiana Health Care Connection	Statewide	Pediatrics, Medicaid Care Organization
Rhenda Hodnett, LCSW Assistant Secretary for Department of Children and Family Services, Division of Child Welfare	Statewide	Child welfare
Madeleine Landrieu Dean, College of Law, Loyola University, New Orleans	1	Law, Higher education
Judge David Matlock **Chief Judge, Caddo Parish Juvenile Court**	7	Child welfare and Juvenile justice
Ron McClain, LCSW, JD Executive Director, Institute of Mental Hygiene, a philanthropic organization targeting Orleans parish	1	Child mental health, philanthropy
Hollis Milton Superintendent, West Feliciana Parish Schools	9	Education
Betty Muller, MD Behavioral Health Medical Director AmeriHealth Caritas Louisiana	Statewide	Child Psychiatry/Medicaid Care Organization
Anthony Recasner, PhD Chief Executive Officer, Agenda for Children, a child advocacy organization and provider of technical assistance and training for publicly funded early learning programs across Southeast Louisiana	Statewide	Advocacy
Kristin Savicki, PhD Lead for Children's Clinical Systems Team within the Office of Behavioral Health (OBH)	Statewide	Child mental health
Tina Stefanski, MD Office of Public Health Regional Medical Director	4	Public health
Clay Walker, J.D. Director of Juvenile Services, Caddo Parish	7	Juvenile justice
Amy Zapata, MPH Director, Bureau of Family Health, Louisiana Department of Health, Office of Public Health	Statewide	Public health

Results

We present select responses from each interviewee focused on the following areas: how they learned about ACEs, how learning about ACEs has impacted their work, identification of barriers, resources and priorities in their individual programs or communities, and identification of the key stakeholders to further the integration of ACEs into their organizations and/or communities. These responses reflect the range of experiences, insights, and concerns from the key informants.

On First Hearing About ACEs

All of the key informants were familiar with ACEs, though some had been familiar for years, and for others, the information was more recent. Most had received ACE training through professional development activities, several had attended presentations by Dr. Felitti and/or Dr. Anda, and others were familiar through other means:

> **OJJ Deputy Secretary Bueche**: "…as far as trauma-informed care, that's been in the realm of juvenile justice for a couple of years… the ACE information for me, it has really been probably within the last six, eight months."
>
> **Mary Margaret Gleason, MD**: "Sometime in residency—2003ish. Fifteen years ago."
>
> **Ron McClain, Institute of Mental Hygiene:** "It's been almost four years. When I came {to IMH}…Vince Felitti… gave the presentation about ACEs at our annual meeting…It was such a wonderful presentation; it really opened my eyes as to a lot of things…I was familiar with how children…through child abuse, both physical and sexual and other issues were … negatively impacted, but I didn't understand how important it was to respond early on….The thing that really hit me and still resonates with me is the impact on morbidity and mortality in terms of somebody has some adverse childhood experiences that could result in maybe living twenty to twenty-five year less than somebody who didn't."
>
> **Tammy DiBartolo, Outreach, Rapides Library**: "I've read a lot about the way you were brought up affects stuff through your whole life, but I probably didn't put a name to it until the first cohort training {for the ACE Education program} in 2015."

However, the impact of the information was not necessarily immediate:

> **Lynn Clark, NE LA Children's Coalition**: "I grew up {in California} a Kaiser kid, so I knew about the ACE study years ago...but I didn't realize how it could be applied until we started to function as a Family Resource Center. …and really began to understand the epigenetics at a deeper level and… I think when it really hit me was when I saw the impact on our constituents."

On the Impact on Work/Aha Moments

For many of those interviewed, learning about ACEs provided clarity and better understanding of the children and families served:

> **Sue Catchings, School Health Administrator**: "Oh, it absolutely impacted my work, and it's still impacting my work, and it's still impacting the people that work with me. So, when

> I first learned about ACEs… it was the cascade of 'Oh my gosh this is what we didn't know. This is the piece of information that none of us really had our arms around."
>
> **Judge Blair Edwards**: "It tremendously impacted my work. It's changed the way that I rule on cases…because I'm more or less trying to get rehabilitation plans whether it's for families or for juveniles so it has changed the way I view an entire case…It changes the way that attorneys have reacted, it changes the way the caseworkers have reacted."
>
> **Superintendent Hollis Milton**: "{It} …it's common sense, you know… some kids are going to come to school with things in their backpack that are just huge that we as adults struggle with. But sometimes it's just so easy to forget about that because of all the pressures and having so many kids and responsibilities but you've got to know who those kids are and find strategic ways to meet their needs or they're gonna fall through the cracks..."
>
> **Clay Walker, J.D., Caddo Parish** "I was just blown away, I was just paralyzed with the amount of information that I wanted to know after I just got that one-hour talk…it was the science behind the kids I'd been working with for twelve years. I applied and was part of the first {Louisiana ACE educator} cohort with Dr. Anda in Alexandria…It was the beginning of changing everything we do in Caddo Juvenile Court. It became, obviously way more focused on trauma, ACEs, prevention, understanding what's going on behind."

For other key informants, the ACE data confirmed or reinforced what they already knew about children and families:

> **OJJ Deputy Secretary Bueche**: "I've been working in this field since '91 …it's sad to see those kids come through knowing that they didn't really have a chance, and this puts some validation on the years I've seen these kids with issues and problems. They are so young and have so many negative type behaviors that it just kind of validates that it was somewhat not their fault…."
>
> **Paulette Carter, Children's Bureau NOLA** "…. the data and the research…back up everything we're doing so mostly it was just kind of like, 'Wow, we knew this.'"
>
> **Mary Margaret Gleason, MD**: "It wasn't so much an 'aha' moment as much as exciting…here was at least some amount of data that supported this idea that early experiences matter and that physical and mental health go together…also…beginning to talk about experiences rather than symptoms in conversations with families can feel easier to them. …ACEs has been really important from a practical perspective in those conversations."
>
> **Betty Muller, MD**: "It was not so much 'aha' but it confirmed everything we learned in psychology/psychiatry about the importance of early childhood rearing, safe environment, trauma, interpersonal relationships, how critically important these are for not just personality development but for long-term welfare."
>
> **Tony Recasner, Agenda for Children**: "….having come to Agenda [after working] in charter schools, it really did give me a lot of insight into the experiences that we had over

> twenty years with children and their families as related to the behavior that the children were exhibiting in the schools….It increased my level of awareness of the impact of these traumatic events, and the new knowledge to me was that the behavior was influenced by the number of traumatic experiences that children were exposed to…what I found is once they {educators} had formal knowledge or theories about what has happened it transformed their responses and it also helped them to organize different approaches to working with kids."
>
> **Kristin Savicki, Children's Systems, OBH** "…it went along with the standard…psychological research in that it puts numbers to things we know already, which is incredibly helpful…it put data and a systematic understanding to a phenomenon that I had really seen all the time in my clinical work. That was a very useful framework for understanding 'Oh, okay, this is what I'm seeing, this is where this is coming from and this really makes sense.'"

For others, the ACE information stimulated new ways of addressing challenging health and social situations:

> **Gina Bergeron, Family Resource Center Region 3**: "I think there were lots of aha moments simply because of the different forums in which we work to educate families and to include how their histories impact their families and their parenting styles. Families had some idea about how their personal histories affected parenting but as far as long-term effects on health, I think that was something new that we were able to bring to families and they really felt a sense of, "Wow, I own this, and I can really change the trajectory of my child's medical health.'"
>
> **Tammy DiBartolo, Outreach, Rapides Library**: "It's when you think about instead of saying to a child, 'What's wrong with you?' say 'What happened to you?'"
>
> **DCFS Assistant Secretary Rhenda Hodnett**: "I remember thinking, can this possibly be legit and how is there not a public outcry….what are the implications of understanding a parent's trauma history in terms of the way they relate to their children…an overwhelming sense this is important information…we need to move forward in some way as a state and in smaller segments of the population as well in trying to figure out the best use of this information and how…we apply it."
>
> **Tina Stefanski**, **MD:** "…It just further made me realize that we're not going to be able to change physical and mental health until we kind of get to some of these root causes and address them…it's the realization that we can keep treating and referring but unless we really try to get to the root problem, we probably won't change behaviors and…won't really get much better outcomes."

On Incorporating into Work

Key informants incorporate ACE education, prevention, and intervention activities into their work in a variety of ways, ranging from staff education and adapting services to incorporation into community and state systems.

In Community Health, Social Services, and Philanthropic Programs:

Gina Bergeron, Family Resource Center Region 3: "It's taught in... our Nurturing Parenting program…now it's incorporated through handouts and sometimes it may be the entire focus of a session, especially if a family is currently still experiencing some ongoing trauma or toxic stress."

Ly**nn Clark, NE LA Children's Coalition**: "One of the things that we are doing organization-wide is trauma-informed care training and that looks different depending on the programs….we're really trying to take a trauma-informed approach in all of our direct service programs…we are training our parents and all who support parents…also DCFS workers…and foster parents…so that we're all speaking the same language and they understand how it fits into mandated parenting …ACE has been so powerful for our families who are mandated to do parenting…we want to create a magnet for families to come for non-mandated parenting classes…so we have Super Saturdays on the third Saturday of the month…in our garden-based environment….we're trying to cluster great resources {in the garden} around the idea of adverse childhood experiences."

Tammy DiBartolo, Outreach, Rapides Library: "It…made me more aware of not to be preachy about it, like try to put myself in their position…I think that means a lot. Because I think these people get told constantly by people in positions of power…how to raise your kid, how to spend your money, those kinds of things…maybe we could come at it on a different level…try to find a place to meet them on their level…I've done (training) here at the library for staff, for foster parents. We haven't done anything {yet} to build resiliency."

Ron McClain, Institute of Mental Hygiene: "Just the urgency to do early intervention and prevention and to recognize the long-term negative impact of some experiences that children have early on has redoubled our commitment to early intervention and prevention, in fact, our board has decided that some forty percent of the grant making in each of our funding cycles should go to early childhood education….We've also partnered with United Way to launch a grade level campaign."

Betty Muller, MD: "{We are} trying to get two or three evidence-based practices, two in particular for the 0-5 year population that would address trauma (Preschool PTSD and Child-Parent Psychotherapy) and possibly Parent-Child Interaction Therapy and Triple-P Parenting…all five of the Medicaid Care Organizations {MCOs}have been on once monthly meetings, LDH {Louisiana Department of Health}has participated…now we're working on fidelity of the models, how we measure and monitor for fidelity, and then eventually, hopefully we'll get a Medicaid specific code for each of these evidence-based practices so that there can be enhanced rates for anybody who's been trained, has certification and then uses them."

Tina Stefanski, **MD:** "I think it has led to more interest in trying to get to these children to offer good psychological/psychiatric care. So, I do think it definitely supported, it reinforced, our interest in doing the child psych clinic/mental health unit. And, I think the understanding through Project Launch that we have very few providers in our community

who see young children who are trained in ACEs, in trauma, recognizing that has…led to …a social worker with the health unit."

In Education and Educational Settings:

Tony Recasner, Agenda for Children,: "…there were faculty members {at previous school} who were really strong child advocates…and they were typically considered the adults with the strong personalities or most even temperament….but it seemed when those adults became aware of {ACE }information, they said, 'Huh, it's not because I'm the tallest, meanest, toughest, most sensitive. It's because I had some early experiences that I can identify with {the children}…it turned their thinking from punishment as a consequence to create opportunities to receive counseling or to be engaged in more problem-solving behaviors…it turned into a set of positive interventions…they {the faculty} were aware at a personal and intellectual level that these kids were not being bad for the sake of being bad…they felt their opinions were {as a result of the ACE training} based in fact…many of those individuals {faculty} are now perceived as sort of experts…their peers look and listen to them differently..."

Ron McClain, **Institute of Mental Hygiene**: "We funded a restorative (justice) approach…an evidence-based process where discipline is administered by bringing together perpetrator and victim to create empathy and restitution… at one of the charter schools…to help the school sites respond to children in a way that doesn't re-traumatize them…and is responsive to and understanding about ACEs."

Sue Catchings, School Health Administrator: "The Louisiana Chapter of the American Academy of Pediatrics (AAP) received a small grant from the AAP and we trained more than 200 physicians and school-based health professionals in Baton Rouge, Alexandria, Shreveport, and New Orleans in ACEs…Westdale Middle School's principal has put trauma-informed care into place and they have a cool-down room…they will not suspend or expel kids…it's had a very calming effect…they are changing the dynamic…I'm very interested in picking some more schools and….help them understand how to do trauma-informed care."

Paulette Carter, Children's Bureau of NOLA: "We are part of the trauma-informed collaborative for schools here in New Orleans…to look at practices and policies through a trauma-informed lens so that there's work with the leadership but also professional development for all the staff…consultation and how both education and mental health can work together to support the child and build resilience...what we're seeing is the teachers are really excited to learn this information but if they're in a school...that is not using trauma-informed care, their attitude about implementing {such care} becomes more negative…it doesn't do any good just to train staff, you need to have leadership involved as well."

In Juvenile Justice:

OJJ Deputy Secretary Bueche: "…one of the things it really made me look at is how we move kids through the system… being more individualized…trying to build on the positives and use those positives to move them through…."

Judge Blair Edwards: "We have truly become a trauma-informed court…I guess trying to figure out what happened to them rather than what they did…I have developed a packet with ACEs {information}, a very simplistic packet and resources. I keep them in the bench and give them to parents and children…I send {staff} to seminars, send them notifications….I do trainings—at the Bar Association, in hospitals, school boards…I'm dedicated to doing in the community where(ever) I can go."

Clay Walker, JD, Caddo Parish: "So starting from ACE training, it's now part of our professional development for detention staff, probation staff. It's annual training for all of our staff. It's on the agenda to become professional development for our school system. …I just did an ACE training from central office, the staff that runs Caddo schools…We have made several changes to our detention center….we removed all weaponry from our detention center…We're teaching kids to regulate their own emotions, we're trying to teach them de-escalation… trying to deal with their ACEs rather than just using more abusive techniques, that is what they are used to."

In Child Welfare:

DCFS Assistant Secretary Rhenda Hodnett: "We do a trauma screening for all youth who are being served in our in-home or foster care programs; the screening was developed as part of Children's Bureau's five-year grant in collaboration with Tulane Child Psychiatry…free training and consultation in trauma-focused CBT for our providers...but there was not an overwhelming number of clinicians who took advantage of it…{we are in} partnership with Office of Behavioral Health and Medicaid providers…to do much better in terms of identifying the trauma history for these kids and being able to provide more appropriate treatment...we're just not there."

Dean Madeleine Landrieu: "…It impacted both my legal work and as an extension of legal work, my non-profit work working with foster care kids. It caused me to pull the trigger on that non-profit to make it actually happen…and what it did for judges…they use trauma informed language of 'What's going on with you? How can I help?'…it is transforming the way judges see people who appear before them…I am on the board of Covenant House and I've been using this ACE work in our board meetings. ...And I have presented to my board on the ACE research and it changes the way our staff interacts with our homeless youth."

In Medicaid Care Organizations (MCOs):

Stewart Gordon, MD: "The idea is to prevent kids from being medicated when it may be better to address what is going on in the household."

Betty Muller, MD: "There's already a big push with the Medicaid health plan to provide or to really look at integrated care…an expectation that physical health and behavioral health could co-exist side by side but that the ultimate plan was that they would be handled simultaneously…There's formal training for the associates within AmeriHealth, the staff within AmeriHealth, but for providers, no, there is not yet formal training. "

In Statewide Efforts:

> **Mary Margaret Gleason**, **MD:** "….part of promoting the use of the SEEK (Safe Environment for Every Kid) {screening tool used by pediatric health care providers} means that they have to learn how to deal with it {adversity, social determinants of health}…we talk about how to talk about a family or child's exposure to adversity…from more of a policy and business perspective, I think the ACEs are packaged in a way that can give people those 'aha' moments. And the idea that there are lifelong implications of these early experiences can be really helpful in educating pediatricians, educating policy people on the systems side who use the language of ACEs…."
>
> **Kristin Savicki, Children's Systems, OBH**: "Not directly. I would say it informs a lot of the work that we do…..And I think an understanding of the trauma-based roots of difficult situations and behaviors later in life definitely informed our conversations on a daily basis and formed the kind of advocacy we do….believing the importance of supporting caregivers to be able to provide safe and warm caregiving environments for kids."
>
> **Amy Zapata, Bureau of Family Health**: "What I think it did was really emphasize we could do a lot of good things and a lot of good helpful things that are meaningful, but I think if we are really trying to impact the health trajectory of somebody and of families under the state it really has shifted…that focus on the early childhood period….a concrete example is sustaining support for the infant mental health consultants who are supporting the home visiting teams…at a community level, Project LAUNCH…{we want to} replicate within every region of the state."

On the Barriers and Challenges

> **Gina Bergeron, Family Resources Center Region 3**: "I do feel like our community has multiple resources, we are lucky….I think the major barrier to accessing those resources is transportation. For most of these parishes we cover, there's no public transportation. …And you can have all the best resources, but if people can't get to it they can't access it, they can't improve…In my opinion, we need more home visitation programs. I think that would 100% help those other barriers…money, funding. Definitely more public funding, that would certainly help, I think, access to more group services."
>
> **OJJ Deputy Secretary Bueche**: "…I think the facilities, the physical part of our facilities, are so old and outdated and not conducive to the programs and stuff we are trying to provide….That's the biggest thing from my perspective, the physical part of it…" (this comment is in reference to the poor conditions of juvenile justice facilities that serve children who have experienced significant adversity, and the negative impact the facilities have on providing services).
>
> **Paulette Carter, Children's Bureau NOLA**: "A lot of the families that we're working with, the parents have had multiple exposures, the children have had multiple exposures so it's like, how do we intervene to prevent that cycle from repeating?"
>
> **Sue Catchings, School Health Administrator**: "I think the biggest problem…is we have school systems in this state that are all about zero tolerance. That language needs to go

away. That language needs to be taken out and we need to start talking about how do we help these kids overcome some of their problems and the anger that they feel because what's happening to them that the school may or may not know. So, I think we need to change the language of our school systems. That's not going to be easy because they are married to this notion of zero tolerance."

Tammy DiBartolo, Outreach, Rapides Library: "There's a big stigma about it if we don't talk about it, it doesn't exist…a lot of them {people in the community} don't want to know things like this are going on or people feel this way so it's a little bit harder to break through….in specific pockets of the parish."

Judge Blair Edwards: "Just the people in general, you know, people not wanting to really accept people for what they are, people want quick fix you know, they think incarceration is the answer for everything, and those are things I can't change. I think education is the key to change. I think another barrier is, it's one thing to have the information and education and it's another thing to have the resources to treat."

Mary Margaret Gleason, MD: "I think as a state, there's been more and more attention to children, which is great, but… there's a woefully insufficient access to any kind of mental health care for children…I think a huge part of prevention is about taking care of mothers beginning prenatally, and I think we do an abysmal job of that….the other challenge for women with substance abuse disorders and young children is…on paper we're told they go to the front of the line...the front of the line is a shorter wait, but the window for motivation for change doesn't stay open necessarily for a long time…so, being at the front of the line with the door closed doesn't really give them better access…they often have very limited support systems and so to go into residential treatment without their child means they have to find someone who can take care of their child while they are in treatment, and that has been one of the barriers we've seen."

Stewart Gordon, MD: "I think initially it is a lack of knowledge…but the challenge is once you {know} you're obligated to do something about it because it pretty easy to identify that there's been an issue. ….it may change our approach a little…One of the challenges is to get folks at this level to comprehend this world of ACEs. The reason I had gotten (social workers) trained was.... I wanted the case managers and social workers…to potentially incorporate the ACEs screen into our assessments….I would like pediatricians to use it in their practice for parents but I don't want to use it if they don't have a resource for parents to turn to after they've identified something."

DCFS Assistant Secretary Rhenda Hodnett: "So I think in my organization the biggest barrier has just been capacity, human capacity. We have lost a tremendous number {of staff} just through cuts in our agency and our turnover rate…we are putting a tremendous amount of effort in stabilizing the workforce and recruiting. Another area is that we simply do not have enough foster families for the kids that we're needing to serve…On a community level, much more education will be valuable."

Dean Madeline Landrieu: "I think the barriers are all related to funding. If I had funding, long-term funding, I would build a curriculum around it. But if I only have one year of

funding, it's like you can't lean forward enough. I could do a certificate program out of the law school on trauma.

Ron McClain, Institute of Mental Hygiene: "I'm going to use the answer to one of the questions posed to Dr. Felitti, 'One of the more effective strategies has to deal with parenting and building the capacity of parents to respond appropriately to their children and also to be aware of the impacts of these experiences with children'. So, I think for me one response has to be working with young people even before they become parents …and this is in the prevention arena to help them understand how important it is to bond appropriately with your children and to avoid some of these adverse childhood experiences. I think one barrier is not nearly enough efforts to engage parents to help them understand what is going on with their children but also helps them to become more civically engaged so that they can advocate within school systems and health systems for a more user-friendly environment for their children."

Betty Muller, MD: "Well, I think there are two barriers. I think one is everyone is consumed with results now, that I need to take care of this problem now whether it be physical health or behavioral health and they're not oftentimes thinking much into the future about what else needs to be in place for this to be successful. At the MCO level…there is a lot more thought about …those members who are at risk of becoming high utilizers… {of } emergency room and inpatient inpatient facilities…what do we need to put into place for continued and future care to really make them the healthiest they can be so they're not, I hate to say this… costing a lot of money."

Tony Recasner, Agenda for Children: "A lot of schools are poorly resourced, they cannot pay for services…but I think they're motivated enough that if they knew more they would do more…the availability of trainers…cost…the need for a more coordinated effort to touch more programs on an annual basis."

Kristin Savicki, **Children's Systems, OBH**: "One simple answer is funding.…A sort of world view issue, I think, is that even if folks have shifted their view about kids, you know, cute little kids who are acting badly because of adverse childhood experiences; it's harder to shift views towards caregivers….to prevent ACEs in kids we need to help caregivers, we need to help parents be able to deal with the stress and the issues in their own lives, deal with mental health and substance abuse concerns, fight poverty, all of these things will help caregivers actually be able to provide safe and warm environments for the kids. That can be a tough sell because there's not a whole lot of sympathy towards caregivers…and the funding for that kind of approach is tricky, the preventative approach.

Tina Stefanski, MD: "Poverty. We have a lot of domestic violence. I think we have a lot of social issues that need to be addressed. Natural disasters, those are some of the things that make it hard to prevent. And then of course, funding… and maybe a lack of will to coordinate. And…awareness of… and physician training…and nurse training and nurse practitioner training…better reimbursement for some of this screening and probably addressing some of these in the primary care setting would be helpful."

Clay Walker, JD, Caddo Parish: "The barriers are DCFS is underfunded. My take on it right now with DCFS is that when they are able to open a case, they do very good work. Their

> funding barriers are such that they don't open many cases…Number two, the school system is so caught up in fighting its own fight for survival—standardized testing, new standards, new court tier one curriculum stuff. ….I don't think they are well-connected to the early childhood community. I think that they, juvenile justice, early childhood and school systems are obvious partners, but they're not partners."
>
> **Amy Zapata, Bureau of Family Health**: "the challenges in …the language and values and accountability and time frame in various systems related to funding."

On the Resources Needed

Given the needs and challenges identified, we wanted to know what resources the key informants felt were needed. Again, the informants provided a wide range of resources at the patient/family, community, and systems levels that could be helpful, including broadening professional and community education, creating reimbursement structures that cover costs, involving parents as advocates, increased inter-agency collaboration, aligning priorities and values, and development of a statewide approach to addressing ACEs:

> **Gina Bergeron, Family Resources Center Region 3**: "…until they {at-risk mothers} learn the science behind ACEs … suddenly it's this motivating factor to end an unsafe relationship or move on to a safer relationship…but when the client says, 'Did I ruin my child?' {who was exposed to domestic violence] or 'How do I reverse this.?'…we need to incorporate resilience into our teaching."
>
> **OJJ Deputy Secretary Bueche**: "….At the community base level as far as re-entry goes and even keeping them out of our care, having more mental health services in the community is a priority, is a big void that we have right now…smaller case-loads for our probation and parole staff, {so} that they'd be able to work a lot more with these kids….Expansion of in-home programs, we used to do some prevention and diversion type stuff. It'd be nice to get back to doing that again… It just takes money and resources to be able to get out there and do it."
>
> **Sue Catchings**, School health administrator: "So for me, we'll never have enough LCSW's because we can't turn them out fast enough…but I think there's got to be a lower level person who probably doesn't have that kind of degree but who is a caring individual who knows how to help people calm down…And parents…we need to get to the parents and talk to them about why trauma-informed care is so important. And we need to have them start going to school board members and saying, 'Why aren't we doing trauma-informed care?'
>
> **Paulette Carter, Children's Bureau NOLA**: "Certainly increase the reimbursement rate, I …take into account that there are going to be lots of failed appointments with some of these families. I think there has to be something built into the system that, you know…get paid a higher rate because the expectation is that there's going to be lots of uninsured people that access their services…..so we have to think about 'okay, what's a non-traditional system that might actually get some of these parents and children engaged?'"
>
> **Lynn Clark, NE LA Children's Coalition:** "A systems approach…so that we're all speaking the same language…(it is) validating…I take a systems approach to everything we do

here…we literally hardwired it (ACEs) in the model for the Family Resource Center…a systems approach is a powerful collective impact approach."

Judge Blair Edwards: "I think training, training our teachers. I think having our teachers being trained, not trained to be an ACE trainer but trained and aware because I think being able to identify children and their behaviors at a younger age…train your doctors."

Mary Margaret Gleason, MD: "…Since ACEs are predictors of health outcomes… it would make a lot of sense for the health system to support families to get more support around some of the more basic ACEs and some of the basic needs that families have. So that's my low hanging fruit idea for the day anyway…put a two-pronged service at the end of the power structure. One would be at the higher levels of government and making sure that they understand how important these decisions that they make are for children and long-term for the community. And then I think that insuring that people on the front line working with children, which means all the professionals but also the parents, appreciate how important these early experiences can be.

Stewart Gordon, MD: "…raising awareness…that was critical and now, we have to figure out a way to build infrastructure to address it, get everybody in tune to doing something about is as early as possible."

DCFS Assistant Secretary Rhenda Hodnett: "I guess one of the things that I would hope could maybe come out of {these discussions} is a master plan …time set aside to think about various sub-populations and how we might actually use this information to drive treatment and services in a very different way or even just understand parents and be able to engage parents in a different way….it's just getting it moved to the top of the list…Joint planning sessions, being able to sit down with people from LDH, our provider network, other related stakeholders to really think about how do we start with manageable steps."

Judge David Matlock: "It's hard work, hard work…we need to care for our caregivers, wrap around foster parents, wrap around counselors in our community…the social networks…need to just walk up and with permission just give them a hug to support, uplift, and resource these people."

Ron McClain, Institute of Mental Hygiene: "Ensure that you have a diverse group of people delivering the messages about ACEs…in terms of equity…poor people, people of color probably are definitely more impacted, and so we should have specific efforts to ensure that those groups are involved. Not only in terms of as participants as who we deliver our message to but as messengers."

Lynn Clark, NE LA Children's Coalition: "You have to be very careful of who's doing the training …depending on their background it is a completely different presentation …we tend to (match) our audience to our speakers."

Superintendent Hollis Milton: "One of the things I gotta do....is pull together all my social workers and just have…a conversation about what are we doing…what are the needs, what are we doing to respond to those needs, what are we doing well, what are some

missed opportunities... And with that what are some things we do short-term, long-term and also what are some low hanging fruit...let us meet periodically, let's put it on the calendar…continue to…do a SWOT, you know your strengths, weaknesses, opportunities, things of that nature...first step is awareness and focus."

Dean Madeleine Landrieu: "I don't think that literature helps. I just don't believe that people can pick something up and read about this-like pamphlets outside of a doctor's office. I think if we had online resources that we could direct people to it might help."

Betty Muller, MD: "Well, I think …if the providers buy into the fact that what you're doing today will have possibly a huge impact on this patient's future, they may be willing to spend a little bit more time. But it becomes a real time crisis management issue that you just don't have time in those 15 minutes to do more than what you can absolutely do, which is address the very pressing present needs. …If you can bill and get reimbursed for case management then you can have time to sit and really think about and plan, 'What does this person need now and what can we put in place that will help prevent more problems down the road if we address it now?'"

Tony Recasner, Agenda for Children: "A published schedule of when and where the trainings are going to be held so that people who have various levels of awareness could sign up for it to participate in it."

Tina Stefanski, MD: "I think provider education and as we said, also the training you know for nurses, medical students, residents; …community awareness. I think maybe prevention by community education…a clearinghouse or someone to help coordinate…get an assessment for the child…link {to trauma-informed services}."

Clay Walker, JD, Caddo Parish: "What we fail to have is any unification around early childhood, that blueprint….you need at a state level, to develop a blueprint, zero to five and it has some maternity, it has a Nurse Family Partnership, it has ACEs, it has that community. If you could develop the game plan and you can be doing the same thing at the children's youth planning board level and then connect those."

Amy Zapata, Bureau of Family Health: "Learning. Really trying to put the weight on ourselves for learning. What are the priorities for Medicaid and for those systems? How do they work? What values do they operate on? Can we try to speak to it all? … It's going to take some time and may take external advocacy too."

On the Priorities for the Future Related to ACE Awareness, Prevention and Intervention

Given the myriad challenges and resources needed, we asked key informants to prioritize efforts regarding ACE awareness and education, prevention and intervention strategies.

Gina Bergeron, Family Services Center Region 3: "…I think there's an awareness… amongst professionals but I do think that everyone would benefit from more training opportunities and training opportunities that would also focus on how to incorporate this into the work everyone does with families."

Paulette Carter, Children's Bureau NOLA: "…it's important to make sure that there is the community and whether it's the school or juvenile court or DCFS, whatever, but those systems that are interacting with our kids also understand the impact of trauma. …we use SAMHSA's Principles of Trauma-Informed Care…for organizations to think about...where are you reinforcing safety…where are you reinforcing transparency, where are you promoting collaboration and mutuality…how do you create a better sense of safety, peer support…which are all principles of trauma-informed care…and then hopefully helping them to figure out, how do you build resilience, how do you not re-traumatize, and at the same time to build resilience among children and families."

Lynn Clark, NE LA Children's Coalition: "Our goal is to foray into the community at large…make a cultural shift within our community…to shift the way people think about early childhood and parenting."

Tammy DiBartolo, Outreach, Rapides Library: "Just to keep doing what we're doing, I mean we just have to chisel away a little at a time and get the word out...giving people a reason for feeling the way they feel, I think that's a success…just giving people a reason, I think is huge."

Judge Blair Edwards: "Basically training, I think that's the key…training in the schools is huge, medical field is huge, and the court system."

DCFS Assistant Secretary Rhenda Hodnett: "Our staff, educate our staff, and they could present information to the families."

Mary Margaret Gleason, MD: "I want our state to be more than just catching up to thinking about it, but thinking about it more broadly and thinking about ACEs together and not necessarily only defined that way…the newest research is about racism {being} an important ACE...it seems likely ACEs play a role in health disparity...that's where some of the implicit bias comes in too much in terms of health care…."

Dean Madeleine Landrieu: "To start embedding this into a law school curriculum in some way because lawyers are problem-solvers and resource managers…. The second priority is to get this in the hands of every teacher in the state. Because I think of the teachers as being interveners."

Ron McClain, Agenda for Children: "When I think about education and preparing social workers and other behavioral health professionals, I think that there should be more in terms of understanding ACEs and curricula and maybe even full courses. I think there's so much that maybe there's a full three-hour course because it's so important."

Superintendent Hollis Milton: "…ACE's …may just be a conversation we need to have statewide too, for the safety of schools…we've got to build strong relationships with each kid but we also need to know a lot more about their trauma and experiences and helping them through that because we are less safe when we don't know… those experiences and we haven't built that relationship…And any support processes we can help them with some of the issues they're going through at home are going to make us safer...you do it

for the right reasons because you want to help that child….But you're also helping everybody on that campus by improving your {school} climate…"

Betty Muller, MD: "Well, I think we that we're moving in that direction actually. …They are working to become a trauma-informed environment so that all associates as well as leadership have an introduction and an appreciation of what trauma does and how you interact with people under the assumption that maybe they are exposed to trauma. …But really opening up and making available to the behavioral health providers training in some evidence-based practices in the zero to five population."

Tony Recasner, Agenda for Children: "I think there is a ready audience for this topic and I don't see any barriers to trainers getting access to school faculties, early childhood faculties and others to learn more about this. Given the lack of mental health professionals in the community, I think the more we can use ACEs to empower people by helping them to think differently about kids, I think that would be enormously helpful."

Kristin Savicki, Children's systems, OBH: "I certainly see knowledge of ACEs popping up around the state…I'm frequently pleasantly surprised when I'm talking to a judge or a legislator or someone who is not traditionally part of the mental health world. Suddenly you realize, oh the ACEs educator program and they've drunk the KoolAid, this is helpful!"

Amy Zapata, Bureau of Family Health: "…if we could identify the really tangible policy changes that could be made and package them in that way, I think that would be helpful."

On Key Stakeholders

Throughout the discussions, informants mentioned various agencies and groups that they are, or need to, work with; there seems to be great desire for better collaboration between agencies to address the needs of children and families affected by ACEs:

Gina Bergeron, Family Resources Center Region 3: "So I would definitely say the judges, the court system, mental health system, obviously the whole substance abuse system, the whole sector of services that go through the Human Services Authority and I don't know, you know, it's probably not a bad idea to get churches involved…And for them to have access to some basic information, as well."

OJJ Deputy Secretary Bueche: "We have juvenile court judges, the Louisiana Center for Children's Rights, Friends and Family of Incarcerated (FFLIC), the district attorneys, the sheriffs, they want these kids to get some help and to get some services so they won't become an adult in their communities…and create additional victims….{but} there's not that many people that really stand up and really advocate for these kids we have…it's somewhere along the lines of 'none of these kids need to go to jail,' or 'these kids need to be locked up…throw away the key...put them in prison and get them off the streets…there's not many people out there who are informed about our population…."

Tammy DiBartolo, Outreach, Rapides Library: "I think one of the things we need to do is reach more into the churches because the churches are huge parts of the community here and they have a lot to do with what happens. ...they're very involved in the community,

they have huge youth groups, huge families which they spend a lot of time and money…it's someplace that we need to look into doing more training."

Judge Blair Edwards: "The stakeholders are your hospitals…the schools and school system…"

Stewart Gordon, MD: "I think one is the people in the field but also just the state leadership at Louisiana Department of Health (LDH), Secretary Gee, the medical directors, Office of Behavioral Health, they can help drive a lot of this, especially as they're designing the next request for proposals."

DCFS Assistant Secretary Rhenda Hodnett: "LDH, provider network, universities, foster parents."

Dean Madeleine Landrieu: "I don't see a clear group of stakeholders. I think that the city keeps missing the mark on trying to curb violence. I think you curb violence by understanding trauma."

Judge David Matlock: "Let's work within our state...but let's not become too internally bred so that we're not also reaching out to Texas, Arkansas, Mississippi, you know, New York, wherever…but let's start at home and network."

Ron McClain, Institute of Mental Hygiene: "Continuing to raise awareness about it. Everybody…should be aware of ACEs and they should be aware of the implications of these experiences and how we respond to them so the more you educate folks about these things, the better it is. The educational professionals who respond to children, have them be more educated about ACEs and also parents. We have to find a way to do a better job at equipping parents to respond to experiences and more important than that, to work a creative culture at home that would make it less likely that children have these experiences."

Betty Muller, MD: "Well, the key stakeholders are us. I mean LDH, the Healthy Louisiana plan, and the behavioral health providers."

Tony Recasner, Agenda for Children: "Teachers, principals, non-profit organization, executive directors, church pastors. I would say New Orleans Police Department would be a huge beneficiary of this. And then I would say organizations in areas that are focused on juvenile justice would be huge stakeholders in this...more of this information to the court systems…And I would say social workers are a gateway…"

Kristin Savicki, **Children's Systems, OBH**: "I think it is a fairly large paradigm shift. I'd say the biggest leadership on that right now is coming from our Medicaid Department."

Tina Stefanski, **MD:** "I think the Human Service District is the key. And hopefully them with us and DCFS. I think the OPH, the Human Service District, the Office of Behavioral Health, the University. For us, it's the judicial system. The media. I'm trying to think of how you get these community messages out."

Clay Walker, JD, Caddo Parish: "I'm focused in on school by school. …I think you can make more of a difference at that local level."

Amy Zapata, Bureau of Family Health: "I think it's really at every level because if there were a greater understanding at a deeper level, in orienting the way we make policy decisions…how would that impact school suspensions or preschool suspensions or other things? I think it's a matter of how do we get deep enough and then how do we make tangible enough, actionable enough, how do we make the information actionable and not just information."

Superintendent Hollis Milton: "I do think we need to think of education as more holistic and really...look at everything holistically to decide what is in the best interest of kids overall, what leads them to be happy and healthy...basically in Louisiana we do have a more at risk population, more at-risk to experiencing some of these adverse experiences and I think we need to spend more time as a state to think about that, how can we improve that because if we can improve that, we can change a generation in their academic outcomes, in their behavioral outcomes, their healthcare, all of those things which is a win for everybody."

SUMMARY OF KEY INFORMANT INTERVIEWS

The thoughtful and diverse perspectives of the key informants provide a deeper understanding of current state ACE awareness, education, and practice initiatives across Louisiana. The rich contributions from these local leaders and advocates both confirmed and extended the data obtained through the survey. Throughout, certain themes and issues emerged regardless of the service sector or geographic location of the interviewee. Interviewees confirmed that efforts towards ACE education and intervention exist at every level---from individual and family work to programs, institutions and systems. There was a consistent recognition that more education of both the public and of professionals is needed throughout the state. Equally important was a need for more collaboration among agencies and among service providers, and the value of ACE education in fostering a language and framework for cross-systems understanding and collaboration. Although more education about ACEs is needed, there was a clear identification of a need for better knowledge and education about mental health services and especially for availability of evidence-based interventions to reduce the harmful effects of adverse experiences and to enhance resilience.

The interviews demonstrated the passionate commitment of these leaders to improving outcomes of those they serve, and the widespread, positive efforts and activities taking place to address ACEs and trauma in Louisiana. They consistently identified a number of complex barriers and priorities that impact the development and implementation of ACE-related activities. At the systems level, lack of funding and the challenge of ensuring long-term planning and commitment to the needs of children and families were high priorities. They identified the need to ensure that system-level policies and procedures do not have the effect of undoing trauma-informed efforts provided to children and families, and the need for a concerted effort to examine how implicit biases impact recognition of problems within systems. While parents were identified as a group who need more information about ACEs and to be more involved in advocating for services for their children, it was also recognized that those who deliver the message matter, specifically noting that there should be involvement of those who are impacted by ACEs not only to receive the message but to be messengers as well. Recognizing the hard work of caring for those affected by trauma, the importance of supporting and uplifting the caregiver was a point of emphasis.

These leaders clearly are sensitive to the impact of ACEs on individuals and the opportunities for their programs and systems to develop creative, community-relevant, and evidence-based approaches to ACE and trauma education, prevention and intervention. There are many good ideas, and a strong desire for collaboration and involvement across systems and across the state to make a difference. Certainly, these leaders provide hope that we can improve the short- and long-term health and social outcomes for children, families, and adults in our state.

SECTION 4

RECENT ACTIVITIES

Since this survey was undertaken in the Spring-Summer of 2018, interest in ACE and trauma-related education and activities has continued to surge across the state. Here we highlight a few of those activities:

- *ACE education has grown rapidly*. The number of ACE Educators trained though the Louisiana ACE Educator program increased from 50 to 150, and the number of individuals who have received ACE education increased from 4,000 at the outset of this project to more than 11,000. The majority of presentations have been for maternal, child, and family-serving programs, and education, community and health organizations, in that order. Possible factors affecting who decides to engage in ACE education includes the readiness for change in the sector, professional education requirements, systems and community buy-in for collaborative efforts, educator specialties, and likelihood of encountering the explicit effects of trauma in one's work. There is significant potential for targeted outreach and engagement with systems interacting with children and families, though this potential is limited by program and ACE Educator capacity. Efforts to recruit ACE Educators from under-represented sectors and communities are underway, as are efforts to tailor ACEs Education to parents who have been impacted by ACEs.

- The first statewide *ACE Summit: Creating a Culture of CARE (Collaboration, Advocacy, Research, Education) to Prevent Child Abuse and Neglect* was held in Lafayette, LA in March 2019. The Summit, supported by a grant from the Louisiana Children's Trust Fund with additional financial support from Blue Cross/Blue Shield of Louisiana, Louisiana Healthcare Connections, the Louisiana Chapter of the American Academy of Pediatrics, and Lafayette General Medical Center, was attended by more than 300 individuals from across professional disciplines and service sectors in the state. The two-day Summit featured national experts Chandra Ghosh Ippen, PhD, and Markita Mays, LCSW, from University of California San Francisco's Child Trauma Research Program, and Dr. Colleen Kraft, immediate past president of the American Academy of Pediatrics. Invited Louisiana leaders presented examples of prevention and intervention efforts taking place in public health, home visiting, schools, child welfare, juvenile justice and community settings. The highly favorable evaluations from attendees indicated a desire to learn more, an appreciation of learning about activities taking place across sectors, and an urgency to continue to build resources for children and families.

- The *Early Childhood Policy Leadership Institute* (ECPLI) is led by faculty from the Tulane Institute of Infant and Early Childhood Mental Health with support from the LA Bureau of Family Health and Zero to Three. The purpose of ECPLI is to develop a cadre of leaders who can impact and influence local and state policy affecting young children and their families. Since its inception in 2013, more than 100 state and local leaders from a variety of service sectors (e.g., judges, policymakers, legislators, state/local government, health care, higher education) have participated in this annual program. ECPLI includes nationally renowned content experts in the areas of early brain and behavioral development, child health, early experience and the roots of health disparity; understanding prevention, early intervention, and treatment of abuse, neglect, and trauma; and creating social change to promote safe, stable, nurturing relationships and environments.

- *Community efforts* to identify and address children affected by trauma are developing across the state. For example, in New Orleans, *The Children of Central City*, created by the NOLA Media group and published by the New Orleans Times Picayune, demonstrated the effects of violence and trauma on children, the challenges of providing adequate resources, and highlighted the efforts of Safe Schools NOLA to provide trauma-informed approaches in classrooms (https://www.pbs.org/filmfestival/2019-festival/children-of-central-city; http://safeschoolsnola.tulane.edu).

  Mayor LaToya Cantrell urged New Orleans to become a trauma-informed city and formed the new Office of Youth and Families to develop city-wide strategies to deal with the effects of trauma and violence (Times Picayune Editorial Board, July 21, 2018). The City Council passed resolutions for recommendations of improvements in youth mental health care and to identify funding streams to support those services, and for the Orleans Parish School Board to adopt trauma-informed practices (Webster, 2018). In October 2019, the Child Trauma Task Force of New Orleans Children & Youth Planning Board published *Called to Care: Promoting Compassionate Healing for Our Children,* a report of their recommendations for moving the city forward (https://www.nolacypb.org/called-to-care-promoting-compassionate-healing-for-our-children).

  Baton Rouge's Mayor-President Sharon Weston-Broome, as part of the Healthy City Initiative, partnered with the Louisiana ACE Educator Program and in collaboration with the Louisiana ACE Initiative to offer ACE education to interested community groups, agencies, and organization in East Baton Rouge parish. In addition, SAMHSA's Resilience in Communities After Stress and Trauma (ReCAST) grant program (https://recast.communityplatform.us/) is supporting the work of community groups to address civil unrest and widespread flooding that took place in Baton Rouge in the summer of 2016, including, among other activities, the Resiliency Summit: Moving Past Trauma, held in Baton Rouge in July, 2019.

  In Shreveport/Bossier City, an active group of professionals and citizens representing diverse service sectors embarked on a collaborative process to address ACEs. This has included ongoing awareness-raising by ACE Educators, resilience-building activities and opportunities coordinated by Step Forward and NWLA Thrive, the creation of The Calming Studio in the Caddo Parish Juvenile Court, mediation and restorative justice options for many juvenile offenders, support for foster parents, training for service providers in trauma-informed therapies such as Trust-Based Relational Intervention (TBRI), and Superintendent Lamar Goree's support for trauma-informed practices in Caddo Parish schools (for more information see https://www.stepforwardnla.org/nwlathrive/; https://www.shreveporttimes.com/story/news/2019/07/24/caddo-parish-juvenile-court-calm-room-studio/1804662001/; https://www.vyjla.org).

  In Terrebonne and Lafourche Parishes, a team of public health and children's advocacy professionals organized the Resilient Communities Conference in September 2019. The conference featured speakers from the ACE Educator Program, Caddo Parish Juvenile Services, The Governor's Children's Cabinet, Terrebonne District Attorney, and Live Healthy Houma. It addressed ACEs, juvenile justice reform, human trafficking, and promoting community resilience.

- *Agency efforts* have also expanded. Louisiana Department of Health, Bureau of Family Health provides family support and coaching using two evidence-based home visiting models: Nurse-Family Partnership and Parents as Teachers. Within these programs, home visitors are using the

NEAR@Home model (Zorrah, et al, 2015) to incorporate trauma-informed practices into their work with families. Home visitors share key discoveries from the fields of neuroscience, epigenetics, ACEs, and resilience (NEAR) with families while offering compassion, support, and validation (see https://partnersforfamilyhealth.org/family-support-coaching-services/).

Both the Tulane and LSUHSC sites of the Early Trauma Treatment Network provide training in Child-Parent Psychotherapy (CPP), an evidence-based, trauma-informed treatment for children aged birth through 5 and their caregivers. Tulane is hosting (CPP) implementation level training for infant mental health professionals (clinicians and supervisors) working in the Bureau of Family Health's home visitation programs (see above). The LSUHSC site offers the CPP implementation level training to mental health clinicians and supervisors throughout the state, currently via the Center for Evidence to Practice Center. For both the LSUHSC and Tulane programs, successful completion of training program results in rostering of mental health professionals to provide this therapy (see Appendix B for more information).

The *Center for Evidence-Based Practice*, established in July 2019, is a collaboration between LSUHSC School of Public Health, Behavioral and Community Health Sciences Program and the Louisiana Department of Health, Office of Behavioral Health. The Center's mission is "to support the state and its agencies, organizations, communities, and providers in the selection and implementation of evidence-based practices and programs to promote youth and family well-being, improve behavioral health outcomes, and to address challenges related to sustaining quality practice" (https://sph.lsuhsc.edu/service/center-for-evidence-to-practice). Though not exclusively focused on ACE and trauma-focused mental health services, the Center is an important resource for increasing access to evidence-based approaches in Louisiana.

These examples strongly demonstrate how ACE education has successfully stimulated active engagement and commitment of professionals, agencies, and communities to deepen education, prevention, and intervention efforts across Louisiana.

SECTION 5

DISCUSSION, IMPLICATIONS, AND FINAL CONSIDERATIONS

The *Awareness, Activities and Approaches for Addressing ACEs* (*AAA for ACEs)* project sought to assess the penetration of ACE education and trauma-informed approaches in Louisiana. It is fair to say that the statewide ACE educational efforts have been quite successful. ACE education was well-penetrated: respondents were representative of the racial/ethnic mix of Louisiana citizens, and served in all regions of the state roughly proportionate to the population size of each region. Similarly, respondents represented a wide range of child and family professionals including providers of direct health and mental health services, home visitors, child welfare professionals, public health professionals, administrators, consultants, community advocates, and educators. There were few respondents from physician, higher education, law enforcement, business, and faith-based communities. Due to the nature of the sampling process, we cannot confidently state that, for the regions where there seemed to be relative over-representation (greater New Orleans, Lake Charles region, and Houma/Thibodaux region) or under-representation (Shreveport area), the findings are a true reflection of ACE education penetration. Notably, the key informant interviews provided examples of ACE-related activities in under-represented sectors, including schools and juvenile justice services. For future educational or evaluation activities, it will be important to target those groups to ensure there is adequate reach into those sectors.

Almost all of the sample, 85%, rated ACE information as important to their work, and endorsed that ACE education is highly valued and relevant. Benefits included increased self-awareness and desire for personal improvement, increased client willingness to seek needed services or support as well as gaining an increased understanding of the relationship between ACEs and health care (Kalmakis & Chandler, 2015). Program administrators noted improved staff development, improved relationships with clients, and better coordination and collaboration with other agencies. Many community advocates perceived their communities were ready for ACE education and identified a range of possible positive community outcomes including better recognition of the impact of trauma on community health, the potential for breaking cycles of violence, and increased support for preventive health efforts and decreased costs of services, and policy changes. A better understanding of how ACE education affects professionals, services, and communities is needed to guide development of new and ongoing activities.

ACE-Related Services

ACE-related services were perceived to yield better diagnosis and service outcomes, including better child protection outcomes. Service providers described a wide range of services and activities that may address ACE and trauma-related issues, including screening and referral, medical observation and interventions, community education, education for prevention of child sexual abuse, nutrition education, maternal child health education, classroom observations, and being a foster parent. Agency administrators indicated their programs engage in a variety of ACE and trauma-related services including direct services, advocacy, education for professionals, community education, research and program evaluation, and spiritual support.

While results as a whole suggest there is a broad range of services availability, these approaches are not necessarily evidence-based or trauma-specific interventions. In addition, we are not able to identify resource rich or perhaps resource deficient programs. Therefore, it is difficult to plan targeted education and/or services in places where it may be needed.

Perhaps most illuminating were the responses from the subset of mental health professionals who work with young children, ages birth-6 years, and their families. Overall, the level of skills and experience, especially with evidence-based therapies aimed at young children, are limited. Fewer than half of the therapists who provided services for young children reported completed training in specialized, evidence-based treatments (EBTs), and few of those who completed the training reported confidence in using these EBTs. Remarkably, for therapies including Circle of Security Parenting, CBITS, PCIT, TF-CBT and TBRI, more respondents indicated confidence in providing the therapy than reported having completed training. It was also striking that, in general, the therapists who had received training reported they use the EBTs infrequently.

These findings are a bit startling, though perhaps not surprising, given the efforts to provide training in evidence-based therapies to mental health professionals (https://laevidencetopractice.com/about-us/updates_reports), and, as demonstrated in this survey, of the urgent need for trauma-informed therapies for Louisiana's children and families. It should be a high priority for future studies to examine why these therapies are not being completed and are not used more frequently. For example, it is possible that the duration and intensity of training is too much for professionals who may have other commitments, or there is lack of infrastructure support within an agency or program, or the professional needs ongoing guidance or supervision that is not provided due to agency time constraints or turnover in professional staff. Perhaps those trained have changed professional role or activities. A lack of confidence suggests they may not have sufficient opportunity to become proficient with the EBTs, or that they do not have sufficient refresher opportunities. This raises the question of whether ongoing support/consultation should be added after formal training is completed to help consolidate what has been learned and to provide assistance with real world applications. Furthermore, attaining the right fit between therapist, therapist's skills and therapy appropriate to the situation, and child and family acceptance, engagement, and availability are additional factors that affect success of treatment (Snowden & Yamada, 2005).

In any case, the provision of appropriate therapy for children and families exposed to trauma is essential. A recent review of treatments for children and youth under age 18 with Post-Traumatic Stress Disorder (PTSD) found several effective approaches to reducing PTSD symptoms, with a range of trauma-focused cognitive behavioral therapies being most effective. Other approaches, including cognitive therapy for PTSD, combination somatic/cognitive therapies, Child-Parent Psychotherapy, and combined trauma-focused CBT demonstrated positive effects. However, supportive therapy, parent training alone, and family therapy did not show improvement compared to wait-list controls (Mavranezouli et al., 2019). While the ACE survey did not specifically address treatment for PTSD, this new study underscores that sometimes, something is not better than nothing. Our study provides one basis for recognizing the availability of current resources and direction for future educational and development efforts.

Barriers for ACE Education and Prevention and Intervention Activities

In addition to insufficient clinical services and trauma-informed expertise to address ACEs, agency barriers included perceptions that such services did not fit, were not a priority, or there was insufficient capacity to provide such services within the agency. Resistance to change, discomfort when being asked about ACEs, and logistical issues for access to services were identified as problematic for clients, and paperwork was rated as problematic for professionals. Certainly, champions within systems are needed; as one administrator stated, a "no-excuse" attitude was necessary to incorporate ACE and trauma-related approaches into programs. Resources for developing and integrating trauma-informed services in health, educational, and social service settings are growing rapidly (for examples, see Branson, Baetz, Horwitz, & Hoagwood, 2017; National Child Traumatic Stress Network, ntcsn.org; Child Welfare Information Gateway, childwelfare.org; Trauma and Learning Policy Initiative,

https://traumasensitiveschools.org/about-tlpi/; Center on the Developing Child, http://developingchild.harvard.edu; Centers for Disease Control and Prevention (2019a), https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm).

Similarly, community advocates identified insufficient community knowledge about ACEs, lack of clarity about how to address ACEs at the community level, other issues with higher priority, and perceived lack of fit with community needs or values as barriers to community development. Familiar challenges, such as lack of funding and community resources to support children and families (e.g., parenting classes, after school programs and programs to use in school for K-4 students; direct services for opioid treatment and medication management; wrap-around services) were identified; however, the importance of coordination and collaboration with other services and professionals was emphasized repeatedly. Future efforts should focus on identifying community needs, setting community priorities, and identifying and mobilizing community resources. Developing community resilience through built environment, socio-cultural, and economic approaches, is emerging as a strategy to address ACEs that go beyond individually oriented interventions (Pinderhughes, Davis, &Williams, 2015).

PRIORITIES AND AREAS FOR EXPANSION AND GROWTH

In addition to more and deeper professional education, and more and better mental health services, a strong priority among survey respondents and key informants was for the development of *trauma-informed approaches in schools*. Specifically, trauma-informed approaches include integrated and coordinated "whole school" approaches that encompass leadership, teacher, and staff development, policy and procedures that allow students to feel safe emotionally and physically. These holistic approaches aim to connect students to the school community, foster a shared sense of commitment to the child, and ongoing adaptation to the needs of students (Cole, Eisner, Gregory, & Ristuccia, 2013). We have noted a few examples of efforts in Louisiana to develop trauma-informed approaches in schools. However, respondents also commented that some school policies, such as the widely used and punitive "zero tolerance" discipline, is counterproductive for children who have experienced trauma, may reinforce trauma experiences, and can undermine therapeutic efforts (note that in addition, "zero tolerance" is also widely regarded as ineffective (https://supportiveschooldiscipline.org/learn/reference-guides/zero-tolerance). We believe that the development of policies and approaches that recognize and consider the impact of trauma on behavior and learning in schools should be an urgent priority in Louisiana.

This leads to one of the findings of the survey: we reached only a small number of *university and medical school faculty*. While those who responded reported they regularly or sometimes incorporate ACE-related content into their courses, it is unlikely that students in child and family-oriented undergraduate and graduate programs are consistently receiving information about ACEs, trauma-informed practice, or gaining skills that can be integrated when they enter the workforce. Similarly, few researchers participated in this survey. The lack of higher education participants is a limitation of the sampling approach. On the other hand, incorporating ACE education and research into undergraduate and graduate education, especially for disciplines that are service-oriented, should be a priority for Louisiana. Not only could such approaches increase the number of professionals ready to address the effects of trauma, Louisiana-focused research may generate data that will be useful in policy and service-delivery decisions that can help "move the needle" to enhance Louisiana's health and social outcomes (Ahmed & Palermo, 2010).

Importantly, key informants identified *parents* as a group who not only need information about ACEs but may need support in addressing their own ACE experiences to avoid the intergenerational impact of ACEs.

In addition, parents could be effective advocates for services for their children, and perhaps could be recruited as messengers and educators about ACEs. To date, the ACE education in Louisiana has been generated and led by professionals, but consideration of including a wider pool of educators could be another effective way of engaging communities. Efforts are just beginning to address ACEs and trauma-related education for parents (for examples, see the National Child Traumatic Stress Networks Center for Parent information and resources, https://www.parentcenterhub.org/national-child-traumatic-stress-network/; Zero to Three's resources on trauma and stress, https://www.zerotothree.org/early-development/trauma-and-stress; and ACEs Connection, https://www.acesconnection.com/blog/handouts-for-parents-about-aces-toxic-stress-and-resilience). However, there are few resources about how to include vulnerable parents as ACE educators. The Self-Healing Communities model (Porter, Martin & Anda, 2016) provides an evidence-based approach to engaging and developing community partners to solve problems and address intergenerational health. In any case, finding ways to communicate with parents, and to incorporate their perspectives and voices into ACE and trauma-related training, is a logical next step.

Strengthening *prevention* efforts was an area identified for additional development, but it was unclear the degree to which ACE education efforts in Louisiana have made the case for the *importance of experience in the earliest years of lif*e. Notably, several of the key informant interviewees emphasized the need for school interventions and juvenile justice reform, but there were few explicit references to the overarching importance of the prenatal period and the earliest years of life as especially promising opportunities for intervention (Knudsen, Heckman, Cameron & Shonkoff, 2006). Perinatal, infant, and early childhood home visiting programs, which promote caregiver health, parenting skills to enhance child development, access to community resources, support for family economic development, and perhaps most importantly, enhance a safe and secure parent-infant relationship, are viewed as essential components of prevention of ACEs (Centers for Disease Control, 2019b). Louisiana implements two of the 18 evidence-based models included in the federally-funded Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program (https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview). However, there remains a strong need to intensify efforts to provide more information about the short-term and long-term benefits of these and related early childhood programs in order to maximize their positive effects. There is also a compelling need to increase awareness among policy makers that for children growing up in high adversity (for example, those in child protective services), the sooner and more effectively the adversities are addressed, the quicker and fuller their recoveries are likely to be.

Respondents and key informants recognized that addressing trauma is hard work and takes a toll on professionals. Those who work with highly traumatized children and families are at increased risk for *secondary trauma and compassion fatigue* (Figley, 1995; Cocker & Joss, 2016; Zorrah et al., 2015). Recognition of the need to address these effects of "trauma work" on professionals is influencing agency and program policies and supports as well as increasing the individual's efforts at self-care, although this was not addressed in our study. Exploring and identifying best practices to support professionals and staff are needed and should be another priority as ACE education and services move ahead.

Finally, respondents demonstrated a passionate commitment to improving outcomes of those they serve. There is a strong, palpable desire for *better collaboration and communication* about needs, strategies, and resources across systems, service sectors, and communities around the Louisiana. Currently, many efforts to address ACE prevention and intervention are coming from the communities themselves, e.g., "bottom up," most of which is stimulated by the state's ACE Educator program. Unfortunately, coordination of efforts often falls short. Communities have a vested interest in their own well-being yet may not have the knowledge of "what's available." The state level often has knowledge and access to numerous resources

but may not recognize the unique concerns of a specific community. Of course, state and local partnerships may provide the most robust solution. In addition, as Porter and colleagues (2016) emphasize, shared and inclusive leadership that respects and recognizes the individual's expertise and wisdom is essential to develop self-healing communities. The response to the ACE Summit suggests there is an appetite for face-to-face meetings that enable participants to hear and learn about what is happening outside of their own communities. The coordinating and connecting role is not easy but is requisite to assuring growth of best practices and resources for ACE education, prevention, and intervention.

STRENGTHS OF THE AAA FOR ACES PROJECT

The *AAA for ACEs* project is the first statewide snapshot of ACE-related activities in Louisiana. Multi-disciplinary and multi-sector in scope and roughly representative of the population of Louisiana, the survey and key informant interviews provided an opportunity to give voice to a wide range of professionals who are deeply concerned about preventing and ameliorating the effects of ACEs in Louisiana. Survey respondents and key informants conveyed high engagement, high commitment, and high priority for ACE-related education, services, and advocacy across the state, and provided numerous practical ideas for further education, advocacy, and resource development. This study provides a baseline from which to assess the progress of the growth and development of ACE and trauma-related activities in Louisiana.

CAUTIONS AND LIMITATIONS OF THE PROJECT

Survey research has a number of limitations that require caution in interpreting the outcomes (Fowler, 2013). As we have noted, inherent in the study design is the possibility of sampling bias in the form of selection bias and non-response bias. We identified potential respondents based on knowledge of individuals or programs who were likely to be interested in the topic. Thus, the individuals who received notice to participate in the survey may not represent fully the population of interest. The snowball technique means that those answering could forward the email request to others they felt might be interested in completing the survey. The number of responses was higher than the 500 we aimed for, yet we do not know how many individuals received but chose not to complete the survey, or to whom the forwarded surveys were sent. There is no way of knowing the number or characteristics of individuals who chose not to participate in the survey, and the respondent pool likely represents a bias toward those who are familiar with ACEs. Based on the self-identified professional disciplines, we presume the survey did not reach a wide range of physicians, researchers, academics/higher education faculty, K-12 educators and administrators, law enforcement, faith-based or business professionals. Thus, our findings may underestimate the activities underway, or over-estimate the commitment to ACE education and activities. To keep the survey short, we limited the detail of information we requested; it is possible that some questions were confusing or required too much effort to answer, thereby limiting responses. We do not have a true baseline, nor do we have follow-up information to determine rate of growth of ACE-related knowledge and activities.

FINAL CONSIDERATIONS

Much of the knowledge of the effects of adversity in childhood has derived appropriately from the luminary Kaiser Permanente Study, conducted by Vincent Felitti and Robert Anda and colleagues (Fellitti et al., 1998). In addition to being the best known and most influential cumulative risk study conducted to date, the study also drew attention to the broader health consequences of early adverse experiences. Though mental health professionals have known for decades that early adversity increased risk for later emerging mental health and substance use disorders, few appreciated the physical health consequences

for heart disease, cancer, pulmonary disease, and others. Calling attention to these effects and stimulating research on cellular and molecular mechanisms linking risk exposures and outcomes are among the ACE Study's most important legacy.

While there is less recognition that studies of cumulative risk began 20 years before the ACE Study (Rutter, 1979) and have continued since (Evans, Li & Whipple, 2013), public appreciation of the importance of these experiences is another major contribution of the ACE study. The ACE study has provided a language and a lens about adversity that seems to resonate powerfully with almost everyone who learns of the study. Despite what might be considered dire consequences of early adversity, the findings are also familiar, understandable, and hopeful, as individuals learn they are not alone, and as research grows into how the effects of adversity can be buffered and resilience can be developed.

It is also important to point out that research continues to advance our understanding beyond the lack of specificity between risks and outcomes that the ACE study clearly illustrates, to a better understanding of specific effects of some types of adverse experiences (Zeanah & Sonuga Barke, 2016). For example, there seems to be some notable differences in the neurobiological and clinical effects of neglect/deprivation on the one hand and abuse/threat on the other (Humphreys & Zeanah, 2015; McLaughlin, Sheridan & Lambert, 2014).

More important for ACE education efforts is the increasing evidence that beyond the ten ACEs in the Kaiser Permanente Study, other ACEs exist and should be considered. For example, racism (Geronimus, 1992; Paradies et al., 2015), corporal punishment (Taylor et al., 2011; Afifi et al., 2017), neighborhood disorganization (Theall et al., 2013), and exposure to community violence (Osofsky & McAlister Groves, 2018) all show considerable adverse effects. A definite educational priority for ACE training is to embrace the original ACE Study findings and also to develop a broader appreciation for important adverse experiences beyond the original ten that were included in that study. Though it may be overwhelming to consider how to address or prevent all of the possible adversities, identification of "core" contributors to adverse outcomes as well as better understanding of how protection and resilience develop may result.

A promising new development for Louisiana is the *Center for Evidence to Practice*, a collaboration between LSUHSC School of Public Health's Behavioral and Community Health Sciences Program and the Louisiana Department of Health-Office of Behavioral Health. The Center's mission is "to support the state and its agencies, organizations, communities, and providers in the selection and implementation of evidence-based interventions to promote youth and family well-being, improve behavioral health outcomes, and to address challenges related to sustaining quality practice" (https://sph.lsuhsc.edu/service/center-for-evidence-to-practice/). The Center is developing and will maintain a menu of training opportunities as well as a list of professionals who are prepared to deliver evidence-based services for children and families served through Medicaid Care Organizations (MCOs).

Over 80 survey participants submitted information about services, programs, or activities that are incorporated into a resource map and listing of trauma-related services and resources in Louisiana (Appendix B). The contact information was confirmed as of November 2019. It is difficult to maintain an up-to-date, complete listing of current services, but this resource list suggests that considerable efforts have been made to address the impact of childhood adversities in communities across Louisiana. It will be essential to continue to identify community and structural barriers that contribute to these ACEs; systems change can be a difficult and arduous process. However, knowledge of ACEs can motivate change that is sensitive and responsive to the experiences of those involved. The findings of this project serve as a baseline upon which future educational programs and research can be developed.

SECTION 6

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APPENDIX A

EVIDENCE-BASED TRAUMA-INFORMED THERAPIES FOR YOUNG CHILDREN IN LOUISIANA

Attachment and Biobehavioral Catch-Up

Evidence base[1]: Well-supported
Child Welfare Relevance[2]: High

Attachment and Biobehavioral Catch-Up (ABC) is designed as an intervention for young children (6 to 24 months for ABC-Infant and 24 to 48 months ABC-Toddler) exposed to deprivation and/or trauma. Explicitly drawn from attachment theory and research, ABC includes three main targets: 1) nurturance, so that parents can become more sensitive to children's distress; 2) synchrony to help parents be more sensitive during non-distress situations (e.g., play); and 3) reducing frightening/intrusive behaviors that maltreating parents are more likely to demonstrate. By enhancing synchrony and nurturance and by decreasing frightening behaviors, the coach enhances the caregiver's responsiveness to the young child, thereby enhancing attachment and regulation.

ABC is provided in the home by trained coaches who conduct 10 manualized, 60-90 minute sessions that include video review and commenting on here-and-now interactions between parents and their infants, addressing the three targets of nurturance, synchrony, and frightening and intrusive behavior. Specific sessions also address the underlying thoughts and feelings of parents that may increase risk for maltreatment and insensitivity, as well as how to navigate child behaviors that push parents away.

Importantly, positive effects of ABC have been observed across different samples and settings, including maltreated children living with foster parents and those living with birth parents, as well as children who experience intercountry adoption. Recently, the intervention has been implemented with success by community agencies.

For more information:
http://www.abcintervention.org

Empirical Base
Manual/overview

Dozier, M., & Bernard, K. (2019). *Coaching parents of vulnerable infants: The attachment and biobehavioral catch-up approach.* New York: Guilford Press.

Selected studies

Bernard, K., Dozier, M., Bick, J., Lewis-Morrarty, E., Lindhiem, O., & Carlson, E. (2012). Enhancing attachment organization among maltreated infants: Results of a randomized clinical trial. *Child Development, 83*, 623-636.

Bick, J., &Dozier, M. (2013). The effectiveness of an attachment-based intervention in promoting foster mothers' sensitivity toward foster infants. *Infant Mental Health Journal, 34*, 95-103.

Lind, T., Bernard, K., Ross, E., & Dozier, M. (2014). Intervention effects on negative affect of CPS-referred children: Results of a randomized clinical trial. *Child Abuse and Neglect, 38,* 1459-1467.

Bernard, K., Hostinar, C.E., & Dozier, M. (2015). Intervention effects on diurnal cortisol rhythms of CPS-referred infants persist into early childhood: Preschool follow-up results of a randomized clinical trial. *JAMA-Pediatrics, 169*, 112-119.

Bernard, K., Dozier, M., Bick, J., & Gordon, M.K. (2015). Intervening to enhance cortisol regulation among children at risk for neglect: Results of a randomized clinical trial. *Development and Psychopathology, 27,* 829-841.

Bernard, K., Dozier, M., & Simons, R.F. (2015). Effects of an attachment-based intervention on high-risk mothers' event related potentials to children's emotions. *Child Development, 86*, 1673-1684.

Lind, T., Raby, L., & Dozier, M. (2017). Attachment and biobehavioral catch-up effects on foster toddler executive functioning: Results of a randomized clinical trial. *Development and Psychopathology, 29*, 575-586.

Zajac, L., Raby, L. & Dozier, M. (in press). Sustained effects on attachment security in middle childhood: Results from a randomized clinical trial of the attachment and biobehavioral catch-up intervention. *Journal of Child Psychology and Psychiatry*.

Child-Parent Psychotherapy

Evidence Base[1]: Supported
Child Welfare Relevance[2]: High

Child-Parent Psychotherapy (CPP) is a dyadic psychotherapy for treating children ages birth through age 5 years who have experienced trauma, mental health, and/or relationship difficulties, and their caregivers. The relationship between the child and caregiver is the target of the treatment and the mechanism for change. CPP focuses both on the child-parent interaction and each partner's perceptions, beliefs, and attitudes about the other. Restoring safety and trust in the relationship is a primary goal of CPP and essential in supporting the child in returning to a normative developmental trajectory. For those who have experienced trauma, creating a joint trauma narrative through acknowledging, processing, and integrating the trauma allows for a new perspective on the traumatic experience leading to more positive cognitive, emotional, and social development and well-being of the child.

Understanding and working within the family's socio-cultural context is paramount. CPP has been used extensively with a range of diverse socioeconomic and ethnic groups, including African American, Latino, Asian, Native American, and multiethnic/multi-heritage families, as well as those who have recently immigrated to the United States.

Treatment generally consists of hour-long, weekly sessions. At times, the caregiver is also seen alone for collateral sessions to process the caregiver's trauma that is not appropriate to discuss with the child present. Duration of treatment varies depending upon the complexity of the family's challenges. In published randomized control trials (RCTs), the length of treatment was around one year, with an average of 33 sessions across all the RCTs.

Outcomes from CPP include improvements in young children's symptoms of posttraumatic stress disorder (PTSD), comorbid diagnoses including depression and anxiety, behavior problems including aggression and attentional difficulties, ability to regulate and manage emotions, and cognitive functioning. Children's perceptions of their caregivers and themselves have improved and increases in secure attachment

relationships have been demonstrated. Caregivers demonstrate improvement in symptoms of PTSD and depressive symptoms and demonstrate more positive interactions and empathy with their children.

Training to implement CPP involves didactic training, active learning through clinical practice and case presentations, supervision/consultation, and agency/team support. There are different models of training, including Learning Collaboratives, CPP Agency Mentorship Programs, or completing an endorsed CPP Clinical Internship.

For more information:
http://childparentpsychotherapy.com

Empirical Base

Manual/overview

Lieberman, A., Ghosh Ippen, C., & Van Horn, P. (2015). *Don't hit my mommy! A manual for child-parent psychotherapy with young children exposed to violence and other trauma* (2nd Edition). Washington, D.C., Zero to Three.

Selected Studies

Cicchetti, D., Rogosh, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18*, 623-649.

Guild, D. J., Toth, S. L., Handley, E. D., Rogosch, F. A., & Cicchetti, D. (2017). Attachment security mediates the longitudinal association between Child-Parent Psychotherapy and peer relations for toddlers of depressed mothers. *Development and Psychopathology, 29*(2), 587-600.

Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 913-918.

Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive interaction and outcome with anxiously attached dyads. *Child Development, 62,* 199-209.

Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(12), 1241-1448.

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Development and Psychopathology, 14,*877-908.

Circle of Security

Evidence base[1]: Promising
Child Welfare Relevance[2]: Medium

The Circle of Security intervention began as a 20-week group treatment for parents of young children. This is now referred to as Circle of Security-Intensive (COS-I). In the group, parents are provided a framework for understanding attachment needs of their young children, including needs to explore and needs to seek closeness, as well as understanding how and why children may cue and miscue their needs. They also learn about their own problematic responses to their children's needs ("shark music") and are encouraged to override problematic reactions.

An 8-session psychoeducational video version of Circle of Security reviews these same topics, using parent volunteers and actors who depict many of the concepts. This is known as Circle of Security-Parenting (COS-P). COS-P may be delivered individually or in groups, or as part of dyadic application of COS in situations in which groups are not feasible or indicated. The COS-P tapes can provide a frame and vocabulary for caregivers to understand the behavior and needs of young children and their reactions to the children. This frame can then be used with a caregiver to review tapes of their interactions with their own child, either after COS-P is viewed or interspersed within the presentations.

Effects on parents' representations, reflective functioning, and emotional availability during interactions have been demonstrated. Increased attachment security and decreases in attachment disorganization in young children also have been demonstrated. A meta-analysis demonstrated medium effect sizes for the efficacy of the intervention for child attachment security, quality of caregiving, and reduction of caregiver depression, and a significant large effect size for improved caregiver self-efficacy.

For more information:
https://www.circleofsecurityinternational.com

Empirical base

Manual/overview

Powell, B., Cooper, G., Hoffman, K., & Marvin, R. (2014). The Circle of Security intervention: Enhancing attachment in early parent-child relationships. New York, Guilford Press.

Selected studies

Cassidy, J., Woodhouse, S.S., Sherman, L.J., Stupica, B., & Lejuez, C.W. (2011). Enhancing infant attachment security: An examination of treatment efficacy and differential susceptibility. *Journal of Development and Psychopathology, 23,* 131-148.

Hoffman, K., Marvin, R., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The Circle of security intervention. *Journal of Consulting and Clinical Psychology*, *74*, 1017-1026.

Huber, A., McMahon, C.A., & Sweller, N. (2015). Efficacy of the 20-week Circle of Security Intervention: Changes in caregiver reflective functioning, representations, and child attachment in an Australian clinical sample. *Infant Mental Health Journal*, *36,* 556-574.

Mothander, P., Furmark, C., & Neander, K. (2018). Adding "Circle of Security – Parenting" to treatment as usual In three Swedish infant mental health clinics: Effects on parents' internal representations and quality of parent-infant interaction. *Scandinavian Journal of Psychology*, *59*, 262–272

Yaholkoski, A., Hurl, K., & Theule, J. (2016) Efficacy of the circle of security intervention: A meta-analysis, *Journal of Infant, Child, and Adolescent Psychotherapy*, *15*, 95-103.

[1,2]Ratings of the evidence base and child welfare relevance of each interventions are cited from the California Evidenced Based Clearinghouse for Maltreated Children.

Parent-Child Interaction Therapy (PCIT)

Evidence Base[1]: Well-supported
Child Welfare Relevance[2]: Medium

Parent–Child Interaction Therapy (PCIT) is a behavioral coaching intervention for parents and their young children (2.5-7 years) who exhibit disruptive behaviors. The original focus of PCIT was with children demonstrating aggressive, oppositional, and impulsive behaviors, though its application has expanded beyond that original focus to include children with emotional problems and those exposed to trauma and deprivation, with demonstrated reductions in maladaptive behaviors.

The assertion of PCIT is that by coaching parents to praise their children's positive behaviors while ignoring their negative behaviors, and teaching them skills in behavior management, that the children will behave well and parents will engage in less conflict with them. PCIT involves *in vivo* parent coaching with the skills of non-directive play therapy and behavior management strategies via a "bug-in-the-ear" to facilitate a two-pronged approach to improving child behaviors.

In the initial phase of treatment, known as Child Directed Interaction, caregivers are taught the PRIDE skills (praise, reflection, imitation, description, and enjoy) and coached to employ those behaviors during sessions in which they interact with the child and in daily "special time" homework outside of sessions. This has the effect of both interrupting usual patterns of interaction that may be counterproductive and providing instead positive parenting behaviors that characterize most parent management approaches. In the second phase, known as Parent Directed Interaction, parents are taught how to provide firm and consistent limits and discipline in response to a young child's misbehavior. Sessions then include coaching parents to give effective commands and following through with a specific and consistent time-out procedure in response to noncompliance. Homework assignments give parents opportunities to practice these new behavior management skills, initially in specific situations at home, with increased generalization over time as parents master the skills.

When applied to children who have experienced trauma, modifications are made. Basically, with maltreated children, caregivers use a "hands-off" time-out procedure, and either removal of privileges or a time-out room if children refuse to comply with time-outs. Unlike standard PCIT, maltreatment-focused PCIT targets caregiver behaviors as a primary domain of change and safety enhancement. It has been found to be equally effective with physically abusive parents, non-offending caregivers, and foster parents.

For more information:
https://pcit-training.com

Empirical Base
Manual/overview

Eyberg, S., & Funderburk, B. (2011). *Parent Child Interaction Therapy Protocol 2011,* PCIT International.

Selected studies

Hakman, M., Chaffin, M., Funderburk, B., & Silovsky, J.F. (2009). Change trajectories for parent-child interaction sequences during Parent-Child Interaction Therapy for child physical abuse. *Child Abuse and Neglect*, *33*, 461–470.

Lanier, P., Kohl, P.L., Benz, J., Swinger, D., & Drake, B. (2014). Preventing maltreatment with a community-based implementation of Parent-Child Interaction Therapy. *Journal of Child and Family Studies*, *23*, 449–460.

Naik-Polan, A.T., & Budd, K.S. (2008). Stimulus generalization of parenting skills during Parent-Child Interaction Therapy. *Journal of Early Intensive Behavioral Intervention*, *5*, 71–92.

Self-Brown, S., Whitaker, D., Berliner, L., & Kolko D. (2012). Disseminating child maltreatment interventions: research on implementing evidence-based programs. *Child Maltreatment*, *17*, 5–10.

Timmer, S. G., Urquiza, A. J., Zebell, N.M., & McGrath, J. M. (2005). Parent-child interaction therapy: Application to maltreating parent-child dyads. *Child Abuse & Neglect, 29*, 825–842.

Urquiza, A. J., & McNeil, C. B. (1996). Parent- child interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment, 1*, 134–144.

Trauma Focused Cognitive Behavioral Therapy—TF-CBT (or Preschool PTSD Treatment-PPT)

Evidence Base[1]: Well-supported
Child Welfare Relevance[2]: High

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for 3- to 6-year-old children, also known as Preschool PTSD Treatment (PPT), is a 12-session psychotherapeutic intervention designed to enhance young children's abilities to manage memories of fearful events by teaching them coping skills and by being with them as they use those skills to manage painful memories. In keeping with early childhood interventions, the caregiver's participation is central, both by hearing the child recount the traumatic experience in various ways and by supporting the child's new coping skills.

Specific techniques include psychoeducation about PTSD for caregiver and child, helping the young child recognize different feeling states, training in coping skills, graduated exposures to trauma-related reminders with three modalities (drawings, imagined, and actual), and safety planning. Caregivers are in the room with the children for sessions at the beginning and end of treatment, but they also observe each session via video even if they are not in the room with the child. The goals are for them to learn the material simultaneously with the child and to increase their empathic appreciation of the child's experience. One therapist works directly with the child and another helps the caregiver understand the child's verbal and behavioral expressions during trauma therapy and discusses the plan for practicing skills as homework. The therapist with the caregiver also provides support in part to model how caregivers are to provide support to their children.

For the treatment to be feasible, it is critical that the child have a narrative of the trauma that can be described and lend itself to developing a hierarchy of frightening exposures. Gradually exposing the young child to frightening memories – in tolerable doses and with support – from mildly scary to very scary -- and encouraging the child to make those memories tolerable by employing new coping skills is what TF-CBT strives to accomplish.

There are many studies of TF-CBT in older children, adolescents and adults, but a growing literature has documented its useful application to younger children. In preschoolers this treatment was originally studied in victims of sexual abuse, but it has been expanded to a variety of traumas in young children and

shown to be effective. Studies have demonstrated reductions in behavior problems generally and posttraumatic symptoms specifically.

For more information:
https://medicine.tulane.edu/departments/psychiatry/dr-scheeringas-lab/manuals-measures-trainings

Empirical Base
Manual/overview
Scheeringa, M. (2016). *Treating PTSD in preschoolers*. New York, Guilford Press.

Selected studies
Cohen J., & Mannarino, A. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*, 42–50.

Cohen J.A., & Mannarino, A.P. A treatment study for sexually abused preschool children: outcome during a one-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 1228-1235.

Deblinger, E., Stauffer, L., & Steer, R. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. *Child Maltreatment*, *6*, 332–343.

Scheeringa, M.S., Weems, C.F., Cohen, J.A., Amaya-Jackson, L., & Guthrie, D. (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three through six-year-old children: A randomized clinical trial. *Journal of Child Psychology and Psychiatry,52*, 853-860.

Trust-Based Relational Intervention

Evidence Base[1]: Promising
Child Welfare Relevance[2]: High

TBRI® is an attachment-based, trauma-informed intervention that is designed primarily to help foster parents meet the complex needs of children in their care who have experienced abuse, neglect, and/or trauma. Because of their histories, it is often difficult for these children to trust the loving adults in their lives, which often results in perplexing behaviors. TBRI® offers practical tools for parents, caregivers, teachers, and others to reframe challenging behaviors as reflections of adverse experiences rather than as defiant or uncooperative actions.

TBRI® uses empowering principles to address physical needs, connecting principles for attachment needs, and correcting principles to disarm fear-based behaviors. While the intervention derives from research on attachment, sensory processing, and neuroscience, the major focus of TBRI® is maintaining connection. This intervention is used with young children through adolescence in a variety of settings.

For more information:
https://child.tcu.edu/about-us/tbri/#sthash.4KqjcJLJ.dpbs

Manual/overview
Purvis, K.B., Cross, D.R., & Sunshine, W. L. (2007). *The connected child: Bringing hope and healing to your adoptive family*. New York, NY, McGraw-Hill.

Selected studies

Purvis, K.B., Razuri, E. B., Howard, A.R., Call, C., DeLuna, J., Hall, J.S., & Cross, D. R. (2015). Decrease in behavioral problems and trauma symptoms among at-risk adopted children following trauma-informed parent training intervention. *Journal of Child & Adolescent Trauma, 8*(3), 201-210.

Triple P Positive Parenting Program (Triple P)

Evidence Base[1]: Supported
Child Welfare Relevance[2]: Medium

Triple P is an intervention for caregivers designed to teach them simple and practical skills to help them become more effective at managing their children's behavior. Triple P has multiple levels of intensity including multi-media, self-directed modules and professional consultations. The multi-tiered approaches include Standard, Group, Enhanced, Self-Directed, and Media. Our focus is on the levels involving treatment by trained mental health professionals.

In fact, most of the research on Triple P is about Standard Triple P, Group Triple P or Enhanced Triple P. Standard Triple P works with single families, while group sessions are conducted within Group Triple P. Both of these approaches use didactic presentations, individual or small group activities, and homework. Parents are encouraged to use differential reinforcement, communication skills, effective consequences for misbehavior, and planned activity scheduling. The goals are to help parents identify possible causes for young children's misbehavior and to develop specific goals for behavior change. Approximately 10 sessions are included in Standard Triple P, whereas Group Triple P is usually five group sessions and three telephone consultations. In Enhanced Triple P, three adjunct modules, tailored to the parents' individual needs, are added. In the Practice module, the goals are to identify and resolve problems with implementing new parenting strategies. In the Coping Skills module, parents are assisted with personal issues, such as depression and anxiety. In the Partner Support module, dual-parent families who are experiencing difficulties in communication, relationships and/or co-parenting are offered support

Triple P has substantial research supporting its effectiveness (including more than 100 RCTs) and can be delivered by a wide variety of trained practitioners from different disciplines. The practitioner has great flexibility to use what is needed for each caregiver to help caregivers become more effective parents.

For more information:
https://www.triplep.net/glo-en/find-out-about-triple-p/triple-p-in-a-nutshell

Empirical Base

Manual/overview

Sanders, M.R., Markie-Dadds, C., & Turner, K. M. T. (1998). *Practitioner's manual for enhanced Triple P*. Milton, QLD: Families International Publishing Pty. Ltd.

Selected studies

Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P - Positive Parenting Program using hierarchical linear modeling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review*, 11, 114-144.

Prinz, R.J., Sanders, M.R., Shapiro, C.J., Whitaker, D.J., & Lutzker, J.R. (2009). Population-based prevention of child maltreatment: The US Triple P system population trial. *Prevention Science, 10*, 1-12.

Prinz, R.J., Sanders, M.R., Shapiro, C.J., Whitaker, D.J., & Lutzker, J.R. (2016). Addendum to Population-Based Prevention of Child Maltreatment: The US Triple P System Population Trial. *Prevention Science, 17*, 410-416.

Sanders, M.R., Cann, W., & Markie-Dadds, C. (2003). The Triple P-Positive Parenting Programme: A universal population-level approach to the prevention of child abuse. *Child Abuse Review***,** *12*, 155–171.

Table 20. Summary of Early Childhood Therapies to Address Trauma

	Target Populations	Targets of intervention	Approach	Theory of change	Delivered by	Cost of training
Attachment and Biobehavioral Catch-up	Caregivers and infants 6 months to 24 months (ABC-infants); 24 to 48 months for ABC-Toddlers)	Caregiver behavior	10 sessions in home	Helping parents override problematic responses elicited by children, reduce frightening behavior, and follow a child's lead and by enhancing nurturance and synchrony	Trained coaches (no clinical experience required)	$7000 per person for 2 days of in-person training and one year of phone supervision with video review
Child-Parent Psychotherapy	Caregivers and children, from pregnancy through 5 years	Emotional and behavioral responses of parent and child to one another	Weekly dyadic sessions, home or clinic, delivered for one about year	Changing parents' understanding of their own responses and child's feelings and behaviors through creating a joint narrative of traumatic experiences and identifying and addressing traumatic triggers that generate dysregulated behaviors and affect.	Trained therapists	For a senior trainer, with a group of 15, an 18-month training (7 face-to-face training days and 18 months of consultation; 2 hours a month) range is $38,000 - $45,000. For less senior trainers, $31,000 for group of 15
Circle of Security	Caregivers and children, birth through 5 years	Parents' understanding of child's needs and of their reactions to child	Video review of parent child interaction	Helping parents understand child behavior as an expression of needs by enhancing their understanding of child cues and miscues and helping parents learn to override anxiety elicited by child behavior	Trained therapists	COS-Intensive training is not currently offered, as the training is being revamped. For COS-Parenting, $1000 for 4-day training with materials included.
Parent-Child Interaction Therapy	Children 30 months to 7 years and their caregivers	Parent behavior with child	Weekly sessions involving *in vivo* parent coaching during parent-child play and behavior	Increasing caregiver attention to child positive behaviors and a consistent and firm approach to limit setting	Trained therapists	$4900 per person for 5 days (40 hours) of in person training, followed by twice monthly consultation (group format of 6-8)

			management strategies			via phone or web-conferencing and video review of 4 key sessions with written feedback from a Certified Master or Level II Trainer.
Trauma-focused Cognitive Behavioral Therapy	Children 36-60 months and their caregivers	Child posttraumatic responses	14 sessions of therapist with child observed by caregivers and therapist	Teaching coping strategies to reduce fearful responses to memories of trauma	Trained therapists	For one day training $2250. For 6 months of phone supervision in small groups is an additional $3000.
Triple P Positive Parenting Program (Levels 4 and 5)	2-12 years	Parents' perceptions of child and themselves as parents, behavior skills of parents,		Instead of coaching phone calls, could do 3-8 sessions	Licensed mental health professionals (trained therapists)	$2500 for 3-day training and accreditation for Level 4; an additional $2100 for 2-day training and one day accreditation for Level 5
Trust Based Relational Intervention	Caregivers of children from early infancy through adolescence	Enhancing parents' connection to and understanding of children whose challenging behaviors result from trauma and deprivation	No fixed number of sessions (often 6-8), can be group or individual and delivered in multiple settings	Training caregivers to understand challenging behaviors as reflections of trauma or deprivation and providing them with more effective and sensitive responses	Parents, foster parents and other caregivers	$3,500 for TBRI® Practitioner Training

APPENDIX B

SERVICES AND ACTIVITY RESOURCES IN LOUISIANA

Here we provide information offered by survey participants about services, programs, or activities that are available to address the impact of ACEs. As shown in Figure 4 below, at least some services are available in all parts of the state. Though the information was confirmed in November, 2019, it is difficult to assure accurate and up-to-date contact information. Notably, though this list is not exhaustive of available resources, it does provide examples of the types of resources that are available to address the impact of childhood adversities in communities across Louisiana.

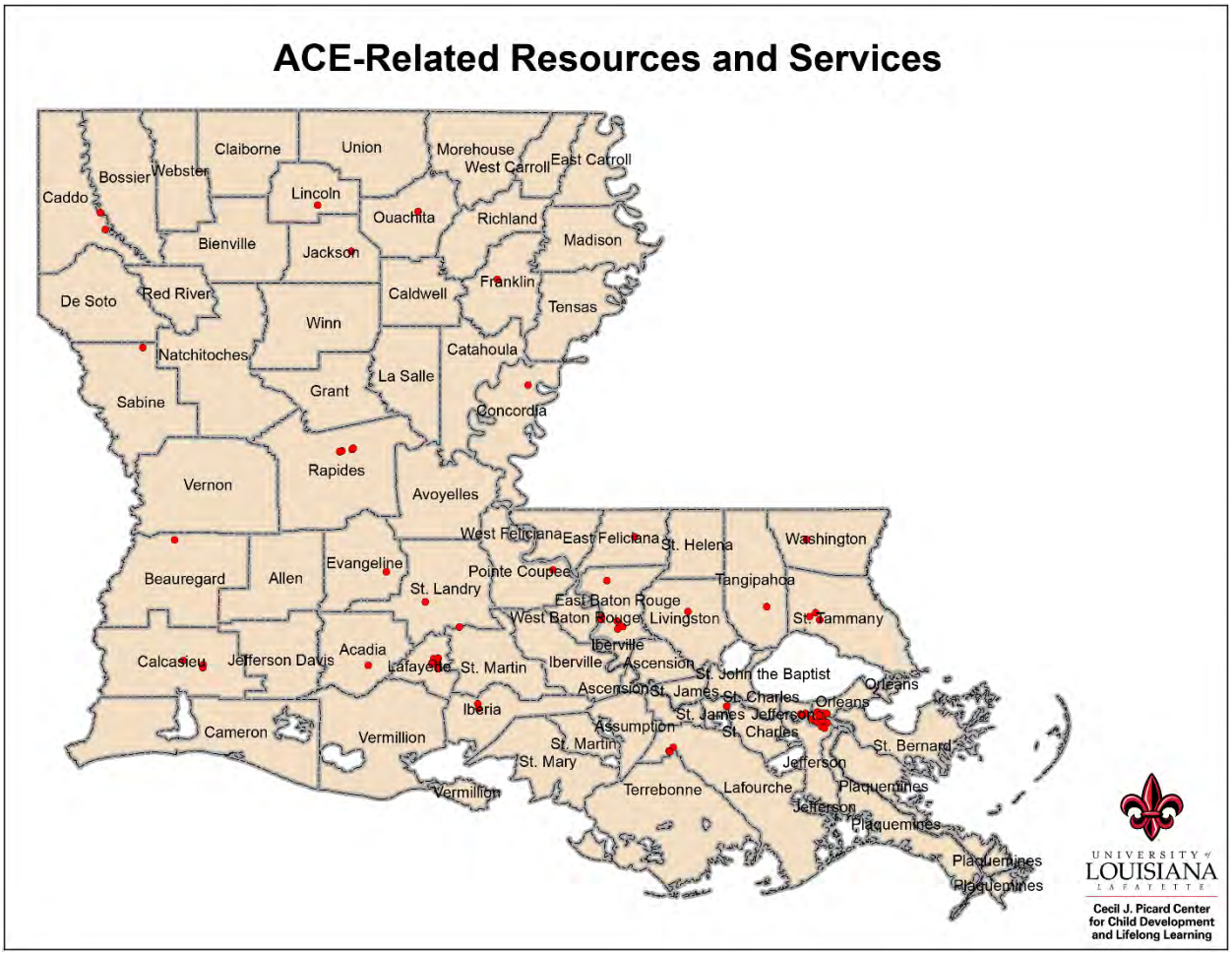

Figure 4. Map of ACE-Related Resources and Services

Statewide Resources

Approval Organizations for Social Work Continuing Education

As the Louisiana State Board of Social Work Examiners, it is our duty to provide all licensed social workers and those thinking about becoming license social workers with adequate resources. If you have questions, please visit our FAQs or email us at socialwork@labswe.org.

Contact: Resilience Center of Northeast Louisiana
Felicia Downs, LCSW
Address: P.O. Box 9021
Monroe, LA 71211
Phone: 318-267-9191
Email: downsfelicia3@gmail.com
Web: https://www.labswe.org/page/approval-organizations-for-social-work-continuing-education

Department of Children and Family Services (DCFS)

DCFS is working to keep children safe, helping individuals and families become self-sufficient, and providing safe refuge during disasters. We care for the well-being and safety of Louisiana's people. Treating all people with dignity, compassion and respect, while providing services with integrity.

Web: http://www.dcfs.louisiana.gov

Louisiana ACE Educator Program

The ACE Educator Program offers ACEs trainings at no cost to organizations and community groups across Louisiana. Our presentation materials have been vetted by experts in the field and are designed to effectively teach audiences across the state about the impact of childhood trauma and promote open, ongoing conversations about these issues.

Contact: Caitlin LaVine, Coordinator
Address: Louisiana Department of Health
Office of Public Health
Bureau of Family Health
1450 Poydras Street, Suite 2013
New Orleans, LA 70112
Phone: 504-568-3504
Email: acepresentation@la.gov
Web: https://partnersforfamilyhealth.org/aces/

Louisiana ACE Initiative

The Louisiana ACE Initiative is a network of child-focused organizations dedicated to creating a common understanding of ACEs within Louisiana communities, educating the child- and family-serving workforce and promoting trauma-informed practices and services in Louisiana.

Contact: Paula Zeanah, Chair
Phone: 504-236-3279
Email: louisianaaceinitiative@gmail.com

Louisiana Association of Educators (LAE)

LAE's mission is to organize and empower educators to promote quality public schools, strengthen the profession, and improve the well-being of public-school children across Louisiana.

Contact: Gretchen Lampe
Address: 8322 One Calais Ave.
Baton Rouge, LA 79809
Phone: 317-457-6253
Web: http://www.lae.org/

Louisiana Department of Health (LDH)

The **Bureau of Family Health (BFH)** works to promote optimal health of all Louisiana women, infants, children, teens, and families.

Web: http://ldh.la.gov/index.cfm/subhome/45

The **Center for Community and Preventive Health** conducts a variety of programs and services designed to improve public health measures in Louisiana. Programs and services this center offers through the LDH Office of Public Health include screenings, health needs assessments, laboratory testing services, infectious disease reporting and nutrition programs.

Web: http://ldh.la.gov/index.cfm/directory/detail/4807

Early Steps provides services to families with infants and toddlers aged birth to three years (36 months) who have a medical condition likely to result in a developmental delay, or who have developmental delays. Children with delays in cognitive, motor, vision, hearing, communication, social-emotional or adaptive development may be eligible for services. Early Steps services are designed to improve the family's capacity to enhance their child's development.

Web: http://ldh.la.gov/index.cfm/directory/detail/609

Healthy Louisiana is Louisiana's name for its new expanded Medicaid program, which provides health insurance coverage to more than 350,000 working Louisianans who could otherwise not afford health care, while bringing both jobs and economic development to the state.

Web: http://ldh.la.gov/index.cfm/directory/detail/4790

The **Office of Public Health (OPH)** is comprised of 1,100 professionals across Louisiana who are charged with protecting and promoting the health of the communities of our state. The agency operates more than fifty programs with staff in 63 parish health units, three specialty clinics, nine regional offices, three centers, fifteen bureaus, and nearly 600 contractual agreements.

Web: http://ldh.la.gov/index.cfm/subhome/16

WIC is a Special Supplemental Nutrition Program for pregnant, breastfeeding, and postpartum women, infants and children up to 5 years of age. WIC provides healthy foods, nutrition education and referrals to other health and social services.

Web: http://ldh.la.gov/index.cfm/subhome/16

The Gift Program (LDH, OPH, BFH)

The Gift is an evidence-based program for Louisiana birthing facilities designed to increase breastfeeding rates and hospital success by improving the quality of their maternity services and enhancing patient-centered care.

Contact: Marci Brewer
Address: 1450 Poydras, Room 2032
New Orleans, LA 70112
Phone: 410-925-9834
Email: Marci.Brewer@la.gov
Web: https://thegiftla.org/

Louisiana Partnership for Children and Families

Giving the children of Louisiana voice for a better life. That's what the Louisiana Partnership for Children and Families (the Partnership) is all about. We are a statewide advocacy organization dedicated to influencing public policy, educating parents and all the citizens of our state and making sure that the services provided are the best for our children.

Contact: Susan E. Nelson, J.D. Executive Director
Address: 445 N. 12th Street,
Baton Rouge, LA 70802
Phone: 225-384-0217
Email: susannelson@gmail.com
Web: http://www.louisianapartnership.org/

Louisiana Public Broadcasting

The mission of Louisiana Public Broadcasting is to provide programming that is intelligent, informative, educational and entertaining. LPB strives to connect the citizens of Louisiana by creating content that showcases Louisiana's unique history, people, places and events.

Contact: Beth Courtney, President and CEO
Address: 7733 Perkins Rd.
Baton Rouge, LA 70810
Phone: 800-272-8161 x4274
Email: bcourtney@lpb.org
Web: https://www.lpb.org/about

Women, Infants, and Children Services (WIC)

WIC is a Special Supplemental Nutrition Program for pregnant, breastfeeding, and postpartum women, infants, and children (under 5 years old). WIC provides nutritious foods, nutrition information, breastfeeding promotion, breastfeeding support and referrals to other health and social services.

Contact: Donna Richards, Public Health Nutritionist
Address: 628 North 4th Street, 2nd Floor
Baton Rouge, LA 70802
Phone: 225-342-1233
Web: https://www.womeninfantschildrenoffice.com/
Alt. Web: http://1800251baby.org/parent/financial-resources/#Food-Assistance

Region 1 Resources – Orleans, Jefferson, Plaquemines, and St. Bernard Parishes

Bright Side, LLC

Marriage and Family Counseling

Contact: Renee Gusman, MS, LPC
Address: 3301 Toulouse St.
New Orleans, LA 70119
Phone: 504-813-0951
Email: rbgusman@yahoo.com
Web: https://new-orleans-la-orleans.opendi.us/7004267.html

Teresa Buchanan, Ph.D.

Educational Consultant

Contact: Teresa Buchanan, Ph.D.
Address: 121 1/2 North Clark St.
New Orleans, LA 70119
Phone: 225-287-0617
Email: terrybuchan@gmail.com

Center for Resilience/New Orleans Therapeutic Day Program (NOTDP)

The Center for Resilience (CfR) is a school-based day treatment program for children enrolled in Orleans Parish public schools in need of intensive academic and behavioral health intervention. Schools and families are encouraged to contact CfR to learn more about children in need of specialized services.

Contact: Monica Stevens, Ph.D.
Phone: 504-988-5405
Email: mstevens@tulane.edu

Alt. Contact: Liz Marcell Williams, Ed.D.
Chief Executive Officer
Address: 1035 Calhoun Street
New Orleans, LA 70118
Cell: 504-723-2066
Office: 504-308-3501
Web: www.cfrla.org
Social: https://www.facebook.com/cfrla/

Children's Bureau of New Orleans

The Children's Bureau of New Orleans promotes growth and resilience through prevention, advocacy, education and intervention. Our mission is to improve the quality of life for children and families in greater New Orleans through valid and proven programs that enhance and strengthen mental health and wellness.

Address: 2626 Canal Street, Suite 201
New Orleans, LA 70119
Phone: 504-525-2366
Web: https://www.childrensbureaunola.org/

Department of Children and Family Services, Orleans

DCFS works to keep children safe, helping individuals and families become self-sufficient, and providing safe refuge during disasters.

Contact: Sharon Worthy
Address: 4404 St. Roch Avenue
New Orleans, LA 70122
Email: ibeworthy@bellsouth.net

Department of Children and Family Services, Orleans

DCFS works to keep children safe, helping individuals and families become self-sufficient, and providing safe refuge during disasters.

Contact: Detra Ward
Address: 1450 Poydras Street, Suite 1600
New Orleans, LA 70112
Phone: 504-568-7441
Email: detra.ward.dcfs@la.gov

Department of Children and Family Services, Jefferson

DCFS works to keep children safe, helping individuals and families become self-sufficient, and providing safe refuge during disasters.

Contact: Mary Smalley
Address: 2150 Westbank Expressway 202, Suite 601
Harvey, LA 70058
Phone: 504-361-6785
Email: Mary.smalley.dcfs@la.gov

Early Steps Service Point of Entry Office, Region 1

Contact: Holly Bell
Address: 1010 Common Street, Suite 2440
New Orleans, LA 70112
Phone: 504-595-3408
Email: hbell@laeasterseals.com

EXCELth, INC.

Our mission is to provide excellence in community-based health care that increases access, reduces health disparities, and improves health outcomes.

Contact: Dr. Shelia J. Webb
Address: 1515 Poydras Street/Suite 1070
New Orleans, LA 70112
Phone: 504-524-1210
Email: swebb@excelth.com
Web: https://www.excelth.com/contact

John Fanning, Ph.D.

Neuropsychologist

Contact: John Fanning, Ph.D.
Address: 715 Pecan Grove Lane
Jefferson, LA 70121
Phone: 504-421-0730
Email: johntfanning@yahoo.com

Human Development Center at LSUHSC

The mission of the Human Development Center (HDC) is to provide leadership and innovation in interdisciplinary education, community service, research, and to disseminate information to strengthen and increase the capacity of local communities to support and include individuals with (developmental) disabilities and their families in all aspects of life in the community.

Contact: Maria T. Blanco
Address: 411 Prieur St, Room 442
New Orleans, LA 70112
Phone: 504-556-7572
Email: mblanc@lsuhsc.edu
Web: https://www.hdc.lsuhsc.edu/

Jefferson Parish Juvenile Services

The Department of Juvenile Services (DJS) is a division of Jefferson Parish government. Our mission is to provide supervision and rehabilitation to troubled youth and their families residing within the confines of Jefferson Parish who have come to the attention of the Jefferson Parish Juvenile Court. Currently, DJS provides services to both delinquent and status offenders.

Address: 1546-B Gretna Boulevard
Harvey, Louisiana 70058
Phone: 504-364-3750
Email: JPJuvenileServices@JeffParish.net
Web: https://www.jeffparish.net/departments/juvenile-services

Kingsley House/Early Ed (A United Way Community Impact Partner)

Kingsley House educates children, strengthens families and builds community.

Contact: Keith Liederman, Ph.D., CEO
Address: 1600 Constance St.
New Orleans, LA 70130
Phone: 504-523-6221, ext. 123
Email: kliederman@kingsleyhouse.org
Web: http://www.kingsleyhouse.org/

Louisiana Children's Museum

Louisiana Children's Museum contributes to the region's future prosperity by engaging children's potential and making that potential visible. Through play, shared explorations, and in dialogue with adults, LCM connects children to each other, adults, their environments and communities.

Contact: Julia Bland, CEO

Address: 15 Henry Thomas Drive
New Orleans, LA. 70124
Phone: 504-523-1357
Email: jbland@lcm.org
Web: https://www.lcm.org/history-mission

Louisiana State University Health Sciences Center (LSUHSC) Infant, Child, and Adolescent Psychiatry

The Infant, Child and Adolescent Psychiatry Division is public sector oriented and has been associated continuously with the State of Louisiana Office of Behavioral Health via a number of public/academic initiatives. The faculty is multidisciplinary providing inpatient and outpatient care in infant and early childhood mental health, autism spectrum disorders, foster care, pediatric psychopharmacology and responses to violence.

Contact: Victoria Sacco
Address: 1542 Tulane Avenue Room 228
New Orleans, LA 70112
Phone: 504-568-2537
Email: lmamon@lsuhsc.edu
Web: https://www.medschool.lsuhsc.edu/psychiatry/

LSUHSC Harris Center for Infant Mental Health

The LSUHSC Department of Psychiatry includes the Harris Center for Infant Mental Health offering training to predoctoral psychology interns, child psychiatrists, post-doctoral psychologists, social workers, and licensed professional counselors. The program is multidisciplinary and fulfills requirements for psychology and child psychiatry raining. Trainees from all disciplines, consistently rank their experience in the Harris Center a top part of their training.

Contact: Susan Gould
Department of Psychiatry
Address: 1542 Tulane Avenue, 2nd floor
New Orleans, LA 70112
Phone: 504-903-9213

LSUHSC Behavioral Sciences Center

LSUHSC Behavioral Health Center is a group practice that addresses the full spectrum of mental health needs, including adolescent medicine, child and adolescent psychiatry, psychology and psychiatry, with emphasis on the family as a whole. Our interdisciplinary approach to mental health includes skillful care guided by the most recent research findings and personalized combinations of medication and psychotherapy.

Contact: Venus Lee, Office Manager
Address: 2025 Gravier St.
New Orleans, LA 70112
Phone: 504-412-1580
Email: susannelson@gmail.com
Web: https://www.lsuhn.com

New Orleans Family Justice Center

New Orleans Family Justice Center is a partnership of agencies dedicated to ending family violence, child abuse, sexual assault, and stalking through prevention and coordinated response by providing comprehensive client-centered, empowerment services in a single location.

Contact: Mary Claire Landry
Address: 701 Loyola Avenue, Suite201
New Orleans, LA 70113
Phone: 504-355-0851
Email: mclandry@nofjc.org
Web: https://nofjc.org/

Priority Health Care, Inc.

Priority Health Care, Inc. is a non-profit organization located on the west bank of Jefferson Parish. PHC's mission is to provide compassionate and high-quality care to persons in underserved communities; to empower them in maintaining a positive quality of life by improvement of health status through the provision of primary and preventive health care services, education, and support services.

Physical: 12A Westbank Expressway, Ste 101
Gretna, LA 70053-3659
Mailing: 4700 Wichers Dr Ste 306,
Marrero, LA 70072-3054
Phone: 504-309-9135
Fax: 504-341-4140

Leigh Anne Terrebonne, Ph.D.

I help patients overcome barriers to change via understanding conscious and unconscious reasons for a patient's difficulties. I have extensive experience helping those with anxiety and mood disorders (including bipolar disorder) as well as substance abuse. I also specialize in the intersection of health and psychology helping optimize patients' physical and emotional health.

Contact: Leigh Anne Terrebonne, Ph.D.
Address: 3705 Coliseum St
New Orleans, LA 70115
Phone: 504-864-0800
Email: lbterreb@bellsouth.net
Web: https://www.psychologytoday.com/us/therapists/leigh-anne-b-terrebonne-new-orleans-la/353941

Metro Centers for Community Advocacy

Metro currently provides wrap-around services including individual advocacy, information and referrals, group support, medical advocacy, legal advocacy, sheltering, individual support, safety planning, and caregiver support to survivors in eight Louisiana parishes.

Contact: Mark Medina
Address: PO Box 1077
Jefferson, LA 70181
Phone: 504-837-5400
Email: mmedina@mccagno.org

Web: http://www.mccagno.org/

Tulane Child and Adolescent Psychiatry

We improve human health and foster healthy communities through discovery and translation of the best science into clinical practice and education; to deliver the highest quality patient care and prepare the next generation of distinguished clinical and scientific leaders.

Contact: Charles H. Zeanah, Jr., MD
Address: 1430 Tulane Avenue #8055
New Orleans, LA 70112
Phone: 504-988-5402
Email: susannelson@gmail.com
Web: https://medicine.tulane.edu/departments/psychiatry/child-adolescentpsychiatry/fellowship/contact-us

Tulane Early Childhood Mental Health Consultation Supports and Services

The Institute of Infant and Early Childhood Mental Health is dedicated to the discovery, dissemination and application of knowledge to promote social and emotional competence in young children locally, regionally, nationally, and internationally.

Contact: Allison Boothe Trigg, Ph.D.
Address: 1440 Canal, TB-8448
New Orleans, LA 70112
Phone: 504-988-2714
Email: aboothe@tulane.edu
Web: https://medicine.tulane.edu/infant-institute

Tulane University Department of Psychology

Psychology Clinic for Children and Adolescents

Contact: Stacy Overstreet, Ph.D.
Address: 6400 Freret St.
New Orleans, LA 70118
Phone: 504-862-3332
Email: soverst@tulane.edu
Web: https://sse.tulane.edu/psyc/clinic/contact

Youth Opportunity Center

Youth are informed and entrusted to make decisions about their own education and future. Youth have adult support in their education before, during and after involvement in the juvenile justice system. Youth have access to high quality career pathways programs, especially in juvenile justice placements.

Contact: Angela Wiggins
Address: 1331 Kerlerec Street
New Orleans, LA 70116
Phone: 504-218-5386
Email: angela.wiggins@rsdla.net
Web: https://www.jjeducationblueprint.org/states/louisiana

Region 2 Resources – Capital Area (Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge and West Feliciana Parishes)

Christina Bays, LCSW

I am a social worker in private practice. I specialize in anxiety disorders, OCD, depression, self-esteem, body image and women's issues including perinatal mood and anxiety disorders. I provide individual and couples counseling and I work to provide a comfortable and nonjudgmental atmosphere.

Contact: Christina Bays, LCSW
Address: 3577 Ramey Dr.
Zachary, LA 70791
Phone: 225-223-2408
Email: christinabayslcsw@gmail.com

East Feliciana Health Unit/WIC Services

Contact: Nicky Cook
Address: 12080 Marston Street
P.O. BOX 227
Clinton, LA 70722
Phone: 225-683-8551
Web: https://www.womeninfantschildrenoffice.com/east-feliciana-parish-health-unit-wic-clinic-louisiana-wcl5638

Catherine Gaston, Infant Mental Health Specialist

Contact: Catherine Gaston
Address: 7920 Wrenwood Blvd, Suite D
Baton Rouge, LA 70808
Phone: 225-892-0661
Email: cathy.gaston@la.gov

Iberville Parish School Board

Our administrators, teachers, and school board members are committed to providing the best possible education to every student in our schools by giving them the necessary skills to become productive citizens. We strive to enhance achievement preparing students for a complex and competitive world.

Contact: Lydia Canova
Address: 58030 Plaquemine Street
Plaquemine, LA 70764
Phone: 225-776-3131
Email: lydiacanova@ipsb.net
Web: www.ipsb.net

Mayor's Office

Contact: Rowdy Gaudet
Address: 222 St. Louis Street, 3rd Floor
Baton Rouge, LA 70802
Phone: 225-389-5109
Web: https://www.brla.gov/588/Mayor-President

The Neuropsychology Center of Louisiana (NCLA)

NCLA offers a wide variety of clinical psychology, neuropsychology, and medical psychology services—Assessments, Psychopharmacological Services, Individual Psychotherapy, Child & Adolescent Individual/Family Psychotherapy, and Individualized Intervention & Rehabilitation Services.

Contact: Darlyne G Nemeth, PhD, MP
Address: 4611 Bluebonnet Blvd., Suite B
Baton Rouge, LA 70809
Phone: 225-926-7500
Email: dgnemeth@gmail.com
Web: http://www.louisiananeuropsych.com/

Our Lady of the Lake Children's Health Pediatric Residency Program

Our Lady of the Lake Children's Health is a collaborative, coordinated and child-focused statewide health network that provides patients with more access to physicians and providers specifically trained to care for children. The network includes hospital-based services at the flagship campus in Baton Rouge and the future freestanding hospital, as well as in Monroe with St. Francis Pediatrics.

Contact: Roberta C. Vicari, MD
Address: Hennessy Blvd. Plaza II, Suite 6004
Baton Rouge, LA 70808
Phone: 225-765-765
Email: Vicari@fmolhs.org
Web: https://ololchildrens.org/location/our-lady-of-the-lake-childrens-health-endocrinology

Riverside Educational Development Center

It is our mission to provide a wholesome, loving environment where children can be children and learn to play and socially interact with one another. We are committed to teach with the highest educational standards that will be age appropriate. We will not discriminate against race, sex, creed, religion, or in any other way.

Contact: Cindy Bennett Beatty
Address: 142 New Roads St.
New Roads, LA 70760
Phone: 225-235-4689
Email: bennett23@bellsouth.net
Web: https://www.redcnewroads.com/Riverside--About-Us.html

Region 3 Resources – **Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, and Terrebonne Parishes**

Lafourche Parish Health Unit (LDH/OPH/WIC)

Contact: Tara Landry
Address: 1434 Veterans Blvd.
Thibodaux, LA 70301
Phone: 985-447-0921
Email: tara.landry@la.gov
Web: http://ldh.la.gov/index.cfm/directory/detail/4809/catid/341

Nicholls State University, Family Service Center

The NSU-Family Service Center's mission is to create safe home environments by enhancing conflict resolution and changing behaviors within the family unit to reduce the probability of child abuse & neglect & improve overall mental health of family members. Home-based & center-based services include family skill building, evidence-based parenting education & visit coaching for families in Lafourche, Terrebonne, Assumption, St. Mary & lower St. Martin parishes.

Contact: Emily Lazzell, Program Coordinator
Address: P.O. Box 2131
Thibodaux, LA 70310
Phone: 985-493-2493
Email: emily.lazzell@nicholls.edu
Web: https://www.nicholls.edu/education/psychology/family-service-center/

Region 3 Office of Public Health (LDH)

Contact: Louise Karisny
Address: 1434 Tiger Drive
Thibodaux, LA 70301
Phone: 985-447-0916, ext. 324
Email: Louise.karisny@la.gov
Web: http://ldh.la.gov/index.cfm/directory/detail/369/catid/13

Region 4 Resources – Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermillion Parishes

ASSIST Agency

Contact: Edna Semar
Address: 11 N. Parkerson Ave.
Crowley, LA 70526
Phone: 337-788-7550, ext. 138
Email: assistshelter@bellsouth.net
Web: http://ldh.la.gov/index.cfm/directory/detail/4378/catid/333

Blumrich Counseling

I enjoy watching growth in my clients and watching them overcome personal obstacles and setting and reaching goals. As a Licensed Professional Counselor, I help to provide emotional growth to others. I have found that there are particular areas I am most interested, including Play Therapy and Sandtray Therapy.

Contact: Janice Sylvester, LPC
Address: 333 South Main
Opelousas, LA 70570
Phone: 337-230-5638
Email: janicesylvester52@yahoo.com
Web: https://www.psychologytoday.com/us/therapists/blumrich-counseling-opelousas-la/126494

CASA of South Louisiana

CASA of South Louisiana (SoLA) recruits and trains community volunteers to advocate for children in the foster care system. CASA of SoLA's mission is to break the cycle of child abuse and neglect and to advocate for safe, permanent, and nurturing homes for children.

Contact: Heather Blanchard, Executive Director
Address: 227 La Rue France
Lafayette, LA 70503
Phone: 337-268-5111
Email: admin@casaofsola.org
Web: www.casaofsola.org

Evangeline Parish Schools

Contact: Roxane West, Special Education Director
Address: 607 Harvey LeBas Drive
Ville Platte, Louisiana 70586
Phone: 337-363-6563
Web: https://www.epsb.com/
Social: https://www.facebook.com/EVPSB/

Faith House

Emergency shelter is available in Lafayette for victims of domestic violence victims and their children needing a safe, temporary place to live. As a resident of Faith House, we provide you with physical necessities, DV counseling, advocacy and referrals.

Contact: Billi Lacombe
Address: PO Box 93145
Lafayette, LA 70509
Phone: 337-232-8954
Email: billi@faithhouseacadiana.com
Web: https://faithhouseacadiana.com/

The Family Tree Education, Information, and Counseling Center

As a primary prevention service, the Community Education program utilizes professional facilitators for a variety of classes teaching individuals to incorporate new skills into their lives and relationships, resulting in improved coping and healthier family systems. The counseling program is comprised of licensed counselors and/or counselors working towards licensure, who provide assistance and guidance in resolving personal, social, or psychological problems and difficulties.

Contact: Marie Collins, MA, LPC, LMFT, LAC, Executive Director
Address: 1602 W. Pinhook Rd., Suite 100A
Lafayette, LA 70508
Phone: 337-981-2180
Email: mcollins@acadianafamilytree.org
Alt. Contact: Lisa LaRochelle, LCSW-BACS, Clinical Director
Alt. Email: lisa@acadianafamilytree.org
Web: www.acadianafamilytree.org

Nelwyn Hebert, Educator

Contact: Nelwyn Hebert
Address: 221 Edgewater Drive
New Iberia, LA 70563
Phone: 337-369-3510
Email: nelwyn@cox.net

Iberia Parish Health Unit

The parish health unit provides immunizations, support for women, infants and children (WIC), family planning resources, nutrition services and more.

Contact: Magan Broussard, RN
Address: 715 B Weldon Street
New Iberia, LA 70560
Phone: 337-373-0021
Email: Magabroussard@la.gov
Web: https://resources.chooselouisianahealth.com/map/iberia-parish-health-unit/

Lafayette Parish Health Unit

Contact: Kristy Lee
Address: 220 W. Willow St., Bldg. A
Lafayette, LA 70501
Phone: 337-262-5616
Email: kristy.lee@la.gov
Alt. Contact: Brooke Chehotsky
Alt. Email: Brooke.Chehotsky@la.gov

University of Louisiana at Lafayette, College of Nursing and Allied Health Professions (CONAHP)

The College of Nursing and Allied Health Professions includes undergraduate programs in nursing, health information management, health services administration, and pre-dental hygiene. Graduate programs are offered in nursing and include the MSN and DNP degrees.

Contact: Paula Zeanah, PhD, MSN, RN
Address: PO Box 43810
Lafayette, LA 70504
Phone: 336-482-0197
Email: paula.zeanah@louisiana.edu
Web: https://nursingalliedhealth.louisiana.edu/about-us

University of Louisiana at Lafayette, Picard Center for Child Development and Lifelong Learning

The Cecil J. Picard Center for Child Development and Lifelong Learning is a research center comprised of a multidisciplinary group of evaluation and research professionals who focus on early childhood, K-12 education, school-based health, poverty's effects on families, and lifelong learning.

Contact: Paula Zeanah, PhD, MSN, RN
Address: 200 E. Devalcourt Street
Lafayette, LA 70506
Phone: 337-482-1552
Email: paula.zeanah@louisiana.edu

Web: https://picardcenter.louisiana.edu/

Region 5 Resources – Beauregard, Allen, Calcasieu, Jefferson Davis and Cameron Parishes

Calcasieu Parish Health Unit/Sulphur (WIC services only)

Address: 201 Edgar Street
Sulphur, LA 70663
Phone: 337-527-6361

Department of Children and Family Services, Lake Charles

Contact: Lee Schmidt
Address: 1919 Kirkman St.
Lake Charles, LA 70601
Phone: 337-764-6046
Email: lee.schmidt.dcfs@la.gov

Jesslyn Langbein, LPC

Private practice and provides home-based services. Accepts Aetna, Amerigroup, LA Healthcare Connections, United Healthcare.

Contact: Jesslyn Langbein, LPC
Address: 126 Sunset Lane
DeRidder, LA 70634
Phone: 337-396-9435
Alt. Phone: 337-463-4534
Email: msjessey@aol.com
Web: http://latrauma.tulane.edu/assets/lakecharles.ypt.providerlist.v1.pdf

Healthy Louisiana, Office of Public Health (LDH)

Contact: Anna Goodwill
Address: 3236 Kirkman St.
Lake Charles, LA 70601
Phone: 337-478-6020, ext. 6035
Email: Anna.Goodwill@la.gov

Region 6 Resources – Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn Parishes

9th Judicial District Court

Contact: Judge Patricia Koch
Address: 702 Murray Street, 5th Floor
Alexandria, LA 71303
Phone: 318-443-6893
Email: Pkoch@9thjdc.com

Alexandria Parish Health Unit (LDH/OPH)

Contact: Charlotte Amphion
Address: 5604A Coliseum Blvd
Alexandria, LA 71303
Email: charlotte.amphion@la.gov

Web: http://ldh.la.gov/index.cfm/directory/detail/4637

Children's Advocacy Network

Children's Advocacy Network champions the needs of abused and neglected children throughout Central Louisiana. Our services include Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Children's Advocacy Center services (Forensic Interviews, Forensic Medical Exams, Family Advocacy, child trafficking service coordination, and multidisciplinary coordination of services), and Court Appointed Special Advocate (CASA) advocacy to children and families in foster care.

Contact: Wade Bond, Executive Director
Address: 1752 Jackson
Alexandria, LA 71301
Phone: 318-445-5678
Email: wbond@childrensadvocacy.net
Web: www.childrensadvocacy.net

Concordia Parish Health Unit (LDH)

Contact: Mary Spann
Address: 905 Mickey Gilley Avenue
Ferriday, LA 71334
Phone: 318-757-6271
Email: mary.spann@la.gov
Web: http://ldh.la.gov/index.cfm/directory/detail/4856

Department of Children & Family Services, Alexandria

Contact: Rita C. Jackson
Address: 900 Murray Street
P.O. Box 832
Alexandria, LA 71390
Phone: 318-487-5204, ext. 224
Email: rita.jackson.dcfs@la.gov

Eckerd Connects

Social services provide.

Contact: Jodie L Roberts II, Program Director
Address: 6501 Coliseum Blvd., Suite 700
Alexandria, LA 71303
Phone: 318-464-6520
Fax: 318- 443-7900
Email: jroberts@eckerd.org

Region 7 Resources – Bienville, Bossier, Caddo, Claiborne, De Soto, Natchitoches, Red River, Sabine, and Webster Parishes

Caddo Parish Juvenile Services

Juvenile Services is a department of the Caddo Parish Commission. It employs 85 people who operate a 24-bed juvenile detention center and a juvenile probation department. It serves the three Judges of Caddo Juvenile Court.

Contact: Clay Walker
Address: 1835 Spring Street
Shreveport, LA 71101
Phone: 318-226-6500
Email: cwalker@caddo.org
Web: http://www.caddo.org/162/Juvenile-Services

Curtis W Spears, LPC

Professional Counseling Therapy Service

Contact: Curtis W Spears, LPC
Address: 8848 Youree Dr.
Shreveport, LA 71115
Phone: 318-364-7800
Email: Cspears283@bellsouth.net
Web: https://sites.google.com/site/curtispearslpc/

Region 8 Resources – Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carrol Parishes

AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana is a managed care provider for Louisiana's Medicaid and the Child Health Insurance Program (LaCHIP). AmeriHealth Caritas Louisiana provides integrated health and behavioral health services as well as substance use treatment.

Contact: Terry Driskill, LPC
Address: 1502 Pine Street
Chatham, LA, 71226
Phone: 318-224-1188
Alt. Phone: 318-957-2530
Web: https://www.amerihealthcaritasla.com/pdf/provider/behavioral-health/mental-health-and-substance-use-provider-directory.pdf

Department of Children and Family Services, Ruston

Contact: Karen Herrington
Address: 811 N Service Road E
Ruston, LA 71201
Phone: 318-251-4101
Email: karen.herrington.dcfs@la.gov

Franklin Parish Health Unit

Contact: Kacie Walley
Address: 6614 Main St.
Winnsboro, LA 71295
Phone: 318-435-2143
Email: kacie.walley@la.gov
Web: http://ldh.la.gov/index.cfm/directory/detail/4801

Project Celebration, Inc.

Project Celebration, Inc. (PCI) is a nonprofit organization located in Northwest Louisiana. Our agency provides direct services to survivors of domestic violence, sexual assault and children experiencing violence. We currently provide services in Bossier, Caddo, DeSoto, Natchitoches, Red River, Sabine and Webster Parishes.

Address: 580 West Main Street
Pleasant Hill, LA 71065
Phone: 318-256-6242
Email: Director@projectcelebration.com
Web: https://www.projectcelebratio.com

Region 9 Resources – Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington Parishes

Livingston Parish Health Unit (LDH)

Contact: Elisha Thornton
Address: 20399 Government Blvd
P.O. Box 365
Livingston, LA 70705
Phone: 225-686-7017
Email: elisha.thornton@la.gov
Web: http://ldh.la.gov/index.dfm/directory/detail/4812

Positive Approaches

Positive Approaches is an outpatient mental health clinic, offering Infant Mental Health Services and other age appropriate services to those ages 0-65 years of age.

Contact: Misty L. Pardee MSW, LCSW
Address: 1505 Washington St.
Franklinton, LA 70438
Phone: 985-237-4880
Email: mpardee@positiveapproachesllc.net
Web: https://www.facebook.com/PositiveApproachesLLC/

Regina Coeli Child Development Center

The mission of Regina Coeli is to provide the highest quality of service to children and families through a community team effort based on the question: “Is it good for children?" Applications are accepted for any child regardless of income. According to Head Start Performance Standards up to 10% of the total children enrolled may be over the poverty income guidelines. In addition, another 35% of the total children may be from families with incomes between 1-35% over the poverty income guidelines.

Contact: Diana Allshouse
Address: 22476 Highway 190
Robert, LA 70455
Phone: 985-318-8800
Email: DAllshouse@rccdc.org
Web: http://rccdc.org/

Region 9, Team B, Maternal and Infant Home Visiting

Southeast Louisiana Area Health Education Center (SELAHEC)

Contact: Alison Blades
Address: 203 Highland Park Plaza
Covington, LA 70433
Phone: 985-871-0210
Email: alison.blades@la.gov
Web: www.selahec.org

St. Tammany Parish Library

Contact: Tanya DiMaggio
Address: 11121 West 21st Ave.
Covington, LA 70433
Phone: 985-893-6280
Alt. Phone: 985-629-1931
Email: tanya@stpl.us
Web: https://www.sttammanylibrary.org/

Therapeutic Partners, LLC

Therapeutic Partners, LLC, is an outpatient behavioral health facility owned and operated by clinicians who believe integrative care vastly improves patient outcomes, and who are committed to providing quality, comprehensive treatment. We offer progressive counseling and a team-based approach to assist children and adults in achieving their highest possible level of functioning, thus improving the overall wellness of our community.

Contact: In-Gyu Jang
Address: 60 Louis Prima Drive, Suite A
Covington, LA 70433
Phone: 985-327-5427
Fax: 985-327-8800
Alt. Contact: Colette Melancon, LCSW
Email: cmelancon@therapeuticpartners.net
Web: http://www.therapeuticpartners.net/contact.html