
RESILIENT KC

THRIVING THROUGH ADVERSITY

# FINAL EVALUATION REPORT

## SEPTEMBER 2017

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## Report Preparation

Marcia Dutcher, M.A.
Senior Research Assistant
UMKC-Institute for Human Development

Sommer, Rose, M.S.
Senior Research Assistant
UMKC-Institute for Human Development

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# I. Introduction

## Executive Summary

This report contains findings of the two-year Resilient KC (RKC) project. The results describe the frequency of response of adverse childhood experiences (ACEs) and resiliency of Kansas City region adults as well as organizational attitudes towards trauma-informed practices and how organizations work together to achieve collective goals.

Trauma Matters KC (TMKC), a multi-sector, bi-state 40+ agency network and the Greater Kansas City Chamber of Commerce (GKCCC) Healthy KC Initiative joined forces to carry out Resilient KC actions in a nine-county bi-state geographical area. In 2015, The Health Federation of Philadelphia announced that RKC was awarded as one of 14 Mobilizing Action for Resilient Communities from across the country to expand their innovative work in addressing childhood adversity. Financial support was provided from Robert Wood Johnson, the California Endowment, Health Care Foundation of Greater Kansas City, and the Black Community Fund. UMKC-Institute for Human Development was contracted to conduct the evaluation.

A unique feature of the RKC project was the formation of workgroups representing six sectors: Health, Education, Business, Community/Faith, Justice, and Armed Services. These workgroups, comprised of community members, created resources specific to their population of interest. During the two-year project, an array of outreach activities with the purpose of educating and raising awareness of trauma informed care (TIC) and resiliency were conducted within the geographical area.

Findings contained in this report, heighten the comparison of RKC with the original Kaiser ACE study and the Philadelphia Urban ACE Survey (PUA). The original Kaiser ACE study conducted by Felliti and Anda in 1998 was a groundbreaking investigation demonstrating that childhood exposure to physical, emotional, and sexual abuse and household dysfunctions can lead to poor health conditions in adult life. Sociologists and psychologists have published numerous articles that have confirmed the results of the 1998 Felliti and Anda ACE study. Another groundbreaking study, the PUA, focused its attention on the prevalence of ACEs in an urban setting by adding expanded ACEs indicators. The RKC ACES/Resilient survey incorporated the original Kaiser study indicators and the Philadelphia Urban study expanded indicators. Unlike previous studies, the RKC project included a survey to measure resilience in order to explore how resiliency might be a factor in addressing ACEs.

Findings within this report also explore the change in trauma-informed care and resiliency attitude among Kansas City regional adults who attended educational series sessions sponsored by the project. In addition, TIC attitude change was explored among employees from 13 organizations using an innovative tool, Attitude Related to Trauma-Informed Care (ARTIC). This tool was developed by the Traumatic Stress Institute of Klingberg Family Centers and Dr. Courtney Baker at Tulane University.

Attention was also given to exploring the attributes of the RKC Learning Collaborative which was comprised of 14 cross-sector organizations. A tool sponsored by Robert Wood Johnson, Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER) was used to measure the elements of the strength and quality of interactions within the learning collaborative.

## Summary Results

***Standard ACEs Indicators:*** Despite the similar characteristics between the original Kaiser and RKC study populations, Kansas City region adults had higher rates of child abuse and neglect as well as household dysfunctional indicators. Over half (57%) of adults experienced emotional abuse while growing up and RKC adults witnessed a parent or adult in their home being physically or emotionally battered four times greater than the rate found in the Kaiser study. When examining the rates of each child abuse and neglect indicator by gender, males had slightly higher rates of emotional (58%) and physical abuse (42%) than females. For the adults who identified as Hispanic/Latino, emotional abuse was experienced more (67%) than those who were not Hispanic/Latino. Black adults experienced more physical (40%) and sexual abuse (37%) as well as emotional neglect (40%) and physical neglect (24%) during their childhood than white adults. Black adults (46%) were also more likely to have grown up in a household with someone who abused substances and almost three more times likely (27%) to have grown up in the home where someone served time or was sentenced to serve time in prison, jail, or a correctional facility than white adults.

***Expanded Urban ACEs Indicators:*** Five expanded indicators taken from the Philadelphia Urban survey assess the impact of stressors in urban environments. The highest rate of expanded indicators among Kansas City adults was being bullied (29%) followed by witnessing violence (27%) and growing up in a neighborhood where they didn't feel safe or that people didn't look out for each other (27%). When examining the ACEs rates of the expanded indicators by gender and race, more (45%) males witnessed violence in their childhood compared to females and more (50%) Black adults witnessed violence in their childhood compared to white adults. Over half (55%) of the black adults experienced discrimination during their childhood compared to 6% of White adults. With the inclusion of the expanded indicators, the majority (87%) of the adults experienced at least one ACE and slightly over half (53%) experienced four or more ACEs.

***Resiliency and ACEs:*** Seven in ten (70%) Kansas City adults rated their resilience as Exceptional or High. As the number of ACEs increased, the percentage of Low and Moderate resiliency rates increased. Approximately 10% of Kansas City adults had Low to Moderate resiliency rates and zero ACEs; 18% had Low to Moderate resiliency rates and 1-3 ACEs; 43% adults who had Low to Moderate resiliency rates had four or more ACEs.

***Trauma Informed Care Attitudes (TIC):*** Education Series participants' overall attitudes about trauma-informed care changed primarily due to the belief of self-care and the belief that a

families' adversities have an impact on the community. Employees from 13 organizations also experienced an improvement in TIC attitudes especially organizations that had prior experiences with trauma-informed practices.

***Learning Collaborative:*** Organizations who participated in the Learning Collaborative perceived that position of an organizations' power and influence and level of involvement was similar to one another, suggesting that the level of involvement is not always contingent on the position of influence an organization may have. Teams also valued staff resiliency and increased knowledge about secondary trauma along with the importance of an organization review and/or revision of their policies and procedures to increase trauma sensitivity with persons who seek their services.

## Recommendations

- Consideration should be made to explore tailored interventions for gender, race, and ethnic populations. In this study, males, black adults and those who identified as Hispanic/Latino experienced some of the standard and expanded ACEs indicators more than their counterparts. Often times, systemic biases exist with these populations therefore any additional resources related to addressing ACEs and resiliency would be beneficial to the Kansas City community.

- Given some of the high rates of expanded urban ACEs indicators experienced by Kansas City adults, consideration should be made to using the expanded urban indicator version in future studies. With a more racially, economic and geographical diverse sample, the inclusion of these indicators could also shed light on how urban communities are perceived and polices defined in the Kansas City region such as the impact of gentrification and health services in the urban core.

- More attention should be given to understanding the hallmark traits of a successful learning collaborative that were introduced to the organizations that participated in the Resilient KC Learning Collaborative. Specific focuses on organizational long term sustainable trauma-informed and resilient practices such as self-care and secondary trauma would be beneficial for all organizations across sectors. Using the results from this study as a springboard for further investigation could be useful. As the demand for partnerships increase, an interdisciplinary learning collaborative will become increasingly important.

## Adverse Childhood Experiences (ACEs)

Communities vary greatly in the number and severity of health and safety problems they face and the resources available to solve these problems (Longhi, Porter, 2009*).* Many of these problems stem from trauma and toxic stress which can rear its ugly head in many circumstances and the consequences found across all systems of care. Today, people with trauma histories have overlapping problems with mental health, substance abuse, and/or physical health and are victims of crime.

Research shows a strong relationship between adverse childhood experiences (ACEs) and high-risk behaviors, diseases, disabilities, and workforce issues (Felitti et al., 1998). Studies demonstrated that stressful or traumatic childhood experiences such as abuse, neglect, witnessing domestic violence, or growing up with alcohol/substance abuse, mental illness, parental discord, or crime in the home are a common pathway to social, emotional, and cognitive impairments that lead to increased risk of unhealthy behaviors, violence or re-victimization, disease, disability, and premature mortality (Hall et. al., 2012). Additional research is exploring how dangerous levels of stress can derail healthy brain development resulting in long-term effects on learning, behavior, and health. The early childhood brain is highly malleable which causes it to be particularly sensitive to chemical influences such as elevated stress hormone levels. When elevated stress hormone levels are frequent or sustained, normal brain development is disrupted (Shonkoff, 2013; Garner, 2014). Such disruptions in brain development during childhood can have damaging effects on learning, behavior and health across the life course (Center on the Developing Child at Harvard University, 2016).

The use of the ACE score as a measure of the cumulative effect of traumatic stress exposure during childhood is consistent with the latest understanding of the effects of traumatic stress on neurodevelopment (Anda et al., 2010; Anda et al., 2006). While they were first identified as risk factors for chronic disease, they have more recently been identified with immediate negative consequences, such as chromosome damage (Shalev et al., 2013) and functional changes to the developing brain (Anda et al., 2010; Cicchetti, 2013; Danese and McEwen, 2012; Teicher et al., 2003). Thus, the more ACEs experienced, the greater the exposure of the developing brain to the body's toxic stress response and the greater the likelihood of developmental difficulties and health problems later in life (Center on the Developing Child at Harvard University, 2016).

In the Felitti and Anda 1995-1997 Centers for Disease Control and Prevention (CDC) Kaiser Permanente ACE study they found that ACEs were prevalent among the population. Slightly less than half (47.9%) of the respondents reported experiencing at least one ACE and one to three (45.3%). In the original Kaiser study, 6.8% of the respondents experienced four or more ACEs. The study also found a dose response relationship between ACE scores and risky behaviors, such as smoking, physical inactivity, and multiple sexual partners. ACEs were found to be linked in a dose response relationship to poor health outcomes in adulthood (Felitti, et al., 1998). As the number of ACEs a person experienced increased the likelihood of poor health outcomes increased as well.

In 2008, the CDC developed an ACE module for use in the Behavioral Risk Factor Surveillance System (BRFSS), a state-based system of telephone surveys, established by the CDC. The ACE module was administered in five states--Arkansas, Louisiana, New Mexico, Tennessee, and Washington (CDC, 2009). In 2010, Wisconsin (Children's Trust Fund, 2010) and the Pennsylvania (BRFSS, 2010) were added. In the original five states, 59% of respondents reported having at least one ACE and 15% had four or more ACEs. Among Wisconsin residents, 56% of the adult population experienced at least one ACE and 14% had an ACE score of four or more. Approximately 53% of Pennsylvania residents experienced at least one ACE and 13% experienced four or more ACEs.

The ACE optional module was included for the first time in the 2014 Kansas BRFSS (KDHE, 2016). This study found that slightly more than half (54.5%) of Kansas adults reported having experienced at least one ACE. About a third of the adults had one or two ACEs; while 13.5% Kansas adults had four or more ACEs.

While several Kansas City region mental health agencies administer some form of ACEs in their clinical practice, few have had the resources to report aggregated findings to the public. In the Kansas City region alone, inter-related problems such as infant mortality, teen pregnancy, obesity and diabetes, suicide, living standards, and access to healthcare are difficult for communities to address because of the complexity of funding streams and programs (MARC, 2013). Another recent report found that the current health status of Kansas City region children have many unmet health needs that will ultimately impact their adult lives (State of Children's Health, 2016).

## Resilience

A growing network of leaders in research, policy, and practice are developing approaches to prevent adverse childhood experiences and mitigate their impact through building resilience. As a result, a plethora of ways to describe resilience has surfaced. The most common term has come to mean an individual's ability to overcome adversity and continue his or her normal development. However, resilience requires individuals have the capacity to find resources that bolster well-being while also emphasizing that it's up to families, communities, and governments to provide these resources in ways individuals value (Unger, 2008; Unger, 2013). It is now widely accepted that resilience is associated with individual capacities, relationships, and the availability

of community resources and opportunities (Luthar et al. 2006; Masten , 2014). Over the last two decades, studies have affirmed that resilience is not a static state, an outcome, or an inherent trait within the individual (Kolar K., 2011; Masten, 2014). Rather, the interactions between an individual's environment, their social ecology, and an individual's assets, promote resilience (Masten, 2014). Consequently, the focus of empirical work continues to expand from identifying protective factors within and defined outcomes related to the individual to include an understanding of the underlying mechanisms and processes located in their environment. Other protective factors that can help to build resiliency in children faced with adversity include intellectual and cognitive ability, academic engagement, social competence, the ability to regulate emotions, self-esteem, a sense of personal control, problem-solving skills, family cohesion and stability, high quality peer relationships, involvement in extracurricular activities and hobbies, and a positive school environment (Haskett, et al., 2006). One undisputed detail is that toxic stress and resilience research go hand-in-hand, like two sides to a coin.

## II. Background of Resilient KC

### Partners and Funders

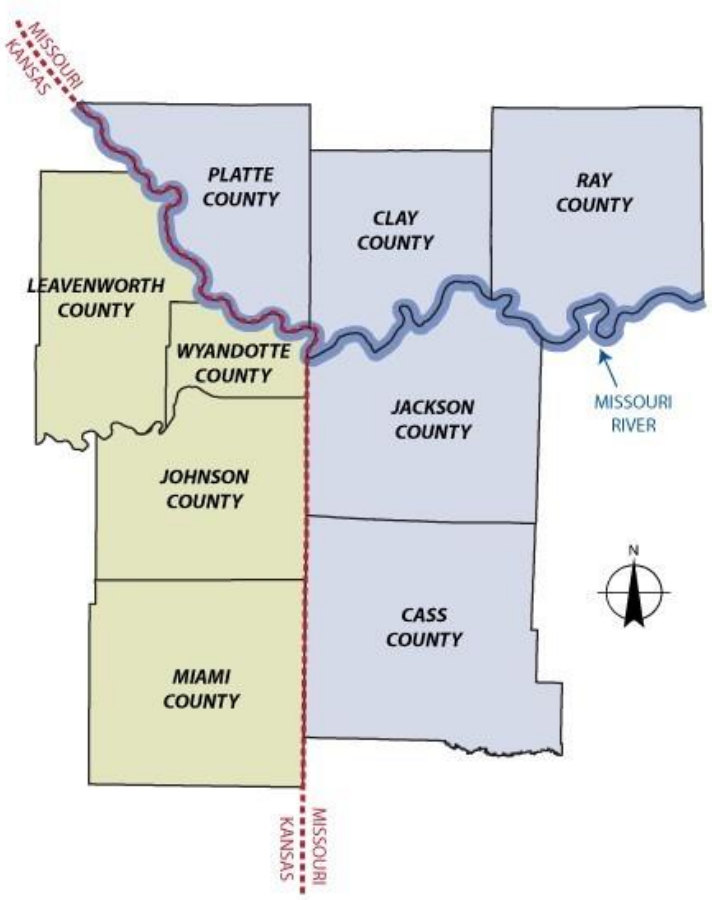
Trauma Matters KC (TMKC) a multi-sector, multi system, bi-state 40+ agency network was initially invited by The Health Federation of Philadelphia, and the Robert Wood Johnson Foundation, and the California Endowment to present a case for participating in a two-year national initiative on adversity and resilience. Coupled with the Greater Kansas City Chamber of Commerce (GKCCC) Healthy KC Initiative, a partnership ensued. Out of this partnership, Resilient KC (RKC) was awarded as one of 14 Mobilizing Action for Resilient Communities from across the country to expand their innovative work in addressing childhood adversity. In October 2015, the two-year RKC project was launched. On a local level, the Health Care Foundation of Greater Kansas City provided financial and technical support for the evaluation portion of the project. In addition, the Black Community Fund provided financial support for data collection. The University of Missouri Kansas City Institute for Human Development spearheaded the participatory action evaluation.

## Goals and Purpose

Resilient KC is comprised of three goals:

- Raise awareness about trauma-informed care
- Collect ACEs and Resilient baseline data
- Build resilient communities

The geographical boundaries of the project were comprised of a nine-county, bi-state area which included: Kansas counties of Wyandotte, Johnson, Miami, and Leavenworth and Missouri counties of Platte, Clay, Ray, Jackson, and Cass. (See map diagram below).




The purpose of the RKC project was to specifically inform the practices-development of the following:

- To explore the frequency of responses of ACEs and resiliency in the Kansas City region
- To explore the attitude change of Summit Education Series participants
- To explore the readiness of organizations to address trauma-informed care and promote resilient practices
- To explore the number and quality of relationships in a learning collaborative

During the two year Resilient KC grant, the community had multiple opportunities to become aware of trauma informed care, secondary trauma, and resiliency. Workgroups representing six sectors were formed. The six sectors included: Health, Education, Business, Community/Faith, Justice, and Armed Services. A member of the Steering Committee served as a co-chair for each group. Workgroups created resources specific to their population of interest. In addition, ACEs and resilience awareness outreach activities were conducted within a multitude of community events, social media, and trainings.

## III. Methodology

The Resilient KC evaluation is based on a participatory action research (PAR) design within a theory of action framework (see Appendices). From this framework a logic model was developed to guide the evaluation team and program stakeholders throughout the various evaluation activities which included:

- ACEs/Resilient survey
- Education Series survey
- Related Learning Collaborative surveys (e.g., organizational Trauma-informed care (TIC) attitude and social network)

### Sample Design

The Kaiser ACEs, BRFSS ACEs, and Urban Philadelphia ACEs studies used an extensive dual frame random digit telephone survey to collect a representative sample of the entire population. The Resilient KC project did not use a randomized sample technique; therefore the findings in this report are not a direct representation of the entire Kansas City Region population (see Table 1). Instead, given the available human resource, a convenience sampling technique was used for all subjects. All data collected was de-identifiable allowing for a participant to have complete anonymity. The proposed sample size of 562 for each of the nine counties in the RKC study was calculated using a prevalence data formula based on the Philadelphia Urban Study expected prevalence of 0.373 (4+ACEs) (PHC, 2013).

Table 1. Demographic Characteristics of Kansas City Region Residents and RKC ACE Survey Respondents

| | Kansas City Region Residents | RKC ACE Study |
|---|---|---|
| **Gender** | | |
| Female | 52.1% (n=747,059) | 78.2% (n=2,795) |
| Male | 47.9% (n=686,450) | 21.6% (n=772) |
| **Race** | | |
| White | 82.9% (n=1,496,031) | 81.7% (2,923) |

| | | |
|---|---|---|
| Black | 17.1% (n=309,623) | 9.7% (n=347) |
| Hispanic/Latino | 10.2% (n=196,049) | 9.7% (n=346) |
| Education Attainment | | |
| Less than High School Diploma | 10.7% (n=146,931) | 3.7% (n=132) |
| High School Diploma/GED | 26.5% (n=362,754) | 6.3% (n=227) |
| Some College (no degree) | 35.7% (n=487,700) | 12.6% (n=450) |
| College Graduate | 27.1% (n=370,614) | 30.6% (n=1,655) |
| All Participants | 1,919,089 | 3,582 |

*Note: 2010 US Census https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml accessed 9/17*

## Procedures

### The ACEs/Resiliency Survey

The ACEs/Resilient survey data collection strategy was multi-faceted. The survey was made available in English and Spanish, and in paper format or on-line through a public link found on the Resilient KC website. The primary data collection strategy involved the six RKC workgroups (Business, Community/Faith, Education, Health, Justice, and Armed Services) and TMKC members who encouraged individuals, friends, family, and co-workers to complete the survey. Several RKC Steering Committee and TMKC members made an organizational mass appeal to their employees to complete the survey and share the link with others. In an attempt to illicit a broader audience, KMBC-Channel 9 provided air-time advertisements in English and Spanish to areas of the Kansas City region and the Healthcare Foundation of Greater Kansas City sponsored radio announcements on KCUR/NPR. In addition, organizations that specifically serve African American individuals, Spanish speaking individuals, and hard to reach populations such as incarcerated individuals distributed a paper version of the survey accessible to their networks. Along with these strategies, the evaluation team collected ACEs/Resilient surveys during special events and various education sessions.

### Education Series

The Education Series was coordinated by the TMKC Education Committee and RKC project director. The series included four sessions that were intended to measure participant attitude change of trauma-informed care and resilience. The data collection was managed by the evaluation team in tandem with the Trauma Matters KC Education Committee members and RKC project director. A fifth session was conducted prior to implementing the evaluation design. The four sessions included in the evaluation were:

Putting the Green in Greensburg: This session transpired at Johnson County Mental Health Center. Attendees included architecture students and individuals representing non-profit organizations. The superintendent of Kiowa County and the local architect who helped build and create a green community after the devastating Greensburg tornado were guests. Approximately 22 participants ensued in a conversation about the greener future of Greensburg and the role resilience plays in creating a safe and welcoming community for all.

Medical Student Group: Attendees included medical students from Kansas City University of Medicine and Biosciences, University of Missouri-Kansas City, and Rockhurst University. Pre-medical students and residents also attended. Approximately 50 students spent two hours rotating between physicians from Children's Mercy Hospital and Truman Medical Center, a social worker, and a hospice representative who all practice trauma informed approaches. The students were also briefly exposed to the ACEs study using the KPRJ ACEs primer video.

Networking Forum: As part of the Chamber's Healthy KC Networking forums, the first segment of the program highlighted trauma informed care and the work of Resilient KC. Health and wellness business professionals attended and were introduced to ACEs, trauma informed approaches, and ways employers can implement practices to help their employees and ultimately impact their bottom line.

Gordon Parks: Gordon Parks Elementary school co-hosted a screening of the film Resilience (KPRJ). Fifty education professionals attended, watched the film, and listened to a panel of local experts from Children's Mercy, Café Gratitude, and Turning Point KC discuss trauma informed approaches and trauma sensitive practices in schools.

Data from the educational series was collected using Research Electronic Data Capture (REDCap), a metadata-driven software. REDCap was chosen because it uses a streamlined electronic data collection system with analytic efficiency, security, and is cost-effective.

Enrollment announcements and instructions for each session were made through the Resilient KC website, during Trauma Matters KC every-other month community meetings, and by word of mouth. Individuals who registered and attended the sessions were sent an on-line pre-test survey prior to the event. For those who were unable to pre-register, access to the pre-test survey were made available in person immediately prior to the beginning of the session. The post-test was sent a couple of days after each completed session to those who had completed the pre-test. At least two reminders were sent to enhance the response rate.

### Trauma-informed Care Attitude Change

The trauma-informed care attitude change data collection were managed by the evaluation team in tandem with the facilitator of the 12-month Learning Collaborative (LC). The Learning Collaborative consists of 14 organizations interested in learning how their organization could improve upon their existing trauma-informed practices and policies. Teams attended a 3-day

orientation held in October 2016. Immediately following the 3-day Learning Collaborative orientation, each team and employees representing their organization were sent the Attitude Related to Trauma Informed Care (ARTIC) pre-test survey using the REDCap on-line software system. Electronic reminders were sent over a two month period. Between May and June 2017, the ARTIC post-test survey was sent to those who had completed the pre-test survey followed by several reminders to enhance a strong response rate.

### Organizational Collaboration

The organizational collaboration data from the administration of the PARTNER tool (Program to Analyze, Record, and Track Networks to Enhance Relationships) were collected during the 10th month of the 12 month program from each team who participated in the Learning Collaborative activity. The Learning Collaborative was formed to promote community learning about trauma, informed care and practices, and resilience in the most cost effective manner possible. The application process was designed for organization to carefully think about why they wanted to participate and where they thought their organization was on the Missouri Model for becoming a trauma informed organization. The model promotes growth through a process of: 1) awareness, 2) sensitivity, 3) responsiveness, and 4) informed care and practices.

## Instrument Design

### Adverse Childhood Experiences (ACEs) Tool

The Resilient KC survey was designed by UMKC-Institute for Human Development evaluation team and the Resilient KC Steering Committee. The survey included ACE questions from the original 1995-1997 CDC Kaiser ACE study and the core ACE questions from ACE module used in the 2008 Behavioral Risk Factor Surveillance System. There were ten types of childhood trauma measured in the Kaiser ACE Study comprised of ten questions. Five are personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who is an alcoholic, a mother who is a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce or separation. There are eight types measured in the BRFSS ACE Module comprised of eleven questions. Three are personal -- physical abuse, emotional abuse, and sexual abuse. Four are related to domestic violence, household substance abuse, household mental illness, and parental separation or divorce.

Following the direction of the Steering Committee for the development of the RKC-ACEs survey, the evaluation team used an expanded version of the original CDC-Kaiser ACE study and the ACEs module used in the 2008 BRFSS to capture adversities related to urban core neighborhoods and communities. The Philadelphia Urban ACE Survey (PUA) report, contracted by Pubic Health Management Corporation (PHMC, 2013), served as a guide for the expanded ACEs question. The RKC-ACEs and the PUA ACE studies measured the 10 original types of

childhood trauma included in the conventional ACEs questions as well as four culturally defensible questions about the following community adversities:

- Neighborhood safety and trust
- Bullying
- Witness violence
- Racism/Discrimination
- Foster Care

Differences in wording between the RKC-ACEs survey, the original Kaiser ACE study, the BRFSS ACE module, and the Philadelphia Urban ACE can be found in the Appendices. Phrasing and responses to the core ACE questions correspond with the Kaiser and BRFSS questions so that all indicators are included. The extended portion of the survey questions followed the PUA survey. It should be noted that the Resilient KC survey did not include health outcome questions. However, 13 descriptive items were added which included: gender, age, race, ethnicity, sexual identity, education level, relationship, employment status, type of employment, county residence, employment location, household annual income, and types of direct services utilized. The RKC-ACEs survey was comprised of a total of 22 ACE items that were used to formulate the 14 ACEs indicators. The survey was available in English and Spanish languages (see Appendices).

### Resilient KC Resilience Tool

The Resilience Tool was used to measure individuals' resilience score. The tool was directly replicated from the Resilience Research Centre—Adult Resilience Measure (RRC-ARM-12) which is an adapted version of the Child and Youth Resilience Measure (CYRM). The CYRM is a screening tool designed to measure the resources (individual, relational, communal and cultural) available to individuals (Liebenberg L., UngarM., Van de Vijver F., 2012; Liebenberg L, Ungar M., LeBlanc, 2013; Ungar M., Liebenberg L., 2011). The CYRM-12 with two optional response ratings of three and five has been validated. Work to validate the RRC-ARM-12 with the two different response ratings is still in progress. For this project, the RKC Resilience Tool consists of the 12 items using a five-point response scale. Higher scores indicate higher levels of resilience. The tool addresses seven factors/processes associated with resilience which include:

| | |
|---|---|
| **Access to Supportive Relationships** | Relationships with significant others, peers, and adults within one's family and community. |
| **Development of Desirable Personal Identity** | Personal and collective sense of purpose, self-appraisal of strength and weaknesses, aspirations, beliefs and values, spiritual and religious identification. |
| **Experiences of Power and Control** | Experiences of caring for one's self and others; the ability to effect change in one's social and physical environment in order to access health resources. |
| **Experiences of Social Justice** | Experiences related to finding a meaningful role in community and social equality. |

| | |
|---|---|
| **Access to Material Resources** | Availability of financial, educational, medical, and employment assistance and/or opportunities, as well as access to food, clothing and shelter. |
| **Experiences of a Sense of Cohesion** | Balancing one's personal interests with a sense of responsibility to the greater good; feeling a part of something larger than one's self socially and spiritually. |
| **Adherence to Cultural Practices** | Adherence to one's local and/or global cultural practices, values, and beliefs. |

## Education Attitude Tool

In tandem with the evaluation team, the Trauma Matters KC evaluation committee developed a pre- and post-test survey. The survey was administered to registered participants' email addresses using the REDCap private electronic system. The purpose of the 15-item questionnaire is to determine the effectiveness of the educational series to achieve improved trauma-informed and resilient attitudes. Responses to the questions were based on a five point scale with "Strongly Disagree" as 1 and "Strongly Agree" as 5 (see Appendices).

### *Attitude Related to Trauma Informed Care (ARTIC) Tool*

The Attitudes Related to Trauma-Informed Care (ARTIC) Tool. As an objective way to determine if trauma-informed care (TIC) is being practiced, the ARTIC tool was identified as an optimum instrument. The ARTIC is the first psychometrically valid measure of TIC. It was developed collaboratively by the Traumatic Stress Institute of Klingberg Family Centers and Dr. Courtney Baker at Tulane University. There are three versions of the ARTIC for human services setting (45-item, 35-item, and 10-item short form) and three versions for education settings. The ARTIC pre- and post-test measures the favorable or unfavorable attitudes of service providers who represented the 13 organizations who participated in the Learning Collaborative (one organization chose not to participate in the ARTIC survey). The ARTIC tool is based on the premise that staff attitudes are an important driver of staff behavior.

ARTIC has five core subscales and two supplementary subscales:

- Underlying Causes of Problem Behavior and Symptoms
- Responses to Problem Behavior and Symptoms
- On-the-Job Behavior
- Self-Efficacy at Work
- Reactions to Work
- Personal support of TIC
- System-Wide Support of TIC

For this project, the Human Services 45-item scale that is used in human service settings and the Education 45-item scaled used in education settings were administered using the REDCap private link electronic system.

### Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER) Tool

The PARTNER is a social network analysis tool designed to measure and monitor collaboration among people or organizations. The tool is sponsored by Robert Wood Johnson Foundation. The tool includes an online survey used to collect data and an analysis program that analyzes the following elements:

- Identification of partners within the collaboration
- Record of the frequency of interactions
- Elements of the strength and quality of the interactions
- Measures of trust and value within the collaboration
- Network scores to report and illustrate changes to collaboration activity over time
- Outcomes measures related to success of the collaborative

## Participants

### ACEs/Resilient Participants

The majority of the respondents of the original Kaiser study were primarily white non-Hispanic, middle class, and had more than a high school education. Three out of four (74.8%) were white (see Table 2.) The majority (75.2%) of the Kaiser study participants had more than a high school education, 35.9% had completed some college, and 39.3% were college graduates or higher. The Resilient KC study participants resembled the Kaiser study participants. The majority of the respondents of the Resilient KC study were primarily white, non-Hispanic, middle class, and had more than a high school education. Four of the five (81.7%) were white. In addition the majority of the Resilient KC study participants had more than a high school education: 12.6% completed some college, and 69.6% of respondents were college graduates or higher. The Kaiser and Resilient KC survey respondents were less racially and socioeconomically diverse than respondents of the Philadelphia Urban survey.

Table 2. Comparisons between the Kaiser, Philadelphia, & Resilient KC Participant Demographics

| | Kaiser Study (1995) | Philadelphia Study (2013) | RKC Study (2017) |
|---|---|---|---|
| **Gender** | | | |
| Female | 54.0% (n=9,362) | 58.3% (n=1,040) | 78.2% (n=2,795) |
| Male | 46.0% (n=7,975) | 45.3% (n=744) | 21.6% (n=772) |
| **Race** | | | |
| White | 74.8% (n=12,968) | 44.1% (n=786) | 81.7% (2,923) |
| Black | 4.6% (n=798) | 42.5% (n=758) | 9.7% (n=347) |

| | | | |
|---|---|---|---|
| Hispanic/Latino | 11.2% (n=1,942) | 3.5% (n=63) | 9.7% (n=346) |
| **Education Level** | | | |
| Less than High School Diploma | 7.2% (n=1,248) | 10.3% (n=184) | 3.7% (n=132) |
| High School Diploma/GED | 17.6% (n=3,051) | 31.4% (n=558) | 6.3% (n=227) |
| Some College | 35.9% (n=6,224) | 22.7% (n=402) | 12.6% (n=450) |
| College Graduate | 39.3% (n=6,813) | 35.7% (n=634) | 69.6% (n=2,487) |
| **All Participants** | **17,337** | **1,784** | **3,582** |

*Note: All participants in each study are 18 years or older.*

A total of 3,757 participants completed the RKC survey. However, 112 or 3% reported they did not live or work within the designated geographical nine county area. In addition 63 or 1.7% did not respond to the residence item. Therefore, results from the survey only include participants who either lived or worked in the geographical nine-county, bi-state region (N=3,582). Based on the convenience sample technique, approximately four out of ten (37.7%) of the participants reported they lived in Jackson County while three out of ten (30.9%) lived in Johnson County. Of the remaining seven counties (Leavenworth, Wyandotte, Miami, Plate, Clay, Ray, and Cass) three counties (Clay, Wyandotte, and Platte) had at least five-percent (11.6%, 8.8%, and 5.5%) of the total surveyed, while Leavenworth, Miami, Ray, and Cass had a cumulative total of 5.6% representing the total percent of participants. Table 3 describes demographics of the five highest participating counties.

As seen below, the percentage of female and male did not vary much by the five counties. However, when examining race and ethnicity characteristics by each county, Johnson, Clay and Platte counties had fewer Black adults than Jackson and Wyandotte counties. Wyandotte County had more Latino adults than any of the four other counties. Wyandotte County also had the highest percentage of adults who had less than a high school degree (25.8%) and the highest percentage of adults unemployed (19.8%).

Table 3. Demographic Characteristics of ACE/Resilient Participants by Counties

| | Jackson County, MO | Johnson County, KS | Clay County, MO | Wyandotte County, KS | Platte County, MO |
|---|---|---|---|---|---|
| **Gender** | | | | | |
| Female | 77.4% (n=1,042) | 79.1% (n=876) | 79.5% (n=329) | 75.0% (n=234) | 83.8% (n=166) |
| Male | 22.3% (n=300) | 20.7% (n=229) | 20.5% (n=85) | 24.4% (n=76) | 16.2% (n=32) |
| Transgender | 0.3% (n=4) | 0.2% (n=2) | _ | 0.6% (n=2) | _ |

| | | | | | |
|---|---|---|---|---|---|
| **Race/Ethnicity** | | | | | |
| Black | 17.3% (n=233) | 3.0% (n=33) | 5.6% (n=23) | 14.4% (n=45) | 3.0% (n=6) |
| White | 74.7% (n=1005) | 90.8% (n=1,004) | 88.9% (n=368) | 58.5% (n=183) | 91.4% (n=181) |
| Latino* | 7.9% (n=106) | 6.2% (n=69) | 2.9% (n=12) | 45.9% (n=144) | 4.0% (n=8) |
| Combination of Races** | 8.0% (n=108) | 6.3% (n=56) | 5.5% (n=23) | 27.0% (n=85) | 5.5% (n=11) |
| **Education** | | | | | |
| <High School Degree | 2.8% (n=38) | 1.1% (n=12) | _ | 25.8% (n=80) | 0.5% (n=1) |
| High School Graduate or GED | 8.7% (n=117) | 2.6% (n=29) | 6.0% (n=25) | 12.6% (n=39) | 1.5% (n=3) |
| Post High School Technical Training | 1.7% (n=23) | 1.0% (n=11) | 1.7% (n=7) | 2.9% (n=9) | 0.5% (n=1) |
| Some college (no degree) | 15.7% (n=212) | 8.8% (n=97) | 10.1% (n=42) | 16.1% (n=50) | 8.1% (n=16) |
| Associates Degree/ Technical Certificate | 5.7% (n=77) | 5.2% (n=58) | 6.0% (n=25) | 7.1% (n=22) | 7.1% (n=14) |
| College Degree | 21.7% (n=292) | 27.5% (n=304) | 27.5% (n=114) | 12.3% (n=38) | 23.7% (n=47) |
| Graduate courses/degree | 43.7% (n=589) | 53.9% (n=596) | 48.5% (n=201) | 23.2% (n=72) | 58.6% (n=116) |

| | Jackson County, MO | Johnson County, KS | Clay County, MO | Wyandotte County, KS | Platte County, MO |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 18-22 | 3.6% (n=48) | 4.2% (n=46) | 2.2% (n=9) | 13.1% (n=41) | 2.5% (n=5) |
| 23-29 | 17.9% (n=241) | 14.8% (n=164) | 14.5% (n=60) | 18.5% (n=58) | 16.7% (n=33) |
| 30-49 | 47.1% (n=635) | 50.2% (n=556) | 57.5% (n=238) | 38.7% (n=121) | 50.0% (n=99) |
| 50+ | 31.4% (n=423) | 30.8% (n=341) | 25.8% (n=107) | 29.7% (n=93) | 30.8% (n=61) |
| **Sexual Identity** | | | | | |
| Heterosexual (Straight) | 87.5% (n=1,179) | 93.8% (n=1,038) | 91.3% (n=378) | 89.2% (n=280) | 92.9% (n=184) |
| Homosexual (Gay/Lesbian | 5.6% (n=76) | 2.8% (n=31) | 2.7% (n=11) | 4.8% (n=15) | 3.5% (n=7) |
| Bisexual (attracted to (both men and women | 6.3% (n=85) | 2.9% (n=32) | 5.1% (n=21) | 3.5% (n=11) | 3.5% (n=7) |
| Other | 0.8% (n=7) | 0.5% (n=6) | 1.0% (n=4) | 2.5% (n=8) | _ |
| **Relationship Status** | | | | | |
| Single | 25.8% (n=348) | 18.8% (n=208) | 17.1% (n=71) | 25.8% (n=81) | 20.7% (n=41) |
| Married | 48.1% (n=648) | 61.9% (n=685) | 62.3% (n=258) | 45.9% (n=144) | 66.7% (n=132) |
| Unmarried partners | 10.8% (n=145) | 7.5% (n=83) | 6.8% (n=28) | 14.6% (n=46) | 5.6% (n=11) |
| Separated | 1.7% (n=23) | 0.4% (n=4) | 1.7% (n=7) | 3.8% (n=12) | 1.0% (n=2) |
| Divorced | 11.2% (n=151) | 9.4% (n=104) | 10.1% (n=42) | 5.7% (n=18) | 5.1% (n=10) |
| Widowed | 2.4% (n=33) | 2.1% (n=23) | 1.9% (n=8) | 4.1% (n=13) | 1.0% (n=2) |
| **Employment Status** | | | | | |
| Full-time | 73.1% (n=985) | 80.0% (n=885) | 80.2% (n=332) | 58.1% (n=182) | 82.3% (n=163) |
| Part-time | 9.7% (n=131) | 9.8% (n=108) | 8.9% (n=37) | 17.3% (n=54) | 8.6% (n=17) |
| Retired | 5.0% (n=68) | 3.9% (n=43) | 3.4% (n=14) | 4.8% (n=15) | 2.5% (n=5) |
| Unemployed | 12.2% (n=164) | 6.3% (n=70) | 7.5% (n=31) | 19.8% (n=62) | 6.6% (n=13) |

*Note: *Latino = Yes, to identifying as Hispanic/Latino*

*Note: **Combination Race = Asian, American Indian Native, Hawaiian or other Pacific Islander, More than one race, and Other race.*

## Education Series Participants

A total of 134 participants completed the pre-test however only 82 participants completed the post-test, for a response rate of 61.2%. Demographic characteristics are described for those who completed the pre- and post-test survey. Most often participants were female, white, college degree or higher, 23 to 29 years old, single, lived in Jackson County, and worked either in Johnson or Jackson counties (see Table 4).

Table 4. Demographic Characteristics of Matched Group Education Series Participants

| | |
|---|---|
| **Gender** | |
| Male | 28.0% (n=23) |
| Female | 72.0% (n=59) |
| **Race/Ethnicity** | |
| Black | 3.7% (n=3) |
| White | 72.0% (n=59) |
| Latino* | 3.7% (n=3) |
| Combination of Races** | 24.7% (n=20) |
| **Education** | |
| H.S graduate/GED or Post H.S. Tech. training | 3.7%% (n=3) |
| Some college (no degree) or Assoc. Degree/Tech Certificate | 23.2% (n=7) |
| College Degree | 32.9% (n=27) |
| Graduate courses/Degree | 54.9% (n=45) |
| **Age** | |
| 18-22 | 15.9% (n=13) |
| 23–29 | 40.2% (n=33) |
| 30–49 | 28.0% (n=23) |
| 50+ | 15.9% (n=13) |
| **Relationship Status** | |
| Single | 48.8% (n=40) |
| Married | 34.1% (n=28) |
| Unmarried partners | 13.4% (n=11) |
| Divorced | 3.7 (n=3) |
| **County live in** | |
| Leavenworth | 1.2% (n=1) |
| Wyandotte | 2.4% (n=2) |
| Johnson | 25.6% (n=21) |
| Platte | 3.7% (n=3) |
| Clay | 15.8% (n=13) |
| Jackson | 42.7% (n=35) |
| **County work in** | |
| Wyandotte | 3.7% (n=3) |
| Johnson | 28.0% (n=23) |
| Clay | 11.0% (n=9) |
| Jackson | 22.0% (n=18) |
| Not employed | 35.4% (n=29) |

*Note: *Latino = Yes to identifying as Hispanic/Latino*
*Note **Combination of Races = Asian, American Indian Native, More than one race, and Other race*

## ARTIC Participants

A total of 535 participants representing 13 organizations completed the pre-test survey, however only 254 participants representing the 13 organization completed the post-test for a 47.5% response rate. Demographic characteristics are described for those who completed the pre- and post-test survey (see Table 5).

Table 5. Demographic Characteristics of ARTIC Participants

| | |
|---|---|
| **Gender** | |
| Male | 19.6% (n=49) |
| Female | 78.7% (n=200) |
| Transgender | .4% (1) |
| **Age** | |
| 18-22. | .8% (n=2) |
| 23-29 | 12.2% (n=31) |
| 30-49 | 53.2 % (n=133) |
| 50+ | 33.6% (n=84) |
| **Race** | |
| Black | 17.6% (n=44) |
| White | 72.8% (n=182) |
| Latino* | 5.6% (n=14) |
| Combination of Races** | 9.6% (n=24) |
| **Sexual Identity** | |
| Heterosexual (Straight) | 92.4% (n=231) |
| Homosexual (Gay/Lesbian) | 2.0% (n=5) |
| Bi-sexual (attracted to both men and women) | 3.2% (n=8) |
| Other | 2.4% (n=6) |
| **Education Level** | |
| < High School Degree | .4% (n=1) |
| High School graduate or GED | (4.0% (n=10) |
| Post High School/Technical training | ½% (n=3) |
| Some college (but no degree) | 8.0% (n=20) |
| Associates Degree/Technical school Certificate | 6.4% (n=16) |
| College Degree (4 year) | 16.8% (n=42) |
| Graduate courses or graduate Degree | 63.2% (n=158) |
| **Relationship Status** | |
| Single | 22.8% (n=57) |
| Married | 55.6% (n=139) |
| Unmarried partners | 8.4% (n=21) |
| Separated or Divorced | 12.4% (n=31) |
| Widowed | .8% (n=2) |

*Note: *Latino = Yes, **Combination of Races = Asian, American Indian Native, Native Hawaiian or other Pacific Islander, More than one race, Other race*

## PARTNER Participants

Fourteen organizations participated in the Learning Collaborative. Each organization created a team that determined their own organization's level of need and processes to achieve their goals. Every other month all the teams came together for two hours sessions to go over topics they had selected. The fourteen organizations are briefly described in Table 6.

Table 6. Learning Collaborative Organization Participants

| Organization | Vision/Description |
|---|---|
| Center School District | A trauma informed district is a safe and respectful environment that enables students and staff to build caring relationships and self-regulate their emotions, behaviors, and academic success, while supporting their physical health and well-being. |
| Mattie Rhodes Center-Northeast | A community development organization dedicated to individuals and family well-being through social services, behavioral health counseling and the arts. |
| ReDiscover | A nonprofit community mental health center that provides comprehensive programs and services for men, women, and children whose lives have been affected by mental illness and/or substance use disorders. |
| Rose Brooks Center | Create a safe, welcoming, inviting, warm, and accessible physical environment for the people we serve and our own work force. Build resiliency among staff and volunteers. Create an environment where all people feel listened to, valued, appreciated, and know they matter even though they will experience the impact of being exposed to trauma. |
| Synergy Services, Inc. | Provides a full continuum of care to assist individuals and families with immediate respite from violence, and services which empower clients to find and choose good options for future safety and success. |
| Wyandot Inc. | Serves mostly Wyandotte County with programs in counseling, crisis intervention and housing. |
| Jackson County Family Court | Family Court Services supports the Family Court in providing interventions for youth and families to ensure accountability, skill development, and protection of the community. |
| Kansas City Rescue Mission | A Christ-centered environment that embraces trauma-informed principles to empower individuals, promote no harm, and meet everyone where they are. |
| Community LINC | To end homelessness, impact poverty and remove barriers to self-sufficiency for families. |
| Preferred Family Health Center | A community-based health center organization that offers services in mental & behavioral health, substance use, employment, developmental disabilities, child welfare and medical. |

| | |
|---|---|
| Children's Mercy Hospital Emergency | Do education to all multidisciplinary groups working in the ED regarding trauma informed care and the effects of secondary trauma. Work to put together initiatives that would increase staff resiliency. Have staff take a resiliency survey to determine the effects of secondary trauma, use the survey to track our staff resiliency over time. |
| Children's Mercy Hospital West | Specialists provide expert care to children and adolescents in Wyandotte County. |
| Greater Kansas City Chamber of Commerce | Provide leadership to help business grow and Kansas City prosper – making KC the best place to live, work, start a business and grow a business. |
| Niles Home for Children Kansas City | To make a positive difference in the lives of hundreds of Kansas City children and families. |

## Analysis

This report presents analyses of the Resilient KC ACE/Resilient survey, Education Series, ARTIC, and PARTNER measurements. It includes descriptive statistics, Chi-Square, and T-test paired sample statistics where appropriate. Alpha level of .05 was used for all statistical tests. A 95% confidence interval was used to characterize the variability and can be thought of as a range of values that will contain the true value 95% of the time. Missing data were excluded from analyses, therefore only valid responses were used in analysis for all instruments.

To determine the ACE total sum, responses were dichotomized to reflect either yes or no to calculate each indicator. For example, when an indicator was measured by two questions, the individual chose the response that qualifies as a correct response ("more often" or "often") on one or both questions within that indicator, the number would be transposed to a yes or "1".

To determine the resilience level, each response was given a numeric value based on a five point scale, with the lowest value response equating "1" and the highest value response equating to "5". The possible total sum ranged from 12 to 60. Resilient level was based on the numeric total sum within each scale.

Chi-square and paired T-test statistics were used to determine improved education attitudes, between each time period. Alpha level of .05 was used for all statistical tests.

For the ARTIC tool, a scale of 1 to 7 was used with 1 = "Strongly Agree", 2 = "Agree", 3 = "Slightly Agree", 4 = "Neutral", 5 = "Slightly Agree", 6 = "Agree", and 7 = "Strongly Agree". Two options on randomly opposing sides were provided for each question; one indicated a favorable trauma-informed care approach while the other indicated a non-trauma informed care approach. Of the 45 items, 19 questions were recoded to account for a favorable response. A numeric value

of 1 to 3 was identified as a favorable response with 1 being the optimum response. T-test using paired sample technique was used to calculate the mean scores.

The PARTNER tool has its own internal analysis program using EXCEL to demonstrate how members are connected, how resources are leveraged and exchanged, and the levels of trust. The program creates visuals to see who is connected to whom and assesses network scores including metrics on the number and quality of relationships, the trust between partners, the value that each partner brings to the larger collaborative, and assessments of the roles that each member of the collaborative play; based on how they are connected to others.

Several considerations should be taken into account when interpreting the RKC findings:

- A convenience sample was used, therefore, individuals who were more prone and able to take a survey completed the survey. Careful consideration should be made to not generalize the data as representative of the entire Kansas City region population. In addition, the survey was primarily completed using an on-line system. Although a paper format was made available, it is likely that a portion of the population who did not have internet access were not aware of the paper format.
- The data collection strategy relied on RKC volunteers, as such the goal of reaching a diverse population representing all six workgroups was not fully met.
- Despite the anonymous nature of the survey, RKC frequency of response findings are self-reported and are subject to bias due to respondents' inability or unwillingness to provide accurate information about their own behaviors or characteristics.

# IV. Findings

## Adverse Childhood Experiences (ACEs)

In the nine-county, by-state Kansas City region, adverse childhood experiences are common. The Resilient KC ACEs findings show that many Kansas City regional individuals experienced stressors related to the community where they grew up. These findings are described in more detail below.

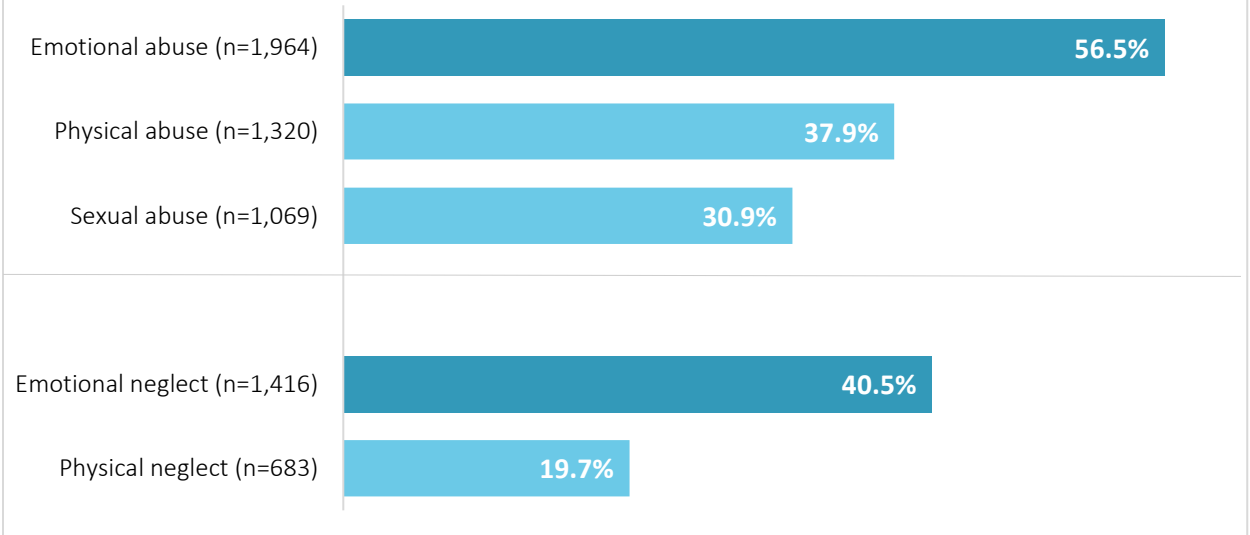
### Child Abuse and Neglect

Kansas City region adults responded to questions that described abuse and neglect. Three in ten (30.9%, n=1,069) adults experienced sexual abuse from an adult at least 5 years older than them during their childhood. Sexual abuse included having been touch or fondled in a sexual way, were told by an adult to touch their body in a sexual way, or an adult forced them to have any type of sexual intercourse while growing up. Of those who experienced sexual abuse in their childhood, three in ten (29.3%, n=1,050) adults experienced only being touched, fondled or told by an adult to touch their body whereas, one in ten (10.0%, n=359) adults experienced an adult who forced them to have sex. Kansas City region adults experienced higher rates of emotional abuse and slightly higher rates of physical abuse during childhood compared to sexual abuse.

Over half of adults (56.5%, n=1,964) experienced emotional abuse while growing up (Figure 1). Before age eighteen they were sworn at, insulted, and put down by an adult or afraid that a parent or adult in their home would physically hurt them. Of those who experienced childhood emotional abuse, slightly over a half (51.1%, n=1830) experienced verbal abuse but not to the extent of being afraid they would be physically hurt whereas over a third (35.7%, n=1278) said that a parent or adult acted in a way that made them afraid they would be physically hurt. Kansas City region adults (37.9%, n=1,320) experienced physical abuse at a lower rate than emotional abuse and slightly higher than sexual abuse. Nearly one-third (32.1%, n=1,150) of respondents reported being physically hurt in any way or received an injury from physical abuse. Of those who experienced physical abuse, one out of four (25.2%, n=903) were severe enough to have left a mark or were injured.


Kansas City residents also reported emotional and physical neglect during their childhood. Four out of ten (40.5%, n=1,416) adults experienced emotional neglect. Emotional neglect is defined as: when no one in their family often or very often made them feel loved or thought of being important or special; or felt that the family didn't look out for each other, feel close to each other, or supported each other. Very little differences (30.2%, n=1,082) and (31.1%, n=1,115) occurred between those who responded "only" to not being loved or "only" to not being close or supportive of each other. Nearly one-fifth (19.5%, n=683) Kansas City region adults reported physical neglect which is 'often' or 'very often' when their family had to cut the size of meals or skip meals because there was not enough money in the budget for food.

Figure 1. Childhood Abuse and Neglect Indicators (n=3,582)



Differences were found between the original Kaiser, RKC and Urban Philadelphia studies. The rates of emotional and physical abuse are higher (22.6%) among Philadelphia adults than Kaiser adults (6.7%). However, compared to the original Kaiser population, Kansas City region adults had higher rates of each abuse, and neglect indicators, see Table 7.

Table 7. Comparison of Abuse and Neglect Indicators - Resilient KC ACEs and Kaiser ACE Study

| Indicator | RKC ACE Survey (N=3,499) | Kaiser ACE Study (N=17,337) |
|---|---|---|
| Emotional abuse | 56.5% (n=1,964) | 10.6% (n=1,828) |
| Physical abuse | 37.9% (n=1,320) | 28.3% (n=4,906) |
| Sexual abuse | 30.9% (n=1,069) | 20.7% (n=3,589) |
| Emotional neglect | 40.5% (n=1,416) | 9.9% (n=1,716) |
| Physical neglect | 19.5% (n=683) | 14.8% (n=2,566) |

When examining child abuse and neglect rates related to gender, male adults in the Kansas City region were more likely than female adults to report emotional abuse during childhood (58.2% compared to 55.8%) (see Table 8). Males were also more likely to report physical abuse during childhood compared to females (41.8% compared to 36.7%). These findings mirror the results from the Philadelphia study where more males than females experienced emotional or physical abuse. Furthermore, females reported sexual abuse at nearly a 10% rate more than males (32.8% compared to 24.1%). Females were also more (41.9%) likely to report emotional neglect compared to males (34.9%). Males and females were similarly as likely to report physical neglect. Of the 11 respondents who reported their gender identity as transgender, at least 80% reported emotional and physical abuse. Slightly over half (57.1%, n=4) of the transgender adults reported sexual abuse while over half (62.5%) or more reported emotional or physical neglect during their childhood.

Table 8. Child Abuse and Neglect Indicators by Gender

| Indicator | Male | Female |
|---|---|---|
| Emotional abuse* | 58.2% (n=436) | 55.8% (n=1,520) |
| Physical abuse** | 41.8% (n=313) | 36.7% (n=999) |
| Sexual abuse*** | 24.1% (n=179) | 32.8% (n=885) |
| Emotional neglect**** | 34.9% (n=264) | 41.9% (n=1,144) |

| | | |
|---|---|---|
| Physical neglect** | 21.3% (n=161) | 18.8% (n=514) |

*Chi-Square, p = .023; **Chi-Square, p = .000, ***Chi-Square, p = .001*

White adults reported a slightly higher rate of emotional abuse during childhood than black adults. Fifty-six percent of white adults reported emotional abuse during childhood and 52.7% of black adults reported emotional abuse (see Table 9). In addition, four out of ten (39.5%) black adults reported physical abuse during their childhood. Over a third (36.9%) of black adults reported sexual abuse and four out of ten (39.5%) reported emotional neglect. Slightly less than one-fourth (23.9%) of black adults reported physical neglect during their childhood. Of the respondents who identified as 'More than one Race', emotional abuse had a higher rate (71.3%) compared to physical abuse (56.6%). Adults who reported "More than one Race" had a higher rate of emotional neglect (57.7%) compared to physical neglect (28.7%). Approximately, four out of ten (44.3%) reported experiencing sexual abuse during their childhood.

Differences within the rates of RKC ACE Indicators among Asian, American Indian Native, Native Hawaiian or Other Pacific Islander, and Other were not tested because the sample size was too small.

Table 9. Child Abuse and Neglect Indicators by Race

| Indicator | White | Black |
|---|---|---|
| Emotional abuse* | 56.0% (n=1,608 | 52.7% (n=183) |
| Physical abuse** | 36.3% (n=1,043) | 39.5% (n=137) |
| Sexual abuse** | 29.4% (n=841) | 36.9% (n=128) |
| Emotional neglect** | 39.0% (n=1,123) | 39.5% (n=137) |
| Physical neglect** | 17.4% (n=500) | 23.9% (n=83) |

*Chi-Square, p = .002; **Chi-Square, p = .000;*

Among those who identified their ethnicity as Hispanic or Latino, three of the five child abuse indicators (emotional and physical abuse and emotional neglect) had a higher than 50% rate compared to the sexual abuse indicator. Nearly seven in ten (67.2%, n=168) Latinos reported experiencing emotional abuse before the age of 18 and about the same (60.7%, n=162) experienced emotional neglect while over half (56.9%, n=144) experienced physical abuse. About four in ten (44.0%, n=99) experienced sexual abuse (see Table 10).

Table 10. Child abuse and Neglect Indicators with Hispanic and/or Latino origin

| Indicator | Yes | No |
|---|---|---|
| Emotional abuse* | 67.2% (n=168) | 32.8% (n=82) |
| Physical abuse* | 56.9% (n=144) | 43.1% (n=109) |
| Sexual abuse* | 44.0% (n=99) | 56.0% (n=126) |
| Emotional neglect* | 60.7% (n=162) | 39.3% (n=105) |
| Physical neglect* | 48.0% (n=129) | 52.0% (n=140) |

**Chi-Square, p = .000;*

## Household Dysfunction

Dysfunction in the household, such as living with a substance-abusing member, living with someone who has a mental illness, witnessing domestic violence, or having a household member be incarcerated, is also a childhood stressor. Kansas City regional adults witnessed a parent or adults in their home being physically or emotionally battered four times the rate of the Kaiser study individuals (50.4%) compared to 12.7%). (See Table 11.) The second highest indicator of household dysfunction was living with someone mentally ill (44.1%); this was slightly over twice the rate found in the original Kaiser study (19.4%). Approximately four in ten (39.6%) adults living or working in the Kansas City region grew up in a household where someone abused substances. This is higher than the approximate

one-fourth (26.9%) of the Kaiser study participants. Finally, 11.5% of Kansas City adults grew up in a household where someone served time or was sentenced to serve time in prison, jail, or other correctional facility. This rate was higher than the Kaiser study which found that 4.7% of the respondents grew up in a household where a member was incarcerated.

Table 11. Household Dysfunction among the Resilient KC ACE Survey and the Kaiser ACE Study

| Indicator | RKC ACE Survey (N=3,582) | Kaiser ACE Study (N=17,337) |
|---|---|---|
| Witnessed domestic violence | 50.4% (n=1,755) | 12.7% (n=2,202) |
| Substance abusing household member | 39.6% (n=1,418) | 26.9% (n=4,664) |
| Mentally ill household member | 44.1% (n=1,581) | 19.4% (n=3,363) |
| Household member in prison/jail | 11.5% (n=411) | 4.7% (n=815) |

When examining results with gender, females were slightly more likely (50.4%) to witness domestic violence compared to males (49.7). Females were also slightly more likely (40.0%) to live in the house with a substance abuser than males (38.1%). (See Table 12.) However, females reported to have lived with a mentally ill household member at a 10% rate more than males (46.1% compared to 39.6%). On the other hand, males were more likely (13.6%) to have grown up in a household where someone was sentenced to serve time in prison, jail, or a correctional facility than females (10.8%). Eight-six percent of the seven respondents who reported their gender identity as transgender had witnessed domestic violence in the home during childhood, Of the nine transgender respondents over half (55.6%) had lived with someone in the household who abused substances or was mentally ill. A third (33.3%) transgender adults lived with a household member who had spent time incarcerated.

Table 12. Indicators of Household Dysfunction byGender

| Indicator | Male | Female |
|---|---|---|
| Witnessed domestic violence | 49.7% (n=374) | 50.4% (n=1,372) |
| Substance abusing household member | 38.1% (n=294) | 40.0% (n=1,119) |
| Mental ill household member* | 36.9% (n=285) | 46.1% (n=1,289) |
| Household member in prison/jail** | 13.6% (n=105) | 10.8% (n=301) |

**Chi-Square, p = .000; **Chi-Square, p = .011*

Black adults (51.3%) were slightly more likely to have grown up in a household where they witnessed domestic violence compared to white adults (48.8%) (See Table 13.). Black adults (45.8%) were also more likely to have grown up in a household with someone who abused substances and almost three more times likely (26.5%) to have grown up in the home where someone served time or was sentenced to serve time in prison, jail, or a correctional facility than white adults. On the other hand, white adults (46.5%) were more likely to have lived with a mentally ill household member compared to black adults (32.6%).

Of the 122 respondents who identified as 'More than one Race', two-thirds of the adults (65.7%, n=85) reported they had witnessed domestic violence in their home during childhood. Approximately half (56.5%, n=70) of the adults had lived with someone who abused substances while less than half (48.4%, n=60) lived with a member of the household who was mentally ill. Slightly over one-fifth (26.6%) of adults who identified their race as 'More than one Race' (25.8%) reported they lived with a household member who had been incarcerated.

Differences within the rates of RKC ACE Indicators among Asian, American Indian Native, Native Hawaiian or Other Pacific Islander, and Other were not tested because the size of the sample was too small.

Table 13. Indicators of Household Dysfunction with Race

| Indicator | White | Black |
|---|---|---|
| Witnessed domestic violence* | 48.8% (n=1,404) | 51.3% (n=178 |
| Substance abusing household member* | 38.9% (n=1,136) | 45.8% (n=159) |
| Mental ill household member* | 46.5% (n=1,360) | 32.6% (n=113) |
| Household member in prison/jail* | 9.0% (n=262) | 26.5% (n=92) |

**Chi-Square, p = .000*

Respondents who identified their ethnicity as Hispanic or Latino had at least a 50% response rate related to one stressor indicators under household dysfunction (witnessed domestic violence household member). (See Table 14.) On the other hand the same population had at least a 50% response rate related to three stressor indicator (emotional and physical abuse and emotional neglect) under child abuse and neglect (see Table 10). Well over half (69.8%) stated that during their childhood they had witnessed domestic violence in the home and nearly four out of ten adults (37.9%) lived with a household member who was a substance abuser. Approximately three in ten (30.9%, n=107) lived with a family member who had a mental illness and nearly one in five (16.5%) had a household member in prison or jail during their childhood.

Table 14. Household Dysfunctional Indicators with Hispanic or Latino origin

| Indicator | Yes | No |
|---|---|---|
| Witnessed domestic violence* | 69.8% (n=178) | 30.2% (n=77) |
| Substance abusing household member* | 37.9% (n=131) | 62.1% (n=215) |
| Mental ill household member | 30.9% (n=107) | 69.1% (n=239) |
| Household member in prison/jail* | 16.5% (n=57) | 83.5% (n=289) |

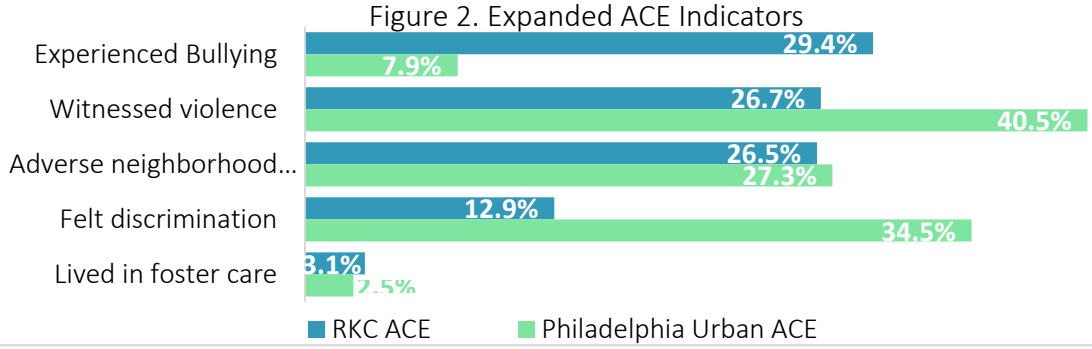
**Chi-Square, p = .000*

## Expanded ACEs Indicators

In addition to the standard ACE indicators from the original Kaiser study, the Resilient KC Steering Committee recommended following the example of the Philadelphia Urban ACE (PUA) study by adding items to assess the impact of stressors in urban environments. The addition of the five expanded indicators of childhood stress created fourteen ACE indicators compared to the nine indicators included in the survey from the original Kaiser study. (The item related to divorce was excluded following the example of the PUA study.)

The additional indicators included: witnessing violence in one's neighborhood, feeling discrimination based on race/ethnicity, feeling unsafe in one's neighborhood, being bullied, and living in foster care. Among Kansas City adults the most highly experienced expanded ACE indicator before the age of 18 was being bullied (29.4%) followed by witnessing violence (26.7%) and growing up in a neighborhood where they didn't feel safe or that people didn't look out for each other (26.5%.) (See Figure 2). On the other hand, among Philadelphia adults the most highly experienced expanded ACE indicator was witnessing violence (40.5%) followed by experiencing discrimination (34.5%). Both communities had less than five percent of adults who had lived in foster care.

Figure 2. Expanded ACE Indicators



Males reported witnessing violence twice the rate of females (44.5% compared to 21.7%). Males also experienced being bullied (32.1%) and growing up in adverse neighborhood(s) (29.8%), which included feeling unsafe or not trusting one's neighbors compared to female adults. (See Table 15.) In addition, males reported a higher (18.2%) rate of experiencing discrimination while growing up than females (12.0%).

Table 15. Expanded ACE Indicators by Gender

| Indicator | Male | Female |
|---|---|---|
| Bullied* | 32.1% (n=239) | 28.5% (n=771) |
| Witnessed violence* | 44.5% (n=334) | 21.7% (n=587) |
| Adverse neighborhood experience** | 29.8% (n=224) | 25.5% (n=694) |
| Felt discrimination* | 18.2% (n=135) | 12.0% (n=324) |
| Lived in foster care | 3.1% (n=23) | 3.1% (n=84) |

**Chi-Square, p = .000; **Chi-Square, p = .037*

As seen in Table 16, slightly over half (54.5%) of the respondents who identified themselves as Black/African American reported they felt that were treated badly or unfairly because of their race and/or ethnicity compared to 5.7% respondents who identified themselves as White/Caucasian. Similarly, half (50.4%) of Blacks compared to Whites (22.3%) grew up hearing or seeing someone being beaten up or being stabbed in front of them in real life. Approximately one-third (35.7%) of Black adults compared to approximately one-fifth (22.3%) of White adults experienced living in a neighborhood where they did not feel safe, where no one looked out for each other, stood up for each other and could not be trusted. Of the five expanded ACE indicators, slightly more Whites than Blacks (29.4% compared to 23.1%) reported they had been bullied more than once.

Table 16. Expanded ACE Indicators by Race

| Indicator | White | Black |
|---|---|---|
| Bullied* | 29.4% (n=842) | 23.1% (n=80) |
| Witnessed violence** | 22.3% (n=640) | 50.4% (n=175) |
| Adverse neighborhood experience** | 23.2% (n=667) | 35.7% (n=124) |
| Felt discrimination** | 5.7% (n=163) | 54.5% (n=189) |

| | | |
|---|---|---|
| Lived in foster care** | 2.5% (n=72) | 6.1% (n=21) |

**Chi-Square, p = .001; **Chi-Square, p = .000*

Respondents who identified their ethnicity as Hispanic and/or Latino reported two stressor indicators under the expanded urban indicators that had at least a 40% rate. Over half, 56.3%, (n=143) experienced living in a neighborhood that was not supportive and about the same 51.0% n=92) had witnessed violence (see Table 17).

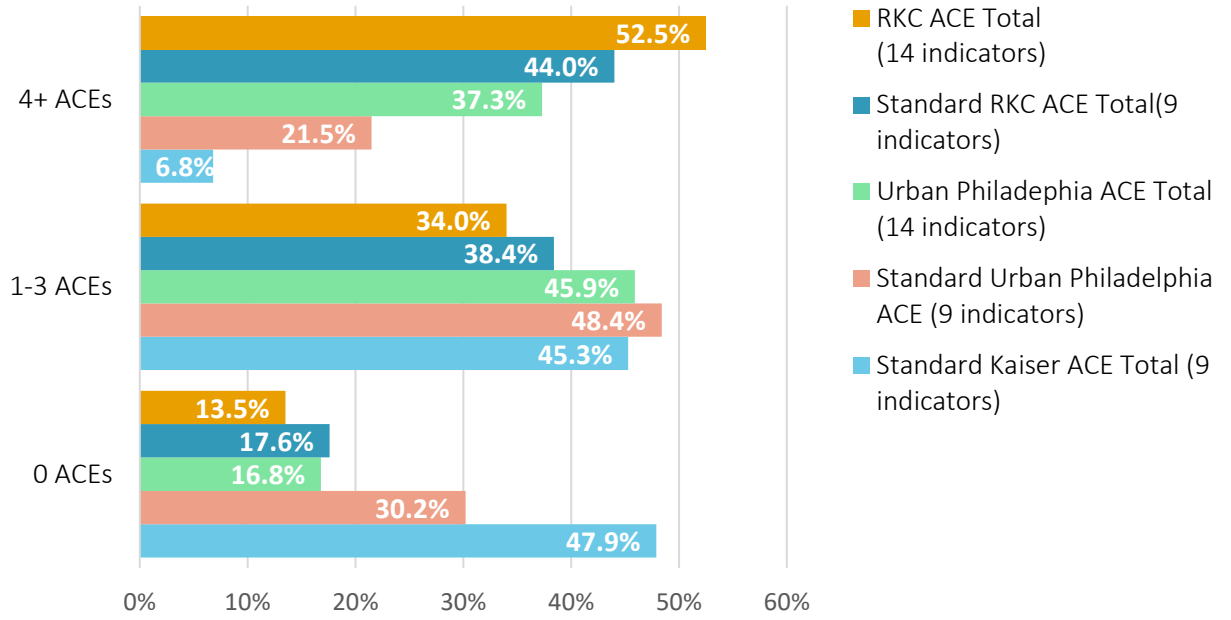
Table 17. Expanded ACE Indicators by Hispanic/Latino Origin

| Indicator | Yes | No |
|---|---|---|
| Bullied | 34.5% (n=80) | 65.5% (n=152) |
| Witnessed violence* | 51.0% (n=123) | 49.0% (n=118) |
| Adverse neighborhood experience* | 56.3% (n=143) | 43.7% (n=111) |
| Felt discrimination* | 43.2% (n=99) | 56.8% (n=130) |
| Lived in foster care** | 6.2% (n=13) | 93.8% (n=198) |

**Chi-Square, p = .000; **Chi-Square, p = .008*

As seen in Figure 3 the percentage of the RKC ACE study adults who experienced at least one ACE increased to 86.5% from 82.4% using the additional expanded ACE survey indicators. The percentage of Kansas City adults who experienced four or more ACEs increased to 52.5% from 44.0% using the additional expanded ACE survey indicators.

Figure 3: Distribution of Standard and Expanded ACE Total Sums




When examining gender and race among the RKC ACE study respondents, approximately over half of the males 54.2% (n=418) and females 52.0% (n=1,452) reported a total sum of four or more ACEs when including the expanded indicators. Among the black adults, nearly two-thirds (62.8%) compared to 50.1% among the white adults experienced four or more ACEs. However, two thirds of those who reported More than one Race 73.4% (n=91) experienced four or more ACEs (see Table 18).

Table 18. Demographics among Kansas City Adults with an Expanded ACE Total of Four or More

| Gender* | |
|---|---|
| *Male*<br>54.2% (n=418) | *Female*<br>52.0% (n=1,452) |

| Race** | | |
|---|---|---|
| *Black*<br>62.8% (n=218) | *More than one Race*<br>73.4% (n=91) | *White*<br>50.1% (n=1,462) |

**Note: Not included in table due to small sample size: Transgender 81.6% (n=9).*
***Chi-Square, p = .000*

In addition, of the 182 respondents who identified their race as either Asian, American Indian Native, Native Hawaiian or other Pacific Islander or Other, 57.7% (n=105) reported they

had experienced four or more ACE indicators. Of the 346 respondents who identified their ethnicity as Hispanic or Latino 59.0% (n=204) reported experiencing four or more ACEs.

Individuals reported their household income and household size in order to determine the percentage of respondents who fell below or above the poverty level established by the federal government. The household size range of the RKC adults is 1 -11. Approximately 45.3% of adults made $75,000 or less annually while approximately one–third (34.0%) adults made $100,000 or more annually (see Table 19).

Table 19. Income Range for Participants

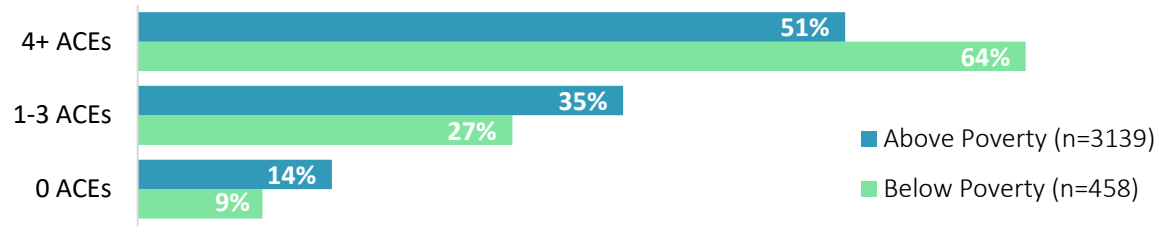
| Income Range | Percentage (number of people)* |
|---|---|
| 0 - 25,000 | 11.8% (424) |
| 25,001 - 50,000 | 17.9% (643) |
| 50,001 – 75,000 | 15.6% (561) |
| 75,001 – 100,000 | 21.2% (764) |
| 100,001 – 150,000 | 19.9% (715) |
| 150,001 – 200,000 | 8.0% (282) |
| 200,001 – 500,000 | 5.0% (194) |
| 500,001+ | Less than 1.0% (14) |

*Note: N=3,597. *160 participants were excluded due to various reasons including undetermined annual income amounts, and incomplete household size or annual income amounts.*

The total number of participants that completed the ACEs survey and included enough information to analyze their poverty level equated to 3,597. The majority, 87.3% (n=3,139) of the adult respondents' income fell above the federal poverty level* (150% of the Federal poverty level was chosen in this study to be an indicator for poverty). The Health and Human Services Poverty Guidelines of 100% of the Federal Poverty Level is stringent; in this study 150% of the Federal Poverty Level was judged to be a more accurate gauge of poverty ($18,090 versus $12,060 for single dwellers, and $36,900 instead of $24,600 for a family of 4 in 2017). Slightly over half, 51.0% (n=1,597) of the respondents that were above poverty level experienced four or more ACEs while approximately one-third (35.0%) experienced at least one to three ACEs. For this study, only 13.0%, (n=458) of the respondents' income level was below the poverty level.

However, as Figure 4 shows, 64.0% of those whose income was below the poverty level (n=458) experienced four or more ACEs while growing up.

Figure 4. Distribution of Poverty Level and ACEs Total




**Note: 150% of the Federal poverty level was chosen to be an indicator for poverty in the above tables and graphs.*

Further examination was completed regarding the participants surveyed with four or more ACEs in respect to the County they resided in. Meaningful information was found when evaluating participants with 4+ ACEs within their respective Counties. As Table 20 shows, some Counties (Cass, Leavenworth, Miami, and Ray) generated small numbers (93, 40, 38, and 28) of participants that were surveyed during this study. However, three of the four counties generated at least 50.0% or more of participants who had 4+ ACEs. For example, Cass County had 93 participants who completed the survey; yet two-thirds (65.6%) reported four or more ACEs. Further examination shows that Ray County had 28 participants who completed the survey compared to 1,349 from Jackson County; yet both counties had slightly over half (57.1% and 58.3%) reported four or more ACEs.

Table 19. Percentage of Surveyed Population with Four or More ACEs by County

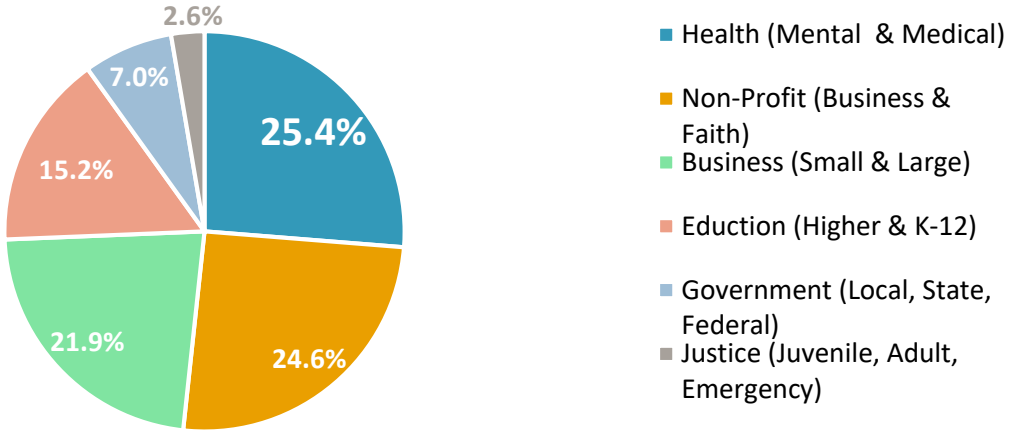
*Note: Excludes those that choose "none of these" categories.*

| County | Sample by County | 4+ ACEs |
|---|---|---|
| Jackson | 1,349 | 58.3% (n=786) |
| Johnson | 1,107 | 46.9% (n=519) |
| Clay | 414 | 51.7% (n=214) |
| Wyandotte | 315 | 46.3% (n=146) |
| Platte | 198 | 51.5% (n=102) |
| Cass | 93 | 65.6% (n=61) |
| Leavenworth | 40 | 55.0% (n=22) |
| Miami | 38 | 47.4% (n=18) |
| Ray | 28 | 57.1% (n=16) |
| TOTAL | (N=3,582) | (N=1,884) |

### *Types of Employment*

Participants selected the type of work that best represents their primary employment. Of the total number of respondents, 15.3% (n=548) reported they were either not employed or retired, therefore they are excluded from this analysis. Figure 6.

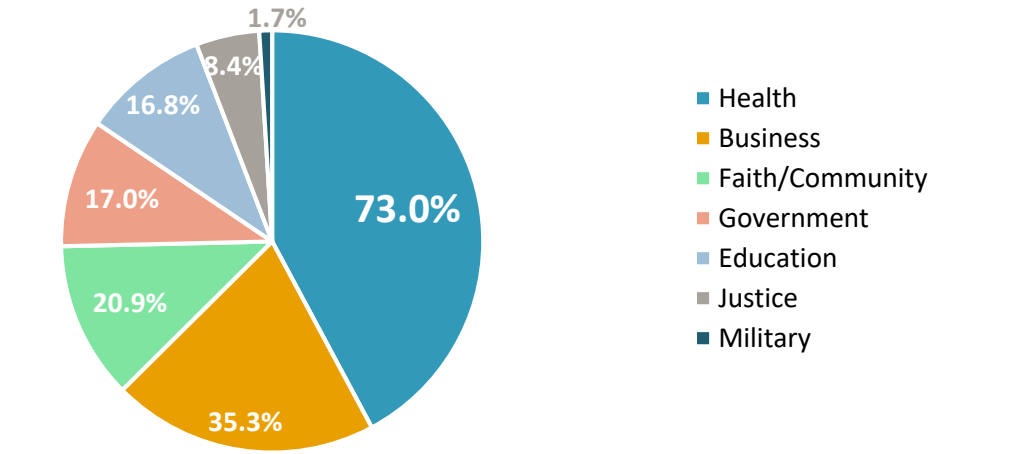
Figure 6. Distribution of Types of Employment




### *Types of Direct Service*

Participants identified what direct services they had received within the past six months. Respondents could check all that apply therefore, more than one service could be selected. The

Figure 7. Distribution of Direct Services




menu of services corresponded with the types of services each of the Resilient KC six workgroups focused on. They included: Business, Health (mental and medical) Education (K-12 and higher education, Faith based/Community centers, Justice (juvenile, adult correction, emergency and government) and Military (armed services and veterans). The findings in Figure 7 show that mental and medical services were often used (73.0%). Business services were used slightly more

than Faith/Community service (35.3% compared to 20.9%) while Government and Education services were used about the same percentage (17.0% and 16.8% respectively).

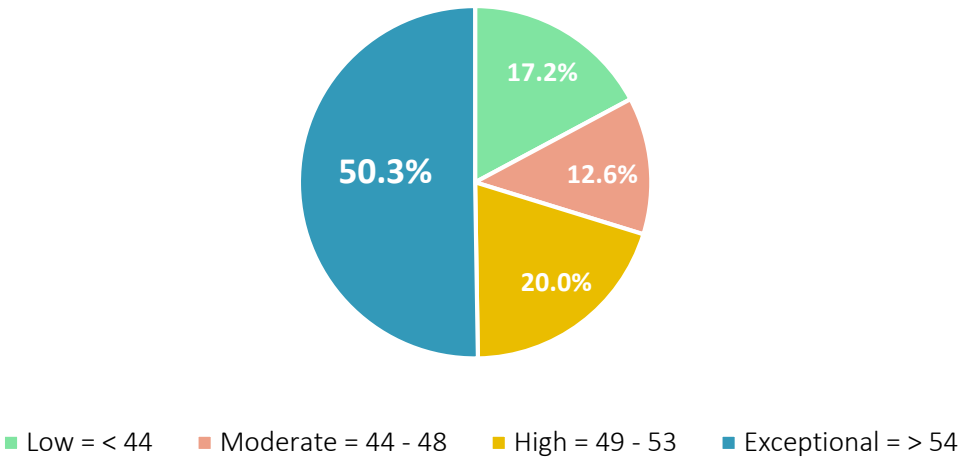
## Resilience

Immediately following the 22-item RKC ACEs survey, Kansas City adults completed a 12-item Resilience survey developed by Resilience Research Centre. Resilience. Participants added up their total sum to determine what level of resiliency they were most likely to practice based on the following norms:

| |
|---|
| **Low** = < 44 –you have a little bit of capability to persevere or reframe adversities |
| **Moderate** = 45 to 48 – you have some capability to persevere or reframe adversities |
| **High** = 49 – 53 -- you have quite a bit of capability to persevere or reframe adversities |
| **Exceptional** = > 54 – you have a lot of capability to persevere or reframe adversities |

Seven in ten Kansas City adults 70.3% (n=2,513) rated their resilience as exceptional or high compared to three in ten 29.8%, (n=1,063) adults who rated their resilience as moderate or low.

Figure 8. Distribution of Resilience Levels




Male and female adults reported about the same resilience within each resilience level (Table 20). Males compared to females had about four percent more Low and Moderate rates of resilience (32.8% compared to 28.6%) and about four percent less High and Exceptional resilience levels (67.2% compared to 71.4%). All (100%, n=9) of transgender adults had either Low or Moderate levels of resilience (see Table 21).

Table 21. Distribution of Resilience Levels by Gender*

| Resiliency Total | Male | Female |
|---|---|---|
| Low = < 44 | 20.8% (n=160) | 16.1% (n =449) |
| Moderate = 44 - 48 | 12.0% (n=92) | 12.5% (n=349) |
| High = 49 - 53 | 21.0% (n=161) | 19.8% (n=553) |
| Exceptional = > 54 | 46.2% (n=355) | 51.6% (n=1,442) |

**Chi-Square, p = .000*

Black and White adults reported about the same resilience within each resilience level. Table 22. Blacks compared to Whites had about five-percent higher Low and Moderate rates of resilience (32.9% compared to 27.5%) and about five-percent lower High and Exceptional rates resilience (67.1% compared to 72.5%). Within adults who identified as 'More than one race' there was only a four percent difference between the Low and Moderate resilience rate and the High and Exceptional resilience rate (48.0% compared to 52.0% respectively).

Table 22. Distribution of Resilience Levels by Race*

| Resiliency Total | White | Black |
|---|---|---|
| Low = < 44 | 15.6% (n=455) | 20.2% (n =70) |
| Moderate = 44 - 48 | 11.9% (n=347) | 12.7% (n=44) |
| High = 49 - 53 | 20.0% (n=585) | 21.0% (n=73) |
| Exceptional = > 54 | 52.5% (n=1,531) | 46.1% (n=160) |

**Chi-Square, p = .000*

Slightly over half, 55.1%, (n=190) of those who identified their ethnicity as Hispanic/Latino reported their resiliency was High or Exceptional. Compared to those who identified as Hispanic/Latino and those who did not, there was a 16.8% increase of Low and Moderate resiliency levels among Hispanic/Latino (see Table 23).

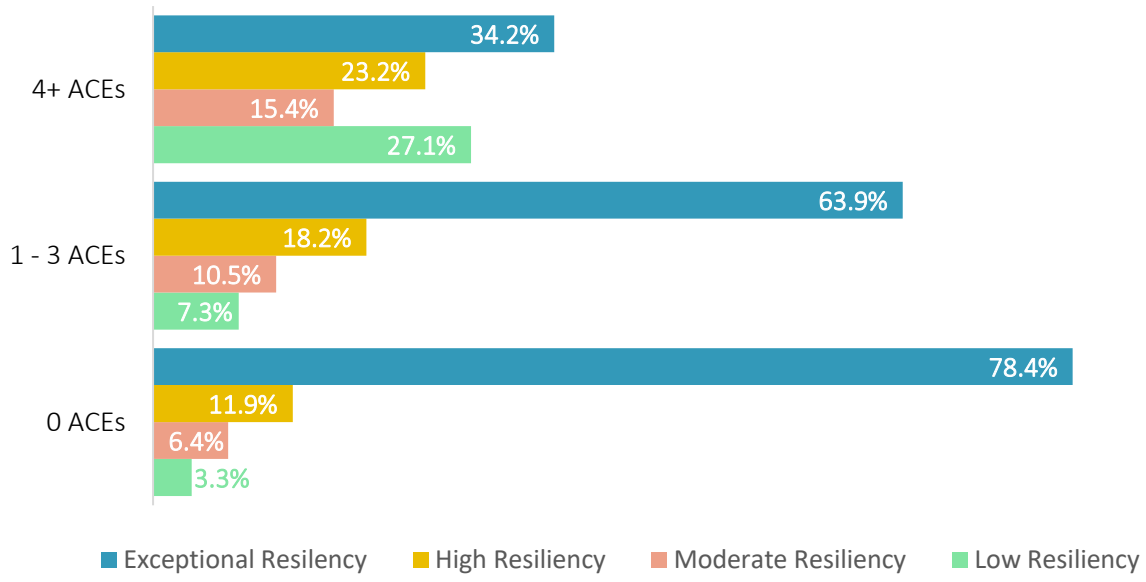
Table 23. Distribution of Resilience Levels by Ethnicity*

| Resiliency Total | Yes | No |
|---|---|---|
| Low = < 44 | 26.1% (n=90) | 16.2% (n =524) |
| Moderate = 44 - 48 | 18.8% (n=65) | 11.9% (n=384) |
| High = 49 - 53 | 22.3% (n=77) | 19.7% (n=637) |
| Exceptional = > 54 | 32.8% (n=113) | 52.2% (n=1,685) |

**Chi-Square, p = .000*

As expected, the higher the rate of ACEs experienced by adults, the higher rate of Low to Moderate resilience rates occur. Approximately four out of ten Kansas City adults, 42.5% (n=799) who experienced four or more ACE indicators reported Low or Moderate resilience compared to 9.7% (n=47) who experienced no ACEs. However, at least half of the adults (57.4%) reported High to Exceptional resilience levels no matter the number of ACE indicators occurred in childhood.

Figure 9. Comparision of the Expanded ACEs Total and Resiliency Level




Males compared to females who had experienced four or more ACEs were likely to have Low to Moderate levels of resiliency (47.1% compared to 41.0%) (see Table 24). The sample size of those who identified as transgender was small (6) however the findings are noteworthy. All (100%) who experienced four or more ACEs had Low to Moderate resilience.

Differences within the Black/African American and White/Caucasian races were minimal. Black adults compared to White adults who experienced four or more ACEs were likely to have a

slightly higher rate of Low to Moderate levels of resiliency. However, differences were noted within adults who identified their race as "More than one race" and reported four or more ACEs. Over half, 58.3% (n=53) had Low to Moderate level of resiliency compared to 41.8% (n=38) who reported High to Exceptional resilience.

For those who identified as Hispanic/Latino, slightly over half (54.4%, n=111) who experienced four or more ACEs were likely to have Low to Moderate levels of resiliency.

Table 24. Demographics among Kansas City Adults with 4+ ACEs and Resiliency Levels

| Gender | | |
|---|---|---|
| | *Male* | *Female* |
| Low to Moderate resilience | 47.1% (n=196) | 40.5% (n=591) |
| High to Exceptional resilience | 56.9% (n=220) | 59.1% (n=858) |
| **Race** | | |
| | *Black* | *White* |
| Low to Moderate resilience | 43.1% (n=94) | 40.3% (n=583) |
| High to Exceptional resilience | 56.1% (n=124) | 59.5% (n=869) |
| **Ethnicity** | | |
| | *Yes* | *No* |
| Low to Moderate resilience | 54.4% (n=111) | 41.1% (n=688) |
| High to Exceptional resilience | 45.6% (n=93) | 58.9% (n=985) |

## Education Series

The Resilient KC Project Director and Trauma Matters Education Committee coordinated four education sessions for participants to become aware of trauma informed care and resiliency. On a four-point scale with 1 = "Strongly Disagree", 2 = "Disagree", 3 = "Agree" and 4 = "Strongly Agree" results show that four of the 15 items produced statistically significant differences (items # 6, 7, 10 & 13.) (see Table 25). Participants improved their attitudes about how traumatic events that happen in families can affect the larger community and that workers in high stress occupations often neglect taking care of themselves. In addition, participants improved their attitude with the belief that if people apply ways of decreasing the effects of severe stress and being flexible the benefits will lead to better health and emotional adjustment and maturity.

Table 25. Differences in Attitude related to Trauma and Resilience

| Question | True or False | Favorable Direction | Pre-test Mean | Post-test Mean | Sig. .05 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| 1. In the U.S. at least half of adults report exposure to at least one traumatic event in their lives | True | Up | 3.38 | 3.60 | .038 |
| 2. People who experience a traumatic event usually will go on with their lives without lasting negative effects. | False | Down | 2.01 | 1.96 | .720 |
| 3. Traumatized children "replay" the dynamics of their pain later in life. | True | Up | 3.11 | 3.40 | .037 |
| 4. If trauma occurs in childhood, it is worse than if it happens to a person later in life. | True | Up | 2.40 | 2.88 | .030 |
| 5. Traumatic childhood experiences affect children's mental health more than their physical health. | False | Down | 3.23 | 3.40 | .145 |
| 6. Traumatic events that happen in families affect the larger community as well. | True | Up | 3.23 | 3.61 | .001* |
| 7. Police, firefighters, EMTs, etc., and healthcare professionals, who have high stress in their work and lives, often neglect taking care of themselves, resulting in health challenges. | True | Up | 3.13 | 3.49 | .004* |
| 8. When people are traumatized by an event, it's because of vulnerabilities in personality or temperament (i.e., some people are resilient and others are not). | False | Down | 2.00 | 2.18 | .218 |
| 9. With professional care and support people can overcome traumatic experiences. | True | Up | 3.26 | 3.48 | .080 |
| 10. If people apply ways of handling and decreasing the effects of severe stress, it will benefit their health. | True | Up | 3.48 | 3.80 | .001* |
| 11. Having the skills to relax one's mind and body on a consistent basis is key to bouncing back from difficulties | True | Up | 3.33 | 3.55 | .123 |
| 12. Breathing techniques, imagery, yoga, or prayer can all be effective ways to manage stress. | True | Up | 3.52 | 3.70 | .154 |
| 13. Being flexible is one of the primary factors in emotional adjustment and maturity. | True | Up | 3.04 | 3.38 | .017* |
| 14. It is better for your overall health to be optimistic than to be pessimistic. | True | Up | 3.39 | 3.66 | .055 |

| | | | | | |
|---|---|---|---|---|---|
| 15. Resilience is an innate personality characteristic and cannot be taught. | False | Down | 1.59 | 1.61 | .853 |

**T-test, statistically significant p<.05*

## Attitudes Related to Trauma Informed Care (ARTIC)

Approximately a third of the participants reported that the mental health or and/or education were primary services their organization provided and nearly half of the organizations served adolescents and teenagers. Table 26 shows that the majority, (89.6%) were employed full-time while three-fourths (76.0%) worked within a department that had one to 15 co-workers. Over two-thirds (68.1%) job responsibilities were in direct service and primarily in one state but generally more than one county.

Table 26. Learning Collaborative Organization Characteristics

| Primary Services* | |
|---|---|
| Mental Health | 38.2% (n=97) |
| Medical Health | 2.0% (n=5) |
| Education | 31.5% (n=80) |
| Business | 1.2% (n=3) |
| Other | 37.0% (n=94) |
| **Age range of Services*** | |
| Pre-natal to Birth | .8% (n=2) |

| | |
|---|---|
| 1 month to 60 months (5 yrs.) | 10.6% (n=27) |
| 6 yrs. to 17 yrs. | 47.6% (n=121) |
| 18 yrs. to 49 yrs. | 24.0% (n=61) |
| 50+ yrs. | 15.7% (n=40) |
| All Ages | 35.4% (n=90) |
| **Employment Status** | |
| Employed Full-time (35 hrs. or more) | 89.6%% (n=224) |
| Employed Part-time (less than 35 hrs.) | 9.6% (n=24) |
| Consultant/PRM (as needed) or Volunteer | .8% (n=2) |
| **Primary Job Responsibility** | |
| Administrative | 22.7% (n=57) |
| Direct service (interact with clients/customers on a regular basis) | 68.1% (n=171) |
| Other | 9.2% (n=23) |
| **Department Size (co-workers)** | |
| 1 – 5 | 37.8% (n=95) |
| 6 - 15 | 38.2% (n=96) |
| 16 – 30 | 15.9% (n=40) |
| 31+ | 8.0% (n=20) |
| **Length of Employment** | |
| Less than 6 months | 8.8% (n=22) |
| 6 months to 12 months | 7.2% (n=18) |
| 13 months to 18 months | 7.6% (n=19) |
| 19 months to 24 months | 8.4 (n=21) |
| 3 to 6 yrs. | 29.5% (n=74) |
| 7 yrs. or more | 38.6% (n=97) |
| **County Administrative Office Location** | |
| Wyandotte | 18.4% (n=46) |
| Platte | 1.6% (n=4) |
| Clay | 2.0% (n=5) |
| Jackson | 77.2% (n=193) |
| Cass | .4% (n=1) |
| **Organization Serves Bi-State** | |
| Yes | 35.1% (n=88) |
| No | 64.9% (n=163) |
| **County Service Locations** | |
| Leavenworth | 5.1 (n=13) |
| Wyandotte | 13.8% (n=35) |
| Johnson | 9.8% (n=25) |
| Miami | 3.9% (n=10) |
| Platte | 9.1% (n=23) |
| Clay | 11.0% (n=28) |
| Ray | 6.7% (n=17) |
| Jackson | 15.7% (n=40) |
| Cass | 8.3% (n=21) |
| Other | 11.0% (n=28) |

*Note: *Does not add up to 100% because of more than one answer*

The ARTIC tool is comprised of five core subscales and two supplementary subscales. A description of the subscales is below:

| | |
|---|---|
| Underlying Causes of Problem Behavior and Symptoms | Emphasizes behavior and symptoms as adaptations and malleable versus behavior and symptoms as intentional and fixed. |
| Responses to Problem Behavior and Symptoms | Emphasizes relationships, flexibility, kindness, and safety as the agent of change versus rules, consequences, and accountability as the agent of behavior and symptom changes. |
| On-The-Job Behavior | Endorses empathy-focused staff behavior versus control focused staff behavior. |
| Self-Efficacy at Work | Endorses feeling able to meet the demands of working with a traumatized population versus feeling unable to meet the demands. |
| Reactions to the Work | Endorses appreciating the effects of secondary trauma/vicarious traumatization and coping by seeking support versus minimizing the effects of secondary trauma/vicarious traumatization and copying by ignoring or hiding the impact |
| Personal Support of Trauma-Informed Care | Endorses being supportive of, and confident about, implementation of TIC versus concerns about implementing TIC. |
| System-Wide Support of Trauma-Informed Care | Endorses feeling system-wide support for TIC versus NOT feeling supported by colleagues, supervisors, and the administration to implement TIC. |

For each of the 35 core items within the five core subscales, participants chose an option between a trauma informed and non-trauma informed statement. For analysis purposes, some scores were reverse coded so that a favorable or trauma-informed response fell between a 1 to 3 mean score with 1 = “Strongly agree”, 2 = “Agree” and 3 = “Slightly agree”. Table 26 shows that respondents slightly improved their attitudes related to trauma informed care with four of the five core subscales. On the Job-Behavior was the only subscale that did not change between the two time-periods.

Participants who determined that their organization had some practice with trauma informed care answered 10 additional questions within the supplementary subscales using the same format as the first 35 items. Participants maintained the same attitude level of “agree” between the two time-periods with the core subscale items. However, there was significant improvement with the secondary subscales, personal support and system-wide supports. Participants improved their attitude from “Slightly Agree” to “Agree” related to trauma-informed care. In addition, when taking into account all seven subscales the overall mean score produced statistical significant differences (2.71 to 2.52 mean; p =.007) (see Table 27).

Table 27. ARTIC Subscales

| Core Subscale | Pre-test Mean | Post-test Mean | Sig. <.05 |
|---|---|---|---|
| 1. Underlying Causes of Problem Behavior and Symptoms | 2.97 | 2.81 | .084 |
| 2. Responses to Problem Behavior and Symptoms | 2.48 | 2.42 | .537 |
| 3. On-The-Job Behavior | 2.44 | 2.44 | .204 |
| 4. Self-Efficacy at Work | 2.55 | 2.44 | .116 |
| 5. Reactions to the Work | 2.53 | 2.40 | .204 |
| **Secondary Subscales*** | **Pre-test Mean** | **Post-test Mean** | **Sig. <.05** |
| 6. Personal Support of Trauma-Informed Care | 3.12 | 2.58 | .000 |
| 7. System-Wide Support of Trauma-Informed Care | 3.65 | 2.51 | .000 |
| **Total Average*** | **2.71** | **2.52** | **.007** |

*Note:*P<.05, T-test*

## PARTNER

Fourteen organizations, each comprised of a small team, represent their organization by attending an initial three-day orientation and subsequent two-hour sessions every other month during the 12-month Learning Collaborative (LC) engagement. The three-day orientation covered the following topics:

- Trauma Define
- Adverse Childhood Experience Research
- Resilience
- Organizational Domains
- Organizational Assessment
- Prevalence Rates
- Brain Science
- Self-Care
- Trauma Informed Principles
- Action Planning

During the last day of the orientation, each team devised a work plan for the remaining months of the LC. A brief description of the team objectives is found in the Appendices.

Team members selected topics they thought would best benefit their organization in becoming a trauma-informed organization. They included:

- Trauma Informed Policies and Procedures
- Trauma Informed Human Resource Practices
- Community Collaboration/PARTNERS Survey
- Self-Care
- Measurement and Outcomes
- Team Sharing

Additional support and coaching was available upon request. The coaching related to concerns that teams may have had when implementing trauma informed principles and practices, additional training for staff, training designed specifically for managers and additional

assessments. Table 28 shows a sampling of some of the type of improvements Learning Collaborative organizations made over the course of the year.

Table 28. Learning Collaborative Organizational Achievements

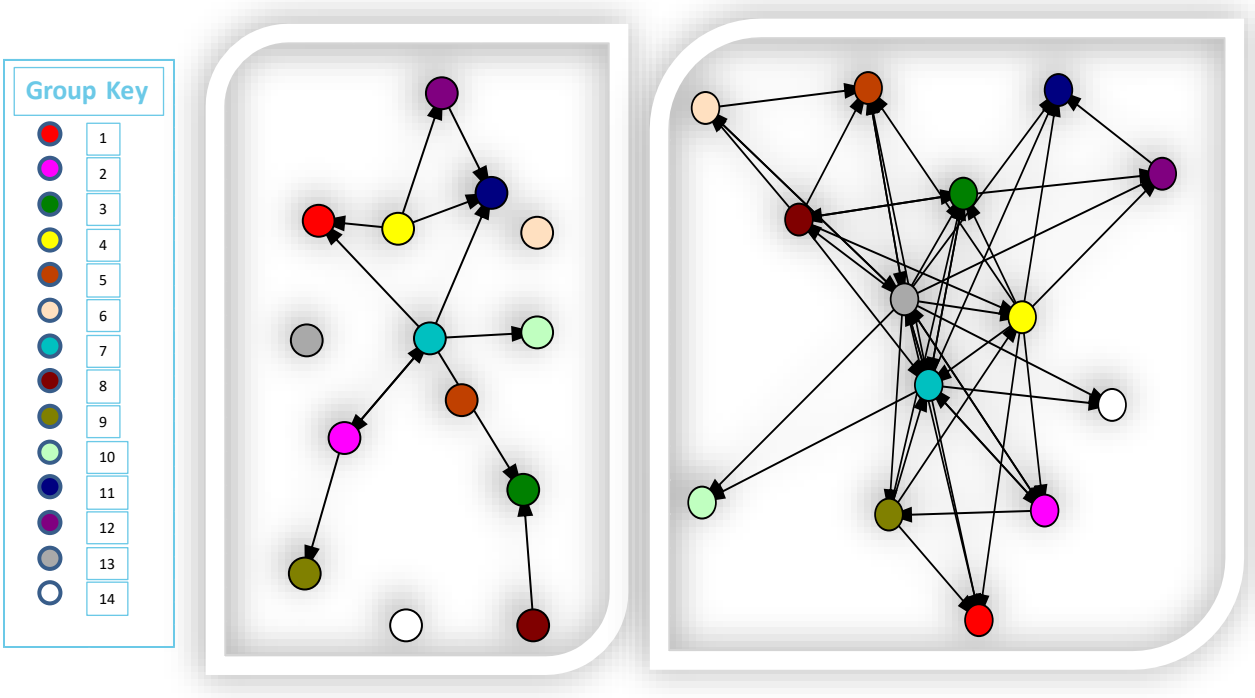
| Organization | 2016-2017 Achievements |
|---|---|
| **Center School District** | • Presentation of teacher self-care (optional session at all District PD).<br>• Presentation of Trauma Awareness-Marsha Morgan (optional session at all District PD).<br>• Mindful May (including: challenge of self-care to staff, self-calming items were rewarded for those that participated, reminders and helpful guidance and tools sent out to staff).<br>• Integrating Prof. Development of PBIS; Trauma informed practices; De-escalation strategies (CPI) at start of the school year to all staff.<br>• Working to integrate Trauma informed practices into a mental health framework for the district<br>• We continue to work to give universal calm down tools for teachers to put in safe seat.<br>• Teachers have begun to take ownership of building strategies into their classrooms such as yoga practices, reminders by safe seats that demonstrate calming strategies, and class meetings that engage in mindfulness strategies.<br>• Conversations are occurring at the admin level to begin incorporating (safety, empowerment, choice, trustworthiness, collaboration). |
| **Children's Mercy West** | • Training included options for staff to complete the ACES survey.<br>• Leading by example emphasizing, "What's happened to you?"<br>• Pain Relief Distractions for patients and their families.<br>• Staff self-care activities, events and daily support. |
| | • Staff training that promoted trauma informed principles with guiding questions. |

| | |
|---|---|
| **Community LINC** | • Family meals.<br>• Book study-The Body Keeps the Score, Trauma Stewardship, and Everything is Normal Until Proven Otherwise.<br>• Resilient Baskets for the Children and Youth (welcome baskets). |
| **Kansas City Rescue Mission** | • Organized actions according to the Substance Abuse Mental Health Administration domains, completed actions in each domain.<br>• Completed multiple assessments with staff, multiple trainings with Board and staff.<br>• Streamlined processes based on trauma informed principles.<br>• Increased collaboration with other community organizations. |
| **ReDiscover Mental Health Center** | • Practice and Policy change related to violent, aggressive incidents with clients.<br>• Completed environment assessment, planned changes according to the assessment.<br>• Developed Debriefing, Policy and Wellness sub committees.<br>• Created Wellness brochures for children, youth and adults. |
| **Rose Brooks Domestic Shelter** | • Created new policies regarding Safety and Security.<br>• Implemented Trauma Informed Supervision.<br>• Addressing vicarious trauma with staff through mindfulness programs.<br>• Collaborated with additional community agencies for additional best practices. |
| **Preferred Family Healthcare** | • Focused on staff engagement and hiring practices.<br>• Environment upgrades.<br>• Revised a multi-step intake process.<br>• Increased trauma specific services. |
| **Mattie Rhodes Center** | • Uplifting staff activities “Mattie Moments” were positive experiences shared at meetings, Brightening Lives slips-real time positive feedback.<br>• Integrating Cultural Competence Committee with Trauma Informed Committee.<br>• Providing “tip of the week” on trauma informed practices |
| **Wyandot Center** | • Social Practice Art project engaging many different departments and the clients.<br>• Client art and their stories reflected throughout the facilities. |


The PARTNER analysis revealed some interesting findings to measure the networking and collaboration among the 14 Learning Collaborating organizations. Attributes considered elements of success include, but not limited to, the distribution of power/influence, level of involvement, frequency of engagement, trust, reliability, and openness to discussion. For the RKC Learning Collaborative, the 14 diverse organizations rated the frequency of connection or interaction with one another. In addition, respondents were able to indicate the direction of the relationship. The visualization network map in Figure 10 shows that four organizations do not have a relationship on a weekly basis with the other organizations in the collaboration. The analysis also shows that only two of the 14 organizations have a bi-lateral relationship on a weekly basis. When viewing the map based on the relationship with one another on a quarterly basis, all 14 organizations are involved in the collaborative by interacting with at least one other organization (see Figure 11). A closer look shows the number of organizations that have a bi-lateral relationship increased dramatically. Over half (57.1%, n=8) had a bi-lateral relationship.

Figure 10.
Weekly Relationship Connections

Figure 11.
Quarterly Relationship Connections




Figures 12 and 13 show maps that indicate the value of two attributes from this collaborative comprised of different sectors; the power/influence and level of involvement. The comparison is defined by the size of the "node" or circle. As a next step teams representing their organization assessed the value of another organization in the collaborative based on the extent the organization has power and influence to impact the RKC Learning Collaborative. They also assessed the organization's level of involvement in the collaborative. The network map on the left shows that one organization (largest dot/dark blue) was considered to hold a more prominent position in the community than the other organizations in the collaborative by being powerful, having influence, success as a change agent, and showing leadership in moving towards trauma informed. Furthermore, the map on the right shows that the same organization has the largest level of involvement; exactly what you want to see in a successful collaborative. On the other end of the spectrum, the map on the left shows three organizations (olive, maroon, and yellow) had less power and influence than some of the other organizations yet, as seen on the map on the right, their level of involvement is strongly committed and active in the partnership and it is an organization that gets things done.

Figure 12.
Power/Influence Attributes

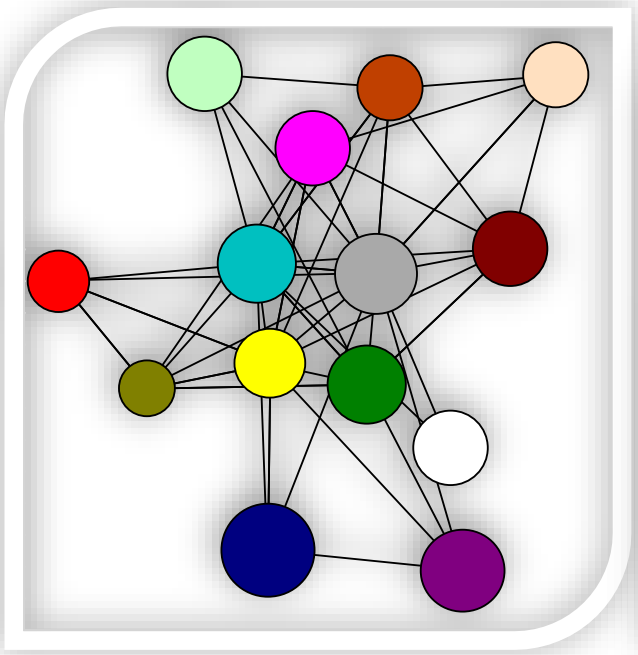
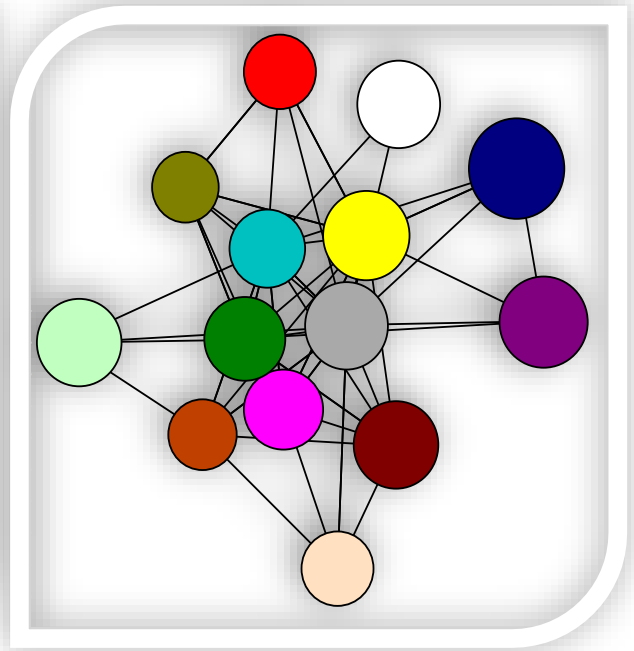


Figure 13.
Level of Involvement Attributes



Each team responded to a series of questions that related to the quality and content of the RKC Learning Collaborative; not the organizations' relationship with one another. Table 28 and Figure 14 below show what outcomes the collaborative valued. Frequencies of responses were counted; a team could select more than one outcome. The collaborative members felt that "increase staff resiliency" and "increased knowledge sharing about secondary trauma among staff" were the most valued outcomes, followed closely by improved TIC and resilient resource sharing, review and revise policy and procedures to increase trauma sensitivity with clients/students, and improved trauma-sensitive communication with clients/students and staff. The least valued outcome of a collaborative was "new sources of data collection".

Table28b. Potential Outcomes of the RKC Learning Collaborative

| Outcomes | |
|---|---|
| Increase staff resiliency | 78.5% |
| Increased knowledge sharing about secondary trauma among staff | 78.5% |
| Review and Revise Policies and Procedures to increase trauma sensitivity with clients/students (e.g., client/student and program manuals, service delivery) | 71.4% |
| Improved trauma-sensitive communication with clients/students and staff | 71.4% |
| Improved TIC and Resilient resource sharing | 71.4% |
| Improved healthy communication among staff | 64.2% |
| Offer free and accessible mental health services for staff (self-care) | 42.8% |
| New Sources of Data Collection | 35.7% |

*Note: Percentages represent the total number of groups that responded to each outcome, and will not equal 100% for that column*

Figure 14. Potential Outcomes of the RKC Learning Collaborative Work


On the last day of the 3-day initial orientation, teams created their own 90-day plan and selected topics they wanted to learn more about. Nearly half (46.2%, n=6) of the teams felt the RKC Learning Collaborative was successful or very successful while the same percentage felt the collaborative was somewhat successful. Not only did teams rate the success of the collaborative, they also identified what aspects of the collaboration contributed to its success. Table 29 and Figure 15 below demonstrate that "exchanging info/knowledge" was most valued, followed by "having a shared mission or goals and "sharing resources".

Table 29. Aspects of Collaboration that Contributed to Success

| Outcomes | |
|---|---|
| Exchanging information and knowledge | 78.6% |
| Sharing resources | 64.3% |
| Having a shared mission and goals | 64.3% |
| Creating useful and interactive resources | 50.0% |
| Bringing together diverse stakeholders | 50.0% |
| Meeting regularly | 42.9% |
| Informal relationships created | 42.9% |
| Collective decision-making | 42.9% |

*Note: Percentages represent the total number of groups that responded to each outcome, and will not equal 100% for that column*

Figure 15. What aspects of collaboration Contribute to this Success?


Finally, team members voiced their opinions on what steps their organization would be willing to invest in the future to move towards being more trauma-informed. Once again, teams had the option of selecting more than one resource. Nearly two-thirds (64.7%, n=11) of the responses favored "site specific training". Of the 17 options, "full executive buy-in" and "site-specific coaching" each received three responses. Teams also identified the kind of format that should be used for any future trauma-informed collaborative. Slightly less than a third (30.8%, n=4) felt collaborating within the same field of work would be the best format for a future trauma-informed collaborative. Interestingly, over half (53.9%, n=7) of the teams felt that using the format they had experienced (interdisciplinary) would be the best format.

## V. Discussion

Ever since Felitti and Anda's groundbreaking Kaiser ACE study, increasing attention is given to ACEs. Investigators have consistently found that early childhood experiences have broad and

long-lasting effects on mental and physical well-being. Previous studies, including the Kaiser, the original BRFSS, the 2013 Urban Philadelphia, and the 2014 Kansas BRFSS have found that over 50% of the population experienced at least one ACE. Fewer (approximately one fifth) experienced four or more ACEs. With the exception of the Urban Philadelphia study, the studies were composed of mainly white, middle class, and highly educated individuals. Although the composition of the RKC respondents was more similar to the previous studies than the Urban Philadelphia study, the findings proved to be remarkably different.

Despite the similar characteristics in the Kansas City region, 87% of the RKC respondents experienced at least one ACE compared to 52% of the Kaiser participants. Of the RKC adults 44% had four or more ACEs when looking at the indicators from the original Kaiser study which was 6.8%, a 37% percentage difference. Furthermore, all the RKC rates of Child Abuse and Neglect indicators were higher than the Kaiser study as well as all the Household Dysfunctional indicators. All of the household dysfunctional rates in the Urban Philadelphia study are also higher than the Kaiser study rates. The rates of emotional abuse and emotional neglect are higher among Kansas City adults than the Kaiser participants--a 50% and 31% difference, respectively. The rates of witnessing domestic violence and living with a mental health family member are also higher among Kansas City adults than the Kaiser participants--a 38% and 25% difference, respectively. Interestingly, when examining the rates of each child abuse and neglect indicators by gender, males had slightly higher rates of emotional and physical abuse than females. When examining the same indicators by race, the rates of emotional abuse of black adults was only slightly lower than white adults, a 3% difference, while the rates of the remaining indicators (physical and sexual abuse, emotional and physical neglect) were all higher for black adults than the white respondents. For those who identified as Hispanic/Latino, the rates of emotional and physical abuse and emotional neglect were the only indicators that were higher than those who did not identify as Hispanic/Latino. Percentage rates among males and females were similar when reporting witnessing domestic violence, substance abuse and mental health household member however, males had a higher rate than females of reporting a household member in prison/jail. Yet rates of witnessed domestic violence, a substance abuse family member in the household and/or household member in prison or jail was found more often among Black participants compared to White participants. Rates of witnessed domestic violence were higher for those who identified their ethnicity as Hispanic/Latino than those who did not. The frequency of responses of ACEs in the Kansas City region suggests that certain populations that are traditionally not seen as at high risk for ACEs necessitates attention for tailored interventions to reduce the impact of ACEs and to prevent ACEs.

The RKC ACE project's geographical boundaries covered a nine-county, bi-state region. This area encompasses rural, suburban, and urban communities. The intent was to collect a robust sample of surveys from each county, however only five of the nine had more than a 5% success rate with two of five (Jackson and Wyandotte) consisting of strongholds in urban areas. In anticipation of this, the RKC ACE survey followed the exemplary Urban Philadelphia expansion survey by adding questions to the traditional ACEs. The expanded survey includes indicators that are related to toxic stressors traditionally found in urban neighborhoods. Kansas City adult residents responded to whether they had grown up witnessing violence, feeling unsafe in their neighborhood; feeling that people in their neighborhood did not look out for each other, stood up for each other or could not be trusted; experiencing discrimination based on their ethnicity and if they had lived in foster care. The RKC survey found that these expanded ACE indicators are prevalent in the Kansas City region. More than a fourth of the respondents said they had been bullied, witnessed violence (someone being beaten or shot in front of them), and felt they did not grow up in a supportive neighborhood. The Urban Philadelphia survey rates in the expanded indicators were 14% higher than RKC rates with adults who witnessed violence and 22% higher than RKC rates with adults who felt discriminated. However, surprisingly there was over a 20% difference in the rate of RKC adults being bullied compared to Philadelphia adults. A closer look shows that assessing the rate by gender and race, males and white respondents were bullied more often than females and black respondents. RKC males had higher rates of witnessing violence than females and upon further investigation, at least half of RKC and Urban Philadelphia black adults witnessed violence (50% and 52%, respectively). The same trend occurred when looking at the rates of feeling discrimination when growing up. RKC males had higher rates of feeling discrimination than females and upon further investigation, at least half of RKC and Urban Philadelphia black adults felt discrimination compared to their white counterparts (55% and 50%, respectively). Nearly half (46 %) who witnessed violence and 52% who experienced discrimination resided in Jackson County, an urban community. These results accentuate the importance of continued research of ACEs in traditional urban neighborhoods.

Approximately 13% of the RKC participants fell under the federal poverty level, however of that small percentage, 64% experienced four or more ACEs. On the other hand, of the majority (87%) of the participants who indicated they were above the poverty level slightly over half (51%) experienced four or more ACEs. Slightly more males than females experienced four or more ACEs while the proportion of Black and those of More than One Race reported four or more ACEs more often than those who identified as white. These findings indicate that income can be a factor in individuals experiencing ACEs but is not exclusive to the poor.

The RKC study is unique among previous ACEs studies in that a resilience measurement immediately followed the ACEs survey. It is important to keep in mind that exposure to ACEs and the toxic stress response does not guarantee poor outcomes. Rather such experiences increase the risk of poor outcomes. Some children who experience ACEs fare better than others and demonstrate positive adjustments and healthy development. Certain factors can help a child to build resiliency and mitigate the negative effects of ACEs. The RKC study found the majority of the respondents reported either a 'High' or 'Exceptional' level of resilience regardless of the number of ACEs they experienced in their childhood. For example, nearly all (90%) of the Kansas City adults who reported zero ACEs had a 'High' or 'Exceptional' level of resiliency. For those who reported one to three childhood toxic stress experiences, nearly two-thirds (64%) had an 'Exceptional' level of resiliency, possessing the capability to persevere and reframe adversities. As to be expected, fewer (34%) who experienced four or more ACEs reported an 'Exceptional' level of resiliency while 27% reported 'Low' resiliency. For the adults who had four or more ACEs, slightly more females than males tended to have 'High' or 'Exceptional' resilience levels. About the same percentage of Black and White adults had either 'Low' or 'Moderate' and 'High' or 'Exceptional' levels of resiliency. These findings suggest that it is more likely that the lower the adversity experiences in a child's life the more resilient they may become. However, even children who have experienced multiple adversities may thrive in adulthood. Further research should be considered to examine the impact resilience has on adverse childhood experiences.

Participants who attended an educational series session improved their overall attitudes about trauma informed care. However, it should be noted that participants started with a somewhat "informed" attitude prior to the session, based on the beginning mean score of 2.95 and ending at 3.18. Nevertheless, individual characteristics of toxic stress that improved significantly related to self-care practices and that the impact of trauma affects families also affects the community.

This study also investigated trauma-informed organizational attitude change from employees representing the 14 organizations who participated in the RKC Learning Collaborative. One organization chose to conduct their own ARTRIC survey separate from the RKC Learning Collaborative group. The majority of the employees self-reported they had worked full-time, interacted with clients or customers on a regular basis, and had been with their organization from three to seven years or more. Results between the time-periods suggest that most employees had an overall favorable attitude that a trauma-informed approach to their work was better than the alternative. Those employees whose organization had prior experience with trauma

informed care practices answered additional questions that were specific to the organization's personal and system-wide support of trauma-informed care practices. There was a statistically significant shift in attitudes between time-periods in that most employees attitudes changed from "slightly agree" to "agree" that their organization was supportive. Additional research should be considered to explore what types of interventions, such as trauma-informed training or coaching delivered directly to employees, affect attitude change in organizations.

Investigating the attributes of what makes a learning collaborative successful is essential where teamwork is required to meet the complex needs of service users in an increasingly interdisciplinary society. The RKC Learning Collaborative addressed some of the attributes that make up a successful collaborative. Results indicate that there is likely to be a more bi-lateral relationship between organizations that met on a quarterly basis than a weekly basis. In addition, when teams rated the other organizations level of power/influence and involvement the results suggest that the level of involvement is not always contingent on the position of influence an organization may have. The results show that teams valued that staff resiliency and increased knowledge about secondary trauma was essential for sustainability. In addition, it is important for an organization's policies and procedures reflect trauma sensitivity, especially for those who see their services. The results also show that teams identified that an interdisciplinary learning collaborative format should be used for future trauma-informed learning but not without some site specific training made available. Although site-specific training was offered in the RKC Learning Collaborative, additional assessment may have needed to be determined before implementation. Further investigation into how other interdisciplinary learning collaboratives operate should be considered as the demand for partnerships increase.

## Limitations of the Current Study

- The sample size and design of the RKC ACEs/Resilient study was limited. The sample size may be too small and homogenous to clearly show a connection between ACE and

resiliency totals. The data collection strategy primarily relied on volunteers with full-time jobs and who also focused on other responsibilities within the project. The lack of reliable data limited the scope of analysis, and as such, advanced statistical analysis could not be conducted. If the ACE/Resilient study is repeated in Kansas City, a reliable methodology should be considered that coincides with available resources.

- Comparison between the RKC ACEs/Resilient study and the Kaiser study should be done with caution. Some of the questions were worded slightly different on the RKC survey and the Kaiser survey. For example, for sexual abuse, the RKC ACE question was divided to make two separate questions similar to the 2008 BRFSS study. For physical neglect, the RKC ACE asked about cutting or skipping meals because there was not enough money for food. The Kaiser study, in addition to assessing if there was enough food to eat, asked whether parental drinking interfered with their care, if they wore dirty clothes, and if someone was available to take them to the doctor. For domestic violence, the RKC study included a reference to verbal abuse which was found in other BRFSS studies. Lastly, to distinguish between reality and fantasy, for one of the expanded questions on witness violence, the RKC ACE question asked "how often, if ever, did you see or hear someone being beaten up in real life (e.g., in front of you)?". The Philadelphia ACE did not include 'in front of you'.

- The ARTIC tool format was confusing to several respondents. The rating scale was unlike the common Likert scale. The ARTIC tool uses a scale of 1-7 with 1-3 and 5-7 being identical with little variance (strongly agree, agree, slightly agree). The location of the item is what determined which side of the scale the respondent was to choose. Consideration to reformatting the survey may yield more reliable responses.

- This report presents initial analysis of the frequency of responses of ACEs, resiliency, organizational attitudes, and learning about trauma-informed care and resilience. It includes descriptive statistics, Chi-Square, and T-test statistics where appropriate. More advanced statistical analyses, such as ANOVA and logistical regression are recommended for future studies that may arise from discussions from the results of this study.

# VI. Listing of Tables and Figures

## Tables



## Figures

# VII. References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# VII. Appendices

**Theory of Change/Action**

Building → Community Impact

| | Exploring | Emerging | Sustaining | System Change | Proof Point |
|---|---|---|---|---|---|
| Pillar I:<br><br>Shared Community Vision | Establish trauma-informed cross-sector partnerships with shared vision and scope.<br>Bring together leaders to guide the process with defined roles and responsibilities.<br>Create a trauma-informed message for varying audiences. | Publish baseline report on trauma-informed organizations, ACEs, and Resiliency. | Operate w/ defined roles and responsibilities.<br>Maintain consistent messaging between partners.<br>Show results of the progress with the community to build momentum. | Maintenance of partnerships after leadership at partner organizations.<br>Shared accountability for improvement of community level outcomes.<br>Share success and challenges w/ community partners. | The majority of community level outcomes are improving consistently |
| Pillar II:<br><br>Evidence Based Decision Making | Work with cross-sector partners to improve community trauma-informed outcomes.<br>Identify shared measurements of ACEs and resilience. | Collect baseline data for community outcomes.<br>Utilize data to prioritize outcomes for initial focus. | Refine outcomes for improved contextual accuracy<br>Collect and connect programmatic data to community outcomes to assist with continuous improvement. | Data sharing that is focused and timely in order to inform continuous improvement of outcomes. | |
| Pillar III:<br><br>Collaborative | Enact a continuous improvement process to improve community level outcomes. | Form/strengthen practitioner and community partnership networks to review community level outcomes. | Utilize networks to improve outcomes and overcome barriers for further improvement of community level outcomes. | Use the continuous improvement process to identify and share community best practices that improve outcomes. | |
| Pillar IV:<br><br>Investment and Sustainability | Establish a backbone organization to maintain the partnership and activities<br>Engage funders to support the trauma-informed work. | Build capacity for data management and collection, facilitation, and partnership/community engagement. | Mobilize the community to implement what works.<br>Establish advocacy agendas to drive policy change | Allocate and align resources to what works in the community to improve outcomes.<br>Secure sustainable funding.<br>Inform the creation of policy to sustain improved outcomes | |

## Comparison of ACE Questions

| Indicator | 2017 Resilient KC ACE (22 questions- 14 categories) | Kaiser ACE (10 questions- 10 categories) | BRFSS (11 questions- 8 categories) | Philadelphia Urban ACE (21 questions-15 categories) |
|---|---|---|---|---|
| Emotional Abuse<br><br>Emotional Abuse | *Sometimes parent or other adults hurt children….*<br>How often did a parent or adult in your home ever swear at you, insult you, or put you down? **More than once**, once, never | Did a parent or other adult in the household often or very often swear at, insult, or put you down or humiliate you or Act in a way that make you afraid that you might be physically hurt? **Yes**, No | How often did a parent or adult in your home ever swear at you, insult you, or put you down? **More than once**, once, never | While you were growing up how often did a parent, step-parent, or another adult living in your home swear at you, insult you, or put you down? **More than once**, once, never |
| | How often did a parent or adult in your home ever act in a way that made you afraid that you would be physically hurt? **More than once**, once, never | | | While you were growing up how often did a parent, step-parent, or another adult living in your home act in a way that made you afraid that you would be physically hurt? **More than once**, once, never |
| Physical Abuse<br><br>Physical Abuse | *Sometimes physical blows occur between parents or other adults in the house, During your first 18 years of life…*<br>How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking. **More than once, once**, never | Did a parent or other adult in the household often or very often…Push, grab, slap, or throw something at you? Or Ever hit you so hard that you had marks or were injured? **Yes**, No | How often did your parents or an adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking. **More than once, once**, never | While you were growing up did a parent, step-parent, or another adult living in your home push, grab, shove, or slap you? **More than once, once**, never |
| | How often did a parent, step-parent, or another adult living in your home hit you so hard that you had marks or were injured? **More than once, once**, never | | | While you were growing up did a parent, step-parent, or another adult living in your home hit you so hard that you had marks or were injured? **More than once, once**, never |

| Indicator | 2017 Resilient KC ACEs (22 questions) | 1998 Kaiser ACE (10 questions) | 2008 BRFSS (11 questions) | 2013 Philadelphia Urban ACE (21 questions-14 categories) |
|---|---|---|---|---|
| Sexual Abuse | *Some people, during their first 18 years of life, had a sexual experience with an adult or someone at least five years older than themselves. These experiences may have involved a relative, family, or stranger.* How often did anyone at least 5 years older than you or an adult, ever touch you sexually or try to make you touch them sexually? **More than once**, **once,** never | Did an adult or person at least 5 years older ever…Touch or fondle you or have you touch their body in a sexual way? Or Attempt or actually have oral, anal, or vaginal intercourse with you? **Yes**, No | How often did anyone at least 5 years older than you or an adult ever touch you sexually?... **More than once, once**, never | During the first 18 years of life, did an adult or older relative, family friend, or stranger who was at least five years older than yourself ever touch or fondle you in a sexual way? **More than once**, once, never |
| Sexual Abuse | How often did anyone at least 5 years older than you or an adult force you to have sex? **More than once**, **once**, never | | …try to make you touch them sexually?... **More than once, once**, never<br>... force you to have sex? **More than once, once**, never | Attempt to have or actually have any type of sexual intercourse, oral, anal or vaginal with you? **More than once, once**, never |
| Emotional Neglect | *During the first 18 years of your life..* Did you often or very often feel that on one in your family loved you or thought you were important or special? **Yes**, No | Did you often or very often feel that.. No one in your family loved you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other? **Yes**, No | Not Asked | There was someone in your life who helped you feel important or special. Very often true, often true, sometimes true, **rarely true, never true** |
| | Did you often or very often feel that your family didn't look out for each other, feel close to each other, or support each other? **Yes**, No | | | |
| Physical Neglect | Did your family sometimes cut the size of meals or skip meals because there was not enough money in the budget for food? **Yes**, No | Did you often or very often feel that… You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? **Yes**, No | Not asked | Your family sometimes cut the size of meals or skipped meals because there was not enough money in the budget for food. **Very often true, often true, sometimes true**, rarely true, never true |

| | Household Dysfunction | | | |
|---|---|---|---|---|
| **Indicator** | **Resilient KC ACE** (22 questions) | **Kaiser ACE** (10 questions) | **BRFSS** (11 questions) | **Philadelphia Urban ACE** (21 questions) |
| Domestic Violence<br><br>Domestic Violence | *Sometimes physical blows occur between parents or other adults in the house. During your first 18 years of life..*<br>How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up? **More than once, once**, never | Was your mother or stepmother: Often or very often pushed grabbed, slapped or had something thrown at her? or Sometimes often , or very often kicked, bitten, hit with a fist, or hit with something hard? Or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife? **Yes**, No | How often di your parents or adults in your home ever slap, hit, kick, punch, or beat each other up? **More than once, once**, never | How often, if ever, did you see or hear in your home a parent, step parent, or another adult who was helping to raise you being slapped, kicked, punched, or beaten up? **Many times, a few times**, once, never |
| | How often, if ever, did you see or hear a parent, step parent or another adult who was helping to raise you being yelled at, screamed at, sworn at, insulted or humiliated? **More than once, once**, never | | | How often, if ever, did you see or hear in your home a parent, step parent, or another adult who was helping to raise you being hit or cut with an object, such as a stick, cane, bottle club, knife or gun? **Many times, a few times**, once never |
| Substance Abuse<br>Substance Abuse | *During the first 18 years of your life…*<br>Did you live with anyone who was a problem drinker or alcoholic? **Yes**, No | Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs? **Yes**, No | Did you live with anyone who "was a problem drinker or alcoholic? **Yes**, No | Did you live with anyone who was a problem drinker or alcoholic? **Yes**, No |
| | Did you live with anyone who used illegal street drugs or who abused prescription medications? **Yes**, No | | Used illegal street drugs or who abused prescription medications? **Yes**, No | Did you live with anyone who used illegal street drugs or who abused prescription medications? **Yes**, No |
| Mental Health | Did you live with anyone who was depressed, mentally ill, or suicidal? **Yes**, No | Was a household member depressed or mentally ill, or did a household member attempt suicide? **Yes**, No | Did you ever live with anyone who was depressed, mentally ill, or suicidal? **Yes**, No | While you were growing up…Did you live with anyone who was depressed or mentally ill? **Yes**, No |
| | | | | Did you live with anyone who was suicidal? **Yes**, No |
| Parental Separation or Divorce | Not asked | Were your parents ever separated or divorced? **Yes**, No | Were your parents separated or divorced? **Yes**, No | Not asked |

| | Household Dysfunction (cont.) | | | |
|---|---|---|---|---|
| **Indicator** | **2016-17 Resilient KC ACE** (22 questions) | **1995 Kaiser ACE** (10 questions) | **2008 BRFSS** (11 questions) | **2013 Philadelphia Urban ACE** (21 questions) |
| Incarcerated Household Member | Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility? **Yes**, No | Did a household member go to prison? **Yes**, No | Did you live with anyone who served time or was sentenced to serve time in prison, jail, or other correctional facility? **Yes**, No | Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility? **Yes**, No |
| | **Expanded Urban Indicators** | | | |
| Witnessed Violence<br><br>Witness Violence | *The next questions are about how often, during the first 18 years of your life, YOU may have seen or heard certain things in your NEIGHBORHOR OR COMMUNITY—NOT in your home or on TV, movies, or the radio...* How often, if ever, did you see or hear someone being beaten up in real life? (e.g., in front of you)? **More than once,** once, never<br><br>How often, if ever, did you see or hear someone being stabbed or shot in real life? (e.g., in front of you)? **More than once,** once, never | Not asked | Not asked | How often, if ever, did you see or hear someone being beaten up, stabbed, or shot in real life? **Many times, a few times**, once, never |
| Felt Discrimination | *Sometimes people are treated badly, not given respect, or are considered inferior because of the color of their skin, because they speak a different language or have an accent, or because they come from a different country or culture…* During your first 18 years of life how often did you feel that you were treated badly or unfairly because of your race or ethnicity? **More than once**, once, never | Not asked | Not asked | While you were growing up… How often did you feel that you were treated badly or unfairly because of your race or ethnicity? **Very often true, often true, sometimes true**, rarely true, never true |

| | | | | |
|---|---|---|---|---|
| **Indicator** | **2016-17 Resilient KC ACE** (22 questions) | **1995 Kaiser ACE** (10 questions) | **2008 BRFSS** (11 questions) | **2013 Philadelphia Urban ACE** (21 questions) |
| Adverse Neighbor-hood Experience | Did you feel safe in your neighborhood(s)? More than once (all or most of the time), **once (sometimes)**, **never** | Not asked | Not asked | Did you feel safe in your neighborhood? All of the time, **some of the time**, **none of the time** |
| | Did you feel people in your neighborhood(s) looked out for each other, stood up for each other, and could be trusted? More than once (all or most of the time), **once (sometimes)**, **never** | | | Did you feel people in your neighborhood looked out for each other, stood up for each other, and could be trusted? All of the time, **some of the time**, **none of the time** |
| Bullied | How often were you bullied by a peer or classmate? **More than once (all or most of the time)**, once (sometimes), never | Not asked | Not asked | How often were you bullied by a peer or classmate? **All of the time, most of the time**, some of the time, none of the time |
| Lived in Foster Care | Were you ever in foster care? **Yes**, No | Not asked | Not asked | Were you ever in foster care? **Yes**, No |

**PLEASE READ INSTRUCIONS CAREFULLY BEFORE YOU START--Your individual answers will not be shared publically. The survey will take about 10 to 12 minutes to complete. All answers are about yourself.**

***The Resilient KC Initiative is a partnership between Trauma Matters KC and The Chamber of Commerce's Healthy KC Initiative.**

***Resilient KC seeks to understand the prevalence of Adverse Childhood Experiences (ACEs, e.g., physical abuse, neglect, growing up in poverty) on the community's overall health in the Kansas City region. Recent research has revealed a strong correlation between ACEs and conditions such as heart disease, smoking rates, depression.**

***By taking this survey, you are helping the Kansas City community become aware of the influence trauma has on our health and a way to learn more about yourself. All information will remain anonymous. Please do not take this survey more than once.**

**Please take a few moments to review the consent**

**Consent for Participation in a Program Evaluation**
**Adverse Childhood Experiences/Resilient Questionnaire**

**Invitation to Participants**

You are invited to participate in the Resilient KC program evaluation project. This program evaluation project will explore the prevalence of Adverse Childhood Experiences (ACEs) and Resiliency in the Kansas City region. This project is a Robert Wood Johnson and Health Care Foundation of Greater Kansas City funded project (October, 2015 - October 2017). Kansas City is one of 14 funded sites in the country participating in a national initiative, called Mobilizing Action for Resilient Communities (MARC). The project is co-sponsored by Trauma Matters KC and Kansas City Chamber of Commerce. The University of Missouri Kansas City-Institute for Human Development (UMKC-IHD) is conducting the evaluation.

**Who will Participate**

Individuals 18 years and older who live in the bi-state nine county Kansas City region. Missouri counties include: Jackson, Clay, Platte, Ray, Cass; Kansas counties include: Leavenworth, Wyandotte, Johnson and Miami counties.

**Purpose**

The purpose of the Resilient KC project is to determine the prevalence of ACEs and Resilience within the targeted population located in the Kansas City bi-state nine-county region. The targeted population includes: Business, Education, Health, Justice, and Community.

**Description of Procedures**

If you choose to participate in this program evaluation project we will ask of you to complete a 10-12minute electronic questionnaire which will be used to collect baseline data on demographics, ACEs and Resilient scores.

**Risks and Inconvenience**

You may experience some stress when completing the questionnaire that contains sensitive information. We will do everything possible to minimize the discomfort or stress you may experience during the questionnaire including:

1. Assure you that you may refuse to answer any questions and it will have no impact on your ability to complete the questionnaire;
2. Assure you that your identity will remain anonymous; in other words your identity will not be linked to your individual answers; and
3. Refer you to resources if you experience severe stress.

**Benefits of participation**

1. Participants who complete the ACEs/Resilient questionnaire receive a resource link for trauma informed care and resilient information (United Way 211 connection to counseling and support for individuals who have suffered from trauma, and the 'we are resilientlkc.org' webpage) and may potentially benefit as a result of these resources.
2. By completing this survey your participation will inform baseline ACEs/Resilient data to the nine-county bi-state Kansas City region, which will help future individuals, help create a trauma-informed community, and have important public health benefits.

**Confidentiality**

The evaluation members will respect the privacy of your information and the confidentiality of the records. All evaluation staff members have received training regarding the confidentiality of records. The electronic questionnaire will allow your information to remain anonymous; in other words no one will be able to link your answers to your identity. Your information will be encrypted when transferred to IHDs computer. All computers at the IHD are password protected. Computer data files are stored on the UMKC-IHD network and backed up daily. Access to the drives on which the data are located is restricted to designated staff. Aggregated data may be shared with Robert Wood Johnson, Health Care Foundation of Greater Kansas City and the other 13 MARC sites and local sources for the purpose of analysis, reporting, publication and other dissemination.

Individuals from the University of Missouri-Kansas City Institutional Review Board (a committee that reviews and approves studies), may look at records related to this study for quality improvement and regulatory functions.

**In Case of Injury**

The University of Missouri-Kansas City appreciates the participation of people who help it carry out its function of developing knowledge through research and program evaluation. If you have any questions about the study that you are participating in you are encouraged to call Ronda Jenson, Principal Investigator, 816-235-6381.

Although it is not the University's policy to compensate or provide medical treatment for persons who participate in studies, if you think you have been injured as a result of participating in this

study, please call the IRB Administrator of UMKC's Social Sciences Institutional Review Board at 816-235-1764.

**Compensation**

There will be no monetary compensation for anyone completing the questionnaire.

**Voluntary Participation**

Participation in this program evaluation is voluntary at all times. You may choose to not participate or to withdraw your participation at any time.

**Alternatives to Participation**

Deciding not to participate or choosing to leave the study will not result in any penalty or loss of benefits to which you are entitled, in other words, you may choose not to answer questions.
By checking "Yes" below you certify that:

(1) You have read and understood this consent form, and are 18 years or older;
(2) You agree to participate in the ACEs/Resilient questionnaire

☐ Yes ☐ No

## Adult ACEs/Resilient Questionnaire

Before answering the brief questions below, we need some important information from you.

What is today's date? _____

What is your gender (sex) ? ☐ Female ☐ Male ☐ Transgender

What is your age? ☐ 18 – 22 ☐ 23 – 29 ☐ 30 – 49 ☐ 50+

How would you describe yourself? ☐ Black or African American ☐ White or Caucasian ☐ Asian
☐ American Indian Native ☐ Native Hawaiian or other Pacific Islander ☐ More than one race
☐ Other race (please specify) _____

Do you identify your ethnicity as Hispanic or Latino origin?
☐ No, not of Hispanic or Latino origin
☐ Yes, Mexican, Puerto Rican, Cuban, or another Hispanic, Latino, or Spanish origin.

How would you describe your sexual identity?
☐ Heterosexual (straight-attracted to the opposite sex)
☐ Homosexual (gay/lesbian-attracted to the same sex)
☐ Bi-sexual (attracted to both men and women)
☐ Other (please specify) _____

What is the highest education level you finished? ☐ Less than High School degree ☐ High school graduate or GED ☐ Post high school technical training ☐ Some college (but no degree)
☐ Associate degree/Technical school certificate ☐ College degree ☐ Graduate courses ☐ Graduate degree

What is your current relationship status? ☐ Single ☐ Married ☐ Unmarried partners
☐ Separated ☐ Divorced ☐ Widowed

What County do you reside in? ☐ Leavenworth ☐ Wyandotte ☐ Johnson ☐ Miami ☐ Platte ☐ Clay ☐ Ray ☐ Jackson ☐ Cass ☐ None of the above

How many people live in your household (include yourself)? _____

What is the estimated total ANNUAL (YEARLY) income of everyone who lives in your household (include yourself)? $_____

What is your current employment status? ☐ Employed Full-time ☐ Employed Part-time
☐ Retired ☐ Unemployed

If you are employed, what County do you work in? ☖ Leavenworth ☖ Wyandotte ☖ Johnson ☖ Miami ☖ Platte ☖ Clay ☖ Ray ☖ Jackson ☖ Cass ☖ None of the above

Please select the answer that best represents your primary employment

| | | | |
|---|---|---|---|
| Small Business | □ | Juvenile Justice | □ |
| Large Business | □ | Adult Correction | □ |
| Non-profit Business | □ | Emergency (police/firefighters, EMS) | □ |
| Mental Health | □ | Active Armed Services | □ |
| Medical Health | □ | Veteran | □ |
| Higher Education | □ | Government | □ |
| K-12 Education | □ | Faith Based | □ |

□ Other (please specify) _____

Please check <u>all that apply</u> where you received direct services within the past 6 months. Suggestions within parentheses are provided as a guide to the type of service.

| | | | |
|---|---|---|---|
| Business (insurance, financial/legal aid) | □ | Juvenile Justice (family court,) | □ |
| Mental Health (substance use) | □ | Adult Correction (drug court,) | □ |
| Medical Health (doctor, dentist, disabilities) | □ | Emergency (police, firefighters, EMS) | □ |
| Higher Education (classes) | □ | Active Armed Services (recruitment) | □ |
| K-12 /GED Education (classes, PTA) | □ | Veteran Services (counseling, benefits) | □ |
| Faith Based (food/clothing) | □ | Community Center (well-being, child-care) | □ |
| None of these | □ | Government (local, state, federal) | □ |

□ Other (please specify) _____

*GO TO NEXT PAGE*

*We would like to ask you some questions about events that happened during your childhood. This information will allow us to better understand problems that may occur early in life, and may help others in the future. Please choose only <u>one</u> answer per question.*

*This is a sensitive topic and some people may feel uncomfortable with these questions. At the end of this questionnaire, you will be given a phone number for an organization that can provide referral for these issues. Please keep in mind that you can skip any question you do not want to answer.*

All questions refer to the time period before you were 18 years of age. Now, looking back before you were 18 years of age—

| | **More than once** | **Once** | **Never** |
|---|---|---|---|
| ***Sometimes parents or other adults hurt children….*** | | | |
| How often did a parent or adult in your home ever swear at you, insult you, or put you down? | □ | □ | □ |
| How often did a parent or adult in your home ever act in a way that made you afraid that you would be physically hurt? | □ | □ | □ |
| How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking**.** | □ | □ | □ |
| How often did a parent, step-parent, or another adult living in your home hit you so hard that you had marks or were inured? | □ | □ | □ |
| ***Sometimes physical blows occur between parents or other adults in the house. During your first 18 years of life…*** | | | |
| How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up**?** | □ | □ | □ |
| How often, if ever, did you see or hear a parent, step parent or another adult who was helping to raise you being yelled at, screamed at, sworn at, insulted or humiliated? | □ | □ | □ |

***Some people, during their first 18 years of life, had a sexual experience with an adult or someone at least five years older than themselves. These experiences may have involved a relative, family friend, or stranger.***

| | More than once | Once | Never |
|---|---|---|---|
| How often did anyone at least 5 years older than you or an adult, ever touch you sexually or try to make you touch them sexually? | □ | □ | □ |
| How often did anyone at least 5 years older than you or an adult force you to have sex? | □ | □ | □ |

***During the first 18 years of your life…***

| | Yes | No |
|---|---|---|
| Did you often or *very* often feel that no one in your family loved you or thought you were important or special? | □ | □ |
| Did you often or *very* often feel that your family didn't look out for each other, feel close to each other, or support each other? | □ | □ |
| Did your family sometimes cut the size of meals or skip meals because there was not enough money in the budget for food? | □ | □ |

***During the first 18 years of your life….***

| | | |
|---|---|---|
| Did you live with anyone who was a problem drinker or alcoholic? | □ | □ |
| Did you live with anyone who used illegal street drugs or who abused prescription medications? | □ | □ |
| Did you live with anyone who was depressed, mentally ill, or suicidal? | □ | □ |
| Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility? | □ | □ |
| Were you ever in foster care? | □ | □ |

***During the first 18 years of your life….***

| | More than Once (all or most of the time) | Once (some times) | Never |
|---|---|---|---|
| Did you feel safe in your neighborhood(s)? | □ | □ | □ |
| Did you feel people in your neighborhood(s) looked out for each other, stood up for each other, and could be trusted? | □ | □ | □ |
| How often were you bullied by a peer or classmate? | □ | □ | □ |

The next questions are about how often, during the first 18 years of your life, YOU may have seen or heard certain things in your NEIGHBORHOOD OR COMMUNITY—
**NOT** in your home or on TV, movies, or the radio.

| | More than Once | Once | Never |
|---|---|---|---|
| How often, if ever, did you see or hear someone being beaten up in real life? (e.g., in front of you)? | □ | □ | □ |
| How often, if ever, did you see or hear someone being stabbed or shot in real life**?** (e.g., in front of you) | □ | □ | □ |

***Sometimes people are treated badly, not given respect, or are considered inferior because of the color of their skin, because they speak a different language or have an accent, or because they come from a different country or culture.***

| | | | |
|---|---|---|---|
| During your first 18 years of life how often did you feel that you were treated badly or unfairly because of your race or ethnicity? | □ | □ | □ |

YOUR TOTAL ACE SCORE _____

*GO TO NEXT PAGE.....*

*You are almost done, just a few more statements to answer. We would like to ask you some questions about your current strengths or how you currently use your resilient skills to cope with tough situations and trauma. This information will allow us to better understand how problems are addressed and may help others in the future. Please choose only <u>one</u> answer per question.*

| | **Not at All** | **A Little** | **Sometimes** | **Quite a Bit** | **A Lot** |
|---|---|---|---|---|---|
| I have people I can respect in my life. | □ | □ | □ | ☐ | ☐ |
| Getting and improving qualifications or skills is important to me. | □ | ☐ | ☐ | □ | □ |
| My family know a lot about me. | □ | □ | □ | ☐ | ☐ |
| I try to finish what I start. | □ | □ | ☐ | ☐ | □ |
| I can solve problems without harming myself or others (e.g. without using drugs or being violent). | □ | ☐ | ☐ | □ | □ |
| I know where to get help in my community. | □ | □ | □ | ☐ | ☐ |
| I feel I belong in my community. | □ | □ | ☐ | ☐ | □ |
| My family stands by me during difficult times. | □ | □ | □ | ☐ | ☐ |
| My friends stand by me during difficult times. | □ | ☐ | ☐ | □ | □ |
| I am treated fairly in my community. | □ | □ | □ | ☐ | ☐ |
| I have opportunities to show others that I can act responsibly. | □ | ☐ | ☐ | □ | □ |
| I enjoy my family's/partner's cultural and family traditions. | □ | ☐ | ☐ | □ | □ |

YOUR RESILIENT SCORE _____

**Consent for Participation in a Program Evaluation Study**
**Trauma-Informed/Resilient Summit Education Series**
**Resilient KC Project**

**Invitation to Participants**

You are invited to participate in the Resilient KC project. The project is a Robert Wood Johnson and Health Care Foundation of Greater Kansas City funded project (October, 2015 - October 2017) to explore the prevalence of Adverse Childhood Experiences (ACEs) and Resiliency in the Kansas City region. Kansas City is one of 14 funded sites in the country participating in a national initiative, called Mobilizing Action for Resilient Communities (MARC). The project is co-sponsored by Trauma Matters and Kansas City Chamber of Commerce. The University of Missouri Kansas City-Institute for Human Development (UMKC-IHD) is conducting the evaluation.

**Who will Participate**

Participants, 18 years and older, who register for Summit Education Series coordinated by the Trauma Matters KC Education committee over the duration of the Resilient KC project (April, 2016 - October 2017).

**Purpose**

The purpose of the program evaluation component of this project is to determine the effectiveness of a series of educational sessions to achieve improved trauma-informed and resilient attitudes. The educational series will provide in-depth information about trauma, secondary trauma and resilient practices. This series will include local, state and national speakers.

**Description of Procedures**

If you choose to participate in this program evaluation we will ask of you to complete a 5 minute electronic baseline and follow-up questionnaire which will be used to collect pre- and post-test data on demographics, trauma and resilient attitudes.

**Risks and Inconvenience**

You may experience some stress when completing the questionnaire that contains sensitive information. We will do everything possible to minimize the discomfort or stress you may experience during the questionnaire including:

1. Assure you that you may refuse to answer any questions and it will have no impact on your ability to complete the questionnaire;
2. Assure you that your identity will remain anonymous; in other words your identity will not be linked to your individual answers; and
3. Refer you to resources if you experience severe stress.

**Benefits of participation**

1. You may gain a new awareness during the completion of the questionnaire related to trauma and self-management.

2. You may be able to share the information with your family, friends, and partners.
3. You may gain personal satisfaction from participating in a project which contributes to the body of knowledge related to ACEs and Resilient practices
4. Your participation will help future individuals and have an important public health benefit.

**Confidentiality**

The evaluation members will respect the privacy of your information and the confidentiality of the records. All evaluation staff members receive training regarding the confidentiality of records. The on-line baseline and follow-up questionnaires will allow your information to remain anonymous; in other words, no one will be able to link your answers to your identity. All data will be stripped of any identifiers and will be stored in a secure database called REDCap. Your information will be encrypted when transferred to UMKC-IHDs computer. All computers at the IHD are password protected. Computer data files are stored on the UMKC-IHD network and backed up daily. Access to the drives on which the data are located is restricted to designated staff. Aggregated data may be shared with Robert Wood Johnson, Health Care Foundation of Greater Kansas City and the other 13 MARC sites and local sources for the purpose of analysis, reporting, publication and other dissemination.

Individuals from the University of Missouri-Kansas City Institutional Review Board (a committee that reviews and approves studies), may look at records related to this study for quality improvement and regulatory functions.

**In Case of Injury**

The University of Missouri-Kansas City appreciates the participation of people who help it carry out its function of developing knowledge through research and program evaluation. If you have any questions about the study that you are participating in you are encouraged to call Ronda Jenson, Principal Investigator, 816-235-6335.

Although it is not the University's policy to compensate or provide medical treatment for persons who participate in studies, if you think you have been injured as a result of participating in this study, please call the IRB Administrator of UMKC's Social Sciences Institutional Review Board at 816-235-1764.

**Compensation**

There will be no monitorial compensation for anyone attending the educational series.

**Voluntary Participation**

Participation in this program evaluation is voluntary at all times. You may choose to not participate or to withdraw your participation at any time.

**Alternatives to Participation**

Deciding not to participate or choosing to leave the study will not result in any penalty or loss of benefits to which you are entitled, in other words, you may choose not to answer questions.

By checking the box "Yes" below you certify that
(1) You have read and understood this consent form, and are 18 years or older;
(2) You agree to participate in the Summit Education Series Questionnaire RKC

◯ Yes ◯ No

*If you marked No please do not complete the survey.

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## Education Pre Survey
## Demographics

1. What is today's date? ____/_____/_____

2. What is your gender? ◯ Female ◯ Male ◯ Transgender

3. What is your age? ◯ 18-22 ◯ 23-29 ◯ 30-49 ◯ 50+

4. How would you describe yourself? ◯ Black or African American ◯ White or Caucasian ◯ Asian ◯ American Indian Native ◯ Native Hawaiian or other Pacific Islander ◯ More than one race ◯ Other race (please specify _____

5. Do you identify your ethnicity as Hispanic or Latino origin? ◯ No, not of Hispanic or Latino origin ◯ Yes, Mexican, Puerto Rican, Cuban, or another Hispanic, Latino, or Spanish origin

6. What is the highest education level you finished? ◯ Less than High School
   ◯ High School graduate or GED ◯ Post High School technical training
   ◯ Some College (but no degree) ◯ Associate degree (Technical School Certificate)
   ◯ College degree ◯ Graduate courses ◯ Graduate degree

7. What is your current relationship status? ◯ Single ◯ Married ◯ Unmarried Partner ◯ Separated ◯ Divorced ◯ Widow

8. What county do you reside in? ◯ Leavenworth ◯ Wyandotte ◯ Johnson ◯ Miami ◯ Platte ◯ Clay ◯ Ray ◯ Jackson ◯ Cass ◯ None of the above

9. What county do you work in? ◯ Leavenworth ◯ Wyandotte ◯ Johnson ◯ Miami ◯ Platte ◯ Clay ◯ Ray ◯ Jackson ◯ Cass ◯ None of the above ◯ I am not employed

## Education Pre Survey

*Instructions: There are 15 statements in this questionnaire. They are statements about trauma and resiliency.* ***You decide the degree to which you agree or disagree with each statement by checking ONE of the responses.*** *STRONGLY DISAGREE - **Check SD** if you feel strongly against the statement, or feel the statement is not true. DISAGREE - **Check D** if you feel you cannot support the statement or that the statement is not true some of the time. AGREE - **Check A** if you support this statement, or feel this statement is true some of the time. STRONGLY AGREE - **Check the SA** if you strongly support the statement, or feel the statement is true most or all the time. UNCERTAIN – **Check U** only when it is impossible to decide on one of the other choices. In answering these statements, please keep these four points in mind: 1. Respond to the statements truthfully. There is no advantage in giving an untrue response because you think it is the right thing to say. There really is no right or wrong answer - only your opinion. 2. Respond to the statement as quickly as you can. Give the first natural response that comes to mind. 3. Check only one response for each statement 4. Although some statements may seem like others, no two statements are exactly alike. Make sure you respond to every statement.*

| Statement | SD | D | A | SA | U |
|---|---|---|---|---|---|
| 1, In the U.S., at least half of adults report exposure to at least one traumatic event in their lives. | | | | | |
| 2. People who experience a traumatic event usually will go on with their lives without lasting negative effects. | | | | | |
| 3. Traumatized children "replay" the dynamics of their pain later in life. | | | | | |
| 4. If trauma occurs in childhood, it is worse than if it happens to a person later in life. | | | | | |
| 5. Traumatic childhood experiences affect children's mental health more than their physical health | | | | | |
| 6. Traumatic events that happen in families affect the larger community as well. | | | | | |
| 7. Police, firefighters, EMTs, etc., and healthcare professionals, who have high stress in their work and lives, often neglect taking care of themselves, resulting in health challenges. | | | | | |
| 8. When people are traumatized by an event, it's because of vulnerabilities in personality or temperament (i.e. some people are resilient and others are not). | | | | | |
| 9, With professional care and support, people can overcome traumatic experiences. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 10. If people apply ways of handing and decreasing the effects of severe stress, it will benefit their health. | | | | | |
| 11. Having the skills to relax one's mind and body on a consistent basis is key to bouncing back from difficulties. | | | | | |
| 12. Breathing techniques, imagery, yoga, or prayer can all be effective ways to manage stress. | | | | | |
| 13. Being flexible is one of the primary factors in emotional adjustment and maturity. | | | | | |
| 14. It is better for your overall health to be optimistic than to be pessimistic | | | | | |
| 15. Resilience is an innate personality characteristic and cannot be taught. | | | | | |

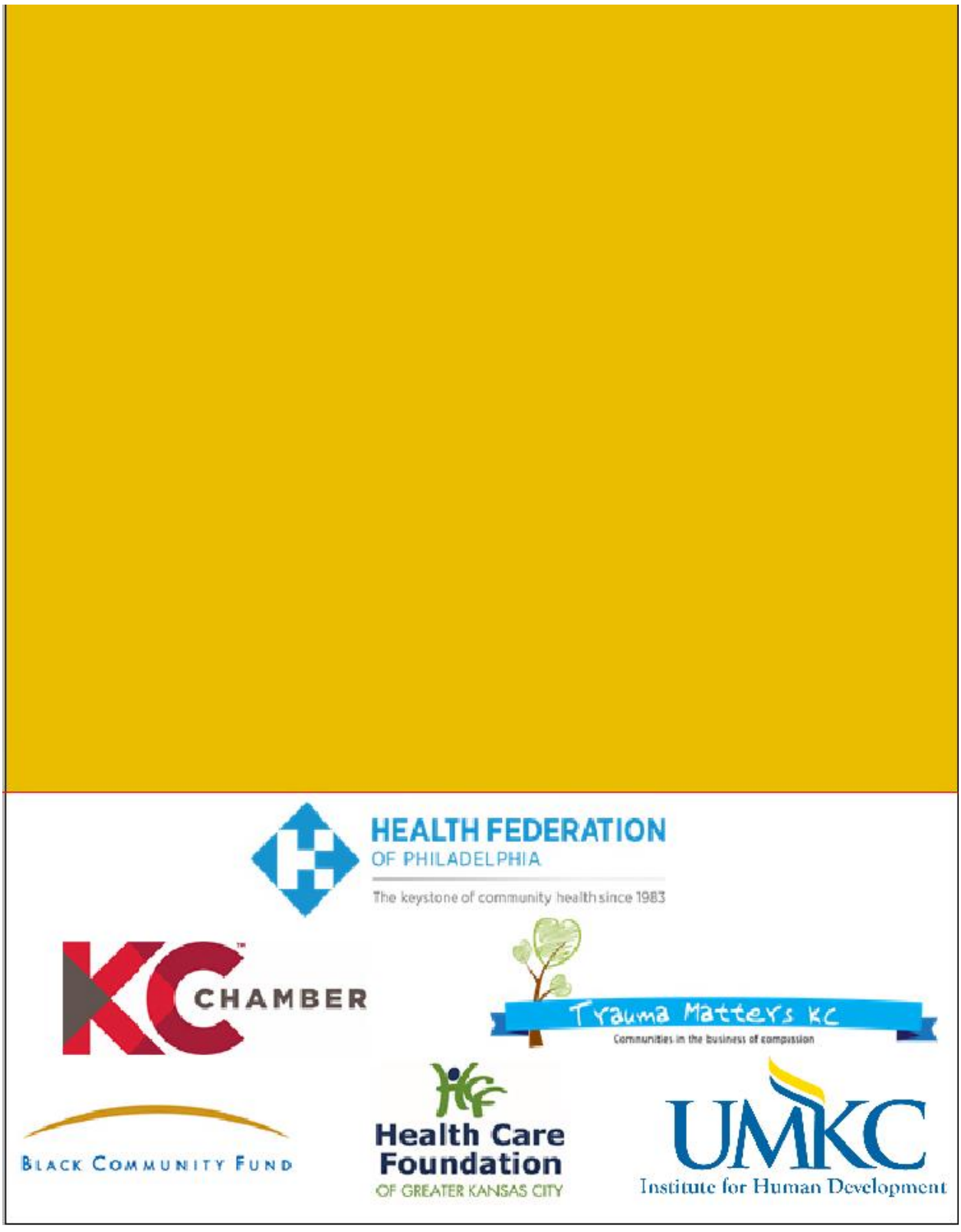
## Learning Collaborative Organizations and Objectives

| Organization | Objectives |
|---|---|
| Center School District | To establish a base line understanding of trauma informed schools among staff member.<br>To establish a base line understanding of trauma informed schools among staff member.<br>Establish connections with the district wellness coordinator assist with professional development focused on staff self-care.<br>Establish connections with the president of Gillis to assist with professional development focused on staff self-care.<br>Collaborate with New Direction to ensure services are available for staff needing more intensive (crisis) self-care support.<br>Collaborate with district PR to update district website to include self-care ideas. |
| Mattie Rhodes Center-Northeast | Communicate clearly to others your intent – use action verbs.<br>Involve complex as well as simple measures in 3 basic areas: performance (skills), knowledge, and attitudes (do, think, believe, and feel).<br>State long-range and short-range goals that are specific, observable, and measurable. |
| Re Discover | Conduct an environment assessment for each location by December 5, 2016.<br>To prioritize needs and recommend changes to administration by February 6, 2017.<br>To create a written policy that requires all staff to attend TIC training within 90 day of hire. |
| | Increase the number and types of safe spaces available to survivors and staff for solitude, meditation, calming, relaxation, etc..<br>Increase shelter residents' knowledge about the safe spaces throughout the Center. |

| | |
|---|---|
| Rose Brooks | Increase the physical and emotional sense of safety experienced by the people we serve and staff.<br>90% of staff will report an understanding of secondary trauma.<br>85% of staff will report an understanding of the impact of secondary trauma.<br>75% of staff will report an understanding of the ways Rose Brooks Center supports them in building resiliency and trauma stewardship.<br>60% of staff will report using a strategy offered or recommended by Rose Brooks Center in reducing the impact of secondary trauma.<br>All staff will have the opportunity to provide feedback & recommendations to agency leadership on how to improve organizational support of building resiliency and providing support for staff experiencing secondary trauma. |
| Synergy Services, Inc. | Create an Oversight Committee (O.C.) with representatives across the agency's sites.<br>Conduct an organizational assessment.<br>Create a communication plan.<br>Engage all levels of the workforce.<br>Engage external organizations in the TIC conversation.<br>Rapidly expand community knowledge of ACES & TIC.<br>Develop screening process.<br>Provide TIC training for all employees throughout employment with the agency. |
| Wyandot Inc. | Provide greater training to help others know processes/procedures before it is time to implement them.<br>Ensure that HR is viewing policies through a TIC lens. |
| Jackson County Family Court | Unavailable. |
| Kansas City Rescue Mission | Increase understanding of an engagement towards TIC initiative.<br>Assess staff attitudes and awareness of ACEs and ARTIC.<br>Gather data and feedback from every level within KCRM organization.<br>Organize data and feedback to develop baselines and produce a data-driven decision making.<br>Introduce staff to TIC and nurture understanding of TIC. |
| Community LINC | Increase number of participants on Resilient Action Team.<br>Introduce concept to staff and stakeholders.<br>Implement program staff check-in.<br>Develop program participation survey.<br>Develop staff survey.<br>Seek grant dollars.<br>Review entry and exiting progress for participants.<br>Review more extensive training options for staff. |

| | |
|---|---|
| Preferred Family Health Center | Provide orientation to the need for TIC to all staff.<br>Recruit trauma-informed committee at Liberty.<br>All staff complete ARTIC Survey.<br>All staff complete ACES Questionnaire.<br>Coordinate Kick-off that combines both sites.<br>Review/revise Adolescent and Adult Client Handbook.<br>Review/revise Adolescent and Adult Residential/Out-patient Program Manual.<br>Integrate ACEs Questionnaire into intake process.<br>Reduce need for multiple staff asking client about trauma during intake process.<br>Review front desk and phone communication.<br>Review client search process.<br>Combine police review process with CARF re-accreditation process.<br>Incorporate stigma-reducing best-practice language using SAMHSA guidelines: Research current recommended terminology; provide staff training; revise forms/templates/documents to reflect new terminology.<br>Review/revise HR practices and staff communications to reflect trauma-informed standards.<br>Combine police review process with CARF re-accreditation. |
| Children's Mercy Hospital Emergency Department | Children's Mercy provides the highest level of complex emergency care to children across the Greater KC area and beyond. We recognize the prevalence of psychological trauma related to or triggered by medical trauma, health care, or personal histories affecting both patients and staff. Education will be provided to all multidisciplinary groups working in the Emergency Department regarding effects of toxic stress, trauma informed care principles and secondary trauma.<br><br>There is recognition that high levels of compassion fatigue may decrease buy-in to trauma sensitive practices. An initial iterative approach will focus on increasing staff resiliency. Baseline data will be collected to review staff levels of compassion satisfaction, secondary trauma and burn out. Follow up surveys will be used to track staff resiliency over time. |
| Children's Mercy Hospital West | Specialists provide comprehensive health care to children and adolescents in Wyandotte and surrounding counties, while also providing and connecting patients and their families to supportive resources within their community. CM West recognizes high prevalence of secondary trauma in healthcare providers and has adopted a goal of increasing staff support and resources to better enable staff to provide high quality and respectful care to our patients. |

| | |
|---|---|
| Greater Kansas City Chamber of Commerce | Unavailable. |
| Niles Home for Children Kansas City | Unavailable. |


HEALTH FEDERATION
OF PHILADELPHIA
The keystone of community health since 1983
KC CHAMBER
Trauma Matters KC
Communities in the business of compassion
BLACK COMMUNITY FUND
Health Care
Foundation
OF GREATER KANSAS CITY
UMKC
Institute for Human Development