Walla Walla, Washington's Community Response to Adverse Childhood Experiences:

A Case Study & Lessons for Minnesota

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Emily Clary

Master of Public Policy Candidate

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Committee Members

Ms. Ann Boerth, Paper Supervisor

Collaborative Policy & Program Consultant, DHS

Dr. Deborah Levison, Committee Member

Professor at Humphrey School of Public Affairs

Dr. Glenace Edwall, Committee Member

Retired Children's Mental Health Director, DHS

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Preface

From 2009 to 2015, I worked as the Jail Programs Outreach Coordinator and Program Developer at the Dakota County Sheriff's Office in Minnesota. My role was to develop programs and provide resources to incarcerated male clients to help them make a smoother transition back into the community upon release from custody. At the annual Minnesota Jail Programs & Services conference in 2014 I had the opportunity, with other jail programmers from across the state of Minnesota, to hear Karina Forrest-Perkins, the former Chief Executive Officer of Minnesota Communities Caring for Children, share research about the negative health and social risk factors associated with exposure to Adverse Childhood Experiences (ACEs).[1]

Ms. Forrest-Perkins presented information about brain science that shows that the human brain can build resilience to ACEs, and further explained that there are ways to build resilience and protective factors into systems to support people who have experienced trauma. Her presentation carried a message of hope that individuals have the capacity to lead healthy lives despite exposure to toxic stress and trauma from ACEs. After learning about ACEs at the conference, I realized it would be valuable to bring this information to the jail since many of the incarcerated men had shared stories with me about their traumatic experiences growing up. Shortly after the conference I received approval from jail administration to offer a trauma-informed Relapse Prevention class at the Dakota County Jail. The focus of the class was to provide an overview about ACEs, the risk factors

[1] Descriptions of terms, acronyms, key informants, and organizations are provided in Appendix A

associated with ACEs, a user-friendly explanation of how toxic stress affects brain development, and a review of strategies that individuals can use to reduce the harmful effects of their ACEs in their personal and family lives. The program was originally taught by Ms. Forrest-Perkins and later led by her husband Jack Perkins.

Ms. Forrest-Perkins and Mr. Perkins emphasized to the incarcerated men that learning about the brain science related to ACEs did not excuse them from harming others, and they noted the criminal justice system would continue to hold the incarcerated men accountable for their actions, regardless of how many ACEs they experienced in childhood. They urged the men to think more deeply about the ways they react to toxic stress and encouraged them to use information from the class to better understand and control their own triggers and negative behaviors instead of resorting to violence or other unhealthy behaviors in high-stress situations. Many of the men who attended the Relapse Prevention class reported that they were transformed after learning about ACEs. For the first time, some men forgave themselves and said they could release some of the shame they carried because of their own experiences with ACEs in childhood. Others revealed they had experienced ACEs and shared how they were unintentionally continuing to perpetuate the harm that they experienced as children in their own families as adults. Many of these men expressed a desire to break the cycle of trauma in their children's generation.

At that time, my role at the jail was primarily focused on referring individuals to resources, such as homeless shelters and temporary employment or low-paid work, and I recognized that most of these would not help the men become self-sufficient. I began exploring evidence-based practices that were effective at deterring people from incarceration and realized that my interests aligned with a prevention framework, so I enrolled in graduate school at the Humphrey School of Public Affairs to learn more about policymaking.

After transitioning from my role at the jail, I had the opportunity to work as an intern during the summer of 2016 with the Minnesota Department of Human Services (DHS) in the Children & Adult Mental Health Divisions. Through this internship, I connected with the ACEs Planning & Implementation Team, a group of state and community advocates that is tasked to implement ACEs-related legislation in Minnesota in July 2017. This legislation will provide training, technical assistance, and funding to communities connected with Minnesota Children's Mental Health Collaboratives and Family Services Collaboratives that are interested in building resilience around ACEs in their communities. Since finishing my internship, I have continued to be involved with the ACEs Planning and Implementation Team because I want to support communities and government agencies developing their capacity to serve children and families through the creation of more trauma-informed systems.

Although I was exposed to very few ACEs as a child, I recognize that many of my friends, family members, and the incarcerated men from the Dakota County Jail have not been as fortunate. I wonder how the lives of those who have experienced ACEs could have been improved if they had the opportunity to attend trauma-informed schools or receive services from trauma-informed mental health, education, and public health systems where practitioners asked children not "what's wrong with you?" but "what happened to you?" This question has served as the impetus for my continued commitment to spreading the word about ACEs and is the catalyst for this paper.

Introduction

A revolution is under way, a ground-shift in the way we think about health and illness, human suffering and strength. It is a revolution with the potential to reshape physical and mental health care practices, schools, social services, juvenile justice systems, communities, families and individual lives. – Martha Davis[2]

This case study draws upon an example of a community-driven, collaborative effort that was effective in increasing awareness and developing resilience strategies to buffer the harmful effects of Adverse Childhood Experiences in the city and surrounding area of Walla Walla, Washington. This paper will inform the work of the ACEs Planning and Implementation Team (APIT) and the Minnesota Children's Mental Health and Family Services Collaborative Coordinators as the state of Minnesota develops its own response to Adverse Childhood Experiences, aided with state funding.

The ACE Study

The Adverse Childhood Experiences study, also known as the ACE Study, by Felitti et al. (1998) revealed that childhood exposure to abuse and household dysfunction is correlated with negative social and health outcomes later in adulthood. Researchers from the ACE Study categorized the primary types of abuse and household dysfunction, coined as Adverse Childhood Experiences (ACEs), to be psychological abuse, physical abuse, sexual abuse, exposure to substance abuse, mental illness, violent treatment of female caregiver, and criminal behavior in the household (Felitti et al., 1998). The ACE Study also identified 10 primary risk factors that can lead to chronic disease, early mortality, and negative social outcomes over an individual's life course including; "smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, any drug

[2] Executive Director for the Institute for Safe Families. Retrieved from http://www.instituteforsafefamilies.org/blog/you-say-you-want-revolution%E2%80%A8-aces-prompt-new-thinking-about-human-suffering-and-strength

abuse, parental drug abuse, a high lifetime number of sexual partners, and a history of having a sexually transmitted disease" (Felitti et al., 1998, pg. 248).

Researchers from the ACE Study mailed the ACE Questionnaire to 13,494 adults enrolled in the Kaiser Permanente Health Plan in California who had received medical services from a specific clinic in 1995 and 1996. The ACE Questionnaire allows individuals to calculate and self-report their ACE Score. The ACE Score is a sum of the ACEs that an individual has been exposed to in childhood. In the ACE Study, over 9,500 individuals returned ACE Questionnaires; more than a 70% response rate. Just over half of the respondents reported experiencing one or more ACEs (Felitti et al., 1998). The number of ACEs that each respondent reported was then cross-referenced with respondents' medical records to identify if each respondent had engaged in or experienced the 10 leading risk factors contributing to negative social and health outcomes at the time. The ACE Study revealed that individuals who reported a higher number of ACEs in childhood, on average, had a higher probability of heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Felitti et al., 1998). The findings revealed that there is a positive correlation between an individual's ACE Score and their probability of experiencing negative health outcomes.

Since the publication of the ACE Study, researchers have also identified a positive association between the number of ACEs reported and a risk of early mortality in adulthood, the number of years an individual experiences a disabling condition in later life, and the likelihood that an individual will have experienced mental health issues such as suicide attempts and depression (Brown 2009; Buffington 2010; Montez 2014). Additionally, research has found a correlation between experiencing ACEs and an individual's probability of engaging in risky social behavior, such as alcohol consumption, drug use, nicotine use, sexual promiscuity, and the likelihood of being incarcerated (Baglivio & Epps 2015; Felitti et al., 1998).

Since 1998, various versions of the ACE questionnaire have been developed and adapted for different audiences or purposes. The most common version of the questionnaire, developed in the original ACE Study, was made for a predominantly white, middle-class population (found in Appendix B). An expanded version of the questionnaire was developed in 2013 for the Philadelphia Urban ACE Study, which includes questions for more socially and racially diverse urban populations.[3] It is important to note that the ACE Questionnaire should not be used as a screening tool since it does not capture frequency or intensity of ACEs, and it cannot predict how people respond to their ACEs. It is merely a simple measure or tool that helps people understand if they may be predisposed to risks because of their experiences in childhood.

NEAR Science

In response to findings from the ACE Study, the Centers for Disease Control and Prevention declared ACEs to be an important and urgent public health issue, and researchers from a variety of disciplines began exploring the phenomenon of ACEs (CDC, 2016). The interdisciplinary cluster of research that converged to address the long-term health outcomes associated with childhood adversity has been coined Neuroscience, Epigenetics, ACEs, and Resilience (NEAR) science.[4] NEAR science incorporates education about the effects of ACEs over the life course and shares strategies about how to build resilience and buffer the harm of ACEs (Thrive Washington, 2017).

[3] The *Findings from the Philadelphia Urban ACE Survey* report includes the expanded questionnaire in Appendix A. Retrieved from http://www.instituteforsafefamilies.org/sites/default/files/isfFiles/Philadelphia%20Urban%20ACE%20Report%202013.pdf

[4] Foundation for Healthy Generations webpage http://www.healthygen.org/what-we-do/near-sciences

Researchers grounded in epidemiology, the study of the spread and determinants of diseases and other health problems, began investigating how ACEs have an impact on the health and well-being of a population (Anda et al., 2006; World Health Organization, 2017). The field of neuroscience, the study of the brain and nervous system, revealed that ACEs can be harmful to neurodevelopment and can alter the structure and functioning of the brain (Anda et al., 2006; The Society for Neuroscience, 2017). Neuroscientists also discovered that the human brain has the capacity to adapt and be resilient, despite negative life experiences such as exposure to ACEs in childhood. This resilience can buffer the negative effects of ACEs and other forms of toxic stress and trauma (Karatsoreos & McEwen, 2013).

Resilience & Protective Factors

The Minnesota Department of Health states that resilience is "the result of a dynamic set of interactions between a person's adverse experiences and his or her protective factors. This interaction is what determines the developmental path towards health and well-being or towards illness and dysfunction," (Minnesota Department of Health, 2017). Resilience has also been described as a type of protective factor that allows us to "develop the capacity to adapt in the face of challenges," (Resilience Trumps ACEs website: *Resilience*, 2015).

The Center for the Study of Social Policy developed a protective factors framework called *Strengthening Families*. This framework consists of five researched-based protective factors that "have been shown to make positive outcomes more likely for young children and their families, and to reduce the likelihood of child abuse and neglect." (Browne, 2014. The five protective factors highlighted in this framework include parental resilience, social connections, knowledge of parenting and child development, social and emotional competence of children, and concrete support in time of need.

The Minnesota Department of Health refers to protective factors as individual biological and developmental qualities and external influences such as family, community, and systems. Protective factors "enable us to counter the risk factors that endanger our health," (Resilience Trumps ACEs website: *Resilience*, 2015). The Minnesota Department of Health has a page on its website called *Resilience to ACEs* (Minnesota Department of Health, 2017), which provides a list of many additional protective factors that have been found to increase resilience, including:

- Close relationships with competent caregivers or other caring adults
- Parent resilience
- Caregiver knowledge and application of positive parenting skills
- Identifying and cultivating a sense of purpose (faith, culture, identity)
- Individual developmental competencies (problem-solving skills, self-regulation, agency)
- Children's social and emotional health
- Social connections
- Socioeconomic advantages and concrete support for parents and families
- Communities and social systems that support health and development, & nurture human capital

NEAR science, resilience, and protective factors provide a framework of understanding and strategies that individuals, families, and communities can adopt to buffer the effects of ACEs.

ACEs Legislation

Driven by the urgency of the ACE Study and the message of hope from NEAR science, the states of Alaska, California, Minnesota, Montana, Vermont, and Washington enacted ACEs legislation that seeks to reduce the harm of ACEs and build resilience strategies into their respective populations. In June 2011, Washington State became the first state in the nation to introduce legislation with House Bill 1965 (HB 1965) which required Washington State to form a committee and draft a report about the feasibility of developing an ACEs-focused public-private partnership entity. During the period that the committee was working on the report, a group of private

philanthropists created the ACEs Private Public Initiative, and invited state and community representatives to join them (L. Porter, personal communication, July 1, 2017).

The ACEs legislation in Washington State was catalyzed, in part, by a report published by Dr. Anda and David Brown in 2010 called *Adverse Childhood Experiences & Population Health in Washington: The face of a chronic public health disaster*. Data in the report were pulled from the 2009 Behavioral Risk Factor Surveillance System (BRFSS) survey which included questions adapted from the ACE Study questionnaire. Survey findings revealed that that 62% of adults in Washington State experienced at least 1 ACE risk factor in childhood (Anda & Brown, 2010, pg. 8-11). This report claimed that ACEs were a "chronic public health disaster" in Washington State and called on policymakers to act.

Research Question

Using lessons learned from key stakeholders who were integral to implementing Washington State's ACE legislation, I undertake a case study in this paper of how the population of Walla Walla, Washington, increased its awareness about ACEs and built resilience strategies into the fabric of its community. This paper begins with a brief overview of the history of legislation related to ACEs in Washington State and then dives more deeply into the case study. The paper highlights insights, lessons learned, and strategies that were used to achieve improvements in resilience at the community level in Walla Walla. Additionally, this paper provides context about the development of the Minnesota ACEs legislation, a review of the similarities and differences between the legislation in Minnesota and Washington State, and presents considerations for the Minnesota APIT. This paper provides information that is especially salient for Minnesota and other states that have adopted ACEs legislation (ACEs response, 2017).

The primary research question for this paper is: **What key components contributed to the success in Walla Walla after community members made a commitment to reduce ACEs and increase their community resilience?**

Methodology for Key Informant Interviews

This paper is informed by 15 key informant interviews, including 9 individuals who supported the ACEs Response in Washington State and 6 individuals who helped develop ACEs legislation in Minnesota. A purposive methodology was used to gather feedback from key informants who were involved in mobilizing and implementing the ACEs legislation at the state level in Minnesota and Washington, and at the community level in Walla Walla, Washington.[5] Purposive sampling strategies are "non-random ways of ensuring that particular categories of cases within a sampling universe are represented in the final sample of a project" (Robinson, 2014, pg. 7). After identifying a key informant from Washington and Minnesota State, a snowball sampling strategy was used which "involves asking participants for recommendations of acquaintances who might qualify for participation," (Robinson, 2014, pg. 13). To "qualify" for an interview, individuals simply needed to be referred by a key informant who had already participated in an interview. A more detailed description of the snowball sampling process to recruit key informants from Washington and Minnesota can be found in Appendix C. A list of key informants is found in Appendix D, and Appendix E, Appendix F, and Appendix G include key informant protocols for the different stakeholder groups representing Minnesota, Washington State, and Walla Walla.

[5] On March 3rd, 2017, the University of Minnesota Institutional Review Board made the determination that the interviews for this project did not meet the federal definition of human subjects research since data collected from key informants focused on specific policies.

After the 15 interviews were scheduled with key informants in Minnesota and Washington State, I did not continue scheduling additional interviews, due to time constraints, even when there were new referrals provided by key informants. Using full and partial transcriptions from the interviews, I identified themes that arose during the key informant interviews. At the end of the writing process, I shared my final draft with all of the 15 key informants and solicited final revisions to ensure that I accurately portrayed their reflections. I received revisions, comments, and approval about the content from 14 of the 15 key informants during this final stage of editing.

Because I only interviewed 15 key informants I was unable to reach data saturation. As a result, this paper has limitations in its scope and generalizability. However, feedback from key informant interviews, paired with the findings from the literature, provides a snapshot of how Washington and Minnesota developed a response to address ACEs in their respective states.

The Washington State ACEs Response

Of the nine key informants from Washington State who were consulted for this paper, two were government and nonprofit leaders responsible for implementing legislative policies related to ACEs statewide, and seven worked to address ACEs and build resilience in Walla Walla and its surrounding area. The key informants from Walla Walla represent a variety of sectors and have expertise in school administration, nonprofit management, health administration, homelessness services, and one individual was a student intern at a community organization in Walla Walla. A brief synopsis of the timeline of the Washington State ACEs Response is located in Appendix H.

History of the Washington ACEs Response Pre-ACEs Legislation: 1989-2010

Washington State has been mobilizing a response to childhood social problems through legislative action at the state level since 1989, although ACEs were not explicitly addressed through

state legislation until 2011 (Washington State Family Policy Council Timeline of Strategic Action for Improving Determinates of Health, 2012). The Washington State Violence Prevention Act (VPA) of 1994 was introduced to improve the seven major social problems related to youth and their families, including high school dropout, youth violence, family violence, child abuse and neglect (and associated out-of-home placements), substance abuse, suicide rates, and teen pregnancy.

In conjunction with the VPA, the Washington State legislature introduced the Revised Code of Washington (RCW) 70.190, which called for the development of Community Public Health and Safety Networks (referred to as 'Networks' in this paper) to reduce youth violence and "at-risk" youth behaviors in communities across the state. The Networks were formed as localized collaborations dedicated to addressing the seven major social problems outlined in the VPA. The RCW 70.190 required each Network to have a 23-member team comprised of representation from both the community and from local human services agencies. Networks, managed by designated part- and full-time Network Coordinators, were required to engage their community members during the development and design phases of their Network's strategic vision. By 1997, a total of 53 Networks were formed across the state of Washington, including 10 tribal Networks. During the time the Networks were being formed in Washington State, the ACE Study was simultaneously being conducted in California, in conjunction with Kaiser Permanente and the Center for Disease Control from 1994 to 1998.

Beginning in 1994, the Family Policy Council, established in 1992 by the Washington State Legislature, was designated as the primary oversight body and lead fiscal agent for the Networks (Silas, Maston & Lieb, 1998). The Family Policy Council was an organization that received guidance from a10-member interagency council that included state leaders from the legislature, offices of the Governor and Superintendent of Public Instruction, and the executives from four state agencies:

Health, Social and Health Services, Commerce and Employment Security, who were committed to supporting the health of children and families in Washington State. In addition to the 10-member council, the Family Policy Council was also supported by a team of staff and a director. Between 1994 and 1997, the newly formed Networks submitted two-year proposals to the Family Policy Council to address youth violence and reduce youth risk factors in their local communities, based on each Network's identified community needs (Silas, Maston & Lieb, 1998). The Family Policy Council allotted planning grants, ranging between $45,000 to $221,000 annually, to the Networks to develop their capacity and formalize their structure and partnerships (Washington State Family Policy Council Timeline of Strategic Action for Improving Determinates of Health, 2012).

Laura Porter was appointed as Director of the Family Policy Council in 1998, and she served in this role until 2013 when the Council was eventually closed by the Washington State Legislature. As the Director, Ms. Porter was delegated operational authority of the agency and responsibility for implementing Network-related policies across the state, as designated by the Council. She recalled, "anything that wasn't at the policy level was my decision to make," (L. Porter, personal communication, March 13, 2017). Ms. Porter worked closely with the Networks across the state.

> We genuinely respected and worshiped their work – so it wasn't like we came into the relationship with local communities [Networks] thinking we knew and they didn't – because the opposite was true. But we were really clear that we had different roles and that there were times when it was our role at the state to be asking really tough questions or prompting a new round of thinking or providing a different set of education that would help everyone be challenged. (L. Porter, personal communication, March 13, 2017)

In 2001, faced with budget cuts, the Family Policy Council had to defund some of the Networks. The legislature required the Family Policy Council to concentrate its funding on the "best performing" Networks; however, the Networks were in the very early stages of their development with the majority only operating for two to three years and not any outcome data to show at that time (Hall, Porter, Longhi, Becker-Green, & Dreyfus, 2012). Ms. Porter lamented that they had to

develop a crude indicator to help them make a decision about which Networks to stop funding. "We decided to use a really simple administrative criteria – to look at the minutes over the last 12 months and see how many people had been regularly showing up at meetings – which is a really bad indicator of community capacity," (L. Porter, personal communication, March 13, 2017). She said these cuts were not very fair because they disadvantaged some Networks for geographic reasons, since some Networks covered a wide area or crossed several mountain ranges, making it difficult to meet in a centralized location. She also believed the cuts unintentionally disadvantaged the tribal Networks for cultural reasons since meetings are not the way most tribes make decisions. She remembered, "So that was really sad…those were some of the worst days at the Council," (L. Porter, personal communication, March 13, 2017).

In 2002, armed with information about the ACE Study, the Family Policy Council decided to prioritize its focus on addressing ACEs through the Networks. The Family Policy Council's Education Director, Krista Goldstine-Cole developed a very effective standard presentation about neuroscience, ACEs and resilience, then trained a cohort of 40 trainers who could help spread the word about ACEs to audiences across the state. From 2005 to 2008, this cohort of trainers educated over 5,000 people about ACEs. In 2007, content about historical trauma was incorporated into the ACEs training, which acknowledged the intergenerational trauma caused by colonization, discrimination, and racism towards marginalized populations in the United States. Information about historical trauma was added in response to an identified need from the tribal Networks for a more culturally-responsive curriculum.[6] Questions were added in 2009 to the Washington State Behavioral Risk Factor Surveillance System (BRFSS) Survey to track the prevalence of ACEs in the

[6] Dr. Maria Yellow Horse Brave Heart (2003) describes historical trauma as "the cumulative and collective psychological and emotional injury sustained over a lifetime and across generations resulting from massive group trauma experiences" (p. 288).

Washington State population. The BRFSS data was published in 2010 and showed a high prevalence of ACEs in the Washington State population, which sparked new conversations about the importance of addressing ACEs in the state.

History of the Washington ACEs Response Post-ACEs Legislation: 2011-2017

In 2011, House Bill 1965 (HB 1965) passed with bipartisan support, which discontinued the funding for the Family Policy Council but kept the Community Public Health and Safety Networks intact (Kagi & Regala, 2012). Although HB 1965 eliminated the Family Policy Council, Ms. Porter continued supporting the Networks with her team under a new name, ACE Partnership, until 2013. "We remained inside of the state agency that had been sort of our sponsoring organization, the Department of Social and Health Services. We stayed there and reported to the secretary at that one agency," (L. Porter, personal communication, March 13, 2017). After the passage of HB 1965, Networks lost funding due to limited resources in the state and only 18 of the 42 remaining Networks continued to sustain their work with alternative, non-public funds. Once the Family Policy Council was dissolved, Ms. Porter noted, "There is no oversight over them [the Networks]. There is a state law that authorizes their existence, but there is no entity with a responsibility for oversight …they are like housing authorities or water districts… quasi-governmental public entities and they stand alone on their own authority," (L. Porter, personal communication, March 13, 2017).

In place of the Family Policy Council, the HB 1965 required a report about the feasibility of developing an ACE focused public-private partnership entity. In response to this invitation, several philanthropic organizations began working together, and, over time, invited state and community representatives to join them. This group was called the ACE Public-Private Partnership Initiative (APPI). The APPI website states:

> Building on this history [of the Family Policy Council], private and public entities have agreed to work together to redesign a platform to integrate community frameworks to better understand how communities can prevent and reduce adverse childhood experiences (ACEs). This work will both build on the work of the Community Public Health and Safety Networks and incorporate new information from initiatives such as Frontiers of Innovation and Strengthening Families Washington. (APPI Website)

APPI differed from the Family Policy Council in that it expanded its leadership to include community partners and private funders, in addition to Washington State government representatives (Kagi, 2011). Ms. Porter recalled that the Washington State Legislature wanted to maintain control over APPI when it was first established, but the major philanthropic agencies who were interested in funding ACEs work in the state pushed back and asked for less state oversight. The private partners refused to "create a public-private partnership that is about a few powerful people [state leaders] controlling communities," (L. Porter, personal communication, March 13, 2017). They believed the Washington State ACEs Response should be "framed as an empowerment model where local communities were controlling their own fate," (L. Porter, personal communication, March 13, 2017). As a result, Ms. Porter reports:

> Instead of forming a whole new entity that would really continue the work [of the Family Policy Council], those philanthropic organizations said 'we will fund an evaluation that …highlights the importance of having more local control and more local efficacy' – and so that's where they invested the money they had set aside …was into an evaluation….and that was a really big disappointment to me that funds did not go directly to the communities for their family support and community building work, but that's what they did. (L. Porter, personal communication, March 13, 2017)

The APPI evaluation, conducted by Mathematica Policy Research, focused on the community-based ACEs Response in five communities in Washington State, including Wenatchee, Okanogan, Skagit, Walla Walla, and Whatcom. APPI provided 3-year grants to support the community-based approaches that the five communities were using to prevent and mitigate ACEs during the course of the evaluation. The final report of the Mathematica Policy Research evaluation released in August 2016 revealed:

> Local community networks in Washington State have succeeded in reducing the effects of adverse childhood experiences (ACEs) such as child abuse and neglect, domestic violence, household substance use, and parent mental illness. The three-year study released by the ACEs Public-Private Initiative, along with its evaluation partners Mathematica Policy Research and Community Science, revealed that community efforts led to increased graduation rates, decreased smoking and alcohol use among pregnant women, and a drop in teen drinking, among other results. (Verbitsky-Savitz, 2016)

The Co-Chair of the APPI Leadership Team, Dr. Peter Pecora, who is also the Managing Director of Research Services for Casey Family Programs and a professor for the University of Washington School of Social Work, said that in addition to evaluation, APPI serves as a clearinghouse to get resources about ACEs and resilience out across the state to the Networks and community members in real time. He also mentioned that APPI serves as a sounding board for partners who are engaged in ACEs work, and APPI provides trainings and workshops across the state, and their co-sponsorship of statewide conferences to spread the word about ACEs and NEAR science.

In January 2017, APPI announced that it will be phasing out at the end of the year. Dr. Pecora shared the decision was made to sunset APPI because the foundations believed that the response to ACEs could be better coordinated by the communities themselves and their partners. Before APPI phases out, however, Dr. Pecora said that APPI is offering trainings for kinship care parents and support staff and 15 tribal nations; and about 15 community cafés around the state to continue conversations about ACEs and resilience.

> Our APPI Leadership couldn't identify a compelling set of things that they wanted to address, and as a big group you recognize when you have done the best you can as a group and its time to move on after 5 years… So we are hoping some of the work will continue with the Foundation for Healthy Generations, some of the work will continue with the Department of Early Learning, some of the work will continue with the Office of Superintendent of Public Instruction…and some of the work will continue with Essentials for Childhood. (P. Pecora, personal communication, April 7, 2017)

Dr. Pecora laments, "My biggest frustration with the APPI work is that we were not able to change policy…state law, administrative regulations, agency rules… APPI never developed any key

policy change proposals…and that was a loss for the state," (P. Pecora, personal communication, April 7, 2017). Although APPI was not responsible for creating new policies to address ACEs at the state level, Dr. Pecora said the work of the Family Policy Council and APPI continues to inform policies supporting children and families in Washington State. Figure I provides a brief summary of several of the many successes that Washington State achieved through the diligent work of the Family Policy Council, Networks, and APPI.

Figure I: **Washington State ACEs Response Successes**

Successes	Descriptions
Cultivated Legislative Champions	Intentionally nurtured relationships with state leadership to ensure there was an "internal voice" who understood NEAR science; most often had champions from the governor's office, senate, and house (at minimum 2/3 of the groups) while the Family Policy Council was operating[7]
Decreased Severity of Social Problems for Funded Networks	Between 1998 – 2006, Networks funded by the state experienced either a decrease or a consistent level of the overall severity of major social problems; while Networks not funded by the state experienced increases in the severity of social problems[8]
Projected Cost Savings Report	A projected cost savings analysis, due to caseloads avoided, estimated that an investment of $8.1 million in the efforts of the Family Policy Council would save $55.87 million in the short-term (between 2009-2011), and would generate a savings of $296 million in the long run; Caseload projections were based on the analysis of four primary indicators including youth felony filings, out of home placements, high school dropout, and teenage pregnancy[9]
Leveraged Foundation Contributions	The work of the Family Policy Council generated interest and attention from over five foundations in Washington State and brought new funding sources to the table to enhance work to address ACEs and build resilience in Washington State[10]
Served as a Model for Other States	Introduced ACEs legislation in 2011, which supported the ACEs Private-Public Initiative (APPI); Several others states later developed ACEs legislation using Washington State as a model; Hosted the Minnesota Learning Journey and informed the development of the ACEs legislation in Minnesota[11] [12]

[7] L. Porter, personal communication, March 13, 2017
[8]Longhi, D., & Porter. Laura. (2009). Community Networks--Building Community Capacity, Reducing Rates of Child and Family Problems: Trends Among Washington State Counties from 1998 to 2006: Executive Summary and Technical Paper. Washington State Family Policy Council.
[9] Schueler, V., Goldstine-Cole, K., & Longhi, D. (2009). Projected cost savings due to caseloads avoided: Technical notes. Washington State Family Policy Council. https://www.digitalarchives.wa.gov/do/DFDCC0A9E76F9B876E95F928303C9A59.pdf
[10] L. Porter, personal communication, March 13, 2017
[11] A. Lynn, personal communication, April 13, 2017
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A Case Study of Walla Walla, Washington

Walla Walla, Washington, is one of several cities around the country that has adopted trauma-informed practices in its local child- and family-serving agencies.[13] It was selected as the focus of this case study because there is rich documentation about the development of its trauma-informed community initiative (referred to in this paper as the 'Walla Walla ACEs Response'). Other trauma-informed cities include: Tarpon Springs, FL; Kansas City, MO; Traverse City, MI; Topeka, KA; Meadville, PA; Gainesville, FL; and Warwick, RI (Stevens, 2014).

Walla Walla may be the most well-known trauma-informed community in the U.S. because it captured national attention after the release of *Paper Tigers*, a documentary that highlights the successes a local Walla Walla alternative school, Lincoln High School, achieved after adopting trauma-informed discipline practices (Redford & Pritzker, 2015). The 2015 Mathematica Policy Research evaluation funded through APPI also found a variety of other initiatives in Walla Walla to be successful at building resilience, addressing ACEs, and educating community members about ACEs. This case study highlights a few of the extraordinary number of organizations and individuals involved in making the Walla Walla ACEs Response a success. A brief synopsis of the Walla Walla ACEs Response is found in Appendix I.

The Walla Walla City Profile

The City of Walla Walla, located in Walla Walla County, is a rural community situated in eastern Washington State. This city covers nearly 13 square miles and has a population of just over

[13] In this paper, 'trauma-informed' refers to communities, organizations, and individuals that take a 'trauma-informed approach' to their work and/or daily activities by recognizing the prevalence of trauma, seeking to understand the causes of trauma, committing to support those who have experienced trauma, and adopting policies and practices to better address trauma (SAMHSA, 2015).

32,000 people (U.S. Census: Quick Facts, 2015). Walla Walla City is home to almost 2,000 businesses, the largest penitentiary in Washington State, six elementary schools, two middle schools, one traditional high school, two alternative high school programs, three colleges, and a technical skills center (U.S. Census: Fact Finder, 2015; Walla Walla Chamber of Commerce, 2017; Walla Walla Public Schools, 2017).

Walla Walla City's racial and ethnic composition estimates from 2015 are provided in Figure II and Figure III (U.S. Census: Quick Facts, 2015). Roughly 88% of the population age 25 years or older has graduated from high school, and the estimated annual median household income in 2015 was $42,000 (U.S. Census: Quick Facts, 2015). As of 2016, the unemployment rate in Walla Walla County was 5.6%, which was slightly higher than the state and national average (Walla Walla Chamber of Commerce, 2017). Per the 2010 Census, just over 22% of the city was living in poverty (U.S. Census: Quick Facts, 2015). Approximately 56% of students are eligible for the USDA free and reduced lunch program in Walla Walla County, which is approximately 12 percentage points higher than the Washington State average (Walla Walla Chamber of Commerce, 2017).

Figure II
2015 Walla Walla City Ethnic Composition Estimates
N=32,237

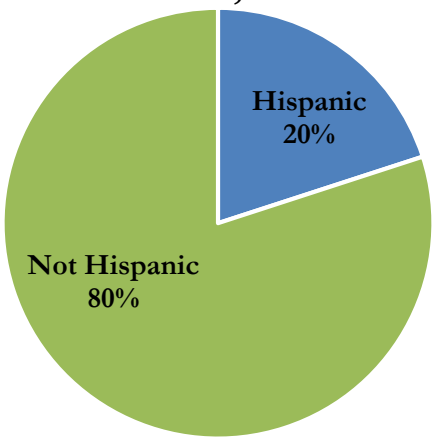

Figure III
2015 Walla Walla City Racial Composition Estimates
N = 32,237

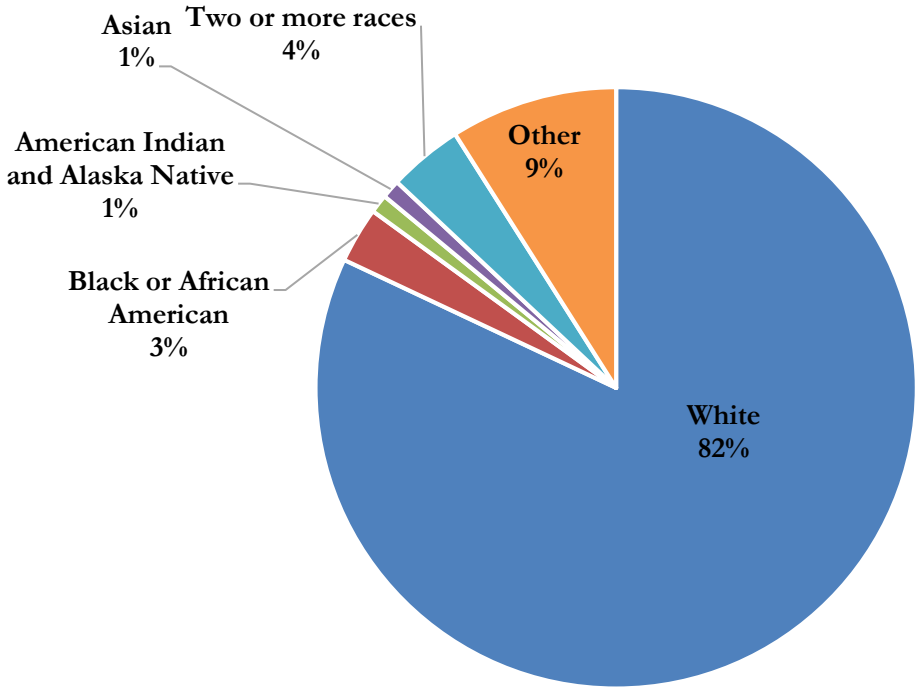

Figure II and ***Figure III*** use data from the U.S. Census: Quick Facts. (2015). Quick Facts: Walla Walla City. Retrieved from https://www.census.gov/quickfacts/table/PST045215/5375775

The Walla Walla ACEs Response

Although the ACE Study was not published until 1998, the Walla Walla Network has been working since it was established in 1994 to reduce the seven major social problems in its community that were outlined in the 1994 VPA. When Teri Barila was hired as the Walla Walla Network Coordinator in 1997, she began working diligently with community members and agencies to build Network partnerships and capacity (Longhi, 2015; Silas & Leib, 1997). Ms. Barila started as a part-time Network Coordinator, working 10 hours per week, but was able to grow the program over time and built funding resources so that she could move into a full-time Network Coordinator role to support the growth of the Network activities.

Ms. Barila recalled that she first learned about ACEs at a quarterly training that was offered by Ms. Porter and the staff at the Family Policy Council. Ms. Barila remembered the Family Policy Council was strategic and systematic about educating the Network Coordinators about the ACE Study and the emerging research that showed how ACEs impact brain development. Ms. Barila considered this intentional education and communication approach by the Family Policy Council to be an integral component that led to the creation of "a movement" that got the full Network system on the same page about ACEs and related brain science in Washington State (T. Barila, personal communication, July 23, 2017).

One of the lessons that Ms. Barila learned was that it takes multiple exposures to get to an "aha! moment" before people can fully embrace the urgency of ACEs. She recalled that it was the third time she heard Dr. Anda speak at the Statewide Network Conference that the information about ACEs really clicked for her. Dr. Anda, the co-principal investigator of the ACE Study, called on the conference attendees from across the state of Washington to mobilize action in their own communities and to educate people about ACEs. He explained communities needed to develop their own innovative, community-based strategies to reduce the incidence of ACEs since the

government was not responding quickly or effectively enough at the state or national level (Community Resilience Initiative, 2015).

> It was when Rob [Dr. Anda]…said 'we are not going to make anything happen at the Olympia level… it's going to happen when this bubbles up from the community level. It's going to happen when every community steps up and says this is important to us.' … And it was the way he worded that that just struck me that day in a different way than the prior exposures to the material, because I think that's for me when it took on a personal note, rather than – 'oh, here's some science and you like science – think about it from the science side' – it was like – 'oh my gosh we have to make this happen at the community level to really have impact.' And so, that moment in time for me was my 'aha!' moment …we need to create a community conversant in the ACE study, in brain development, and in resilience (T. Barila, personal communication, March 17, 2017)

In response to Dr. Anda's call for action, communities across Washington State started developing responses to ACEs through their Networks, and in 2008 a broad base of community and agency leaders from Walla Walla began building the Walla Walla ACEs Response. The Walla Walla ACEs Response sought to mitigate the harmful effects caused by ACEs, reduce the incidence of ACEs, educate community members about ACEs, and introduce resilience strategies into the fabric of the local human-serving government, private, and nonprofit agencies to improve the health and well-being of the children, youth and families in the Walla Walla community (Community Resilience Initiative, 2015).

To spread the word about ACEs to community members and practitioners in Walla Walla, Ms. Barila coordinated a conference at the Walla Walla Community College in 2008 and invited Dr. Anda to speak as the keynote. He addressed a room of 168 individuals living and working in the Walla Walla community; most attendees were practitioners from human and social services, and a handful were community members who did not work in the public or nonprofit sector. Ms. Barila recalled that the most memorable moment at the conference was when her friend, Annett Bovent, a typically reserved woman and one of the few community members in the audience, took the microphone during the Q&A.

> She [Ms. Bovent] turns around and you see tears streaming down her face - and she said 'I just found out that I have all 10 ACEs – and I heard Rob [Dr. Anda] say my childhood is not my fault. I am not the bad parent that many of you in this room made me feel I was.' And you could have heard a pin drop. It was so powerful. So that was really the second 'aha!' moment for me. If a parent in her first exposure to this…can turn on a dime like that with this information… if we can get this information into parents' hands then they can see that they are not bad parents. (T. Barila, personal communication, March 17, 2017)

At the time of the conference, Ms. Bovent was a single mother of three children who had experienced all 10 ACEs. She was dealing with housing instability and had experienced homelessness with her children three times over a 12-year period. Despite the unpredictability and other stressors in her life, she changed her parenting approach after learning about the harmful effects of ACEs. She reflected: "Once you are informed about the ACEs it is easier to realize what is negative and what's not… it's easier to eliminate the bad stuff because you are aware of it," (A. Bovent, personal communication, April 12, 2017). Since first hearing Dr. Anda speak in 2008, Ms. Bovent said that she has tried to spread the word about ACEs and resilience to almost everyone she meets. She has publicly shared her personal story about ACEs 100 times to audiences – some as large as 500 people. In her testimonial featured in Resilience Trumps ACEs, she said:

> I woke up and realized that nobody is going to change you and nobody is going to do anything for you - you have to be willing to change and do something for yourself… I've had so much negative in my life and not hardly any positive and so I went through the motions with my kids trying to parent them the best I knew but now I'm in the middle of it, I'm involved… and they are listening to me. They know when I want something… they know where it is coming from. (Resilience Trumps ACEs, 2016)

In addition to, Ms. Bovent, a parent transformed by Dr. Anda's message, several Walla Walla agencies also began adopting trauma-informed practices as part of the Walla Walla ACEs Response. Ms. Barila and Mark Brown founded the Children's Resilience Initiative in 2009 to increase resilience and spread the word about ACEs and protective factors to the Walla Walla community members experiencing ACEs. Ms. Barila received a $40,000 planning grant from a local foundation that helped the Children's Resilience Initiative bring more agencies and partners around the table to enhance the Walla Walla ACEs Response. The partners began meeting more formally in early 2010

and established two guiding goals: "creating a community conversant in ACEs, brain architecture and resilience" and embedding "those principles into daily practices of every partner at the table" (T. Barila, personal communication, March 17, 2017). Dr. Kelly Jedd McKenzie, a former Whitman College student who interned at the Children's Resilience Initiative from fall 2010 through spring 2011, shared that she worked with the organization as it was just getting up on its feet. She reflected that "one of the cool things about Walla Walla is that it was a grassroots, community-led thing. It was coming from people in the community who identified a need," (K. J. McKenzie, personal communication, April 20, 2017).

The Children's Resilience Initiative was the primary organization spreading the word about ACEs and resilience in Walla Walla. Since its inception, the Children's Resilience Initiative has delivered thousands of presentations to community members and practitioners in Washington State and nationally about the ACE Study, brain development, resilience, strategies and tools to help parents foster resilience, an overview of the Walla Walla ACEs Response, and a review of the Resilience Trumps ACEs Community Action Manual.

The APPI evaluation conducted by Mathematica Policy Research revealed that by 2014, approximately 42% of Walla Walla residents were at least somewhat familiar with ACEs (Verbitsky-Savitz, 2016). Ms. Barila believed that approximately 80% of the child- and family-serving agencies in Walla Walla were also somewhat familiar with the topics of ACEs and resilience by 2014 (T. Barila, personal communication, March 17, 2017). Ms. Barila remarked:

> You try to bring that community awareness by being out there at community events – you create those opportunities for exposure by parents – you do fun, engaging things... we do resilience treasure hunts on Main Street downtown, we had the city proclaim that October is resilience month and we do all kinds of events and activities – particularly during the month of October to highlight that, including huge banners hanging out on Main Street and other banners hanging up all through downtown and special events – anything we can think of to raise the awareness among the general public. But, of course, more intensively we work with the agency folks. We meet every month. (T. Barila, personal communication, March 17, 2017)

Friends of Children of Walla Walla (referred to as '*Friends'* in this paper), a local mentoring organization, also incorporated knowledge about ACEs into its work. *Friends* was founded in 1999 by Ms. Barila and a group of her committed colleagues to provide children in Walla Walla a safe, mentoring relationship with a positive and reliable adult. Ms. Barila ran the program for its first 5 years and considered *Friends* to be a vital component of the "scaffolding" that helped build resilience at the community level in Walla Walla (T. Barila, personal communication, July 23, 2017).

Today, the *Friends* mentoring program has 186 active mentors who provide mentoring services through a community-based program and a school-based program to 10 schools in the Walla Walla area. Jim Byrnes, who became the Executive Director of *Friends* in 2015, shared that all of the *Friends* mentors receive a basic training about ACEs and ongoing trainings are offered for those who choose to engage in deeper learning. He emphasizes to the mentors that the most important thing they can do to support children with ACEs is to show up consistently for the youth. The home page of the *Friends* website states that "Adverse Childhood Experiences (ACEs) has been declared the number one childhood trauma in the United States. The number one antidote to this is providing a child a caring adult relationship once a week for at least one year," (Friends of Children of Walla Walla, 2017).

Since taking his role, Mr. Byrnes has been working to expand the reach *Friends* by increasing advertisements for the program and recruiting more mentors to meet the demand of children needing a positive, caring adult in their lives. He believes that having a mentor for 35 minutes a week can help students build self-esteem, social awareness, and improve their academic success. He shared that when students begin working with a mentor:

> They want to achieve more and they start studying and they start showing up… no matter what's going on with their home life… Once they get a mentor then they become – well sometimes they become rock stars and other kids take notice and next thing you know they are getting more friends and when they get more friends they have better self-esteem and any bullying that may happen stops. You know, it really is a reduction in bullying for these

> kids and being recipients of bullying and then, next thing you know, everything else starts rising up. Teachers notice it and all the other kids notice it. (J. Byrnes, personal communication, March 17, 2017)

Another organization that adopted trauma-informed practices was Lincoln High School (referred to as 'Lincoln' in this paper), the alternative high school in Walla Walla. In 2007, Jim Sporleder, a highly regarded school administrator in town, asked the Walla Walla Superintendent for a transfer to Lincoln because he was concerned about the state of the school. He recalled that back then "there were 5 gangs in the building and they were throwing signs at each other and you never knew when something was going to break out," (J. Sporleder, personal communication, March 18, 2017). Another key informant recalled that before Mr. Sporleder started, "Lincoln School was the school that had horrible absenteeism, a horrible time with low test scores, a horrible time with lots of police interaction, horrible time with discipline issues that were very, very disruptive," (S. Ledington, personal communication, April 13, 2017).

When Mr. Sporleder first transferred, Lincoln had approximately 75 students enrolled but the average daily attendance was only 50 students. After he was posted at Lincoln, he recalled that enrollment climbed to approximately 200 students. Mr. Sporleder approached his work at first as a strict disciplinarian because he wanted to hold students accountable for their actions and create a safer school environment for the students. He remembered, "I had some pretty hard core kids – the gangs were running the building and they did not want to give it up," (J. Sporleder, personal communication, March 18, 2017). During this time, the Children's Resilience Initiative was continuing to build momentum around the Walla Walla ACE Response with its partners, including the Assistant Superintendent from the Walla Walla School District. Ms. Barila recalled that she invited Mr. Sporleder to attend as well but "he was dealing with such a challenging environment, he found it hard to break away from school to attend," (T. Barila, personal communication, July 23, 2017). Mr. Sporleder had the opportunity to learn about trauma-informed discipline practices in

2010 at the Hope to Resilience Conference in Spokane, Washington, and heard from molecular biologist, John Medina, who spoke about human brain development:

> It's hard to explain… in 90 minutes of his keynote speech he turned me upside down. I have always been a real strong relationship guy and I always would say that my discipline teaches and I was very anti-punitive discipline strategies… and after John Medina's presentation, it hit me that what I thought was teaching was punitive… When Dr. Medina said that we have kids coming to school in high escalation and they are in a fight, flight, freeze mode... and that they physiologically can't learn or problem solve – that goes against everything we have been trained as educators since you never say a student can't learn. And, he also shared that when they are in that state their behavior is out of their control – and my training and my philosophy has always been "behavior is a choice" – and so if you choose to misbehave and create an infraction then you needed to be held accountable with a consequence that matched. (J. Sporleder, personal communication, March 18, 2017)

When Mr. Sporleder returned from the conference to Lincoln, he told his staff about ACEs, shared that many of Lincoln's students are constantly in an escalated state because of their trauma, and explained his discipline was going to look different at Lincoln moving forward. Mr. Sporleder worked with Ms. Barila to bring in Natalie Turner, an expert in developing trauma-informed schools, to train his staff in the trauma-informed school model. After adopting the model, he was shocked by how quickly he saw improvements in student reactions to the new discipline approach. He recalled that when he had students referred to his office, instead of explaining to students how their behavior was having a negative impact on the school, he would ask what was causing their negative behavior. He said, "Day one when I asked questions to kids they just opened up. I was just blown away," (J. Sporleder, personal communication, March 18, 2017). Mr. Sporleder provided a comparison between his former, more traditional discipline model and the trauma-informed model:

> If the kid would yell at me in the traditional mode – you know, he better put his seat belt on. Kid comes in and yells at me once I understood trauma, I would say, 'man, it looks like you are having a really tough day. I want to give you some time. I don't want to make a decision now – I would rather have a calm conversation'… What happens is when you have those conversations with kids, you teach them about stress, the brain, and I spent a lot of time talking to kids about their triggers. If they would get to me before their trigger went off I had lots of options. If they blew up, I didn't have as many options… when you are in a relationship with kids they appreciate the fact that you allow them to have some time to gather themselves. (J. Sporleder, personal communication, March 18, 2017)

Mr. Sporleder partnered with the Children's Resilience Initiative for support in addressing ACEs at Lincoln, and they provided funding for a Resilience Class, a Parenting Support Class for teen moms, a Resilience Awareness Campaign through art and media, and recruited 30 guest speakers to connect with the students and share about adversity and resilience at Lincoln. These speakers included a Chief of Police and a nursing student who had been incarcerated. The purpose of these speakers was to provide the students with real life examples of adults who had struggled with adversity, but who had "made it through" with resilience. Mr. Sporleder also partnered with Ms. Barila and Ms. Porter on an evaluation and pilot study that assessed staff learning through a survey and focus groups (T. Barila, personal communication, July 23, 2017). In addition, a confidential ACEs assessment was conducted of the students at Lincoln that revealed the student body had an average of 5.5 ACEs (J. Sporleder, personal communication, March 18, 2017).

After adopting a trauma-informed approach to discipline, Lincoln achieved statistically significant reductions in its behavioral issues and suspensions as well as improvement in its high school graduation rates. In the year after the school adopted a trauma-informed approach to discipline, the school experienced an 83% drop in out-of-school suspensions, a 40% reduction in expulsions, 47% decrease in written referrals, and 64% fewer school resource officer police reports at the school (Stevens, 2012). The documentary *Paper Tigers*, released in 2015, highlights the success that Lincoln experienced after implementing its new approach to discipline. *Paper Tigers* revealed that after the trauma-informed approach was adopted there were also 75% fewer fights at Lincoln, five times more seniors graduated annually, and three times more seniors began enrolling in college after graduation (Redford & Pritzker, 2015).

Mr. Sporleder believed that Lincoln could not have achieved its gains in student outcomes without the partnership of The Health Center. The Health Center offers an array of services including primary medical care, behavioral health services such as counseling, anger management,

crisis support, and referrals to case management and other community-based services. Responding to a need identified by community leaders in Walla Walla, The Health Center established a site at Lincoln in 2008 to "advance the success of students by addressing their physical, emotional, and social needs" (The Health Center, 2017). The Executive Director of The Health Center, Dr. Stan Ledington, shared how students from Lincoln used The Health Center services once it opened:

> It's a resource for kids that were having behavioral meltdowns or were not showing up at school or had anxiety or depression… not necessarily preventing ACEs, but helping build resilience on the other end and helping kids who suffered or struggled because of adverse occurrences or events in their early life. Helping them learn some life skills and how to self-regulate… The Health Center provides very real supports for their unmet medical needs or their unmet social or emotional needs and helped them with skills and competencies around how to deal with emotions, how to interact socially, and how to be healthful in terms of the life skills and practices that they were engaging in (S. Ledington, personal communication, April 13, 2017).

The Health Center started as a volunteer organization but later expanded and paid its staff. After The Health Center was found to be an asset at Lincoln, additional Health Center sites were developed at an elementary school and middle school in Walla Walla. At the elementary school, the school has experienced a significant decrease in discipline referrals since The Health Center opened on-site. Dr. Ledington mentioned that almost 90% of teachers reported that they saw behavioral improvements after students received mental health counseling from The Health Center, and 99% of the parents were positive about the improvements they saw in their students' behavior after working with The Health Center staff. The traditional Walla Walla High School has committed to developing a Health Center site in the next year, and Dr. Ledington shared three additional schools have been "begging" to establish new Health Centers on-site. Although he would like to continue expanding, he noted it takes significant resources and strategic planning to get a health center up and running (S. Ledington, personal communication, April 13, 2017). Although it has been difficult to meet the growing demand for Health Centers, the Walla Walla County Board of Commissioners implemented a 0.1% sales tax in January 2012 dedicated to expanding mental health and chemical

health services in the county (Walla Walla County, 2016). Dr. Ledington shared this innovative sales tax has paid for most of the mental health providers at The Health Centers and provides an ongoing stream of revenue that allows The Health Center to "have a sustainable organization rather than going from one little grant to the next," (S. Ledington, personal communication, April 13, 2017).

Another organization that adopted a trauma-informed approach is the Jubilee Youth Ranch (referred to as 'the Ranch' in this paper), a Christian boarding school founded in 1995. The Ranch is located near Walla Walla in Prescott, Washington, and serves young men ages 13-18 years who are struggling with behavior issues or academic performance (Jubilee Leadership Academy website, 2017). Approximately 40 students reside at the Ranch, and the annual length of stay is around 17 months. A racially and socioeconomically diverse group of young men are referred to the Ranch, primarily by caregivers, from all over the country (R. Griffin, personal communication, April 11, 2017). According to its website, the Ranch provides "a safe Christian environment and professional therapy for students to uncover and conquer adverse childhood experiences such as abuse, major loss, parental failure, or adoption," (Jubilee Leadership Academy website, 2017). Some of the most common challenges faced by young men at the Ranch are experiences with death of a loved one, attachment issues, a family history of drug and alcohol use, neglect, and exposure to emotional and physical abuse (R. Griffin, personal communication, April 11, 2017).

The Executive Director of the Ranch, Rick Griffin, first learned about ACEs when he collaborated with Ms. Barila and Ms. Porter from the Family Policy Council on a project, and later explored the topic through independent research. He asked Ms. Barila and Mr. Brown from the Children's Resilience Initiative to offer a seminar about ACEs and resilience to his staff in 2009 and reported that while the information was well-received by his staff, they were not clear how to apply the information to their work. He explained how what he learned about ACEs shifted his approach to his work at the Ranch with both the youth and staff:

> We were looking first at how to serve in a different way. I think that's what really impacted me most. We have got these youth and we have been working with them from a behavioral management point of view – you know, punishment and rewards – and really started to look at that not being the most effective way to deal with folks who have a traumatic history. So really trying to see how we can serve our youth differently... and trying to expand it because I had so many staff that say, this is where I came from too... I think that was the piece that really got us focused more than anything was right after that we did a survey of ACEs for our staff and our students and we found out that our students and staff were... both hovering above 6 ACEs on average... I started becoming captivated on how am I going to work with our staff to make these changes when they have so many ACEs? That became a focal point of our work as well. R. Griffin, personal communication, April 11, 2017)

Since first being trained about ACEs in 2009, the Ranch continued its learning journey for several more years before it implemented a change in its practices. The Jubilee Youth Ranch Board voted to formalize its trauma-informed approach in 2014, and the Ranch has since become one of the first licensed trauma-informed programs of its kind in the nation. Mr. Griffin shared:

> The trauma-informed approach for us has now taken us to look beyond the behavior – it is not about the behavior that they are exhibiting – that is really just symptomology of their communication that they are trying to share with us. What's driving that behavior and what is really – what are they trying to communicate through that behavior? And how is their stress impacting their ability to learn from us? I think that's really what separates us really from most of the programs now in this industry is that understanding… Most programs use punishment as their primary sense of accountability because that is their approach to changing behavior – finding a deterrent for the student. If they find a strong enough deterrent, then the student will do something different… that approach, we believe, really can re-traumatize individuals. We are trying to look at holding them accountable with consequences that are much more trauma-informed, much more conscious of their traumatic histories – of the stress level – really trying to shape our programming based on that. (R. Griffin, personal communication, April 11, 2017)

Mr. Griffin shared how the students responded after learning about ACEs and resilience:

> Some of the changes were immediate - understanding, 'wow, this is what's happened to me and some of my decisions are based on some of my experiences.' It really relieved them from the guilt and the shame that came from their bad behavior. They realized that they do some stupid things and just don't know why. And felt really bad about that. 'I am destroying my parents and don't know why.'…I think the thing that changed with the students the most was empathy for their own parents – they weren't blaming their parents any longer for their poor parenting practices – they were able to say – 'wow, maybe my parents have ACEs, too' – and their parents didn't know any better. And they were able to see that they don't come from bad parents – that they came from parents who were probably hurt and didn't have a different set of skills which to parent them from. That really helped with reconciliation in the family to help them understand you didn't have a bad mom or a bad dad – you had someone

> who probably didn't know how to handle their own ACEs – a real critical understanding I think for our kids. (R. Griffin, personal communication, April 11, 2017)

Figure IV provides a review of some of the Walla Walla successes outlined in this case study. It is important to note that the accomplishments Walla Walla experienced because of its educational campaign through the Children's Resilience Initiative to get its community conversant in ACEs and resilience, the trauma-informed approaches implemented at Lincoln, the counseling and support provided by The Health Center, the new discipline practices adopted by Jubilee Youth Ranch, the expansion of the *Friends* mentoring program, and Ms. Bovent's shift in parenting practices are only a few of the many successes that occurred because of the Walla Walla ACEs Response.

Although not covered in depth in this paper, evaluation was an important strategy used to get buy-in for the Walla Walla ACEs Response. Evaluation helped generate and sustain funding for the Washington State and Walla Walla ACEs Response because it illuminated the value of adopting a trauma-informed community approach and served as a data-driven mechanism to attract funders and other partners to the effort. It is critical that evaluation be integrated into an ACEs Response.

Because of the widespread successes that occurred in the Walla Walla community, in October 2013 the Walla Walla Mayor Jerry Cummins acknowledged the diligence of all of the partners supporting the movement, and signed a proclamation that declared October to be Children's Resilience Month in Walla Walla (T. Barila, personal communication, July 27, 2017). This proclamation explained there is evidence that childhood trauma and ACEs are correlated with negative behavioral and health problems, which is detrimental to communities. In the proclamation, the Mayor urged residents to "become informed about childhood trauma and how to create resilience in individuals who have suffered such trauma" and "to integrate these principles into their everyday work and practice," (City of Walla Walla, 2014).

Figure IV: **Walla Walla ACEs Response Successes**

Categories	Description of Successes
Academic & Behavioral Improvements in Schools	**Lincoln High School** achieved: an 83% drop in out-of-school suspensions, a 40% reduction in expulsions, a 47% decrease in written referrals, 64% fewer school resource officer police reports at the school, 75% fewer fights at Lincoln, five times more seniors graduating annually, and three times more seniors enrolling in college after graduation[14]
Behavioral & Academic Improvements in Schools	Since establishing a **Health Center**, the elementary school has experienced; a significant decrease in discipline referrals, 90% of teachers report that they see behavioral improvements after students receive mental health counseling from The Health Center, and 99% of the parents are positive about the improvements they see in their students' behavior after working with The Health Center[15]
Agency Awareness of ACEs	80% of community organizations and agencies that served children and families were educated about NEAR science by 2012[16]
Community Awareness of ACEs	42% of community members surveyed were at least somewhat aware of ACEs & resilience[17]
Family Awareness of ACEs	Annett Bovent modified her parenting practices after learning about ACEs and reports an improved relationship with her children[18]
Educational Outreach	168 individuals attended a conference about ACEs, with keynote speaker Dr. Robert Anda in 2008; Annett Bovent delivered her testimonial about ACEs over 90 times to audiences as large as 500 people; the **Children's Resilience Initiative** offered thousands of presentations to community members and practitioners about ACEs in Washington State and nationally[19]
Innovation in Funding	The Walla Walla County Board of Commissioners adopted a 0.1% sales tax in January 2012 dedicated to expanding mental health and chemical health services in the county[20]
Organizational Development	The **Children's Resilience Initiative** was formed in 2009 to spread the word about ACEs[21]
Organizational Development	**The Health Center** was developed at Lincoln High School in 2008; The Health Center developed an additional site at an elementary and middle school; and a site is under way at the traditional high school in Walla Walla[22]
Organizational Development	**Friends of Children of Walla Walla** increased its mentoring capacity to reach more youth and has 186 active mentors who operate a community-based program and 10 school programs[23]
Organizational Development	**Jubilee Youth Ranch** formalized its commitment to a trauma-informed approach in 2014; became one of the first licensed trauma-informed programs of its kind in the U.S.[24]
Political Commitments	Mayor Cummins declared October as **Children's Resilience Month** in Walla Walla in 2013[25]

[14] Stevens, J. (2012). Lincoln High School in Walla Walla, WA, tries new approach to school discipline. https://acestoohigh.com/2012/04/23/lincoln-high-school-in-walla-walla-wa-tries-new- approach-to-school-discipline-expulsions-drop-85/ ; Redford, J. and Pritzker, K. (2015). Paper Tigers: One School's Unlikely Success Story. KPJR Films. http://kpjrfilms.co/paper-tigers/

[15] S. Ledington, personal communication, April 13, 2017

[16] T. Barila, personal communication, March 17, 2017

[17] Mathematica Policy Research 2016, pg. 45

[18] A. Bovent, personal communication, April 12, 2017

[19] T. Barila, personal communication, March 17, 2017; A. Bovent, personal communication, April 12, 2017

[20] Walla Walla County (2016). 0.1% Treatment Sales and Use Tax for Chemical Dependency or Mental Health Treatment http://www.co.walla-walla.wa.us/docs/RFPTreatmentTaxFundingnarrative_2017.pdf

[21] T. Barila, personal communication, March 17, 2017

[22] Health Center. (2017).Mission. https://thehealthcenterww.org/; S. Ledington, personal communication, April 13, 2017

[23] J. Byrnes, personal communication, March 17, 2017

[24] R. Griffin, personal communication, April 11, 2017

[25] City of Walla Walla. (2014). Proclamation. https://acestoohigh.files.wordpress.com/2014/10/crimonth.jpg

Lessons Learned & Recommendations

Key informants shared their insights about lessons learned during the development of the Walla Walla ACEs Response and provided recommendations for other collaborative groups interested in developing a response to ACEs in their own communities. There were a dozen primary lessons learned and recommendations that surfaced during the key informant interviews, including: 1) Trust Needs to Be Built Between Community Members and Practitioners; 2) Diverse Sectors Must be Represented - Including Community & Parent Voices; 3) Create a Continuum of Support; 4) Develop a Shared Vision; 5) Committed Champions are Key, but Leadership Must Also be Expanded; 6) Shared Learning Opportunities Help Minimize Turf Wars; 7) Communication Should Be Strategic; 8) It Takes "a Village" to be Successful; 9) There Are Many Ways to Grow An ACEs Response; 10) Diversify Funding Streams; 11) A Paradigm Shift Takes Time - Be Patient; and 12) Identify Long Term Goals, Maintain Self-Care, and Celebrate Successes Along the Way.

Figure V illustrates if the implications drawn from the lessons learned are relevant at the community level, or both the state and community levels.

1) Trust Needs to Be Built Between Community Members & Practitioners

The importance of building trust with community members was also noted by several key informants. Ms. Bovent shared:

> When you are working with very hurt and vulnerable people, building trust needs to come before you can shove down their throat so much information that they back away from it. If you do a little bit at a time, build the trust, take them for a cup of coffee, go for a walk or something, then you are building that trust with them... Then they can see that you mean business and that you really want to be there to support them and help them. (A. Bovent, personal communication, April 12, 2017)

She also urged practitioners in the human services and social services to be more considerate when working with parents. She reflected on her experience working with human services practitioners:

> I just wanted to be treated like a person, and working with the professionals in the past I was always treated as a number and placed blame upon and fingers would get pointed 'you're just a bad parent, why don't you just straighten up, why don't you just do this, why don't you just do that'– and that's not how I want to be treated. I want to be treated with respect and be treated as a human being, and I have come across a lot of people who… feel the same way. They get the same kind of treatment… people that don't understand the ACEs and have not been educated yet… But once you learn about the ACEs, it's easier to pull yourself back and say – 'well, it's not their fault – it's the hand of cards they were dealt.' (A. Bovent, personal communication, April 12, 2017)

2) Diverse Sectors Must be Represented - Including Community & Parent Voices!

In addition to educating practitioners from human services agencies in town, Mr. Griffin stated that every sector in the community has to be on board and he pushed for "institutionalizing" the information so that every sector and community member can use a shared framework for understanding NEAR science. He reflected the Walla Walla ACEs Response could have been stronger if they had broadened their scope of engagement with stakeholders outside of the social services sector. Several key informants talked about the value of listening to the wisdom of parents and involving community members when building an ACEs Response. Dr. Pecora talked about the importance of consulting community members most affected by ACEs when developing strategies to address ACEs:

> Really going down to the people who might be affected by the strategies to get their take on it. And to have very frank discussions in their neighborhoods, in their environments about what you are thinking about doing and what would they think would work. And sometimes that means people operating out of their comfort zones and that is really crucial and…there may need to be some community repair work, in that some communities have been burned by researchers or they've been taken advantage of by foundations or government agencies have really been unfair to them, so just be aware that (P. Pecora, personal communication, April 7, 2017).

Dr. Ledington offered a cautionary anecdote to illustrate what can happen if the community is not a part of the conversation:

> We had a request to open a school-based health center in our neighboring community that has a beautiful new high school and middle school – we were excited because they had space ready for the clinic. They invited us to come and do that. So we went trotting down, ready to roll this out. We are all proud about who we are and what we do and what our outcomes

> have been and we didn't do anything with the community in terms of getting their buy-in with what we were doing so a couple of vocal community members derailed and stopped us by complaining loudly to the school boards that this was not what they wanted and not what they need. Our learning there is before you get too happy and throwing stuff on the front page of the paper, it is really important that you have some community listening, and have some community support, and have a groundswell of agreeing that this is important and this is the direction or approach that we think is going to be helpful. (S. Ledington, personal communication, April 13, 2017)

3) Create a Continuum of Support

Ms. Barila shared that a successful ACEs Response needs to be a community-wide effort that makes space for parents to be at the table:

> Any child in that school [trauma-informed school] setting walks other avenues– and if those other avenues aren't trauma informed too – what good has it done for the school to be trauma-informed? So, I would say – develop a strong community-based community coalition so everybody is at the table and we help support each other as we each – so my newest analogy that I use – we had a bunch of puzzles printed online – which is the Heart of the Matter …the puzzle is broken up into puzzle pieces and it's called "My Piece Matters"… Because I agree when teachers say 'but what good is it for me to do this if it falls apart at home?' (T. Barila, personal communication, March 17, 2017).

She also stressed the importance of getting the information embedded into many sectors:

> I agree when teachers say 'but what good is it for me to do this if it falls apart at home?'...Nothing else is going to matter ultimately if we don't help the parents increase their skill set. I believe that that is the number one outcome of this work. It almost has nothing to do with the kids to begin with – it has everything to do with the adults across all sectors so that they are self-regulated, they are self-aware, they know all of this and they then put that into action. (T. Barila, personal communication, March 17, 2017)

Ms. Bovent also recommended that human service representatives from the school district, counselors, and homeless agency advocates should collaborate more closely with each other by adopting a wraparound approach when dealing with individuals who have experienced ACEs so practitioners do not re-traumatize individuals. "That way you are not putting that individual through more stress and more pain by having to bring it up so many times," (A. Bovent, personal communication, April 12, 2017).

4) Develop a Shared Vision

Bringing diverse stakeholders to the table to identify a strategic plan is crucial to the success of a coordinated ACEs Response. Dr. Ledington said it is vital to build a joint platform with a broad base of agency stakeholders and community members so that children can receive trauma-informed support in their community. He shared that a collective impact approach can be helpful for collaborative groups to build a strategic vision to "get some sort of consensus, some sort of a sense of what is most pressing – what is a solution or remedy, what is the least costly way to approach doing this, and if there are resources that can be pooled or silos that can be broken down," (S. Ledington, personal communication, April 13, 2017).[26]

To maximize impact of an ACEs Response, Dr. Pecora encouraged collaborative groups to develop a theory of change and logic model for their work, and to "begin with the end in mind. Target a particular community goal, identify community-change strategies appropriate to that goal, and then align the community's collaborative network and collective capacity to support those strategies," (P. Pecora, personal communication, April 7, 2017). He also expressed the need for someone to be able to effectively organize cross-sector meetings as the group develops a vision and strategic plan:

> I think that it takes a committee. You might have one leader who spearheads it, but you need people who can think very specifically and people who can think systematically and from an ecological systems point of view. You need to rely on people with different perspectives and people from different levels of government and the community - who bring different perspectives. And I think that is the challenge in leadership is how do you make sure in whatever you are doing you have that different strata - different levels - represented in meaningful ways? Which means you need to have someone who really knows how to design productive meetings. (P. Pecora, personal communication, April 7, 2017)

[26] Hanleybrown, Kania, & Kramer (2012) list the five components of collective impact as "a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and the presence of a backbone organization," (Hanleybrown, Kania, & Kramer, 2012, pg. 1).

Ms. Porter said that it is important to have some individuals who are focusing on a high level vision of a community's response to ACEs while others focus on the individual social problems and interventions:

> We found it very unusual in almost any community in the state to have a group of people that understood that their job was to take that meta view over the community as a whole and that is essential that there be a small group of people who agree that not only are they going to pay attention to any one issue they care about or any one agency they work for but they also have a role as thought partner to be really thinking about what is happening with the community as a whole. Are we changing things? Are things staying the same? Are they getting worse? Are they getting better? And looking at sort of the big strategic aims of the community and having an honest enough conversation to be able to say "look, we are all doing our work extremely well, but together we are still failing" or "we are all doing our work extremely well together but we are competing? But to be able to take that meta view is really important and pretty rare and often requires an outside person to prompt it. (L. Porter, personal communication, March 13, 2017)

5) Committed Champions are Key, but Leadership Must Also be Expanded

At the state level, Ms. Porter shared that it was critical to engage policymakers in order to create a sustainable funding source for the Networks and Family Policy Council. She remembered that at any given time there was a champion in the Washington Governor's Office, the Washington State Senate, or the Washington State House of Representatives who was willing to prioritize the state efforts to address ACEs:

> Our best years had a strong champion in two out of those three. I don't think in any of those years did we have a champion in all three. But maintaining at least two out of three really made a big difference so we intentionally tried to nurture those relationships. When we would get a new governor and we knew that governor wasn't going to be supportive, then we would re-double our efforts to really meet the needs of and pay attention to our House and Senate champions. We tried at every turn to make sure to have 2/3 of those groups sort of covered in terms of an internal voice that understood our work and could stand up inside of their caucus and really talk about it. (L. Porter, personal communication, March 13, 2017)

At the community level, most of the key informants mentioned the persistence and dedication of several key community leaders who championed the Walla Walla ACEs Response were

integral to the successes of the movement. Ms. Porter reflected on the leadership qualities that she found most effective at mobilizing an effective response to ACEs through the Networks:

> In every case where we had really amazing results there was one person or a very small group of people – maybe three or four – that were just relentlessly committed to improving the children's lives and family lives – and it was not a job to those people- it was a life mission or a calling or they might describe it in different ways, but that sort of unending commitment. So that is essential and it will emerge on its own. It's not like you can totally grow it but you can notice it and pay attention when it starts showing up – so that's one thing I would say. You have Teri Barila in Walla Walla – and we saw that around the state with a variety of leaders- where, you know, get out of their way because they are not leaving. And I used to sometimes refer to that as healthy belligerence because it was often those people that would be pushing back on the requirements we would be making out of our office if they weren't relevant (L. Porter, personal communication, March 13, 2017)

Ms. Barila and Jim Sporleder were mentioned most frequently by the key informants as the drivers of the Walla Walla ACEs Response. Ms. Bovent, Mr. Byrnes, and Dr. Ledington acknowledged that Ms. Barila and Mr. Sporleder helped them become aware of ACEs (A. Bovent, personal communication, April 12, 2017). Mr. Byrnes referred to Ms. Barila as the "Queen of Resilience" and Dr. Ledington called her the "ACE guru prophet" (J. Byrnes, personal communication, March 17, 2017; S. Ledington, personal communication, April 13, 2017). Dr. Ledington recalled, "Pretty sure she [Ms. Barila] was the voice that spread the ACEs message in our community and got us all thinking about that. And as you know from talking to her, she is a community organizer that never sleeps and never rests. She has a bow, a target, and she just goes until she gets there," (S. Ledington, personal communication, April 13, 2017).

Ms. Barila shared that an agency partner from the juvenile justice department once said:

> When Teri asks me to come and do something I might as well say 'yes' the first time because she won't say stop until I say 'yes' – so let's just get it over with. He was being funny but, you know, that's a huge compliment because a lot of this is about that persistence, perseverance –having that focus, retaining the focus, and no matter what you don't let people tell you 'no.' (T. Barila, personal communication, March 17, 2017)

Dr. Jedd McKenzie recalled that Ms. Barila had a knack for getting people to the table to talk about ACEs and resilience. "I think Teri is just a force to be reckoned with because she knows

everyone and she will just call people up on the spot," (K. J. McKenzie, personal communication, April 20, 2017). Mr. Sporleder also said that Ms. Barila was a key player in the success experienced at Lincoln. "I always say if there was no Teri there was no Lincoln… I think our sustainability as a community is wrapped around Ms. Barila – if Teri left, I don't know what would happen," (J. Sporleder, personal communication, March 18, 2017).

Although there were strong champions supporting the Walla Walla ACEs Response, it is also crucial to expand leadership opportunities more broadly in the community. Several key informants believed that it was vital to garner buy-in from agency administration to achieve a successful ACEs Response. Ms. Bovent emphasized the importance of engaging leaders from the school district, the police department, child protection services, doctors and nurses, local businesses, and homeless shelters since these are the individuals who have the capacity to make the greatest immediate impact (A. Bovent, personal communication, April 12, 2017).

Mr. Sporleder believed administrators need to be the primary drivers of an ACEs Response in schools. As a trainer who helps school administrators develop their capacity to offer a trauma-informed model, he also advises administrators to hire staff that align with the trauma-informed model because in his own experience it was challenging to work with staff that did not buy into the approach.

> It's painful for me going to a school and know that two to three teachers are doing trauma-informed practices – and then kids leave those classes and go back into a punitive environment – it just sets them up. So, if you are going to have sustainability, then it has to be this is how we do business… If you are going to do a trauma-informed approach, it has to be led by the principal. If the principal is not on board – I won't go to a school or a district unless I know the principal is the one initiating the call… You can't mobilize without the principal leading because it is a mind shift. It's the understanding that you can't get where you want to be until you build those relationships… If the principal is not leading it – it is not sustainable. (J. Sporleder, personal communication, March 18, 2017)

Dr. Jedd McKenzie also noted that anyone can be a successful leader in this work and mentioned that Ms. Barila has a Master's in Fisheries Management, but has still been able to

contribute substantially to the Walla Walla ACEs Response. "I always feel really inspired by that anyone can get into this and can make this kind of difference," (K. J. McKenzie, personal communication, April 20, 2017).

6) Shared Learning Opportunities Help to Minimize Turf Wars

Ms. Porter said that one way to reduce turf wars was to bring people together for shared learning opportunities. She mentioned the Family Policy Council held four low-cost education events yearly that provided opportunities for the Network coordinators and partners to discuss pressing issues related to ACEs across the state.

> I think one of the strategies for reducing turf wars is hosting dialogue and hosting education events where everybody is invited and it sort of rebuilds the social – the good feeling among people when people are learning together, which helped create learning communities. (L. Porter, personal communication, March 13, 2017)

7) Communication Should Be Strategic

Ms. Porter emphasized the importance of having a clear communication plan for engaging champions and local partners in the Washington ACEs Response through the Networks. She recalled:

> We also had a lot of strength in terms of Democrat supporters and Republican supporters and we were very, very careful to make sure we were getting any kind of communication or, you know, the arguments we were making to the public we made sure we were testing those with our leaders in both parties before we released them out into the community…We ran around the state and made sure Kiwanis and Rotary in the most conservative and most liberal parts of the state could sign on to this framework.... And that way, when we went back to report to the legislature we knew we weren't going to have one caucus fighting the other one – but both of them had reasons to support the work. (L. Porter, personal communication, March 13, 2017)

Ms. Barila also believed that in order to get a community conversant in ACEs and resilience, individuals need to have opportunities to get multiple exposures or "doses" of the information. She

said part of making this possible was "just getting it out there!" (T. Barila, personal communication, March 17, 2017). She also said that it was important to embrace a variety of communication strategies, styles, methods, and media to create opportunities for people to process the information in a variety of ways. She believed that it is normal to process the information through multiple exposures and shared a story about a woman who heard five presentations from her:

> [The woman] asked why I waited till the fifth time to talk about resilience. I said, that material has always been there. She was blown away. The point is, she was processing the ACEs the first couple of times, then the brain stuff the next couple, then finally was able to hear the resilience on the fifth round. We know people have to process in their own ways and styles. (T. Barila, personal communication, July 23, 2017)

Leaders of the Walla Walla ACEs Response worked diligently to spread the word about NEAR science so their community could have a shared understanding and common language about how to talk about ACEs so that community members and child- and family-serving agencies were saturated with the information. Ms. Barila said, "What you are really trying to do, I think, is to get everybody to understand that common language. …you have to have that common language and that common agenda and that sense of urgency that anybody even thinks this matters," (T. Barila, personal communication, March 17, 2017). Dr. Jedd McKenzie reiterated the need to disseminate information about NEAR science, especially to those working with children:

> I think just getting the word to people who are really struggling with these issues – those teachers at Lincoln High School who were struggling with students who have a lot of stress in their lives and also have a lot of issues in school. I think those are the people who really want this information and want to figure out how to do something better. So, I think as much as you can get it to those people that are kind of on the front lines of dealing with this – I think that can be a really impactful way to keep it going… People like Annett Bovent and Jim Sporleder are really good examples of how just shifting your perspective on this can be really impactful and can change the way you interact with the world and interact with people you are working with. So, I think the awareness is a really big thing and I think it is kind of a first step. (K. J. McKenzie, personal communication, April 20, 2017)

Dr. Ledington also agreed that getting the word about ACEs and resilience is important for all members of the community. "It's about having access for at-risk parents and families as well as

having parenting training and parenting support that is not punitive, but that becomes the norm in the community that this is a healthy, normal thing for us to do is to figure out how to be good parents," (S. Ledington, personal communication, April 13, 2017). He noted this work requires a long-term approach, and shared the strategies he has used to spread the word about ACEs, resilience, and the work of The Health Center. His team has developed PowerPoints they use when presenting to different area clubs, school boards, and the local National Alliance for Mental Illness chapter:

> We get on the agenda in lots of different places and talk about what we are doing. We also have funding from local foundations. Some of them have events and we try to present at those events to get the community going. We also are busy writing op-ed pieces for the newspaper and we go and have met with the editorial staff with the newspaper and have gotten their buy-in on this. Those are a lot of the things we do – just getting up and letting people know. We also have a big mailing list of people that we know are interested in us. So, those things like the annual report go out to a large group of folks… it's work. (S. Ledington, personal communication, April 13, 2017)

Mr. Griffin mentioned that one communication strategy that can be used to get buy-in is showing partners how the information about NEAR science is relevant to their work. He recalled that many sectors have struggled to understand how information about ACEs and resilience affects their work and that it took a while for some partners, such as the chamber of commerce or the local workforce centers, to get on board:

> They [the Chamber of Commerce] didn't realize that this impacted their staff – that this impacted people coming in late for work, and their stakeholders, even their donors or investors also have ACEs – so, this is broader than just the context of social services, and especially children. So, I think that is something that certainly would have helped us to respond more effectively if we could have known – had the insight – to expand it broadly from the beginning. (R. Griffin, personal communication, April 11, 2017)

Ms. Barila said sometimes people would ask, "Why do I need to know this? I am not a brain scientist!" She would reply that when people are educated about ACEs they can improve the work they are "already desperately trying to achieve," (T. Barila, personal communication, March 17,

2017). She used Mr. Sporleder as an example and said he was able to find a more effective way to work with students after adopting the trauma-informed approach.

> 'The champion comes from seeing that he or she can get what they wanted all along', is one of Jim's [Mr. Sporleder's] favorite lines because he is a pretty strict traditionalist – I think he would call himself –-so, what did he really want? He wanted his kids to graduate? What did he find out by doing it this way? He could get kids to graduate! So, he got what he wanted and yes, it took some extra time to make that shift and to get everybody trained and to handle all the nay-sayers. (T. Barila, personal communication, March 17, 2017)

Some partners needed to witness the positive changes from the Walla Walla ACEs Response before they could buy into the message. Ms. Barila said some practitioners warmed up to the idea of adopting a trauma-informed approach to discipline in schools after they learned about Mr. Sporleder's work at Lincoln. She recalled his worked helped other agencies build confidence and say, "Wow! Well, if Jim can do that, I can do that," (T. Barila, personal communication, March 17, 2017).

Mr. Byrnes said that spreading the word about NEAR science is challenging:

> The biggest thing is bringing awareness as to the effects of ACEs which is, you know, sometimes difficult to understand. Some people don't want to recognize the fact that they have ACEs… getting the awareness out there and the education out to the population to show that when kids have ACEs, it affects the entire population – the entire community – it doesn't just affect those people "over there". It affects everybody. And it sometimes is a surprise to see which kids have ACEs and which kids have a lot of ACES – but it still affects the whole entire community. I think that's the biggest problem in getting this out. (J. Byrnes, personal communication, March 17, 2017)

8) It Takes "a Village" to Be Successful

Ms. Barila said an effective community effort that addresses ACEs and builds resilience has to be community-based and must bring many partners to the table. She recalled that when the producers of *Paper Tigers* documentary were considering the focus of the documentary, they interviewed nine different partners of the Walla Walla ACEs Response and ultimately decided to focus on Lincoln because the data was so compelling. Ms. Barila said:

> And I think that's the one missing element that comes out of the *Paper Tigers* documentary is that loss of the community-wide focus. Because any child in that school setting walks other avenues – and if those other avenues aren't trauma informed, too – what good has it done for the school to be trauma-informed? (T. Barila, personal communication, March 17, 2017)

She emphasized that schools that commit to adopting a trauma-informed approach, like Lincoln, need the support of ALL other sectors and partners within the community to maximize the effectiveness of this valuable shift in practices in the school setting.

9) There Are Many Ways to Grow An ACEs Response

Mr. Byrnes believed that an ACEs Response should be mobilized with a grassroots approach:

> All the people that are in the foundational aspect of it, like the agencies that deal with children and families and the school – getting them on board – and then going out and advertising to the community about what's going on – I think you have to build it from the bottom up. And… the base foundation is your partners and your community partners that are looking to help the kids… Get them on board first and everybody goes out and spreads the word. It's kind of evangelical – but it's not. It's just good work and starting with a good foundation and getting everyone on the same page. (J. Byrnes, personal communication, March 17, 2017)

Mr. Griffin believed that both a top-down approach and a grassroots approach are needed to create a strong response to ACEs:

> A top-down approach can help it to move faster because they are able to start freeing things up in terms of policies and procedures to allow some new thinking to come into it where originally we thought looking at it from the grassroots levels was how it was going to be pushed through. The grassroots level is a very important and obviously helps to get it out to those that are most marginalized in the community – looking at a grassroots approach. But you definitely can see that it can be quickly thwarted, or even redirected, if those policy makers in an organization are not bought into the philosophy. It really has to be almost a dual approach – that top down as well as grassroots approach. We have seen approaches if you only go top-down, sometimes those most marginalized individuals in the community, in those community sectors, are not addressed because they don't have any representation sometimes with government leadership, they don't have any representation with administration from hospitals and schools and whatnot... the power of the grassroots is getting to those most marginalized individuals. (R. Griffin, personal communication, April 11, 2017)

Ms. Porter shared there is not a magic formula of sectors that makes this work successful, rather it is simply important to have a diversity of opinions represented at the table:

> We didn't find that there was a particular combination of sectors that needed to be present. They were all different combinations of sectors sitting at the table across the state and all different combinations of different forms. It didn't seem to be so critical about which combination, but it was critical that there be leadership that held different perspectives from each other. (L. Porter, personal communication, March 13, 2017)

10) Diversify Funding Streams

Despite the successes the Family Policy Council and Networks had experienced prior to 2011, Ms. Porter recalled there were five primary reasons that the legislature discontinued funding for the Family Policy Council, namely due to (1) economic reasons; (2) political tensions and turf wars; (3) concerns about separation of powers; (4) shifting political priorities; and (5) a push for a public-private partnership.

First, the Family Policy Council was "formed as kind of a ten year experiment and we were past the ten year line and there was a recession," (L. Porter, personal communication, March 13, 2017). Second, Ms. Porter believed that "turf wars" may have contributed to the decision to sunset the Family Policy Council. In hindsight, Ms. Porter regretted the Family Policy Council had published so many reports about the Network successes, since these publications may have brought too much attention to their work. She hypothesized that the Networks and Family Policy Council could have been funded longer if their work was out of the public eye.

> One of the reasons the Family Policy Council was zero-funded probably was because of turf at the state level, because we started to be able to report really stunningly impressive outcomes and some of our sister prevention programs really didn't like it - they really felt threatened by that. (L. Porter, personal communication, March 13, 2017)

Ms. Porter also recalled that around the time that HB 1965 was passed, there was political tension mounting and some opponents to the Family Policy Council and the Networks believed that they held too much power at the local level. Ms. Porter shared:

> A lot of what the communities and Networks wanted was to challenge the programming delivered by the state – which was threatening to upper level decision makers – and communities wanted to suggest different programming delivered by the state. So, the more mature the networks got, the more threatening their policy recommendations got. So, I wish we anticipated that better - obviously if we understood that was going to be how it unfolded maybe we could have done some anticipatory guidance for the top level of the government and should have gotten them more on board before we started getting these big recommendations coming through the door. (L. Porter, personal communication, March 13, 2017)

The third reason that the sustainability of the Family Policy Council was threatened was because the Governor at the time was concerned the Family Policy Council was not maintaining a clear separation of powers.

> The governor at that time really hated that there was a council that had both of the legislators and her cabinet members on one body. She was a really strong proponent of separation of powers and she never liked the dynamics that happened when the legislators and executive branch officials were all in the room together at the Family Policy Council meetings. (L. Porter, personal communication, March 13, 2017)

Fourth, Ms. Porter remembered the house and the senate were in a debate over where to focus public funding for children and families at the state level, which caused a shift in funding priorities.

> The senate has always taken the argument that we should take a life course approach to prevention, and the house was increasingly, over the years, shifting their point of view believing that all prevention dollars should be invested in the first three years of life. (L. Porter, personal communication, March 13, 2017)

Finally, Ms. Porter said some partners of the Family Policy Council had been advocating to move its work to a private-public partnership at the time the HB 1965 was enacted, as opposed to a publicly funded initiative, since there were several major philanthropic organizations interested in committing millions of dollars to address ACEs in Washington State (L. Porter, personal communication, March 13, 2017). Ms. Porter recalls that the combination of these five factors made it difficult to sustain funding and support for the Family Policy Council, which ultimately led the organization to sunset.

> So all of that wrapped up in a crazy debate that people that had been our champions sort of began backing off and saying 'well it looks like you can get private funding, so maybe you don't need a Family Policy Council,' and our strongest critics saying 'hey, we wanted the money to shift anyways over to zero to three' and 'we really hated it that legislatures were talking together with executive branch officials and its okay with us that it goes away.' And all of that which was the perfect storm. (L. Porter, personal communication, March 13, 2017)

The history of the Family Policy Council shows that despite the strong documented successes of the Networks, even the most effective programs are vulnerable and can be eliminated if there is a lack of political collaboration. As a result, collaborative efforts seeking to address ACEs should be mindful that federal and state funding may only be temporary and should not be counted on for long term support of an ACEs response.

11) A Paradigm Shift Takes Time - Be Patient!

Developing a community-wide effort to reduce ACEs is slow work that requires a paradigm shift. Most of the key informants shared they met resistance during the development of the Walla Walla ACEs Response. Mr. Sporleder recalled that he struggled at first to make the shift to a trauma-informed approach to discipline because it went against all of his training. He recollected he was "sick to his stomach" the first time he decided not to suspend a kid since he was concerned that he would be sending a message to staff that he was not holding students accountable. "But man, when I asked him what was going on in his life and he started telling me, I could just see the de-escalation begin. And I had learned enough that I knew I had to give kids time to calm down," (J. Sporleder, personal communication, March 18, 2017).

Ms. Barila said many practitioners continue to struggle to embrace a trauma-informed approach because of their training. She explained that child protection case managers may view caregivers on their caseloads as bad parents who need to be punished, which makes it difficult for them to buy in to the trauma-informed approach. She noted that teachers and school administrators

also cite that they already too overwhelmed with their current workloads to adopt a new mode of operating:

> The typical response there is 'I can't do anything more.' Well, part of the education on that kind of an answer is that we are not asking you to do anything more. We are asking you to understand the framework of this [trauma-informed] approach because everything else you do should be from that framework … You do a lot of education on that in which you really come to understand that some people have some pretty strong mental models. (T. Barila, personal communication, March 17, 2017)

Ms. Barila recalled that during presentations she and her training team also experienced some hesitancy, especially in the early stages of the Walla Walla ACEs Response as the Children's Resilience Initiative attempted to make the community more conversant in NEAR science. She heard people say, 'This isn't the first time we have been told that kicking your kid and abusing your child is not a good thing – what's so exciting about this?' To that, she responded:

> And that's where I think the brain science side ***is*** the news. The ACE Study itself – we even call it a dead end if you only stop with the ACE Study material – because if you stop only with the ACE Study you haven't done anything. It was connecting it to our brain architecture and how critical the daily experience and the environment is... that's what's new. We can now literally, through the PET scan, see what the maltreatment – toxic stress – does to brain development... We now know what we can do that can change that trajectory. And the more we know about the epigenetics... around how the genes get turned off or on... how can you not be excited about that? We can literally change the next generation - and the next generation – when we understand the whole epigenetics side of this. (T. Barila, personal communication, March 17, 2017)

Mr. Griffin described the challenge he experienced attempting to get all of his staff to adopt the trauma-informed approach:

> It was a slow start with staff – we had to actually get to a point where we said – if you can't embrace this approach, then this may not be the best place for you to work… in their mind, they had always been raised with punishment and if you don't punish a kid he's not going to learn the lesson. We kept saying 'he is not learning the lesson, because he is deactivating the part of his brain that helps him to really learn'… there are some staff that really couldn't make that connection easily – so we spent a lot of time in training in really helping them make that paradigm shift and really trying to understand that. We finally had to set a timeline that said if… this is not something that feels right for you, then we really need to look at finding you a new place to work. (R. Griffin, personal communication, April 11, 2017)

Dr. Jedd McKenzie emphasized that it requires patience to address ACEs in a community:

> One of the things I think I got from it [working at Children's Resilience Initiative] was that this is slow, slow work, and it takes a lot of time and it takes a lot of talking to people and it takes a lot of false starts… It's a challenge kind of getting people to the table to talk about these things – and things are slow, you know, it takes a long time to make things happen… trying to figure out when is the best time to do them, what are the best questions to ask, those kinds of things, you know, are kind of iterative sometimes – and so you do one thing and you realize, 'oh, that didn't really work,' and you do another thing and you change kind of incrementally… So people trying to work with teams here or teams of this program– how do we make those more accessible and generally complementary. (K. J. McKenzie, personal communication, April 20, 2017)

12) Identify Long Term Goals, Maintain Self-Care, and Celebrate Successes Along the Way

The Resilience Trumps ACEs Community Action Manual encourages groups to identify baseline measures early on in the process (Barila & Brown, 2013). It is important to identify measurable short-term, interim, and longer-term goals, since some outcomes take longer than others to be observed.

> When communities want to prevent ACEs they will generally either choose to focus on teens or they will choose to focus on little children. When you focus on the teens, you see outcomes more quickly, like dropping out of school - just because there are not as many years between the work you are doing and high school graduation. You can see those outcomes more rapidly. When communities focus on early childhood, they may have a better shot at reducing the total number of ACEs because they are in relationship with families for more years….but it takes longer to build the outcomes. And I think if you only focus on the early years you will not necessarily reduce the ACEs because a lot of the ACEs happen in children later – not all of them happen in the first three years. So, this issue of how can we conceptualize the focus of their work becomes really important. And if they could understand more about if we want to deliver some quick wins to get people really excited, then we have to strategically design early work in a way where at least some of the measurable kinds of things could reasonably occur within three or four years - but we don't want to limit our work to only that because we will not get the longer term, bigger outcomes we are aiming for. (L. Porter, personal communication, March 13, 2017)

Shifting to a trauma-informed approach across sectors in a community will take time, so once long-term goals are defined, it is important for partners of an ACEs Response to prioritize self-care along the way. Because working with people who have experienced ACEs can be draining and

overwhelming, it is essential to find balance when engaging in this work. Jim Sporleder said he struggled to maintain balance when he was working at Lincoln. Since most of his students had five or more ACEs, he recalled it was as if he was running a "trauma hospital" since he was always running from one crisis to the next. "Having to do everything kept my stress level really high, but I could bring it down real quick for the kids – but I carried a lot of stress," (J. Sporleder, personal communication, March 18, 2017).

It is also helpful to take time to celebrate stories of people who have used information about NEAR science to improve their lives. For example, in 2009, Ms. Bovent transitioned into permanent homeownership, and in 2013, she founded Hope Heals out of her home, a foundation that provides household donations to people who are transitioning out of homelessness to permanent housing. Since 2013, she has helped thousands of people with her foundation, and she was named a Community Hero by KAPP-KVEW local news station in 2016. "I just want people to know somebody cares. My hope is that I can touch one person each time I share my story," (KAPP-KVEW Local News, 2016). Stories like Ms. Bovent's build momentum and can help people recognize the value of developing a community-wide effort to address ACEs.

Figure V: **Venn Diagram of Level Lessons Learned from Key Informants**

The Minnesota ACEs Response

Champions across Minnesota have been working to address ACEs since the ACE Study was first released. During the decade after the release of the ACE Study, the information was "percolating" in communities and agencies across the state, but there was not a coordinated effort to address ACEs at the state level until closer to 2008. A brief timeline of the Minnesota ACEs Response is located in Appendix J; however, it is important to note that this timeline is limited in its scope since its primary focus is on the efforts that were happening at the State of Minnesota. Therefore, the timeline only captures a few of the *many* parallel efforts that were mobilizing a response to ACEs in communities across Minnesota at that time.

History of the Minnesota ACEs Response Pre-ACEs Legislation: 2008-2014

The Children's Mental Health and Family Services Collaboratives (referred to as 'Collaboratives' in this paper) were created by the Minnesota State Legislature in 1993 as entities that work with a multi-disciplinary team of children and youth-serving human services organizations and family members to address the needs of youth with complex problems through prevention and early intervention strategies (Minnesota Department of Human Services, 2017). The 90 Collaboratives have a clearly defined governance structure and are required to partner with specific agencies within the communities in which they operate. In the years leading up to 2008, the Collaboratives experienced significant cuts to their federal funding streams due to policy changes by the Bush Administration, which slowed their funding to "a trickle of federal money", recalled Dr. Glenace Edwall, who was Minnesota's Children's Mental Health Director at the time. She said that many Collaboratives had to scale back their activities, although few went out of existence because of the cutbacks (G. Edwall, personal communication, April 7, 2017).

Despite major cuts to funding, most Collaboratives sustained their governance authority, which Dr. Edwall believed to be a reflection of the strength and value of the local networks across the state. She said that Ann Boerth, State Coordinator for the Collaboratives, was "the shepherd through all of that change," (G. Edwall, personal communication, April 7, 2017). After the funding cuts, the Collaboratives narrowed their scope to focus on two priority areas; early childhood prevention and children's mental health. The Collaboratives wanted to know how they could incorporate both priority areas in a way that would have an impact on children's mental health (G. Edwall, personal communication, April 7, 2017). Ms. Boerth recognized that both priority areas could be addressed if Collaboratives framed their work around ACEs and resilience, so she began a campaign to spread the word to the Collaboratives about NEAR science (G. Edwall, personal communication, April 7, 2017).

Between 2008 and 2012, momentum to address ACEs began building across the state of Minnesota, and state agencies began focusing on ACEs, resilience, and prevention. Dr. Edwall remembered "there was increasing awareness of the ACE work itself, and I certainly credit Jane Kretzmann with bringing Rob Anda in several times to different sets of people so the message was beginning to percolate in the community through lots of different ways," (G. Edwall, personal communication, April 7, 2017). She believed that "pressure" from this widespread education about ACEs served as a catalyst for further action. She said that the commissioners of Minnesota Department of Human Services (DHS), Minnesota Department of Health, and Minnesota Department of Education all designated time for their staff to learn about ACEs and to collaborate between the departments to develop a more coordinated approach. The Governor's Children's Cabinet was also reformulating at the time and considered adopting ACEs as a priority for their work, which "generated a lot of learning" in the state (G. Edwall, personal communication, April 7, 2017).

Becky Dale, the Chief Operating Officer of Minnesota Communities Caring for Children (MCCC), recalled that prior to 2011, similar work around ACEs was emerging in separate places but the champions had not yet crossed paths at that time. She said Jane Kretzmann, a representative from Elders for Infants and the Project for Babies, Ms. Boerth, and Dr. Edwall were working to address ACEs in their spheres of influence at the state level, while MCCC was working to address ACEs at the community level (B. Dale, personal communication, April 17, 2017).

Around 2012, Dr. Edwall recalled that a newfound "discovery" of the value of prevention was also growing at the federal level which provided an opportunity for Minnesota to receive a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to improve the statewide coordination of prevention efforts across mental health, corrections, and special education agencies. In 2013, Anna Lynn, then a representative from DHS, was awarded a SAMHSA planning grant to help the state advance its coordination around ACEs. The SAMHSA grant created a Policy Delegation, comprised of six state agency representatives, who received technical assistance from the funder for the duration of the grant. The Policy Delegation went to Washington, D.C. for technical assistance. During the trip, the Policy Delegation decided to shift Minnesota's from early childhood to resilience in later childhood and early adolescence. When they returned home to Minnesota, Dr. Edwall spread the message across the state about the new priority towards resilience promotion in later childhood and early adolescence. At the same time, Ms. Lynn began thinking about strategies to build resilience from ACEs in the state by looking to Washington State for guidance.

In 2013, leaders from MCCC, DHS, United Way, the University of Minnesota, and additional community partners sought financial support, aided with funds from the SAMHSA grant, to purchase the Minnesota license for the *Understanding Adverse Childhood Experiences: Building Self-Healing Communities* curriculum (referred to as the 'ACE Interface curriculum' in this paper). In

February 2013, a core group of trainers from diverse backgrounds and geographic locations were trained to deliver the ACE Interface curriculum in Minnesota to spread the word about ACEs across the state. (Additional information about ACE Interface can be found in Appendix K.) "The goal was to keep getting the ACE message out everywhere, kind of with the understanding that each sector would then deal with it in the way that was appropriate to them," (G. Edwall, personal communication, April 7, 2017). These trainers were given the flexibility to customize the message for diverse audiences, while still rooting the presentations using foundational material that would create a consistent message and understanding across the state. Since 2013, over 130 presenters have been trained to present the curriculum – including 60 active trainers who have completed the full certification process.

In 2013, Ms. Lynn organized a Learning Community (referred to as the 'ACE Delegation' in this paper) to learn about the Washington State ACE Response. The ACE Delegation sought to identify who the main stakeholders were that needed to be at the table to mobilize the ACEs Response in Minnesota, and discussed what they could replicate from the Washington State ACEs Response. The ACE Delegation brought together approximately 18 representatives from the community, private, public agencies, and nonprofits who took a four day "Learning Journey" to Washington State in June 2013 to learn about the prevention efforts happening in Washington State (A. Lynn, personal communication, April 13, 2017). The Learning Journey sought to take lessons from Washington State and use them to inform the prevention work that was growing in Minnesota at that time. Ms. Boerth recalled that it seemed like a natural fit to connect the work of the Collaboratives with the Minnesota ACEs Response, similar to the work that Washington State had done through its Networks:

> This would make sense to connect them with Collaboratives where we didn't have to start from scratch. We already had networks that had been in place for about as long as

> Washington had been doing this work and the Collaboratives had already done some really exciting work around prevention and early intervention. So, this would be a natural way of taking the Collaboratives to the next level. Really energizing and infusing this work with what they had already been doing – hopefully it would even strengthen their networks and partnerships. (A. Boerth, personal communication, April 4, 2017)

Meanwhile, Dr. Edwall and Ms. Kretzmann (referred to as the "ultimate tag team" by Dr. Edwall) were strategizing about how to spread the word about ACEs more intentionally across the state with policy makers, educators, and funders. Dr. Edwall was able to bring the right state players to the table, and Ms. Kretzmann, with a background working for foundations and the University of Minnesota, was able to engage stakeholders from the private and education sector. Together, they organized educational sessions about ACEs with legislators and state agencies. Ms. Kretzmann invited Dr. Anda back to Minnesota to educate both parties of the state legislature about ACEs to "make sure they all got the same message" (G. Edwall, personal communication, April 7, 2017). Ms. Kretzmann noted they were planting seeds in the legislature and state agencies, and although there was redundancy in the messaging - it was strategic (J. Kretzmann, personal communication, April 7, 2017). Dr. Edwall and Ms. Kretzmann coordinated a series of lectures at the state level, and requested the attendance of staff from all of the child-serving programs in the state agencies, so they could learn together about ACEs. They trained staff from the Minnesota agencies including the Department of Education, the Department of Health, the Department of Corrections, the Department of Public Safety, DHS, and whoever else that expressed interest. These lectures provided a "touch point for shared language and common understanding" across the state agencies. Dr. Edwall shared:

> What we need is a common framework that uses the expertise of the University, brings it into the state departments, and then we have this natural flow that goes back and forth, and helps us create a framework that incorporates ACE but is bigger than ACEs – that's really the developmental lens…that has been my personal message, and if there is any one thing that I would hope I left as a legacy to this work, it is that everybody who touches kids and families needs to have this larger developmental understanding. (G. Edwall, personal communication, April 7, 2017)

Ms. Kretzmann stated that she was determined at this time to bring in diverse stakeholders, including Native American and African American families. She said, "I realized if we don't get the information into the hands of the people most affected by it – that's a big mistake," (J. Kretzmann, personal communication, April 7, 2017).

In 2014, the Trauma Informed Social Innovation Lab was held, which brought people working to address ACEs together to align their networks. Kate Bailey, Development Director of MCCC, remembered that it felt like "a real pulling together" at the time, (K. Bailey, personal communication, April 17, 2017).

History of the Minnesota ACEs Response Post-ACEs Legislation: 2015-2017

By 2015, there were a multitude of developments and groups that were working to address ACEs. Several Minnesota agencies, including the Department of Health and the University of Minnesota, began incorporating questions from the ACEs Questionnaire into their data tools. Some of the most noteworthy surveys that adopted ACE questions include the Minnesota BRFSS, the Minnesota Student Survey, and the University of Minnesota Boynton Student Survey (A. Boerth, personal communication, April 4, 2017). On March 12, 2015, Representative Rena Moran, who served on the Minnesota House of Representatives and worked for MCCC, pushed a resolution through the house that declared:

> The principles of brain development, the connection between mental and physical health, the concepts of toxic stress, adverse childhood experiences, buffering relationships, and the roles of early intervention and investment in children are important strategies for the well being of all Minnesota Children. (Policy Resolution Related to ACEs, 2015)

In May 2015, during the same legislative session that the ACEs resolution was heard, the Minnesota State Legislature approved ACEs legislation to allocate $726,000 from the governor's budget during the 2018-2019 fiscal year to the human services budget to:

> Provide training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma. (2016 Minnesota Statutes, Section 245.4889)

Ms. Boerth served as the primary author of the 2015 ACEs legislation. Due to a budget shortage, funding for the 2015 ACEs legislation from the governor's budget was deferred for distribution until July 2017. Tasked to implement the Minnesota ACEs legislation, she formed the ACEs Planning and Implementation Team (APIT) in summer 2016 to develop a plan for rolling out the legislative-funded ACEs training and related activities to the Collaboratives. Once funding becomes available, the Collaboratives will be the primary recipients of the ACEs training funded through this legislation. APIT is comprised of representatives from DHS, MCCC, and other advocates who are committed to mitigating the negative effects of ACEs in Minnesota. MCCC was selected, as a sole source contract, to deliver the ACEs training to the Collaboratives using the ACE Interface curriculum since they are the only entity in the state with approval to use the curriculum. In addition to educating the Collaborative communities about NEAR science, the ACEs legislation also provides technical assistance and funding for Collaborative communities to participate in community conversations and ongoing learning opportunities to generate continued interest in addressing ACEs. MCCC will also conduct train-the-trainer opportunities so representatives from Collaboratives can be trained to deliver the ACE Interface curriculum in their own communities. Once community cohorts have been trained, Collaboratives will develop community action plans that outline strategic approaches for addressing ACEs in their communities. After community action plans have been developed, Collaboratives will have the opportunity to submit proposals to the state to fund community resilience initiatives, which are pilot programs that Collaboratives can develop to "build community capacity (especially intensive training) among local child-serving agencies to provide trauma prevention and trauma-informed care," (2016-2017 Governor's Budget – Department of Human Services).

Early in 2016, Collaborative Coordinators decided to review the statewide collaborative priorities to reflect current and emerging needs in the state. Increasing efforts to introduce and integrate approaches informed by ACEs, resilience, and trauma provided further impetus to take another look at the priorities. The Collaboratives revised their statewide priorities in September 2016 which resulted in the *Minnesota Collaboratives Strategic Framework* listing the following statewide priorities to guide their future work:

- Promote mental health and well-being of children, youth and young adults
- Support healthy growth and social emotional development of children, youth and young adults
- Strengthen resilience and protective factors of families, schools and communities

In summer 2016, MCCC and DHS undertook their first joint project and planned the Midwest ACE Summit for November 2016. This is an annual event convening individuals from across the region to engage in deeper learning about ACEs. The keynote speakers included Dr. Roy Wade Jr., Sam Simmons, Dr. Henry Emmons, and Ms. Porter. The event:

> Brought people across the region together in shared learning that went beyond the Adverse Childhood Experiences (ACE) Study to focus on deeper issues of historical trauma and successful strategies for helping individuals and communities heal, build resiliency, and prevent future ACEs. (Minnesota Communities Caring for Children, 2017)

Ms. Dale and Kate Bailey believed that momentum is growing and noted that leadership supporting the Minnesota ACEs Response has also been continuing to expand (B. Dale, personal communication, April 17, 2017). Ms. Bailey agreed:

> My own awareness has expanded, but I feel like the number of organizations and agencies working on things that are around trauma-informed care has really grown. And just from our own work, we know that just our piece of the puzzle has reached thousands and thousands and thousands of Minnesotans, so it just feels like the knowledge base out there is there are just so many more people who are aware…I feel like constantly people are saying, there is so much bubbling up around this – I mean, it's felt like that for years, so I don't know how to quantify now the bubbling up versus then the bubbling up because it has always felt like momentum. (K. Bailey, personal communication, April 17, 2017)

Parallels between Minnesota & Washington ACEs Response

Reviewing the history of how Minnesota and Washington approached a response to ACEs through their Collaboratives/Networks provides context about the similarities and differences of the two states. This history provides context to inform how the recommendations and lessons learned in Washington State can be transferred to Minnesota, and which components may not be as easily replicated. Figure VI provides a comparison of the ACEs Responses in Minnesota and Washington.

Key Similarities

Although the Washington State ACEs Response and Minnesota ACEs Response are being carried out on different timelines and with different oversight and funding capacities, their longstanding Collaborative/Networks structures provide a valuable framework for mobilizing a coordinated, multi-sector response to ACEs at the community level. Champions of the Minnesota and Washington ACEs Response at the state level have worked to embed NEAR science into the work of the Collaboratives/Networks even before ACEs legislation was enacted. Washington State began working to address ACEs through the Networks in 2002, and Minnesota began using the ACE Interface curriculum to spread the word about ACEs in communities represented by Collaboratives in 2014.

In addition, both Washington State and Minnesota used their Collaboratives/Networks as mechanisms to deliver information about ACEs to communities across the state. Both states use customizable curriculums that have core focus areas, which allow the states to provide consistent messaging and a common language about NEAR science, while allowing flexibility to be receptive to the needs of diverse populations. In addition, both states made a commitment to ensure that local communities *drive* the development of their community-based ACEs response. Ms. Boerth recalled when she was developing the ACEs legislation in Minnesota she connected with Ms. Porter, who

reviewed the proposal. Ms. Boerth said, "It was very reaffirming to hear her say, 'I've seen many proposals, but this is just the one that reminds me most of what we did in Washington and it seems like it really has a chance of going somewhere.' So, that was really good to hear," (A. Boerth, personal communication, April 4, 2017)

Key Differences

Reflecting on the differences between the ACEs Responses in the two states, Washington State's ACEs Response is more mature than Minnesota's because it has more than a decade of history embedding information about NEAR science into its work through the Networks via the efforts of the Family Policy Council and APPI. Ms. Boerth said another difference between Minnesota and Washington is that Washington State invested more money to address ACEs than the state legislation in Minnesota (A. Boerth, personal communication, April 4, 2017). Ms. Boerth explained the Minnesota proposal is more modest than the funds the Family Policy Council received during the development of their ACEs Response and she hoped that a more modest proposal would lead to ongoing, sustainable funding (A. Boerth, personal communication, April 4, 2017). Dr. Edwall also noted the two states have also approached their work from different lenses; Washington State's work has been guided by more of a community health orientation and Minnesota's has come from a mental health perspective (G. Edwall, personal communication, April 7, 2017).

The Minnesota and Washington ACEs Legislation also have two distinct funding capacities and scopes. Washington State's HB 1965, which formed the APPI, provided funding to sustain pilot programs in five communities, and funded an in-depth evaluation of the Washington State ACEs Response through Mathematica Policy Research. Minnesota's ACEs Response, on the other hand, will provide training about NEAR science to many collaborative communities, and will then provide those communities with resources to develop community action plans to address ACEs. Reflecting on the differences, Ms. Dale remarked:

> One of the things that I personally struggle with is 'How do we not set ourselves up to have WA level results without WA level resources?' And everyone sees how well Washington did it – why can't you? …we need to make sure what we are saying we are doing to succeed is in line with the inputs we have to put into it. (B. Dale, personal communication, April 17, 2017)

The Minnesota ACEs Response that will be implemented through the ACEs legislation has flexibility built into its scope, yet it has specific objectives listed. The Washington State ACEs Response, which began closer to 2002, had a more flexible foundation.

> I think the fact that we had such a broad charge - our job was to reduce the rates of seven major social problems - and that was an impossible task, but the advantage of it was that it had enough breadth in the set of goals for us to continuously justify sort of a two-generation approach and this notion that we have to be in it for the long haul. Some of those key things that were important in that work happened because we had such a huge mission. (L. Porter, personal communication, March 13, 2017)

Ms. Kretzmann said, "Everyone envies Washington…we didn't have a Family Policy Council, but we did have the Collaboratives with Ann Boerth being a steady hand behind the scenes…You need people behind the scenes," (J. Kretzmann, personal communication, April 7, 2017). Ms. Lynn also believed that Minnesota could benefit by having a "statewide container that can help build and sustain capacity for this movement," (A. Lynn, personal communication, April 13, 2017). She said Minnesota needs a structure, similar to that of the Family Policy Council that can provide oversight in the state because Minnesota currently lacks capacity to play this role. She reflected about how the learning journey helped her realize the value of an oversight agency like the Family Policy Council in Washington State:

> Washington was saying – 'you let people know and they do great things' - in some cases that happens and in many cases it doesn't because they didn't have the capacity. They don't have the network. They don't have the resources. People get fired up! I've been meeting with local public health across the state and people are like, yeah, we have had a lot of ACE trainings - we had 200 people come to an ACE training, and then we had 50 people come to a planning meeting after that. And then no one was leading that. They don't have a staff person. They have a collaborative coordinator, but it is like a half-time person. You need people to organize a community and organizing takes a lot of work. And you just need layers of support for that. If public health wants to engage, they don't necessarily have the skills to be organizers. They need new skills. (A. Lynn, personal communication, April 13, 2017)

Figure VI: **Comparison of the Minnesota & Washington State ACEs Response through the Networks/Collaboratives**

Key Components	Minnesota	Washington
Structured/Interdisciplinary Groups Addressing Problems Affecting Children & Families	Collaboratives	Networks
Year Collaboratives/Networks Established	1993	1994
Number of Operating Networks/Collaboratives (as of 2017)	90	~20
Oversight Over Collaboratives/ Networks	Department of Human Services	Family Policy Council (1994-2012); ACEs Private-Public Initiative (2012-2017)
Year NEAR science became primary focus of Collaboratives/Networks	2016	2005
ACEs Legislation	Minnesota Statutes, Section 245.4889	Washington HB 1965
Year ACEs Legislation Enacted	2017	2011
Community-Driven Approach	Yes	Yes
Commitment to Expanded Leadership	Yes	Yes
Components of ACEs Responses through the Collaboratives/Networks	1. Training on NEAR to be offered to Collaborative Communities 2. Community Cohorts of NEAR trainers (using ACE Interface curriculum) will be developed 3. Supplemental Trainings will be offered to Collaborative communities based on interest/need 4. Community Action Plans will be developed 5. Collaboratives will propose/implement Community Resilience Projects	1. Networks communities are trained about NEAR 2. Community contracts were developed with Family Policy Council that identified measures and priorities of interest for each community 3. Community Action Plans were developed in Network communities 4. Community Resilience Projects were funded for five communities, after a competitive process by APPI 5. Mathematica Policy Research evaluated the effectiveness of the projects

Considerations for the Minnesota APIT & Collaborative Coordinators

This paper highlights the reflections of 15 key informants from Washington State and Minnesota who helped mobilize a response to ACEs in their respective areas of influence and communities. It provides a deeper dive into the foundational components and successes of the Walla Walla ACEs Response. It is important to be mindful that the lessons learned in Walla Walla are shaped by the unique community needs and context-specific factors of that place, such as the size of the city, geographic location, income distribution, racial and ethnic composition, and the political environment in Washington State. While many of the lessons learned can be transferred to other communities, this paper does not suggest that they will produce the same results in every community. Communities, like those connected with the Collaboratives in Minnesota, that seek to reduce their ACEs and build their community resilience should not only consider their community context and community challenges, but should also take inventory of their community assets and protective factors as they undertake the development of their own ACEs Responses.

Walla Walla's lessons for Minnesota affirm the need to build capacity by strengthening competencies, leadership, and organization. This case study of Walla Walla only offers a glimpse into the many organic, trauma-informed activities that have occurred in that community; therefore, its scope is limited. Informed by the lessons learned from Washington State, the Minnesota ACEs Response can use targeted and diverse communication methods in a variety of medium at the state and community level. This approach will allow for multiple exposures of NEAR science, which will help attract legislative and community champions to this effort, and will ensure the information can resonate with a greater diversity of stakeholders. At the state level, the APIT can identify and cultivate relationships with champions in the house, senate, governor's office, and the state agencies to garner support for the Minnesota ACEs Response. Building relationships with state leadership will increase the likelihood that the ACEs legislation will be sustained after the 2018-2019 fiscal year.

At the community level, the Collaborative Coordinators should work with their partners to spread information about NEAR science throughout the various sectors in their communities. In addition, Collaboratives should expand leadership to community members and parents most affected by ACEs to build community trust. By expanding leadership, an ACEs Response is more likely to be sustained when a strong champion in the community retires or no longer has capacity to lead.

Collaborative communities should also be intentional about diversifying funding streams as they build a local ACEs Response since the sustainability of even the most effective initiatives can be threatened at the state level due to political uncertainties. To ensure the community-driven process is honored and embedded at the state level with the APIT, and at the community level through the Collaboratives, community members should be consulted during the planning and implementation phases of the Minnesota ACEs Response, even when developing a logic model and theory of change for the effort. This consultation could be achieved through community cafés or listening sessions in Collaboratives' communities that have received training about NEAR science, which will help build trust between the Collaboratives' communities and the state. Appendix L provides links to additional resources and learnings that highlight trauma-informed initiatives across the country. These resources can be shared with all parents, community members, and practitioners working to address ACEs.

Creating trauma-informed communities is extremely urgent since people will continue to face dire health and social outcomes if individuals, communities, and systems do not adapt their approaches to become trauma-informed. Developing an ACEs Response is messy, requires patience, will take time to build, and will continually evolve in its scope and activities. Despite this, the solution is *simple*. Dr. Edwall shared that an ACEs Response basically requires a "**shift in mindset that leads to greater compassion**," which she believes is necessary for systems change (G. Edwall,

personal communication, May 18, 2017). This compassion should be applied in *all* organizational practices and individual interactions, not just adopted by human-serving organizations and caregivers, or targeted for those who have experienced a high number of ACEs. An ACEs Response challenges individuals and systems to embrace a trauma-informed paradigm shift that recognizes the impact of trauma, and acknowledges the need to change institutional practices and policies that are counterproductive, and that may even re-traumatize individuals who have experienced ACEs and historical trauma.

Given that most of us have experienced at least one ACE, it is likely that even those who have not been directly affected by ACEs have family members, work colleagues, and friends who have experienced ACEs. An ACEs Response can not only help prevent and reduce the transmission of ACEs to future generations, but it can also support individuals who have experienced ACEs, and can create opportunities for healing. All of us have a role to play in creating trauma-informed communities. As Ms. Barila stressed, "Everybody has a piece of this puzzle and we are not going to have it work if people are walking around with one piece of the puzzle. You need the whole puzzle built…it truly does take a community-wide response, including every single parent," to achieve an ACEs Response (T. Barila, personal communication, March 17, 2017).

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Appendix A: Glossary of Terms & Organizations

ACE Interface, LLC: a company, co-founded by Laura Porter and Dr. Rob Anda, that licenses the use of the *Understanding Adverse Childhood Experiences: Building Self-Healing Communities* curriculum http://www.aceinterface.com/

ACE Questionnaire: a tool with 10 questions that allows individuals to calculate and self-report their ACE Score (see ***Appendix B***: *Finding Your ACE Score*) https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf

ACE Score: the sum of the ACEs that an individual has been exposed to in childhood (see ***Appendix B***: *Finding Your ACE Score*) https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf

ACE Study: the seminal study by Felitti et al. (1998) that revealed that childhood exposure to abuse and household dysfunction is correlated with negative social and health outcomes later in adulthood https://www.cdc.gov/violenceprevention/acestudy/about.html

ACEs Legislation: any state legislation that explicitly makes a commitment to address adverse childhood experiences through statute http://aceresponse.org/give_your_support/Legislation_16_52_sb.htm

ACEs Planning & Implementation Team (APIT): a group of state and nonprofit leaders in Minnesota who are planning to deliver the ACEs trainings and subsequent phases to the Children's Mental Health and Family Services Collaboratives

ACEs Private-Public Initiative (APPI): A nongovernmental public-private partnership, created "to reduce adverse childhood experiences (ACEs) using research and evidence-based approaches to prevent and intervene in ACEs of children during their first five years of life," (Kagi, 2011). http://www.appi-wa.org/

Adverse Childhood Experiences (ACEs): the primary childhood risk factors that lead to chronic disease and negative social outcomes over an individual's life course including; emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, violent treatment towards mother, household substance abuse, household mental illness, parental separation or divorce, and having an incarcerated household member

Children's Mental Health and Family Services Collaboratives (Collaboratives): public entities in Minnesota that work with a multidisciplinary team of child- and youth-serving human services organizations and family members to address the needs of children and youth with complex problems through prevention and early intervention strategies https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/collaboratives/

Children's Resilience Initiative: a nonprofit agency founded in Walla Walla in 2009 to increase resilience and spread the word about ACEs and protective factors to community members experiencing ACEs https://www.resiliencetrumpsaces.org/

Collaborative Coordinator: a part-time, full-time, or contracted individual who leads the strategic work of a Collaborative (internal focus), and serves as the face and voice of the Collaborative in their community (external focus)

Collective Impact Approach: "requires a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and the presence of a backbone organization" (Hanleybrown, Kania, & Kramer, 2012, pg. 1)
https://ssir.org/articles/entry/channeling_change_making_collective_impact_work

Community Cohort: refers to a diverse group of 15 - 30 people from a community who can be trained with the *Understanding Adverse Childhood Experiences: Building Self-Healing Communities* curriculum and will be expected to share the training widely throughout the community; Phase II of the Minnesota ACEs legislation

Community Conversant in ACEs and Resilience: An idea generated by the Children's Resilience Initiative and other community leaders in Walla Walla that seeks to educate as many community members and community organizations as possible about NEAR science in order to create a strong local response to ACEs. The goal is to 'saturate' people - agency practitioners and families - with the information so they have a chance to get multiple exposures to the information.

Community Public Health and Safety Networks (Networks): 23 member, localized collaborative groups that were created in communities across Washington State to reduce youth violence and "at-risk" youth behaviors http://app.leg.wa.gov/rcw/default.aspx?cite=70.190.060

Family Policy Council: established by the Washington State Legislature in 1992 as 10-member council of public officials and a director to provide oversight to the Networks and serve as their lead fiscal agent https://www.youtube.com/watch?v=0d1Ambm4l-g

Friends of Children of Walla Walla (*Friends*): nonprofit mentoring agency in Walla Walla, Washington http://wallawallafriends.org/

Historical Trauma: describes "the cumulative and collective psychological and emotional injury sustained over a lifetime and across generations resulting from massive group trauma experiences" (Maria Yellow Horse Brave Heart, 2003, p. 288)

Hope Heals Foundation: a foundation that provides household donations to people who are transitioning out of homelessness to permanent housing
https://www.facebook.com/HopeHealsWallaWalla/

House Bill 1965 (HB 1965): known as the first ACEs legislation in the United States - enacted in 2011 by the Washington State legislature that discontinued funding for the Family Policy Council and created the ACEs Private-Public Initiative (State of Washington HB 1965, 2011-2012) http://app.leg.wa.gov/billsummary?BillNumber=1965&Year=2011

Jubilee Youth Ranch: a Christian boarding school located in Prescott, Washington, that serves young men ages 13-18 years who are struggling with behavior issues or academic performance http://schoolforboys.com/

Key Informants: individuals who have first-hand knowledge about a community or policy

Lincoln High School: an alternative high school in Walla Walla that adopted trauma-informed discipline practices http://www.wallawallalincolnhs.org/about-our-school/about-us

Minnesota Communities Caring for Children (MCCC): the nonprofit organization that holds the license to deliver the *Understanding Adverse Childhood Experiences: Building Self-Healing Communities* curriculum in Minnesota; the organization selected to deliver the ACEs training to the Collaboratives in Minnesota https://www.pcamn.org/

Minnesota Department of Human Services (DHS): provides services to Minnesotans in 87 counties and 11 tribes and **"**helps ensure that Minnesota seniors, people with disabilities, children and others meet their basic needs and have the opportunity to reach their full potential" (Minnesota Department of Human Services, 2016) https://mn.gov/dhs/

Minnesota Statutes, Section 245.4889: Minnesota's first legislation to explicitly target ACEs; approved funding from the governor's budget to the human services budget to provide "training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma" (2016 Minnesota Statutes, Section 245.4889) https://www.revisor.mn.gov/statutes/?id=245.4889

NEAR Science: An interdisciplinary approach to the study of trauma and stress; Neuroscience, Epigenetics, ACEs and Resilience http://www.healthygen.org/what-we-do/near-sciences

Network Coordinator: a part-time or full-time individual who managed the work of a Community Public Health and Safety Network in Washington State

***Paper Tigers*:** documentary released in 2015 highlighting the success that Lincoln experienced after implementing its new approach to discipline http://kpjrfilms.co/paper-tigers/

Purposive Sampling: a qualitative research methodology that uses "non-random ways of ensuring that particular categories of cases within a sampling universe are represented in the final sample of a project" (Robinson, 2014, pg. 7)**;** a strategy used to identify key informants for this paper

Protective Factors: internal and external qualities that "enable us to counter the risk factors that endanger our health" (Resilience Trumps ACEs website: *Resilience*, 2015) https://www.resiliencetrumpsaces.org/resilience-trumps-aces/resilience/protective-factors

Resilience: a type of protective factor that allows us to "develop the capacity to adapt in the face of challenges" (Resilience Trumps ACEs website: *Resilience*, 2015) https://www.resiliencetrumpsaces.org/resilience-trumps-aces/resilience

Resilience Trumps ACEs: a website developed by the Children's Resilience Initiative that provides educational materials, resources, and an online store that has parent and child-friendly tools that can be used to facilitate discussions and learning about ACEs and resilience https://www.resiliencetrumpsaces.org/

Revised Code of Washington (RCW) 70.190: established the 53 Community Public Health and Safety Networks in Washington State in 1994 http://app.leg.wa.gov/rcw/default.aspx?cite=70.190

Seven Major Social Problems – through the enactment of the VPA, Washington State prioritized addressing high school dropout, youth violence, out-of-home placement, child abuse and neglect, substance abuse, suicide rates, and teen pregnancy as the seven major social problems affecting children and youth and families http://www.wsipp.wa.gov/ReportFile/1205/Wsipp_A-Plan-for-Evaluating-Washington-States-Violence-Prevention-Act_Full-Report.pdf

Snowball Sampling: a qualitative methodology that "involves asking participants for recommendations of acquaintances who might qualify for participation," (Robinson, 2014, pg. 13); a strategy used in this paper to identify key informants

The Health Center: established on-site at Lincoln High School in Walla Walla, Washington, in 2008 to provide youth with primary medical care, behavioral health services such as counseling, anger management, crisis support, and referrals to case management and other community-based services https://thehealthcenterww.org/

Toxic Stress: referred to as "excessive or prolonged activation of stress response systems in the body and brain" (Center on the Developing Child, 2017) http://developingchild.harvard.edu/science/key-concepts/toxic-stress/

Trauma-Informed: in this paper, this term is used to refer to communities, organizations and individuals that take a ***trauma-informed approach***

Trauma-Informed Approach: "A program, organization, or system that is trauma-informed: *Realizes* the widespread impact of trauma and understands potential paths for recovery; *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and Seeks to actively resist *re-traumatization*" (SAMHSA, 2015) https://www.samhsa.gov/nctic/trauma-interventions

Understanding Adverse Childhood Experiences: Building Self-Healing Communities Curriculum: a curriculum, designed by Laura Porter and Dr. Rob Anda, which is called "a proven educational framework and strategy for rapidly disseminating information about the ACE study, along with neurobiology that explains why ACEs have so much effect in people's lives, and what we can all do to dramatically improve health and resilience for this and future generations" (ACE Interface, 2014)

Walla Walla ACEs Response: the trauma-informed community initiative that sought to mitigate the harmful effects caused by ACEs, reduce the incidence of ACEs, educate community members about ACEs, and introduce resilience strategies into the fabric of the local human-serving government, private, and nonprofit agencies to improve the health and well-being of the children, youth and families in the Walla Walla community

Walla Walla, Washington: a city located in eastern Washington State that is the focus of the case study in this paper because it developed a multi-sector, trauma-informed community initiative to address ACEs

Washington State Violence Prevention Act (VPA) – the VPA was enacted in 1994 to improve the seven major social problems affecting youth and their families http://www.wsipp.wa.gov/ReportFile/1205/Wsipp_A-Plan-for-Evaluating-Washington-States-Violence-Prevention-Act_Full-Report.pdf

Appendix B: Find Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…
Swear at you, insult you, put you down, or humiliate you? Or
Act in a way that made you afraid that you might be physically hurt?

If yes enter 1 _____

2. 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?

If yes enter 1 _____

3. Did an adult or person at least 5 years older than you 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?

If yes enter 1 _____

4. 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?

If yes enter 1 _____

5. 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?

If yes enter 1 _____

6. Were your parents ever separated or divorced?

If yes enter 1 _____

7. 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 at least a few minutes or threatened with a gun or knife?

If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

If yes enter 1 _____

10. Did a household member go to prison?

If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score[27]

[27] The language for ***Appendix B*** was pulled from the National Council of Juvenile and Family Court Judges. There are several iterations of the tool but this is a common version. Retrieved from http://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf

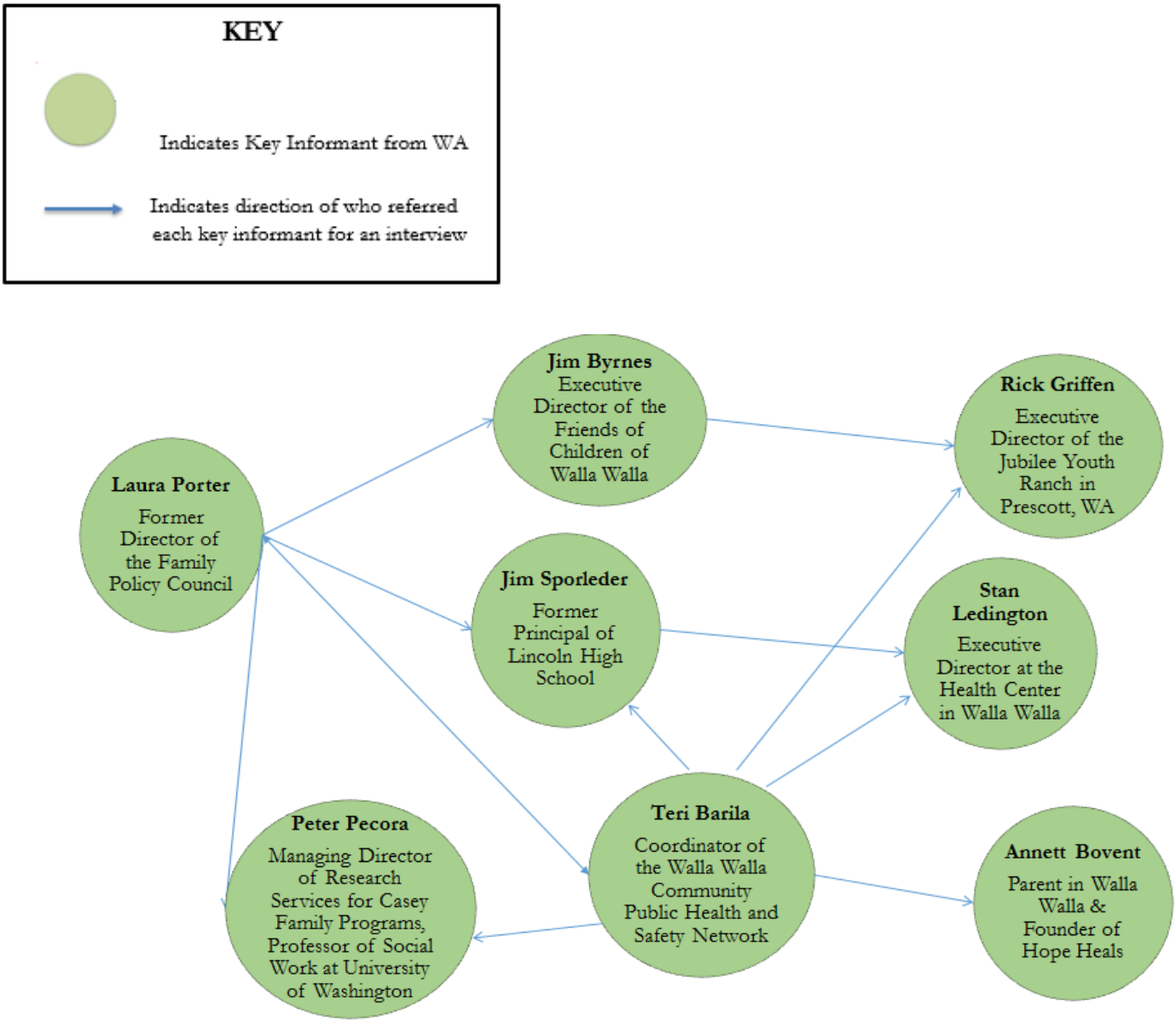
Appendix C: Methodology & Key Informant Recruitment Process

Using purposive methodology, I identified a list of over 30 potential key informants who had a connection to the Minnesota statewide ACEs legislation, the Washington State ACEs legislation, or the community-based ACEs Response in Walla Walla, Washington. Working from this initial list of key informants, I identified a key individual from Minnesota and a key individual from Washington State to interview for this paper. Ms. Boerth and Ms. Porter were selected as my initial key informants because they played similar roles in their respective states in providing guidance and oversight to their Collaboratives/Networks. Ms. Boerth currently oversees the 90 Collaboratives in Minnesota and Ms. Porter coordinated the 53 Networks in her role as the Director of the Family Policy Council. Both the Collaboratives and the Networks were formed to address complex needs that children and youth were experiencing, such as youth violence.

Nine key informants provided insight about the Washington State ACEs Response. The first person I interviewed was Laura Porter, the former director of the Family Policy Council, who was closely connected with the ACEs legislation in Washington State. Based on referrals from Ms. Porter, I connected with eight additional key informants who were involved in the effort to reduce ACEs and build resilience in Washington State. Ms. Porter then recommended that I connect with Ms. Barila, Walla Walla Network Coordinator, to gain insight about the ACEs Response in Walla Walla. From there, I connected with Mr. Byrnes, executive director for a mentoring nonprofit called Friends of Children of Walla Walla. Based on a referral from Ms. Barila, I also connected with Mr. Sporleder, the former principal of the Lincoln High School in Walla Walla, and Ms. Bovent, a parent from Walla Walla. Mr. Sporleder referred me to Mr. Griffin, the executive director at the Jubilee Youth Ranch and encouraged me to connect with someone from The Health Center in Walla Walla, so I reached out to Dr. Ledington, the executive director at The Health Center. Several key informants also recommended that I speak with Dr. Pecora, the Managing Director of Research

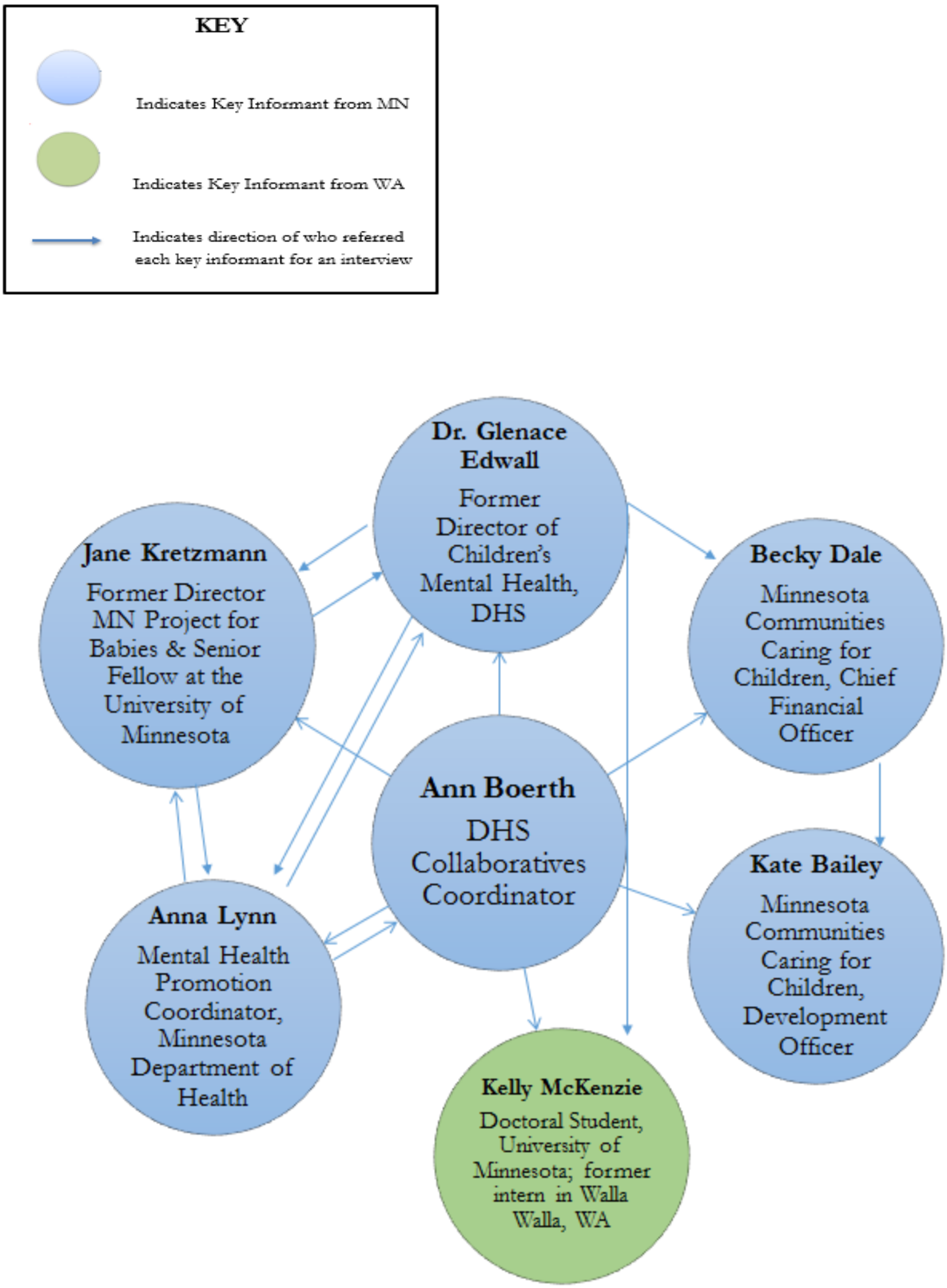
Services for Casey Family Programs and professor for the University of Washington, School of Social Work, who was a member of the ACE Private-Public Partnership Initiative at the state. The ninth Washington State interviewee was identified by a key informant from Minnesota. Figure VII shows the referral process for recruiting key informants in Washington.

***Figure VII*: Washington Key Informant Recruitment Process**



A total of five key informants were recruited from Minnesota who provided context and background about the development of the Minnesota ACEs response. Ms. Boerth, the representative from DHS and primary author of the ACEs legislation, was the first person I interviewed in Minnesota. She referred me to Dr. Jedd McKenzie, a University of Minnesota doctoral student who previously worked for the Community Resilience Initiative in Walla Walla, Washington. She also referred me to Ms. Kretzmann, a Senior Fellow at the University of Minnesota, and the former director of the Project for Babies. Ms. Boerth also connected me with Dr. Edwall, the former Children's Mental Health Director from DHS. Ms. Boerth, Ms. Kretzmann, and Dr. Edwall all encouraged me to connect with Ms. Lynn, who is currently on staff at the Minnesota Department of Health, but who had formerly been engaged in prevention work at DHS. Ms. Boerth also encouraged me to connect with Ms. Dale, Chief Operating Officer at MCCC. Ms. Dale then referred me to Ms. Bailey, Development Director at MCCC, who was also involved in developing the ACEs legislation in Minnesota. Figure VIII shows the referral process for recruiting key informants in Minnesota.

Figure VIII: **Minnesota Key Informant Recruitment Process**



Appendix D: List of Key Informants

Kate Bailey: Development Director of Minnesota Communities Caring for Children

Teri Barila: Began working as the Walla Walla Network Coordinator in 1997 and became the Co-Founder of Children's Resilience Initiative in 2009

Ann Boerth: Collaborative Policy & Program Consultant; Provides technical assistance to the 90 Children's Mental Health and Family Services Collaboratives in Minnesota[28]

Annett Bovent: Parent who shifted her parenting practices after learning about NEAR science; Named a Community Hero by KAPP-KVEW local news station in 2016; Founded Hope Heals, an organization that provides resources to families moving out of homelessness[29]

Jim Byrnes: Executive Director of Friends of Children of Walla Walla, a mentoring nonprofit[30]

Becky Dale: Chief Operations Officers of Minnesota Communities Caring for Children; Oversees ACE Interface training curriculum implementation[31]

Dr. Glenace Edwall: Retired Children's Mental Health Director[32]

Rick Griffin: Executive Director at Jubilee Leadership Academy and Jubilee Youth Ranch[33]

Jane Kretzmann: Senior Fellow at the University of Minnesota; Former Director of the Project for Babies; Representative from Elders for Infants[34]

Dr. Stan Ledington: Executive Director of The Health Center in Walla Walla; Founding Board Member of The Health Center in 2008[35]

Anna Lynn: Mental Health Promotion Coordinator at the Minnesota Department of Health; Former Department of Human Services staff member who submitted the SAMHSA grant that created the Policy Delegation and the ACE Delegation; Organized a Learning Journey to Washington State to learn how Minnesota could replicate some of the work of the Family Policy Council and Networks[36]

Dr. Kelly Jedd McKenzie: Former Intern with the Children's Resilience Initiative in Walla Walla, Washington, from 2010-2011; Received her Ph.D. in Developmental Psychology from the University of Minnesota in 2017[37]

Dr. Peter Pecora: Co-Chair of the ACEs Private-Public Partnership; Managing Director of Research Services for Casey Family Programs; Professor for the University of Washington School of Social Work[38]

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[28] A. Boerth, personal communication, April 4, 2017
[29] Jim Sporleder bio https://www.resiliencetrumpsaces.org/we-are-cri/our-team/jim-sporleder
[30] J. Byrnes, personal communication, March 17, 2017
[31] Becky Dale bio http://www.pcamn.org/staff/
[32] Glenace Edwall bio http://www.nashp.org/glenace-edwall-932/
[33] Rick Griffin blog http://www.acesconnection.com/blog/beyond-paper-tigers
[34] Jane Kretzmann bio https://cehdvision2020.umn.edu/authors/jane-kretzmann/
[35] Stan Ledington bio https://thehealthcenterww.org/new-exec-director/
[36] Anna Lynn bio http://www.health.state.mn.us/divs/cfh/topic/mentalhealth/contact.cfm
[37] Dr. Kelly Jedd McKenzie bio http://www.cehd.umn.edu/icd/people/gradstudents/jedd.html
[38] Peter Pecora bio https://socialwork.uw.edu/faculty/professors/peter-j-pecora

Laura Porter: Former Director of the Family Policy Council from 1998-2013; Co-Founder of ACE Interface, LLC, the entity that developed the curriculum founded in NEAR science that Minnesota Communities Caring for Children in Minnesota has held the license for since 2013; Senior Director of The Learning Institute at the Foundation for Healthy Generations [39]

Jim Sporleder: Retired Principal who was responsible for shifting to the trauma-informed model at Lincoln High School in Walla Walla, WA; Currently serves as a trauma-informed coach, consultant, keynote speaker, and a trainer with the Children's Resilience Initiative

[39] Laura Porter bio http://www.aceinterface.com/Laura_Porter.html

Appendix E: Washington State Key Informant Protocol

1. In what capacity did you/have you supported the ACEs response in Washington State?

2. When did you begin working towards ACEs reduction in Washington State?

3. What was the political landscape/environment during the time that you were supporting this work? Was political buy-in from Washington State legislature crucial to the success of the initiative?

4. What ACEs-related social problems were you/are you most interested in changing? What did you hope to achieve through your work?

5. What type of leadership was supporting the ACEs initiative?

6. How did individuals/agencies maximize collaboration and minimize "turf wars" when working towards reducing ACEs?

7. How did the Networks engage communities as they worked to reduce ACEs?
   Probes:
   - Through charismatic outreach/leadership? A structured approach?

8. What indicators did you select to measure and why? How did you collect the data? How did you measure success?
   Probes:
   - In the short-term, interim, long-term?
   - What was the most helpful to collect?
   - What was a waste of time to collect? What was resource-intensive?
   - What changes in public health indicators were you tracking?
   - Where did you get the data from? Internal or external systems?
   - Greater leadership around ACEs in your community?
   - Increased public awareness about the issue?
   - The development of additional policies that focus on reducing ACEs?

9. Did these local data/trends shape the focus of your ACEs response? Were there other factors that influenced which ACE indicators to address (political, feasibility, etc.)?

10. How did the political landscape hurt or help the movement of the ACEs response in Washington State?

11. Did you experience success working on the ACEs Reduction initiative in Washington State? If so, what did that success look like and what "key ingredients" contributed to that success?
    Probe:
    - How were community resources successfully leveraged?

12. Why were some of the Networks not as successful as others in their ACEs response from a policy perspective?

13. What challenges and/or lessons did you learn when working toward reducing ACEs in Washington? What were some of the main challenges for the networks?

14. In what ways could the work coordinated by the Network in your community or at the Washington State level been enhanced?
    ***Probes*:**
    - Was there need for stronger leadership
    - Communication?
    - Funding?
    - Organizational capacity?

15. Can you talk about funding and its sustainability over time for your Network?

16. What lessons should we pass on to other initiatives who re attempting to reduce the incidence and spread of ACEs in their own communities? What recommendations do you have for other groups, such as the Minnesota Collaboratives, who are working on their own response to ACEs?

17. Are there aspects of the ACEs response in Washington that couldn't easily be replicated? If so, what are they?
    Probes:
    - Political environment?
    - Leadership?
    - Funding streams?

Appendix F: Walla Walla Key Informant Protocol

1. What was your role in the ACEs reduction work in Walla Walla?

2. When did you begin working towards ACEs reduction in Walla Walla?

3. What specific ACEs-related issues was/is your community experiencing?

4. What specific social problems did you seek to address through your work?

5. In what ways did you engage the community and/or expand leadership of the work of the Network in Walla Walla?

6. When, if ever, did you realize/notice that community-level indicators were changing/improving as a result of the work within your community network?
   Probe:
   - What revealed that the indicators were changing?

7. How did individuals/agencies maximize collaboration and minimize "turf wars" when working towards reducing ACEs?

8. Did you experience success working on the ACE Reduction initiative in Walla Walla? If so, what did that success look like and what "key ingredients" contributed to that success?
   Probe:
   - How were community resources successfully leveraged?

9. What challenges and/or lessons did you learn when working toward reducing ACEs in Walla Walla? What were some of the main challenges for your community?

10. In what ways could the work coordinated by your community or agency been enhanced?
    ***Probes*:**
    - Was there need for stronger leadership
    - Communication?
    - Funding?
    - Organizational capacity?

11. What lessons should we pass on to other initiatives who re attempting to reduce the incidence and spread of ACEs in their own communities? What recommendations do you have for other groups, such as the Minnesota Collaboratives, who are working on their own response to ACEs?

12. Are there aspects of the ACEs response in Walla Walla that couldn't easily be replicated? If so, what are they?
    Probes:
    - Political environment?
    - Leadership?
    - Funding streams?

Appendix G: Minnesota State Key Informant Protocol

1. How did ACEs legislation get mobilized and passed in Minnesota?

2. What was your role?

3. Who else was involved?

4. Was there a political party that was particularly vocal a strong advocate or was this a bipartisan issue?

5. Was there opposition? If so, what were the main reasons?

6. Was it modeled after another place (Washington? Other inspirations)? How did the proposed ACEs legislation reflect/differ from the Washington State legislation?

7. Other key informants I should interview?

Appendix H: Timeline of the Washington State ACEs Response

Timeline	ACEs Response
1989-1993	Leaders in the Washington State government — including elected, appointed, and state officials — discussed strategies to improve health for children and families; 50 focus groups were held around the state to discuss aspects and approaches to transform health in the state[i]; Family Policy Council (FPC) was codified by RCW 70.190 to improve health services, with a focus on children and families[ii]
1994-1998	The ACE study is conducted in conjunction with Kaiser Permanente and the CDC
1994	The Washington State Legislature passed E2SHB 2319 Washington State Violence Prevention Act (VPA) to reduce the rate of violence — particularly youth violence — in the state; The RCW 70.190.050 Community Public Health and Safety Networks (Networks) were created to achieve measurable, cost effective reductions in the seven major problem areas affecting youth and families including: violent crime, dropping out of school, teen substance abuse, child abuse or neglect, teen pregnancy, domestic violence, teen suicide, out-of-home placements; The FPC was designated to provide oversight over the Networks; The Washington State Institute for Public Policy (WISPP) was written into the VPA to provide an evaluation framework plan to monitor the effectiveness of the Networks in addressing the seven major problem areas[iiiivv]
1995	The FPC was allotted $5.2 million/year from Washington State General Funds to support the planning and development of the Networks; 53 Networks received funding, including 10 tribal Networks; WISPP designed an evaluation plan to assess the effectiveness of Networks[vi]
1996	The FPC was allotted $5.2 million/year from Washington State General Funds to support the planning and development of the Networks; 53 Networks received funding; Networks developed proposals to address at least three of the seven major problem areas, based on their unique community needs[vii]
1997	The FPC was allotted $5.2 million/year from Washington State General Funds to support the planning and development of the Networks; 53 Networks received funding; Networks proposed strategies to reduce the identified social problems in their communities; 52 of the 53 Networks submitted proposals that targeted at least three of the seven major social problem areas that were identified in the VPA; Grants from the FPC to the Networks ranged from $45,000 to $221,000 [viii]
1998	Laura Porter was appointed Director of the FPC; The FPC was allotted $5.2 million/year from Washington State General Funds to support the planning and development of the Networks; 53 Networks received funding; Grants from the FPC to the Networks ranged from $45,000 to $221,000; Networks implemented their proposed strategies; the state began measuring community capacity of the Networks; there were investments in basic research to understand causal links, healing, and community capacity measures[ix]
1999	The FPC was allotted $4.4 million/year from Washington State and Federal Combined Funds; 53 Networks received funding; Grants from the FPC to the Networks ranged from $45,000 to $221,000; to support the planning and development of the Networks; A tool was used to assess if community capacity of the Networks was improving[x]
2000	The FPC was allotted $4.4 million/year from Washington State and Federal Combined Funds; 53 Networks received funding; Grants from the FPC to the Networks ranged from $45,000 to

	$221,000; Networks proposed tangible pilot projects to address the identified social problems they were working to reduce in their communities[xi]
2001	Due to funding cuts, the FPC was only allotted $3.3 million from Washington State and the FPC had to defund several networks and only 36 continued to receive funding[xiixiii]
2002-2004	The FPC made ACEs a priority focus area for the Networks in 2002; The FPC was allotted $3.3 million/year from Washington State; 36 Networks received funding
2005	The FPC was allotted $3.3 million/year from Washington State; 36 Networks received funding; 40 practitioners were trained by the FPC to present about ACEs and more than 5000 people were trained over the next three years;
2006	The FPC was allotted $3.3 million from Washington State; 39 Networks received funding
2007	The FPC was allotted $2.9 million from Washington State; 39 Networks received funding from the FPC; FPC staff began working with tribal groups and embedded historical trauma as a focus in the training about ACEs and resilience; A Severity Index was used to understand where ACEs occur at high rates in communities across the state[xiv]
2008	The FPC was allotted $2.9 million from Washington State; 39 Networks were funded; An evaluation of Community Capacity revealed that Networks helped reduce the seven major social problems, even in communities that had a higher rate of the problems than the state average[xv]
2009	The FPC was allotted $2.9 million from Washington State; 39 Networks received funding from the FPC; Analysis on projected caseload savings was published by the FPC which indicated that there are approximately $7 saved in caseload spending per $1 of state funding invested in the Networks – – these savings were estimated at $56 million between 2009-2011- and projected a long term savings of $296 million over time; ACE questions were added to the Washington State Behavioral Risk Factor Surveillance System (BRFSS); the FPC began partnering with the Bill & Melinda Gates Foundation; the FPC developed the Community Capacity Development Model[xvi]
2010	The FPC was allotted $1.4 million from Washington State; 39 Networks received funding from the FPC; Washington ACEs data becomes available through the BRFSS from elementary schools, high schools, juvenile courts, and the trends prompt additional conversations in state[xvii]
2011	The FPC was allotted $1.4 million from Washington State; 42 Networks received funding from the FPC; House Bill 1965 is passed with bipartisan support, which discontinued the FPC in 2012, but kept the Networks in place; the ACE Public-Private Partnership was developed to carry on the ACE Reduction Efforts in WA[xviii]
2012	Funding for the FPC was discontinued and the APPI was formed; Networks lost funding and only 18 of the 42 remaining networks were able to continue their work with alternative funds; APPI granted 3-year grants to 5 communities (Wenatchee, Okanogan, Sakgit, Walla Walla, Whatcom)
2013-2016	APPI received funding from the Washington State Legislature to conduct a retrospective evaluation on the 5 sites in partnership with Mathematica Policy Research; Mathematica Policy Research, in conjunction with Community Science, assessed the community capacity of the 5 networks; Resilience Collective Community Capacity (ARC3) Survey was developed[xix]
2017	APPI announced that it will sunset at the end of 2017

Appendix I: Timeline of the Walla Walla, Washington ACEs Response

1994	The Walla Walla Community Network was established through the E2SHB 2319 Washington State Violence Prevention Act (VPA) to reduce the child abuse and neglect rate, the domestic violence rate, the youth violence rate, school dropout rate, and out-of-home placement rate in its community[xx]; ACE study is conducted in conjunction with Kaiser Permanente and the CDC (1994-1998)[xxi]
1995-1996	The Walla Walla Network began developing a strategic vision for its work; the Jubilee Youth Ranch is established in 1995[xxii]
1997	Teri Barila was hired as the Walla Walla Network Coordinator; The Walla Walla Network was awarded $79,300 from the Family Policy Council (FPC) to fund community-based initiatives to reduce youth risk-factors in the Walla Walla community[xxiii]
1998-2006	Teri Barila began building partnerships to address youth risk-factors in the community[xxiv]; Friends of Children of Walla Walla (a mentoring nonprofit) was founded in 1999[xxv]
2007	Teri Barila attended a statewide Network conference and learned about ACEs from Dr. Rob Anda, who was the co-principal investigator of the ACE Study[xxvi]; Jim Sporleder transferred to Lincoln High School to serve as the administrator[xxvii]
2008	Teri Barila invited Dr. Rob Anda to educate 168 Walla Walla community members and practitioners about the ACE Study at the local community college[xxviii]; Annett Bovent attended the conference and addressed the audience about her experience with ACEs[xxix]; The Health Center established a site at Lincoln High School[xxx]
2009	Children's Resilience Initiative was founded by Teri Barila and Mark Brown to increase resilience and spread the word about ACEs in Walla Walla; Teri Barila received a planning grant of $40,000 from a local foundation to spread the word about ACEs and to enhance the Walla Walla ACEs Response[xxxi]; Jubilee Youth Ranch staff are trained about ACEs[xxxii]
2010-2011	Jim Sporleder attended the Hope to Resilience Conference in 2010 and was transformed by John Medina's message and decided to change his approach to discipline at Lincoln High School[xxxiii]; Dr. Kelly Jedd McKenzie works as an intern at the Children's Resilience Initiative and collected surveys about community awareness of ACEs in Walla Walla[xxxiv]
2012	Funding for the FPC was discontinued and the APPI was formed; the majority of the Networks lost funding and only 18 of the 42 remaining networks were able to continue their work with alternative funds; Walla Walla received a 3-year grant from APPI since it was selected as one of five communities to participate in the Mathematica Policy Research evaluation[xxxv]; the Walla Walla County Board of Commissioners implemented a 0.1% sales tax in January 2012 to expand mental health and chemical health services in Walla Walla County[xxxvi]
2013-2015	APPI conducted a retrospective evaluation of Walla Walla and 4 other sites across the state; Mathematica Policy Research revealed that by 2014, approximately 42% of Walla Walla residents were at least somewhat familiar with ACEs[xxxvii]; Jubilee Youth Ranch adopts a trauma-informed approach in 2014; Jim Byrnes becomes Executive Director of *Friends* in 2015[xxxviii]; *Paper Tigers* documentary is released in 2015, highlighting *Lincoln's* trauma-informed discipline practices[xxxix]
2016	Mathematica & Community Science assess community capacity of Walla Walla + 4 other networks[xl]

Appendix J: Timeline of the Minnesota ACEs response

1993	Children's Mental Health and Family Services Collaboratives (Collaboratives) were established by the Minnesota State Legislature[xli]
1994-2007	The Collaboratives built their community partnerships and developed their strategic focus; the Collaboratives received steady federal funds until the George W. Bush Administration significantly cut federal dollars that were sustaining the work of the Collaboratives[xlii]
2008-2011	Funding cuts by the Bush Administration partly led Collaboratives to narrow their focus to two priorities: early childhood prevention and children's mental health[xliii]; momentum to address ACEs began building across the state of Minnesota[xliv]; the Governor's Children's Cabinet was also reformulating at the time and considered adopting ACEs as a priority for their work[xlv]
2012	A newfound "discovery" of the value of prevention was also growing at the federal level and Minnesota received a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to improve the statewide coordination of prevention efforts across mental health, corrections, and special education agencies[xlvi]
2013	First ACE Interface cohort of presenters trained; Anna Lynn received a SAMHSA planning grant and formed a Policy Delegation of 6 state representatives to coordinate work around ACEs in Minnesota; Anna Lynn organized an ACE Delegation of 15 representatives from the community, private, public agencies, and nonprofits who took a "Learning Journey" to Washington State together[xlvii]
2014	The Trauma Informed Social Innovation Lab was held, which funded a collaborative project to bring as many people as they could connect with together to align networks that were working to address ACEs[xlviii]; ACE Interface curriculum is adopted by MCCC
2015	March 12, 2015, Representative Rena Moran moved a resolution about the value of the trauma-informed approach through the Minnesota House of Representatives[xlix]; the Minnesota State Legislature approved Minnesota Statutes, Section 245.4889 which committed $726,000 from the governor's budget to the human services budget 2018-2019 fiscal year to address ACEs across the state of Minnesota[l]
2016	The ACEs Planning and Implementation Team (APIT) was formed to develop a plan for rolling out the legislative-funded ACEs initiative to the Collaboratives; Minnesota hosted the Midwest ACE Summit
2017	Minnesota ACEs legislation is set for funding starting July 1, 2017

Appendix K: ACE Interface Curriculum Details

The ACE Interface *Understanding Adverse Childhood Experiences: Building Self-Healing Communities* curriculum provides a customizable, comprehensive training that has been vetted by national content experts. The ACE Interface curriculum, designed by Ms. Porter and Dr. Anda, is called "a proven educational framework and strategy for rapidly disseminating information about the ACE study, along with neurobiology that explains why ACEs have so much effect in people's lives, and what we can all do to dramatically improve health and resilience for this and future generations" (ACE Interface, 2014).

ACE Interface only allows one sponsoring organization in Minnesota to oversee the development and delivery of the Master Trainer Education Package. MCCC is the one organization in Minnesota qualified to offer the highly specialized, intensive training courses that contain all the necessary components for a uniform, statewide approach, to spreading the word about NEAR science. MCCC is a nonprofit organization with a strong commitment and history of working to reduce the harm of ACEs in communities across Minnesota. MCCC maintains a network of presenters who represent diverse cultures, regions and sectors of the state. It also conducts community cafés and circles of parents, has regional directors placed across the state to help coordinate the training, and has existing community relationships, which made it the natural fit for the ACE Interface license.

To become a certified trainer of the ACE Interface *Understanding Adverse Childhood Experiences: Building Self-Healing Communities* curriculum, individuals attend a two day train-the-trainer training and complete several additional steps to receive certification to train others using the curriculum. Once certified, they receive technical assistance and support from MCCC as needed, and access to a network of certified Minnesota trainers.

Appendix L: Additional Resources

Publications

- **Advancing the measurement of collective community capacity to address adverse childhood experiences and resilience**

Citation: Hargreaves, M. B., Verbitsky-Savitz, N., Coffee-Borden, B., Perreras, L., White, C. R., Pecora, P. J., ... & Hunter, R. (2017). Advancing the measurement of collective community capacity to address adverse childhood experiences and resilience. *Children and Youth Services Review*, *76*, 142-153. http://www.sciencedirect.com/science/article/pii/S0190740917301664

- **Projected cost savings due to caseloads avoided: Technical notes.**

Citation: Schueler, V., Goldstine-Cole, K., & Longhi, D. (2009). Projected cost savings due to caseloads avoided: Technical notes. Washington State Family Policy Council. https://www.digitalarchives.wa.gov/do/DFDCC0A9E76F9B876E95F928303C9A59.pdf

- **Reducing adverse childhood experiences (ACE) by building community capacity: A summary of Washington Family Policy Council research findings**

Citation: Hall, J., Porter, L., Longhi, D., Becker-Green, J., & Dreyfus, S. (2012). Reducing adverse childhood experiences (ACE) by building community capacity: A summary of Washington Family Policy Council research findings. *Journal of prevention & intervention in the community*, *40*(4), 325-334. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3483862/pdf/wpic40_325.pdf

- **Self-Healing Communities: A Transformational Process Model for Improving Intergenerational Health**

Citation: Porter, L., Martin, K. & Anda, R. (2016). Self-Healing Communities: A Transformational Process Model for Improving Intergenerational Health. The Robert Wood Johnson Foundation. http://www.rwjf.org/en/library/research/2016/06/self-healing-communities.html

Blogs & Infographics

- **2016: Building on Scaffolds of Hope and Strength, MARC**
  http://marc.healthfederation.org/washington/update/2016-building-scaffolds-hope-and-strength

- **Robert Wood Johnson Foundation**
  http://www.rwjf.org/en/library/infographics/the-truth-about-aces.html

- **Walla Walla: Collective Action and Data Drive Trauma-Informed Change, SAMHSA**
  https://blog.samhsa.gov/2016/08/25/walla-walla-collective-action-and-data-drive-trauma-informed-change/#.WUBB6uvytpg

Toolkits & Workbooks

- **Overcoming a Difficult Childhood workbook**

Ms. Bovent strongly recommended the Overcoming a Difficult Childhood workbook, which is a faith-based lesson book and study guide developed by David M. Lockridge. She said the manual was a user-friendly resource that she found very helpful as a parent.
http://www.aceovercomers.com/product-store.html

- **Resilience Trumps ACEs Community Action Manual**

Ms. Barila recommended this resource to help individuals learn strategies and lessons to "reduce ACEs and foster Resilience in your community" (T. Barila, personal communication, March 17, 2017). The Children's Resilience Initiative, which developed the Resilience Trumps ACEs Community Action Manual, described it as a "guide to community action," (Resilience Trumps ACEs website: Presentations, 2015). This $25 manual provides user-friendly strategies and lessons learned during the development of the Walla Walla ACEs Response (Barila & Brown, 2013).
https://shop.opendoorcommerce.com/resiliencetrumpsaces/teaching-tools/378-resilience-trumps-aces-community-action-manual.html

Websites

- **ACES Connection Network**

Per the website, launched in 2012, *"ACEs Connection is a social network that accelerates the global movement toward recognizing the impact of adverse childhood experiences in shaping adult behavior and health, and reforming all communities and institutions -- from schools to prisons to hospitals and churches -- to help heal and develop resilience rather than to continue to traumatize already traumatized people*…[the network] *comprising ACEs Too High and ACEs Connection, receives generous support from the Robert Wood Johnson Foundation and The California Endowment."*
http://www.acesconnection.com/

- **ACE Response**

Per the website, "*We seek to raise awareness of ACEs and mobilize comprehensive responses to ACEs across the lifespan in order to prevent ACEs and their consequences. ACE Response grew out of a partnership between Prevent Child Abuse America and the University at Albany (SUNY) School of Social Welfare. Consistent with the mission of the ACE Think Tank and Action Team New York, this website seeks to raise awareness of adverse childhood experiences (ACEs) and mobilize comprehensive responses to them across the lifespan in order to prevent ACEs and their consequences."*
http://www.aceresponse.org/

- **ACEs Too High**

Per the website, launched in 2012, "*ACESTooHigh is a news site that reports on research about adverse childhood experiences, including developments in epidemiology, neurobiology, and the biomedical and epigenetic consequences of toxic stress. We also cover how people, organizations, agencies and communities are implementing practices based on the research. This includes developments in education, juvenile justice, criminal justice, public health, medicine, mental health, social services, and cities, counties and states."*
https://acestoohigh.com/

- **Community Science**

Per the website: *"Community Science is an award winning research and development organization that works with governments, foundations, and non-profit organizations on solutions to social problems through community and other systems changes. Using state-of-the-art qualitative and quantitative methods, Community Science's goal is to strengthen the science and practice of community change in order to build healthy, just and equitable communities."* This organization helped develop, design, implement and evaluate the ACEs and Resilience Collective Community Capacity Survey (ARC3 Survey).
http://www.communityscience.com/news-detail.php?news=207

- **Mobilizing Action for Resilience Communities (MARC)**

Per the website, "*The Mobilizing Action for Resilient Communities (MARC) program brings together 14 sites actively engaged in building the movement for a just, healthy and resilient world. A mix of cities, counties, regions, and states, these communities are all building a culture of health by translating the science of Adverse Childhood Experiences (ACEs) into practices and policies that foster resilience. … MARC is coordinated by The Health Federation of Philadelphia with support from the Robert Wood Johnson Foundation and The California Endowment."*
http://marc.healthfederation.org/shared-learnings/from-problems-to-issues-making-trauma-informed-policy-change

- **Resilience Trumps ACEs**

Per the website, Resilience Trumps ACEs helps mobilize "*the community through dialogue to radically reduce the number of adverse childhood experiences while building resilience and a more effective service delivery system."* This website is maintained by the Children's Resilience Initiative. It has an online store with tools for children and families to talk about resilience, and a toolkit for practitioners to "reduce ACEs and foster Resilience in your community.
https://www.resiliencetrumpsaces.org/

- **The Washington State ACEs Private-Public Initiative (APPI)**

Per the website, *"The ACEs Public-Private Initiative (APPI) is a group of private, public and community organizations in Washington State working together to reduce children's exposure to trauma—or "adverse childhood experiences" (ACEs)—and the substantial social, emotional and physical tolls that may result."*
http://www.appi-wa.org/

Documentaries

- **Paper Tigers** - http://kpjrfilms.co/paper-tigers/about-the-film/

Per the website, *"More than two decades ago, two respected researchers, clinical physician Dr. Vincent Felitti and CDC epidemiologist Robert Anda, published the game-changing Adverse Childhood Experiences Study. It revealed a troubling but irrefutable phenomenon: the more traumatic experiences the respondents had as children (such as physical and emotional abuse and neglect), the more likely they were to develop health problems later in life — problems such as cancer, heart disease, and high blood pressure. To complicate matters, there was also a troubling correlation between adverse childhood experiences and prevalence of drug and alcohol abuse, unprotected sex, and poor diet. Combined, the results of the study painted a staggering portrait of the price our children are paying for growing up in unsafe environments, all the while adding fuel to the fire of some of society's greatest challenges. However, this very same study contains the seed of hope: all of the above-mentioned risk factors — behavioral as well as physiological — can be offset*

by the presence of one dependable and caring adult. It doesn't need to be the mother or the father. It doesn't even need to be a close or distant relative. More often than not, that stable, caring adult is a teacher.

It is here, at the crossroads of at-risk teens and trauma-informed care, that Paper Tigers takes root. Set within and around the campus of Lincoln Alternative High School in the rural community of Walla Walla, Washington, Paper Tigers asks the following questions: What does it mean to be a trauma-informed school? And how do you educate teens whose childhood experiences have left them with a brain and body ill-suited to learn?

In search of clear and honest answers, Paper Tigers hinges on a remarkable collaboration between subject and filmmaker. Armed with their own cameras and their own voices, the teens of Paper Tigers offer raw but valuable insight into the hearts and minds of teens pushing back against the specter of a hard childhood.

Against the harsh reality of truancy, poor grades, emotional pain, and physical violence, answers begin to emerge. The answers do not come easily. Nor can one simply deduce a one-size-fits-all solution to a trauma-informed education. But there is no denying something both subtle and powerful at work between teacher and student alike: the quiet persistence of love."

***Viewings of the film are held around the country and are posted on the website**
*****This film can also be streamed on Amazon Video (currently listed at $3.99 for the rental) or purchased online***

- **Resilience** - http://kpjrfilms.co/resilience/about-the-film/

Per the website, "*Researchers have recently discovered a dangerous biological syndrome caused by abuse and neglect during childhood. As the new documentary* Resilience *reveals, toxic stress can trigger hormones that wreak havoc on the brains and bodies of children, putting them at a greater risk for disease, homelessness, prison time, and early death. While the broader impacts of poverty worsen the risk, no segment of society is immune. Resilience, however, also chronicles the dawn of a movement that is determined to fight back. Trailblazers in pediatrics, education, and social welfare are using cutting-edge science and field-tested therapies to protect children from the insidious effects of toxic stress—and the dark legacy of a childhood that no child would choose."*

****Viewings of the film are held around the country and are posted on the website***

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