



1-11-12
Report to the Legislature

Adverse Childhood Experience Initiative

Chapter 70.305 Laws of 2011 Sec. 3
E2SHB 1965

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INTRODUCTION

Statutory Requirement for this Report - Summary

Chapter 70.305, Laws of 2011 Sec. 3 (E2SHB 1965) requires the “Secretary of the Department of Social and Health Services and the Director of the Department of Early Learning”... to “convene a planning group to work with interested private partners to:

- (1) Develop a process by which the goals identified in section 1 of this act shall be met:
 - a) “Identify and promote the use of innovative strategies based on evidence-based and research-based approaches and practices; and,
 - b) Align public and private policies and funding with approaches and strategies which have demonstrated effectiveness.”
- (2) Develop recommendations for inclusive and diverse governance to advance the adverse childhood experience initiative.”

“The Planning Group shall submit a report on its progress and recommendations to the appropriate legislative committees no later than December 15, 2011.”¹

About Adverse Childhood Experience

Adverse Childhood Experience² is a most powerful determinant of the public’s mental, physical, and behavioral health and workforce productivity. E2SHB 1965, laws of 2011, established an ACE Initiative. Because this initiative is focused on ACE prevention and mitigation, the magnitude of the solution it offers is truly transformative. Washington holds a unique confluence of powerful data, a track record of success, and partners from many sectors with commitment to this common purpose: preventing ACEs and mitigating their effects³. E2SHB 1965 called for an Advisory Planning Committee⁴ to make recommendations for a process for achieving the goals of the act and for inclusive and diverse governance and shared responsibility across sectors to advance the Initiative.

Adverse Childhood Experience (ACE) is defined in E2SHB 1965: “Adverse childhood experiences” means the following indicators of severe childhood stressors and family dysfunction that, when experienced in the first eighteen years of life and taken together, are proven by public health research to be powerful determinants of physical, mental, social, and behavioral health across the lifespan: child physical abuse; child sexual abuse; child emotional abuse; child emotional or physical neglect; alcohol or other substance abuse in the home; mental illness, depression, or suicidal behaviors in the home; incarceration of a family member; witnessing intimate partner violence; and parental divorce or separation. Adverse childhood experiences have been demonstrated to affect the development of the brain and other major body systems.

Recommendations

The Planning Committee process for developing recommendations included meetings, interviews of committee members, and small group conference calls that were open to committee members and interested parties. Given the short timeline for the work of the committee and difficulty scheduling meetings, the recommendations in this report are a composite of agreements expressed in meetings plus individual and small group conversations and best thinking of the co-chairs of the committee.

¹ The full text of the act is included as attachment 1

² For more information, see attachment 5: What are Adverse Childhood Experiences?

³ For more information, see attachment 6: Health and Social Problems Attributable to ACEs

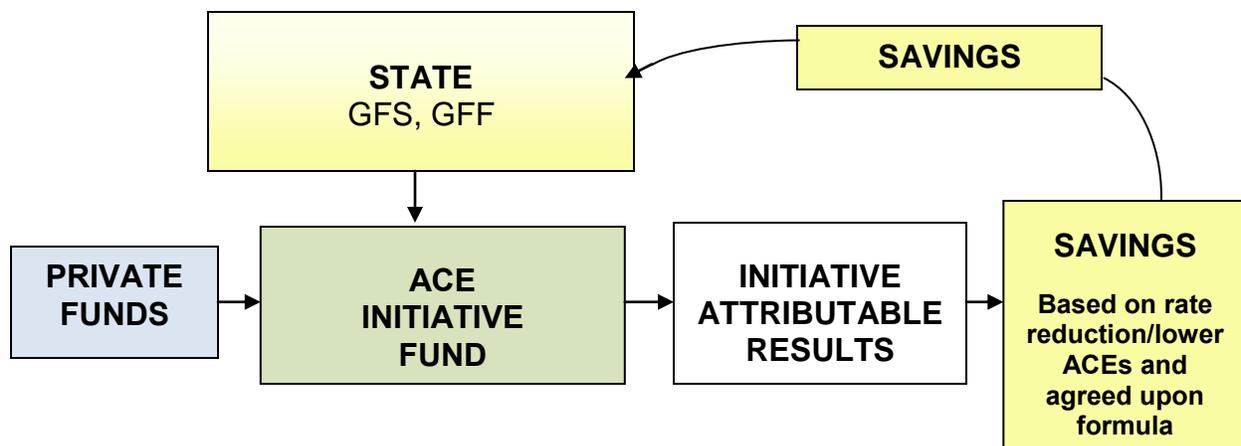
⁴ For more information, see attachment 2: Committee Membership

COMMITTEE REPORT

Regarding the Process by Which the Goals of This Act Shall Be Met

Recommendations:

1. **Encourage state agencies to adopt an ACE orientation across state government and through the states purchasing power.** Encourage state agencies that provide services or funding for communities, families, and children to adopt prevention of ACEs and mitigation of their effects as an orientation in their work, and encourage agencies to bring that orientation to scale. This orientation is not in conflict with the agencies adopting an early childhood orientation in their work; these two orientations are complementary and mutually reinforcing.
2. **Encourage state agencies to recognize and promote a community-driven approach to implementing the ACE orientation.** Incentivize collective impact collaboration at the local level using grant award criteria, access to education and data, and other mechanisms that align state resources with locally tailored systems and help to build each community's own capacity to prevent ACEs and mitigate their effects.
3. **Explore a financing mechanism that uses the financial benefits of prevented ACEs to sustain and scale effective approaches to improving child and family outcomes.**
 - a) Provide a mechanism for the state to participate in development of a formula for reliable prediction of state avoided costs due to prevention of ACEs and their effects. The formula should break out the costs avoided to state, federal, and private sector separately, and provide detail about anticipated timeline for cost avoidance, decade by decade, as a cohort ages.
 - b) Consider how such a formula might be used in state budgeting. For example: As each cohort of children arrives at their 18th birthdays, they carry with them the accumulation of ACE categories (ACEs) they will have for their entire lives. Carrying fewer ACEs means experiencing fewer mental, physical, behavioral and workforce problems, and less need for costly government services. A formula for reliable prediction of the dollar value of each unit reduction in median ACE scores among children aging into adulthood will enable the state to use ACE information collected in the Behavioral Risk Factor Surveillance System in 2009, 2010 and 2011 as a baseline for system performance valuation. With this information, the state could forecast avoided costs, and use the forecast in budget decision making.



- c) Seek private funding for participatory comprehensive community change evaluation. This evaluation would help public and private funders know which results are attributable to the Initiative, and which are attributable to other factors. This type of evaluation documents the strategies, system and service changes and processes occurring in communities that are associated with reductions in ACE prevalence. Community leaders are engaged throughout the evaluation process, and therefore can use evaluation findings to continuously improve local strategy and programming. It will be important that the evaluation identify specific impacts and significant contributors to preventing ACEs and mitigating their effects. Although this type of evaluation is expensive, it is extremely useful for identifying and promoting the use of innovative strategies based on evidence-based and research-based approaches and practices. It also can provide clear information to inform decisions about resource and strategy alignment.
4. **Participate with interested private sector leaders in developing an organizational structure and governance, or set of operational agreements, that fully and reliably support the sectors to execute functions that help participating entities achieve greater results together than they could acting individually.**

Functions that add value to all parties should be defined by the parties. These may include: managing projects, gathering and analyzing data, developing a shared measurement system, exchanging lessons learned, learning about emerging research findings, supporting community-level coalitions, facilitating dialogue that supports learning and resource alignment to prevent ACEs and mitigate their effects.

Regarding Inclusive and Diverse Shared Responsibility and Governance to Advance the Initiative

Recommendations:

5. **Structure governance as a Collective Impact Initiative⁵ – a long term commitment on the part of important actors from multiple sectors to a common agenda for preventing ACEs and mitigating their effects.**
 - a) To realize the state’s goal of inclusive and diverse governance, form should follow function. The most important part of the Initiative is supporting interested parties to align their work across sector lines to achieve more together than we could by acting alone. The form of governance for the Initiative should derive from the parties actually working together, executing functions that add value to the organizations and their customers at this time.
 - b) Providing leadership support to the interested parties is an important staff function. That staffing is a vital part of successful partnership. Therefore, it is recommended that the state commit to providing a portion of the staffing needs of the Initiative using existing allocated staff resources. A shared staffing model makes sense, at least through the formative years when the partnership is establishing the timing, content, functions, operating principles, agreements, and the seasonal rhythm of work that will add value to the parties, given their unique organizational rules and cultures.
 - c) The work of the initiative during the formative phase should build on the extraordinary success that Washington has had. Over the last 15 years, Washington has invested in multiple strategies such as evidence based practice, system changes to prevent and catch problems when they first occur, and community capacity development. We have outpaced the nation in lowering crime, delinquency, and other costly problems. Washington is ready for a next transformation; one that

⁵ For more information, see attachment 4: Collective Impact Highlights

provides open invitation for people from all walks of life to help to build pathways to opportunity by protecting children from toxic stress during development and supporting recovery and resilience throughout the lifespan.

- d) Collective impact initiatives are long term commitments to a common agenda. While there has been some good progress developing the private-public partnership focused on preventing ACEs and mitigating their effects, more conversation is needed among and between private funders, state leaders, community leaders and important actors from other sectors in order to work out the details of how this partnership can and should work in the long term.

Collective Impact Initiatives provide effective governance when:

1. There is a tough problem that no one entity can solve on its own,
2. Leadership from several sectors are committed to solving the problem,
3. There is sufficient data to create a common measurement system for assessing progress,
4. Many organizations make long term commitments to work in a way that supports and is coordinated with the work of others,
5. Those long-term commitments are ratified through a constitution or other instrument that states the working agreements among the parties engaged with the Initiative,
6. Each organization is free to chart its own course, yet be held accountable to common purpose.

What makes Collective Impact Initiatives work?

1. Common understanding of the problem,
2. A joint approach to solving it,
3. A shared measurement system that enables participants to hold one another accountable,
4. Willingness to change what's done based on the facts about what's working,
5. An independent backbone organization with dedicated staff for project management, data management and facilitation.

6. **Preserve high levels of interest.**

Several parallel and interrelated processes occurred during the period of time in which the committee was developing this report. These processes indicate the high level of interest and commitment necessary for a Collective Impact Initiative on the part of leaders in multiple sectors. These processes included:

- a) Identification of a group of private funders interested in making a multi-year commitment to community capacity development focused on ACE prevention and mitigation. The group of private funders is currently involved in a number of related activities and investments in Washington. These funders come together to inform one another of these activities and find ways for deeper collaboration in mutually reinforcing ways. Many of the activities occur in partnership with the state. The collective impact from both state and private funders bringing ACE science into their investments and partnerships is greater than the impact that any single funder could produce on their own. During 2011, funders attended educational events, participated in dialogue, and considered a business plan that served as a starting point for their discussions about how they might work collaboratively to achieve purposes they hold in common with the state: preventing Adverse Childhood Experiences and mitigating their effects.
- b) Increased education about ACEs within established systems of community-based coalitions has increased citizen and professional awareness, commitment and interest in taking collective action to prevent ACEs. State agencies built these coalitions as a part of their work with communities. These systems include, but are not limited to Community Public Health and Safety Networks, Community Mobilization against Substance Abuse and Violence, and Early Learning Coalitions. It is through measurement of the effects of increased community capacity on social/health/justice outcomes using the Family Policy Council Community Capacity Development model that

Washington has evidence of the power of communities to make significant improvements in ACE prevalence.

- c) Key informant interviews conducted and analysis delivered to the Family Policy Council. The interviews document interest and specific recommendations for action from the faith, early learning, public health, K-12 education, and justice sectors. Information gathered from these sector leaders serves to identify (1) prospective champions within each sector; and, (2) specific products and services that would support each sector making a substantive contribution to the common purpose.

7. Preserve vital strengths.

- a) E2SHB 1965 is the first state policy in the nation that recognizes the importance of Adverse Childhood Experience and calls for action. ACEs drive high cost illness, social problems, and government programs. With this law, the Legislature and the Governor make a powerful invitation for uncommon partners to develop together a way of working with one another that will make a big difference for this and future generations. The state's continued leadership is vital to the success of this Initiative.
- b) Community-driven decision making in Washington is a well-established means for improving child, family, and community results. Coalitions focused on issues related to child and family wellbeing are already working in concert with one another reviewing community data, generating common metrics for evaluating collective efforts, prioritizing and aligning available cash and in-kind resources, and managing projects that are "owned" by many organizations working toward common purpose. The investment that the state has made in developing community capacity to solve tough problems is substantial. The system of mature coalitions, their ways of working together, and the community capacity they have already built, should be formally recognized as assets that are a part of the state's contribution to the Initiative. Additionally, state agencies should be encouraged to use the existing infrastructure of coalitions as a part of their ACE prevention and mitigation orientation.
- c) Private and federal dollars were used for gathering the data necessary to deliver detailed community-specific information about the prevalence, interrelatedness and effects of the most powerful determinant of the public's health: Adverse Childhood Experience. Analysis of these data can inform strategic investment decisions. These data provide a foundation for shared measurement across multiple sectors. Because they are data about the population as a whole, they tell an important story about the places where, despite effective programs that produce great results in times of crisis or need; our collective efforts are failing to prevent ACE accumulation.

8. Invite Others to Step Forward.

An important part of the state's role in the Initiative is anticipating important questions that will need to be answered during each initial phase of the Initiative. By anticipating the critical questions that will need to be addressed in each phase, the state can promote the initiative by inviting others to step forward.

Examples of key questions for the first three phases of the initiative are included below.

PHASE ONE (January, 2012 - December 2012): *Vision, Process and Commitments for Working Together.*

1. What's possible, if more sectors were fully partnered in this work? What shared vision and way of working will galvanize leaders throughout the state?
2. What are the mechanisms for inviting new investors, sectors, communities to contribute to preventing ACEs and mitigating their effects?

3. How will the shared values of communities, funders, the state, and various sectors be realized?
4. How do decision-making processes support continuous expansion of leadership and alignment of efforts for collective impact at the local and state levels?
5. What are the mechanisms for surfacing values conflicts that could prevent success?
6. What instruments will be used, and who will develop them, to ratify agreements in this formative stage, and to set the stage for future growth of the collaboration and its success?
7. How will avoided state costs due to ACE prevention and mitigation be reliably predicted? Who, what, when, how will measurement occur?
8. How will comprehensive community change evaluation occur? What are the standards for such evaluation? Who will do/contribute to the evaluation?
9. If a durable financing agreement is developed, how will that financing work?

PHASE TWO (January, 2013 - December 2016): *Agreements and Strategic Practices to Support Continuous Improvement and Optimize Outcomes*

1. What menu of strategies will the parties to the initiative employ in these early years? What resource assessment will be done to avoid duplication of effort and support efficient use of resources? How will Initiative participants determine that their strategies are mutually reinforcing?
2. How will changes in strategy/decisions be negotiated if they relate to the management of the fund or they have implications for the how others will need to work in order to generate mutually reinforcing activities?
3. What patterns can we see in the data we have that provide insights into how society is collectively and unintentionally generating the ACE prevalence we currently have?
4. What inter- and intra-sector activities support a robust learning environment with conditions necessary for wide spread effective application of ACE related science into practice, rigorously tests effectiveness, and rapidly disseminates success?
5. What educational products, practices, and promotional efforts support sector interest in embedding ACE science into improvements in the way their sector works? What potential partners have an interest in, and resources for, developing these products?
6. Do we need to be a different kind of partner in places that have many problems occurring at very high rates, and population with very high ACE prevalence, than we are in places with few problems occurring at high rates and low ACE prevalence?
7. How and where will the FPC model for building each community's own capacity for preventing ACEs and mitigating their effects be deployed, and by whom, in order to get the greatest possible savings, and thereby fuel sustainable financing for future work?
8. What's possible, if more sectors were fully partnered in this work?
9. What is the best future business model/governance structure for fund management and leadership expansion?

PHASE THREE (January, 2017 - December 2021): *Managing Expansion; Optimizing Savings*

1. How will decisions be made about the menu of strategies the Initiative employs as it matures and picks up additional partners?
2. Given what we learn about documented changes in community that lead to cost savings, what changes do we need to make in the way we work or the work we do in order to build more success?
3. What changes to state or federal policy or practice are suggested by the data?
4. Do we need to be a different kind of partner in places that have many problems occurring at very high rates, and population with very high ACE prevalence, than we are in places with few problems occurring at high rates and low ACE prevalence?
5. Which investments/practices/approaches are high leverage, in terms of generating more effective communities and producing avoided costs associated with preventing ACEs and mitigating their effects?
6. How do we optimize re-investment of avoided costs?

Attachments

Attachments include:

1. *Full text of Chapter 70.305 Laws of 2011 "Sec. 3*
2. *Committee Membership*
3. *Networks and Coalitions Referenced in the Act*
4. *Collective Impact⁶ Highlights*
5. What are Adverse Child Experiences (ACEs)?
6. Health and Social Problems Attributable to ACEs

Full text of Chapter 70.305 Laws of 2011 Sec. 3

- (1) (a) The secretary of the department of social and health services and the director of the department of early learning shall actively participate in the development of a nongovernmental private-public initiative focused on coordinating government and philanthropic organizations' investments in the positive development of children and preventing and mitigating the effects of adverse childhood experiences. The secretary and director shall convene a planning group to work with interested private partners to: (i) Develop a process by which the goals identified in section 1 of this act shall be met; and (ii) develop recommendations for inclusive and diverse governance to advance the adverse childhood experiences initiative.

(b) The secretary and director shall select no more than twelve to fifteen persons as members of the planning group. The members selected must represent a diversity of interests including: Early learning coalitions, community public health and safety network, organizations that work to prevent and address child abuse and neglect, tribes, representatives of public agencies involved with interventions in or prevention of adverse childhood experiences, philanthropic organizations, and organizations focused on community mobilization.

(c) The secretary and director shall cochair the planning group meetings and shall convene the first meeting.
- (2) The planning group shall submit a report on its progress and recommendations to the appropriate legislative committees no later than December 15, 2011.
- (3) In addition to other powers granted to the secretary, the secretary may:
 - (a) Enter into contracts on behalf of the department to carry out the purposes of this chapter;
 - (b) Provide funding to communities or any governance entity that is created as a result of the partnership; and
 - (c) Accept gifts, grants, or other funds for the purposes of this chapter."

⁶ "Collective Impact", by John Kania and Mark Kramer, *Stanford Social Innovation Review*, Winter 2011

Committee Membership

Note: additional individuals requested involvement, received e-mail notification of meetings, products, and invitation to attend meetings.

Susan Dreyfus	Co-Chair & Secretary, Department of Social and Health Services
Bette Hyde	Co-Chair & Director, Department of Early Learning
Kelly Bohannon	Department of Early Learning
Jody Becker-Green	Department of Social and Health Services
Cynthia Juarez	Early Learning Coalitions
Jim Cooper	Community Mobilization
Christin Jameson	Council for Children & Families
Kelly Baze	Port Gamble S'Klallam Tribe
Margie Reeves	Community Public Health and Safety Networks
Allene Mares	Department of Health
Greg Williamson	Office of the Superintendent of Public Instruction
Carol Lewis	Philanthropy NW

Networks and Coalitions Referenced in the Act

Section 1, lines 6-17: “The legislature recognizes that many community public health and safety networks across the state have knowledge and expertise regarding the reduction of adverse childhood experiences and can provide leadership on this initiative in their communities. In addition, a broad range of community coalitions involved with early learning, child abuse prevention, and community mobilization have coalesced in many communities. The adverse childhood experiences initiative should coordinate and assemble the strongest components of these networks and coalitions to effectively respond to the challenge of reducing and preventing adverse childhood experiences while providing flexibility for communities to design responses that are appropriate for their community.”

COMMUNITY MOBILIZATION AGAINST SUBSTANCE ABUSE AND VIOLENCE (COMMUNITY MOBILIZATION)

Developed in 1989 by Washington State (RCW 43.270), Community Mobilization is a state program administered by the Department of Commerce that provides grant funds to communities for carrying out countywide coordinated strategies for reducing substance abuse and violence. The grant is based on population and includes accountability for outcomes related to reducing tobacco use, youth underage drinking, prescription and other drug abuse, bullying, and domestic and other violence. Every county in Washington has a contractor to do community organizing and provide funding for locally tailored programs and strategies. Active Community Mobilization Policy Boards consisting of representatives from education, local government, law enforcement, prevention, treatment and parents are required and are responsible for local decision making in regards to this funding.

Community Mobilization uses a model for positive youth development called “Communities that Care.” This model was developed by researchers at the University of Washington, and is an evidence-based practice. In addition to Communities that Care, contractors have experience implementing evidence-based programs with fidelity including: Strengthening Families; Parenting Wisely; Project Alert; Parents as Teachers. While all contractors work to reduce substance abuse, half of the contractors report working to prevent one or more categories of Adverse Childhood Experience, as defined in E2SHB 1965. Local

partners include: multi-sector leaders, local government, residents with interest in preventing substance abuse and violence.

Department of Commerce program administration staff participate in a number of state-level planning and coordinating groups, and deliver a training curriculum called: The Art and Science of Community Organizing.

COMMUNITY PUBLIC HEALTH AND SAFETY NETWORKS

In 1994, Community Public Health and Safety Networks (Networks) were formed by the state as quasi-governmental entities to be the local affiliates of the Family Policy Council, and to engage communities in reducing the rates of seven major social problems. The Network system's primary purpose is building community capacity to reduce childhood trauma and its effects. Networks observe what works in their communities by tracking common outcome and progress indicators. This learning is reported to the Family Policy Council and fed back into the system and to the research field for verification and replication to effect change on a broader scale.

A fundamental principle of the Networks is to ensure that all voices that make up the community are engaged in decision making in a manner that effectively fosters expansion of community capacity for solving tough problems. Networks have collaborative boards that bring together residents and professionals to align resources and work toward a common purpose. Networks coordinate with community coalitions involved with early learning, child abuse prevention, and community mobilization to assure their common planning, assessments, and strategies leverage the greatest impact.

The Network system is structured with flexibility to allow for shifts in resources and to form partnerships with other local initiatives as opportunities develop. Networks learn and share emerging knowledge and practices with other partners around the State through their statewide system.

The Family Policy Council and Community Networks started working directly with the co-principle investigators of the Adverse Childhood Experiences (ACE) study in 2002. Since then Networks have trained thousands of professionals, parents and other residents throughout the state about ACE-related issues and solutions, and supported practice and policy improvements informed by the ACE science.

ACE research reinforces what Networks have been learning since their inception in 1994, that- most social problems are interconnected and symptomatic of deeper root causes. Networks have a unique ability to understand the dynamics of a "cumulative stressors" model and the interconnectedness of trauma. Across the State, though delivering a variety of programs and engaging in different specific intervention and reform strategies, Networks are documenting the rate reduction of ACEs.

COUNCIL FOR CHILDREN AND FAMILIES

Formed by the state in 1982, the Council for Children & Families (CCF) was originally named the Washington Council for Prevention of Child Abuse and Neglect. CCF is a state agency with a Governor-appointed Executive Director who serves a board of state officials and non-governmental/citizen members. The agency holds a federal grant, the Community-Based Child Abuse Prevention (CBCAP), which focuses on community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs, and activities to prevent child abuse and neglect. In addition to this work, the agency provides competitive grants to community-based organizations and offers technical assistance and support to enhance organizations' capacity to produce and evaluate results for both innovative and evidence-based prevention models. Program investment reflects a focus on primary and secondary prevention of child abuse and neglect with an emphasis on serving the needs of parents with infants and toddlers (0-3), pregnant and parenting teens, and through universal and targeted public awareness campaigns.

CCF focuses on building five Protective Factors developed to reduce risk and create optimal outcomes for children, youth and families. These Protective Factors are associated in research literature with lower rates of child abuse and neglect. They are: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. The protective factor approach serves as a platform for coordination across diverse initiatives and fosters the development of common language and goals for families within the context of CCF's child maltreatment prevention work.

The Council for Children and Families is scheduled to sunset June 30, 2011, with certain responsibilities moving to the Department of Early Learning (E2SHB 1965, laws of 2011). CCF and DEL share goals and an adaptive approach to working with communities.

EARLY LEARNING REGIONAL COALITIONS SUPPORTED BY DEPARTMENT OF EARLY LEARNING AND THRIVE BY FIVE WA

Washington has an unparalleled opportunity to create a coordinated, statewide, systems-based approach to early learning in Washington. In 2010, Thrive, the Department of Early Learning (DEL), and the Office of Superintendent of Public Instruction (OSPI) – Early Learning Partnership members – released the *Early Learning Plan (ELP)*, a roadmap for building an early learning system that identifies 36 clear, coordinated strategies to ensure every child starts life with a foundation for success.

The Early Learning Regional Coalitions are vital to the implementation and ultimate success of the Early Learning Plan. Over time, the regional coalitions will play an increasingly larger role in the state early learning efforts. Because they reach families, organizations and potential supports in ways that the larger state organizations and potential supporters in ways that the larger state organizations and agencies can't do on their own, they will help ensure that we serve and reach all families across the state. DEL and Thrive are committed to helping local organizations and communities connect their efforts with the Early Learning Plan, strengthen partnerships, build local capacity and expertise, and reach more children and families with high quality programs and services.

For the past several years, both DEL and Thrive have been funding and supporting the 10 Early Learning Regions (DEL through its Infant-Toddler Interdisciplinary Childcare Consultation initiative and Thrive through its Community Momentum grant strategy). Although early learning collaborations have been happening across the state for many years, the creation of the Early Learning Plan, specifically strategy #34 in the ELP, has brought new intentionality and focus on building an early learning system that is strongly rooted and connected with the work happening at the regional level. The Early Learning Regional Coalitions play an important role in coordinating and connecting resources and programs in their communities, getting information out to families about the importance of early learning, promoting and implementing key strategies of the Early Learning Plan (literacy, WaKIDS, home visiting, family engagement, preK-3 alignment, etc.), and creating key advocates who help generate local and state support for early learning.

Collective Impact⁷ Highlights

Introduction

Large scale social change requires broad cross-sector coordination, yet the social sector remains focused on the isolated intervention of individual organizations. **Collective impact** is the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem. On the other hand, funding of traditional models of collaboration have yielded **isolated impacts** from funding solutions embodied within single organizations. Currently 1.4 million nonprofits compete to invent independent solutions to major problems. Strive, a nonprofit subsidiary of Knowledge Works in Cincinnati is cited as a shining example as it demonstrated improved student success in dozens of key areas across three large public school district despite the recession and budget cuts..

5 Conditions of Collective Success

1. **Common agenda:** a shared vision for change, a common understanding of the problem, and a joint approach to solving it through agreed upon actions.
2. **Shared measurement system:** agreement on the ways success will be measured and reported and a short list on indicators that enables participants to hold each other accountable.
3. **Continuous communication:** regular meetings and in-between communication tools that build experience so participants recognize and appreciate common motivation behind their shared efforts and that also build a common language.
4. **Mutually reinforcing activities:** encourage each participant to undertake specific set of activities in a way that supports and is coordinated with the actions of others. Each organization is free to chart its own course consistent with the common goals and informed by the shared measurement of results.
5. **Independent backbone support organization**, including dedicated staff to fulfill three roles (project management, data management and facilitation)

Adaptive Leadership

The success of collective impact initiatives rests on 4 leadership qualities:

1. Ability to **focus attention** and create a sense of urgency
2. Skill to **apply pressure** without overwhelming stakeholders
3. Competence to **frame issues** in ways that expose both opportunities and difficulties
4. Strength to **mediate conflict**

New Roles for Funders⁸

- Shift from funding organizations to leading a long-term process of social change
- Help create and sustain the collective processes, measurement reporting systems and community leadership that enable cross-sector coalitions to arise and thrive

⁷ “Collective Impact”, by John Kania and Mark Kramer, *Stanford Social Innovation Review*, Winter 2011

⁸ See also “Catalytic Philanthropy” and “Leading Boldly” in the *Stanford Social Innovation Review*, Fall 2009

What are Adverse Child Experiences (ACEs)?

ACEs are stressful or traumatic experiences that include the following categories (with prevalence):

- Physical abuse (28%)
- Sexual abuse (21%)
- Emotional abuse (11%)
- Neglect: Emotional (15%), Physical (10%)
- Mental ill, depressed or suicidal person in the home (17%)
- Alcoholic or drug addicted care giver (27%)
- Witnessing domestic violence against the mother or step-mother (13%)
- Incarceration of any family member (6%)
- Loss of a parent to death, abandonment, or divorce (23%)

ACE Score

Calculate individual ACE Score by adding the number of different categories of ACEs, not the intensity or frequency of a single category. The higher the ACE Score, the greater the incidence of co-occurring conditions from this list.

ACEs are common. ACEs tend to occur in clusters. More ACE categories result in more health and social problems in the population. And the resulting effects of ACEs will vary from person to person.

Why are ACEs important?

Adverse Childhood Experiences (ACE) are the most powerful determinant of public health and social functioning.⁹

ACEs Affect Childhood Brain Development

The toxic stress children may experience during sensitive periods of brain development lead to emotional, social and cognitive impairments. Those impairments lead to behaviors that in turn cause expensive health and social problems.

ACEs in Washington State

Washington State is the first in the nation to have detailed information about ACE prevalence and its relationship to mental, physical, behavioral health, and other factors that affect worker performance, parenting and intergenerational transmission of trauma. The importance of ACEs in Washington is documented in the following report, *Adverse Childhood Experience & Population Health in Washington: The Face of a Chronic Public Health Disaster*, located on the Family Policy Council website: <http://www.fpc.wa.gov/publications/ACEs%20in%20Washington.2009%20BRFSS.Final%20Report%20%207%202010.pdf>

Reducing ACE Prevalence in Washington

Categorical approaches to the common and diverse health and social problems caused by ACEs are not effective. The current “siloed” approaches scattered in existing human service, health, education, etc. systems are understandable from a historical perspective, but to succeed in the future a coordinated effort that links existing human service systems and improves community capacity to reduce ACEs is needed. Community and service improvements must include information about ACEs and their effect on human development that creates a common framework for change. This will contribute to: community norms that effectively build the foundations of healthy development, more meaningful diagnoses, earlier and improved treatment of exposed children and their families, and better integration of health care, prevention, social services, public school systems, and legal venues.

⁹ The original ACE study, a collaboration between the Centers for Disease Control (CDC) and Kaiser Permanente HMO, was initiated in 1994 with over 17,000 enrolled insurance recipients in San Diego, CA. Attention to the childhood origins of a myriad of health and social problems across the lifespan illuminates the enormous impact on population health and resulting cost.

Health and Social Problems Attributable to ACEs

Diseases	Ischemic heart disease, cancer, chronic lung disease, skeletal fractures, sexually transmitted diseases, liver disease, chronic obstructive pulmonary, autoimmune, lung cancer
Risk factors	Smoking, alcohol abuse, promiscuity, obesity, illicit drug use, injection drug use, multiple somatic symptoms, poor self-rated health, high perceived risk of AIDs
Mental Health	Depression, anxiety, hallucination, panic reactions, sleep disturbances, memory disturbances, poor anger control
Sexual and reproduction health	Early age at first intercourse, sexual dissatisfaction, teen pregnancy, unintended pregnancy, teen paternity, fetal death
Health care cost	Prescribed multiple classes of drugs, psychotropics, bronchodilators
Problems in workforce	Absenteeism, low productivity, high perceived stress, impaired job performance, poor family relationships, body pain, addiction, poor health
Family instability	Relationship problems, marriage to an alcoholic, household drug use, risk of perpetuating or being a victim of domestic violence, premature mortality in family members
Poor academic achievement	Learning disability, attention problems, poor social skills, repeated suspensions and expulsions, drop out, low grade point average, criminal behavior
Criminal justice	Victimizations, victim of family violence or rape, perpetrations of criminal acts leading to incarceration